

To all -

The core concepts that I feel are important (as discussed at the October meeting) are that:

- 1) High-quality, safe patient care is improved by consistency in approach by a particular air provider, whether that be in treatment guidelines, equipment, or QI data evaluation. Having multiple layers of requirements for those providers with multi-LEMSA coverage is wasted time, effort, and money, and diverts from the goal of improving care.
- 2) LEMSA's should have the opportunity to be involved in a feedback loop for air providers who are interfacing with single LEMSA's (or a few LEMSA's) for their accreditation and QI needs. That feedback includes the revision of treatment protocols or procedures, additions/deletions to scope, and the use of QI to focus on particular training or educational needs.
- 3) There is strength in evaluation of data that is collected in a uniform manner, and can be evaluated both between different air providers and across a single air provider's entire operation (when LEMSA's focus on perhaps the smaller number of calls they have, trends are hard to see or may be statistically insignificant).

To that end, I put together a little "discussion paper" and flow chart that outlines some of the concepts that I discussed yesterday. This is really to address issues of the multi-LEMSA coverage, though I think single LEMSA air providers certainly should be working cooperatively with their LEMSA with uniform data, QI, etc. I elected to call the LEMSA who acts as a base for accreditation, scope, guidelines as the "Host LEMSA" to avoid some confusing terminology with regard to the word "base."

The main concept of the flow chart is that a uniform set of data be available to all agencies, and that QI feedback should be coordinated between the provider, host LEMSA, and other LEMSAs in order to complete the QI loop and to allow input of those other "non-host" LEMSAs. It's clear that some LEMSA's will not be as involved in the process, but to me, providing a structure for input is important rather than simply delegating the duties to the host LEMSA. I think the RN-RN configured agencies may not see the need for the "host LEMSA" format because accreditation is not involved. QA and individual case reviews will still need close relationship between the air provider and the involved LEMSA's (as I note at the bottom). I do wonder how much these "host LEMSAs" will see this as a burden - previously my concept was to have a regional structure to address things instead of host LEMSA's but I think no one was interested in creating a new bureaucratic layer in the process.

I also threw in the state's role with CEMSIS data on the flow chart. I think all of us have not been thinking about the data flow pattern of air providers, though it

would seem that the point of origin of the call should be where the data flows from.

I didn't put my name on this document because it is just my collected thoughts and not a campaign for me pushing through something. But I think if we are going to try to sell any of this to medical directors and administrators, we need to lay out those ideas in the most cogent way we can. I think it's important that we outline the somewhat dysfunctional, incomplete, and wasteful structures we now have as part of that discussion so that they can see why an alternative is being proposed. I have tried to describe our current system based on my knowledge of it state-wide, but it may be skewed toward my own exposure.

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