JOSH GREEN, M.D.
GOVERNOR OF HAWAIʻI
KE KIAʻĀINA O KA MOKUʻĀINA ʻO HAWAIʻI

KENNETH S. FINK, M.D., M.P.H., M.G.A.
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STATE OF HAWAI'I
DEPARTMENT OF HEALTH
KA ʻOIHANA OLAKINO
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HONOLULU, HI 96801-3378

In reply, please refer to:
File:

January 20, 2026

The Honorable Ronald D. Kouchi,
President and Members of the Senate
Thirty-Third State Legislature
State Capitol, Room 409
Honolulu, Hawaii 96813

The Honorable Nadine K. Nakamura,
Speaker
and Members of the House of
Representatives
Thirty-Third State Legislature
State Capitol, Room 431
Honolulu, Hawaii 96813

Dear President Kouchi, Speaker Nakamura, and Members of the Legislature:

For your information and consideration, I am transmitting a copy of the Report from the Aeromedical Services Working Group to the Legislature, pursuant to Senate Concurrent Resolution 86, Session Laws of Hawaii 2025.

In accordance with Section 93-16, Hawaii Revised Statutes, I am also informing you that the report may be viewed electronically at:

https://health.hawaii.gov/opppd/department-of-health-reports-to-2026-legislature/

Sincerely,

Kenneth S. Fink, M.D., M.P.H., M.G.A.
Director of Health

Enclosures

c: Legislative Reference Bureau
Hawaii State Library System (2)
Hamilton Library

STATE OF HAWAIʻI

2025-2026 AEROMEDICAL SERVICES WORKING GROUP REPORT

KA ʻOIHANA OLAKINO

January 2026

DEPARTMENT OF HEALTH

EMERGENCY MEDICAL SERVICES & INJURY PREVENTION SYSTEMS BRANCH

RIGHT PATIENT, RIGHT PLACE, RIGHT TIME, RIGHT NOW

PURSUANT TO SENATE CONCURRENT RESOLUTION 86 (SCR 86) 2025
SUBMITTED TO THE THIRTY-THIRD LEGISLATURE
REGULAR SESSION OF 2026

Prepared pursuant to Senate Concurrent Resolution 86 (2025) to inform legislative action on statewide aeromedical services governance, funding, and emergency preparedness.

Emergency Medical Services and Injury Prevention Systems Branch
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting State Emergency Medical Services Chief &
State Trauma Program Manager
Garrett.Hall@DOH.Hawaii.gov

This report is dedicated to
Chief Kazuo Scott Ku‘ika‘aleoPelepohākalani Leithead Todd
Fire Chief, County of Hawai‘i, Hawai‘i
(1979 – 2025)

Chief Todd devoted more than 21 years to Hawai‘i County Fire Department, serving the community that raised him. Appointed Fire Chief in 2021, he led more than 350 emergency medical technicians, paramedics, firefighters, ocean lifeguards, aeromedical professionals, search and rescue teams, and support staff across Hawai‘i’s largest and most geographically complex island. Under his leadership, the department modernized operations, acquired critical apparatus and aeromedical resources, expanded EMS, and strengthened community-based risk reduction and preparedness efforts.

His leadership extended statewide through his service as Chair of the Hawai‘i State Fire Council, where he collaborated with county, state, and federal partners to advance fire prevention, training standards, interoperability, mutual aid coordination, and disaster preparedness across Hawai‘i.

A trusted partner and advocate, Chief Todd understood the vital role of EMS, Fire, and emergency aeromedical services[1] in delivering timely, lifesaving care, particularly for island communities. He championed emergency aeromedical transport as a critical component of Hawai‘i’s EMS system, improving access to definitive trauma, burn, and specialty care while advancing equity and patient outcomes through thoughtful planning and operational readiness.

Chief Todd was not only a leader, but a connector, showing up with humility, presence, and genuine care. He lifted those often unseen, welcomed new leaders, and brought people together across disciplines with trust and respect. His passion for keeping people safe set a lasting example for EMS and Fire professionals statewide.

On behalf of the Senate Concurrent Resolution Aeromedical Services Working Group, the Hawai‘i Department of Health, and the Emergency Medical Services and Injury Prevention Systems Branch, we honor and remember Chief Kazuo Todd for his enduring support of Hawai‘i’s EMS and emergency aeromedical systems.

While we mourn his sudden passing, we are deeply grateful for the legacy of service, resilience, and aloha he leaves behind. May his light, like the enduring glow of Pele, continue to guide us forward.

Chief Kazuo Todd is survived by his wife, Miko; his daughter; his parents; and his siblings. To his ‘ohana and loved ones, we extend our deepest condolences and heartfelt aloha. He will be deeply missed, and his legacy will continue to shape public health and safety across our islands.

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Legislative Snapshot

The Problem: Hawai'i's aeromedical transport system is under increasing system-level strain that threatens timely access to definitive care, emergency preparedness, and health equity statewide. Demand for emergency and interfacility aeromedical transport continues to grow, while governance structures, staffing capacity, and coordination mechanisms have not kept pace with modern clinical, operational, and geographic realities.

Key challenges include:

- Emergency and interfacility aeromedical transport times that routinely exceed nationally recognized benchmarks.
- Insufficient Department of Health (DOH) Emergency Medical Services and Injury Prevention Systems Branch (EMISPSB) staffing dedicated to statewide aeromedical coordination, oversight, and quality governance.
- The absence of a centralized, statewide medical communications and transfer coordination capability for aeromedical services.
- Rising operational costs combined with outdated reimbursement structures that threaten system sustainability.
- Disproportionate delays, access limitations, and financial burden experienced by rural and neighbor island communities.

Why This Matters to Hawai'i

In an island state, ***aeromedical transport is not optional infrastructure, it is a core public safety, healthcare access, and disaster preparedness function***.

- Neighbor island and rural residents depend on aeromedical transport for timely access to trauma, stroke, cardiac, burn, and specialty care.
- Delays in aeromedical response increase the risk of preventable morbidity and mortality while reducing the availability of EMS resources for other emergencies.

- Hawai'i's exposure to hurricanes, wildfires, volcanic activity, tsunamis, and mass-casualty incidents requires coordinated, multi-island aeromedical readiness.
- Without centralized coordination, hospitals, EMS agencies, and aeromedical providers must independently compete for limited aircraft and crews during emergencies.
- Equitable access to definitive care cannot be achieved without statewide coordination, clear authority, and sustained governance.

What Senate Concurrent Resolution 86 (2025) Asked For

Senate Concurrent Resolution 86 (2025) requested the Department of Health to convene an Aeromedical Services Working Group to:

- Assess statewide aeromedical service needs;
- Identify barriers to predictable, stable air ambulance services; and
- Develop recommendations for procedures, protocols, and funding to strengthen aeromedical services statewide.

Priority Recommends

Based on its findings, the Working Group recommends the following priority actions:

1. **Establish permanent, dedicated aeromedical staffing within the Department of Health EMS Section** to support statewide coordination, oversight, quality improvement, and disaster readiness.
2. **Support the Modernize Hawai'i Revised Statutes §321-221 through §321-237** to reflect modern aeromedical operations and clarify statewide authority and accountability.
3. **Establish a centralized, scalable statewide Medical Communications (MEDICOM) Center** to coordinate emergency and interfacility aeromedical transport as part of Rural Healthcare Transformation Program.
4. **Sustain and expand a unified statewide EMS aeromedical data and communications platform** to support real-time situational awareness, performance monitoring, and system accountability.

5. **Adopt nationally recognized accreditation frameworks** to strengthen clinical, safety, and operational standards without duplicative or overly prescriptive regulation.

Immediate Legislative Actions Requested (FY 2026–2027)

To advance these recommendations, the Working Group requests that the Legislature:

- Appropriate recurring funds and establish permanent Department of Health EMS aeromedical staffing in Hawai‘i Revised Statutes (HRS).
- Authorize statutory modernization of HRS Chapter 321 to support statewide aeromedical coordination and governance.
- Support planning and phased implementation of a statewide Medical Communications (MEDICOM) Center, including integration with rural healthcare transformation efforts.
- Sustain funding for the unified statewide EMS and aeromedical data infrastructure.

Executive Overview

Hawai‘i’s aeromedical transport system is a critical component of the State’s emergency medical services, healthcare delivery, and disaster response infrastructure, ensuring time-sensitive access to definitive care across geographically isolated islands and rural communities. Reliance on aeromedical transport for emergency response and interfacility transfer of high-acuity patients continues to increase, driven by limited local specialty resources, hospital capacity constraints, and geographic distance.

The Aeromedical Services Working Group found that existing statutory and administrative frameworks no longer reflect the complexity of modern aeromedical operations. Hawai‘i Revised Statutes (HRS) §321-221 through §321-237 and Hawai‘i Administrative Rules (HAR) §11-72 predate current emergency and interfacility transport capabilities, advanced critical care transport models, and the need for real-time, statewide situational awareness. As a result, ambiguity in authority, roles, and accountability has contributed to fragmented coordination, transfer delays, limited system visibility, and challenges in long-term planning and resilience.

DOH EMSIPSB currently lacks dedicated aeromedical staffing capacity to fulfill its statutory responsibilities for statewide coordination, oversight, data governance, and disaster preparedness. Staffing levels have remained largely unchanged for more than twenty-five years, despite substantial growth in emergency medical services (EMS)

demand, aeromedical utilization, patient acuity, regulatory complexity, and expectations for real-time data integration and quality improvement. This mismatch between responsibility and capacity constrains the State's ability to ensure consistent aeromedical governance, accountability, and readiness.

Recent advancements in statewide EMS data modernization represent a significant step forward. Effective January 1, 2026, all licensed aeromedical providers are required to participate in a unified EMS electronic patient care record system, enabling standardized data capture and near–real-time system visibility. However, the absence of a centralized, statewide aeromedical coordination and transfer structure continues to limit the State's ability to translate data into timely, coordinated operational decision-making.

Financial sustainability, workforce stability, equity, and disaster preparedness remain cross-cutting challenges. Rising operational costs, stagnant reimbursement, and delayed payments threaten service availability, while patients, particularly those on neighbor islands, face unavoidable financial exposure and access disparities. Hawai‘i's vulnerability to large-scale disasters further underscores the need for centralized coordination, interoperable communications, and clearly defined authority for aeromedical operations during emergencies.

What Happens If We Do Nothing

Without legislative action, Hawai‘i's aeromedical system will continue to operate under fragmented authority, limited coordination, and insufficient staffing capacity. Emergency and interfacility transfer (IFT) delays will persist, increasing the risk of preventable morbidity and mortality for time-sensitive conditions. Disaster response will remain vulnerable due to the absence of centralized situational awareness and coordination. Reliance on the United States Military and Coast Guard for civilian medical transports will continue, leaving the state dependent upon military resources that have the potential of being deployed on national defense missions, leaving our state most venerable. **Most critically, rural and neighbor island communities will continue to experience inequitable access to definitive care, reinforcing geographic and health disparities that aeromedical transport is intended to mitigate.**

II. Legislative Background

For more role information, please see the original Senate Concurrent Resolution 86 in Appendix A.

Per Senate Concurrent Resolution No. 86 (SCR 86), Senate Draft 1, House Draft 1, of the Thirty-Third Legislature of the State of Hawaii (2025), DOH was requested to convene an Aeromedical Services Working Group (“Working Group”). The resolution acknowledges that timely access to primary and specialty healthcare is critical for Hawai‘i residents, particularly those living in rural communities where access to advanced trauma care, specialists, and subspecialists is limited.[2]

The Legislature further recognized that patients in these communities face higher risks of poor outcomes for serious time-sensitive conditions such as stroke, heart attack, and traumatic injuries. At the time the resolution was passed, Hawai‘i’s aeromedical system is heavily burdened and relied on a single statewide provider, leaving the State vulnerable to service disruptions caused by aircraft maintenance, crew shortages, or operational grounding. Since then, the Hawai‘i aeromedical system has grown from a single statewide provider to three (3) licensed aeromedical providers.

SCR 86 identifies numerous barriers to strengthening Hawai‘i’s aeromedical system, including insufficient funding, inconsistent procedures and protocols, and the absence of a coordinated statewide planning framework. To address these challenges, the resolution established a multidisciplinary working group comprising of representatives from DOH, state and county emergency management agencies, legislative health committees, health systems, insurers, and both independent and established aeromedical providers.

III. Role of Working Group

For more role information, please see the original Senate Concurrent Resolution 86 in Appendix A.

The working group was requested to:

1. Study and assess emergency aeromedical services needs across the State and in each county; and
2. Develop and recommend future procedures, protocols, and funding to increase the predictability and stability of air ambulance medical services for the State.

The working group was further requested to submit a report of its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2026.

The working group is further requested to dissolve on June 30, 2026.

IV. Working Group Members

Based on SCR 86, the working group is comprised of the following members:

Hawai'i State Department of Health, Emergency Medical Services & Injury Prevention Systems Branch: *Acting Branch Chief*	Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Chair of Senate Committee on Health & Human Services *Senator*	Senator Joy San Buenaventura
Vice Chair of House Committee on Health *Representative*	Representative Sue L. Keohokapu-Lee Loy
Hawai'i Emergency Management Agency *Operations Chief*	Jack Lee
Honolulu Emergency Management Agency *Director*	Randal Collins, Ed.D., CEM
Maui Emergency Management Agency *Operations Chief*	Jake Kiyohiro
Kaua'i Emergency Management Agency *Administrator*	Elton S. Ushio
Hawai'i Emergency Management Agency *Administrator*	Talmadge Magno
Healthcare Association of Hawai'i *Chief Executive Officer (CEO)*	Hilton Raethel, MPH, MHA
Hawai'i Association of Health Plans: Hawai'i Medical Service Association *Government Relations Manager*	Walden Au, MBA
Health System Operating in the State: Queen's Health System *Vice President of Patient Care*	Ashley Shearer, LCSW, CSAC
Representative Provider Hawai'i County: Hawai'i County Fire Department Emergency *Medical Services Battalion Chief*	Kilipaki Kanae, EMT-P
Representative Provider Honolulu County: Optimum Air *Chief Strategy Officer*	Jon Rosati
Representative Emergency Aeromedical Provider: Air Methods *Senior Vice President*	Anthony "Tony" Raymond, RN
Representative Emergency Aeromedical Provider: Hawai'i Life Flight *Regional Director*	Brent Lopez

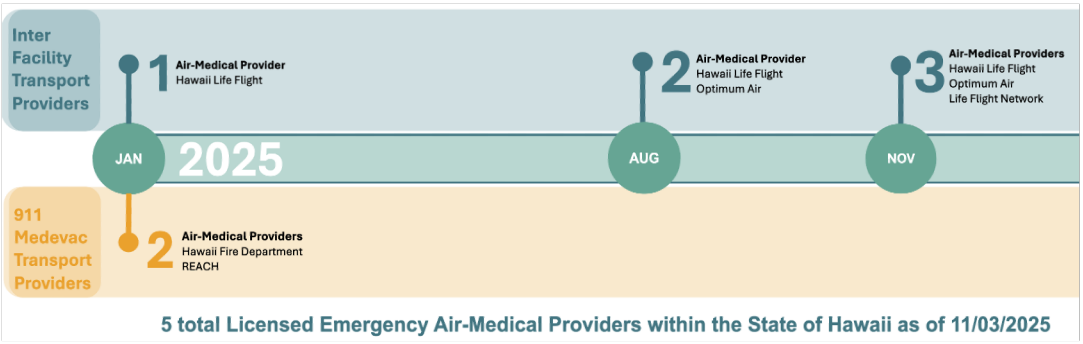
Working Group Invited Participants

Global Medical Response (GMR) *Vice President of Operations, Pacific Region*	Christopher Shrader
Hawai‘i State Department of Health *Deputy Director of Health Resources*	Debbie Kim Morikawa
Hawai‘i State Department of Health *Assistant to Deputy Director of Health Resources*	Curtis Pruder
Hawai‘i State Department of Health, Emergency Medical Services & Injury Prevention Systems *Medical Director of Hawaii County*	Terrance Jones, MD, FACEP
Queen’s Medical Center *Director of Patient Flow*	Heather Liana Ku‘ualoha Texeira Beyer, RN, BSN
Hawai‘i Medical Service Association *Government Policy and Advocacy Coordinator*	Amelia Castro
Kauai Emergency Management Agency *Executive Officer*	Solomon Kanoho
Hawai‘i State Department of Health Emergency Medical Servcies and Injury Prevention Systems Branch (EMSIPSB) *Assistant to Acting EMSIPSB Chief*	Andrew Yonemura

V. Overview Hawai‘i Aeromedical / Air-Medical Landscape

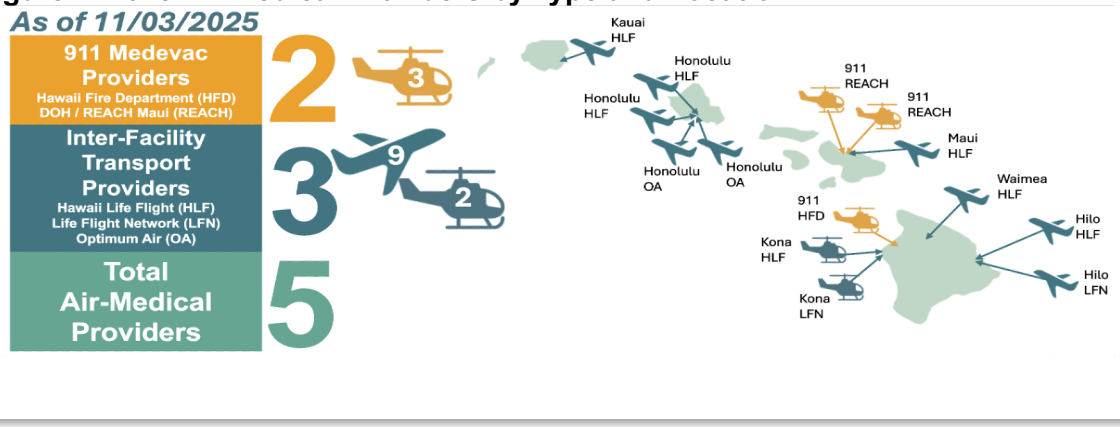
Historically, Hawai‘i’s civilian emergency air-medical transport system was predominantly served by a single provider. For more than three decades, Hawai‘i Life Flight, including its predecessor air ambulance operations, functioned as the principal civilian emergency and interfacility transport (IFT) air-medical inter-island transport provider in the state. Following the closure of other civilian air ambulance operators, including LifeSave KuPono in 2022, and Air Methods, Hawai‘i Life Flight remained the sole major civilian air-medical provider supporting critical interfacility transport statewide.[3,4]

Figure 1: 2025 Total Licensed Air-Medical Providers in Hawaii Timeline



However, over the past year, Hawai‘i’s air-medical landscape has rapidly expanded. As of November 3, 2025, there are now three (3) IFT air-medical transport providers operating in the State: Hawai‘i Life Flight (HLF), Optimum Air, and Life Flight Network (LFN); reflecting increased demand for air-medical services and a diversification of available system resources. (see **Figure 1** and **Figure 2**)[5]

Figure 2: 2025 Air-Medical Providers by Type and Location



VI. Hawai‘i State Aeromedical / Air-Medical Data

Prior to January 1, 2026, DOH EMSIPSB did not enforce mandatory use of a standardized aeromedical EMS electronic patient care record (ePCR) / electronic health record (EHR) system for licensed aeromedical providers operating within the state. During this period, DOH relied on voluntary data submissions from aeromedical agencies, resulting in limited standardization, delayed reporting, and incomplete system-level visibility of aeromedical operations and patient care.

Under new leadership within the DOH EMS branch, and in accordance with HRS requirements related to EMS licensure, oversight, and data reporting, regulatory and operational governance of aeromedical EMS data has been strengthened.[6] Effective January 1, 2026, all aeromedical providers licensed to operate in the State of Hawai‘i are required, as a condition of licensure, to utilize the DOH funded aeromedical EMS (ePCR/EHR) system. This mandate establishes a unified, statewide aeromedical data infrastructure and supports standardized, timely, and accurate data capture for regulatory compliance and system oversight.

Image Obtained from https://www.lifeflight.org/service-area/hawaii/

Moving forward, DOH will maintain near real-time aeromedical EMS data systems that enable interoperability between aeromedical providers and receiving hospitals. This integration supports improved clinical continuity, system performance monitoring, quality improvement, and trauma system oversight by providing timely, standardized, and actionable aeromedical data across the continuum of care.

All data regarding transport times and transports presented in this report were manually reported and represent the most current aeromedical data available prior to full implementation of the mandated ePCR platform and associated licensing requirements. These data should be interpreted within the context of pre-integration reporting limitations and serve as a baseline for future analyses following full system adoption.

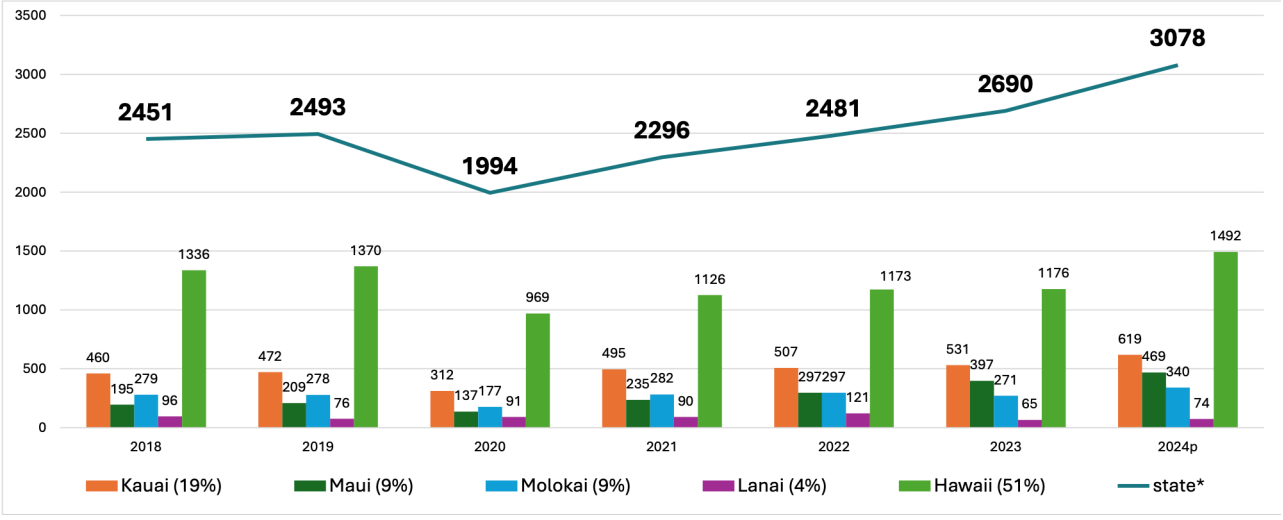
Transport Volume

Air-medical transport volume in Hawai'i has shown a steady increase since 2020, with an average of more than 500 additional air-medical transports per year compared to pre-2020 levels. This growth reflects increasing demand on the system and heightened reliance on air-medical services to access definitive care. (see **Figure 3**)[7]

Images Obtained from https://www.hawaiilifeflight.com/our-fleet

Figure 3: Hawaii Air-Medical Ambulance Flights by Patient Pick-Up Location 2018-2024*

*Total for 2024 data through October 31, 2024. State total includes 143 (1%) flights from Oahu and 492 (4%) from unrecorded locations.



Wheels-Up Time Key Performance Indicator (KPI)

Wheels-up time is a nationally recognized aeromedical Key Performance Indicator (KPI) defined as the interval from the time an aeromedical resource is dispatched, and the flight is accepted to the time the aircraft departs ("wheels-up").[8,9]

Analysis of statewide aeromedical transport data from November 2022 through October 2024 demonstrates the following performance trends: (see **Figures 4-6**)

- The **statewide average wheels-up time was 122 minutes** from flight acceptance to aircraft departure.
- **Only 18 percent of flights met the 30-minute wheels-up benchmark**, indicating limited ability to achieve rapid deployment.
- **More than 50 percent of flights exceeded one hour**, reflecting a consistent performance pattern across the system rather than delays attributable to isolated providers.

Figure 4: Wheels-Up Time KPI Average Minutes*

*Data for this figure was pulled from November 1, 2022, through October 31, 2024. Should be also noted that between January 1, 2018 and October 31, 2024 the island of Oahu / County of Honolulu was 1% or less of air-medical transports across the state so the following data does not include air-medical data for Oahu / Honolulu.

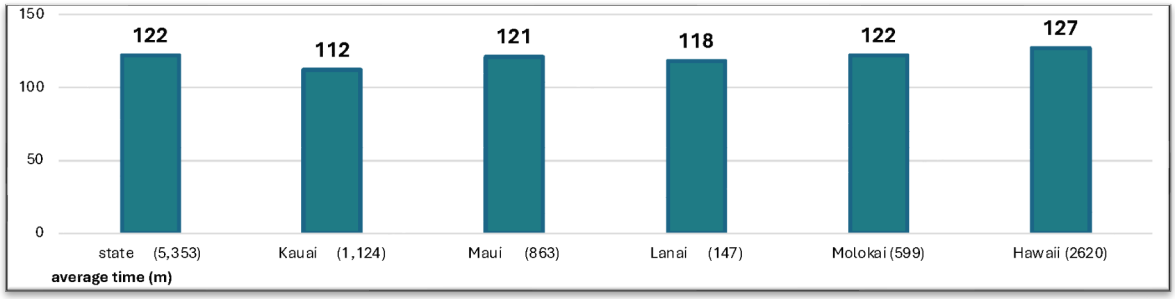
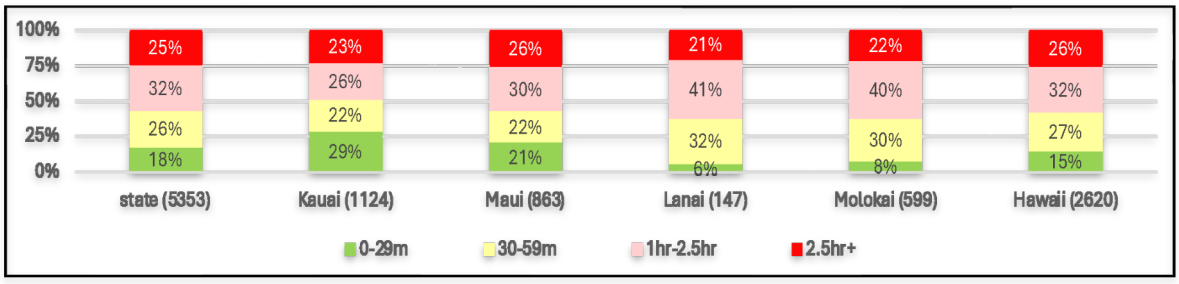


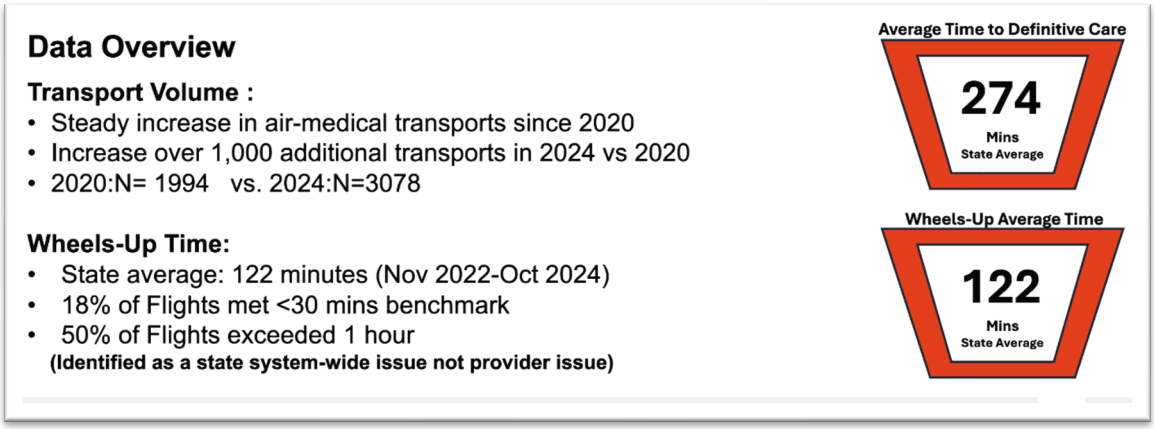
Figure 5: Wheels-Up Time KPI by Percentage of Flights

*Data for this figure was pulled from November 1, 2022, through October 31, 2024. Should be also noted that between January 1, 2018, and October 31, 2024, the island of Oahu / County of Honolulu was 1% or less of air-medical transports across



These findings indicate statewide system-level structural and operational constraints impacting aeromedical response readiness and timeliness across the State of Hawai'i.

Figure 6: Transport Volume and Wheels-Up Time Summary



National clinical and operational guidance recommends substantially shorter response times for aeromedical activation. According to a joint policy statement from the National Association of EMS Physicians (NAEMSP) and the American College of Emergency Physicians (ACEP), which aligns with Commission on Accreditation of Medical Transport Systems (CAMTS) standards, the recommended goals for primary scene responses are:

- **Dispatch-to-Departure (Wheels-Up) Goal:** Less than **10 minutes** after activation[10]
- **Dispatch-to-Patient Contact Goal:** Ideally **25–30 minutes** for rural and remote regions

Response times exceeding these benchmarks should be clearly documented, with justification that may include factors such as weather conditions, geographic distance, or mechanical limitations.

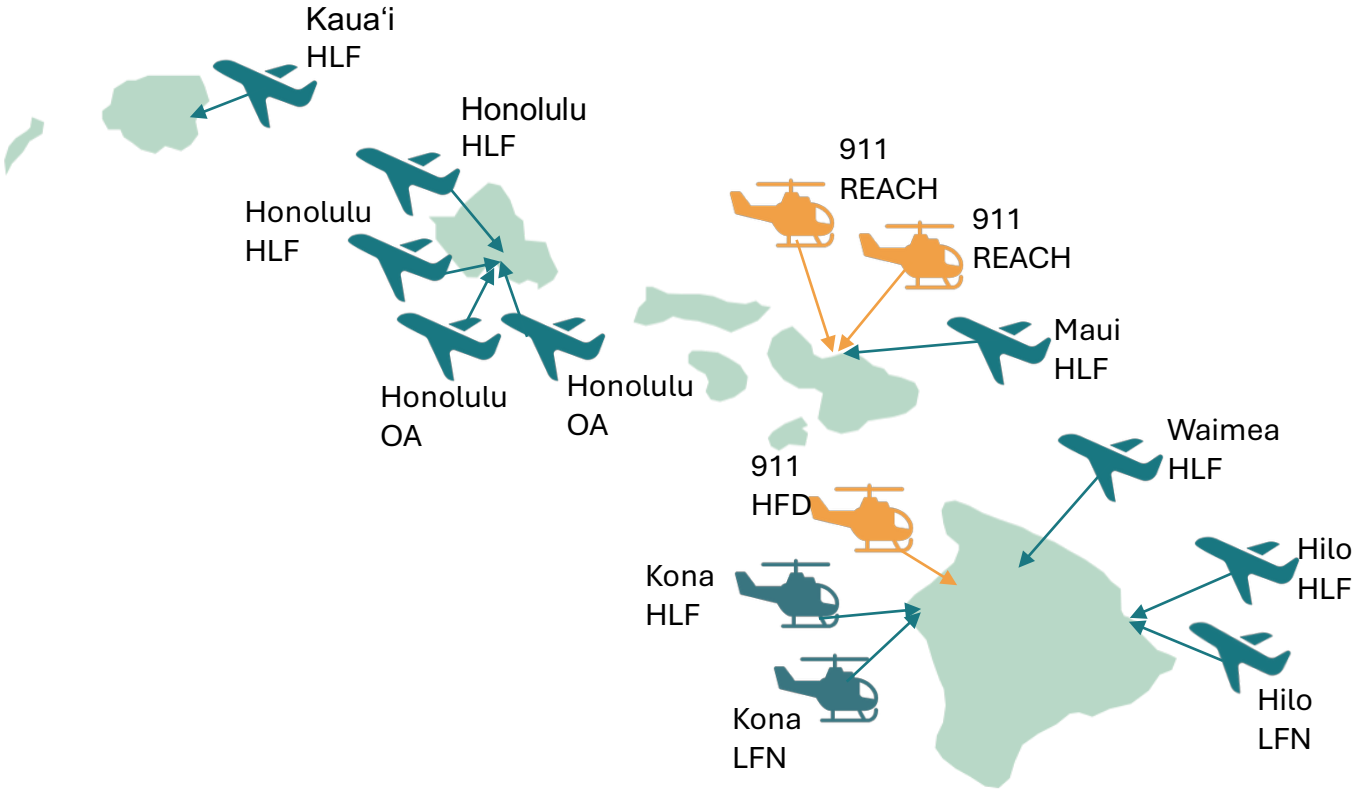
Based on these findings, the working group recommends that DOH EMSIPSB act upon with HRS §321-230 and establish the State Emergency Aeromedical Services Quality Improvement Committee. The committee should be comprised of representatives from trauma care, emergency medicine, aeromedical transport services, and tertiary care providers, and be charged with reviewing, analyzing, and monitoring data collected through standardized aeromedical quality improvement KPI measures.

These performance KPI measures should include, but not be limited to, wheels-up time and other KPIs that collectively evaluate system readiness, timeliness, access, and overall performance of the emergency aeromedical system statewide. The purpose of the committee would be to support data-driven system oversight, continuous quality

improvement, patient safety evaluation, and evidence-based policy and operational decision-making.

It is further recommended that this committee report to the State Emergency Medical Services Advisory Committee (EMSAC). In partnership with DOH EMSIPSB, EMSAC should identify and appoint committee members with aeromedical expertise. Participation in this committee should be required for all licensed aeromedical providers operating in the State of Hawai'i, with a minimum expectation of quarterly participation, as a condition for maintaining state licensure as an aeromedical provider.

To ensure meaningful performance improvement and patient safety review, it is also recommended that the Emergency Aeromedical Services Quality Improvement Committee operate under and recognize HRS §624-25.5 as an exempt committee from Sunshine Law requirements, allowing protected review of cases, including those that fall outside established KPI thresholds, in accordance with recognized quality improvement and patient safety best practices. This falls in line with state and federal legislative justification where policy and models show that open-government laws routinely include carve-outs for peer review patient safety and quality improvement.[11, 12]



Scene Time: Arrival on Scene to Departure with Patient

Scene time is defined as the interval from an aeromedical aircraft's arrival on scene, whether at an incident location, hospital, or designated rendezvous point, which includes time aeromedical crew arrival at patient, to departure time with the patient. This measure is a critical operational KPI reflecting on-scene clinical care, patient assessment and stabilization, patient packaging, and coordination with ground responders.

Analysis of statewide aeromedical transport data from November 2022 through October 2024 demonstrates the following:(see **Figure 7**)

- The **statewide average scene time was 40 minutes.**

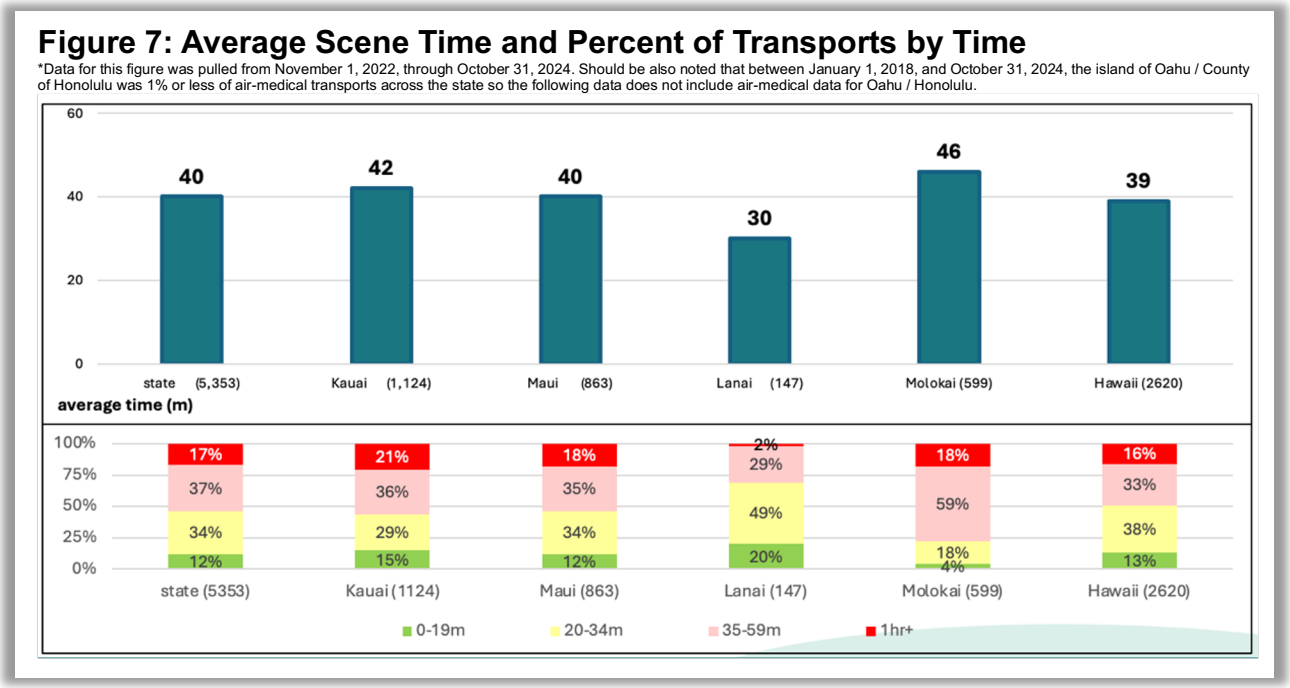
- Average scene times varied across islands, ranging from 30 minutes on Lāna'i to 46 minutes on Moloka'i, with Kaua'i (42 minutes), Maui (40 minutes), and Hawai'i Island (39 minutes) aligning closely with the statewide average.

Only 12 percent of statewide transports achieved a scene time of less than 20 minutes, while: (see **Figure 7**)

- **37 percent** occurred within **20–34 minutes**
- **37 percent** required **35–59 minutes**
- **17 percent exceeded one hour** on scene

Figure 7: Average Scene Time and Percent of Transports by Time

*Data for this figure was pulled from November 1, 2022, through October 31, 2024. Should be also noted that between January 1, 2018, and October 31, 2024, the island of Oahu / County of Honolulu was 1% or less of air-medical transports across the state so the following data does not include air-medical data for Oahu / Honolulu.



Several islands demonstrated a higher proportion of extended scene times: (see **Figure 7**)

- **Moloka‘i** experienced the highest percentage of scene times exceeding 35 minutes, with **59 percent** lasting 35–59 minutes and **18 percent exceeding one hour**.
- **Kaua‘i and Maui** each had over **35 percent** of transports in the **35–59 minute range**.
- **Lāna‘i**, while demonstrating the shortest average scene time, showed nearly **one-third of transports exceeding 35 minutes**, reflecting variability despite lower call volume.

These findings suggest that prolonged scene times are a recurring statewide pattern, likely influenced by factors such as patient acuity, limited on-scene resources, rural and remote access challenges, interagency coordination, and aircraft configuration or staffing models. The consistency of extended scene times across islands indicates system-level operational considerations rather than isolated performance issues.

Reducing scene time, while maintaining patient safety and clinical quality, remains an important opportunity for improving aeromedical system efficiency, time-sensitive access to definitive care, and overall emergency medical systems of care performance in the State of Hawai‘i.

Interval from Dispatch to Destination with Patient (Total Transport Time)

The interval from dispatch to arrival at the destination facility with the patient represents a critical system-level performance measure reflecting access to definitive care, geographic constraints, operational efficiency, and coordination across the emergency aeromedical system. This metric captures the full duration of patient movement from initial activation through arrival at the receiving facility.

Analysis of statewide aeromedical transport data from November 2022 through October 2024 demonstrates substantial variability in transport times across the State of Hawai'i.

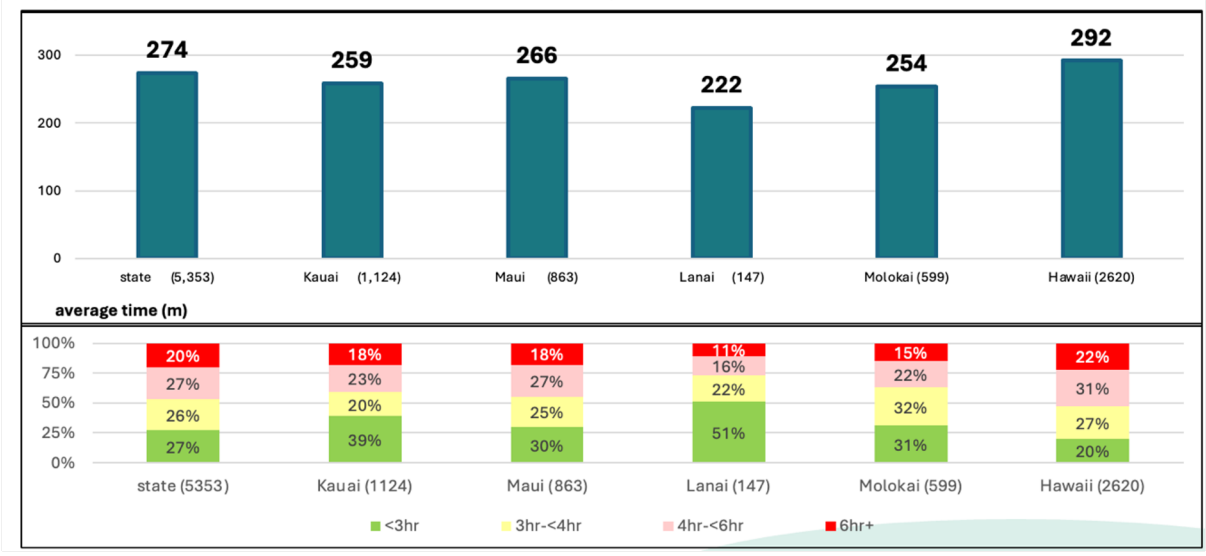
Statewide, the **average interval from dispatch to destination with patient was 274 minutes**. When examined by island region, average transport times were as follows: (See **Figure 8**)

- **Hawai'i County: 292 minutes**
- **Maui County: 266 minutes**
- **Kaua'i County: 259 minutes**
- **Moloka'i: 254 minutes**
- **Lāna'i: 222 minutes**

These values reflect the unique geographic and logistical challenges associated with inter-island and rural aeromedical transport; however, they substantially exceed nationally recognized benchmarks for rural emergency care access.

Figure 8: Average Time Interval from Dispatch to Destination with Patient

*Data for this figure was pulled from November 1, 2022, through October 31, 2024. Should be also noted that between January 1, 2018, and October 31, 2024, the island of Oahu / County of Honolulu was 1% or less of air-medical transports across the state so the following data does not include air-medical data for Oahu / Honolulu.



National clinical guidance emphasizes rapid access to definitive care, even in rural and remote environments**.** According to the National Association of EMS Physicians (NAEMSP), American College of Emergency Physicians (ACEP), American College of Surgeons (ACS), and trauma system best-practice guidance, rural and remote patients requiring time-sensitive specialty care should **ideally reach an appropriate receiving facility within 60 to 120 minutes from initial EMS activation**, inclusive of transport time. While allowances are recognized for distance, weather, and aircraft availability, transport intervals extending beyond this window are considered high-risk for adverse patient outcomes and indicative of system access limitations.

Distributional analysis of Hawai'i's aeromedical transports demonstrates that extended transport times are common across the system: (see **Figure 8**)

- **27 percent** of transports were completed in under **three hours**
- **26 percent** required **three to four hours**
- **27 percent** required **four to six hours**
- **20 percent** exceeded **six hours**

These findings indicate that the majority of aeromedical transports exceed nationally recommended rural access timeframes, with prolonged delays occurring across all island regions.

Regional variation further highlights disparities in access. Lāna'i had the highest proportion of transports completed within three hours (51 percent), while Hawai'i County had the highest proportion of transports exceeding six hours (22 percent). These patterns reflect structural challenges related to distance, limited specialty availability, aircraft positioning, and inter-island coordination.

Collectively, these data indicate that dispatch-to-destination intervals in Hawai'i represent a system-wide challenge, rather than isolated operational inefficiencies. Prolonged transport times have implications for patient outcomes, EMS and aeromedical resource availability, continuity of care, and health equity, particularly for residents of rural and neighbor island communities.

These findings underscore the importance of ongoing, data-driven oversight of the emergency aeromedical system, including evaluation of asset placement, destination protocols, interfacility transfer coordination, and integration with the statewide trauma system. Monitoring this KPI alongside wheels-up time and other aeromedical performance measures is essential to guiding quality improvement initiatives and legislative policy decisions such as establishing the MEDICOM Center for emergency and trauma transfer coordination aimed at improving timely access to definitive care across Hawai'i.

VII. National Best Practices

Assessment of Hawai'i s air-medical system performance is informed by nationally recognized clinical, operational, and accreditation standards for emergency medical transport and trauma care. These benchmarks are established by federal agencies, professional medical societies, accreditation bodies, and military aeromedical doctrine, and are widely used to evaluate access to time-sensitive definitive care in both civilian and remote/rural environments.

Aeromedical Time-to-Care Standards

National trauma system guidance emphasizes timely access to definitive care as a critical determinant of survival and functional outcomes.

The Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), and the American College of Surgeons Committee on Trauma (ACS-COT) **identify a target of less than 120 minutes from incident occurrence or injury to arrival at a facility capable of providing definitive trauma or surgical care**, particularly for rural and frontier regions where geography and distance may limit access.[13]

For **non-remote and urbanized regions**, national trauma literature commonly cites an **ideal benchmark of less than 60 minutes**, often referred to as the "Golden Hour," from injury to definitive care, recognizing that earlier intervention is associated with improved outcomes.[14]

Military aeromedical doctrine establishes more stringent operational benchmarks, reflecting decades of combat and austere-environment experience. These standards emphasize rapid deployment and early patient contact, including:

- A **30-minute "wheels-up" goal from activation**, and
- **60 minutes from activation to point-of-injury contact**, aligning with the principle of minimizing time to advanced medical intervention.

These benchmarks are used by the United States Department of War (DoW) for aeromedical evacuation and have informed civilian air-medical practices in remote and frontier systems, including those in Alaska and Montana.[15]

Dispatch and Response

Best practices for air-medical dispatch and response emphasize rapid activation, efficient coordination, and continuous performance monitoring.

The **National Association of EMS Physicians (NAEMSP)** and the **American College of Emergency Physicians (ACEP)** joint policy statement recommends the following operational targets for primary responses:

- **Less than 10 minutes** from activation to aircraft departure ("wheels-up time"), and
- **25 to 30 minutes** from dispatch to patient ("point-of-injury") contact in rural or geographically isolated regions, with documented justification for delays exceeding these benchmarks due to weather, distance, or mechanical constraints.[16]

The **Commission on Accreditation of Medical Transport Systems (CAMTS)** further emphasizes that while no universal fixed time limit applies to all settings, accredited programs are expected to define response targets appropriate to their mission profile, track variations, and incorporate response interval analysis into quality management processes.[17]

National Best Practices for Aeromedical / Air Medical Accreditation

National best practices for emergency aeromedical services emphasize the importance of formal accreditation, standardized clinical and operational requirements, and continuous quality improvement to ensure patient safety, system reliability, and accountability. Accreditation serves as a key mechanism for verifying that aeromedical programs meet nationally recognized standards for clinical care, aircraft safety, crew qualifications, operational readiness, and performance improvement.

The Commission on Accreditation of Medical Transport Systems (CAMTS) is the nationally recognized accrediting body for aeromedical and specialty medical transport services in the United States. CAMTS accreditation is widely regarded as the gold standard for air medical programs and is endorsed or referenced by organizations including the National Association of EMS Physicians (NAEMSP), the American College of Emergency Physicians (ACEP), and state trauma system authorities.

CAMTS accreditation standards require aeromedical providers to demonstrate compliance across multiple domains, including but not limited to:

- **Clinical governance and medical oversight**, including defined medical direction and evidence-based clinical protocols
- **Crew configuration and qualifications**, including appropriate licensure, training, and ongoing competency assessment
- **Aircraft safety and operational standards**, encompassing maintenance, aviation risk management, and flight safety programs
- **Dispatch, activation, and response procedures**, including policies to support timely and appropriate utilization
- **Quality management and performance improvement**, with routine review of operational and clinical KPIs
- **Patient safety and risk management**, including protected case review and adverse event analysis

A core component of CAMTS accreditation is the requirement for a formal Quality Management Program that includes routine analysis of performance metrics such as response times, transport intervals, patient outcomes, safety events, and utilization patterns. Accredited programs must demonstrate the ability to identify system issues, implement corrective actions, and monitor improvement over time.

National best practices further recognize that state-level oversight and integration with trauma and EMS systems are critical to maximizing the value of accreditation. Many states require or strongly encourage CAMTS accreditation as a condition of aeromedical licensure, participation in trauma systems, or eligibility for emergency response designation. This approach promotes consistency, transparency, and accountability across providers, while reducing variability in care delivery.

Best Practice Standards for Medical Communications Centers

National best practices for modern emergency and trauma systems emphasize the use of centralized Medical Communications (MEDICOM) Centers to coordinate emergency transfers, aeromedical and ground transport, and site-of-care sourcing across regions. These centers function as single points of system-wide coordination, integrating real-time clinical information, transport asset availability, and receiving facility capability to ensure patients are delivered to the **right level of care, at the right place, in the right timeframe**.

Organizations including the **American College of Surgeons Committee on Trauma (ACS COT)**, the **National Association of EMS Physicians (NAEMSP)**, and the **American College of Emergency Physicians (ACEP)** identify centralized medical communications and transfer coordination as foundational elements of effective trauma and emergency care systems; particularly in rural, frontier, and geographically complex environments. [18,19]

Nationally recognized MEDICOM Centers support system performance through the following functions:

- **Centralized intake and triage of emergency transfer** and transport requests
- **Real-time site-of-care sourcing**, incorporating trauma level, specialty services, ICU capacity, and bed availability
- **Integrated coordination** of ground, rotor-wing, and fixed-wing transport assets
- **Standardized physician-to-physician communication workflows**
- **Reduction of serial phone calls and fragmented transfer** decision-making
- **Real-time situational awareness across EMS**, aeromedical providers, and facilities
- **Data capture** for quality improvement, system performance monitoring, and outcomes analysis

These centralized functions are specifically designed to reduce system-level delays, which national evidence identifies as a primary driver of preventable morbidity and mortality.

Outcome Evidence and Time-to-Definitive Care

Outcome data consistently demonstrate that **mortality rates increase sharply after 120 minutes from the time of injury or onset of critical illness to arrival at definitive care**. This finding is well documented across trauma, stroke, sepsis, and cardiac emergencies and forms the basis of national time-based performance expectations.[20, 21]

As a result, national best practices emphasize system engineering and coordination rather than focusing solely on individual provider performance. Delays most often occur due to fragmented transfer processes, lack of centralized situational awareness, and inefficient site-of-care decision-making, all of which are addressed through MEDICOM Center models.

Evidence from Arkansas: Benefits of a Centralized MEDICOM Model

The State of Arkansas provides a nationally recognized example of the benefits of a centralized, statewide MEDICOM Center integrated across EMS, trauma, and aeromedical services. Arkansas's system coordinates all interfacility trauma and specialty transfers through a centralized communications hub, ensuring rapid identification of appropriate destination facilities and efficient deployment of transport resources.

Published evaluations of the Arkansas model demonstrate:

- Reduced time to definitive trauma and specialty care
- Improved trauma system throughput
- More appropriate utilization of aeromedical assets
- Reduced interfacility transfer delays
- Improved system-level situational awareness during high-volume or surge events
- Improved patient outcomes through earlier access to definitive care

Importantly, Arkansas's MEDICOM Center enables system-wide performance monitoring, allowing the state to identify structural barriers, optimize asset placement, and continuously improve transfer workflows, rather than relying on retrospective, provider-specific reviews alone.[22, 23, 24]

Relevance to Rural and Island-Based Systems

In rural and island-based systems, national guidance recognizes that centralized MEDICOM Centers are essential infrastructure, not optional enhancements. Geographic distance and limited specialty availability cannot be eliminated; however, system-level coordination can significantly mitigate delay by ensuring immediate activation of appropriate transport, rapid site-of-care identification, and avoidance of secondary or tertiary transfers.

By aligning emergency medical services, aeromedical providers, and receiving facilities through a centralized MEDICOM model, states can improve equity of access, reduce variability in care, and strengthen compliance with EMTALA transfer requirements.[25]

National best practices support the establishment of centralized Medical Communications (MEDICOM) Centers as a core component of high-performing emergency and trauma systems. Evidence demonstrates that these centers improve time to definitive care, system efficiency, resource utilization, and patient outcomes, particularly in rural and geographically complex states.

Integration of a MEDICOM Center within statewide aeromedical, EMS, and trauma governance structures supports data-driven oversight, continuous quality improvement, and evidence-based policy decision-making, ensuring that emergency patients receive timely, appropriate care regardless of location.

VIII. Priorities and System Needs

To protect public health, improve emergency readiness, strengthen rural access, and ensure fiscal accountability, the 33rd Legislature should prioritize the following system needs:

1. **Support Modernize State Authority, Oversight, and Staffing (HRS §321 / HAR §11-72)**
   Update statutes and rules to reflect modern aeromedical emergency and interfacility transport operations, clarify authority, and establish additional staffing resources dedicated to aeromedical accountable for statewide governance.

2. **Establish Statewide Triage and Transfer Coordination (MEDICOM Center)**
   Create statutory support for a scalable, centralized MEDICOM Center to coordinate triage of emergency and interfacility transfers, provide real-time situational awareness, and reduce delays, especially for neighbor islands.

3. **Support on going modernization of unified Statewide EMS Aeromedical Data & Communications Platform**
   Standardize statewide aeromedical data capture and interoperability across counties, hospitals, dispatch, and licensed providers to enable performance monitoring, quality improvement, and evidence-based funding decisions.

4. **Improve Timeliness to Definitive Care (System Performance Gaps)**
   Address system-level causes of prolonged wheels-up time, scene time, and dispatch-to-destination time through coordinated protocols, asset placement planning, and performance accountability.

5. **Strengthen Workforce Standards and Safety Through National Accreditation Pathways**
   Require statewide consistency in clinical standards, training, and safety oversight using flexible national accreditation frameworks (e.g., CAMTS/NAAMTA/NSPA) without duplicative regulation.

6. **Advance Patient Equity and Financial Protections**
   Reduce patient financial exposure and confusion related to air medical billing and membership programs, and support reimbursement stability to protect service availability for rural and neighbor island residents.

7. **Increase Disaster Preparedness and Multi-Island Response Capability**
   Formalize roles and interoperable, redundant communications for multi-island aeromedical coordination during hurricanes, wildfires, tsunamis, volcanic activity, and mass-casualty incidents.

IX. Cost and Funding

This Cost and Funding section is intentionally focused on two critical and interrelated areas essential to the stability and performance of Hawai'i's aeromedical system:

1. Workforce DOH EMSIPSB staffing; and

2. Cost and funding considerations associated with emergency 9-1-1 aeromedical medevac services.

The Working Group determined that these two areas represent the most immediate and actionable fiscal priorities requiring legislative attention to ensure patient safety, system coordination, and statewide emergency readiness. Dedicated aeromedical staffing within DOH EMSIPSB is foundational to effective governance, oversight, and coordination of both emergency and interfacility aeromedical transport across the State.

This report does **not** include cost modeling or funding recommendations for interfacility aeromedical transports. Based on current system assessment, the Working Group believes that the presence of three licensed interfacility aeromedical providers operating in Hawai'i provides sufficient supply to meet current interfacility transport demand. At this time, the primary challenges related to IFTs are operational effectiveness, coordination, and system integration, not provider availability or market capacity.

Accordingly, the Working Group's recommendations prioritize strengthening statewide coordination, data integration, and operational governance rather than expanding or subsidizing interfacility transport capacity. Achieving these objectives requires dedicated DOH aeromedical leadership and programmatic staffing to guide coordinated efforts across both emergency medevac and interfacility transport systems.

Investing in permanent aeromedical staffing within DOH EMSIPSB enables the State to lead clinically driven, payer-agnostic coordination of emergency and interfacility aeromedical services; improve operational efficiency; enhance data-informed decision-making; and ensure preparedness for system surges and disasters. The cost considerations presented in this section are therefore framed to support

sustainable emergency aeromedical readiness while establishing the governance capacity necessary to optimize the full aeromedical continuum of care statewide.

To evaluate the sustainability, adequacy, and readiness of Hawai'i's emergency aeromedical system, DOH EMSIPSB conducted cost modeling that incorporates current utilization, existing aeromedical resources, reimbursement structures, and nationally informed operational cost assumptions. These estimates are intended to support system-level planning and legislative decision-making and should be interpreted in the context of the assumptions and limitations described below.

Workforce Staffing Resources

The Working Group recommends the recurring state investment required to establish dedicated aeromedical staffing within the DOH EMSIPSB. These resources are necessary to provide statewide leadership, coordination, and oversight for both emergency 9-1-1 aeromedical medevac and interfacility aeromedical transport operations.

State funding recommendations described in this section supports system readiness, public safety, and emergency preparedness. These funds do not subsidize aeromedical providers and do not generate profit; they enable the State to meet its statutory responsibilities for governance, coordination, quality oversight, and disaster readiness.

Estimated Annual Staffing and Operational Cost

The Working Group identified the following minimum staffing and operational resources required to establish a functional statewide aeromedical program within DOH EMSIPSB:

Staffing / Category	Description / Scope	Estimated Annual Cost
State EMS Aeromedical Director	Clinical and operational leadership, statewide governance, medical oversight, disaster coordination	$175,000 - $250,000
Aeromedical EMS Specialist	Program coordination, data oversight, compliance monitoring, interagency coordination	$75,000
Aeromedical EMS Program Planner	Strategic planning, protocol development, system design, performance improvement planning	$75,000
Total Estimated Annual Need		$325,000 - $400,000

At present, DOH EMSIPSB does not have dedicated aeromedical staffing or operational funding to support these functions. All aeromedical oversight responsibilities are absorbed within existing EMS Section roles that are already operating at full capacity.

As a result:

- The entire estimated annual cost represents a current funding gap.
- No recurring General Fund appropriation exists to support statewide aeromedical governance, coordination, or planning.

MEDICOM Center Funding

The Working Group did not review planning and initial development costs for the statewide Medical Communications (MEDICOM) Center. As this initiative is currently included within the State Rural Healthcare Transformation Center initiative. For this reason, the Working Group does not recommend a separate or additional MEDICOM Center funding request at this time.

Specialized Transports Funding

Due to aircraft weight limitations, cabin configuration constraints, and limited availability of heavy-lift or specialty-capable aeromedical assets, the State of Hawai‘i is highly dependent on the United States Coast Guard to support bariatric and large-patient emergency transports, as well as certain complex rescue and inter-island transfer missions.

This reliance reflects a system-level limitation in civilian aeromedical capacity, rather than an operational shortcoming of existing providers. While the Coast Guard remains a critical and valued federal partner, its primary mission is national defense and maritime safety, not routine civilian medical transport. Continued reliance on Coast Guard assets for patient transports underscores the need to evaluate long-term civilian aeromedical capacity and readiness within the State.

The Working Group does not have recommendations for specialized transports funding solutions at this time but will continue to evaluate with DOH EMSIPSB staff.

Current Aeromedical Resource Availability

As of December 2025, Hawai'i's aeromedical landscape includes a limited number of aircraft and providers, distributed across emergency 9-1-1 and interfacility transport roles: (see **Figure 2**)

Two (2) 9-1-1 Medevac Providers

- Hawai'i Fire Department (HFD)
- DOH/REACH Maui (REACH)

Three (3) Interfacility Transport (IFT) Providers

- Hawai'i Life Flight (HLF)
- Life Flight Network (LFN)
- Optimum Air (OA)

In total, five (5) air-medical providers operate statewide, supporting both emergency 9-1-1 response and IFT needs. However, the number of aircraft, rotor-wing capacity, and specialty configurations remains limited relative to geographic demand and patient acuity.

Based on system performance, geographic distribution, and national best-practice considerations, **DOH EMSIPSB estimates that seven (7) dedicated 911 Medevac units are required statewide to meet emergency response needs.** Current resource availability therefore represents a capacity gap, particularly during periods of concurrent calls, adverse weather, or high-acuity events.(see **Figure 2**)

Cost and Reimbursement Assumptions

The cost modeling presented in **Figure 9** is based on the following assumptions:

- The **Medicare base rate for air-medical transport in Hawai'i** is **$6,404.44** per transport.
- The **State of Hawai'i EMS contracted rate** for air-medical transport is **$13,733.50** per transport.
- The **average number of air-medical transports statewide is approximately seven (7) per day**, with an estimated **three (3) transports per day classified as 9-1-1 Medevac responses**, resulting in approximately **1,800 emergency aeromedical transports annually**.
- The State currently subsidizes emergency aeromedical services at **$2,500,000 per 9-1-1 Medevac unit**.
- Based on system performance, geography, and access needs, **seven (7) 911 Medevac units** are estimated to be required statewide.

Estimated Revenue Under Current Rate Structures

Using the annual estimate of 1,800 transports for 9-1-1 Medevac, the following revenue scenarios were modeled:

- If every transport were reimbursed at the full State of Hawai'i EMS contracted rate, total annual billing revenue would be approximately $24,720,300.

- If every transport were reimbursed at the Medicare base rate, total annual billing revenue would be approximately $11,527,992.

These scenarios illustrate the substantial gap between reimbursement levels and the fixed costs required to maintain aeromedical readiness.

Estimated System Need and Funding Gap for 9-1-1 Medevac

The estimated annual operational need to support seven (7) fully subsidized 9-1-1 Medevac units statewide is approximately $24.5 million. This estimate is based on an assumed operational cost of $3.5 million per rotor/base station per year.

Current State funding, including approximately $3.1 million in State General Funds, covers only a fraction of this need, resulting in a significant structural funding shortfall, even under optimistic reimbursement assumptions.

Important Cost Exclusions and Limitations

The estimated costs presented include only annual operational expenses and do not include:

- Aircraft acquisition or lease costs
- Helipad construction or maintenance
- Base station startup costs
- Capital equipment purchases
- Long-term infrastructure investments

As such, these figures represent baseline operational estimates, not comprehensive lifecycle costs. All estimates are contingent upon the stated assumptions, and recommends careful review when evaluating funding strategies or system design changes.

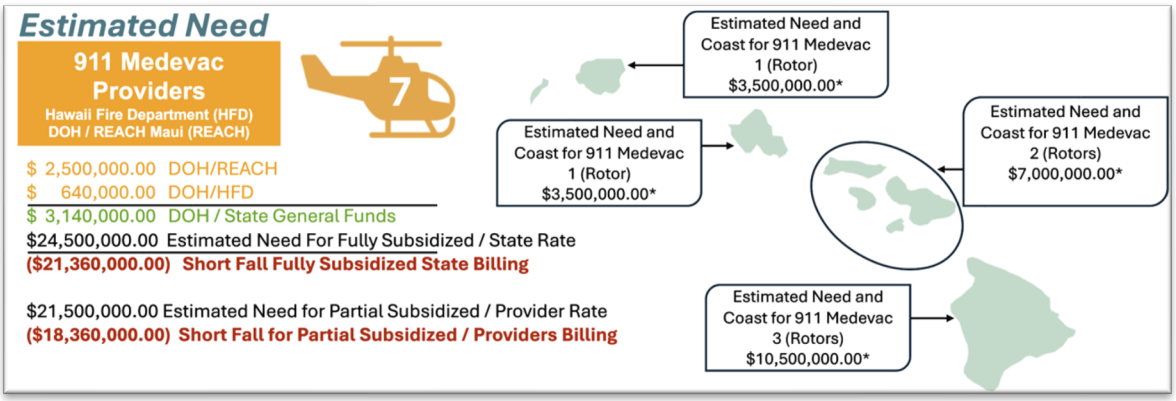
Policy Implications

The combined analysis of current resource availability, cost modeling, and reimbursement structures demonstrates that Hawai‘i’s emergency aeromedical system faces structural limitations in both capacity and funding. Dependence on federal assets for specialized transports, limited civilian aircraft availability, and reliance on per-transport reimbursement models collectively underscore the need for stable, readiness-based state investment.

Addressing these gaps is essential to ensuring equitable access, system resilience, patient safety, and timely delivery of definitive care across Hawai‘i’s geographically diverse communities.

Figure 9: Estimated Aeromedical Resources Needed to Run 9-1-1 Services

*Estimated cost includes only operational cost of $3,500,000.00 per base station does not include the cost of the rotor craft, helipad, base station startup fees. Please review all DOH Assumptions evaluating these numbers associated with estimated cost.



X. Working Group Recommendations

Strengthen DOH EMS Staffing Resources for Aeromedical

Statutory modernization and system coordination efforts cannot succeed without adequate staffing and funding within the DOH EMS Section. Staffing levels have remained largely unchanged for over twenty-five (25) years despite growing EMS demand and complexity. Continued reliance on ad hoc solutions undermines long-term system accountability and resilience.

The Working Group recommends:

1. Establish permanent, dedicated staffing within the DOH EMS Section to support statewide aeromedical oversight, including at a minimum: State Air Medical Director, State Air Medical Coordinator, and Aeromedical Program Planner and/or Program Specialist.

2. Ensure EMS Section staffing and budgeting levels are aligned with statutory responsibilities under HRS §321, including aeromedical regulation, clinical governance, data oversight, communications systems, disaster preparedness, and interfacility coordination.

3. Provide dedicated funding to support EMS and aeromedical regulatory, data, and coordination functions, recognizing that these responsibilities represent ongoing public health and emergency preparedness functions rather than time-limited projects.

4. Align EMS and aeromedical staffing investments with long-term system sustainability, ensuring adequate capacity for continuous quality improvement, real-time situational awareness, statewide coordination, and disaster response readiness.

Strengthening EMS Section staffing and budgeting capacity is a foundational requirement for successful implementation of all subsequent recommendations outlined in this report.

Modernize Hawaii Revised Statutes (HRS) §321-221 through §321-237

While current statute authorizes EMS and aeromedical operations, HRS §321-221 through §321-237 do not fully reflect the scope or public health role of modern aeromedical transport, resulting in fragmented coordination and limited long-term planning. Modernizing these statutes, in coordination with updates to HAR §11-72, is the most effective way to address system challenges and establish clear authority for statewide aeromedical triage, coordination, and transfer functions.

The Working Group recommends:

1. Update HRS §321-221 through §321-237 to explicitly establish statewide authority for aeromedical patient triage, coordination, and transfer, including both emergency response and interfacility transports, with clear delineation of roles, responsibilities, and accountability.

2. Codify the establishment of a centralized, scalable statewide MEDICOM Center within statute, including authority for real-time coordination, situational awareness, and inter-island aeromedical resource management during routine operations, system surges, and disasters.

3. Authorize and support a unified statewide EMS data and communications platform, including mandatory participation by licensed aeromedical providers, to enable real-time data exchange, system oversight, quality improvement, and trauma system integration.

4. Incorporate statutory authority to adopt flexible, nationally recognized accreditation frameworks for aeromedical and transport coordination services, supporting consistent safety and clinical standards without imposing duplicative or overly prescriptive regulation.

5. Explicitly establish and authorize permanent aeromedical staffing within the DOH EMSIPSB, including a State Air Medical Director, State Air Medical Coordinator, and Aeromedical Program Planner or Program Specialist, recognizing aeromedical coordination as a core public health and emergency preparedness function rather than a time-limited initiative.

Statewide MEDICOM Center

A statewide Medical Communications (MEDICOM) Center is essential to coordinated emergency and interfacility aeromedical transport in Hawai'i's geographically isolated environment. Fragmented transfer processes currently contribute to delays and force clinicians and EMS personnel to manage complex logistics without real-time visibility into aircraft availability, weather, hospital capacity, or competing priorities. Centralized coordination improves equity by prioritizing clinical need, reduces provider burden, and strengthens disaster readiness during multi-island emergencies. Inconsistent secondary public safety answering point (PSAP) capabilities across counties remain a key implementation gap.

The Working Group recommends:

1. Establish clear statutory authority for a statewide patient transfer and coordination center to enable standardized, transparent, and efficient management of interfacility transfers and aeromedical activations.

2. Support the Rural Healthcare Transformation funding to implement interoperable data and communications systems connecting EMS dispatch, ground and air EMS providers, hospitals, hospitals transfer centers, fire services, and incident command centers.

3. Update interoperable communication systems linking EMS dispatch, aeromedical providers, hospitals, and incident command structures.

4. Require real-time sharing of critical data (aircraft status, hospital capacity, staffing constraints) through PSAP-enabled coordination.

5. Standardize communication protocols, terminology, and escalation pathways across counties and agencies, including the uniform adoption of common operational time and performance metrics, such as:
    - ETA-P (Estimated Time of Arrival to patient at the transferring hospital)
    - ETA-D (Estimated Time to Destination or definitive care with the patient)
    - Wheels Up (aircraft departure readiness and launch confirmation)
    - State KPI for time to definitive care targets

Accreditation Framework for Aeromedical and Coordination Services

Accreditation provides a standardized framework for evaluating safety, clinical readiness, and operational performance in aeromedical transport. Recognizing multiple nationally accredited pathways promotes consistent clinical, training, and aviation safety standards across providers while accommodating Hawai'i's diverse operational environments. This approach strengthens patient and crew safety, supports transparent contracting and accountability, aligns the State with national and federal best practices, and avoids unnecessary restrictions on provider participation. Administrative rulemaking may be used to define compliance and phased implementation.

The Working Group recommends:

1. Recognize multiple national accreditation pathways (such as CAMTS, NAAMTA, NSPA) for aeromedical and transport coordination services.

2. Link accreditation requirements to state contracting, quality benchmarks, or participation in coordinated statewide systems.

3. Support providers in achieving accreditation through reasonable timelines or phased adoption strategies.

4. Establish administrative rulemaking authority for compliance monitoring, documentation, and recertification procedures.

Unified Ground and Air EMS Data Infrastructure

Hawai'i has achieved full participation of all ground 9-1-1 and interfacility transport EMS agencies using the single statewide EMS ePCR/EHR data system and has set a target of January 1, 2026, for inclusion of all aeromedical EMS providers. As of January 14, 2026, onboarding of aeromedical providers into the same EMS platform is in progress and expected to be completed in early 2026..

The Working Group recommends:

1. Continue to support the DOH's data modernization efforts and completion of a statewide a single unified EMS electronic data platform and single EMS electronic medical record for both ground and aeromedical ambulance providers.

2. Require real-time data exchange between hospitals and EMS agencies to support clinical decision-making and statewide situational awareness.

3. Standardize documentation, reporting requirements, and quality-improvement metrics across counties.

Strengthen Workforce Training and Clinical Standards for Aeromedical Services

A highly trained and experienced workforce is the foundation of safe and effective aeromedical transport. Unlike routine EMS operations, air medical services operate in high-risk environments that combine complex clinical decision-making, aviation safety considerations, and time-sensitive interfacility coordination. Variability in training, experience, and clinical standards can increase patient risk, strain system capacity, and place pressure on 9-1-1 services.

The Working Group recommends:

1. Establish minimum workforce training and competency standards for aeromedical and critical care transport personnel participating in statewide systems.

2. Require aeromedical providers to demonstrate defined interfacility transport experience before participating in primary 9-1-1 Medevac dispatch operations.

3. Standardize core clinical protocols, including airway management, patient stabilization, and handoff procedures.

4. Require participation in statewide quality improvement and clinical performance monitoring initiatives.

5. Support joint training and simulation exercises involving aeromedical providers, hospitals, EMS, and fire services.

6. Ensure DCCA is reporting out to EMS System all licensed EMS personnel both ground and air medical.

Advance Health Equity, Patient Financial Protections, and Consumer Transparency in Aeromedical Transport

Aeromedical transport is essential to healthcare equity in Hawai'i, yet rural and neighbor island communities face disproportionate access and financial burdens. During emergencies, patients cannot choose providers or navigate billing, underscoring the need for clinically driven, payer-agnostic triage, reduced secondary transfers, billing transparency, and statewide monitoring of patient financial impact. Air medical membership programs may add confusion due to varying coverage and provider response; improved transparency can reduce unexpected billing while preserving clinically driven emergency care.

The Working Group recommends:

1. Require aeromedical utilization and triage decisions to remain payer-agnostic and clinically driven.

2. Incorporate equity considerations into statewide aeromedical planning, prioritizing access for rural and neighbor island populations.

3. Require standardized, clear disclosure of air medical membership coverage limitations and conditions.

4. Implement public education initiatives to improve consumer understanding of aeromedical transport billing, memberships, and patient protections.

5. Encourage contractual or voluntary reciprocity mechanisms among aeromedical providers when clinically appropriate to reduce patient financial burden.

6. Incorporate transparency and consumer protection requirements into statewide aeromedical coordination and contracting frameworks.

Enhance Disaster Preparedness and Communication Systems for Aeromedical Operations

Hawai'i, faces unique risks, including but not limited to hurricanes, wildfires, volcanic activity, and mass-casualty incidents requiring multi-island coordination. Aeromedical services are essential during these events, yet vulnerabilities in communication, situational awareness, and coordination can compromise response effectiveness. Cataclysmic events often coincide with infrastructure outages, weather constraints, and surges in demand, requiring resilient and interoperable systems.

Integrated preparedness and communication systems strengthen resilience by:

- Ensuring continuous operations during infrastructure failures.
- Supporting unified command and decision-making across agencies.
- Enabling rapid prioritization of limited aeromedical resources.
- Improving public health and safety and during prolonged events.

The Working Group recommends:

1. Integrate aeromedical coordination, landing zone access, and hospital readiness into statewide disaster preparedness and response plans.
2. Ensure scalable coordination structures capable of supporting mass-casualty incidents and multi-island evacuations.
3. Ensure aeromedical coordination structures are capable of supporting multi-island evacuations, mass-casualty incidents, and prolonged disaster operations.
4. Design and maintain landing zones and helipads to remain operational during infrastructure disruptions.
5. Conduct regular multi-agency drills and exercises that include aeromedical transport, landing zone operations, and interfacility transfer scenarios.
6. Establish clear command, coordination, and communication roles for aeromedical operations during declared emergencies and disasters.

Address Funding and Reimbursement Challenges to Ensure System Sustainability

Aeromedical transport is resource-intensive, yet reimbursement rates have not kept pace with rising operational costs, workforce demands, and safety requirements. Stagnant national reimbursement benchmarks, delayed payments, and administrative procurement processes strain system sustainability and can delay time-sensitive patient care. A stable funding framework is necessary to enable procurement flexibility, ensure continuity of care during surges and disasters, support workforce training and safety infrastructure, and prioritize clinically driven care over administrative or payer-related barriers.

The Working Group recommends:

1. Standardize procurement for EMS and Aeromedical services, similar to trauma system funding procurement exemptions which allow for immediate contracting and the ability to obtain lifesaving resources during emergency medical care without delays from current standard administrative processes.

2. Establish a predictable funding structure that supports statewide continuity of care, invests in workforce training and safety infrastructure, and prevents service gaps. One consideration is adopting a model where a percentage or all of the EMS and Aeromedical billing reimbursement funding received by the State of Hawai‘i goes into the EMS special fund.

3. Implement expedited funding mechanisms for critical resources, including personnel, equipment, and communication systems, to maintain high standards of emergency response.

4. Address reimbursement gaps by monitoring differences between state fee schedules, Medicare rates, and actual service costs, ensuring financial viability for providers.

5. Strengthen patient protections by advocating for federal enforcement of payment timelines and compliance with the No Surprises Act.

6. Develop sustainable contracting models, such as direct billing arrangements, that reduce state financial exposure while maintaining equitable access and patient protections.

XI. Next Steps / Call to Action

DOH EMSIPSB will move forward with implementation of the Working Group's recommendations in partnership with county EMS agencies, hospitals, aeromedical providers, and state and federal emergency management partners. Progress on these actions is dependent on establishing dedicated DOH aeromedical staffing; DOH currently has no dedicated aeromedical staff capacity to lead statewide coordination.

Immediate Legislative Action Required (FY 2026–2027)

To enable implementation, the Legislature is requested to:

1. **Fund permanent DOH EMSIPSB aeromedical staffing** to lead statewide governance, coordination, quality oversight, and disaster readiness; and

2. **Support statutory modernization of HRS Chapter 321 (§321-221–237)** to clarify statewide authority, accountability, and the role of a statewide MEDICOM Center.

Administrative Implementation Priorities (Upon Staffing)

Upon establishment of dedicated staff, DOH will prioritize:

- **Statewide aeromedical coordination and governance**, including clear roles, accountability, and standardized workflows for emergency medevac and interfacility transport (IFT).

- **MEDICOM Center implementation and integration** through the Rural Healthcare Transformation Program, including standardized communication protocols and interoperability with EMS data systems.

- **Quality improvement and performance monitoring**, including KPI reporting and statewide clinical governance structures.

- **Workforce standards and accreditation alignment**, including participation in nationally recognized accreditation pathways and joint training with EMS, hospitals, and aeromedical providers.

- **Equity and patient financial protections**, including payer-agnostic utilization practices, consumer transparency, and reduction of avoidable patient financial burden.

- **All-hazards disaster preparedness**, including coordinated multi-island response planning, landing zone/helipad readiness, and integration into statewide emergency operations.

XII. Conclusion

Hawai‘i’s aeromedical system is essential to public safety, health equity, and disaster readiness. This report finds that current statutory language, coordination infrastructure, and DOH EMSIPSB staffing capacity have not kept pace with modern aeromedical operations or statewide demand.

The Working Group respectfully urges the Legislature to take immediate action to:

1. **Fund permanent DOH EMSIPSB aeromedical staffing** to provide statewide governance, oversight, and coordination;
2. **Support Modernize HRS Chapter 321 (§321-221–237)** to clarify authority and accountability for emergency and interfacility aeromedical coordination; and
3. **Support implementation of a statewide MEDICOM Center** through the Rural Healthcare Transformation Program and sustain the unified EMS data infrastructure.

These actions will improve timeliness to definitive care, reduce delays, strengthen multi-island coordination, and ensure that **the right patient is transported to the right place, at the right time — right now — regardless of island, geography, or resources.**

Appendices

Appendix A: Senate Concurrent Resolution 86 2025
Appendix B: Working Group Meeting Power Point Slides
Appendix C: Working Group Meeting Minutes

Appendix A: Senate Concurrent Resolution 86 2025 Full Text

https://www.capitol.hawaii.gov/sessions/session2025/bills/SCR86_HD1_.pdf

THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.C.R. NO. 86 S.D. 1 H.D. 1

SENATE CONCURRENT RESOLUTION

REQUESTING THE DEPARTMENT OF HEALTH TO CONVENE AN AEROMEDICAL SERVICES WORKING GROUP.

WHEREAS, it is of critical importance to the State to ensure residents have prompt access to primary health care; and

WHEREAS, most rural communities in the State have fewer health care resources compared to communities on Oahu, including access to advanced levels of trauma care, medical specialists, and subspecialists; and

WHEREAS, patients in these rural areas are at greater risk of poor health outcomes for serious medical conditions, such as heart attack, stroke, and traumatic bodily injuries; and

WHEREAS, the existing aeromedical services system is overburdened and is currently served by only one statewide aeromedical services provider, for which there are few viable and cost-effective alternatives in the event of a grounding, for example, due to maintenance issues or crew availability; and

WHEREAS, there are a number of barriers to expanding the aeromedical services system, including insufficient funding, plans, procedures, and protocols; now, therefore,

BE IT RESOLVED by the Senate of the Thirty-third Legislature of the State of Hawaii, Regular Session of 2025, the House of Representatives concurring, that the Department of Health is requested to convene an Aeromedical Services Working Group; and

BE IT FURTHER RESOLVED that the working group is requested to consist of the following members:

(1) The Director of Health, or the Director's designee;

(2) The Chair of the Senate Standing Committee on Health and Human Services, or a member appointed by the President of the Senate;

(3) The Chair of the House of Representatives Standing Committee on Health, or a member appointed by the Speaker of the House of Representatives;

(4) The Director of the Hawaii Emergency Management Agency, or the Director's designee;

(5) The Director of the Department of Emergency Management of the City and County of Honolulu, or the Director's designee;

(6) The Administrator of the Maui Emergency Management Agency, or the Administrator's designee;

(7) The Administrator of the Kauai Emergency Management Agency, or the Administrator's designee;

(8) The Administrator of the Hawaii County Civil Defense Agency, or the Administrator's designee;

(9) A representative of the Healthcare Association of Hawaii, to be selected and invited to participate by the Director of Health;

(10) A representative of the Hawaii Association of Health Plans, to be selected and invited to participate by the Director of Health;

(11) One representative from a health system operating in the State, to be selected and invited to participate by the Director of Health;

(12) At least two representatives from independent providers operating in the State, one of whom that operates in the County of Maui, Kauai, or Hawaii, to

be selected and invited to participate by the Director of Health; and

(13) Two representatives from providers of emergency aeromedical services who have conducted operations in the State within the last five years and can provide comprehensive air medical services with rotor- and fixed-wing support, to be selected and invited to participate by the Director of Health; and

BE IT FURTHER RESOLVED that the working group is requested to, at a minimum:

(1) Study and assess emergency aeromedical services needs across the State and in each county; and

(2) Develop and recommend future plans, procedures, protocols, and funding to increase the predictability and stability of air ambulance medical services for the State; and

BE IT FURTHER RESOLVED that the working group is requested to submit a report of its findings and recommendations, including any proposed legislation, to the Legislature no later than twenty days prior to the convening of the Regular Session of 2026; and

BE IT FURTHER RESOLVED that the working group is requested to dissolve on June 30, 2026; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Health, Director of the Hawaii Emergency Management Agency, Director of the Department of Emergency Management of the City and County of Honolulu, Administrator of the Maui Emergency Management Agency, Administrator of the Kauai Emergency Management Agency, Administrator of the Hawaii County Civil Defense Agency, President and Chief Executive Officer of Healthcare Association of Hawaii, and President of Hawaii Medical Association.

Appendix B: Working Group Meeting Power Points

Aeromedical Services Working Group
Senate Concurrent Resolution 86

November 4, 2025

09:00 AM to 10:00 AM

Microsoft Teams Virtual Meeting by Invite Only

This meeting will be recorded.

Agenda: Aeromedical Services Working Group

0900	**Welcome, Opening Remarks** *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0905	**Introduction of Working Group Members** *Working Group*
0915	**Overview of Aeromedical / Air-Medical Landscape** **Presentation of Statewide and County-level Aeromedical Services** *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0935	**Discussion: Initial Priorities and Information Needs** *Working Group*
0945	**Administrative Items and Next Steps: Meeting Dates** *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0955	**Closing** *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
1000	**Adjournment**

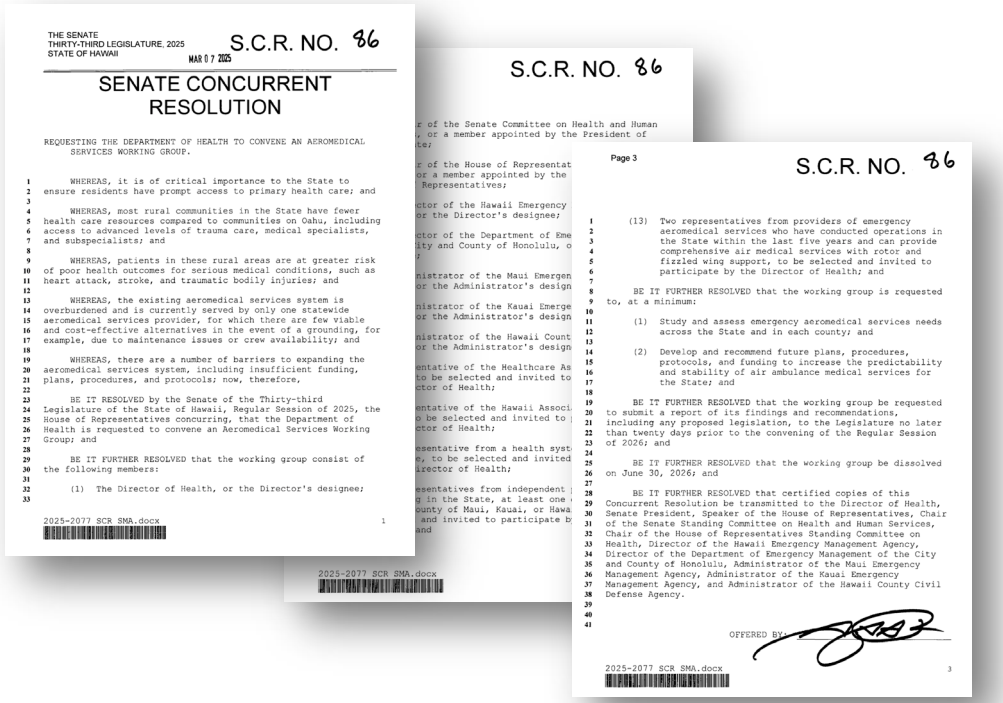
Welcome, Opening Remarks

Aloha

Senate Concurrent Resolution 86; Request to Working Group (at a minimum) to:

1. "*Study and assess emergency aeromedical services needs across the State and in each county; and*"
2. *"Develop and recommend future plans, procedures, protocols, and funding to increase the predictability and stability of air ambulance medical services for the State; and"*
3. *Submit a report of working groups findings and recommendations, including any proposed legislation, to the Legislature no later than* ***January 1, 2025***

https://www.capitol.hawaii.gov/sessions/session2025/bills/SCR86_.PDF



THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.C.R. NO. 86

MAR 07 2025

SENATE CONCURRENT RESOLUTION

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WHEREAS, it is of critical importance to the State to ensure residents have prompt access to primary health care; and

WHEREAS, most rural communities in the State have fewer health care resources compared to communities on Oahu, including access to advanced levels of trauma care, medical specialists, and subspecialists; and

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WHEREAS, the existing aeromedical services system is overburdened and is currently served by only one statewide aeromedical services provider, for which there are few viable and cost-effective alternatives in the event of a grounding, for example, due to maintenance issues or crew availability; and

WHEREAS, there are a number of barriers to expanding the aeromedical services system, including insufficient funding, plans, procedures, and protocols; now, therefore,

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2025-2077 SCR SMA.docx 1

S.C.R. NO. 86

2025-2077 SCR SMA.docx

Page 3 S.C.R. NO. 86

(13) Two representatives from providers of emergency aeromedical services who have conducted operations in the State within the last five years and can provide comprehensive air medical services with rotor and fixed wing support, to be selected and invited to participate by the Director of Health; and

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OFFERED BY:

2025-2077 SCR SMA.docx 3

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Introduction of Working Group Members

Each Working Group Member has 1 minute for a quick introduction to fellow members

Chair of Senate Committee on Health & Human Services	Sen. Joy San Buenaventura
Vice Chair of House Committee on Health	Rep. Sue L. Keohokapu-Lee Loy
Director Hawaii Emergency Management Agency (Designee)	Jack Lee (Operations Chief)
Director Honolulu Emergency Management Agency	Dr. Randal Collins
Administrator Maui Emergency Management Agency (Designee)	Jake Kiyohiro (Operations Chief)
Administrator Kauai Emergency Management Agency (Designee)	Solomon Kanoho (Executive Officer)
Administrator Hawaii Emergency Management Agency	Talmadge Magno
Healthcare Association of Hawaii	Hilton Raethel (CEO)
Hawaii Association of Health Plans (Designee)	Walden Au (Government Relations HMSA)
Health System Operating in the State	Ashley Shearer (VP Patient Care Queens)
Representative Provider Hawaii County	Kilipaki Kanae (Battalion Chief EMS Hawaii Fire)
Representative Provider Honolulu County	Jon Rosati (Chief Strategy Officer, Optimum)
Representative Emergency Aeromedical Provider	Anthony Raymond (Sr. VP Air Methods)
Representative Emergency Aeromedical Provider	Jacob Mayer (Director, Hawaii Life Flight)

Overview of Air-Medical Data

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS

Acting EMS Branch Chief and State Trauma Program Manager

Overview of Aeromedical / Air-Medical Landscape

Inter Facility Transport Providers

JAN 2025

1 Air-Medical Provider
Hawaii Life Flight

AUG

2 Air-Medical Provider
Hawaii Life Flight
Optimum Air

NOV

3 Air-Medical Providers
Hawaii Life Flight
Optimum Air
Life Flight Network

911 Medevac Transport Providers

2 Air-Medical Providers
Hawaii Fire Department
REACH

5 total Licensed Emergency Air-Medical Providers within the State of Hawaii as of 11/03/2025

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Overview of Aeromedical / Air-Medical Landscape

As of 11/03/2025

911 Medevac Providers
Hawaii Fire Department (HFD)
DOH / REACH Maui (REACH)

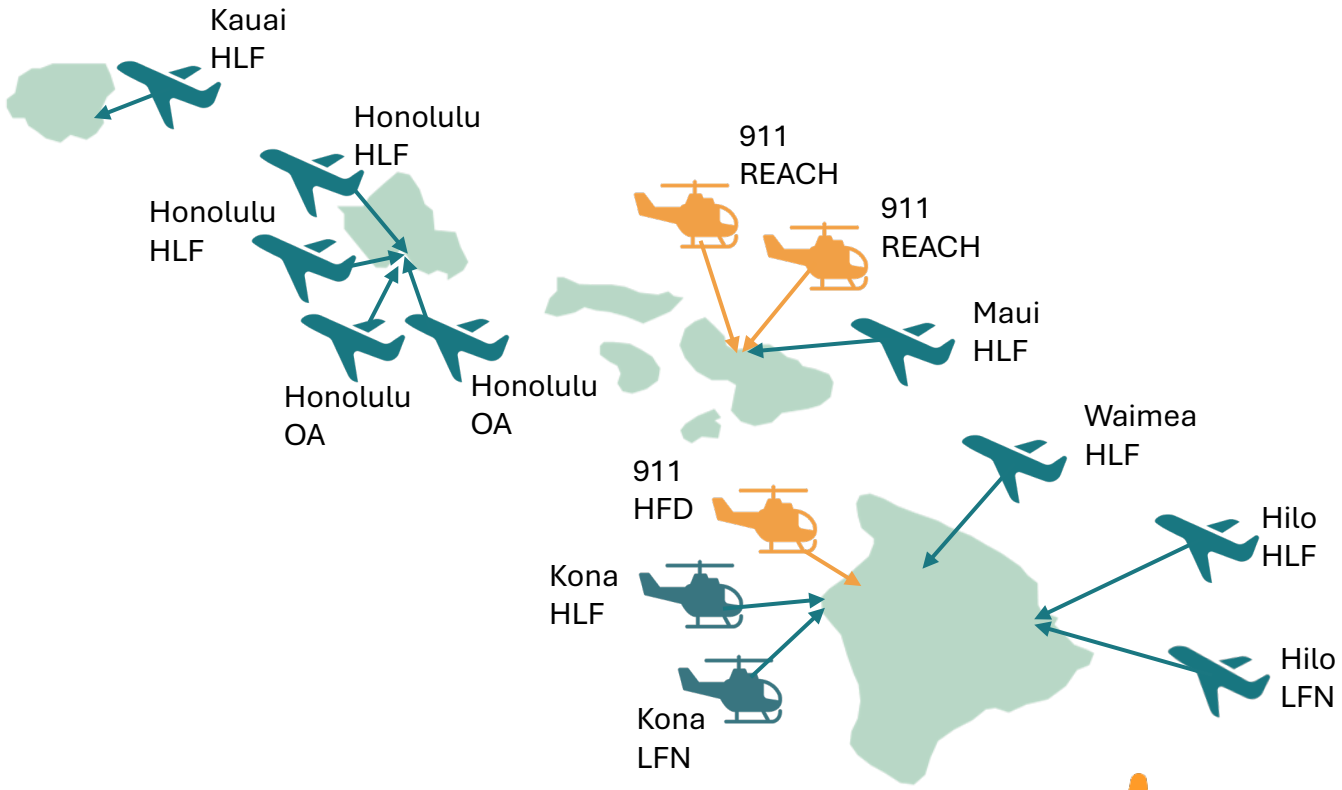
2

Inter-Facility Transport Providers
Hawaii Life Flight (HLF)
Life Flight Network (LFN)
Optimum Air (OA)

3

Total Air-Medical Providers

5



Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Overview of Air-Medical Best Practices

For rural/frontier regions, systems may adopt an **extended access target of ≤ 120 minutes** to account for distance and geography." — *CDC/HRSA/ACS-COT Trauma System Access Measures, 2011.*

"Response and transport intervals must be appropriate to the mission profile, geographic area, and needs of the population served. Variations due to distance, weather, or operational constraints shall be tracked, analyzed, and reported in quality management." — *Commission on Accreditation of Medical Transport Systems (CAMTS)*

"The time from injury to arrival at a facility capable of providing **definitive surgical or trauma care should not exceed approximately 60 minutes**, except in extraordinary circumstances." — *American College of Surgeons, Committee on Trauma (ACS-COT), "Resources for Optimal Care of the Injured Patient," 2022.*

Federal and Military Benchmarks: U.S. DoW aeromedical evacuation benchmarks (for combat & remote response operations) allow up to **30 minutes "wheels-up time"**, with a target of **60-minute "point-of-injury" reach time,** similar to the "Golden Hour" framework used in civilian trauma systems. Civilian remote programs (e.g., Alaska, Montana) often adopt comparable targets.

Overview of Air-Medical Best Practices

The recommended time for primary scene (Medevac) helicopter responses: **Dispatch to Departure goal less than 10 minutes after activation ("wheels-up time")**; Dispatch to Patient **("point of injury")** contact goal ideally less that **25 to 30 minutes for rural and remote** regions, justification for greater than 30 mins should be documented (e.g. weather, distance, mechanical) — *National Association of EMS Physicians (NAEMSP) and American College of Emergency Physicians (ACEP) joint policy statement that aligns with CAMTS operational standards.*

"EMS systems must demonstrate that extended intervals in remote areas are due to unavoidable geography or weather, not system delay." — *NAEMSP Position Paper: Air Medical Services Utilization (2021)*

CAMTS accreditation standards (Edition 12, 2024) define expectations for **air medical response intervals**: No universal fixed limit, but most accredited programs aim for **≤ 25–30 minutes total** in **rural/remote** conditions. **Source:** CAMTS Standards 12th Ed. §§ 03.02.04–03.02.07 (2024).

EMS Air-Medical and EMS transport outcome data have shown that **mortality increases sharply after 2 hours (>120 minutes)**, **but outcomes between 60–120 minutes are not statistically different in rural cohorts** when advanced prehospital care and air transport are available.

Overview of Air-Medical Data

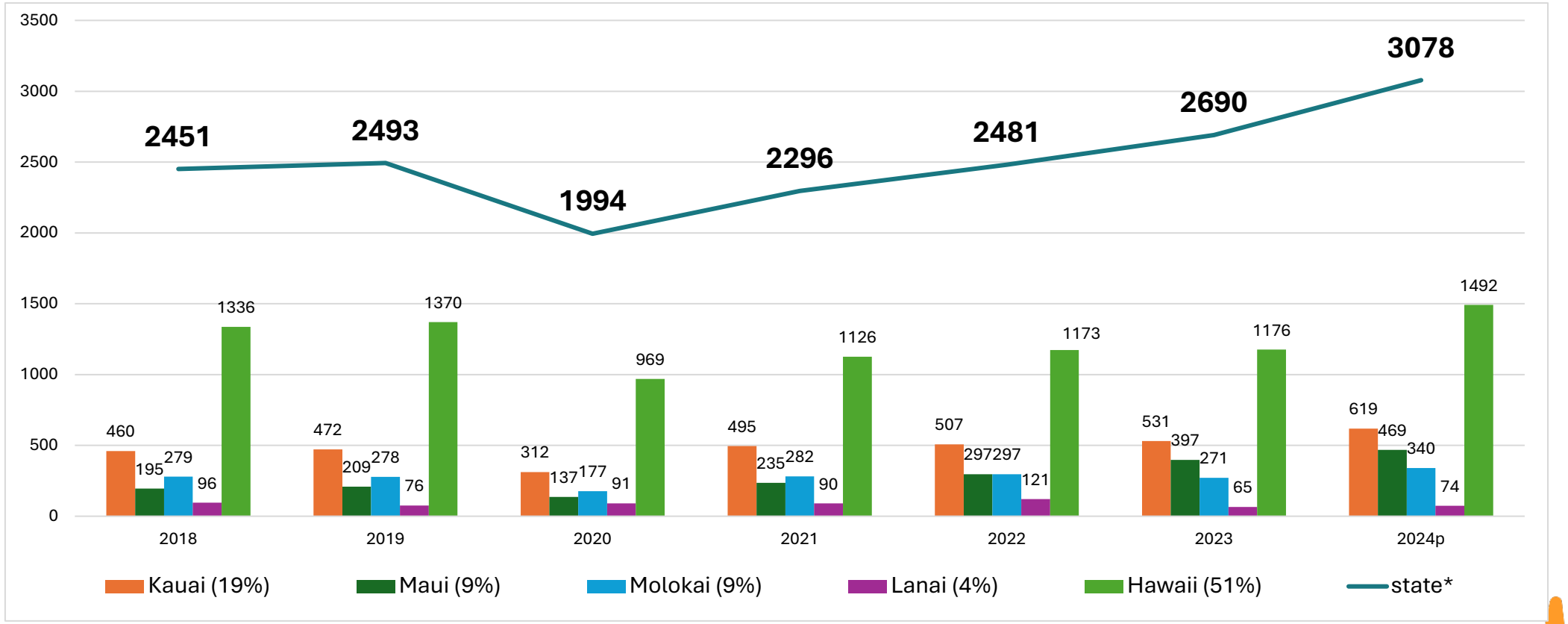
Important note the following data do not include Air-Medical Flight Data for Oahu / Honolulu.

For the time period 2018 to 2024 reporting for, Oahu/Honolulu made 1% or less of air-medical flights

*State total includes 143 (1%) flights from Oahu and 492 (4%) from unrecorded locations

Estimated Flights, by patient pick-up location, 2018-2024*

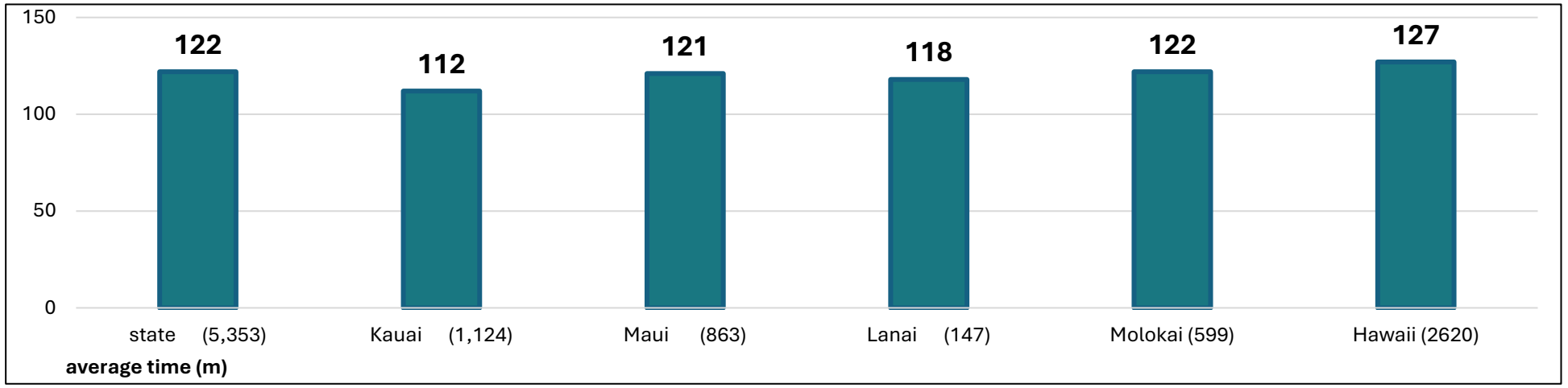
(*Total for 2024 data through October 31, 2024)

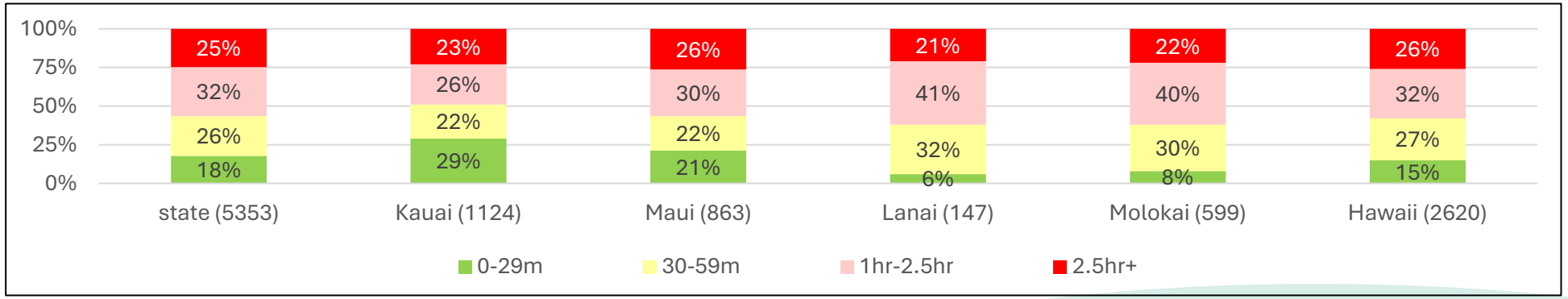


*State total includes 143 (1%) flights from Oahu and 492 (4%) from unrecorded locations

Right Patient, Right Place, Right Time, Right Now

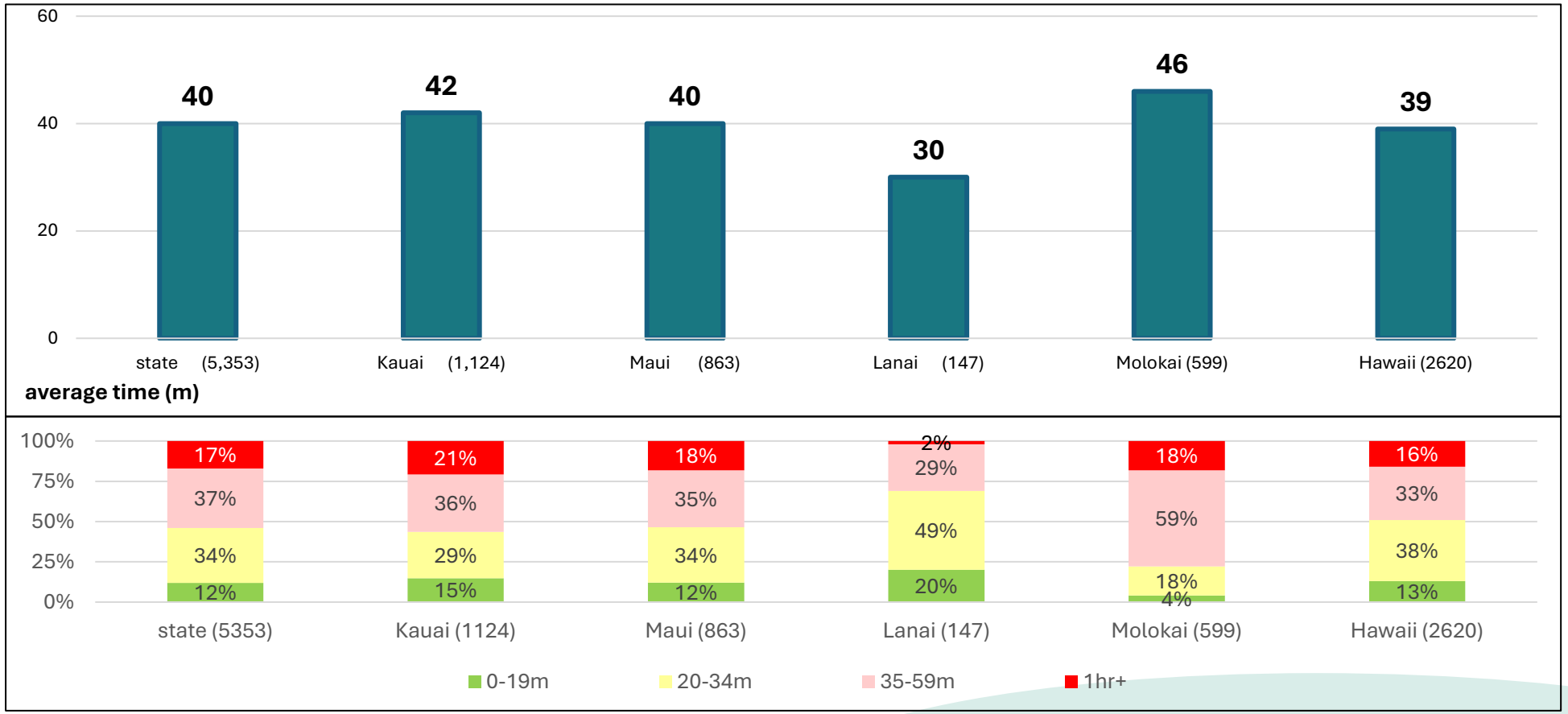
Interval From Dispatch to Depart to Pick Up Patient "Wheels-Up Time" Average Minutes 11/2022 – 10/2024





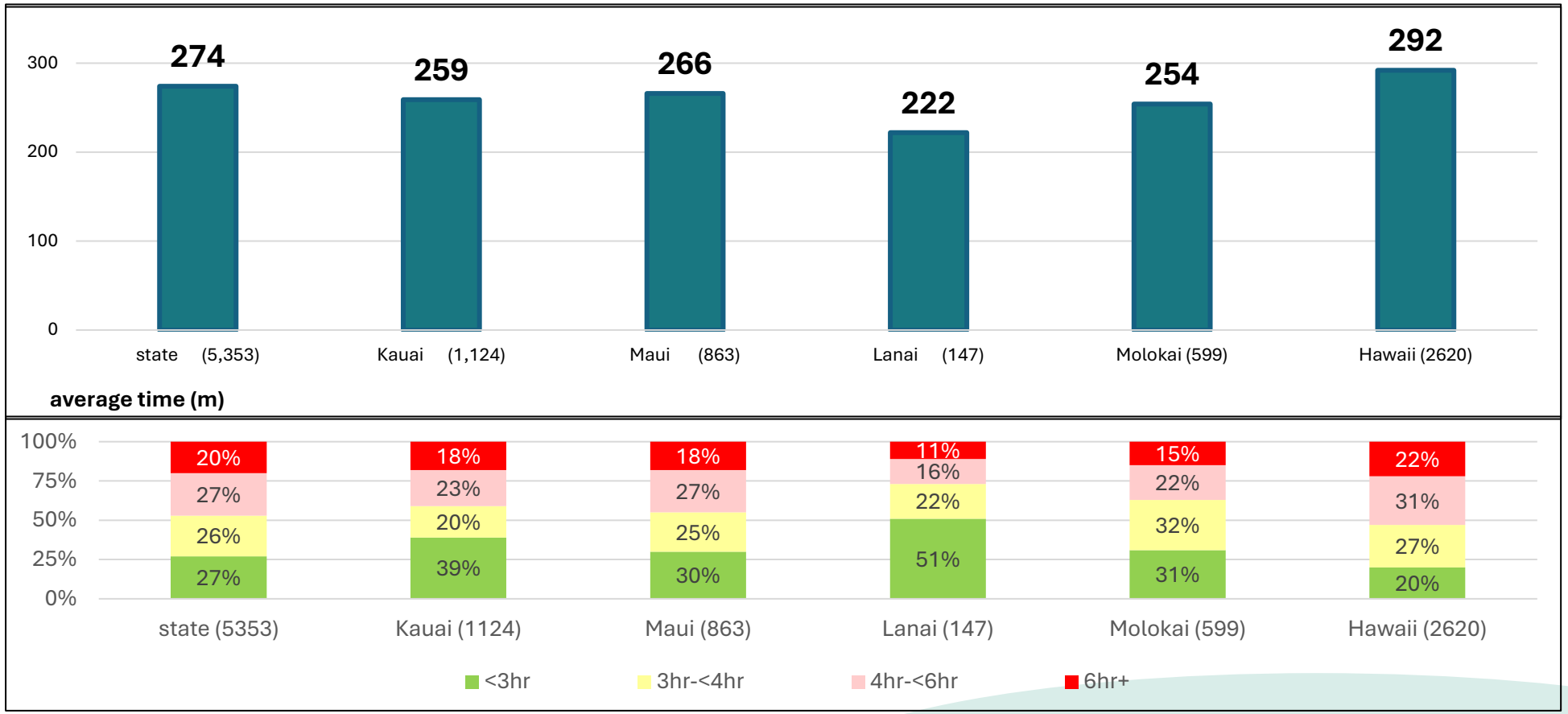
Right Patient, Right Place, Right Time, Right Now

Interval From Arrive to Scene to Depart with Patient Average Minutes 11/2022 – 10/2024



Right Patient, Right Place, Right Time, Right Now

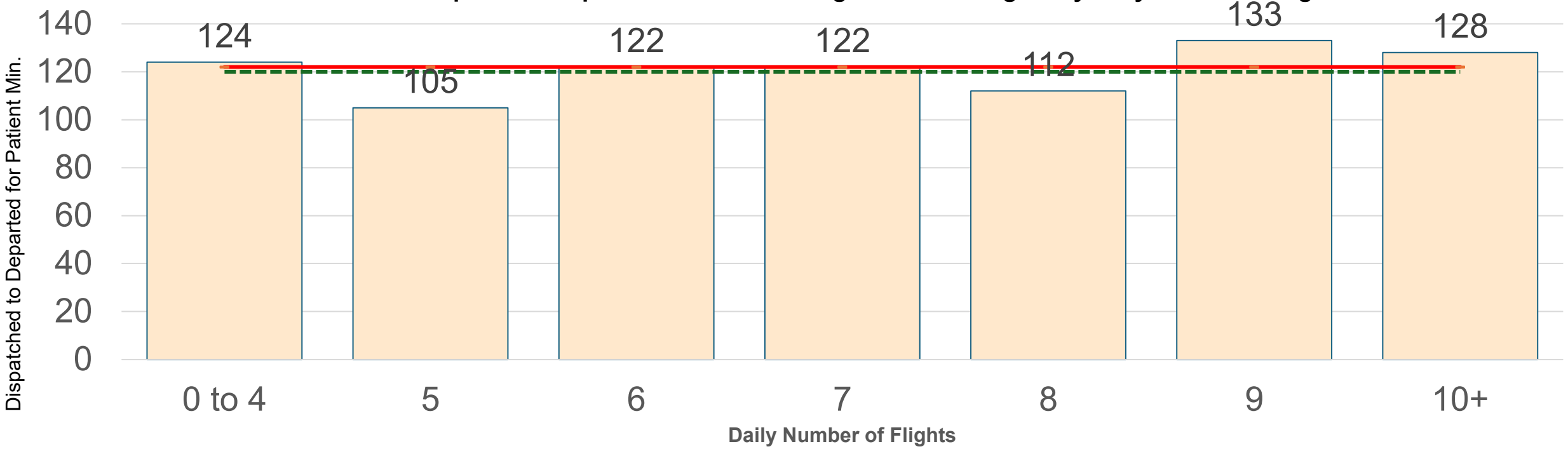
Interval From Dispatch to Destination with Patient Average Minutes 11/2022 – 10/2024



Right Patient, Right Place, Right Time, Right Now

Overview of EMS Air-Medical Data

Dispatched Average "wheels-up time" in minutes from Dispatch to Depart for Patient for Neighbor Island flights by daily number of flights 11/2022 to 10/2024



Red Line Average 122 Minutes "wheels-up time"

Green Line Acceptable Rural Average 120 Minutes to definitive care

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Overview of Aeromedical / Air-Medical Landscape

Estimated Need

911 Medevac Providers

Coast Estimated Needs Assumptions

- Medicare Base Rate Hawaii $6,404.44
  Source: 2025 ambulance fee schedule | FCSO Medicare
- Hawaii EMS Contracted Rate $13,733.50
  Source: State of Hawaii EMSIPSB 2025_Ambulance_Fee_Increase.pdf
- Average Number of Air-Medical Transports per day 7, Estimate 3 911 Medevac = 1,800 Estimated Yearly
- State Subsidized at $2,500,000.00 per 911 Medevac Unit
- Estimated 7 needed 911 Medevac Units
- If every transport received full State of Hawaii EMS Contracted Rate $24,720,300.00 in Billing Revenue
- If every transport received full Medicare Base Rate $11,527,992.00 in Billing Revenue

Overview of Aeromedical / Air-Medical Landscape

Estimated Need

911 Medevac Providers
Hawaii Fire Department (HFD)
DOH / REACH Maui (REACH)

$ 2,500,000.00 DOH/REACH
$ 640,000.00 DOH/HFD

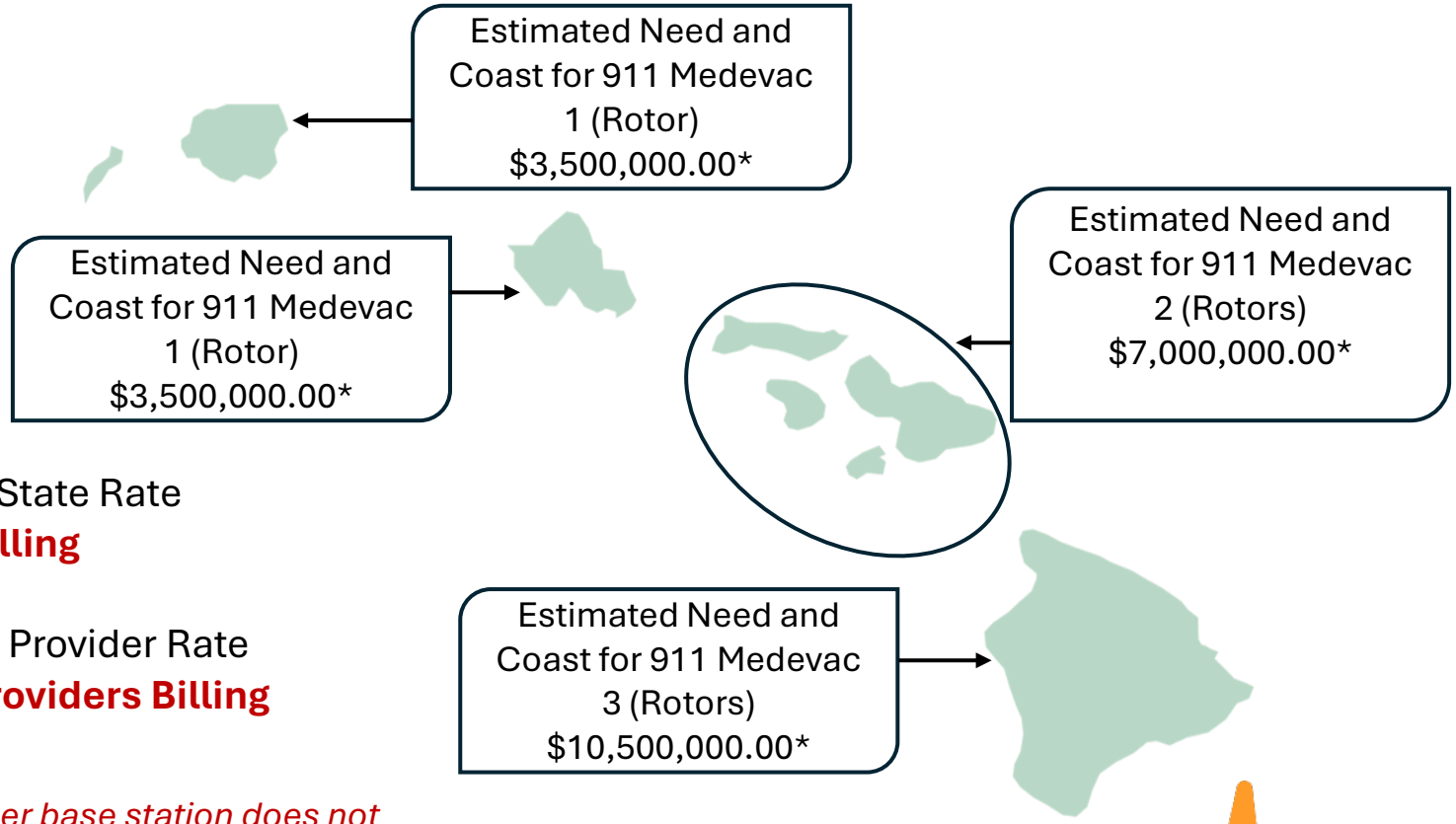
$ 3,140,000.00 DOH / State General Funds

$24,500,000.00 Estimated Need For Fully Subsidized / State Rate

($21,360,000.00) Short Fall Fully Subsidized State Billing

$21,500,000.00 Estimated Need for Partial Subsidized / Provider Rate

($18,360,000.00) Short Fall for Partial Subsidized / Providers Billing



**Estimated cost includes only operational cost of $3,500,000.00 per base station does not Include the cost of the rotor craft, helipad, base station startup fees. Please review all DOH Assumptions when speaking to these numbers.*

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

DOH Actions Over Past 10 months of 2025

- Licensed in record time, processed 2 new air-medical provider licensing applications in less that 2 weeks (14 days) from received.
- Implemented mandate for all EMS and Air-Medical transports data to be captured using the State of Hawaii electronic medical record system in compliance with HRS 321, effective 1/1/2026 all providers must be compliant to stay licensed in State.
- Established Air-Medical Permitted Interaction Group (PIG) of the Emergency Medical Services Advisory Committee (EMSAC) to provide recommendations on …..
- Draft legislation for modernization of HRS 321-
- Completed strategic planning meeting with EMS, Air-Medial, and Hospitals to identify key focus items:
  1. Request Emergency and Trauma Medical Communications (MEDICOM) and Transfer Coordination Center and Medical Communication Upgrades to HIWIN
  2. Additional resources including DOH Staff, Medevac 9-1-1 ambulances, mobile units, rapid response vehicles, dedicated landing zones/helipads
  3. Statewide Triage and Transfer protocols and establish Medevac 9-1-1 air-medical dispatching to scene
- Implementing Phase 1 of Medical Communications Update, DOH Medicom Center to establish electronic reporting of EMS Aircraft Availability to centralized dashboard for hospital transfer centers and emergency departments, by January 1.
- Rural Healthcare Transformation Proposal submitted to request for additional investments in critical Medical Communications and transport resources.

Discussion: Initial Priorities and Information Needs

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS

Acting EMS Branch Chief and State Trauma Program Manager

Administrative Items and Next Steps: Meeting Dates

Closing

Mahalo

Garrett.Hall@doh.Hawaii.gov
Cell 808-217-4640

Aeromedical Services Working Group
Senate Concurrent Resolution 86

November 18, 2025

09:00 AM to 10:00 AM

Microsoft Teams Virtual Meeting by Invite Only

This meeting will be recorded.

Agenda: Aeromedical Services Working Group

0900 Welcome

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager

0905 Minutes and Recap: Overview of Aeromedical / Air-Medical Landscape
Presentation of Statewide and County-level Aeromedical Services

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager

0920 Discussion: Initial Priorities and Information Needs

Aeromedical Working Group

- Identifying Barriers to Expanding the Aeromedical Services System
- Recommendations for Future Plans, Procedures, Protocols, and Funding
- Ground Interfacility Transport Infrastructure / Aeromedical Fixed Wing Ground Transports
- Hospital Bed Availability & Physician-to-Physician Acceptance
- Medicom Center: Emergency and Trauma Transfers
- Multiple Casualty Event vs Mass Causality Incidents (MCI) and Medical Operations Coordination Center (MOCC)
- Medevac 9-1-1: Policies and Protocols

0955 Closing

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager

1000 Adjournment / Next Meeting

Welcome

Aloha & Welcome

Senate Concurrent Resolution 86; Request to Working Group (at a minimum) to:

1. "*Study and assess emergency aeromedical services needs across the State and in each county; and*"
2. *"Develop and recommend future plans, procedures, protocols, and funding to increase the predictability and stability of air ambulance medical services for the State; and"*
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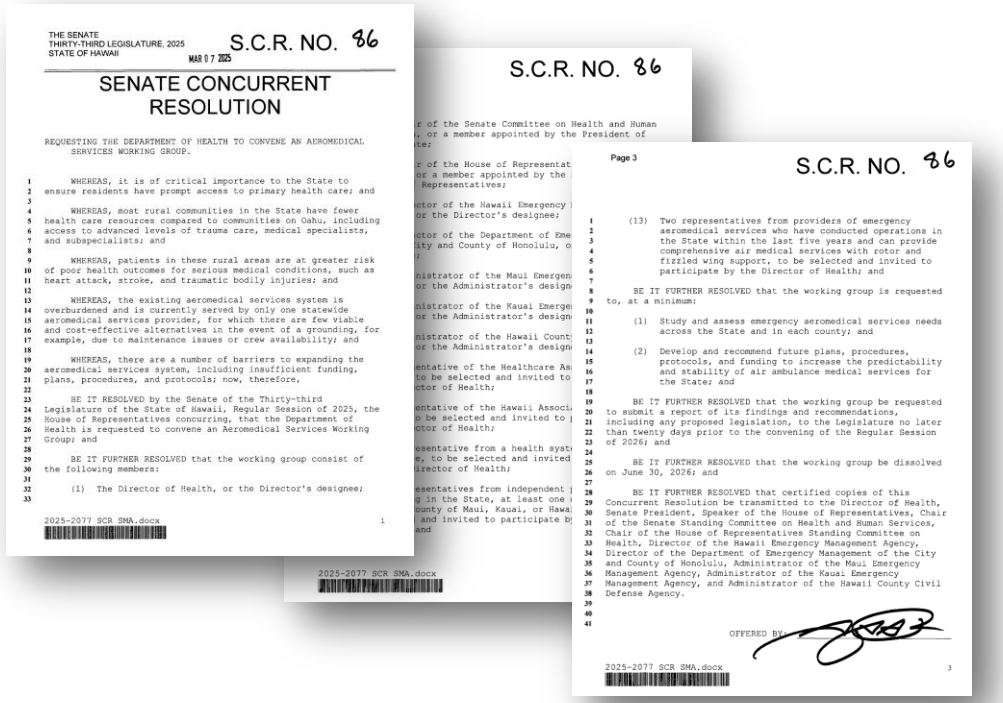
https://www.capitol.hawaii.gov/sessions/session2025/bills/SCR86_.PDF



THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.C.R. NO. 86

MAR 07 2025

SENATE CONCURRENT RESOLUTION

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2025-2077 SCR SMA.docx

S.C.R. NO. 86

Page 3

S.C.R. NO. 86

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OFFERED BY:

2025-2077 SCR SMA.docx

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Overview of Air-Medical Data

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS

Acting EMS Branch Chief and State Trauma Program Manager

Overview of Aeromedical / Air-Medical Landscape

Inter Facility Transport Providers

JAN 2025

1 Air-Medical Provider
Hawaii Life Flight

AUG

2 Air-Medical Provider
Hawaii Life Flight
Optimum Air

NOV

3 Air-Medical Providers
Hawaii Life Flight
Optimum Air
Life Flight Network

911 Medevac Transport Providers

2 Air-Medical Providers
Hawaii Fire Department
REACH

5 total Licensed Emergency Air-Medical Providers within the State of Hawaii as of 11/03/2025

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Overview of Aeromedical / Air-Medical Landscape

As of 11/03/2025

911 Medevac Providers
Hawaii Fire Department (HFD)
DOH / REACH Maui (REACH)

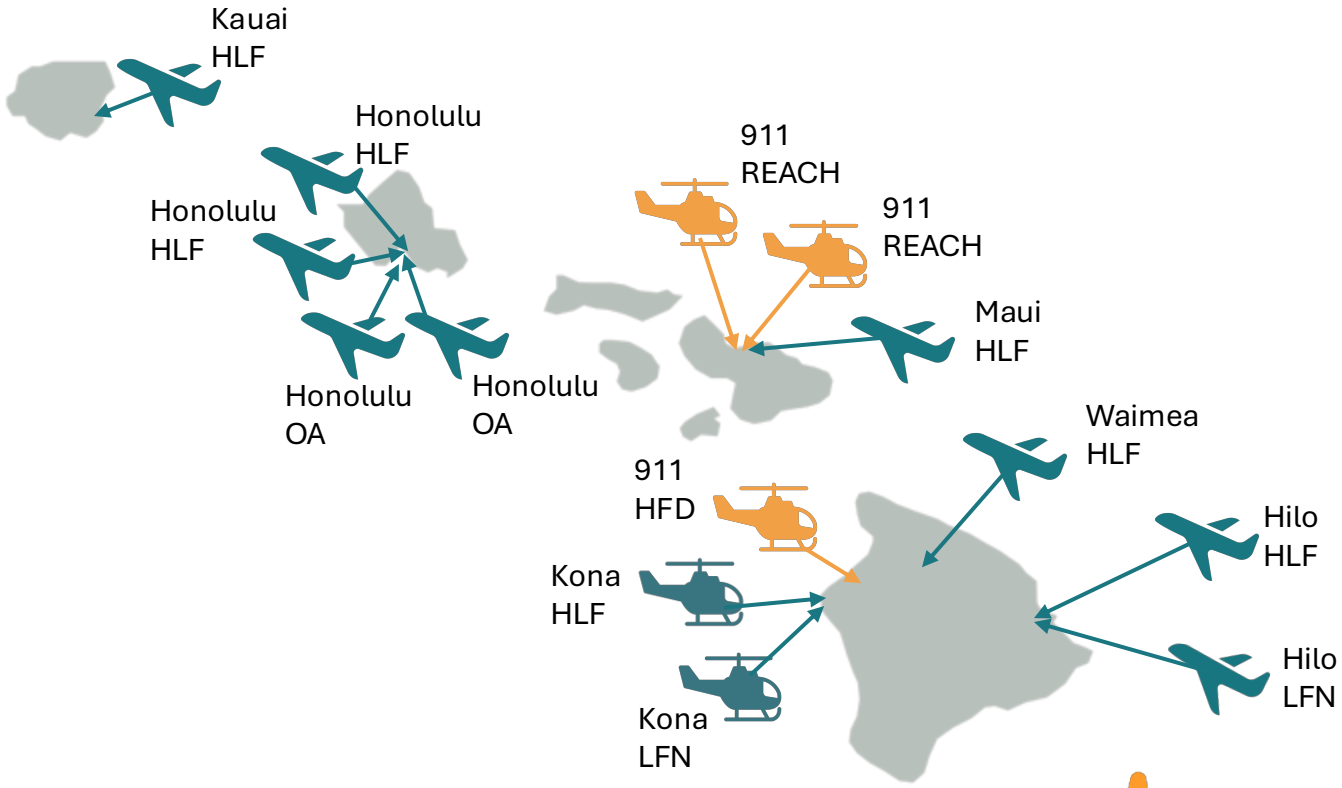
2

Inter-Facility Transport Providers
Hawaii Life Flight (HLF)
Life Flight Network (LFN)
Optimum Air (OA)

3

Total Air-Medical Providers

5



Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Overview of Aeromedical / Air-Medical Landscape

Clinical Best Practices & Benchmarks

National Standards:

- Target <120 minutes from time of incident to definitive care
- Ideal < 60 minutes for non-remote areas
- Military: 30 mins or less wheels-up, 60 minutes or less to definitive care

Dispatch Goals:

- < 10 minutes from activation to dispatch
- < 25-30 minute arrive at patient in rural areas

Outcome:

- Mortality increases sharply after 120 minutes
- Emphasis on system delays vs. provider performance

Average Time to Definitive Care

Wheels-Up Average Time

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A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Overview of Aeromedical / Air-Medical Landscape

Data Overview

Transport Volume :

- Steady increase in air-medical transports since 2020
- Increase over 1,000 additional transports in 2024 vs 2020
- 2020:N= 1994 vs. 2024:N=3078

Wheels-Up Time:

- State average: 122 minutes (Nov 2022-Oct 2024)
- 18% of Flights met <30 mins benchmark
- 50% of Flights exceeded 1 hour

(Identified as a state system-wide issue not provider issue)

Average Time to Definitive Care

Wheels-Up Average Time

Overview of Aeromedical / Air-Medical Landscape

Cost Modeling & Estimated Need

Current State of Hawaii Funding for Air-Medical

- $3.1M in State General Funds

Estimated Full Need: $24.5 to support the following need:

- 3 Rotors for Hawaii Island
- 2 Rotors for Maui
- 1 Rotor for Oahu
- 1 Rotor for Kauai

Assumptions based on the $24.5 need:

- $3.5Million per rotor (operational yearly cost)
- Based on ≈ 1,800 annual 911 Medevac Transports
- State DOH Fee Schedule Rate: $13,733 per transport
- Budget-nutural scenario assumes full reimbursement

Discussion:
Initial Priorities and Information Needs

Aeromedical Working Group Members

Discussion: Initial Priorities and Information Needs

- Identifying Barriers to Expanding the Aeromedical Services System
- Recommendations for Future Plans, Procedures, Protocols, and Funding
- Ground Interfacility Transport Infrastructure / Aeromedical Fixed Wing Ground Transports
- Hospital Bed Availability & Physician-to-Physician Acceptance
- Medicom Center: Emergency and Trauma Transfers
- Multiple Casualty Event vs Mass Causality Incidents (MCI) and Medical Operations Coordination Center (MOCC)
- Medevac 9-1-1: Policies and Protocols

Closing Remarks / Next Meeting

Right Patient, Right Place, Right Time, Right Now

Mahalo

Garrett.Hall@doh.Hawaii.gov

Cell 808-217-4640

Aeromedical Services Working Group
Senate Concurrent Resolution 86

November 25, 2025

09:00 AM to 10:00 AM

Microsoft Teams Virtual Meeting by Invite Only

This meeting will be recorded.

Agenda: Aeromedical Services Working Group

0900	Welcome and Roll Call *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0905	Review of Definitions *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0920	Medicom Center / Transfers Discussion *Working Group*
0930	Open Discussion *Working Group*
0958	Closing Remarks *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
1000	Adjournment / Next Meeting

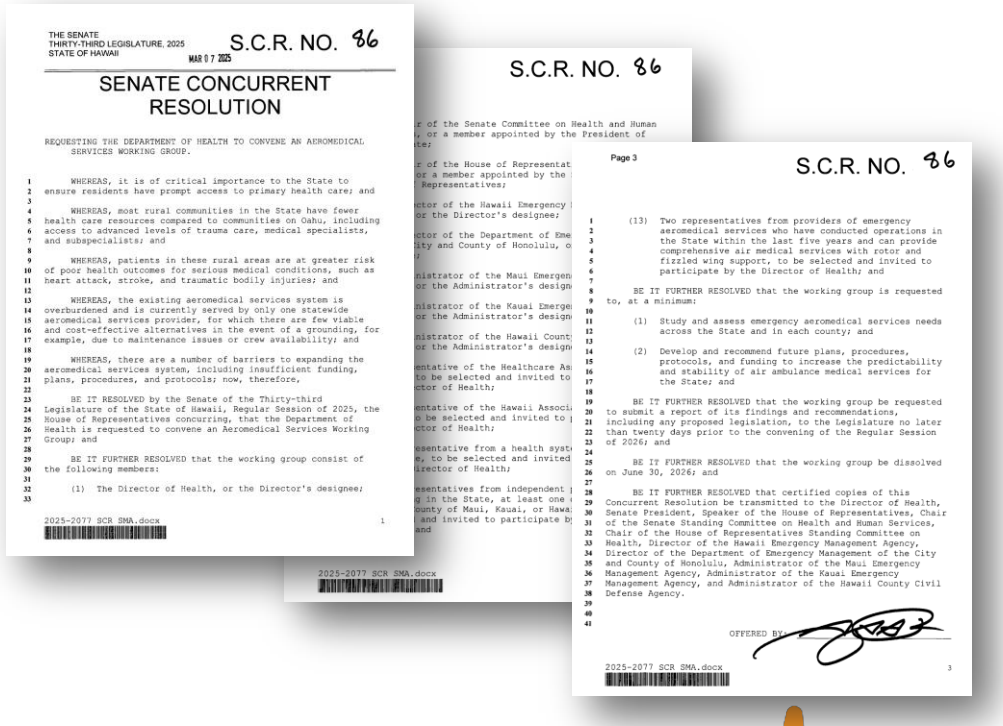
Welcome

Aloha & Welcome

https://capitolwebsite.azurewebsites.net/sessions/session2025/bills/SCR86_HD1_.htm

Senate Concurrent Resolution 86; Request to Working Group (at a minimum) to:

1. "*Study and assess emergency aeromedical services needs across the State and in each county; and*"
2. *"Develop and recommend future plans, procedures, protocols, and funding to increase the predictability and stability of air ambulance medical services for the State; and"*
3. *Submit a report of working groups findings and recommendations, including any proposed legislation, to the Legislature no later than* ***January 1, 2026***



THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.C.R. NO. 86

MAR 07 2025

SENATE CONCURRENT RESOLUTION

REQUESTING THE DEPARTMENT OF HEALTH TO CONVENE AN AEROMEDICAL SERVICES WORKING GROUP.

WHEREAS, it is of critical importance to the State to ensure residents have prompt access to primary health care; and

WHEREAS, most rural communities in the State have fewer health care resources compared to communities on Oahu, including access to advanced levels of trauma care, medical specialists, and subspecialists; and

WHEREAS, patients in these rural areas are at greater risk of poor health outcomes for serious medical conditions, such as heart attack, stroke, and traumatic bodily injuries; and

WHEREAS, the existing aeromedical services system is overburdened and is currently served by only one statewide aeromedical services provider, for which there are few viable and cost-effective alternatives in the event of a grounding, for example, due to maintenance issues or crew availability; and

WHEREAS, there are a number of barriers to expanding the aeromedical services system, including insufficient funding, plans, procedures, and protocols; now, therefore,

BE IT RESOLVED by the Senate of the Thirty-third Legislature of the State of Hawaii, Regular Session of 2025, the House of Representatives concurring, that the Department of Health is requested to convene an Aeromedical Services Working Group; and

BE IT FURTHER RESOLVED that the working group consist of the following members:

(1) The Director of Health, or the Director's designee;

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S.C.R. NO. 86

2025-2077 SCR SMA.docx

Page 3 S.C.R. NO. 86

(13) Two representatives from providers of emergency aeromedical services who have conducted operations in the State within the last five years and can provide comprehensive air medical services with rotor and fixrled wing support, to be selected and invited to participate by the Director of Health; and

BE IT FURTHER RESOLVED that the working group is requested to, at a minimum:

(1) Study and assess emergency aeromedical services needs across the State and in each county; and

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BE IT FURTHER RESOLVED that the working group be dissolved on June 30, 2026; and

BE IT FURTHER RESOLVED that certified copies of this Concurrent Resolution be transmitted to the Director of Health, Senate President, Speaker of the House of Representatives, Chair of the Senate Standing Committee on Health and Human Services, Chair of the House of Representatives Standing Committee on Health, Director of the Hawaii Emergency Management Agency, Director of the Department of Emergency Management of the City and County of Honolulu, Administrator of the Maui Emergency Management Agency, Administrator of the Kauai Emergency Management Agency, and Administrator of the Hawaii County Civil Defense Agency.

OFFERED BY:

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Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Review of Definitions

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS

Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager

Aeromedical / Air-Medical Definitions

Aeromedical: or “aero-medical” is the broad umbrella term for medicine involving aircraft combine with the aviation domain, and commonly used in miliary doctrine as a standard phrase for moving causalities by air with care being provided while en-route. The term is sometimes used interchangeably with the civilian term air-medical or “air medical”.

Air Medical: or “air-medical” is civilian air ambulance services transporting and treating patients with the use of aircraft. The term is sometimes used interchangeably with the military term aeromedical or “aero-medical”.

Air-Medical Services: means medical care and transport of patients by a licensed air ambulance operator with qualified medical personnel, and regulated as part of the statewide emergency medical systems of care.

Emergency Air-Medical Services: means a response system that provides immediate critical care and transport of a patient by aircraft to a facility that provides specialized medical care.

Aeromedical / Air-Medical Definitions

Definitive Care: means the final specialized medical level treatment that actually treats the underlying injury or illness, delivered at an appropriate facility as designated or approved by the department, not just temporary stabilization, should not require additional transports of patient.

Air-Medical Estimated Time of Arrival (ETA): means the total time in minutes and/or hours from time licensed air-medical provider accepts flight until the air-medical providers are at the patient's bed side of the transferring facility.

Air-Medical Estimated Time of Arrival to Definitive Care: means the total time in minutes and/or hours from time licensed air-medical provider accepts flight until the patient care arrives at the definitive care facility

Wheels Up: means the total time from air-medical provider accepting the flight until the air-craft is in air to the patient at the transferring facility.

Medicom Center / Transfers Discussion

Aeromedical Working Group Members

Open Discussion

Aeromedical Working Group Members

Closing Remarks / Next Meeting
Happy Turkey Day!

Mahalo

Garrett.Hall@doh.Hawaii.gov
Cell 808-217-4640

Aeromedical Services Working Group
Senate Concurrent Resolution 86

December 2, 2025

09:00 AM to 10:00 AM

Microsoft Teams Virtual Meeting by Invite Only

This meeting will be recorded.

Agenda: Aeromedical Services Working Group

0900	Welcome and Roll Call *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0905	Operational Coordination Discussion *Working Group*
0920	Open Discussion *Working Group*
0958	Closing Remarks *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
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Welcome

Aloha & Welcome

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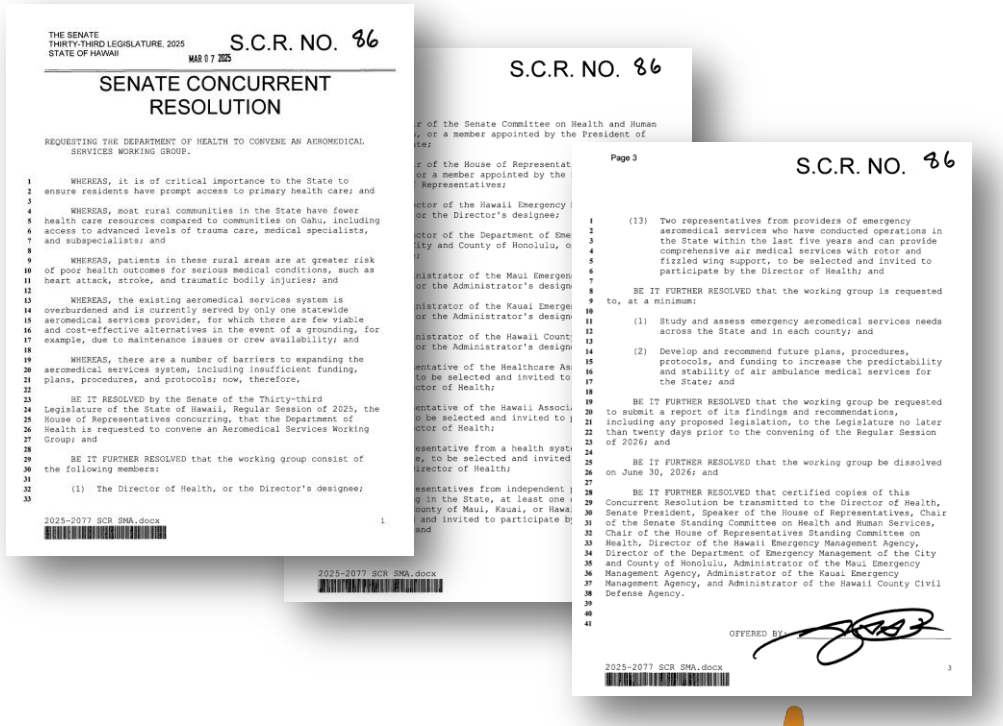

THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.C.R. NO. 86

MAR 07 2025

SENATE CONCURRENT RESOLUTION

REQUESTING THE DEPARTMENT OF HEALTH TO CONVENE AN AEROMEDICAL SERVICES WORKING GROUP.

WHEREAS, it is of critical importance to the State to ensure residents have prompt access to primary health care; and

WHEREAS, most rural communities in the State have fewer health care resources compared to communities on Oahu, including access to advanced levels of trauma care, medical specialists, and subspecialists; and

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BE IT RESOLVED by the Senate of the Thirty-third Legislature of the State of Hawaii, Regular Session of 2025, the House of Representatives concurring, that the Department of Health is requested to convene an Aeromedical Services Working Group; and

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S.C.R. NO. 86

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Page 3 S.C.R. NO. 86

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Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Operational Coordination Discussion

Aeromedical Working Group Members

Aeromedical Consensus

Aeromedical Group Consensus:

Modernizing Hawaii Revised Statues (HRS) §321

- Update statutory language to formally adopt definitions for the *MEDICOM Center*.
- Establish a foundation for a statewide patient transfer coordination center, designed to grow and scale over time.
    - Focus on future-proofing the system to adapt to evolving healthcare, technology, and emergency response needs.

Accreditation Framework

- Recognize multiple accrediting bodies (e.g., CAMTS, NAAMTA, NSPA) based on provider type.
    - Accreditation improves safety, quality, and standardized practices across all medical transport and coordination services.

Emergency Medical Services (EMS) Ground and Air Unified Information Systems

- Support development of a unified statewide EMS data and communication platform.
    - Enhances interoperability, situational awareness, and efficiency across agencies and healthcare partners.

Aeromedical Talking Points

Aeromedical Talking Points:

Funding and Resources

Aeromedical Memberships
- Consumer protections

Communications Systems Upgrades
- Support Hawaii Wireless Interoperability Network (HIWIN) integration with Hospital Base Stations, Air Medical, 911 Dispatch
- Smart911 Statewide Integration
- Secondary Public Safety Answering Points (PSAP) for EMS (Ground and Air)

Disaster / Preparedness Medical Operations Command Center
- Integration of Air Medical resources for critical disaster responses (Tsunami's, Wildfires, etc.)

Open Discussion

Aeromedical Working Group Members

Closing Remarks

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS

Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager

Mahalo

Garrett.Hall@doh.Hawaii.gov
Cell 808-217-4640

Right Patient, Right Place, Right Time, Right Now

Aeromedical Services Working Group
Senate Concurrent Resolution 86

December 23, 2025

09:00 AM to 09:30 AM

Microsoft Teams Virtual Meeting by Invite Only

This meeting will be recorded.

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Agenda: Aeromedical Services Working Group

0900	Welcome and Roll Call *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0905	Draft Final Report of Aeromedical Services Working Group - Discussion *Working Group*
0925	Closing Remarks *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
1000	Adjournment / Next Meeting

Welcome

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Aloha & Welcome

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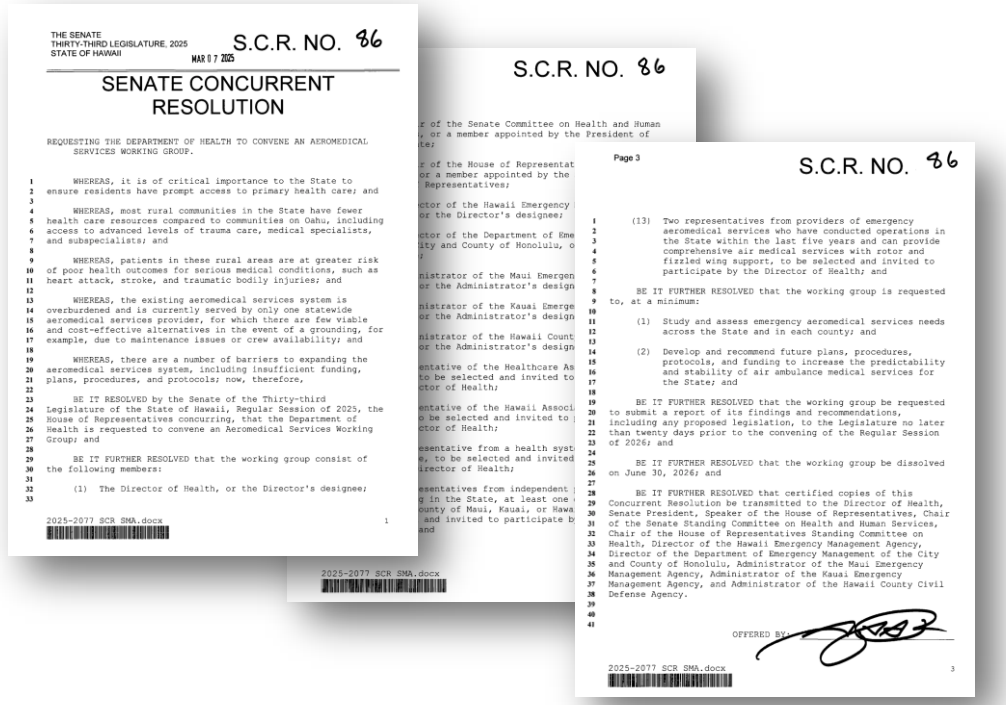

THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.C.R. NO. 86

MAR 07 2025

SENATE CONCURRENT RESOLUTION

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2025-2077 SCR SMA.docx

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OFFERED BY:

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Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Happy Holidays

Happy Holidays

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

DRAFT

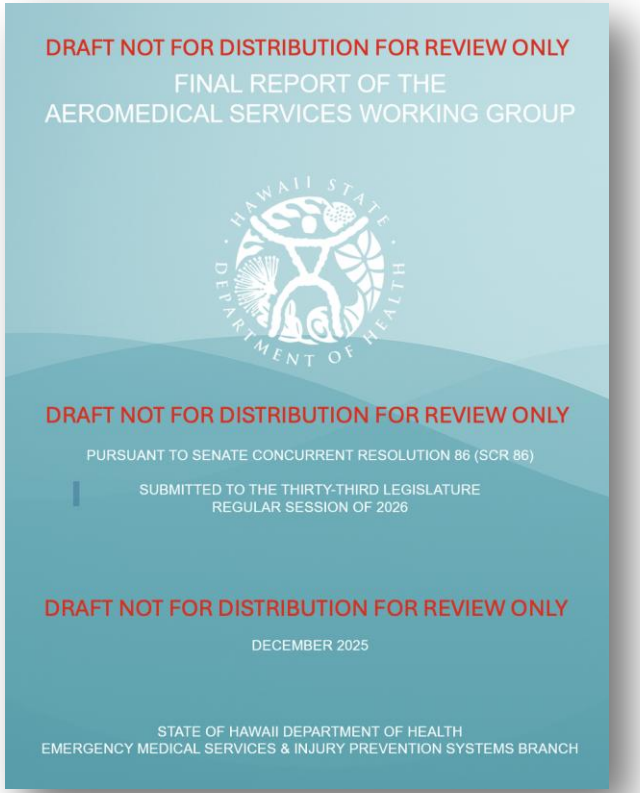
Final Report of Aeromedical Services Working Group

Aeromedical Working Group Members

Aeromedical Recommendations

Aeromedical Working Group Recommendations:

A. Modernizing Hawaii Revised Statues (HRS) §321 and Hawaii Administrative Rules §11-72
B. MEDICOM Center: Statewide Emergency Trauma Transfer Coordination
C. Accreditation Framework and Coordination Services
D. Unified Statewide EMS Aeromedical Data and Secondary 9-1-1 Public Safety Answer Points (PSAPs)
E. Strengthen Workforce Training and Clinical Standards for Aeromedical Services
F. Advance Health Equity and Patient Protections in Aeromedical Transport
G. Improve Transparency and Consumer / Patient Understanding of Air Medical Membership Programs
H. Enhance Disaster Preparedness and Communication Systems for Aeromedical Operations
I. Address Funding and Reimbursement Challenges to Ensure System Sustainability



Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Open Discussion

Aeromedical Working Group Members

Closing Remarks

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS

Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager

Happy Holidays

Happy Holidays

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Mahalo

Garrett.Hall@doh.Hawaii.gov
Cell 808-217-4640

Aeromedical Services Working Group
Senate Concurrent Resolution 86

January 6, 2026

09:00 AM to 09:30 AM

Microsoft Teams Virtual Meeting by Invite Only

This meeting will be recorded.

Agenda: Aeromedical Services Working Group

0900	**Welcome and Roll Call** *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
0905	**Draft Final Report of Aeromedical Services Working Group - Discussion** *Working Group*
0925	**Closing Remarks** *Garrett D. Hall, MS, BSN, RN, CSTR, CAISS* *Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager*
1000	**Adjournment / Next Meeting**

Welcome

Aloha & Welcome

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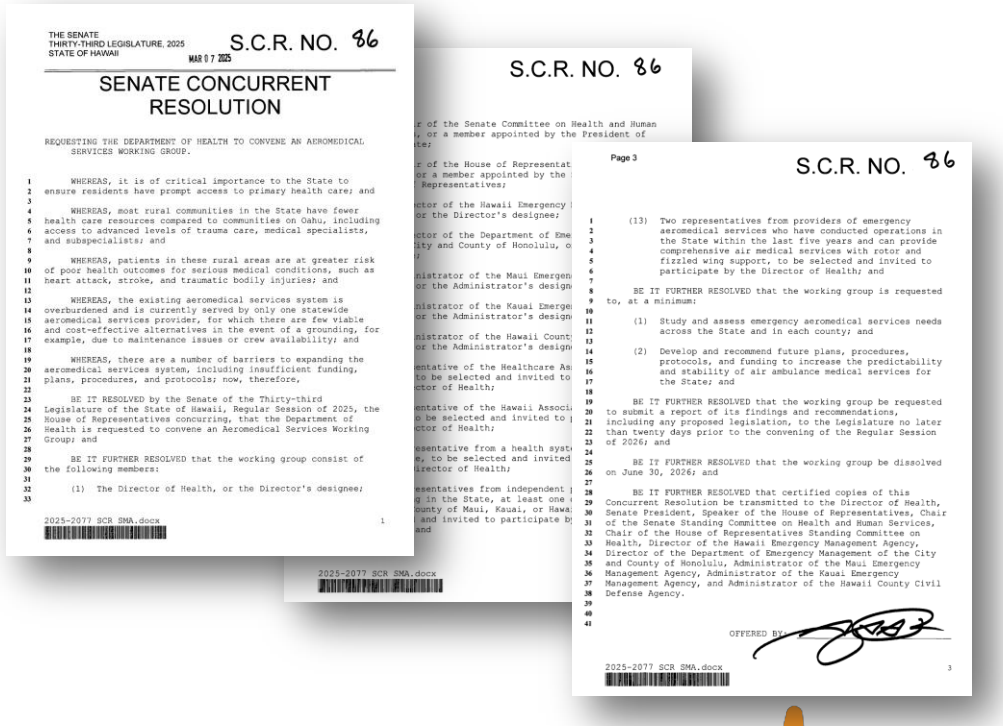

THE SENATE
THIRTY-THIRD LEGISLATURE, 2025
STATE OF HAWAII

S.C.R. NO. 86

MAR 07 2025

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S.C.R. NO. 86

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Page 3 S.C.R. NO. 86

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OFFERED BY:

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Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Happy New Year

Happy New Year

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

DRAFT

Final Report of Aeromedical Services Working Group

Aeromedical Working Group Members

Aeromedical Recommendations

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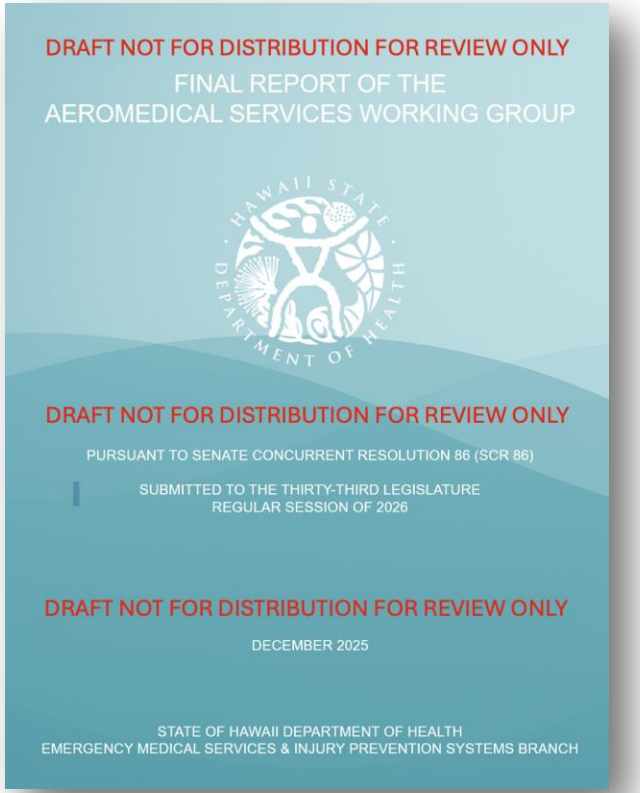

Right Patient, Right Place, Right Time, Right Now

A Prepared and Safe Hawaii Starts with Trauma and Emergency Medical Services Modernization

Open Discussion

Aeromedical Working Group Members

Closing Remarks

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS

Acting Emergency Medical Services and Injury Prevention Systems Branch Chief & State Trauma Program Manager

Mahalo

Garrett.Hall@doh.Hawaii.gov
Cell 808-217-4640

Appendix C: Working Group Meeting Minutes

AEROMEDICAL WORKING GROUP

MEETING MINUTES

Tuesday, November 4, 2025
9:00 AM – 10:00 AM

Virtual Meeting

Recoding Link (People With Existing Access)

Committee Members Present: Garrett Hall, Sen. Joy San Buenaventura, Rep. Sue Keohokapu-Lee Loy, Leif Ericson Fautanu (for Jack Lee), Jake Kiyohiro, Solomon Kanoho, William “Bill” Hanson (for Talmadge Magno), Hilton Raethel, Walden Au, Ashley Shearer, Kilipaki Kanae, Jon Rosati, Anthony Raymond, and Jacob Mayer.

Committee Member Absent: Randal Collins

This meeting was recorded

MEETING MINUTES

0900 Welcome, Opening Remarks

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS, Acting EMSIPS Branch Chief and State Trauma Program Manager

- Garrett Hall welcomed attendees and introduced the agenda: a presentation on Hawaii's air medical landscape and a review of current data from the Department of Health.

0902 Introduction of Working Group Members

Working Group

- Each member introduced themselves. Presences and absences noted on page one.

0908 Overview of Aeromedical / Air-Medical Landscape:
Presentation of Statewide and County-level Aeromedical Service

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPSB Branch Chief and State Trauma Program Manager

1. Current Air Medical Landscape

- As of November 3, 2025:
  - Three interfacility transport providers: Hawaii Life Flight, Optimum Air and Life Flight Network.
  - Two 911 medevac providers: Hawaii Fire Department and REACH.
  - 14 total aircraft resources: 11 Interfacility, Three (3) 911 medevac.

2. Best Practices & Benchmarks

- National Standards:
  - Target: <120 minutes from incident to definitive care (CDC, HERSA, ACS).
  - Ideal: <60 minutes for non-remote areas.
  - Military benchmark: 30-minute wheels-up, 60-minute to point of injury.

- Dispatch Goals:
  - <10 minutes from activation to dispatch.
  - <25–30 minutes to patient in rural areas.

- Outcome Data:
  - Mortality increases sharply after 120 minutes.
  - Emphasis on system delays vs. provider performance.

MEETING MINUTES

3. Data Overview

    - Transport Volume
        - Steady increase in air medical transports since 2020.
        - Over 1,000 additional transports per year since 2020.

    - Wheels-Up Time:
        - State average: 122 minutes (Nov 2022–Oct 2024).
        - Only 18% of flights met the <30-minute benchmark.
        - Over 50% exceeded 1 hour — identified as a system-wide issue.

4. System Stress & Emergency Response

    - Discussion on “blue sky” vs. “gray sky” conditions.
    - Past incidents (e.g., Maui explosion, Kauai diversions) showed strain on resources. Will consider exploration of Mass Casualty Incident (MCI) with flight response.
    - William Hanson shared county-level planning for mass casualty events and integration with tools like Pulsara for patient tracking.

5. Cost Modeling & Estimated Need

    - Current Funding: $3.1M in state general funds for 911 medevac.
    - Estimated Full Need: $24.5M to support:
        - 3 rotors for Hawaii Island
        - 2 for Maui
        - 1 each for Oahu and Kauai

    - Assumptions:
        - $3.5M per rotor (operational only).
        - Based on ~1, 800 annual 911 medevac transports.
        - State reimbursement rate: $13,733 per transport (idealized).
        - Budget-neutral scenario assumes full reimbursement, which is not currently achieved.

0953 Discussion: Initial Priorities and Information Needs

Working Group

- Jon Rosati (Optimum Air):
    - Offered to share two months of response time data.
    - Emphasized efficient use of existing resources and triaging to avoid misallocating 911 assets.

MEETING MINUTES

0953 Discussion: Initial Priorities and Information Needs (Continued)

Working Group

- Jacob Mayer (Hawaii Life Flight)
  - Raised concern about delays due to lack of bed acceptance at receiving facilities.
  - Suggested tracking these delays alongside air transport metrics.

- William Hanson
  - Shared county-level efforts with the National Mass Violence Center.
  - Recent triennial mass casualty exercises at Hilo Airport.

0957 Administrative Items and Next Steps: Meeting Dates

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPSB Branch Chief and State Trauma Program Manager

- Weekly meetings will continue through January 1, 2026, to meet the legislative reporting deadline.
- Andrew Yonemura will coordinate scheduling and logistics.
- Members are encouraged to email Garrett or Andrew with specific topics or data requests.
- Meeting slides, agenda, and the recording will be shared with the working group.
- Final report will include data and recommendations for legislative submission.

1000 Adjournment

Meeting adjourned at 10:00AM HST.

GC9JZ6x9

Emergency Medical Services and Injury Prevention Systems Branch (EMSIPSB)

Hawaii State Department of Health (DOH)

AEROMEDICAL WORKING GROUP

AGENDA

Tuesday, November 18, 2025
9:00 AM – 10:00 AM

Virtual Meeting

Link: Meeting Link
Meeting ID: 293 723 727 984 60
Passcode: GC9Jz6x9

This meeting will be recorded

If you need an auxiliary aid/service or other accommodation due to a disability, contact Andrew at (808) 204-2616 or email andrew.yonemura@doh.hawaii.gov as soon as possible. Requests made as early as possible have a greater likelihood of being fulfilled.

Upon request, this notice is available in alternate/accessible formats.

AGENDA

Note: Agenda items may be taken out of order
The times listed are approximate and subject to change

0900 Welcome
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0905 Recap: Overview of Aeromedical / Air-Medical Landscape
Presentation of Statewide and County-level Aeromedical Service
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPSB Branch Chief and State Trauma Program Manager

0920 Discussion: Initial Priorities and Information Needs
Aeromedical Working Group

Identifying Barriers to Expanding the Aeromedical Services System

Recommendations for Future Plans, Procedures, Protocols, and Funding

Ground Interfacility Transport Infrastructure

Bed Availability & Physician-to-Physician Acceptance

Medicom Center: Emergency and Trauma Transfers

Mass Casualty Incident (MCI) & Medical Operation Coordination (MOC)

Medevac 9-1-1: Policies and Protocols

0955 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPSB Branch Chief and State Trauma Program Manager

1000 Adjournment

AEROMEDICAL WORKING GROUP

MEETING MINUTES

Tuesday, November 18, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Recoding Link (People With Existing Access)

Committee Members Present: Garrett Hall, Elton Ushio, Talmadge Magno, Hilton Raethel, Walden Au (joined after roll call), Ashley Shearer, Kilipaki Kanae, Jon Rosati, Anthony Raymond, and Chistopher Shrader.

Committee Member Absent: Senator Joy Buenaventura, Representative Sue Keohokapu-Lee Loy, Jack Lee, Randal Collins, Jake Kiyohiro,

This meeting was recorded

MEETING MINUTES

0900 Welcome, Opening Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Garrett Hall welcomed attendees and introduced Christopher Schrader, the new representative from GMR, replacing Jacob Meyer.
- Christopher Schrader introduced himself as VP of Operations for GMR Pacific Region, overseeing air and ground operations in Hawaii and California.

0905 Recap: Overview of Aeromedical / Air-Medical Landscape
Presentation of Statewide and County-level Aeromedical Service
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Discussion of clinical benchmarks and Hawaii's performance metrics.
- Review of dispatch goals, outcome data, and cost modeling.
- Emphasis on the need for improved coordination and system-wide standards.
- Garrett Hall committed to providing a glossary of definitions and clarified that data was sourced from provider reports and will be standardized under a new platform by January 2026.

1. 911 Vs. Interfacility Transport
    a. Garrett Hall explained the current model and proposed a shift toward direct-to-definitive-care transport.
    b. Hilton Raethel requested a breakdown of 911 vs. interfacility transports; Garrett estimated ~50–60% are emergency transports.

0931 Discussion: Initial Priorities and Information Needs
Working Group

- Jon Rosati and Ashley Shearer highlighted inefficiencies in current ETA coordination.
- A short-term solution is being piloted with the three air providers and Queens Transfer Center.

0941 Identifying Barriers to Expanding the Aeromedical Services System
Working Group

- Discussion on whether to expand the number of providers or optimize current resources.
- Hilton Raethel and Jon Rosati expressed concern about sustainability and cost, recommending a focus on coordination and efficiency.

0947 Recommendations for Future Plans, Procedures, Protocols, and Funding
Working Group

- Garrett Hall inquired about the group support/opposition of the MEDCOM Center initiative.
- Christopher Schrader asked for clarification on the MEDCOM Center's role.
- Garrett Hall outlined:
  - Short-term: centralized triage and ETA visibility.
  - Long-term: scalable coordination hub for multi-casualty and mass casualty events.
  - Not a dispatch or resource allocation center.
  - Will support both 911 and interfacility coordination.
  - Legislative updates are underway to modernize EMS statutes and clarify MEDCOM roles.

0959 Mass Casualty Vs Multi-Casualty
Working Group

- Kilipaki Kanae raised the need for clear definitions.
- Garrett Hall acknowledged the variation across islands and agencies.
  - The group will revisit this topic in the next meeting and propose standardized definitions.

1001 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Members are asked to email **Andrew Yonemura** with:
  - Support or concerns regarding the MEDCOM Center.
  - Additional items to include in the legislative report.
- Definitions and outstanding discussion points (e.g., MCI vs. multi-casualty) will be addressed in the next meeting.

1004 Adjournment

Meeting adjourned at 10:04AM HST

AEROMEDICAL WORKING GROUP

AGENDA

Tuesday, November 25, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Link: Meeting Link
Meeting ID: 293 723 727 984 60
Passcode: GC9Jz6x9

This meeting will be recorded

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AGENDA

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The times listed are approximate and subject to change

0900 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0905 Review of Definitions
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

Mass Casualty vs. Multi-Casualty Distinction
Working Group

911 vs. Interfacility Transport (IFT) Distinction
Working Group

0920 911 vs. Interfacility Transport (IFT) Data Review
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0930 Medicom Center / Transfers Discussion
Working Group

0940 Open Discussion
Working Group

0958 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

1000 Adjournment

AEROMEDICAL WORKING GROUP

MEETING MINUTES

Tuesday, November 25, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Recoding Link (People With Existing Access, Expires 12/26/25)

Committee Members Present: Garrett Hall, Representative Sue Keohokapu-Lee Loy, Jake Kiyohiro, Solomon Kanoho (for Elton Ushio), Talmadge Magno, Hilton Raethel, Walden Au, Ashley Shearer, Kilipaki Kanae (joined after roll call), Jon Rosati, and Brent Lopez.

Committee Member Absent: Senator Joy San Buenaventura, Jack Lee, Randal Collins, and Anthony (Tony) Raymond

This meeting was recorded

MEETING MINUTES

0901 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Garrett Hall welcomed attendees and acknowledged the holiday weekend.
- Andrew Yonemura conducted roll call.

0905 Review of Definitions
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Reviewed proposed definitions for inclusion in the Department of Health's legislative package:
  - Air Medical vs. Aeromedical: Civilian vs. military terminology.
  - Air Medical Services: Licensed air ambulance transport with qualified personnel.
  - Emergency Air Medical Services: Immediate critical care and transport.
  - Definitive Care: Final treatment at a designated facility.

- ETA Definitions:
  - Air Medical ETA: From flight acceptance to bedside arrival.
  - ETA to Definitive Care: From flight acceptance to definitive care facility.
  - Wheels Up: From flight acceptance to aircraft airborne en route to patient.

0910 Medicom Center / Transfers Discussion
Working Group

- Proposal to modernize Statute 321 to define a centralized Medcom Center.
  - Group consensus supports the concept.
- Phase 1 pilot using TransferNet underway.
- Emphasis on flexibility and adaptability in implementation.

0918 Open Discussion
Working Group

National Acrediation

Broad support for requiring accreditation.

- Multiple accrediting bodies (e.g., CAMTS, NAAMTA, NSPA) should be recognized based on provider type.
- Accreditation ensures safety, quality, and standardization across services.

Unified Information Systems

Strong support for a unified EMS data platform, similar to hospitals using Epic.

- Benefits include improved patient outcomes, efficiency, and disaster readiness.
- References to Epic or TransferNet are illustrative; the goal is system-wide interoperability, not product endorsement.
- Workgroup endorsed for continued data modernization and platform unification.

Healthcare & EMS Deserts

Counties are not physically connected; no mutual aid via ground transport. Air medical coordination is essential due to geographic isolation.

- All air medical providers are being moved to the HighWind communication platform.
- Establish secondary Public Safety Answering Point (PSAP)s in each county.
- Use nurse triage or community paramedicine to reduce unnecessary 911 dispatches.
    - Keep ambulances available for true emergencies.
- Unified systems are critical for responding to tsunamis, wildfires, and other emergencies.

- Air transport will be vital for moving critically injured patients.

Operational Priorities and Phased Approach

Jon Rosati, from Optimum Medicine emphasized starting with operational coordination and communication. Suggested:

- Leveraging existing 24/7 communication centers across providers.
- Creating a clinical subgroup to align protocols and practices.

Garrett Hall confirmed an existing statutory Air Medical Working Group can take on clinical standardization.

Vision and Next Steps

Garrett Hall encouraged members to:

- Think innovatively about workforce development (e.g., rotations for advanced practice nurses.)
- Contribute ideas for certification, training, staffing, and preparedness.
- Provide input for the legislative report due in December.

0955 Closing Remarks

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Garrett Hall thanked participants on behalf of the Department of Health.
- Noted upcoming holiday schedule and encouraged continued collaboration.
- Next meeting will focus on gathering member-driven recommendations for the final report.

0958 Adjournment

Meeting adjourned at 09:58AM HST

AEROMEDICAL WORKING GROUP

AGENDA

Tuesday, December 02, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Link: Meeting Link
Meeting ID: 293 723 727 984 60
Passcode: GC9Jz6x9

This meeting will be recorded

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AGENDA

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The times listed are approximate and subject to change

0900 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0905 Operational Coordination Discussion
Working Group

0920 Open Discussion
Working Group

0958 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

1000 Adjournment

AEROMEDICAL WORKING GROUP

MEETING MINUTES

Tuesday, December 2, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Recoding Link (People With Existing Access, expires January 4th 2026)

Committee Members Present: Garrett Hall, Representative Sue Keohokapu-Lee Loy, Jack Lee, Solomon Kanoho [for Elton Ushio (joined after roll call)], Talmadge Magno, Walden Au, Ashley Shearer, Kilipaki Kanae (joined after roll call), and Brent Lopez.

Committee Member Absent: Senator Joy San Buenaventura, Jake Kiyohiro, Randal Collins, Hilton Raethel, Jon Rosati, and Anthony (Tony) Raymond

This meeting was recorded

MEETING MINUTES

0901 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Garrett Hall welcomed attendees.
- Andrew Yonemura conducted roll call.

0905 Operational Coordination Discussion
Working Group

- Online transport requests are sent to all three providers statewide.
- Providers have 4 minutes to respond with an ETA; the shortest ETA wins the transport.
    - Security agreements are being finalized.
- Target go-live date: December 8, 2025 in partnership with the Queens Transfer Center.

0910 Aeromedical Consensus
Working Group

- Medicom Center/Coordination Center
- Accreditation framework for air medical providers.
- Endorsement of a unified EMS information system.

0912 Aeromedical Talking Points
Working Group

Quality Measures & System Monitoring.

- Real-time quality monitoring is active via the EMS Advisory Council.
- Airway management is the current focus; more measures may be added for air medical.

Resources Availability

Ashley Shearer (Vice President of Patient Care, Queen's Health System) and Heather Beyer (Director of Patient Flow, Queen's Health System) stated:

- No additional resources needed for Queen's Medical Center

- Communication and Estimated Time of Arrival (ETAs) have improved.

Brent Lopez (Regional Director, Hawaii Life Flight) told the group that known delays in ground transport were reported.

Funding & Reimbursement Challenges

Air medical reimbursement rates have not been updated nationally in over 15 years.

- State fee schedule (~$13,000) is higher than Medicare but still below average costs ($25K–$30K).
- CMS reimbursement delays and payer denials remain a challenge.
- The No Surprises Act has helped, but enforcement and payment timelines are still problematic.
    - Federal Air Deregulation Act limits state authority on pricing.
- Some contracts allow direct billing to reduce state costs.

Air Medical Memberships

Two providers in Hawaii offer air medical memberships.

- Garrett Hall (Acting Branch Chief, EMSIPSB) raised concerns about consumer confusion due to similar provider names.
    - Memberships may not cover transport if a different provider responds.
    - Recommendation to increase transparency and public education.
    - Potential for contractual clauses to require reciprocity.
- Ms. Shearer explained that in emergent situations, transport decisions are payer-agnostic and based on safety and speed.
- Ms. Beyer recalled past practices where providers honored each other's memberships to reduce patient burden.

911 Air Medical Response Expansion

Only two counties currently have 911 air medical response programs.

- Interest from private providers to enter the 911 air transport space.

- Kilipaki Kanae (EMS Battalion Chief for Hawaii Fire) recommended to require providers to have at least one year of interfacility transport experience before entering 911 dispatch.

Disaster Preparedness & Communication Systems

Mr. Lopez recommended to consider all rotor assets for disaster relief scenarios.

- Discussion on Smart 911 and communication system upgrades.
- Integration with CAD and PSAPs to improve dispatch accuracy.

0956 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

Garrett Hall thanked participants on behalf of the Department of Health.

0959 Adjournment

Meeting adjourned at 09:59AM HST

Items for Next Meeting

1) Recommendation to include funding and reimbursement challenges in legislative report.
2) Support for public education on air medical memberships.
3) Recommendation to require one year of interfacility transport experience before 911 dispatch eligibility.
4) Encouragement to include disaster preparedness planning in future discussions.

AEROMEDICAL WORKING GROUP

AGENDA

Tuesday, December 09, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Link: Meeting Link
Meeting ID: 293 723 727 984 60
Passcode: GC9Jz6x9

This meeting will be recorded

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AGENDA

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The times listed are approximate and subject to change

0900 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0905 Aeromedical Consensus / Report
Working Group

0920 Open Discussion
Working Group

Funding and Reimbursement Challenges

Operational Coordination

Air Medical Membership

One Year Experience of Interfacility Transport Before 911 Eligibility

Aeromedical Planning for Disaster Preparedness

0958 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

1000 Adjournment

AEROMEDICAL WORKING GROUP

MEETING MINUTES

Tuesday, December 9, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Recoding Link (People With Existing Access)

Committee Members Present: Garrett Hall, Jack Lee, Randal Collins, Solomon Kanoho [for Elton Ushio (joined after roll call)], Talmadge Magno, Hilton Raethel, Walden Au, Ashley Shearer, Kilipaki Kanae, Jon Rosati, Anthony (Tony) Raymond and Brent Lopez.

Committee Member Absent: Senator Joy San Buenaventura, Representative Sue Keohokapu-Lee Loy, and Jake Kiyohiro.

This meeting was recorded

MEETING MINUTES

0901 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Garrett Hall welcomed attendees.
- Andrew Yonemura conducted roll call.

0903 Aeromedical Consensus / Report
Working Group

Chief Hall shared the draft layout of the 2026 report:

- Title page with working group members and attendees
- Executive summary
- Background on SCR 86 and Hawaii's air medical system
- Data and national benchmarks
- Priority needs and system challenges
- Recommendations and next steps
- Appendices with reference documents

Draft report to be distributed by next Monday for review and feedback.

0907 Open Discussion
Working Group

Funding and EMS Procurement Challenges

Chief Hall explained strict procurement regulations under DOH hinder rapid implementation of air medical services.

- Example: Pulsara stroke triage tool faced challenges renewing its pilot due to procurement constraints
- Hilton Haethel (CEO, Healthcare Association of Hawaii) agreed that there are procurement hurdles.

Operational Coordination

Jon Rosati (Chief Strategy Officer of Optimumedicine) shared feedback:

- Queens Medical Center's centralized transfer system is effective.
- Other hospitals using Transport.net report transparency issues and coordination challenges.
- Many facilities default to calling Hawai'i Life Flight due to familiarity.
- Coordination often falls to overburdened staff, highlighting the need for a central coordination center.

Ashley Shearer (VP of Patient Care for Patient Flow at Queen's Medical Center) confirmed:

- In-house provider presence improves collaboration and efficiency.
- Queens has dedicated transfer staff, unlike other hospitals relying on multitasking personnel.
- Transport.net rollout is promising and may improve fairness and ease across systems.

Chief Hall shared a web-based company, Smartsheet is going to be utilized to estimated arrival times from air providers by region.

- Intended to support hospitals not yet integrated into Transport.net.

Infrastructure Needs

Chief Hall prompted discussion on infrastructure gaps:

- Landing zones and helipad access
- Hospital readiness
- Communication and interoperability
- Emergency preparedness

Brent Lopez (Regional Director from Hawaii Life Flight) shared feedback:

- Helipad access issues at hospitals on Kona, O'ahu, Moloka'i, and Lāna'i.
- Some facilities (e.g., Castle) repurpose helipads for parking.
- Big Island hospitals like Hilo and North Hawai'i have improved infrastructure.
- Development of point-in-space GPS approaches in partnership with Life Flight Network for hospitals in Kona, Hilo, North Hawai'i, and Queens.

- Allows safe helicopter landings in poor weather using instrument-guided GPS paths.
- Requires FAA approval and third-party vendor support.
- State funding could help expand this capability.

Landing Zone Standardization

Chief Hall emphasized:

- Reducing patient handoffs between transport modes improves safety.
- Need for defined and updated landing zones, especially in rural areas and pediatric care (e.g., Kapiʻolani Medical Center lacks a pediatric helipad).
- Suggested a statewide published report identifying strategic, approved landing zones.

Kilipaki Kanae (Kilipaki Kanae, EMS Battalion Chief from Hawaiʻi Fire Department) supported:

- Infrastructure improvements would enhance health equity and public safety.
- Pre-designated landing zones improve accessibility and reduce ground transport times.
- Critical care transport relieves pressure on 911 services and improves patient outcomes.

Mr. Lopez added:

- Many hospitals lack nearby landing zones, forcing off-site landings and use of 911 ambulances.
- A Maui project is developing standardized naming for landing zones to improve clarity for all stakeholders.

Garrett requested all counties to submit summaries of their landing zone infrastructure and needs for inclusion in the report.

Additional Recommendations and Next Steps

Garrett noted areas fthat was previously discussed:

- Utilization and triage standards
- Performance metrics (e.g., ETA tracking)

- Workforce training and clinical standards
- Health equity and patient financial protections

0958 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

Garrett Hall thanked participants on behalf of the Department of Health.

1000 Adjournment

Meeting adjourned at 10:00AM HST

Items for Next Meeting

1) Draft Report
2) Ask counties to send brief summaries of current landing zone infrastructure and needs.

AEROMEDICAL WORKING GROUP

AGENDA

Tuesday, December 23, 2025

9:00 AM – 9:30 AM

Virtual Meeting

Link: Meeting Link
Meeting ID: 293 723 727 984 60
Passcode: GC9Jz6x9

This meeting will be recorded

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AGENDA

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0900 Welcome
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0905 Aeromedical Report Review
Working Group

0928 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0930 Adjournment

AEROMEDICAL WORKING GROUP

MEETING MINUTES

Tuesday, December 23, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Recoding Link (People With Existing Access)

Committee Members Present: Garrett Hall, Representative Sue Keohokapu-Lee Loy, Jake Kiyohiro, Elton Ushio, Talmadge Magno (joined after roll call), Hilton Raethel, Walden Au, Heather Beyer (for Ashley Shearer), Jon Rosati, and Brent Lopez.

Committee Members Absent: Senator Joy San Buenaventura, Jack Lee, Randal Collins, Kilipaki Kanae, and Anthony (Tony) Raymond.

This meeting was recorded

MEETING MINUTES

0901 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

- Garrett Hall welcomed attendees.
- Andrew Yonemura conducted roll call.
- Mr. Hall gave holiday well-wishes, appreciation for members' participation during the holiday season.
- Prior meeting was canceled due to illness.

0903 Draft Final Report of Aeromedical Services Working Group – Discussion
Working Group

Draft report (Word) sent to all working group members.

How to provide feedback:

- Save a local copy of the Word file and append your name to the filename.
- Turn on Track Changes and enter edits/comments directly;
    - if not comfortable with Track Changes, highlight and type comments plainly.
- Email your edited file to Andrew for collation.

DOH will aggregate feedback into a master document.

Funding and EMS Procurement Challenges

Mr. Hall explained the recommendations:

- Modernize HRS §321 and update HAR 11-72 (EMS rules).
- Clarify and operationalize the MEDCOM Center in statute for statewide triage/transport coordination.
- Establish an accreditation framework & licensing model for air ambulances (integration into HRS §321 may require a WG amendment to the Governor's package).
- Develop unified EMS air medical data and secondary PSAP pathways to strengthen communications and performance monitoring.
- Workforce, training & clinical standards to sustain service quality statewide.

- Health equity & patient protections—ensure equitable access to time-sensitive air transports across all islands.
- Consumer education on air medical membership programs; note West Coast reciprocity/co-op models.
- Disaster preparedness & communications for air medical operations.
- Funding & reimbursement for system sustainability (three providers now operating statewide).

Notes: Wording will be refined; some items may be consolidated to remove duplication. Prior consensus indicated on first two to three items; formal consensus will be confirmed after written feedback.

Timeline

Member feedback: As soon as possible due to legislative timelines.

- DOH branch: Will collate and finalize the report based on member submissions.
- Final draft to be shared by next Tuesday's meeting (12/30/25.)
    - After, it will be routed to Deputy Director and Director of Health for approval and submission to Legislature by January 1, 2026.

Member Discussion & Comments

Hilton Raethel (CEO, Healthcare Association of Hawaii) had no additions to add and will review the material.

Brent Lopez (Regional Director from Hawaii Life Flight) shared that he appreciates the Department of Health's work and that he will review and respond ASAP.

Jake Kiyohiro (Operations Chief, Maui Emergency Management Agency) had no comments to add and gave a holiday greeting.

Walden Au (Government Relations Manager, Hawaii Medical Service Association) had no comments to add and gave a holiday greeting.

Representative Sue Keohokapu-Lee Loy clarified with Mr. Hall:

- Save with member's name, enable Track Changes.
- Edit directly, highlighting, and plain comments are also acceptable.

- Legislative session: Weekly placeholders appreciated; members may be asked for testimony or presence as bills move.

A separate, member-run working group continues work on communications and tracking (including a pilot with Queens).

- Some areas require security assessment of the tool/product; that group will continue work outside this WG.
- DOH will roll out a web-based air resource availability dashboard on the DOH website January 1:
- Free tool; statewide single dashboard to view estimated aircraft availability and times to aid hospital EDs in arranging transports to definitive care.
- DOH outreach to each air medical provider (meetings Dec 29); hospital-wide webinar on Dec 30 in partnership with Healthcare Association of Hawai'i (HAH).

Talmage Magno (Administrator, Hawai'i County Civil Defense Agency): Appreciated the inclusion; noted the importance of this work for major events (e.g., statewide tsunami).

Dedication Page

Rep. Keohokapu-Lee Loy proposed a dedication page in the report honoring Hawaii Fire Chief, Kazuo Todd:

- Chief Todd, a longstanding champion of this work and emergency services statewide.
- Debbie Morikawa (Deputy Director of Health, State of Hawaii Department of Health) was supportive.
    - She will confer with Attorney General's to ensure no conflicts.
- No Objections voiced.

0927 Closing Remarks

Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

Mr. Hall thanked participants on behalf of the Department of Health and gave recognition of Chief Todd's contributions and the loss felt across EMS.

Mr. Hall requested Rep. Keohokapu-Lee Loy to share draft wording for the dedication/acknowledgment page; follow-up on a separate Big Island quality measures acknowledgment.

0930 Adjournment

Meeting adjourned at 09:30AM HST

Items for Next Meeting

All Members

1) Review the draft; save with your name; use Track Changes or clearly highlighted comments.
2) Focus on highlighted sections (e.g., Conclusion; Section 8 including cost estimate updates).
3) Email edited files to Andrew.

Rep. Sue L. Keohokapu-Lee Loy

4) Provide draft dedication wording for Chief Todd.
5) Coordinate with DOH on the Big Island quality measures acknowledgment.

Debbie Morikawa / DOH

6) Consult AGs regarding dedication/acknowledgment page to ensure no conflicts.

AEROMEDICAL WORKING GROUP

AGENDA

Tuesday, December 30, 2025

9:00 AM – 10:00 AM

Virtual Meeting

Link: Meeting Link
Meeting ID: 293 723 727 984 60
Passcode: GC9Jz6x9

This meeting will be recorded

If you need an auxiliary aid/service or other accommodation due to a disability, contact Andrew at (808) 204-2616 or email andrew.yonemura@doh.hawaii.gov as soon as possible. Requests made as early as possible have a greater likelihood of being fulfilled.

Upon request, this notice is available in alternate/accessible formats.

AGENDA

Note: Agenda items may be taken out of order
The times listed are approximate and subject to change

0900 Welcome and Roll Call
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

0905 Aeromedical Report Review + Dicussion
Working Group

0958 Closing Remarks
Garrett D. Hall, MS, BSN, RN, CSTR, CAISS
Acting EMSIPS Branch Chief and State Trauma Program Manager

1000 Adjournment

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[10] *Braude, D., Hutton, K., & LaValley, J. (2005).* Benchmarking mean dispatch, lift-off and scene times in rotor-wing air medical transport scene flights. *Air Medical Journal, 24(5), 206.*

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