STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Joe Manchin III
Governor

Martha Yeager Walker
Secretary

MEMORANDUM

TO: All WV Medical Command Centers
All WV EMS Providers
All WV Licensed EMS Aeromedical Agencies
All Regional Program Directors
All Regional Medical Directors

FROM: William D. Ramsey, M.D. William D. Ramsey MD
State EMS Medical Director

DATE: April 20, 2009

RE: Coordination of Scene Aeromedical Response

The following information is provided to review and clarify the policy and procedures to be utilized by EMS providers and Medical Command Centers concerning the coordination of scene aeromedical responses within West Virginia.

1. West Virginia EMS providers will continue to operate according to WV EMS System protocols concerning scene aeromedical requests (*Field Aeromedical Protocol 9105*) and *Trauma Assessment and Management Procedures (TAMP Protocol 4101, 5101, and 6101).*

2. As is currently the policy, all requests for scene aeromedical response within West Virginia will continue to be made to the jurisdictional Medical Command Center. Medical Command will determine the closest available helicopter and arrange for the alert or response if appropriate.

3. If an aeromedical dispatch center receives a call directly from a scene or 911 center within West Virginia, the aeromedical dispatch center will forward the

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call directly to the jurisdictional Regional Medical Command Center for processing and coordination of the scene aeromedical response.

4. As is currently the policy, the appropriate destination of the patient will be determined by the EMS line officer in charge at the scene under the direction of the Medical Command Center.

5. Patients who meet criteria for aeromedical transport from the scene should be transported to a Level I or II trauma center not to Level III trauma centers. Patients which do not require Level I or II trauma services should be transported **by ground** to the Level III trauma centers or closest appropriate facility. All destination decisions are under the direction of the jurisdictional Medical Command Center.

6. Aeromedical services must keep the appropriate Medical Command Center informed anytime they are flying within that regional area to assure that Medical Command will have accurate and up to date information on the location of the helicopters if needed for scene flights. Regional Medical Command Centers must also keep adjacent medical command centers informed of any aeromedical activity between regions.

7. Aeromedical services must provide clear and accurate information as to the availability of the specific ship requested. If the aeromedical service operates ships in more than one location, it is vitally important the aeromedical dispatch center be specific as to which ship is actually available and its true location so Medical Command can respond the closest ship available.

8. All Regional Medical Command Centers will maintain a log of all scene aeromedical requests and responses occurring within their region. This log shall include at a minimum the date, time, caller, type of request, location, criteria, if response was granted, any extenuating circumstances which may have necessitated an aeromedical response, aeromedical service which responded, response times, and final disposition of patient. This information will be monitored and reviewed by the Regional Medical Director and by the State Medical Director as required or requested.

With the proliferation nationwide of Helicopter EMS (HEMS) Programs as well as the alarming increase in fatal accidents within the HEMS arena it is critical that the West Virginia Trauma and EMS System assure proper utilization of the aeromedical resource. Utmost care must be taken to assure use of this resource is appropriate and indicated and does not place patients, providers, or the public at greater risk than is indicated based on the medical needs of the patient. With these factors in mind the following clarifications and guidelines should be utilized by all West Virginia EMS agencies when considering utilization of aeromedical service for scene responses:

1. WV EMS providers, when requesting a scene aeromedical response, must be prepared to provide to their jurisdictional Medical Command Center basic

triage information confirming the triage indicators which necessitate aeromedical transport from the scene. If the EMS provider confirms that the patient meets any of the following Major trauma indicators **AND** helicopter transport is significantly quicker and of clinical benefit, the Regional Medical Command Center will immediately respond the closest helicopter:

- Systolic BP<90 (Adult) (Pediatric specific hypotension)
- Respiratory Rate <10 or >29.
- GCS <9 (GCS 9-14 when considered with other associated factors)
- Flail Chest
- Pelvic fracture
- Paralysis from spine trauma
- Open or depressed skull facture
- Rapidly declining mental status
- Penetrating injuries to head, neck, or torso
- 2 or more proximal long-bone factures
- Paralysis or vascular compromise of limb
- Crushed, degloved, or mangled extremity
- Amputation proximal to wrist or ankle
- Combination trauma with burns
- Penetrating injuries to extremities proximal to elbow or knee

2. If an EMS provider is considering aeromedical transport based merely on mechanism of injury, age, pregnancy, or other "at risk" criteria then more detailed consultation with Medical Command must occur prior to dispatch of the helicopter. The closest helicopter will be placed on "alert". Based on this consultation Medical Command will assist the EMS agencies in determining the best mode and destination for the transport of the patient. If this consultation with Medical Command determines that aeromedical transport is medically indicated then the helicopter will be launched.

Mechanism of injury criteria include:

- High risk auto crash (intrusion >12 inches, ejection, death in same passenger compartment, rollover without restraint).
- Pedestrian struck by auto at >20 MPH.
- Motorcycle crash > 20 MPH.
- Falls greater than three (3) times the patients height.
- Exposure to blast or explosion

3. EMS providers should be very diligent at providing the following information to their jurisdictional Medical Command Center:
   - Ground drive time to closest designated Level I or II trauma center (< or > 30 minutes) **Note: If the drive time to a designated Level I or II trauma center is less than 30 minutes and there is no extrication delay at the**

scene aeromedical transport is rarely indicated, unless there are extenuating circumstances.

- Name of closest hospital and closest designated trauma center
- Patient's specific trauma triage indicator(s) which require aeromedical response
- Any extenuating circumstances which may justify aeromedical transport (i.e.: extreme distances in very rural areas, major highway closings, etc.)

4. WV EMS agencies should also make their primary dispatch centers aware of the importance of providing specific patient triage indicators to Medical Command. This is particularly important if the dispatch center is involved in relaying the request to the Regional Medical Command Center.

The above procedures will assure that we continue to provide the best care possible for the patients we serve and utilize all available resources wisely. If you have specific questions you may contact me or Deron Wilkes, Chief of Operations for OEMS. As outlined in the above memo we will be monitoring all aeromedical responses within West Virginia and make appropriate revisions or additions to these procedures as required.

Thank you for all you do to provide quality emergency care to the citizens of West Virginia.

WDR/nll

cc: Jerry Kyle
David Kappel, M.D.
Deron Wilkes