The three documents below list all the comments received by CAMTS related to the three progressive draft versions of the accreditation standards that have been posted on the CAMTS website over the past 10 months. Each comment is dated and numbered and appears just as it was submitted (copied and pasted). The comments were not modified in any way. Suggestions received from committee members or from others that did not arrive through the web site, are documented but not numbered. Below each, in red font, is the Standards/Consensus Committees comment related to each suggested change. Noted changes from the first draft were include in the posting of the second draft and changes to the third draft included changes from the first two drafts.

Expected time schedule for implementation:

- **June 2018** – Final vote by the Standards Committee on the 11th Edition
- **July 2018** – Ratification of the Standards by the CAMTS Board of Directors
- **January 1, 2019** – Effective date of the 11th Edition Standards

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Submitted comments for Standards Changes from the 10th Edition to the 11th Edition Standards

**First Draft Comments**

Committee responses are in red.

Date 08/20/2017 #1

Standard # - Suggested Change and Rationale for Change

**03.01.03. Emergency Critical Care**
First, thanks for including PAs! It does seem unnecessary to specify "appropriately educated and trained" physician assistants; this should be understood for all of the listed professions, and I'm not clear what is gained by adding it only for PAs. I'm sure that we also only want appropriately educated and trained RN's, RT's, paramedics and physicians; if this isn't spelled out for them, I'm not sure why it should be listed for PAs. All PAs undergo a standardized curriculum during their original education, and by specifying the 3000 hours of critical care experience later in the paragraph, you already specify the necessary requirements for additional training/experience. Would it be OK to simply list "Primary care provider may also be a resident or staff physician, Respiratory Therapist, Physician Assistant or a Paramedic"
The committee agrees with your suggestion to delete “appropriately educated and trained”. The wording will be changed in the next draft.

Standard # - Suggested Change and Rationale for Change

03.01.04 Intensive Care  I don’t see any mention of PAs under the intensive care category. Would it be possible to list us as a crew member option under this section as well? If an RN or a resident physician are able to serve as primary care provider, could PA also be included as well (with the same 3000 hours of critical care experience expected of the RN crew member)? Thanks for your consideration.
While we are currently not accrediting anyone at the intensive care category, we do want to assure the wording is correct. The committee agrees with your suggestion and the wording will be changed in the next draft.

09/15/2017 #2
Standard # - Suggested Change and Rationale for Change:

03.01.04 Intensive Care  Should include Physician Assistant into this section as well. PA’s often deliver care at tertiary ICU’s and should therefore be eligible to also provide tertiary level care during transport.
I could easily argue that an ICU PA would be an ideal transport provider (especially the many PA’s who had years of EMS experience prior to attending their PA program). Just want to make sure that the standards are appropriately including all relevant providers.
While we are currently not accrediting anyone at the intensive care category, we do want to assure the wording is correct. The committee agrees with your suggestion and the wording will be changed in the next draft.

09/28/2017 #3
Standard # - Suggested Change and Rationale for Change:

01.03.01 MARKETING AND EDUCATION FOR THE PUBLIC--1. Clear identification pertinent to the aviation authority of the company that is operating the aircraft is on the program's website, in marketing materials and on the aircraft.

Suggested change--Clear identification (Font not less than 11, stand alone, and in the vicinity of program's logo.) pertinent to the aviation authority of the company that is operating the aircraft is on the program's website, in marketing materials and on the aircraft.
The committee believes this suggestion is too specific and the type of media may have to dictate the size of the font (business card vs bill board for example). The committee does however agree with the intent of your suggestion and will be changing the wording in the next draft to indicate “the font size is appropriately sized for the type of media being used”.

Standard # - Suggested Change and Rationale for Change:

01.09.01 Meetings--1.b. Minutes are dated, and personnel present are clearly identified by title or function. (e.g., Director, RN, EMT-P, RRT)

Suggested change--Minutes are dated, and personnel present are clearly identified by title or function. (e.g. Director, Flight Physician, RN, EMT-P, RRT) Flight Physicians, for the most part, don't make meetings or don't make themselves a part of the flight program unless actually flying. Flight Physicians should be attending continuing education, program meetings, survival training, AMRM, etc. with the rest of the program personnel. A part of the team...
The committee understands your comment and believes the Standards, as written, as well as the basic premise that all Standards are applied based on the program’s mission statement and scope of practice serve to guide the expectations and education.

Standard # - Suggested Change and Rationale for Change:

**03.05.01 ORIENTATION, TRAINING, AND CONTINUING EDUCATION PROGRAM REQUIREMENTS**

1. Initial training program requirements for all full-time and part-time Critical Care and ALS provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent responsibility.

Suggested change--Initial training program requirements for all full-time and part-time Critical Care (including: Flight Physicians, RN's, EMT-P's, etc.) and ALS provider must successfully complete a comprehensive training program or show proof of recent experience/training in the categories listed below prior to assuming independent responsibility.

Flight Physicians, for the most part, don't make meetings or don't make themselves a part of the flight program until flying. Flight Physicians should be attending continuing education, program meetings, survival training, AMRM, etc. with the rest of the program personnel. I have visited a couple of programs that had Flight Physicians. The Flight Physicians are part of the team but could not operate some equipment (3 channel IV pumps, Suction, Cardiac Monitors, etc.) relying on the RN to carry them. They should be able to operate as part of the team...

The committee acknowledges and agrees with your concern but has elected to keep the wording the same. The committee feels all discipline should meet this Standard, so it is not necessary to specifically indicate just some disciplines, which might imply missing others.

Standard # - Suggested Change and Rationale for Change:

**03.05.01 ORIENTATION, TRAINING, AND CONTINUING EDUCATION PROGRAM REQUIREMENTS**

2. Continuing education/staff development must be provided and documented for all full-time and part-time Critical Care and ALS Providers. These must be specific and appropriate for the mission statement and scope of care of the medical transport service.

Suggested change--Continuing education/staff development must be provided and documented for all full-time and part-time Critical Care (including: Flight Physicians, RN's, EMT-P's, etc.) and ALS Providers. These must be specific and appropriate for the mission statement and scope of care of the medical transport service.

Flight Physicians, for the most part, don't make meetings or don't make themselves a part of the flight program until flying. Flight Physicians should be attending continuing education, program meetings, survival training, AMRM, etc. with the rest of the program personnel. I have visited a couple of programs that had Flight Physicians. The Flight Physicians are part of the team but could not operate some equipment (3 channel IV pumps, Suction, Cardiac Monitors, etc.) relying on the RN to carry them. They should be able to operate as part of the team...

The committee acknowledges and agrees with your concern but has elected to keep the wording the same. The Standard should apply to all disciplines and calling out just some might exclude others.

Standard # - Suggested Change and Rationale for Change:

**03.06.01 MEDICAL CONFIGURATION OF THE TRANSPORT VEHICLE**

17.d. Patients that are loaded head forward must additionally be restrained with a shoulder harness restraint.
Suggested change--Patients that are loaded head forward must additionally be restrained with a shoulder harness restraint. Those patients that are loaded feet forward must additionally be restrained with a 'foot bag' restraint.

"When flying patient’s feet forward, the FAA regulations require a means to prevent the patient from sliding out of the restraints. LifePort provides a foot bag restraint to meet the requirements. All of LifePort’s STC configurations that orient the patient in a feet forward position require the use of a foot bag restraint. Please reference 14 CFR 27.785 (k) for specific details." XXXXX’s STC does not require 'foot bag' restraints. Not sure how they slipped through the Feds with this one, especially since LifePort didn't. We are in this career to save patients, if possible, adding a 'foot bag' restraint system may aid in keeping a patient on-board an aircraft with a forward impact and is common sense. If you need further information regarding this Federal Regulation, please let me know and I'll be happy to provide... The proposed wording in the Standards has been changed to:

Patients that are loaded head forward must additionally be restrained with a shoulder harness restraint. (RW/FW) For patient loaded feet first, a foot bag is encouraged (RW).

Standard # - Suggested Change and Rationale for Change:

06.04.03 THE PILOT-IN-COMMAND (PIC) QUALIFICATIONS--3. PIC must be ATP rated; SIC is strongly recommended to be ATP rated and must complete a certification holder's approved SIC training program.

Suggested change--The PIC must possess at least a commercial single-engine, multi-engine or turbojet certificate and instrument rating. ATP certification is preferred. A Second-In-Command is required when carrying passengers under IFR unless the operation (and the pilot) is approved for use of an autopilot in lieu of a Second-In-Command. An ATP is required for turbojets, or airplanes with 10 or more passenger seats.

This is a change by the FAA regarding FAR Part 135 Pilot Certificates. These changes are primarily for those pilots not desiring to fly commuter, airlines, etc. The cost of obtaining an ATP certificate is also getting pricey and eventually there will be a shortage of pilots able to fly EMS...
The committee acknowledges and agrees. The Standard will be revised in to:

ATP is required within five years of hire.

10/18/2017 #4

Standard # - Suggested Change and Rationale for Change:

03.01.03 Emergency Critical Care Crew

a. A minimum of two medical personnel (who are licensed according to state and/or national requirements) who provide direct patient care plus a vehicle operator

• One member of the clinical crew is a licensed nurse with CEN, CCRN, CFRN or CTRN (or equivalent national certification) within 2 years of hire (required). Primary care provider may also be a resident or staff physician, Respiratory Therapist, appropriately educated and trained Physician Assistant or a Paramedic. Nurses, Respiratory Therapists, Physician Assistants and paramedics who are the primary care providers must have 3 years of critical care experience.
(Critical care experience is defined as no less than 4000 hours’ experience in an ICU or an emergency department.) In addition, nurses and paramedics in the primary-care-provider role must have pre-hire experience in the medications and interventions listed below as well as IABP management (if part of scope of care), central line monitoring, left arterial wedge pressure monitoring and ventilator management.

b. Additionally, medical directors and clinical leadership must have direct responsibility to qualify the experience and competencies of applicants for a primary care provider role and set the minimums as they pertain to the autonomous care required for their specific scope of service.

c. If crewmember is a paramedic, then FP-C or CCP-C required within 2 years of hire along with 3 years (minimum of 4000 hours) of ALS experience. If crewmember is a respiratory therapist, then RRT required with 3 years (minimum of 4000 hours) ED or ICU experience required. (see section 03.05.01 for advanced certifications)

Suggested change-- With states having critical care paramedic programs, there is no language for critical care paramedic. Utilization of a nurse is not always available in underserved area. A Critical Care Paramedic or FP-C Paramedic is sufficient for providing critical care level of service to the patient. The primary care provider should be at minimum a certified registered nurse or critical care paramedic/FP-C with the second care provider being either a respiratory therapist, paramedic, or advanced EMT specially trained by the service to assist the primary care provider. The committee reaffirmed the Standard as written and believes three years of experiences in a critical care role is important for services offering critical care as part of their scope of services. While the committee realizes this might be difficult for some programs to achieve, it is not a reason to reduce the Standard. Keep in mind that accreditation is based on substantial, and not necessarily 100% compliance, with the overall CAMTS Standards. Programs need to hire the most qualified and experienced personnel they can and assure they are competent to care for patients within the program’s scope of services and the employees’ scope of practice. This would be cited as a deficiency and the program would be asked to submit an action plan for achieving compliance. In some cases, this might mean waiting until the new hire has worked within the program for three years.

10/30/2017 #5
Standard # - Suggested Change and Rationale for Change:

**3.01.03 Emergency Critical Care 2a** Asking for better clarification of Standard 3.01.03 Emergency Critical Care 2a. Clinical Crew. Would like standard to be very specific if one crew member must be (has to be) a RN or can the crew consist of a team without a RN such as Paramedic / Paramedic or a Paramedic / RRT.

The current 10th Edition Standards allow the primary caregiver in the Emergency Critical Care category to be a registered nurse, physician, or paramedic. We will be adding/changing the wording to add physician assistant to that list and making the wording clear that any of these, as well as a respiratory therapist, can be the second caregiver.

Standard # - Suggested Change and Rationale for Change:

**Standard 3.01.04 Intensive Care** Same as request above but for Standard 3.01.04 Intensive Care. Does one crew member of the team have to be a RN or can the team be a Paramedic / Paramedic or Paramedic / RRT

The current 10th Edition Standards allow the primary caregiver in the Emergency Critical Care category to be a registered nurse, physician, or paramedic. We will be adding/changing the wording to add physician
assistant to that list and making the wording clear that any of these, as well as a respiratory therapist, can be the second caregiver.

11/02/2017 #6
Standard # - Suggested Change and Rationale for Change:

3.01.03 Emergency Critical Care number 2
For required certifications, I would like to see C-NPT, certified Neonatal pediatric transport included. This certification is specific to neo-peds transport but does include critical illnesses, environment of care, scene safety and flight principles. This should be the certification for neopeds critical care transport personnel as the other certifications listed such as CEN, CFRN and CTRN have mostly adult content. Pediatric CCRN is good as well but does not include transport specific principles.
The committee agrees the C-NPT should be added to the list for those clinical staff providing exclusively neonatal and/or pediatric care. The CAMTS Board has already been accepting this, but we will assure the Standards reflect that in the next draft. We will also be encouraging a transport certification where available to the role.

11/14/2017 #7
Standard # - Suggested Change and Rationale for Change:

02.03.07 Safety and Environment
2. Equipment and Operations Around the Transport Vehicle (For medical configuration see Section 03.06.01)
h. Transport vehicle equipment
   • It is strongly encouraged to install the following on helicopters (reference NTSB recommendations):
   Remove the Helicopter Terrain Awareness and Warning System (HTAWS) and Flight data recording devices suggestion, they are required by the FAA.
   While the FAA does require these items, the deadline and enforcement has not yet begun. Once that occurs we may drop those items from the list. Please note these items are “strongly encouraged” and not mandatory. Keep in mind also that the CAMTS Standards are used outside the United States as well, so while they may be required under FAA regulations they may not be in another county.

11/28/2017 # 8
Standard # - Suggested Change and Rationale for Change:
03.01.03 Emergency Critical Care & 03.01.04 Intensive Care
SUGGESTED CHANGE:
Primary care provider may also be a resident or staff physician, Respiratory Therapist, appropriately educated and trained Physician Assistant or a Paramedic. Nurses, Respiratory Therapists, Physician Assistants and paramedics who are the primary care providers must have 1 YEAR of critical care experience. If crewmember is a paramedic, 1 YEAR (minimum of 1800 hours) of ALS experience. If crewmember is a respiratory therapist, then RRT required with 1 YEAR (minimum of 1800 hours) ED or ICU experience required.
RATIONALE: Strongly suggest lowering the required years of experience from 3 years down to 1 year. The main reason for this proposal is the shortage in workforce. Nationally we are suffering from an RN, Paramedic, and RT shortages. Recruiting these roles can be challenging without the experience requirements and at times the experience requirements force air medical programs to turn away competent, safe, and skilled individuals due to this standard. Furthermore, the 3 year requirement implies that it takes this amount of time for a caregiver to become competent in their field. However, there is little to no strong evidence to support this theory. In fact I would contest an individual with one year of experience can be every bit as successful as an individual with 3 or more years experience.
The committee reaffirmed the Standard as written and believes three years of experiences in a critical care role is important for services offering critical care as part of their scope of services. While the committee realizes this might be difficult for some programs to achieve, it is not a reason to reduce the Standard. Keep in mind that accreditation is based on substantial, and not necessarily 100% compliance, with the overall CAMTS Standards. Programs need to hire the most qualified and experienced personnel they can and assure they are competent to care for patients within the program’s scope of services and the employees scope of practice. This would be cited as a deficiency and the program would be asked to submit an action plan for achieving compliance. In some cases, this might mean waiting until the new hire has worked within the program for three years.

Standard # - Suggested Change and Rationale for Change:
07.04.02 Vehicle Operator
SUGGESTED CHANGE:
Suggest removing the following language from the standards completely:
REMOVE: Surface vehicle operator must have a minimum of 2 years experience as a licensed driver or operator of an ambulance. [had program who wanted to interpret this as 2 years experience driving a car]
RATIONALE: It is very common for many ALS ground programs to utilize EMT-B’s as drivers, and since we recruit from these types of programs Paramedics would not possess or have the opportunity to possess the ambulance operator experience necessary. In essence the Paramedics would be getting the clinical experience needed and are not spending time driving the ambulance in order to build up ambulance operator time. Furthermore, standard 07.04.02 effectively prohibits air medical programs from hiring RN's as they typically do not possess positions that would have given them ambulance operating opportunities. This would reduce the ability for a program to fly Nurse- Nurse configurations. Furthermore, any Paramedics that were hired from a hospital based ER or ICU would not be qualified to drive the ambulance, again due to lack of opportunities in these settings. Standard 07.04.03 already ensures the ambulance operator is safe and competent to operate. The defensive driving training and EVOC programs are made to ensure operators are safe and competent to perform ground vehicle operations.
Standard 07.04.02 presents restrictions without evidenced base benefit. The committee has elected to delete the phrase “of an ambulance” from the Standard. The driving experience does not have to be in an ambulance, rather two years as a licensed driver. We know there are programs that may hire new EMT drivers with less than two years of driving an ambulance, which is acceptable, if they meet all the other training requirements including the EVOC training.

**Standard # - 03.05.01 Patient Care Education**

**SUGGESTED CHANGE:**
Advanced Trauma Life Support (ATLS) according to the American College of Surgeons, ATLS audit, ATCN for Nurses, Transport Nurse Advanced Trauma Course (TNATC) or Transport Professional Advanced Trauma Course (TPATC) or equivalent (not required for neonatal, OB, or respiratory therapists who do not provide trauma related cares)

**RATIONALE:**
With primary RN and/or Paramedic on board the role of specialty team member such as an RT, Neonatal team member, or OB team member would not require a working knowledge or competency of Advanced Trauma Life Support. These specialties would focus on their specific roles such as OB would manage obstetric specific complications while our primary RN and Paramedic would attend to any trauma related injuries. Likewise, the RT would maintain focus on airway and ventilator management, while primary team focuses on trauma cares. Another option would be allow programs to write these types of exceptions into their Scope of Care policy which would provide rationale as to why the standard may not apply.

The committee agrees that a trauma certification is not needed for those roles not providing trauma care and that the Standard does not require revision. The would be reflected in the program’s scope of care and role delineation.

12/04/17 via e-mail
Overall thoughts-
1. A lot of standards are vague and leave room for interpretation. I see the good in that from a management standpoint, but from a practical standpoint and site visit standpoint, which interpretation is right? By leaving standards vague the target for compliance can move.
2. Consider tying some standards not necessarily to mode of transport but to type of transport. There are a good number of things that are reasonable for one type to track over the other. EMS v. interfacility v. long range.
3. 02.01.07 Making all of these metrics mandatory for all of the categories will be needless paperwork in some instances. Not all programs fit all of these chosen metrics in a way that will be useful data- if you want to require tracking more than two, that’s fine. But by saying they are all required may leave programs tracking things that are meaningless to them because they are required versus tracking 5 things important to them that they picked in each category (either from a list to choose from as is now, or just giving the number of things each department should be tracking). This moves from the standpoint of improvement to regulatory.

The Standards Committee would like to thank you for your comments.

1. **02.01.07 Performance metrics** - change is to are in the description.
#5-
c. Specify what changes you’re looking for reporting. A weather change from sunny to rainy in Oregon is
something that will happen every 15 minutes. Not something we will pay attention to. Rain to sleet or an ice storm that holds up operations, we can pay attention to that (and it is already noted under UR).

d. time from request to lift is a silly metric for people that do long range or fixed wing only - people outside of EMS really. To many variables in private transport for that to be a meaningful number by itself. If the delay is weather, or mx, or staffing, that should be noted under UR.
e. missed flights. For long range and international teams in on demand services this isn’t a useful metric. What is the definition of missed?

“Missed” is being revised in the definitions to state that “quotes” are not considered acceptance and should not be counted as “missed” when not completed. Verbiage has been added noting missed and aborted volume is required for the PIF (Program Information Form). Letters c. and d. have been removed from the draft.

2. 03.01.03 - adding in capnography. Nice.
   Thank you for your comment.

3. Pg 55 - for RTs- RRT AND ACCS? Both, or one or the other?
   This Standard has been clarified as follows:
   Respiratory therapists are required to be registry-eligible and obtain RRT with one year od hire and obtain ACCS (for adult teams) or NPS or C-NPT (for pediatric/ neonatal teams) within two years of hire.

4. pg 60 - I saw the move of “disaster” to the different page. Does this, however, leave a loophole regarding freelance responses in general?
   Two similarly worded standards were combined, and freelance responses remain addressed in Standard 03.02.13 # 5.

5. pg 66-67: blood temps don’t match up.
   The wording will be changed to indicate the blood temperature should be maintained “as determined by the issuing blood bank.”

02/12/18 # 9

01.06.01 There is a well-defined line of authority.
   a. Managers require by policy that any encounter with an unmanned aerial system (UAS) while in flight require reports submitted to local law enforcement and ATC on a timely basis.
      a. Policy defines who is responsible to notify and submit a written report to local authorities

   Recommendation: Add laser strikes - Laser strikes have been around longer than UAS and are every bit as menacing and dangerous. Laser strikes are reportable to the proper authorities as well.

   FAA - "All aircrews are requested to immediately report incidents of unauthorized laser illumination by radio to the appropriate ATC controlling facility. Reports should include event position (e.g., latitude/longitude and/or FRD), altitude, color of laser beam(s), originating direction, and any other information believed necessary for ATC, law enforcement, and other governmental action taken to safeguard the safety and efficiency of aviation operations in the National Air Space."

   "Aircrews flying in uncontrolled airspace are requested to immediately broadcast a general laser illumination caution on the appropriate UNICOM frequency. This general caution should include
the following:
Phrase “UNAUTHORIZED LASER ILLUMINATION EVENT.”
• Event time in UTC, general positional information (e.g., location and altitude). General description of event (e.g., color, intensity, and direction of beam). On arrival at destination, all aircrews that have been affected by an unauthorized laser illumination are requested to complete the Laser Beam Exposure Questionnaire. The questionnaire is located on the FAA’s Laser Safety Initiative Web site at http://www.faa.gov/about/initiatives/lasers/ and can be electronically submitted. The questionnaire may also be printed and faxed to the WOCC at (202) 267-5289, ATTN: DEN, or emailed to laserreports@faa.gov. Items in the questionnaire include:
  Your name and telephone
  Date and time of the incident (UTC)
  Flight number
  Aircraft call sign, tail number and type
  Nearest major city; state
  Location: latitude/longitude and/or fixed radial distance
  Aircraft altitude and heading
  Laser color
  Approximate bearing and distance of laser origin from aircraft
  Cockpit illuminated?
  Any flight crew injuries or effects?

Laser strikes are being added to the Standard.

List complete as of March 12, 2018

These came from within the committee and therefore do not have to have a written and documented response.

*****Items added by a committee member 02/12/2018

In the Glossary:

Cross Country – “Generally when the destination is greater than 25 nautical miles from the departure point”. (The FAA definition of “cross country” is a landing at an airport no less than 50 nautical miles from the point of departure.

Heavy Jet – “Hawkers and Gulfstreams, that have empty weights of 20,000 pounds or more” {no reference to mid-sized jets} (A Hawker is considered a “midsized jet” by most aviation people). I don’t know if this matters or not, but I thought I’d point out that no one in the aviation world defines a heavy jet by this weight. Usually the size is determined by cabin volume, not weight.

The above two comments are being referred to the CAMTS Aviation Advisory Committee for discussion and advice.
Under Education and Certification Matrix A: TCCC is not listed

This course is a part of PHTLS which is listed. Would this be a course we would use with the new standards related to Special Operations Accreditation? I guess I would ask why a civilian based program would chose this course over PHTLS?

Base on the following description from the website below, if the Transport Team could provide a reason that this course was needed, it would be alright, but I would rather leave it as an exception than put on the MATRIX. Thanks, Renee Holleran

The TCCC course introduces evidence-based, life-saving techniques and strategies for providing the best trauma care on the battlefield. NAEMT conducts TCCC courses under the auspices of its PHTLS program, the recognized world leader in prehospital trauma education.

NAEMT’s TCCC courses use the PHTLS Military textbook and are fully compliant with the Department of Defense’s Committee on Tactical Combat Casualty Care (CoTCCC) guidelines. It is the only TCCC course endorsed by the American College of Surgeons.

The TCCC-MP (TCCC for Medical Personnel) course is designed for combat EMS/military personnel, including medics, corpsmen, and pararescue personnel deploying in support of combat operations. NAEMT also offers Tactical Emergency Casualty Care (TECC) for civilian tactical EMS.

The TCCC-AC (TCCC for All Combatants) course is designed for non-medical military personnel and includes first responder skills appropriate for soldiers, sailors, airmen and marines.

NAEMT’s TCCC courses are taught by a global network of experienced, well-trained instructors. To support course sites, instructors and students, NAEMT maintains a network of tactical affiliate faculty both in the U.S. and internationally, and staff at its Headquarters Office. Course administration is streamlined and cost-effective.

The Standards Committee agrees with Dr. Holleran’s comments (in blue above) and the Standard will not be changed.

Under Quick Reference – Equipment B

Require Medical Equipment/Supplies for ECC

- Respiratory – Video assisted laryngoscopy (this equipment should not be required. Nice to have, but it should not be required). No where in the standards does it state it’s required, but it’s listed under required medical equipment/supplies. The conflict should be resolved.
- Medical Surgical – pelvic stabilization device, escharotomy supplies, sonography for determination of death or placing lines (Again, not referenced in the standards, and should not be required)

Required Medications – These are not necessary on most long-range FW flights. If the patient is currently taking, they are taken from the sending hospital.

- antibiotics
- blood products
• potassium
• hypertonic normal saline
• osmotic diuretics
• vitamin K

Under Clinical Team Initial Training:

• License & Certs – “Advanced Certification in licensed role (within 1 year of hire)” (located in the back of the standards book) – Standard 03.01.03.2.a and c. states 2 years (the discrepancy needs to be fixed)

The Committee recognizes the Quick Reference Guild needs to be updated and will address these issues as part of that update, following the approval of the 11th Edition Standards.

Competencies – Neonatal Resuscitation Program – Standard 03.05.01.3.e states “NRP required if medical personnel care for high-risk OB and/or neonatal patients” (in the back of the standards, quick reference guide for training, it states for ECC you must have NRP. The standard doesn’t require it. The discrepancy should be fixed)

The Committee recognizes the Quick Reference Guild needs to be updated and will address these issues as part of that update, following the approval of the 11th Edition Standards.

03.06.01 (#17c). Not all stretcher manufacturers establish a maximum weight limit for the stretcher. The words, “if established by the manufacturer” should be added to that standard. If is there is no limit established by the manufacturer, how does a provider comply with this standard?

The Committee elected to not make a change to this Standard. The current Standard states: “Policy indicated the maximum gross weight on the stretcher (inclusive of the patient and equipment) as consistent with the manufacturer’s guidelines”. While the manufacturer may not have published weight limits the program should still have policy that addresses weight limits. This may be based on aircraft limits, safe movement of the patient, etc. If there are no manufacturer weight limits guidelines, then it is implied there does not need to be compliance with manufacturer’s weight limits.

06.04.01 (3). Most FW programs work remotely and are not at “base” often. The requirement for a “quiet area for flight planning” isn’t realistic. Most pilots these days do this on their phone or iPad, wherever they happen to be at the time. Recommend to remove it entirely.

The Committee has elected to leave the Standard as written. The policy states: “Certificate holder’s operations facilities must include a quiet area for flight planning, training, record-keeping and rest”. The committee realizes that many fixed wing pilots can use their phones or iPad for pre and post flight preparations and documentation and may never even enter the operation facilities. The committee still feels a quiet area should be provided at the operations facilities that allows them a place of planning, training and rest. The operations facilities may be separate from the bases.

First Draft list completed as of March 21, 2018
Submitted comments for Standards Changes from the 10th Edition to the 11th Edition Standards
Second Draft Comments
Committee responses are in red.

Date: 03/11/18 # 1
Standard # - Suggested Change and Rational for Change:
03.01.03 Emergency Critical Care
2. Clinical Crew A.
- Respiratory Therapist care capable of being in the primary role. As many are current transport organizations. Please include Respiratory Therapist as being able to perform in the Primary Care Provider role. According to the AARC RRT’s are capable of providing care as a primary care provider in the transport setting. A like are RN and EMT-P counterparts whom RT’s have the same if not more education than.

Date: 03/11/18 # 2
Standard # - Suggested Change and Rational for Change:
03.03.00 CLINICAL CARE SUPERVISOR
03.03.01 If transport nurses are part of the medical team, they must report to a nurse or physician on clinical issues.
-This rationale does not work for multidisciplinary healthcare teams that employ RN, RRT, and EMT-P’s as crew members. This prevents RRT’s and EMT-P’s from being employed in Clinical Supervisor roles within transport teams and thus favors nursing as being majority leadership in the transport setting. These roles should be open to all clinical members of the transport team and not just RN’s. There is no
reason why a RN must report to a MD/DO or another RN for clinical care issues. RN’s are not the superior to other clinical care

The Standards Committee has elected to keep the Standard the same. As stated in the Standard “on clinical issues”. A paramedic or RRT could be a manager or supervisor when it comes to non-clinical issues such as operational policies and issues, scheduling, etc. Having a nurse report to another nurse or a physician for clinical issues is also consistent with Joint Commission and CMS standards and general nursing practice. If there is a nurse in a position above the Clinical Care Supervisor, it is also acceptable for a nurse to report clinical issues to him/her and as stated in the Standard, it is also acceptable to report clinical issues to a physician.

Date: 03/11/18 # 3
Standard # - Suggested Change and Rational for Change:
03.05.00 section D on page 63. Currently states that an RRT must obtain ACCS/NPS/C-NPT. I do not understand why an RRT should be required to take multiple credentialing exams based of the patient population served. Unless I am misunderstanding this, it is for RRTs to fall in line with RNs being required to have an advanced certification. I think it would be fine for an RRT to get an advanced cert. I feel that asking them to sit for multiple credentialing exams is whole other ball game. It is difficult enough to find respiratory therapists already and I would think that this will make finding staff exponentially worse. The Committee reviewed this issue and will work on rewording the Standard to clearly state that only one, and not multiple, of the advanced certifications is required, “as most appropriate to the patient population”.

Date: 03/11/18 # 4
Standard # - Suggested Change and Rational for Change:
I strongly disagree with the suggestion of RRTs be registered with ACCS, NPS, C-NPT (page 63). This will neither benifit our patients, employers nor employees. If there is a topic that is not covered in other certifications, remove those from our long list of certification requirements, or condense to one certificate.
The Committee reviewed this issue and will work on rewording the Standard to clearly state that only one, and not multiple, of the advanced certifications is required, “as most appropriate to the patient population”.

Date: 03/14/18 #5
Standard # -
Suggested Change and Rationale for Change:
h. Current respiratory therapists ‘are required to be registry-eligible and obtain RRT within one year of hire and obtain certifications (RRT and ACCS (for adult teams) or NPS or C-NPT (for pediatric/neonatal teams) required for respiratory therapists who conduct critical care transports and have been employed for more than within 2 years or hire.
Suggested change:
For RRTs this is not a credentialing issue. We are required to take up to (3) exams for our credentialing. Simply cramming for an exam for certification that will not benefit the RT except to letters to their name has no impact on their ability to perform their duties during a critical care transport. The wide variety of transports is beneficial to programs from a learning curve and RTs are utilized in every aspect of care adult to neonatal. To simply "require" RTs to pay $1000 for these tests, which have no baring on their ability to perform their duties, is abominable where RNs only have to have (1) certification. The committee realizes that this maybe misleading and will be changing the wording related to respiratory therapist to:

If second is a respiratory therapist, then RRT required within one year along with one of the following as appropriate to the patient population(s) transported: NPS, ACCS or CNPT within 2 years of hire. Three years (minimum of 4000 hours) ED or ICU experience is also required. ICU experience may be a combination of adult, pediatric and/or neonatal. If the respiratory therapist is a third team member/non-regularly scheduled crew member, the RRT and certification requirements are waived.

Date: 03/15/18  # 6
Standard Number: 03.05.02 Safety Education
Recommendation: Add disaster response education and simulation to the list of safety components for the in-flight and surface transport environment in those programs that have the potential for disaster response.
Rationale: A disaster component to safety education will add accountability to the programs who have a potential for disaster response by encouraging both timelines for review/practice and documentation of demonstrated skill and understanding.
The committee believes the Standards adequately cover disaster education, however we will attempt (based on page layout and the publication software) to move the reference box for the FEMA training into the actual Standards to make it easier to understand. We will also expand the list of those required to have training to include anyone that might be assigned to assist with a disaster response. This will include mechanics, communication staff and administrative staff and support personnel. We will also eliminate the course number version (IS 700.a to IS 700) and reference the most current version.

Standard # - 03.05.03 Community Outreach Safety Program
Recommendation: Do not remove the freelance statement (1. e..).
Rationale: While this statement is a duplicate of 03.02.14, its importance in the disaster setting is extremely important. Convergent volunteerism, the arrival of unexpected or uninvited personnel wishing to render aid at the scene of a large-scale emergency incident (Cone et al 2003) continues to be a problem with disaster response. Effective disaster planning relies not only on the jurisdiction but also at an inter community level. (Auf der Heide, 2003). Our ability to prevent convergent volunteerism aids in the inter community response during a disaster response and the additional recommendation in this standard is not unreasonable if it prevents the risk to safety from convergent volunteerism.
Recommendation: Under 1. h., consider expanding the requirements in the education matrix for those organizations who have committed to the possible participation of a disaster response request. Require RW Medical and Ground to also have IS 700.a and IS-800.b. Require FW-pilot to have IS-100, IS-200.b,
and IS-700.a if that pilot will have the potential to respond to a national disaster. Maintenance and support staff who may also respond should have all FEMA introductory courses as well.

Rational: While some of the required FEMA courses are introductions, any crew member designated as someone who may potentially respond should have a basic understanding of federal response procedures and expectations. This includes pilots, mechanics, and support personnel in addition to active crew members. Even a basic understanding of these unique response settings will aid in the decrease of convergent volunteerism and ultimately make the disaster response more safe and effective for all involved.

The committee believes the Standards adequately cover disaster education, however we will attempt (based on page layout and the publication software) to move the reference box for the FEMA training into the actual Standards to make it easier to understand. We will also expand the list of those required to have training to include anyone that might be assigned to assist with a disaster response. This will include mechanics, communication staff and administrative staff and support personnel. We will also eliminate the course number version (IS 700.a to IS 700) and reference the most current version. We will also clarify in the consolidated standards regarding freelancing responses, 03.02.14, “to individual events or disasters”.

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Date: 03/16/18 # 7
04.03.02 #3 "Example of Evidence to meet compliance"
Please change NAACS Certified Flight Communicator Course to IAMTCS Certified Communicator Course.
Name of organization was changed in 2016
The committee agrees and will make the changes throughout the Standards.
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Date: 03/16/18 – From Linda Haynes – Standards Committee
03.01.02 ALS 7. K, GAMUT ECG interpretation for STEMI patient.

We do not currently provide data based on our mission profile and how we interpret the standard. When we arrive an ECG is already performed, interpreted by the requesting physician, STEMI care started and decision to call us for transport.

Could we consider adding (encouraged). When I look at my GAMUT summary report there seems to be low program participation for this metric

The committee agreed to keep the Standards as written. The metric is based on procedures actually performed by the program and does not include those done by others before or after. Programs are evaluated based on their scope of services. For some that might mean a rather large volume of a specific patient type and for others a smaller or non-existent volume. If it is done, it should be measured.
Date: 03/22/2018 # 8

Standard # - **01.06.01 (6)** change "law enforcement and ATC" to "law enforcement and/or ATC" since only the laser encounter would require both. Contacting law enforcement would be optional in the case of UAS and not applicable to birds.
The committee agrees and will make the change.

Standard # - **02.02.03 (2.)** Statement is too restrictive. Patients may also need to be transferred to surface vehicle when aircraft is forced to land short of the intended destination due to adverse weather or aircraft mechanical malfunction.
The committee believes the wording is appropriate and addresses normal operation. In emergency situations, such as a forced landing, you just do what must be done in the best interest of the patient. Other services may not be available.

Page 36. The statement "• It is strongly encouraged to install the following on helicopters (reference NTSB recommendations): (RW) " might be better expressed as "If not required by AHJ, it is strongly encouraged to install the following on helicopters (reference NTSB recommendations): (RW)" because flight data recording device is required by FAR in the U.S.
The committee agrees and will make the changes.

Standard # - **05.07.00 HELIPORTS**. This entire section consists of worthy recommendations, but it is a little puzzling to me since I understand the Standards to apply to the air medical provider organizations. The air medical provider typically does not operate, manage, or control the physical heliport facilities other than to provide safety training to personnel who use the heliport and make suggestions or requests related to the safety of the heliport and surrounding environment. In very many cases, there is no business connection at all between a receiving hospital and an air medical service that delivers patients to that facility. In short, the air medical service cannot effectively dictate these standards to the hospitals that may receive patients transported by the air medical service.
Wording will be reworded to:

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05.07.01 If the program is the owner of the helipad or for helipads where the program’s helicopter(s) is/are based, the helipad should: (Other hospitals should be encouraged to follow the same Standards)
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Standard # - **05.07.03** Temporary scene landing sites (see References) must be:

It also seems strange to attempt to set a "hard" standard for temporary scene landing sites, using the phrase "must be". Scene landing sites are what they are, and it is the pilots responsibility to assess the suitability of each such site and to make a decision to land or to require that the patient be moved to a more acceptable location. The issue with this entire heliport section is whether it really lies within the proper scope of these Standards.
The committee feels the wording is appropriate and represents the minimum safe standards for a scene landing site. We will however, add to the Standards that the landing zone training provided must cover these requirements.

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Standard # - **03.05.00 Orientation, Training, and Continuing Education Program Requirements**

Suggested Change: Pediatric Advanced Life Support (PALS) or Advanced Pediatric Life Support (APLS) or Emergency Nursing Pediatric Course (ENPC) according to the AHA, ACEP and ENA (PALS, APLS or ENPC required for neonatal team members transporting pediatric patients greater than 44 weeks corrected gestational age)

**Rationale:**

Current practices in the NICU do not support the use nor do they have standards regarding the age when PALS is a more appropriate means for resuscitation. The infant’s development is not defined as complete until 40 weeks of gestation whether that is in utero or extrauterine life. This standard is saying that we would treat an ex-24 week gestational infant and a term 40 week gestation infant at 30 days of age the same when they are physiologically and clinically different. This is not standard practice in NICUs. Therefore a corrected gestational age should be used to define the standard on the infants versus a number of days of extrauterine life.

The committee believes the Standard should remain as written. There are multiple definitions of “neonatal” and “new born” however, the definition of < 28 days is the commonly acceptable medical definition. In most cases the exact information about the patient is not known until the transport team arrives. The program should follow their own definitions. The training should include those courses that are appropriate for patients, or potential patients, within the scope of services of the program.

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**Date: 03/23/2018 # 9**

**Standard # -**

As a Manager of transport RTs, I would like to ask you re-consider the advanced certification requirement for RTs. It has already become significantly difficult to find RTs with the current prehire requirement of 3 years of ICU, even though we are fortunate to be in one of the top 20 largest hospitals in the U.S RTs are not assigned to one area rather they rotate throughout the house. Even if they request to be assigned to an ICU or ICUs only, this is not possible. The advanced certification requirement will be a disincentive to some, further reducing the pool of willing and capable applicants. Even our current staff have concerns about whether or not it is worth the trouble. It is also a budgetary consideration – This will add approximately $4,000 in cost that I have to be able to justify. It would be worth looking for literature that demonstrates a positive correlation between certified RTs and performance/outcomes? While that amount may not seem insurmountable, currently our hospital is looking for 70 million in cuts and for any expense reductions conceivable. And like many places, where there is reimbursement/compensation for advanced certifications for nurses, there is not for RTs. This sows dissension among the team on the theme of “why do the nurses get this and we don’t.” There is also an RT shortage like I have never seen before. Our hospital is currently offering sign on bonuses of $4,000, even in the face of the huge expense reductions. If you do decide to proceed ahead, please have a way to share any available literature you may have to support the cost with programs

The committee realizes that this maybe misleading and will be changing the wording related to respiratory therapist to:
If second is a respiratory therapist, then RRT required within one year along with one of the following as appropriate to the patient population(s) transported: NPS, ACCS or CNPT within 2 years of hire. Three years (minimum of 4000 hours) ED or ICU experience is also required. ICU experience may be a combination of adult, pediatric and/or neonatal. If the respiratory therapist is a third team member/non-regularly scheduled crew member, the RRT and certification requirements are waived.

Date: 03/25/18 Comment from Renee Holleran, RN, PhD Committee Member

Just my thought for page 63

f. Current nursing certifications (such as C-NPT for teams that transport neonatal and/or pediatric patients, CEN, CCRN, RN-C, CFRN and CTRN) (REMOVE AND REFER TO THE MATRIX. THERE IS TALK OF MAKING ONE CERTIFICATION FOR BOTH AIR AND GROUND) pertinent to scope of care and patient population required for nurses who have been employed for more than 2 years. C-NPT strongly encouraged for teams that transport pediatric (requiring specialized care in a PICU) and/or neonatal patients. (REMOVE AS NOTED ABOVE). A CERTIFICATION THAT IS FOCUSED ON PATIENT TRANSPORT OR THE SCOPE OF THE TRANSPORT SERVICE IS STRONGLY ENCOURAGED. (SEE EDUCATION MATRIX FOR EXAMPLES).

I am afraid as things rapidly change as with education in general, we paint ourselves into a corner. The committee agrees that we should move to transport specific certifications. For the 11th Edition of the Standards we will continue to allow the other advanced certifications but add: “Transport specific certifications are strongly encouraged.” We will likely move to “required” in the 12th Edition.

Date: 03/28/2018 # 10

Standard # -

Suggested Change and Rationale for Change:

h. Current Respiratory therapists are required to be registry-eligible and obtain RRT within one year of hire and obtain certifications (RRT and ACCS (for adult teams) or NPS or C-NPT (for pediatric/neonatal teams) required for respiratory therapists who conduct critical care transports and have been employed for more than within 2 years or hire. (such as RRT and NPS) strongly encouraged – CNPT or ACCS strongly encouraged for pediatric and neonatal teams I don’t think RRT’s need to have ACCS, NPS or CPNT. We are required to have NRP, PALS, ACLS and BLS which is more than enough to do our job. Requiring us to have the additional certifications will cost us extra time and money out of our own pockets and I’m just not interested. IF we wanted those certifications we can get them on our own without them being required.

The committee realizes that this maybe misleading and will be changing the wording related to respiratory therapist to:

If second is a respiratory therapist, then RRT required within one year along with one of the following as appropriate to the patient population(s) transported: NPS, ACCS or CNPT within 2 years of hire. Three years (minimum of 4000 hours) ED or ICU experience is also required. ICU experience may be a combination of adult, pediatric and/or neonatal. If the respiratory therapist is a third team member/non-regularly scheduled crew member, the RRT and certification requirements are waived.
Date: 03/29/2018  #11

**03.05.01** In regard to the Advanced Certifications for Respiratory Therapists (RT), for Teams that perform all age group specialty transports, this standard would have the RT required to obtain 2 different specialty certifications. That is more than the nurses or paramedics are required to obtain. The service and/or employee should be able to decide which specialty certification most meets the needs of the patient population in which that service provides care. This will not be cost effective for the transport companies nor will assist in the recruitment of RT’s. Please reconsider this standard. The committee realizes that this maybe misleading and will be changing the wording related to respiratory therapist to:

*If second is a respiratory therapist, then RRT required within one year along with one of the following as appropriate to the patient population(s) transported: NPS, ACCS or CNPT within 2 years of hire. Three years (minimum of 4000 hours) ED or ICU experience is also required. ICU experience may be a combination of adult, pediatric and/or neonatal. If the respiratory therapist is a third team member/non-regularly scheduled crew member, the RRT and certification requirements are waived.*

Date: 04/01/2018 # 12

**Standard #** - Suggested Change and Rationale for Change:

**03.01.03 (2) (a):** Please consider revising "licensed nurse" to "registered nurse or advanced practice nurse". Arguably, an LPN/LVN is a licensed nurse, but may not be appropriate for critical care as a primary provider. Similarly, some adult and pediatric teams are using advanced practice nurses and their primary caregivers, separately licensed in some states from RN. If CCRN/CFRN/CTRN is not required for this level, it should be clear the primary caregiver must be at least an RN, not LPN/LVN. The committee agrees and will change the wording to “registered nurse”.

**Standard #** - Suggested Change and Rationale for Change:

**03.01.04 (2) (a):** Please consider adding a provision for “advanced practice nurse” holding critical care certification as Acute Care Nurse Practitioner (ACNP), Emergency Nurse Practitioner (ENP), or Acute (or Critical) Care Clinical Nurse Specialist (ACCNS or CCNS) in an appropriate age group for the program *or* another advanced practice certification (e.g., ANP, FNP, etc.) with CCRN, CFRN, or CTRN. Rationale: as an ACNP and ACCNS currently flying for a CAMTS-accredited program, it seems redundant to have to take both CCRN and ACNP (or CCNS) boards when the acute care NP/CNS boards are, according to current examination and scope-of-practice outlines, essentially advanced practice critical care certifications. Because they are not specifically authorized in CAMTS standards, however, we currently have to maintain CCRN, CFRN, or CTRN certification in addition to our ACNP or CCNS boards. It is always acceptable to exceed the CAMTS Standard, which in this case, requires a registered nurse. The advanced practice certifications, however, are not transport specific and may not cover medical transport. The CFRN or CTRN certifications focus on medical transport. No changes are planned for this Standard.

Date 04/17/2018: The following recommendation was made by the CAMTS Board Medical Protocol Review Committee following the April 2018 CAMTS Board meeting.
03.02.05
Change the wording to read: “The medical director updates the medical guidelines at least annually to ensure current best practices. The medical guidelines are in written format and include an updated attestation signed and dated by the medical director.”
The committee agrees and will make the change.

The following comments were made by the CAMTS Aviation Safety Committee from their April 27th meeting and were discussed by the CAMTS Standards Committee:

1. **Glossary Definitions:** The CAMTS Standards Committee asked the Aviation Advisory Committee for clarification/guidance on the following proposed definitions in the Glossary of the CAMTS Standards:
   - Cross Country – Generally when the destination is greater than 25 nautical miles from the departure point
   - Heavy Jet – Hawkers and Gulfstreams, that have empty weights of 20,000 pounds or more.

   The Committee had no recommended changes. Eileen will research definitions as defined by the insurance company and advise Ashley, who is a member of the Standards Committee.

2. **IIMC Training:** The current verbiage if the second draft for the 11th edition Standard’s reads: 3b. Inadvertent Instrument Meteorological Conditions (IIMC) recovery procedures conducted solely by reference to instruments every six months at a minimum or IFR currency if operating IFR. It is strongly recommended that quarterly IIMC training be implemented. It was agreed to revise this to read: “It is strongly encouraged to practice IIMC recovery and completion of an instrument approach at least once per quarter. For non-IFR-certified rotorcraft, the pilot should perform such maneuvers as are appropriate to the rotorcraft’s installed equipment, the certificate holder’s operations specifications, and the operating environment.”

   The Standards Committee agrees with the recommendation and will include the proposed wording.

3. **Helmet Standards:** It was agreed to revise the standards to encourage compliance with the standards, which will be referenced, set by the Department of Interior and U.S. Forest Service. Mr. Crossen suggested we distribute the OAS Helmet standards summary to the entire committee.

   The Committee feels the OAS Helmet standards are too complex to include as part of the CAMTS Standards, however we will include them as reference.

4. **Oxygen Requirements:** It was agreed to not change the current standards for crewmember use of oxygen, but to add requirements for training to recognize and avoid hypoxia.

   The Committee agrees to not make any changes to the oxygen requirements however the training requirements will be reworded as...

06.04.04
3. Annual recurrent training to minimally include the following and verified by written criteria, outlines or curriculum:
a. Part 135 instrument proficiency check as required by national aviation regulations i.e., FAR 135.297 for operations that conduct IFR flights

f. Annual review of infection control, medical systems and installations on the aircraft, patient loading and unloading procedures and altitude physiology to include signs and symptoms of hypoxia.

5. **ATP requirements**: There was agreement to the proposed draft revision to recommend ATPs be obtained within 5 years of hire.
   The Committee agrees to change the wording to: Under Fixed Wing – highlighted changes

   **3. ATP is required within 5 years of hire.** PIC must be ATP rated; SIC is strongly recommended to be ATP rated and must complete a certificate holder’s approved SIC training program.

   Page 117

6. There was also discussion about simulator training – currently it is strongly encouraged in the standards (with no differentiation about the type of simulator). Mr. Pagano recommended we have the different types of simulators listed in the Glossary section of the standards.
   The Committee agreed to not include the different types of simulators in the 11th Edition.

7. There was also discussion regarding crash resistant fuel systems which was added in the 11th Edition Draft to the list of strongly encouraged installations on helicopters (standard 02.03.07 2. h.). Mr. Pagano stated the FAA will be requiring all newly manufactured helicopters have crash resistant fuel systems.
   The Committee believes it will be a few more years before all helicopters meet the FAA requirements and will leave the wording as “strongly encouraged” for the 11th Edition.

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The following recommendations were made by Linda Meiner, a committee member:

For consideration:

01.03.01 1 Sentence construction seems clumsy – can we work on this?

01.07.01 5 change driver to surface ambulance operator – apply to any other similar references
   The Committee agrees with the recommendation and will include the changes.

01.09.02 1.a EtCO2 – clarify use with advanced airway in place, clarify EtCO2 vs waveform capnography
   The Committee agrees with the recommendation and will include the change.
03.05.01 3 Competencies  Move statement regarding transport specific competencies from intro paragraph to f, g and h  OR as f. with 3 sub-sections
The Committee agrees with the recommendation and will include the changes.

05.06.02 9 should this be 05.06.03?
The Committee agrees with the recommendation and will include the change.

05.07.00 “evacuation drill” free floating, where does it belong?
The Committee agrees with the recommendation and will eliminate the stray words.

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Second Draft list complete as of May 11, 2018
Submitted comments for Standards Changes from the 10th Edition to the 11th Edition Standards

Third Draft Comments

Committee responses are in red.

5/10/2018 – From Brett Henyon – committee member
I have one for the standards review updates….Seems pretty clear cut but isn’t ‘spelled out’ as clearly in the standards as it could be. We see programs having staff attend clinical between flight shits, or take ACLS / PALS etc. or attend school (either graduate or undergraduate work). The idea of rest period between shifts is just that – rest. I just had one on my last survey and he looked exhausted!

01.07.00 Staffing #5 Personnel (including communications specialist) must have at least 10 hours of rest (pilots must have 10 hours of rest consistent with Part 135 regulations or as consistent with AHJ regulations) with no work related interruption prior to any scheduled 12 hours or more or prior to any on-call shift greater than 12 hours that is scheduled to precede or follow a scheduled on duty 12-hour shift. The intent is to preclude back-to-back shifts with other employment, educational requirements or school, commercial or military flying, or significant fatigue causing activity prior to a shift.

The committee agrees with the suggestions and will make the change.

5/12/2018 – From Steve Sittig – committee member
I have been thinking long and hard about all the comments regarding advanced certs for the transport RT's. I think we as a standards committee need to put out there it will not kick folks off a team or deny accreditation for their program.

We would treat this no different than the nurses or medics based on level of not totally meeting the standard.

To not try and raise the bar for RT after 6 plus years of "strongly encouraged" for all is an issue. Could we somehow put this out there as a comment from the committee?

The committee agreed to make no further changes and to handle RT certification just the same as is done with the nursing and paramedic certifications. CAMTS accreditation is based on substantial compliance with the Standards and not necessarily complete compliance. If a program fails to meet this standard they would be asked to provide their plan for corrective actions, just as it is does with any other deficiency. CAMTS has also added to the Preface statement. “available resources” as follows: Recognizing the uniqueness of each air medical and surface transport service, the Commission will apply the Standard in the context of the program mission statement, scope of care and available resources.” to consider the wide diversity of labor and other resources that are available to programs.
05/14/2018 #1
Standard # 03.01.04 (2a): There is a typographical error, listing "physician's assistant" rather than "physician assistant". Should read physician assistant, which is the correct nomenclature.
The committee agrees with and will make this change.

05/15/2018 #2
Standard # 03.01.04
Only a minor change, in this section a PA is referred to as a "Physician's Assistant". More correctly, there is no apostrophe, so it should be Physician Assistant. This would also make it consistent with the other areas of the standards which are written correctly. Not a huge deal, just trying to help out. Thanks for all the hard work that has gone into these. Again, a huge THANK YOU for including PA's into the transport standards.
The committee agrees and will make this change.

Standard # 03.03.01
This may be asking a lot, but might it make sense to include PA's as possible clinical care supervisors for nursing staff? PA's clinically supervise nurses in most other aspects of healthcare and this does not seem like a huge stretch, but it would open transport management roles to PA's interested in advancing in a flight organization.
The Standards Committee has elected to keep the Standard the same. As stated in the Standard “on clinical issues”. A PA could be a manager or supervisor when it comes to non-clinical issues such as operational policies and issues, scheduling, etc. Having a nurse report to another nurse or a physician for clinical issues is also consistent with the Joint Commission (for Accreditation of Healthcare Organizations) and Centers for Medicare and Medicaid Service (CMS) standards and general nursing practice. If there is a nurse in a position above the Clinical Care Supervisor, it is also acceptable for a nurse to report clinical issues to him/her and as stated in the Standard, it is also acceptable to report clinical issues to a physician.

05/25/2018 #3
Standard # 02.03.07 Safety and Environment
2.d.d. Head-strike envelope:
I would suggest adding language that requires that the helmets utilized are specifically designed for aviation operations. I have seen at least one program that is considering a tactical helmet for their crews instead of an aviation grade helmet.
The committee agrees to add the new wording to specify that helmets should be designed for aviation operations. We will also include, as a reference, more specific helmet standards.

05/25/18 – From Linda Meiner – Committee Member
In discussion over the last year, and in a recent CAMTS publishing, the issue of yearly review/revision of P&P and Guidelines was raised and it was stated “we” were considering extending the review/revise period to at least every 2 years. I may have missed the discussion in our meetings – have we considered this?

From the most recent AMJ – “An example of this is AS 01.06.03, which requires an annual review of the policies. Many hospital-based programs review policies every 2 years because that is the Joint Commission’s requirement, so we are in the process of reviewing a change or clarification to this standard through the Standards Committee.”

The committee agrees that the list of policies within programs continues to grow and that an annual review of all management policies can be difficult for many programs. The committee agrees to make the change to every two years for operational policies. The Standard requiring annual reviews of medical protocols will remain the same.

05/27/2018 # 4

Standard # 03.01.03 and 03.01.04 - Professional Licensure

I am not sure why the CCP-C and/or FP-C requirement for Paramedics and the CFRN, CCRN, CEN or CTRN for nurses is being eliminated from this standard? I strongly disagree with this. It seems that's we are lowering the standard for critical care team configurations when we should be increasing them. Possessing these certs will add a great deal of knowledge and experience to the team which I have to assume is why they were added in the first place. I would also suggest adding CCEMTP as a required license within 2 years. Please do not roll back professional licensing standards at any level, especially when it comes to clinical care. These advanced certs should be required of both nurses and paramedics and should be changed anywhere in this document where it suggests otherwise.

It was not the intent of the committee to decrease this standard and we will assure that the Standards for Emergency Critical Care (03.01.03) and Intensive Care (03.01.04) remain the same. The committee did intend to increase the standard for Advanced Life Support (03.01.02) by making the advanced certifications “strongly encouraged” for paramedics. The committee has made a format change by moving all the advanced certifications to one location in section 03.05.01. *** The committee also discussed and continues to support that the CCEMTP is a course and not a licensing nor does not meet the requirements of an advance certification.

05/28/2018 # 5

Standard # 03.05.01 3h

Says respiratory therapists are required to obtain either ACCS, NPS, or C-NPT. What is the evidence that will improve patient safety or outcomes. It will add cost. Benefit for that cost needs to be shown. Has evidence been published that shows benefit to the patient?

The Committee believes any advanced or specific education and certification is not only a benefit for the patient but also the care giver. Studies have show that providers with higher levels generally obtain better patient outcomes and have higher quality care than those without the advanced training and/or certification. The Standard will remain as stated in the draft.
Our facility is a specialized team. We are hospital based and only transport patients 10 lbs or less. When we are called out our team of RN and RT replace the unit based crew members. I think in cases like ours the certification of C-NPT or CFRN should be required. We are labeled "Elite" and with that title we should have the credentials to prove it. My RT’s are already required to be RRT before they can apply and have 1 year to obtain the NPS credential.

The committee believes this is now outlined in the draft Standards. No further changes are needed.

The committee also thanks you for your support.

As explained above, I don’t allow you to apply without being RRT and 1 year to obtain NPS. Adding C-NPT just makes you better at what you do. Education is the key to being successful. This is not a profession for the faint of heart. If you are going to do it then have the credentials to show me how much you want it.

The committee believes this is now outlined in the draft Standards. No further changes are needed.

June 1, 2018 from Jon Gryniuk, Committee Member

I found an issue that I need to report.

“03.05.01 3.g. g. Current paramedic certifications (such as NRP) strongly encouraged for paramedics who have been employed for more than 2 years and are conducting ALS/BLS and critical care transports. In addition, FP-C or CCP-C certifications required for paramedics who conduct critical care transports and have been employed for more than 2 years. Where available for the role and patient population(s) transported, a transport-specific certification is strongly encouraged."

This is totally confusing and we are betting a lot of questions on it. My understanding of the intent was to only strongly encourage FP-C or CCP-C for those programs performing BLS/ALS transport but still require it for those conducting critical care transports.

So, we need to correct this language.

“g. Current paramedic certifications (such as NRP) strongly encouraged for paramedics who have been employed for more than 2 years and are conducting ALS/BLS and critical care transports. In addition, FP-C or CCP-C certifications required for paramedics who conduct critical care transports and have been employed for more than 2 years. Where available for the role and patient population(s) transported, a transport-specific certification is strongly encouraged."

The committee agrees and will make the changes as suggested.
My first request for consideration is recommending that the wraps in which we place our patients for transport are fire-resistant. Our crews are outfitted in Nomex & it may be a step in the right direction to protect our patients with a fire-resistant wrap as well. The committee is not aware of any fire-resistant patient wraps nor what the impact would be on patient care, cost and infection control. The committee believes this suggestion needs further research and, in lieu of holding up the 11th Edition of the Standards, this issue will be moved for consideration within the 12th Edition once further information is obtained.

Secondly, I may have missed it but I wanted to ensure there are recommendations regarding the crews' psychological and emotional well-being, along with the physical well-being. Resilience training, suicide prevention training, trained peer support teams, and a defined response plan above & beyond the PAIP would likely help with the day-to-day traumas our crews face, as well as with incidents and accidents. The committee agrees with the recommendation that more needs to be done related to crew well-being. The Standards will be updated in several sections, including administrative support and staff and management education to reflect these changes.

I finally had an opportunity to review the CAMTS 11th edition changes, and have some comments related to the collection of GAMUT data. I struggle with the value added for our program, which provides transport at the Intensive Care level, to be required to submit GAMUT data for ALL GAMUT metrics. There are many metrics which do not apply to us as an Intensive care transport program. Additionally, we do not have a dedicated QM person, so this work is done by staff volunteers who are given business time between flight shifts. We have to provide metrics to the Institution and to the State which are also different, so the workload becomes too great to add non-value added data collection and reporting.

I would rather see some verbiage around data metrics which reflect the scope of care to include identified GAMUT metrics and those representative of the patients being transported. That would make more sense to me. As with most standards, the program is measured within their defined scope of care and services. The program should select the GAMUT metrics that are relevant to their level of care to assure and improve quality patient care. Not all GAMUT metrics may be required. Although we have wording in this respect at the beginning of the Patient Care section, 03.01.00, we have revised the verbiage to further clarify this intent. Also keep in mind, the GAMUT metrics are constantly evolving and the list changes over time. The most recent list can be found on the GAMUT website.
Standard 03.02.02 Medical Direction
The current Standard states …..” In addition, the medical director must be current and demonstrate competency or provide documentation of equivalent educational experiences…..”. The question was, “What is current?”. The physicians on the Board call thought that current should be at least every three years (an accreditation cycle).

The committee agrees that several items listed under this Standard change more frequently with new research and education. The Standard will be changed to include .... “(at least every three years”) ... after the following items:

7. Hazardous materials recognition and response
8. Human Factors – Crew Resource Management
14. Stress recognition and management
15. Sleep deprivation, sleep inertia, circadian rhythms and recognizing signs of fatigue

Note: We will be adding resilience training in conjunction with stress recognition and management.

As of June 14, 2018

The 11th Edition comment period has been closed and the changes will be moved on to the Standards/Consensus Committee for a final vote. Comments received after this date will be considered for the 12th Edition.