

~~Texas Department of
State Health Services
Air Medical Committee:
Alternative State Survey Process Work Group~~

1
2

Air Medical Service
Alternative State Survey Process
~~Comprehensive Clinical Management~~
~~Program (CCMP)~~ —
Program Criteria
Draft Document (January 2008)

39 **Introduction and Overview**

40
41 This manual is designed to help EMS providers understand the ~~Comprehensive Clinical~~
42 ~~Management Program (CCMP) Texas State Air Medical Service Alternative Survey~~
43 ~~Process (ASP)~~ planning, application and approval processes. It serves as a planning and
44 pre-assessment guide for organizations administering or planning to administer a ~~CCMP (~~
45 ~~ASP)~~.

46
47 EMS has evolved in Texas from very humble beginnings. The first piece of legislation
48 that had to do with what would become Texas EMS was passed in about 1943. Article
49 4590b required a traction splint and a first aid kit and an attendant with eight hours of
50 first aid training to use them. There were no vehicle requirements. The first aid kit was
51 not even defined. It was left to the attorney general to decide that it would consist of 15
52 simple items such as scissors, bandages and splints. EMS basically remained unchanged
53 until about 1971. At that time the Texas Department of State Health Services' Civil
54 Defense and Traffic Safety Division decided to begin offering voluntary ECA training to
55 the citizens of Texas in a twenty-four hour course in their communities. The first air-
56 medical program in Texas was established in Houston in 1976.

57
58 The next major legislative change in EMS occurred in 1984. In that year the Texas
59 legislature passed the first comprehensive EMS Act in Texas and for the first time the
60 "ambulance driver" was required to be an ECA. Fortunately many communities were also
61 training EMTs and a few were even training Paramedics.

62
63 In the eighties and nineties Texas adopted Federal Department of Transportation standard
64 curriculums for EMTs as well as modified DOT curriculums for Paramedics, and EMS
65 training began to be offered in various junior colleges around the State.

66
67 EMS in Texas continues evolving rapidly. Today's evolution includes sophisticated
68 trauma systems and the system participants, which includes Air Medical Service
69 providers, are being called upon to do learn more, do more and be more than ever before;
70 which includes Air Medical providers. The key to continued success is no longer just
71 willingness to serve. The key to success is ongoing improvement and professional
72 development.

73
74 The Comprehensive Clinical Management Program (CCMP) is was the next step in the
75 evolution of EMS in Texas. Even though the CCMP is offered as a "recertification"
76 option, it is truly an EMS provider function. The CCMP is **not** simply minimum
77 standards that a provider must meet for a state license. It is a voluntary option that EMS
78 providers may attempt in order to raise the bar in their communities. ~~Operating a~~
79 ~~successful CCMP will require experience and resources that many providers will not~~
80 ~~want to dedicate on a full-time basis. There is nothing wrong with that decision;~~
81 ~~participating in the CCMP is strictly voluntary.~~ Air Medical Service EMS providers that
82 choose to attempt this option are doing so of their own free will and accept the higher
83 standards imposed by a program such as the CCMP.

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

85 Building off the great work set forth in the CCMP manual we have defined what
86 providers have been expecting for years, proof of a higher level of training and clinical
87 competency of our Air Medical Service Providers and a survey process to measure that
88 level of training and clinical competency. This proof will be substantiated in the
89 acquisition of CAMTS accreditation by all Air Medical Service providers in the State of
90 Texas. The State Air Medical Service Survey Process will be an alternative process to
91 validate a high level of care required of CAMTS accreditation, and will be a
92 comprehensive look at the clinical and medical operations of a provider holding a Texas
93 State Air Medical Service License.

~~Medical Control System versus Agency~~

94
95 ~~There are several Medical Control Systems across Texas that offer medical direction,~~
96 ~~oversight, and education to multiple individual agencies. It is recognized that individual~~
97 ~~agencies within the system may have varying resources, organizational cultures or~~
98 ~~philosophies towards the CCMP process. CCMP is tied to the provider license and~~
99 ~~should be pursued by willing agencies in coordination with their Medical Control~~
100 ~~System. Through the process, the System and/or agencies should strive to demonstrate~~
101 ~~how they fulfill the requirements of CCMP for the entities wishing to achieve CCMP.~~

106 **Planning and Preparation**

108 **Submitting a Program Application**

109 Anyone who has the desire and dedicated resources necessary to maintain a Provider License
110 as an -Air Medical Service -CCMP may submit an application for a CCMP-ASP as set forth
111 in rule 157.yy (number to be assigned later.) The application should be submitted to the
112 appropriate DSHS EMS regional office prior to initiating service for new programs and prior
113 to 2010 for established programs. Upon reviewing the application, regional DSHS or DSHS-
114 appointed personnel will ~~want to~~ meet with the applicant to begin an evaluation of the
115 applicant's ~~skills, abilities~~ training, resources, and plans concerning clinical management.
116 ~~Those who have the abilities and resources to support a successful CCMP will be encouraged~~
117 ~~to continue their planning by completing a self-assessment.~~

119 **The Application – A Self Study**

120 All of the planning and preparation a provider carries out in anticipation of accomplishing at the
121 alternative state survey process providing a CCMP must be documented in the CCMP
122 A application and supporting documents. The application and supporting documents are
123 intended to be a thorough self assessment of the CCMP-Air Medical Service Provider and
124 provide the background material necessary to demonstrate program ~~matic~~ compliance. The
125 application and supporting material will be verified in-during a site visit.

126
127 The application is available on the DSHS website.

128
129 In preparing the application, information must be well organized and in a manner that
130 clearly indicates the providers willingness and ability to support an Air Medical Service

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

131 Program CCMP. The application must be produced on standard 8 ½ by ~~11-inch~~11-inch
132 paper and all pages must be numbered consecutively. Please see the ~~CCMP-A~~Application
133 for exact ~~application~~ submission requirements, including the number of copies to be
134 submitted and the applicable fee.

135
136 After reviewing a complete application and supporting documents, the regional office shall
137 notify the program of deficiencies or, noting none, notify the provider of the intent to perform
138 a site visit.

139
140 Upon review and determination that the application is complete, a letter will be sent to
141 the medial director and the Air Medical Service provider administrator to outline the
142 procedures for setting up a site visit. Such notification shall take place no later than sixty-
143 days (60) from the submission of a complete self-assessment.

144
145 In addition to addressing all the program components in the application, complete records
146 must be maintained documenting problems, successes, administrative actions and
147 program revisions that unfold as the program progresses. The site visit team at the initial
148 and subsequent site visits will review all files. ~~CCMP-Established air-medical~~Air
149 Medical Service programs applicants must be able to produce documentation that
150 supports at least six months of programmatic compliance with the ~~CCMP~~Alternative
151 Survey Criteria. Air Medical Service programs applying for initial licensure must show
152 documentation of protocols, policies and procedures that comply with the ASP standards
153 Air Medical Service along with documentation of associated training of all personal on
154 compliance with the protocols, policies and procedures set forth by the Air Medical
155 Service provider.

156
157 This supporting documentation will include demonstrate the development of plans of
158 how program activities will be documented, how staff will be evaluated and how
159 outcomes can be substantiated. During the site visit, the team will ask for such
160 documentation.

161
162 **The Site Visit**

163 ~~After the application is approved, the program will be site visited. The site visit will~~
164 occur upon the approval of the completed application. The regional office shall notify
165 the program in writing at least 90 days in advance of the proposed visit. The program and
166 regional staff shall agree upon an appropriate date for the site visit. However, the
167 program will not be allowed to delay the site visit more than 90 days beyond the date
168 proposed by the DSHSDepartment.

169
170 The site visit team will be composed of department representatives along with an Air
171 Medical Service physician medical director, ~~and an Air Medical Service~~ provider
172 administrator, and one other personnel member that can be comprised of an educator, line
173 staff personnel, pilot or FAA representative who is approved to conduct on-site ~~CCMP~~
174 Alternative State Process review of Air Medical Service providers.reviews. The applicant
175 agency shall be responsible for reasonable expenses incurred by the non-department
176 members conducting the review.

177

178 **Typical Schedule for the Site Visit Evaluation**

179 The full exposure of the program to the site visit evaluation team provides the evaluators
180 with an awareness of both the objective and subjective components of the program. The
181 ~~medical director or provider administrator establishes site visit team will establish~~ the
182 actual schedule. It may vary to accommodate the program and its personnel, but it may
183 not exempt any program personnel from participation and it may not exempt any program
184 component from review.

185

186 The schedule should include but is not limited to the following program personnel and
187 types of activities:

188

- 189 | ▪ Meeting with the ~~air medical~~Air Medical Service medical director and provider
190 administrator to review the schedule of activities planned for the site visit.
- 191 | ▪ Interviewing the provider's staff to obtain general reactions to the program and to assess
192 the feelings of involvement in the total program. As this is a comprehensive program, staff
193 of all levels and from all aspects of the provider (billing, ~~dispatch- communications,~~
194 ~~medical care operations, mechanics, pilots~~ etc.) must be included.
- 195 | ▪ Reviewing of records ~~to assess the manner in which the program maintains records~~ of all
196 aspects of the program.
- 197 | ▪ Interviewing hospitals ~~(including receiving facilities)~~, RAC officers and other appropriate
198 regional personnel to assess their relationship with the applicant provider as related to the
199 provision of adequate patient care, ~~if applicable, for a renewal or established provider.~~
- 200 | ▪ ~~Site visits of bases, equipment and personnel.~~
- 201 | ▪ Preparing an initial report to allow the evaluators to provide a short oral summary of
202 findings, conclusions, comments, and concerns regarding the program's compliance with
203 guidelines. Program representatives may respond to this report and allow for clarification
204 to insure that the final report is reflective of the current state of the program. (A final
205 written report will be mailed to the program director within 30 days of the site visit.)

206

207 **Program Approval**

208 When the agency receives the final written report, they have three options. They can
209 forward the report to the appropriate DSHS office to be considered with their application;
210 they can forward the report with additional documentation in support of modifications
211 and additions made to their program to meet areas of deficiency; or the provider can keep
212 the report and withdraw their application for consideration of ~~CCMP-an Air Medical~~
213 ~~Service Provider License designation~~ at that time. (Draft Language)

214

215 | Once an agency successfully completes a site visit, it will become an approved ~~CCMP~~
216 ~~Licensed Air Medical Service~~ provider ~~by DSHS~~. If the program is found to be in
217 substantial compliance with established criteria and standards, and all fees and required
218 documents have been submitted, the department shall approve the program for a period to
219 coincide with the provider's license renewal period and issue an approval number. The
220 provider administrator and medical director shall receive a written report of the site-
221 review team's findings, including areas of exceptional strength, areas of weakness and
222 recommendations for improvement.

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

223
224
225
226
227
228
229
230
231

Approval of the program shall be specific to the named medical director and all aspects of the Air Medical Service Survey Criteria ~~CCMP~~ must be maintained at all times. If at any time, a provider agency changes any aspect of the originally completed survey process ~~CCMP~~ it must be reported immediately to the ~~T~~DSHS regional office with an explanation. The ~~T~~DSHS office will determine if another site visit is necessary to ensure compliance with the rule. The ~~T~~DSHS regional office may perform unannounced site visits at any time.

Program Re-approval

232
233
234
235
236
237
238
239
240

To be eligible for re-approval, the program shall maintain all the requirements of this manual, submit an application and non-refundable fee of \$XXX.00 and prepare an update to the program’s self-assessment that addresses significant changes in the program’s personnel, structure, processes, policies or procedures. The agency must also document progress toward correction of any deficiencies identified by the program or the department and may have to host another on-site review if one is deemed necessary by the department or requested by the program.

Appeals Process:

241
242
243
244
245
246
247
248
249
250

A program is eligible to contest the site survey results, in writing, through DSHS State Offices no more than (XX) calendar days after receipt of rejection of application for initial or renewal licensing. Appeals must include supporting documentation of how you meet or exceed the outlined Air Medical Service Survey expectations or your immediate corrective actions to accommodate the requirements that are deficient. The appeal will be reviewed and decision for approval, rejection or temporary approval until the time that the deficiencies have been corrected. The Air Medical Service Provider will receive written notice within (XX) of calendar days after receipt of appeal of the decision of DSHS.

251
252
253
254
255

Section 1

Credentialing and Privileging of Patient Care Providers

256
257
258
259

A. Initial Assessment of New Field Care Providers

260
261
262
263
264
265

The term “candidate” refers to new job applicants, individuals seeking promotion or position changes, and those achieving a new EMS, RT or RN certification. ~~This term covers all EMS professionals, career and volunteer.~~

266
267
268

For ~~all types of EMS agencies~~Air Medical Service Programs, the initial screening and assessment of candidates is a difficult, time consuming and often arduous task. Although personnel may share the same ~~color patch certification or license~~, the education, training,

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

269 | and experience among similarly certified or licensed individuals varies greatly. Failing to
270 | identify poor candidates can cost an agency time, resources and reputation, and may
271 | potentially expose the agency to unnecessary risk and litigation.

272 |
273 | This requires that systems implement and maintain strong initial assessment programs.
274 | This preliminary assessment tool will allow the agency's management and medical
275 | director to have insight into the candidate's strengths and weaknesses thereby facilitating
276 | successful completion of the credentialing process for that individual.

277 |
278 | The screening process not only identifies candidates optimally suited for success, the data
279 | collected during the process will provide the system valuable information for the quality
280 | improvement program. The data can be used to design education programs to bring
281 | candidates to entry-level requirements. Over time, initial assessment data can be
282 | correlated to job performance data to provide predictive measures for future hiring and
283 | promotions.

284 |
285 | A prerequisite to any initial screening process is the presence of a comprehensive
286 | position description. Hiring qualifications should include experience relevant to the
287 | program's scope of care and patient population and may includeing but is not limited to:

288 |
289 | Specific position duties:

- 290 | • Essential duties and responsibilities
291 | • Education qualifications
292 | • Professional experience
293 | • Computer skills
294 | • Language skills
295 | • Math skills
296 | • Reasoning ability and critical thinking skills
297 | • Interpersonal and communication skills
298 | • Certificates, licenses, and registration
299 | • Physical demands of the position

300 |
301 | Initial assessment should begin with a thorough screening to insure that candidates meet
302 | the minimum qualifications and requirements outlined in the position description. The
303 | process usually continues with an assessment of the candidate's knowledge, skills and
304 | experience.

305 |
306 | Agencies should be able to provide the job description for each clinical and operational
307 | position and document a process by which candidates are screened to insure that they
308 | meet the minimum qualifications for the position for which they desire.

309 |
310 | **Required:**

- 311 | Written assessment of didactic knowledge
- 312 | • This knowledge evaluation should be specific to the certification level of the
 - 313 | applicant and focus on clinical information.

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

- 314 • Agencies should NOT rely on the Texas Department of State Health Services
315 or National Registry examination as their written assessment tool.
316 • Agencies are encouraged to use a numeric scoring system to allow the agency
317 and candidates to easily assess the level of preparedness for the candidate.
318 The use of non-specific Pass/Fail criteria is discouraged.
319

320 Situation-based practical assessment

- 321 • This evaluation is designed to assess the candidate’s ability to process
322 information and make quality clinical decisions. It may also provide insight
323 into the candidate’s interpersonal skills.
324

325 Practical skills assessment

- 326 • In addition to the situation-based assessment, many agencies may choose to
327 conduct separate practical skills evaluations on of certain skills. Most elect to
328 do this if they cannot devise a method of including the skills in the situational
329 assessments. No matter which method a program chooses practical skills
330 assessments must be performed.
331

332 Background Investigation

- 333 • This portion of the process should include verification of TDSHS
334 certification, BNE licensure, NBRC licensure, and research into the
335 candidate’s criminal history, FBI finger print background check, work history,
336 driving record, and administrative history with the Bureau of Emergency
337 Management at a minimum.
338

339 Other

- 340 • Presence of detailed position descriptions for all positions relative to the Air
341 Medical Service crew-CCMP.
342 • Documentation of the screening process of applications to insure minimum
343 qualifications are met.
344 • Documentation of Medical Director involvement in the initial screening
345 process criteria development.
346

347 **Desired:**

348 Personality profiles

- 349 • Many industries, including the National Football League and law
350 enforcement, perform personality profiles on potential candidates. These
351 evaluations can identify personality traits that correlate with job satisfaction
352 and overall successful performance in the specific industry.
353

354 | In ~~most-some~~ systems, the Medical Director may have limited involvement in the actual
355 | hiring process. It is understood that different systems will have different approaches to
356 | the initial assessment process. It is recommended that the Medical Director take an
357 | active participation in all aspects of hiring. At a minimum, the medical director shall be
358 | familiar with the details of the assessment process. Likewise, the medical director may

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

359 | ~~have a range of participation in the actual screening process. This might include an~~
360 | ~~interview or participation in scenario based evaluation.~~

361
362 In Medical Control Systems, the new hires are not the employees of the medical control
363 firm or the Medical Director, but rather the individual agency. The initial screening
364 process is one of the best opportunities for risk management with respect to clinical
365 issues. The agency should be able to demonstrate how they incorporate the medical
366 control system into the hiring process assist them in determining the suitability of each
367 candidate for the system.

368
369 Ideally, the Medical Director (or employees of the Medical Control System on behalf of
370 the Medical Director) actively participate in the initial screening process of the
371 | individuals agencies. At a minimum, Medical ~~d~~irectors are encouraged to participate
372 in the cumulative review of candidates and have a voice in the final selection of
373 successful candidates.

374
375 | Applicants ~~should~~-must be able to demonstrate the Medical Directors involvement in the
376 initial screening process.

377
378

379 | **B. Credentialing Process**

380
381 Formal credentialing of healthcare providers has its origins in hospital compliance with
382 the standards that later became the Joint Commission on Accreditation of Hospital
383 Organizations (JACHO). Originally focused solely on physicians, in recent years it has
384 expanded to include a variety of professionals providing patient care. The application of
385 credentialing concepts to the EMS setting is long overdue.

386
387 Accreditation and empowerment to credential began in 1912 at Third Clinical Congress
388 of Surgeons of North America. A proposal for hospital standards ultimately led to the
389 JCAHO.

390
391 Joint Commission definition of credentialing:
392 *Process of obtaining, verifying, and assessing the qualifications of a health care*
393 *practitioner to provide patient care services in or for a health care organization.*
394

395 The primary purpose of credentialing is to ensure that any individual who wishes to
396 provide patient care is qualified and competent to exercise the clinical privileges granted.

397
398 Credentialing is a process of differentiating membership on the staff (or employment)
399 from specific clinical privileges. It seems like such a simple issue, but is actually quite
400 complex.

401
402 The Medical Director is charged with the responsibility for:

- 403
404 |
- The appropriateness of ~~the pre-hospital~~ care provided under his or her direction.

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

- 405 • Approving the level of pre-hospital care rendered by each provider regardless of
- 406 the level of state certification or licensure.
- 407 • Establish and monitor compliance with field performance guidelines.
- 408 • Establish and monitor compliance with training guidelines that meet or exceed the
- 409 minimum standards set forth in TDSHS regulations.
- 410 • Developing and monitoring a Quality Assurance process(es) all areas of clinical
- 411 care including ~~for~~ chart reviews.
- 412 • Suspend ~~a certified EMS individual~~ any authorized medical personnel from
- 413 medical care duties for due cause.
- 414

415 The credentialing process is specific to the medical director. It is separate from other
416 issues:

- 417 General employment (employer)
- 418 General certification or licensing (Texas Department of State Health Services,
419 BNE or NBRC)
- 420 Operations and Management (Chief or CEO)
- 421

422 In most systems, the medical director has an area of authority over patient care, including
423 defining and controlling each provider's clinical privileges. This provides local decision-
424 making and accountability for the medical director. Separate from certification and
425 licensure which is a state minimum, credentialing allows a way ~~to raise the bar when~~
426 communities services wish to do so individual Air Medical Services providers to
427 establish their minimums above those of state requirements.-

428
429 While the credentialing process is labor intensive, it provides superior protection to
430 medical directors and agencies against malpractice and administrative liability.

431
432 **Required:**

- 433 • **Documentation that certification and/or licensure is verified**
- 434 • Documentation of a system that requires each patient care provider to demonstrate
- 435 skills appropriate for their level of training to the satisfaction of the medical
- 436 director.
- 437 • An established process for reintegration (i.e. bringing a individual from
- 438 administration back to the field).
- 439 • An established policy for administrative personnel to remain field credentialed
- 440 • Bi-annual (at a minimum) field evaluation by a Field Training Officer (or like
- 441 position). Evaluation will consist of demonstration of patient care skills, scene
- 442 control skills conduct becoming of an EMS-Air Medical Service provider, etc.
- 443 • **ONLY THOSE INDIVIDUALS CREDENTIALLED BY THE MEDICAL**
- 444 **DIRECTOR WLL BE ELIGIBLE FOR AUTOMATIC RECERTIFICATION.**
- 445
- 446
- 447

448 **C. Didactic Initial Education:**

449

450 As Air Medical Service Providers it is imperative to establish a didactic component of
451 initial education of all medical personnel. This education should be specific and
452 appropriate for the mission statement and scope of care of the Air Medical transport
453 service. This educational experience should include but is it not limited to:

454
455 **Required:**

- 456 • Advanced airway management
- 457 • Altitude physiology and stressors of flight.
- 458 • Anatomy and physiology along with assessment of adult, pediatric and neonatal
459 patients, as appropriate, within the programs scope of care.
- 460 • Aircraft and ambulance orientation including safety procedures (for all crew
461 members including specialty team members)
 - 462 ○ Emergency procedures for depressurization for fixed wing.
 - 463 ○ Emergency access and egress training.
 - 464 ○ Orientation to all emergency procedures.
 - 465 ○ ~~Air Medical~~ Air Medical Service Crew Resource Management including
466 human factors, stress recognition and management.
 - 467 ○ Survival training.
- 468 • Cardiac emergencies and advanced cardiac critical care.
- 469 • Mission specific education for patient populations encountered (ie environmental
470 emergencies, high risk OB, multi-system trauma, neonatal emergencies, thermal
471 related injuries, etc.)
- 472 • Disaster and triage including Haz-Mat recognition and response.
- 473 • Radio communications.
- 474 • Hemodynamic monitoring, pacemakers (invasive and non invasive), automatic
475 implantable cardiac defibrillators, intra-aortic balloon pump, central lines,
476 pulmonary artery and arterial catheters, ventricular assist devices and
477 extracorporeal membrane oxygenation (ECMO).
- 478 • Infectious control.
- 479 • Mechanical ventilation and respiratory physiology for adult, pediatric and
480 neonatal patients, including oxygen therapy in the transport environment.
- 481 • Pediatric medical and trauma emergencies.
- 482 • Pharmacology
- 483 • Quality Management education.
- 484 • Respiratory emergencies.
- 485 • Scene management.

486
487 **D. Preceptor / Internship/Clinical Component of Initial Training.**

488
489 The term “internship” is used to refer to on the job training, mentoring, and/or precepting.
490 Such a process can be applied to students, new employees, and those that are promoting
491 or changing to new positions. The term “preceptor” is used generically to refer to an
492 actual preceptor, field training officer, mentor, or other such person that works directly
493 with an individual participating in an internship.
494

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

495 Initial assessment identifies candidates that possess the requisite traits necessary to be
496 successful in a particular position. Ensuring success requires job specific mentoring,
497 training, and skill building.

498
499 | The internships and clinical rotations provides the opportunity for individual care
500 providers to transition into the actual work environment under the guidance of an
501 | experienced preceptor. ~~The internship~~This process allows the opportunity for new
502 caregivers to refine clinical patient assessment and therapeutic skills in the presence of a
503 preceptor thereby accelerating the maturation process while protecting the public from
504 | errors due to lack of experience on the part of a new Air Medical Service provider. The
505 new caregiver can become proficient in the delivery of quality patient care while
506 becoming familiar with system specific operational practices.

507
508 Ideally, the internship would involve direct patient care across numerous patient
509 interactions with a variety of presenting complaints, ranging from stable to critical.
510 However, budget, manpower, and call volume realities may make this goal difficult if not
511 | impossible. Air Medical Service CCMP candidates must be able to demonstrate an
512 effective internship process. They may make use of mixture of scenario based
513 evaluations and actual life patient care observation. If scenario based evaluation is
514 utilized, the agency must be able to demonstrate how the process duplicated the realism
515 and spontaneity of actual emergency responses.

516
517 There must be a defined process for selecting and training the preceptors. The Medical
518 Director, in consultation of other appropriate parties, should make the final selection of
519 preceptors. In addition, preceptors should be individually authorized to mentor and
520 | oversee up to specific certification or licensing levels. ~~This allows basic EMTs to~~
521 ~~potentially precept other EMTs. Further, a new paramedic with a wealth of previous~~
522 ~~EMS experience may be an excellent preceptor for a lower level of certification, even if~~
523 ~~the medical director is not comfortable with the individual precepting other paramedics.~~

524
525 Post episode reviews (i.e. chart audits and interviews) are not a substitute for real-time
526 preceptor evaluation.

527
528 Various individuals within the organization may develop preceptor training. Agencies
529 may also choose to outsource this development process. Regardless of who develops the
530 training program, the medical director is responsible for approving the clinical aspects of
531 the training program.

532
533 | An internship and clinical manual describing the objectives, content, and measurement
534 | points of the internship and rotations must be developed and distributed to all preceptors
535 and candidates. The manual should include all the necessary forms to document the
536 progress and successful completion of the internship. Agencies must be able to
537 demonstrate how internship objectives have been fulfilled.

538
539 To insure consistency and to allow the preceptor to monitor the progress of each
540 individual candidate, interns should be assigned to one specific preceptor. In some

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

541 cases, additional preceptors may be necessary to meet special needs, but the number of
542 different preceptors for any individual candidate should be kept to a minimum.

543
544 The preceptor is responsible for insuring that the intern is thoroughly briefed on all
545 operational and clinical issues that impact patient care, including but not limited to:

- 546
- 547 • Individual protocols
- 548 • Individual clinical procedures
- 549 • Operational and clinical policies
- 550 • Documentation
- 551 • Radio communication
- 552 • Territory orientation
- 553 • Flight operations orientation
- 554 • Safety
- 555 • Unit operations
- 556 • Infection Control Practices
- 557 • Mutual Aid Response
- 558 • Agency norms and culture
- 559
- 560

561 On accommodating airframes, interns will ride as “third” person on the ambulance
562 aircraft until the preceptor establishes that the intern has met pre-established
563 competencies as defined by the Medical Director

564
565 On airframes that cannot accommodate a “third” person, interns will ride as a “second”
566 person until the preceptor establishes that the intern meets the prerequisites for
567 independent duty as determined by the Medical Director. The Internship Manual should
568 address how the preceptor monitors and measures the intern’s progress.

569
570 Clinical experiences will be based on the programs mission, scope of care and patient
571 population. Measurable objectives need to be developed and documented for each
572 experience listed below reflecting hands-on experience versus observation only. The
573 following areas will need to be included for the scope of practice in areas in which the
574 team transports.

- 575 • Adult, pediatric and neonatal critical care.
- 576 • Adult, pediatric and neonatal emergency care.
- 577 • Invasive procedures ~~on~~—utilizing either animal models, human cadavers or
578 HPSHuman Patient Simulators— for demonstration of invasive procedure
579 competencies. equivalent for practicing invasive procedures.
- 580 • Neonatal intensive care.
- 581 • Obstetrics.
- 582 • Prehospital critical care.
- 583 • Tracheal intubations with no less the 5 live intubations which could include
584 animal labs, cadaver and Human Patient Simulator (HPS) experience as well as
585 alternative airway management.

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

586

587 | The pre-requisites for independent duty shall require at a minimum, that the intern
588 | demonstrate thorough understanding of aircraft safety, the agency protocols, ability to use
589 | protocol and procedure manuals as a reference tool, and proficiency in clinical
590 | procedures as listed above. Agencies are encouraged to develop measurement tools for
591 | other operational areas that impact patient care as well.

592

593 | Proficiency in clinical procedures must be verified by a second evaluator for objectivity
594 | purposes, in addition to the assigned preceptor.

595

596 | It is recommended that the intern be evaluated on a representative sample of call types,
597 | such as adult, pediatric, trauma and others identified by the medical direction.

598

599 | Toward the conclusion of the internship, the intern must complete protocol testing.
600 | Although this evaluation may include a practical component, agencies are encouraged to
601 | utilize a written assessment tool so that a broader scope of material may be assessed.
602 | The medical director, in coordination with other appropriate parties, must establish
603 | pass/fail criteria for the protocol evaluation.

604

605 | Organization must have an established re-education/remediation process for those that are
606 | not successfully in completing the process.

607

608 | Upon completion of the internship, the intern should complete a comprehensive
609 | evaluation of the internship process. The agency should use this information to modify
610 | and improve the process for future candidates.

611

612 | **Required:**

613 | Defined preceptor selection process:-

614

615 | • The Medical Director with consultation of other appropriate parties must

616 | select be involved in the selection of appropriate preceptors.

617 | • The medical director must approve the development and training of

618 | preceptors.

619 | Internship proficiency criteria:-

620

621 | • In ~~accommodating~~accommodating airframes, interns will ride as 3rd person until
622 | the preceptor establishes that the intern has met pre-established competencies
623 | as defined by the Medical Director

624

625 | • In airframes that cannot accommodate a “third” person, interns will ride as a
626 | 2nd person until preceptor establishes that the intern meets the prerequisites for
627 | independent duty as determined by the Medical Director.

628

629 | • Intern must demonstrate proficiency to another evaluator.

630

631 | • Intern must demonstrate understanding of aircraft safety, protocols, procedure
632 | manuals, and proficiency in clinical procedures to the agency’s standard.

633

634 | • The Intern must attend an initial didactic ~~initial~~-training session.

635

636 | • Clinical internships must be completed.

637

638 | • A process that allows the intern to evaluate the internship program.

639

640 | • A process to promote preceptor rating ~~inter-rater~~ reliability

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

- 632 • A process for remediation and reeducation must be defined

633

634 **Desired:**

- 635 • A representative sample of call types (minimum number to be determined by
636 the Medical Director) of critically ill adult patients, pediatric patients and
637 trauma patients) will be correctly cared for by the intern prior to release from
638 internship.

639

640

641 **Section 2**

642 **Required Professional Development**

643

644 | ~~Comprehensive Clinical Management~~Air Medical Service Programs must implement and
645 maintain professional development programs designed to reinforce current knowledge
646 and to expand the knowledge base of the out of hospital ~~pre-hospital~~ provider.

647

648 Professional development is the natural outgrowth of an outcomes based quality
649 improvement program. Through the QI program, an agency will define objectives that
650 must be addressed through professional development.

651

652 The professional development hours required in this section may be defined by the
653 Quality Improvement process objectives, other clinical or operational topics, career
654 development, or other items deemed appropriate by the agency. This section is being
655 considered outside the Quality Improvement section so that agencies may have the
656 flexibility to allocate the professional development hours as necessary to fulfill agency
657 goals. However, the QI program may be the exclusive source for Professional
658 Development objectives.

659

660 Agencies will provide a minimum number of professional development hours for their
661 personnel designed to meet objectives identified through the quality improvement
662 program. The minimum number of hours for each certification shall be:

- 663 • 24 hours per year for certified and licensed Paramedics
664 • 20 hours per year for EMT-Intermediates
665 • 16 hours per year for Basic Emergency Medical Technicians
666 • 10 hours per year for Emergency Care Attendants

667

668 | Other ~~EMS-Air Medical Service~~ personnel (i.e., flight nurses, Respiratory Therapists, and
669 communications personnel) will be required to obtain at least minimum continuing
670 education as directed by the certifying or licensing authority. These hours may be
671 concurrent with the requirements above.

672

673 At least 50% of professional development hours shall be in-person training.

674

675 Agencies shall offer professional development on at least a semiannual basis.

676

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

677 Professional development should span the three domains of learning (cognitive,
678 psychomotor, and affective.) as appropriate.

679
680 The medical director shall be responsible for defining and approving the objectives of the
681 professional development hours. The actual content development and presentation may
682 be delegated to appropriate individuals. However, the medical director is responsible for
683 insuring that the content meets the defined objectives.

684
685 In larger systems or in Medical Control Systems, multiple instructors may be necessary to
686 reach all the employees of the agency(s). Because of this, the potential exists for
687 inconsistency in instructional delivery and the failure to meet the objections of the
688 program. Agencies should be able to demonstrate the methods used to promote
689 consistent delivery of the objectives and an evaluative process that monitors for potential
690 deviation. Methods to promote consistent delivery might include curriculum develop by
691 the instructional group, providing supporting materials for the curriculum, meetings of
692 the instructional staff to discuss the material, or having instructors attended session prior
693 to instructing.

694
695 Agencies should be able document strengths in their training program and describe how
696 they overcome weaknesses. They should be able to document:

- 697
- 698 • credentials of their instructional staff
 - 699 • involvement of the medical director
 - 700 • correlation of quality review to educational objectives
 - 701 • correlation of prospective goals to educational objectives
 - 702 • meet the varying needs of the their staff
 - 703 • administrative support for professional development
 - 704 • appropriate methodology for the objectives offered
 - 705 • appropriate class size for the objectives offered
 - 706 • inter-rater reliability where appropriate
 - 707 • method to evaluate long term impact of professional development activities
- 708

709 In addition to the quality improvement driven professional development needs addressed
710 above, agencies are ~~encouraged to~~ required to ensure that personnel remain credentialed
711 in nationally endorsed courses (or a determined equivalent) such as, Advanced Cardiac
712 Life Support, ~~Basic-Advanced~~ Trauma Life Support, and Pediatric Advanced Life
713 Support. ~~(or locally determined equivalent).~~—Some form of provider oriented CPR
714 certification for Adult, Pediatric and Neonatal patient populations is ~~encouraged~~ required
715 as well. The maintenance of these credentials shall be in addition to the professional
716 development requirements outlined above.

717
718 The following is a suggested list of credentials by certification:

	CPR	Cardiac	Trauma	Pediatrics	<u>Neonatal</u>
EMT	X		X	X	
<u>IntermediateFlight Nurse</u>	X	<u>X</u>	X	X	<u>X</u>

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

<u>Flight Paramedic</u>	X	X	X	X	<u>X</u>
<u>Physicians</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>	<u>X</u>
<u>Respiratory Therapists</u>	<u>X</u>	<u>X</u>		<u>X</u>	<u>X</u>

719

720

Agencies shall maintain appropriate records, including but not limited to:

721

- Current certifications and credentials

722

- Objectives

723

- Lesson plans

724

- Attendance rosters

725

- Completion records

726

- Course evaluations

727

728

Agencies are encouraged to reference the continuing education rule for guidelines for

729

appropriate continuing education documentation.

730

731

Required:

732

Professional development hours.

733

- 24 hours per year for EMT-P's

734

- 20 hours per year for EMT-Is

735

- 16 hours per year for EMTs

736

- 10 hours per year for ECAs

737

- Other EMS All personnel (i.e., flight nurses, flight paramedics, Respiratory Therapists, and communications personnel) will be required to obtain at least minimum continuing education as directed by the certifying or licensing authority.

738

739

740

741

Content and delivery.

742

- The CE content shall be defined and approved by the Medical Director.

743

- The CE content must be driven by the results of Quality Improvement efforts.

744

- At least 50% of CE is in-person training

745

- CE occurs on at least a semiannual or quarterly basis.

746

- Evidence that the instruction spans the three learning domains

747

- Documentation of programmatic strengths and performance improvement plan for weaknesses.

748

749

- Must include annual review of:

750

- Hazardous Materials

751

- Human Factors and Crew Resource Management (including specialty team members)

752

- Infectious Control

753

- State EMS rules and regulations regarding ground and air transport.

754

- Stress recognition and management.

755

- Survival Training (including specialty team members).

756

- Medical patient transport considerations (assessment/treatment/preparation handling/equipment)

757

- Day and night flight protocols

758

- General aircraft safety including (including specialty team members):

759

760

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

- 761 • Emergency shut down and evacuation procedures.
- 762 • Aviation terminology and communications procedures including
- 763 emergency frequency uses.
- 764 • In flight and ground fire suppression procedures (fire extinguishers)
- 765 • In flight emergency landing procedures.
- 766 • Safety in and around the aircraft, including FAA rules and regulations
- 767 pertinent to safety for medical team members, patient(s) and lay
- 768 individuals.
- 769 • Specific capabilities and limitations for each aircraft used, which
- 770 includes backup aircraft.
- 771 —Use of emergency locator transmitter (ELT)

-
- 772
 - 773 • Scene landing operations.
 - 774
 - 775 • Hospital landing site changes or special needs review.
 - 776
 - 777 • Patient loading and unloading (including specialty team members).
 - 778
 - 779 • Refueling policy for normal and emergency situations.
 - 780
 - 781 • Survival training/techniques/equipment that is pertinent to the
 - 782 environment/geographic coverage area of the medical service (including
 - 783 specialty team members)
 - 784

Desired:

- 786 • ~~EMTs remain current on basic cardiac and current pediatric treatment~~
- 787 ~~techniques.~~
- 788 • ~~EMT-Is remain current on basic cardiac, current pediatric and basic trauma~~
- 789 ~~treatment techniques.~~
- 790 • EMT-P's/Flight nurses remain current on a nationally recognized and
- 791 organized educational program for advanced cardiac, advanced trauma ~~and~~
- 792 advanced pediatric, and advanced neonatal treatment ~~treatment~~ techniques.
- 793 • Flight paramedics remain current on a nationally recognized and organized
- 794 educational program for advanced cardiac, advanced trauma, advanced
- 795 pediatric, and advanced neonatal treatment techniques.
- 796 • Physicians remain current on a nationally recognized and organized
- 797 educational program for advanced cardiac, advanced trauma, advanced
- 798 pediatric, and advanced neonatal treatment techniques.
- 799 • Respiratory Therapists remain current on a nationally recognized and
- 800 organized educational program for advanced cardiac, advanced pediatric, and
- 801 advanced neonatal treatment techniques.

Desired:

- 802
- 803
- 804 • A method for ensuring consistent instructional delivery across multiple
- 805 instructors

806
807

Section 3

809 Protocol/Standards of Care Management

810

811 (Note: The term “protocol” will be used synonymously with the terms patient care
812 guidelines, standing delegated orders, standing orders, and local standard of care.)

813

814 Protocol review and evaluation should be an on-going process. However, many agencies
815 elect to make this a once a year process, or worse ignore the process all together. The
816 former assumes that protocol knowledge degrades minimally throughout the year and
817 only needs to be refreshed and re-measured annually. The latter assumes that ~~pre-~~
818 ~~hospital~~ personnel are all knowing and that there is no knowledge degradation in the
819 industry’s health care providers.

820

821 Intuitively, we know that neither of these assumptions is accurate. As humans,
822 knowledge actively degrades from our memory. Only through consistent practice or
823 reinforcement are we able to maintain cognitive and practical efficiency over time.

824

825 In truth, ~~EMS-Air Medical Service~~ personnel do not have to be all knowing or all
826 remembering to make quality patient care decisions. Having a strong base knowledge
827 and a solid set of user-friendly protocols as reference material should allow the provider
828 ample knowledge, as long as it is used wisely. However, occasions will occur in which
829 the provider is unable to reference the protocols in a timely fashion, leaving them will
830 little more than their innate resources. Therefore, it is recommended that agencies
831 implement and maintain some form of on-going protocol reinforcement.

832

833 Protocol evaluation is a three-step process.

834

1. Maintaining current protocols

835

2. Ongoing protocol reinforcement

836

3. Ongoing surveillance of protocol compliance (found in the PI Section)

837

838 The medical director is responsible for ensuring that the protocols are updated routinely
839 and that they reflect the current clinical trends and best practices of the industry. While
840 the medical director is responsible for the protocol content, the process of insuring that
841 they remain current can be delegated and shared among the staff. Often, ancillary
842 personnel perform the routine duties for the medical director. Field staff often takes an
843 active role in this process as well. Anecdotally, the greater the staff participation in
844 protocol development, the greater the compliance with the protocols. As each new
845 breakthrough in clinical fronts occurs, a medical director must assess its application to the
846 ~~pre-hospital~~ Air Medical Service arena.

847

848 While medical directors are responsible for considering current industry trends, they are
849 not bound to accept and incorporate those trends in the clinical practice. There are
850 numerous reasons why a particular trend might not be incorporated. Agencies must
851 balance the benefit to patients with the cost of implementation, including financial,

852 administrative and operational investments. The agency should be able to demonstrate a
853 cost-benefit process used to determine when and if a particular protocol change should be
854 implemented.

855
856 Regardless, on-going protocol review against current literature should be executed on at
857 least an annual basis. Many agencies elect to do this on a quarterly basis, dedicating each
858 period of the calendar to a particular component of the practice, i.e. medical, cardiac,
859 trauma, or pediatrics.

860
861 Traditionally, protocol evaluation has taken the form of a written examination. Many
862 agencies rely on this method, especially when new versions of the protocols are
863 disseminated. Many alternative methods are available to agencies. In fact, one might
864 attempt to implement a variety of methods in order to maintain interest in the process and
865 reach a diverse population of learners.

866
867 Here are a few examples:

- 868 • Monthly case study with a protocol assessment on the topic. This might be
869 accomplished in the classroom, on the internet, or as a independent study item
- 870 • Periodic “game” competition using Trivial Pursuit, Jeopardy, or similar game
871 formats to make the session more enjoyable
- 872 • Monthly open book study sheets on rotating topics
- 873 • Medical Director led discussions or forums

874
875 The goal is two-fold. First, get the personnel to open and re-familiarize themselves with
876 the protocols. Second, to provide documentation and compliance of the same.

877
878 Regardless of the method, the medical director is responsible for defining the content and
879 approving the methodology of assessment. The medical director may defer to the
880 administration and others versed in adult learning methodology to find the right mix of
881 instruction and measurement for the particular agency’s personnel mix.

882
883 Through such a process, agencies will find that a small number of personnel will fail to
884 demonstrate the level of proficiency defined by the medical director. A remediation
885 process, complete with an improvement timeline, must be defined in policy. To be fair to
886 the provider and to insure that that the provider meets expectation, reassessment must
887 have be substantively different than original evaluation.

888
889 Decisions on re-evaluating the entire span of content or focusing on the area requiring
890 improvement are the discretion of the medical director or designee.

891
892 **Required:**

893 | Protocol Review:

- 894 • Must be ongoing, updated against current literature and must be
895 executed/approved by the Medical Director.
- 896 • Documentation of process for assessing relative benefit from protocol
897 revisions (ex. cost/benefit analysis)

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

898

899 Knowledge assessment:-

900

- A protocol assessment that reflects the ongoing protocol review.

901

- The criteria will be jointly defined by the Medical Director and by the provider's administration.

902

903

- The assessment's structure and content must be defined/approved by the Medical Director.

904

905

- A defined remediation process with established timelines.

906

- The reassessment must not be substantially different than the original, but must assess the identified weaknesses.

907

908

- A defined re-education process & timeline that clearly identifies the criteria for successful completion and for revocation of credentials.

909

910

Recommended:

911

912 Protocol Review.

913

- Inclusive process involving local medical community and EMS staff

914

915

Section 4

916

Communication Center

917

918

The communication center for Air Medical Service programs will serve as the link between the pilot, the medical crew and the ground contact during the medical transport. The center will function to provide continuity of communications. This center will receive and coordinate all requests for the medical transport service. There should be evidence within the program that the communications specialist participates in staff meetings, as well as, safety and quality improvement meetings. The communication specialist is an integral part of the Air Medical Service program team and there should be evidence of participation within the group.

919

920

921

922

923

924

925

926

To ensure role clarification it should be understood that communication for Air Medical Service providers will be accomplished through "communication" centers, not to be synonymous with an accredited FAA dispatch or ATC center. Communication through these providers will be utilized to maintain contact with the medical personnel for response ready status and/or patient coordination and communication of patient status change.

927

928

929

930

931

932

The pilot maintains command of the aircraft during a mission and the communication specialist serves only to provide additional information as requested. The communication specialist has the responsibility to ensure communication regarding patient condition, status and ETA (estimated arrival time) to receiving facilities and must be an effective link amongst medical care providers.

933

934

935

936

937 A. Roles and Responsibilities of Communicators

938 The communication specialist must have direct or indirect communication with the
939 medical and aviation personnel at all times. Equipment should be functioning and in
940 good repair in the center and in the aircraft.

941 At minimum, one communication specialist must be present in the communication
942 center at all times for the duration of the mission. This specialist should be trained on
943 the initial coordination of a mission that includes the communication and
944 documentation required to complete that mission. This training should include the
945 ability to screen for a flight turn down by other programs in the area when applicable.
946 Communication must be maintained incrementally with the medical crew member
947 from initiation of flight until arrival back at base in order to maintain flight crew
948 status and availability.

949 • Training and or certification will be maintained, according to communication
950 center SOP. The communication specialist shall have basic knowledge of EMS
951 roles and operations. Participation is required in safety, staff and quality meetings
952 by a representative of the communication center. The communication specialist
953 must have knowledge of FAR and industry related information or changes as they
954 are relevant to the Air Medical Service industry and operations. There must be
955 proof of yearly competency in flight following for each communication specialist.
956 Provide proof of yearly training on and abiding by FAA sterile cockpit rules and
957 other FAA regulations is required to ensure the safety of each mission. Training
958 should also include weather and METAR interpretation training. The
959 communication specialist is not required to be a weather interpretation expert but
960 at least possess general knowledge and understanding of postings so that
961 information may be relayed to the pilot when needed.

962 Proof must be provided by the program and communication center of participation in
963 weather turndown notification systems appropriate to your region. Each region has
964 its own regional advisory council that should create or endorse an avenue of
965 communication whereby weather turn down notifications are communicated and
966 received. It is imperative that the program participates in the regional advisory
967 council and that either a representative of the communication center is involved or
968 that information is communicated in a timely manner to this group. There should be
969 participation in EMS systems for updated status of aircraft availability and mass
970 casualty availability as needed.

971 NAACS certification by Communicators is preferred.

972 -

973 **B. Policy and Procedures**

974 Established Policy and Procedure to reflect basic communication and operations
975 between the center and ground, air and LZ coordinators and/or facilities is imperative.
976 These should be reviewed annually and updated as needed.

977 There should be retention of paperwork/database information for a period of (XX)
978 years. Audio recordings of call taking and radio traffic must be retained for a
979 minimum of 30 days.

980 There should be a process in place to ensure complete and ongoing quality
981 improvement including feedback and procedure for loop closure. A representative
982 from the communication center should be involved in this process.

983
984 **C. Safety**

985 In an effort to fully integrate the entire flight team and ensure a safe operation, there
986 will be participation in daily and routine briefing and debriefings. These should occur
987 at each shift change and following each mission. The communication specialist
988 should be involved in an annual safety in service which could be AMRM, CRM or
989 equivalent content.

990 In an effort to ensure a well rested, alert individual, the communicator must have 8
991 hours of uninterrupted rest time prior to scheduled shift. Personnel have the right to
992 call a “time out” and be granted a reasonable amount of rest time without retribution
993 when working extended periods of time or periods high call volume.

994 There must be an accessible PAIP (Post Accident/ Incident Plan) with proof of
995 training and documented annual proficiency. Training and knowledge on types of
996 aviation emergencies and proof of emergency preparedness drill should be
997 documented to include fire drill, forces of nature, helicopter mishaps, etc.

998 There should be a back up system in place to the computerized systems utilized for
999 flight following. Hard copies of aviation maps must be readily available to
1000 communicators with training on interpretation to provide assistance to flight crews
1001 when an alternate system must be relied upon.

1002
1003 **D. Flight Following**

1004 The intention of flight following is to maintain awareness of the flight crew and patients
1005 status, in service and launch capabilities and safety of the crew. In no way does a
1006 communications center dispatch flights. The PIC (pilot in command) remains the final
1007 decision maker on flight launches and flight activities not pertaining to direct medical

1008 care. The medical crew and communications center aid in decision making by providing
1009 valuable information and input into the call.

1010 Call taking will consist of obtaining information that is pertinent to flight related
1011 activities and medical decision making efforts by the entire team and must consist of:

- 1012 ○ A dedicated phone line for flight requests.
- 1013 ○ Point of contact and call back number for sending agency, suspected
1014 injury/illness, weight and height of patient and destination requested
1015 should be obtained at the time of the call.
- 1016 ○ All flights will be screened for turn downs by other agencies and
1017 information obtained will be communicated to the pilot and medical crew
1018 prior to launch.
- 1019 ○ Landing Zone information, point of contact and frequency or channel to
1020 contact LZ coordinator.
- 1021 ○ Inter facility requests will include, MOT information, destination of
1022 patient and ground transportation coordination, if needed.

1023 Flight following will consist of obtaining information that is pertinent to flight safety and
1024 patient information.

- 1025 ○ VFR flight following shall not impede the communication needs of the
1026 pilot with appropriate ATC centers.
- 1027 ○ VFR flights will update location on an established regular basis not to
1028 exceed every 15-minutes and locations will be documented during flight.
- 1029 ○ IFR flights should have a system in place to notify the communications
1030 center of appropriate launch and landing times as well as diversion from
1031 the original flight plan which will require a change in patient transport
1032 needs.
- 1033 ○ All IFR flight plans should be known by communications prior to launch.
- 1034 ○ PAIP activation if crew has not checked in and is unable to be contacted
1035 30 minutes after expected arrival time.

1036

1037

1038 **Section 5**

1039 **Safety Standards**

1040

1041 While the likelihood of being involved in a survivable, post-crash fire is low; the
1042 consequence of not being properly attired is extremely high.

1043

1044 Currently, there are no Federal flammability standards or regulations that exist pertaining
1045 to uniforms for ~~Air Medical~~Air Medical Service personnel, airline pilots or flight
1046 attendant personnel beyond the standards applied to consumer clothing. In Advisory
1047 Circular A-96-88, the FAA stated: "Safety experts agree that in order to decrease the
1048 chance of sustaining burns, it is better to wear long sleeves and pants, than it is to wear

1049 short sleeves and short pants. In addition, ‘natural’ fibers such as wool and cotton are
1050 better than synthetic fabrics. Also it is better to have low-heel shoes which are enclosed,
1051 and straps or laces are encouraged while sandals are discouraged.”

1052
1053 Flammability assessments performed by Thiokol Chemical Corporation (July 1967) and
1054 separate testing performed by the Department of the Navy (December 1987)
1055 demonstrated that Nomex® was superior to cotton in its flame retardant ability but both
1056 were susceptible to heat transfer. Both reported reduction in heat transfer when multiple
1057 layers of natural fibers were worn.

1058
1059 Rotor-wing incidents and crashes place occupants at increased risk for head trauma due
1060 to blunt force impact with cabin / cockpit interiors and potential head strikes associated
1061 with improperly secured equipment within the aircraft. To reduce the likelihood of
1062 significant head trauma, helmet use is strongly encouraged. Helmets with visors
1063 deployed offer added protection to cockpit occupants in the event of windscreen
1064 penetration associated with bird strikes during forward flight.

1065
1066 The program leadership is responsible for ensuring safety principles and practices are
1067 established and followed by those working for the program. Appropriate equipment for
1068 ~~Air Medical~~Air Medical Service providers is essential to their safety and those they care
1069 for. The program should address the following elements:

1070
1071 **Required Uniform Equipment:**

- 1072 Rotor-Wing Operations
- 1073 • Boots or sturdy ankle supporting footwear;
 - 1074 • Flame retardant clothing:
 - 1075 ○ Clothing must have reflective material or reflective striping on uniforms
 - 1076 for nighttime operations;
 - 1077 • Flight helmets with visor(s);
 - 1078 • Appropriate outerwear pertinent to survival in the environment;
 - 1079 • Undergarments:
 - 1080 ○ Encourage personnel to wear only natural fibers (i.e. cotton) under flight
 - 1081 uniforms.

- 1082
1083 Fixed-Wing Operations
- 1084 • Boots or sturdy ankle supporting footwear;
 - 1085 • Flame retardant clothing;
 - 1086 • Appropriate outerwear pertinent to survival in the environment;
 - 1087 • Undergarments:
 - 1088 ○ Encourage personnel to wear only natural fibers (i.e. cotton) under flight
 - 1089 uniforms.
 - 1090 • Hearing protection if required by aircraft makes and type.

1091
1092 Additionally, programs must have written policies & procedures for Rotor-Wing and
1093 Fixed-Wing operations addressing the following items pertaining to ~~Air Medical~~Air
1094 Medical Service Personnel and Patient Safety:

1095

1096

1097

1098

1099

1100

1101

1102

1103

1104

1105

1106

1107

1108

1109

1110

Section 6

1111

Quality Improvement

1112

For centuries, humankind has striven to improve upon the status quo. There has been a continuous process of examining present day performance in an attempt to improve understanding, efficiency, and outcomes.

1115

1116

1117

1118

1119

1120

1121

1122

1123

1124

Quality Improvement is an ongoing system that includes retrospective review, concurrent review, and prospective forecasting of clinical care. Quality Improvement also combines a circular response through measurement of identified goals and sentinel events, identifying opportunities for improvement, re-education, process redesign, and measurement of corrective efforts. It is the process of taking a collective look in the mirror, and discovering what parts of the service ~~need-we-want~~ to improve~~ments.?~~ Should we find that we are satisfied with the reflection, we need to be able to explain why.

1125

1126

1127

1128

The ultimate goal of Quality Improvement focuses on enhancing the provider's ability to provide patient care and excellent customer service while continuing to be clinically sophisticated and fiscally responsible.

1129

1130

1131

The ultimate goal focuses on providing better care and service tomorrow than we are capable of today.

1132

1133

1134

1135

1136

1137

1138

Information discovered as a result of a legitimate quality improvement program MAY be protected from discovery in administrative hearings and civil litigation. The Texas Department of State Health Services, the legislature and the Courts recognize that this protection is necessary so that employees and volunteers are encouraged to bring items of concern in matters of policy, protocol, or treatment to the attention of the QI manager. Agencies are encouraged to learn how to provide optimal protection for their QI process.

1139

1140

Quality Improvement is a non-punitive process designed to provide opportunities for personal and/or professional growth for the individual and agency. In order to be

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

1141 successful, the entire firm must embrace the philosophy. This may be a difficult concept
1142 for some to understand. One's past experience may indicate that it is much easier to
1143 punish than to teach. Because of this, many staff members doubt the sincerity of the
1144 commitment to grow, and instead, fear punishment.

1145
1146 Disciplinary action is a last resort for any quality improvement program. Disciplinary
1147 action should be reserved for extreme instances of repeated violations of protocol or
1148 policy despite remediation efforts, the breach of confidentiality, or refusal to participate
1149 in the quality improvement program.

1150
1151 Participation of the medical director is essential. As Medical Director, responsibility and
1152 liability begins when the call is received. The medical director is responsible for every
1153 phase of the emergency response ~~from the dispatch information collection and pre-arrival~~
1154 ~~instructions to the timely arrival of the EMS unit,~~ and the actions of the personnel until
1155 the release of the patient. A QI program serves to provide a monitoring mechanism for
1156 patient care, response times, equipment and apparatus, and patient outcomes. QI
1157 provides a platform from which to direct continuing education, allowing CE to be tailored
1158 to the specific needs of the service and it provides a consistent and even handed measure
1159 to determine problem trends that may require intervention by the medical director.

1160
1161 It is the system administrator's duty to ensure the viability of the quality improvement
1162 program. Open mindedness cannot be overemphasized. The nature of quality
1163 improvement may be threatening to the administration. No one enjoys being scrutinized.
1164 Thus, the role of the administration is to make the process non-threatening so that looking
1165 in the mirror is a less painful process.

1166
1167 Staff members should be given the opportunity to actively participate in the program.
1168 Peer review auditing and upward evaluation of clinical practice provides the staff
1169 member with avenues to effect positive change and may serve to improve morale.

1170
1171 In order for the process to be efficient, a limited number of people should be involved at
1172 any one time. This group of people should include representation of the agency from all
1173 levels. The medical director and the administrator should remain active in the process,
1174 but other members should be rotated so that anyone willing to participate has the
1175 opportunity to do so.

1176
1177 Other potential participants in the Quality Improvement Committee include:

- 1178 • Medical Director
- 1179 • Clinical Manager
- 1180 • Field Representative
- 1181 • Field Supervisor Representative
- 1182 • Hospital ER Representative
- 1183 • Representation from the local physician community
- 1184 • Professional Educator
- 1185 • Billing Representative
- 1186 • Communications Representative

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

- 1187 • Pilot
- 1188 • Mechanic
- 1189 • Administrative Assistant

1190

1191 Quality improvement is a problem solving process. It is comprised of five familiar
1192 components that closely mirror the problem solving process used in patient care and other
1193 daily activities.

1194

1195 The components are:

- 1196 • Assessment
- 1197 • Goal setting
- 1198 • Plan development
- 1199 • Intervention
- 1200 • Progress evaluation

1201

1202 Monitoring and evaluation involves continuously collecting data about important aspects
1203 of care/service, analyzing the data and recommending needed steps to improve based up
1204 on the analysis. The lingering question ~~for EMS~~ is “how to carry out monitoring and
1205 evaluation?”

1206

1207 A sample, well proven, 10-step Monitoring and Evaluation process.

1208

- 1209 1. Assign responsibility
- 1210 2. Delineate scope of care
- 1211 3. Identify important aspect of care
- 1212 4. Identify indicators
- 1213 5. Establish thresholds for evaluation
- 1214 6. Collect and organize data
- 1215 7. Evaluate care
- 1216 8. Take actions to improve care
- 1217 9. Assess effectiveness of action
- 1218 10. Communicate findings

1219

1220 Some example indicators to assess may include:

1221

- 1222 • Response Scene times
- 1223 • Protocol compliance
- 1224 • Endotracheal intubation success
- 1225 • Cardiac arrest survival
- 1226 • Specialty patients (pediatric, OB)
- 1227 • IABP or Invasive Monitoring Patients
- 1228 • Pain management
- 1229 • Unit hour utilization
- 1230 • Controlled substance use
- 1231 • Invasive Procedures

1232

1233 | The strengths of using a monitoring and evaluation system are: 1) ~~include that~~ it is a
1234 | viable method of performance improvement; and 2) it is a systematic approach that
1235 | guides staff through this difficult and time consuming event. It emphasizes the
1236 | importance of collecting data - the lynch pin of improvement efforts - related to valid and
1237 | reliable indicators.

1238

1239 | It also emphasizes linking improvement actions to that data so that changes are made
1240 | based on solid information rather than intuition.

1241

1242 | Organizations are encouraged to set priorities for improvement by first cataloging the
1243 | range of services provided and then giving priorities to the most important aspect – those
1244 | that are high risk/low volume (less than 30 per period), high risk/high volume(greater
1245 | than 30 per period), and/or problem prone. Agencies should consider building a matrix
1246 | of these situations to focus their monitoring and evaluation system.

1247

1248 | With the advent of electronic patient care records, chart review may take many forms
1249 | beyond reading a written record. Agencies should be able to demonstrate an appropriate
1250 | method of chart review given their resources and abilities. Random audits of at least 5%
1251 | of high risk/high volume or 100% of high risk/low volume should be included. Agencies
1252 | should be able to demonstrate their approach to reviewing particular problem prone
1253 | situations.

1254

1255 | Agencies must demonstrate the methods used to define the review process, including the
1256 | sampling methodology, filters, and triggers.

1257

1258 | An organized method of obtaining direct observation through field evaluations and
1259 | feedback from hospital personnel should also be considered.

1260

1261 | Finally, organizations should consider the needs and expectations of “customers.”
1262 | Measuring their satisfaction can provide valuable assessments of the quality of care
1263 | rendered by an organization.

1264

1265 | A small number of steps can be summarized for implementation of a complete
1266 | monitoring and evaluation program:

1267

Set priorities for measurement

1268

Identify worthwhile indicators– identify audit filters

1269

Teach staff how data for the indicators can be collected

1270

Encourage staff to study data

1271

1272 | The agency is also responsible to insure that the corrective action plans are implemented
1273 | and reassessed, also known as “closing the loop.”

1274

1275

1276

1277

A. Ongoing Performance Improvement

1278

1279 | Evidence of ongoing surveillance of field implementation of the agency's protocols is
1280 essential. Ongoing review as previously described merely demonstrates that the protocols
1281 were reviewed by the medical director and that personnel were exposed to the material.
1282 The final piece of the protocol puzzle is ongoing surveillance of the protocols in the
1283 actions of the field personnel. Again, many methods are available to an agency to fulfill
1284 this goal.

1285

1286 Typically, surveillance falls into two broad categories:

1287 Direct observation

1288 Retrospective review

1289

1290 **Direct Observation**

1291 Direct observation can be accomplished by peer review, field training officers, the
1292 medical director, or others charged with performing field evaluations. Some agencies
1293 | prefer that the evaluator ride as a third participant on the ~~ambulance~~-aircraft so that they
1294 can view the call from beginning to end. Others rely on a third party arriving on scene
1295 and performing the evaluation. Still others have an appropriate party meet the crew at the
1296 receiving facility or rely on hospital staff to review the progress and initial outcome of
1297 the patient. Ideally, an agency would incorporate all three aspects into the evaluation
1298 process. Regardless, an agency must be able to demonstrate some form of practical
1299 protocol compliance.

1300

1301 For some agencies on scene evaluation is an unrealistic expectation. Barriers, such as
1302 financial constraints, low call volume, expansive territory, or an unreasonably small or
1303 large staff, might necessitate an alternative method of observation. In these cases, an
1304 agency might look to realism training or scene simulations as a legitimate method of
1305 measuring “real world” protocol compliance.

1306

1307 **Retrospective Analysis**

1308 | Retrospective analysis is most often accomplished by auditing ~~run~~charts or patient care
1309 ~~run~~report (PCR) records. While this may be the most time efficient method of assessing
1310 protocol compliance, it is also the most biased. First, auditing ~~run~~records makes the
1311 giant assumption that the record accurately reflects the actions and timeline of the actual
1312 call. At a minimum, the run record is an annotated description of the call's events,
1313 devoid of contextual reference. Agencies must promote accurate and thorough
1314 documentation by their field crews.

1315

1316 Agencies forced to rely on retrospective analysis, should define a minimum data set of
1317 objective criteria in which to evaluate protocol compliance.

1318

1319 | Although not condoned, it is not unreasonable to believe that the average ~~pre-hospital~~
1320 provider paints the best picture possible of the call just completed. Often, real time data
1321 is lost and the times documented are an estimate at best.

1322

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

1323 In addition, retrospective analysis does not have the benefit of context. Minor deviations
1324 or protocol interpretations may seem less defensible when considered in an air-
1325 conditioned room, out of the rain, or away from screaming bystanders. Many times,
1326 making decisions with the information available at the time cannot be compared to those
1327 made after more complete, thoughtful deliberation.
1328

1329 Again, regardless of the method, the agency must demonstrate an effective method of
1330 providing actual compliance with the written protocols. The agency must develop a
1331 policy or procedure for managing protocol deviations as well.

1332 Required:

1333 On going Performance Improvement

- 1334 • A five component problem solving process with the following components:
 - 1335 1. Assessment
 - 1336 2. Goal Setting
 - 1337 3. Plan Development
 - 1338 4. Intervention
 - 1339 5. Progress Evaluation
- 1340 • There shall be an assessment of the provider's daily activities.
- 1341 • Agencies shall have measurable clinical indicators that are regularly assessed for
1342 compliance with established thresholds.
- 1343 • An appropriate, organized and prioritized monitoring and evaluation system for
1344 compliance with documentation standards, correct protocol selection, and
1345 appropriate patient care.
- 1346 • ~~An annual cardiac arrest survival analysis in accordance with Utstein Criteria and~~
1347 ~~reporting to the TDSHS Regional office.~~
- 1348 • All individual performance of skills (~~5 minimum~~) will be tracked for each patient
1349 care provider.
- 1350 • There shall be an assessment of the following categories:
 - 1351 1. Personnel/Staffing
 - 1352 ~~2. Response Fractions and Averaging with correct statistical monitoring.~~
 - 1353 ~~3.2.~~ Clinical Care (Skills performance, Protocol Selection, Patient
1354 Assessment, etc.)
 - 1355 ~~4.3.~~ Customer Relations program.
 - 1356 ~~5.4.~~ Education
 - 1357 ~~6.5.~~ Administrative/operational policies
 - 1358 6. Compliance with Safety Guidelines
 - 1359 7. Compliance with Infection Control Practices

1363 **B. Complaint Resolution Process**

1364
1365 Customers (i.e. patients, family members, facility representatives, first responders, tax
1366 payers, etc.) contact their local ~~Air Medical Service~~EMS agency with a variety of
1367 questions and concerns, complaints and/or compliments. ~~Air Medical Services-EMS~~
1368 ~~agencies~~ must be responsive these issues, insuring that the public's interest is addressed.

1369
1370 Tracking and monitoring the substance of such inquiries will aid an agency in better
1371 meeting the needs of its customer base and/or constituency. Informal and formal
1372 complaints provide the agency with insight into areas of potential improvement.
1373 Questions and comments may demonstrate a need for greater public awareness or
1374 advertising on a particular topic or issue. Compliments and other expressions of
1375 gratitude provide the agency and its employees with a glimpse of the good work that is
1376 done in the community. Regardless of its motivation or content, customer feedback is a
1377 valuable tool for system improvement.

1378
1379 Examples

- 1380 ~~•The local nursing home complains that a paramedic handles a patient roughly~~
1381 ~~•A citizen reports that an ambulance was speeding on the freeway~~
- 1382 • A mother calls to report how much she appreciated the Think Child Safety program
 - 1383 • The trauma surgeon reports a good patient outcome because the crew rapidly assessed
1384 the patient
 - 1385 • You receive a card thanking the crew for their timely response and quality care
 - 1386 • A caller thinks you should be doing more to combat drunk driving
 - 1387 • Through your website, a citizen e-mails a request asking why you bill for services
1388 when you they pay taxes to support the agency
 - 1389 • A fire chief feels that response times are slipping

1390
1391 Constructing and adhering to a service inquiry protocol is an essential step in tracking
1392 and analyzing customer service inquiries. Such a protocol insures that the customer's
1393 concern is documented, investigated, and appropriate steps taken to maintain or enhance
1394 the system's performance. This includes complaints, comments, and compliments.

1395
1396 Components of a Service Inquiry Protocol:

1397
1398 Intake

1399 As noted in the examples above, initial contact with the agency may occur through a
1400 variety of channels. An agency should establish and advertise a variety of means for the
1401 public to contact the agency. Such variety encourages public comment and enhances the
1402 likelihood that any given citizen will correspond with the agency.

1403
1404 Examples of intake opportunities include:

- 1405 • Phone
- 1406 • Address
- 1407 • Email
- 1408 • Website
- 1409 • Billing department
- 1410 • Customer satisfaction survey
- 1411 • Dedicated comment field on invoices
- 1412 • Suggestion boxes in local ER's
- 1413 • Customer Inquiry Hotline

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

1414

1415 The person or collection device receiving the initial contact should attempt to record the
1416 customers name, contact number, and general nature of the inquiry. Additional
1417 information, such as specific call data, can be very helpful.

1418

1419 Policy

1420 The agency must establish and maintain a service inquiry policy/procedure. The policy
1421 should define what constitutes an inquiry.

1422

1423 The policy should address what should be done when a complaint, concern, or
1424 compliment is received by an interested party (another professional in the field, patient,
1425 citizen, co-worker, etc.). The policy shall address what information should be gathered,
1426 appropriate consultation of supervisors, the timely implementation of a resolution and the
1427 appropriate type of feedback to the individuals involved in the incident. Each of these
1428 areas is further discussed below.

1429

1430 Documentation

1431 Regardless of the method of initial contact, all inquiries should be routed to central point
1432 to be recorded in a logbook and forwarded to the appropriate party for further information
1433 gathering.

1434

1435 Investigation

1436 (The term “investigation” should be implied to mean appropriate follow-up on both
1437 positive and negative customer service inquiries. ~~It f~~-does not necessarily refer to a
1438 potential disciplinary situation.)

1439

1440 It is recommended that the lead investigator should make contact with the customer. This
1441 conveys a sense of importance to the customer, letting them know that their complaint,
1442 concern, or compliment is important to the agency. During this contact, the investigator
1443 can get more specific information regarding the event or issue.

1444

1445 In situations involving customer complaints, the investigator should inform the customer
1446 of the complaint investigation process, a timeline for completion, and inquire as the
1447 feedback that the customer expects. Often customer do not want feedback, they merely
1448 want to make you aware of a situation. If feedback is requested, the investigator should
1449 inform the customer that the agency cannot discuss potential disciplinary action, but will
1450 be happy to inform them of the general outcome of the investigation and resolution of the
1451 complaint.

1452

1453 Knowing that there are two sides of every story, it is imperative that the agency personnel
1454 involved have an opportunity to relate their version of the event. Even in complimentary
1455 cases, the personnel may be able to report actions or strategies they initiated that caused
1456 the customer to be especially grateful. Certainly, if a particular crew receives an
1457 extraordinary amount of positive customer appreciation, the agency should observe the
1458 crew’s actions and attempt to seed similar behavior in other personnel.

1459

1460 Both customer and personnel accounts of the event should be documented by the
1461 investigator. Written accounts by the personnel may be helpful as well, especially if
1462 disciplinary action is anticipated.

1463
1464 The investigator should document what they believe to be chain of events based on the
1465 information obtained from all pertinent parties.

1466
1467 Referral
1468 In some cases, the investigator will find it necessary to include other individuals in the
1469 investigation and decision-making process. The agency administrator, medical director,
1470 human resources coordinator and immediate supervisors are likely to be advised of the
1471 situation or called upon to craft and prudent outcome.

1472
1473 Closure
1474 At the conclusion of the investigation, feedback should be given to all parties involved.
1475 For praise situations, this might include providing a copy of the appreciation letters to the
1476 employee and their personnel file.

1477
1478 In quality improvement and/or disciplinary situations, personnel should be coached in
1479 method to avoid similar situations in the future. In some cases, case studies can be
1480 developed and published so that the entire agency can benefit from what might have been
1481 an unusual situation.

1482
1483 Follow-up with the customer will often provide a since of closure and satisfaction.
1484 Customers expect that service will not always be delivered at peak efficiency. They
1485 know that individuals have bad days. In most cases, what really matters is how an
1486 agency responds to their concerns. Demonstrating that the agency listened and
1487 responded in an appropriate manner may be all that is necessary to convert a dissatisfied
1488 complainer into a completely satisfied customer.

1489
1490 Record Keeping
1491 One of the first steps in the service inquiry protocol should be the recording of the
1492 complaint, concern or compliment in some form of inquiry log. The person maintaining
1493 the log should be charged with insuring that inquiries are handled in an appropriate time
1494 frame and returned for filing. Should this person recognize that a particular inquiry has
1495 not been closed, this should be reported to a person of sufficient authority who can urge
1496 the process to a resolution.

1497
1498 To be anything more than a complaint resolution process, an agency must maintain
1499 inquiry records and periodically complete a trending analysis. The importance of such a
1500 process has been previously discussed, but its importance cannot be under-emphasized.

1501
1502 **Required:**
1503 Complaint Resolution Process
1504 • A centralized location and/or process for receiving inquiries.

- 1505 • An established triage process to direct inquiry resolution along potential disciplinary
1506 or Quality Improvement avenues
1507 • A process that ensures the confidentiality of all complaints and investigations.
1508 • A method to track/trend the nature of each inquiry and feed data into the Quality
1509 Improvement program.
1510
1511

C. Response to Sentinel Events

1512
1513
1514 Emergent problems (sentinel events) may arise in any of the categories and topics listed
1515 above. The most noticeable tend to fall in the clinical arena. These problems are the
1516 ones that tend to get everyone's attention, spread quickly through the agency, and cause
1517 each individual to comment on how they would have handled the situation differently.
1518 They are also the problems that are most likely to cause spontaneous, adverse reactions
1519 from supervisors, managers, and the medical director.
1520

1521 The first question one must ask when faced with such a situation, clinical or not, is what
1522 was the root cause of the decisions and/or actions that were made. Was it due to malice or
1523 a defective process? The cause should determine whether the corrective action should be
1524 handled via operations (discipline) versus quality improvement (growth).
1525

1526 Assuming you find the error was made due to a deficit in processes, it is the agency's
1527 obligation to prevent the error and similar errors in the future.
1528

1529 Various mechanisms can be instituted to find problems. An ~~Air Medical Service-EMS~~
1530 ~~provider~~ should provide formal methods of data analysis. Other more informal methods
1531 such as the "grapevine" can also be used. The most common method of finding problems
1532 is the "grapevine". Some services require complaints and/or concerns to be in writing.
1533 Because people are often reluctant to "document" concerns against a peer, quality
1534 improvement requires that hearsay concerns be investigated.
1535

1536 All aspects of the problem must be investigated. How and why the problem occurred
1537 should be the focus. Each individual involved should be asked about their observations
1538 and opinions of the incident as it occurred, and retrospectively, what they would do
1539 differently.
1540

1541 Given time and due consideration, rather than immediate reaction to a given problem, the
1542 QI process may discover extenuating circumstances which may justify the decisions
1543 made, or point to a simple education/training solution, rather than a punitive solution
1544 based on reflex.
1545

1546 Trending is important to know how often this situation presents itself. In addition, an
1547 attempt should be made to assess how likely others have been and/or would be to make
1548 the same decisions and actions.
1549

1550 Resolution and prevention may take many forms. Most common is some form of
1551 education to bring all personnel to a higher minimum competency level. Often, re-
1552 engineering of the work place or effort may improve efficiency or avoid future problems.
1553 Protocols may be revised or clarified. Likewise, policies or procedures may be
1554 developed or re-written. Administrative or clinical controls may be implemented to
1555 accommodate the new information received during the process.

1556
1557 Quality improvement is a dynamic process that is used to not only improve the service to
1558 the community, but to prove the value of your agency to the community. Excellence can
1559 only be achieved with active participation in a process that explores daily activities.
1560 Activities that demonstrate excellence should be documented and emphasized. Those
1561 needing improvement must be recognized and adapted. In the end, the public will receive
1562 a higher level of care in a more efficient manner.

1563
1564 **Required:**

1565
1566 **Sentinel Event Management**

- 1567 • There shall be a definition for sentinel event and “near-misses.”
- 1568 • There shall be an assessment of the provider’s response to emergency problems
1569 (sentinel events). (equipment failures, supply deficiencies, medication errors,
1570 fleet failures, etc.)
- 1571 • A system in place to monitor customer satisfaction and conflict resolution with
1572 the system (Patients and Hospital Personnel are considered customers)

1573
1574
1575
1576 **D. On-Going Corrective Action**

1577
1578 No Quality Improvement or Service Inquiry system could ever be complete without on-
1579 going corrective action. The whole purpose of the improvement cycle is to ensure that
1580 problem areas are corrected and that the corrections can be documented.

1581
1582 By documenting any on-going corrective action, a provider can ensure that the Quality
1583 Improvement and Formal Complaint Tracking Process are directing its improvement
1584 activities.

1585
1586 Some examples of on-going corrective action are: education for personnel with an
1587 identified deficiency, re-engineering of the work place to improve efficiency, revision of
1588 protocols for clarification and policies or procedures developed or re-written to address a
1589 new problem or issue.

1590
1591 | All **CCMP Air Medical Service** providers must document problems and report the action
1592 taken to correct these problems. This documentation must be used to create a reporting
1593 structure that will allow for analysis of trends and statistics and still protect the
1594 confidentiality of the documents being studied.

1595

Requirements for ~~Air Medical~~Air Medical Service-CCMP Alternative Survey Process Approval

~~This reporting system must also include a public performance report. As “public servants,” EMS providers have a responsibility to report their strengths, weaknesses and corrective actions to the citizens that they serve. Many local governments will have performance criteria by which to judge one’s outcomes. A CCMP provider must set its minimum standards at or above the local expectations.~~

Required:

On-Going Corrective Action

- At least annual documentation of the results of the Quality Improvement efforts and Formal Inquiry Tracking Process. Areas of the program determined to be in need of improvement will be identified, objectives developed and implemented, reassessed, and reported.
- Efforts to resolve and reassess identified individual deficiencies will be documented.
- ~~• A developed reporting structure that includes a public performance report.~~
- Privilege/confidentiality policies and methods.

Section 57

Established Committees

While the medical director is ultimately responsible for the quality of ~~pre-hospital~~ care provided under his/her license, quality care is dependent on more than just the input of the medical director. Every facet of an agency’s operation can and does impact the patient’s overall therapeutic experience. Many of these areas are far beyond the scope of the medical director’s knowledge, skill, experience, or interest.

Even within the clinical arena, those delivering the care have a vested interest in the development of the agency’s therapeutic personality. Experience tells us that those employees long for involvement as it increases a sense of personal value and contribution to the agency. A positive side effect of such involvement is the fact that employee involvement fosters ownership in the decisions and greater compliance and satisfaction with the process. In situations where a plan obtains limited success, the inclusion of a variety of personnel in the planning and implementation process dilutes the negative impact of the failed operation on any one person.

Every agency is composed of personnel who have opinions on how to get the job done (just ask the personnel). Personnel have a unique vantage point within the agency and many times have a wealth of knowledge and ideas that could enhance area of the operation that impact the provision of clinical care.

Traditionally, we think of committees as small working groups that exist into perpetuity. Over time, it is common for committees to stagnate and become counterproductive. This does not necessary need to be the case. In fact, it may be beneficial for such groups to have a limited scope and a defined lifespan.

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

1642

1643 A task force or working group can be formed to explore a particular topic, formulate a
1644 report and implement the result. Once complete, the group is disbanded and new group is
1645 composed to tackle the next opportunity. Such an approach maximizes the opportunity
1646 for individual participation and tends to promote a greater degree of enthusiasm within
1647 the organization.

1648

1649 Regardless of the approach, there are a limitless number of areas for personnel to
1650 contribute. Listed below are a variety of committee examples that an agency should
1651 consider. Just as the Incident Command System can be consolidated or expanded in
1652 scope dependent on the demands of the particular incident, so too can the committee
1653 options listed below dependent on the size and nature of the agency.

1654

~~Motor Vehicle Collision/Driving Management~~

1655 ~~The operation of an emergency vehicle offers heightened liability to the EMS agency~~
1656 ~~beyond that experienced in other clinical settings. The establishment of specific driving~~
1657 ~~policies and procedures to monitor driver performance are essential to limit an agency's~~
1658 ~~liability. Investigative procedures and accident review must also be addressed. Agencies~~
1659 ~~should promote safe driving practices that enhance the overall comfort of the~~
1660 ~~transportation experience. Rough, erratic, or dangerous driving will detract from quality~~
1661 ~~patient care.~~

1662

Safety Review

1665 Workplace injuries and exposures pose a significant threat to physical health pre-hospital
1666 providers and to the financial health of the agency. A safety committee is designed to
1667 review workplace practices and offer suggestion and/or policies that promote a safer
1668 work environment. Specific attention should be dedicated to the proactive review of
1669 infection control methods, ~~and~~ techniques, aviation safety, crew resource management,
1670 communications center, etc.

1671

Quality Improvement Committee

1673 In most agencies, the QI process utilizes a committee to review clinical care and
1674 recommend improvement strategies.

1675

Education Committee

1677 In conjunction with the Quality Improvement process, the education committee
1678 recommends, develops, and implements professional development programs. Many of
1679 these will be clinically focused to meet proactive or retrospective clinical QI needs.
1680 However, other aspects of the QI process, including the Service Inquiry Protocol, may
1681 identify issues not traditionally classified as clinical, but important to patient's overall
1682 outcome. Examples might include such things as preceptor training or conflict resolution
1683 skills.

1684

~~EMD/Medical~~ Communications Committee

1686 Quality clinical care begins when the phone rings in the communications dispatch center.
1687 The ~~EMD~~ committee should be charged with monitoring compliance with the ~~EMD~~

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

1688 | protocols, ~~delivery of pre-arrival instructions, and~~ phone etiquette, compliance with
1689 | weather reporting turndowns, EMS systems updates and daily briefing. ~~In addition, the~~
1690 | ~~committee should explore the correlation between the EMD determinants, paramedic~~
1691 | ~~assessment, and hospital discharge diagnosis.~~

1692 |
1693 | Public Information and Education Committee (Optional)

1694 | Outreach programs designed to raise awareness and promote the health and safety of the
1695 | community are an important part of many Air Medical Service Programs ~~EMS agencies.~~
1696 | The responsibility for assessing the need and meeting the demand falls to a Public
1697 | Information and Education Committee.

1698 |
1699 | Product Evaluation Committee

1700 | The delivery of pre-hospital-out of hospital care is advancing at a pace equivalent to the
1701 | health care industry as a whole. Because of this, a tremendous number of new products
1702 | and supplies are being introduced each year. Agencies owe it to their constituency,
1703 | personnel, and patients to critically review these potential advancements for their efficacy
1704 | and utility, ~~not to mention their financial impact in the Air Medical Service environment.~~

1705 |
1706 | Protocol Development and Review Committees

1707 | Many medical directors have found it near impossible to research every advancement and
1708 | alteration in clinical practice across the broad horizon of pre-out of hospital care. In
1709 | general, ~~EMS~~ Air Medical Service ~~p~~Personnel are extremely interested in remaining
1710 | current in EMS clinical issues. Consequently, they are often eager to participate in
1711 | committee work in specific areas of clinical interest. An agency might establish small
1712 | work groups focused on areas such as cardiac, respiratory, trauma, or pediatrics.

1713 |
1714 | Customer Satisfaction Committee

1715 | Agencies have a vested interest customer satisfaction. Meeting the expectations of
1716 | patients and the constituency at large is essential for the long-term success of an agency.
1717 | Failure to address satisfaction issues might lead to public discord, hostility and eventually
1718 | threats of changing who provides service to a particular population or facility.

1719 |
1720 | Agencies must take advantage of the resources found in their employee roster. The
1721 | intellectual experience of sharing ideas through a collaborative environment will promote
1722 | quality patient care and a more productive workplace.

1723 |
1724 | **Required:**

1725 | Committee(s): That identify, plan, implement and evaluate opportunities to improve
1726 | performance in all areas of the EMS system. Some examples are:

1727 | ~~• Motor vehicle collision/driving management~~

- 1728 | • Protocol development
- 1729 | • Safety review including exposures, lifting, immunizations, etc.
- 1730 | • Education committee (to develop content of CE)
- 1731 | • Quality Improvement committee
- 1732 | • ~~EMD/medical e~~Communications committee
- 1733 | • Medication tracking/use committee

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

- Public information and education committee (Optional)
- Other committees as determined by ~~local authorities~~ agency needs

The agencies may include participation in outside committees as well (RAC, COG, etc)

Section 68

Medical Director and CCMP-Survey Coordinator Qualifications

No ~~Comprehensive Clinical Management-Air Medical Service~~ Program can possibly succeed without the dedication and support of an active medical director. Although the amount of time needed may vary depending upon the provider, the medical director for an Air Medical Service Program CCMP must be prepared to spend several hours to several days a week working with the provider and its staff.

The medical director is responsible for the overall clinical aspects of the provider, ~~and is therefore ultimately responsible for all aspects of the CCMP. In order to qualify as a CCMP medical director, e~~Each physician should address the following elements:

Required:

Medical Director

Must be:

- Physician licensed to practice in Texas and shall be registered as an EMS medical director with the Texas Department of State Health Services;
- Familiar with the design and operation of EMS-Air Medical Service systems;
- Experienced in emergency care of acutely ill or injured patients;
- Actively involved in:
 - The emergency management of acutely ill and/or injured patients;
 - The training and/or continuing education of EMS-Air Medical Service personnel, under his or her direct supervision, at their respective levels of certification;
 - The medical audit, review, and critique of the performance of ~~EMS~~ personnel under his or her direct supervision;
 - The administrative and legislative environments affecting regional and/or state prehospital organizations;
- Knowledgeable about local multi-casualty plans;
- Familiar with dispatch and communications operations of ~~prehospital emergency units;~~ Air Medical Service aircraft and
- Knowledgeable about laws and regulations affecting local, regional, and state EMS operations.

Agencies are strongly encouraged to have a contract with their Medical Director that requires the Medical Director to be responsible for the following:

- Approve the level of ~~prehospital~~ care that may be rendered locally by each of the ~~EMS~~ personnel employed by ~~and/or volunteering with the EMS~~ the Air Medical

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

- 1779 | Service agency under the medical director's supervision, regardless of the level of
1780 | state certification or licensure, before the ~~certificant~~ individual is permitted to
1781 | provide such care to the public;
- 1782 | • Establish and monitor compliance with field performance guidelines for ~~EMS~~ Air
1783 | Medical Service personnel;
 - 1784 | • Establish and monitor compliance with training guidelines which meet or exceed
1785 | the minimum standards set forth in the Texas Department of State Health Services
1786 | EMS certification regulations;
 - 1787 | • Develop, implement, and revise protocols and/or standing delegation orders, if
1788 | appropriate, governing ~~prehospital~~ care and medical aspects of patient triage,
1789 | transport, transfer, dispatch, extrication, rescue, and radio-telephone-telemetry
1790 | communication by the EMS;
 - 1791 | • Direct an effective system audit and quality assurance program;
 - 1792 | • Determine standards and objectives for all medically related aspects of operation
1793 | of the ~~EMS~~ Air Medical Service program including the inspection, evaluation,
1794 | and approval of the system's performance specifications;
 - 1795 | • Function as the primary liaison between the ~~EMS~~ Air Medical Service
1796 | administration and the local medical community, ascertaining and being
1797 | responsive to the needs of each;
 - 1798 | • Take or recommend appropriate remedial or corrective measures for ~~EMS~~ Air
1799 | Medical Service personnel, in conjunction with local ~~EMS~~ Air Medical Service
1800 | administration, which may include, but are not limited to, counseling, retraining,
1801 | testing, probation, and/or field preceptorship;
 - 1802 | • Authority to suspend a certified ~~EMS~~ or licensed individual from medical care
1803 | duties for due cause pending review and evaluation;
 - 1804 | • Establish the circumstances under which a patient might not be transported;
 - 1805 | • Establish the circumstances under which a patient may be transported against his
1806 | or her will in accordance with state law, including approval of appropriate
1807 | procedures, forms, and a review process;
 - 1808 | • Establish criteria for selection of a patient's destination; and
 - 1809 | • Develop and implement a comprehensive mechanism for management of patient
1810 | care incidents, including patient complaints, allegations of substandard care, and
1811 | deviations from established protocols and patient care standards.
 - 1812 | • Be an active participant in the local Regional Advisory Committee including the
1813 | Medical Directors Committee and Air Medical Service Committees.

1814 |
1815 | In addition the agreement should outline the specific responsibilities and authority of
1816 | the medical director(s) and the ~~EMS~~ Air Medical Service administration. The
1817 | agreement should describe the process or procedure by which a medical director may
1818 | withdraw responsibility for ~~EMS~~ Air Medical Service personnel for noncompliance
1819 | with the Emergency Medical Service Act, the Health and Safety Code, Chapter 773,
1820 | the rules adopted in this chapter, and/or accepted medical standards;

- 1821 |
1822 | **Required:**
- 1823 | • Active ongoing participation in State and/or RAC Medical Director and Air
1824 | Medical Service Committees

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

- 1825 | • The Medical Director is current and active in patient care as a healthcare
1826 | professional in the care of critical patients.

1827

1828

1829 | **Desired:**

- 1830 | • Have completed the National Association of EMS Physicians Medical Director
1831 | Training Seminar (or Texas College of Emergency Physicians Course when
1832 | available) or the Air Medical Physician Association (AMPA) Air-Medical
1833 | Director's course.
- 1834 | • Membership in NAEMSP
- 1835 | • Attend the Texas College of Emergency Physicians Annual EMS Physicians
1836 | Seminar and/or EMS State of the Science
- 1837 | • Membership in the EMS Physicians of Texas
- 1838 | • ~~Active participation in State and/or RAC Medical Director committees~~

1839

1840

1841 | **Required**

1842

1843 | CCMP-Survey Coordinator

- 1844 | • Agency must designate a CCMP-Survey Coordinator who is responsible for the
1845 | administrative functions related to the CCMP-Air Medical Service Program
- 1846 | • Dedicate staff time sufficient to fulfill the program ~~matic~~ requirements. ~~of CCMP~~
- 1847 | • Provide CCMP Air Medical Service program organizational chart and describe the
1848 | administrative reporting structure of the CCMP Survey Coordinator
- 1849 | • Document quality improvement experience and/or training sufficient to
1850 | implement and maintain CCMP Texas Air Medical Service standards

1851

1852

1853 | **Section 79**

1854 | **Other Background Information**

1855

1856 | The CCMP-Air Medical Service Alternative Survey application will require additional
1857 | background information about the service area, the agency, and other related matters.
1858 | This information will be used to establish context for the reviewers and assist in
1859 | preparing them for the site visit.

1860

1861 | Providing this information will expedite the site visit and help agencies achieve their goal
1862 | of CCMP-Texas Air Medical Service accreditation.

Texas Department of State Health Services			
Comprehensive Clinical Management Program			
Scoring Criteria			
1) Credentialing and Privileging of Patient Care Providers	Acceptable	Deficient	N/A
A. Initial Assessment of New Field Care Providers			
Required:			
Written assessment of didactic knowledge evaluation should be specific to the certification level of the applicant and focus on clinical information.			
Agencies should NOT rely on the Texas Department of State Health Services or National Registry examination as their written assessment tool.			
Agencies are encouraged to use a numeric scoring system to allow the agency and candidates to easily assess the level of preparedness for the candidate. The use of non-specific Pass/Fail criteria is discouraged			
Appropriate Situation-based practical assessment is utilized			
Background Investigation is completed on all personnel. This portion of the process should include verification of TDSHS certification, and research into the candidate's criminal history, work history, driving record, and administrative history with the Bureau of Emergency Management.			
Presence of detailed job descriptions			
Documentation of screening process of applications to insure minimum qualifications are met			
Documentation of Medical Director involvement in the initial screening process			
Desired:			
Practical Skill assessment in addition to the situation-based assessment.			
Personality profiles are utilized			
B. Credentialing Process			
Documentation that certification and/or licensure is verified			
Documentation of a system that requires each patient care provider to demonstrate skills appropriate for their level of training to the satisfaction of the medical director.			
An established process for reintegration (i.e. bringing a individual from administration back to the field)			
Bi-annual field evaluation by a Field Training Officer (or like position). Evaluation will consist of demonstration of patient care skills, scene control skills, conduct becoming of an EMS provider, etc			
Only those individuals credentialed by the medical director will be eligible for automatic certification			
The presence of a policy that defines those covered by the CCMP program			
C. Preceptor/Internship			
Required:			
Defined preceptor selection process. The Medical Director			

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

with consultation of other appropriate parties must select appropriate preceptors. The medical director must approve the development and training of preceptors.			
Interns will ride as 3 rd person until the preceptor establishes that the intern has met pre-established competencies as defined by the Medical Director			
Interns will ride as a 2 nd person until preceptor establishes that the intern meets the prerequisites for independent duty as determined by the Medical Director.			
In addition to the preceptor, the intern must demonstrate proficiency to another evaluator.			
A process that allows the intern to evaluate the internship program.			
Desired:			
A representative sample of call types (minimum number to be determined by the Medical Director) of critically ill adult patients, pediatric patients and trauma patients will be correctly cared for by the intern prior to release from internship.			
2. Required Professional Development			
Required:			
Professional development hours.			
24 hours per year for EMT-P's			
20 hours per year for EMT-Is			
16 hours per year for EMTs			
10 hours per year for ECAs			
Other EMS personnel (i.e., flight nurses, <u>Respiratory Therapists</u> , and communications personnel) will be required to obtain at least minimum continuing education as directed by the certifying or licensing authority			
CE occurs on at least a semiannual or quarterly basis.			
Evidence that the instruction spans the three learning domains			
Documentation of programmatic strengths and performance improvement plan for weaknesses			
The CE clinical content shall be defined and approved by the Medical Director.			
At least 50% of CE is in-person training			
Desired:			
EMTs remain current on basic cardiac and current pediatric treatment techniques.			
EMT-Is remain current on basic cardiac, current pediatric and basic trauma treatment techniques.			
EMT-P's remain current on a nationally recognized and organized educational program for advanced cardiac, advanced trauma and advanced pediatric treatment techniques			
Desired:			
A method for insuring consistent instructional delivery across multiple instructors			

3) Protocol/Standard of Care Management			
Required:			
Protocol review must be ongoing, updated against current literature and must be executed/approved by the Medical Director.			
Documentation of process for assessing relative benefit from protocol revisions			
Knowledge Assessment - A protocol assessment that reflects the ongoing protocol review.			
The criteria will be jointly defined by the Medical Director and by the provider's administration.			
The assessment's structure and content must be defined/approved by the Medical Director.			
A defined remediation process with established timelines.			
The reassessment must substantially different than the original, but must assess the identified weaknesses			
A defined re-education process & timeline that clearly identifies the criteria for successful completion and for revocation of credentials.			
Desired:			
Inclusion process involving local medical community and EMS staff			
4) Quality Improvement			
A. Ongoing Performance Improvement			
Required:			
A five component problem solving process with the following components: <ul style="list-style-type: none"> • Assessment • Goal Setting • Plan Development • Intervention • Progress Evaluation 			
There shall be an assessment of the provider's daily activities.			
Agencies shall have measurable clinical indicators that are regularly assessed for compliance with established thresholds.			
An appropriate, organized and prioritized monitoring and evaluation system for compliance with documentation standards, correct protocol selection, and appropriate patient care.			
Assessment of key performance indicators such as: <ul style="list-style-type: none"> • Personnel/Staffing • Response Fractiles and Averaging with correct statistical monitoring. • Clinical Care (Skills performance, Protocol Selection, Patient Assessment, etc.) • Customer Relations program. • Education • Administrative/operational policies 			

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

A monthly Random Chart Review of at least (5% or 30 whichever is greater) of all runs for compliance with documentation standards, correct protocol selection, and appropriate patient care.			
An annual cardiac arrest survival analysis in accordance with Utstein Criteria and reporting to the TDSHS Regional office.			
Individual performance of skills (5 minimum) will be tracked for each patient care provider.			
Desired:			
Monitoring of customer satisfaction			
B. Complaint Resolution Process			
Required:			
A centralized location for receiving complaints.			
An established triage process to direct complaint resolution along potential disciplinary or Quality Improvement avenues.			
A process that ensures the confidentiality of all complaints and investigations.			
A method to track/trend the nature of each complaint and feed data into the Quality Improvement program.			
C. Response to Sentinel Events			
There is a definition of sentinel event and “near misses”			
Evidence of agency appropriate response to emergency problems such as equipment failures, supply deficiency, medication errors, fleet failures, etc			
Appropriate recordkeeping and tracking of sentinel events			
Investigation of sentinel events involves appropriate parties			
D. On-Going Corrective Action			
Required:			
Annual documentation of the results of the Quality Improvement efforts and Formal Complaint Tracking Process; and content of Continuing Education or individual training sessions to resolve identified deficiencies.			
Evidence to resolve and reassess identified deficiencies			
Individual versus system issues are identified			
A developed reporting structure that includes a public performance report.			
Privilege/confidentiality policies and methods.			
Remediation and improvement strategies comply with DSHS CE requirements as appropriate			
Evidence of Medical Director involvement in the remediation and improvement process			
5) Established Committees			
Required:			
Committee(s): That identify, plan, implement and evaluate opportunities to improve performance in all areas of the EMS system.			
Desired:			
Agency includes participation from outside agencies			

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

6) Medical Director and CCMP Coordinator			
Required:			
Medical Director licenses to practice in Texas and shall be registered as the EMS Medical Director with DSHS			
Medical Director shall be:			
<ul style="list-style-type: none"> Familiar with the design and operation of EMS systems 			
<ul style="list-style-type: none"> Experienced in prehospital emergency care of acutely ill or injured patients 			
<ul style="list-style-type: none"> Actively involved in the emergency management of acutely ill and/or injured patients; 			
<ul style="list-style-type: none"> Actively involved in the training and/or continuing education of EMS personnel, under his or her direct supervision, at their respective levels of certification 			
<ul style="list-style-type: none"> Actively involved in the medical audit, review, and critique of the performance of EMS personnel under his or her direct supervision 			
<ul style="list-style-type: none"> Actively involved in the administrative and legislative environments affecting regional and/or state prehospital EMS organizations 			
<ul style="list-style-type: none"> Knowledgeable about local multi-casualty plans 			
<ul style="list-style-type: none"> Familiar with dispatch and communications operations of prehospital emergency units 			
<ul style="list-style-type: none"> Knowledgeable about laws and regulations affecting local, regional, and state EMS operations 			
Medical Director is contractually responsible to:			
<ul style="list-style-type: none"> Approve the level of prehospital care that may be rendered locally by each of the EMS personnel employed by and/or volunteering with the EMS under the medical director's supervision, regardless of the level of state certification, before the certificant is permitted to provide such care to the public 			
<ul style="list-style-type: none"> Establish and monitor compliance with field performance guidelines for EMS personnel 			
<ul style="list-style-type: none"> Establish and monitor compliance with training guidelines which meet or exceed the minimum standards set forth in the Texas Department of State Health Services EMS certification regulations 			
<ul style="list-style-type: none"> Develop, implement, and revise protocols and/or standing delegation orders, if appropriate, governing prehospital care and medical aspects of patient triage, transport, transfer, dispatch, extrication, rescue, and radio-telephone-telemetry communication by the EMS 			
<ul style="list-style-type: none"> Direct an effective system audit and quality assurance program 			
<ul style="list-style-type: none"> Determine standards and objectives for all medically related aspects of operation of the EMS including the inspection, evaluation, and approval of the system's performance specifications 			

Requirements for ~~Air Medical~~ Air Medical Service-CCMP Alternative Survey Process Approval

<ul style="list-style-type: none"> Function as the primary liaison between the EMS administration and the local medical community, ascertaining and being responsive to the needs of each 			
<ul style="list-style-type: none"> Take or recommend appropriate remedial or corrective measures for EMS personnel, in conjunction with local EMS administration, which may include, but are not limited to, counseling, retraining, testing, probation, and/or field preceptorship 			
<ul style="list-style-type: none"> Authority to suspend a certified EMS individual from medical care duties for due cause pending review and evaluation 			
<ul style="list-style-type: none"> Establish the circumstances under which a patient might not be transported 			
<ul style="list-style-type: none"> Establish the circumstances under which a patient may be transported against his or her will in accordance with state law, including approval of appropriate procedures, forms, and a review process 			
<ul style="list-style-type: none"> Establish criteria for selection of a patient's destination 			
<ul style="list-style-type: none"> Develop and implement a comprehensive mechanism for management of patient care incidents, including patient complaints, allegations of substandard care, and deviations from established protocols and patient care standards. 			
<ul style="list-style-type: none"> Be an active participant in the local Regional Advisory Committee 			
Desired:			
Have completed the National Association of EMS Physicians Medical Director Training Seminar			
Membership in NAEMSP			
Attend the Texas College of Emergency Physicians Annual EMS Physicians Seminar			
Active Membership in the EMS Physicians of Texas			
CCMP Coordinator			
Agency must designate a CCMP Coordinator who is responsible for the administrative functions of the CCMP program			
Dedicate staff time sufficient to fulfill the programmatic requirements of the CCMP			
CCMP organizational chart clearly describes the administrative reporting structure of the CCMP program			
Evidence of quality improvement experience and/or training sufficient to implement and maintain CCMP standards			

1863
1864
1865