Pfeiffer, Nadine

From: Thomson, David <THOMSONDA@ECU.EDU>
Sent: Tuesday, June 20, 2017 5:46 PM
To: Rulescoordinator, Dhsr
Subject: 10A NCAC 13P 0410

Dear Sir or Madam:

I am writing regarding 10A NCAC 13P.0410, "Components of Medical Oversight for Air Medical Programs."

Overall, I applaud the move to codify the medical oversight of air medical programs that are operating in North Carolina. However, I have some general reservations about the proposed regulation, as well as some comments on specific sections.

The general comment is that much of this regulation should be covered under subsections .0401, .0402, and .0404. The requirements for medical oversight, quality improvement, staffing, and RAC participation should be the same, whether the vehicle is a ground ambulance or an air ambulance. These are medical issues that are independent of the type of vehicle.
Several of the requirements vary depending on the location of the organization or the receiving hospital. This is not a patient centered approach. The requirements should be based on the location from which the vehicle typically responds, not the hospital where the patients are received, because the RAC should serve to assure the quality of care for North Carolinians who reside within that RAC. If a base, whether it is an air or a ground base, is not serving the needs of the community in which it is based, that information should be developed and utilized in that community, not kept in a trauma center many miles away.

Comments on several sections:
(d) (8): "continued membership and active participation in each Trauma RAC containing the majority of hospitals where the program transports patients for admission;"
This section is problematic in that a program could have several bases, each located in a different RAC and each of those bases could potentially transport patients to a hospital located in yet another RAC. This has the potential that a program could choose the RAC in which they participate. That RAC might not be the best to review the patient care activities that could, potentially, happen in another part of the state.
I suggest that air medical programs be expected to participate in the RAC in which their base is located. If they have bases in several RACs, then they would be expected to participate in all of those RACs. This assures that these programs have proper oversight, and it also assures that these programs have the ability to comment on local issues that might be unique to that region.

The other part of section (d) on which I would like to comment is:
(d) (12): "a method providing for the organized and coordinated dispatch of resources between air medical programs to enhance scene safety, ensure only the number or air medical resources needed respond to the incident location are provide, and arrange for the receiving hospital to prepare of the incoming patient."
Any regulation that has as its goal the coordination of <u>dispatch</u> is likely to run afoul of the FAA. In aviation the word "dispatch" has a very specific meaning, and only licensed dispatchers and pilots may dispatch an aircraft.
Although states are charged with patient safety, aviation safety is a Federal responsibility, and a regulation that coordinates aviation services with the purpose of enhancing scene (aviation) safety is likely preempted by the Airline Deregulation Act.
If a coordination center is developed, it would have to be run by the NCOEMS. Finding funding to create and operate such a facility is likely to be difficult.

This proposal begs the question: have there been instances of problems of too many aircraft responding to a scene, or of any incidents or accidents involving helicopters at a motor vehicle crash scene? How would a coordinating center prevent such an accident? It is likely that the money spent on such an endeavor could be better used to educate EMS providers on how to choose and set up landing zones, especially if there are likely to be multiple helicopters landing.

Section (e) comment:
This section proposes to regulate aircraft that come into North Carolina from other states, and identifies both fixed and rotor wing programs as the subject of the regulation. This section is likely to be difficult, if not impossible, to enforce. First, the enforcement tool, revocation of program approval, assumes that the program has, or desires to have a North Carolina permit. Any fixed wing program that is bringing a patient into North Carolina, or carrying a patient from North Carolina, would be unlikely to seek this prior approval unless they were physically based in North Carolina. In that case, section (e) would not apply. They might only bring patients to North Carolina once or twice a year, making it unfeasible to comply with this process. Rotor wing programs in adjoining states, who might provide mutual aid, might just ignore the rule or might decide not to respond to requests, rather than run afoul of the regulation. In either case it would not serve the interests of the people of North Carolina.

Thank you for the opportunity to comment,

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