ASSOCIATION OF AIR MEDICAL SERVICES

January 10, 2011

Docket Operations, M-30
US Department of Transportation
1200 New Jersey Avenue, SE
Room W12-140, West Building Ground Floor
Washington, DC 20590-0001

Re: Docket Number FAA-2010-0982

Dear Administrator Babbitt:

The Association of Air Medical Services (AAMS) welcomes the opportunity to comment on the FAA's proposed rule regarding safety initiatives within the helicopter air ambulance industry and appreciates the FAA's effort in this area. A continual emphasis on safety improvement is a top priority for air ambulance operators, medical crews, and the patients they serve.

Established in 1980, the Association of Air Medical Services (AAMS) is an international association which serves providers of air and ground medical transport systems. The association, a voluntary non-profit organization, encourages and supports its members in maintaining a standard of performance reflecting safe operations and efficient, high-quality patient care.

As you may know, many in the air medical industry have voluntarily made positive strides over the past several years to enhance aviation safety. The industry has been steadily embracing technological advances that increase safety, even ahead of government regulation, and has been striving to create a more vigilant and safety-minded culture throughout the industry. However, there is undoubtedly more that can be done. AAMS has long supported many of the safety initiatives brought forth by Congress, the Federal Aviation Administration (FAA), and the National Transportation Safety Board (NTSB) and is pleased to be able to assist the FAA in this latest rulemaking.

526 KING STREET
SUITE 415
ALEXANDRIA, VA
22314-3143

(703) 836-8732
FAX (703) 836-8920
WWW.AAMS.ORG

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General Comments:

AAMS supports appropriate measures that increase the safety environment throughout the air medical industry. As such, AAMS supports the FAA's efforts put forth in this rulemaking. Before addressing specific provisions within the rulemaking, we will first make general comments that relate to the rulemaking and the role of the FAA and industry in maintaining an industry wide safety-minded culture.

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First, implementation of this rule will require unified FAA-wide effort to expedite education and certification. AAMS embraces the technological advances that are recognized in this rulemaking. We also note that many in the industry have been implementing these changes ahead of the rulemaking. During this process, AAMS is aware of many instances where providers faced lengthy and needless delays in receiving FAA certification and approval for use of new technologies. These delays were caused by a number of different issues, including paperwork errors, limited FAA resources, and misinterpretation of FAA guidance that can vary from region to region. In order for industry to successfully implement these technological changes, the FAA must be prepared to provide industry and FAA personnel the proper guidance in order to expedite the certification process in a timely manner.

Second, the current rulemaking and any future guidance from the FAA must have a long-term focus. Technology in the air medical industry is developing rapidly. While AAMS appreciates and supports the FAA's efforts to incorporate valuable technological advances in this rulemaking, we also note that the regulatory process is inherently slow and burdensome. This rule must be finalized in a manner that preserves the flexibility necessary for industry and the FAA to adapt in the future to evolving technology.

Finally, the proposed rule contains a number of new equipment requirements for air medical flights. AAMS fully supports these requirements, but in order not to jeopardize the critical medical mission of these flights, the new equipment mandates must also address the Minimum Equipment List (MEL) requirements and outline relief procedures that would allow service to temporarily continue in case of malfunction.

Part 135 criteria for all helicopter air medical flights with Medical Crew on Board:

AAMS is supportive of applying Part 135 safety criteria (i.e. weather minimums, duty time requirements, etc) to all helicopter air medical flights with a medical crew on board. However, the details of this proposal leave too many concerns that must be answered before this provision is finalized. Many in the air medical industry already apply the more restrictive Part 135 weather minimums and duty time requirements to flights currently classified as Part 91 (i.e. return or ferrying flights with medical personnel on board). While we believe that codifying these requirements via regulation would provide a stable and consistent enforcement of a widely-used practice, the FAA must first address the many potential unintended consequences that exist under the proposed language. We suggest that the FAA work with industry stakeholders to determine the legal, regulatory, and practical implications of the proposed language. We are particularly concerned that the proposed language may severely limit opportunities for IFR and proficiency training, unlike the language in OpSpecs A021d. We also note that many air medical programs are utilizing GPS approaches that have been FAA approved under Part 91. We question whether these programs will be forced to revert back to VFR approaches until the FAA is able to reapprove a GPS approach under Part 135.

Operational Control Centers

AAMS agrees that Operation Control Centers (OCCs) are an essential component to risk assessment and flight management. However, while we support the concept of OCCs consistent with AC 120-96, we question whether the approach taken in this proposed rule is appropriate for the air medical industry.

The proposed rule would apply the operation control center mandate to programs operating 10 or more aircraft. AAMS questions the arbitrary nature of this provision. While programs with fewer aircraft would clearly be unable to comply with the requirements of the proposed rule, they would also clearly benefit by maintaining the functionality of an OCC. Rather than basing OCC requirement on the number of aircraft, we suggest it may be more appropriate to base requirements on the number of missions flown and the geographical area covered. Operations with a smaller number of flights over a small geographical area would have less stringent OCC needs than an operation covering a large number of flights over a large area. Smaller operations should have the ability to subcontract with larger providers or private vendors for certain flight tracking and communication services while maintaining ultimate operational control of the flight.

In addition, the training, qualification, and duty time requirements set forth of Operational Control Specialist appear to be derived from the Part 121 world and not necessarily consistent with the air medical industry. For example, the duty time limitation for the Operations Control Specialist would result in a shorter work period than those of the pilot or medical crew. We would also caution the FAA, in its discussion of certification requirements for Operational Control Specialists, not to unintentionally or unnecessarily prevent other qualified individuals from assuming such responsibilities. For example, non-flying pilots, air traffic controllers, etc, would be qualified Operational Control Specialists based upon the requirements of their current certification. Additional OCS training and certification could be unnecessarily duplicative and burdensome in those cases.

Several large air medical operators have already established formal OCCs within their organizations. There are also many smaller operators who have established excellent operational control systems without a formal OCC. AAMS believes the FAA should become more familiar with the operational control programs already being used in the air medical industry in order to develop an OCC program that will be more appropriate and provide more benefit to the air medical community

Increase VFR Weather Minima

AAMS notes that this proposed regulation would essentially codify for all VFR air medical flight segments the weather minimums currently in effect through Operations Specification A021. AAMS supports this provision. However, AAMS opposes that provision that would require operators to designate a Local Flying Area (LFA). While we recognize that the designation of an LFA may be beneficial in that it would allow operators to utilize local weather minimums based upon local familiarity, there are some

areas where the utilization of cross country weather minimums would be preferable. AAMS would support replacing the word "must" with the word "may" so that operators would have the flexibility to use the most appropriate method for their specific areas.

IFR operations at airports and heliports without weather reporting.

The proposed rule would allow certificate holders to obtain operations specifications permitting IFR operations into and out of locations without a weather reporting facility if they are able to obtain weather reports from an approved weather reporting facility located within 15 NM of the destination landing area. AAMS supports efforts to promote the use of IFR whenever possible. We ask that this provision be amended to include language from Operations Specification A021 allowing the use of local area weather forecast information as an alternative when a weather reporting facility is not located with 15NM of the destination landing area. Many providers have developed IFR approaches using local area forecast pursuant to Operations Specification A021. The proposed regulation as currently written would have the detrimental result of reducing the ability of providers to use IFR which runs counter to the safety benefits cited by the FAA in the proposed rule.

IFR to VFR transitions.

The proposed rule would establish weather minima for transitions to the VFR segment of an instrument approach. Pilots conducting an IFR approach would, upon reaching a point in space at a minimum descent altitude, continue the flight to the landing area under VFR if conditions permit. AAMS supports this provision and notes that it is consistent with current policy under Operations Specification A021.

VFR flight planning.

This section requires pilots to perform pre-flight planning to determine the minimum safe altitude along the planned en route phase of flight when conducting VFR air ambulance operations. AAMS supports this provision as it mirrors currently policy outlined in Operations Specification A021. We also suggest the safety benefits of this provision would also be appropriate for other Part 135 helicopter activity.

Pre-Flight Risk Analysis

This provision would require certificate holders to establish procedures for pre-flight risks assessments and to document these procedures in their operations manual. Risk assessment is an essential safety function that is critical for proper management of air medical flights. As such, AAMS fully supports this proposal. We would request, however, that care be taken to avoid pre-flight risk assessments that would duplicate the efforts of operational control centers, safety management systems, or other such programs. While we support the use of established pre-flight procedures, this must be done in a manner that will compliment, and not needlessly duplicate, the efforts of other programs. We also note that the requirement to maintain risk assessment worksheets on

file for 90 days appears to be excessive and needlessly burdensome. A thirty day requirement would be consistent with other recordkeeping requirements and should provide ample opportunity for the records to be reviewed if necessary. Finally, AAMS seeks clarification regarding the requirement that the pilot in command sign the pre-flight assessment worksheet, noting the date and time of completion. In many instances, such worksheets are completed electronically through a standard computer program. In these instances, would the FAA consider electronic signatures as sufficiently meeting this requirement? Otherwise, we would suggest that the FAA drop the signature requirement or consider alternative procedures for electronic worksheets that might not be conducive to the timely acquisition of the PIC's physical signature. We would also like to address the requirement to include whether another air ambulance operation has refused or rejected the flight as part of the pre-flight risk assessment. While AAMS agrees that this information is useful in the risk assessment process, it is not easily obtained, nor is it required that competing operations share this information with one another. AAMS would support the inclusion of this information in a pre-flight risk assessment whenever it is available; however, we oppose making it mandatory for the successful completion of the risk assessment. If it were mandatory, we would ask for clarification as to what criteria or procedures the FAA would expect for successful completion of this requirement.

Medical personnel pre-flight briefing.

The proposed rule would require that medical personnel on board a helicopter air ambulance flight receive a supplemental pre-flight safety briefing with information specific to helicopter air ambulance flights. This information would be in addition to the passenger briefing currently required under Part 135. As an alternative to the proposed pre-flight safety briefing, certificate holders would be permitted to provide training every 2 years to medical personnel through an FAA–approved training program.

AAMS supports this requirement for a pre-flight safety briefing for medical personnel. In order to avoid confusion and inconsistent enforcement of this provision, AAMS suggest the FAA work with the industry to develop standardized criteria and procedures to be used for these briefings.

IFR alternate airport weather minima.

As the FAA notes in its proposed rule, this provision is adapted from the current alternate airport weather requirement in §91.169 and from the weather minima in Operations Specification H105 issued to part 135 helicopter operators conducting IFR operations. AAMS support this provision as these criteria are currently being used under Operations Specification A021.

Load manifest requirements for all part 135 aircraft.

The proposed rule would require a load manifest for single engine aircraft to be filed prior to each leg of a Part 135 flight. While AAMS supports the intent to maintain accurate load manifest records, we are concerned that the regulation as written contains no contingency in the event that electronic communication is not available. It is the nature of the air medical industry to operate in remote areas where cellular coverage may not be reliable or available at all. In addition, leaving a hard copy with emergency personnel on the scene is not a reliable option as there is no guarantee the emergency officials will understand the requirements involved and may not properly maintain the hard copy.

For those flights in remote areas less conducive to electronic communication, critical medical missions should not be unnecessarily delayed on a paperwork technicality on an otherwise safe flight. In these instances, we suggest the pilot, after a good faith, yet unsuccessful, effort to transmit the load manifest, be allowed to take off in a timely manner and transmit the necessary information to its base of operation as soon as reasonably possible.

However, AAMS has also heard from some operators and pilots who are concerned with the added distractions that may be created at accident scenes. They feel that pre-flight planning would determine the maximum patient weight that could be safely added, relieving the need to provide an updated load manifest at the scene.

In addition, in determining the informational requirements contained in the load manifest, the FAA should be aware that federal privacy laws, in particular the Health Information Portability and Affordability Act (HIPAA), may prohibit air medical operations from electronically transmitting certain identifiable patient information. In addition, the medical condition of the patient may not make it feasible to obtain that patients name. Again, the timely transportation of the patient should not be jeopardized by such instances.

Helicopter terrain awareness and warning system.

The rule would require HTAWS (a helicopter specific utilization of TAWS technology) for all helicopters used in air ambulance operations. The FAA would give certificate holders 3 years from the effective date of the final rule to install HTAWS that meets the standards of TSO–C194. The NPRM then applies the requirement to future TSO's in relationship to HTAWS.

AAMS supports efforts to mandate HTAWS for all helicopters used in air ambulance operations. As you know, the air medical industry has steadily increased its use of HTAWS in an effort to reach full utilization of the technology. However, as we previously stated, in order to meet the compliance timeframe set forth in the proposed rule, the FAA must be prepared to issue proper guidance to industry and FAA personnel in order to expedite the approval process to accommodate the increased installation of

this technology on air medical aircraft. In addition, as technology in this area is rapidly evolving, this regulation should be written in a way that provides the ability of the FAA and industry to adapt to new technologies in a timely and efficient manner. Finally, we ask that the final rule outline appropriate relief measures that would allow operations to continue in the event that this technology is temporarily inoperable. Such relief measures are common practice for other technologies, yet are not included in the proposed rule.

Light-weight aircraft recording system (LARS).

The FAA is considering requiring certificate holders conducting helicopter air ambulance operations to install a light-weight aircraft recording system (LARS) in their helicopters. This requirement would have ramifications beyond the cost and installation of the equipment. The FAA is specifically seeking comments on whether operators that are required to install LARS for accident investigation would also use those systems to improve daily operations, including whether operators would be more likely to participate in an FAA-approved Flight Operations Quality Assurance (FOQA) program if required to equip helicopters with LARS.

While AAMS supports the installation of LARS in air medical helicopters, we do not feel there is enough specification in the proposed rule, or within the industry, to justify a firm regulation at this time. In addition, we believe the cost estimates put forth by the FAA are grossly low. Reports from providers that are already utilizing LARS suggest that the FAA's estimate for purchase and installation are 4 to 5 times too low. In addition, the FAA's estimates appear to not take into account ongoing costs for program maintenance, data storage and report development.

We recognize the data gathering value that LARS could provide not only to accident investigations but also for industry FOQAs and other safety improvement programs. AAMS supports a proactive forward-looking approach to FOQA programs whereas the information gathered is used for educational and risk mitigation purposes, rather than disciplinary action. In order to promote increased use of LARS, we suggest the FAA work with the air medical industry to develop standard data capturing standards and requirements that can be a precursor to a future rule in this area.

Radio Altimeters.

The proposed rule would require radio altimeters in all helicopters operating under Part 135. AAMS supports this requirement and notes that the vast majority of air medical helicopters are already equipped with radar altimeters. In the case of a temporary malfunction, we ask that this rule provide operators the ability to continue operating for a limited time under acceptable alternative procedures as prescribed by the minimum equipment list (MEL).

Definition of over water flights and safety equipment for over water flights.

AAMS agrees with the change of definition for "extended overwater operations". We feel this change will satisfy the issue of hop scotching resulting in great distances between shore and platforms. We note that this issue seems isolated to operators providing their services in support of offshore oil operations. The broad application and amendment proposed by the FAA in adding 135.168 will not benefit all other operations or passengers, and in particular Helicopter Air Ambulance services that do not schedule flights over water but occasionally find themselves beyond gliding distance from shore. These operational factors should be more thoughtfully contemplated and the resolution be more effectively targeted.

Upon review of the suggestions proposed by industry as a result of the 135/125 ARC (Rotorcraft 21F), which, the FAA has commented they agree with, it appears those suggestions were followed to a limited extent in the proposed part 135.168. However, this proposal will unfortunately result in unintended consequences negatively effecting operations not intended to operate overwater.

The raft equipment required by the proposed 135.168 for flights overwater would result in an increased empty weight and present significant costs and down time for installation and preventative maintenance for all aircraft. This addition would restrict range unnecessarily. Operators that are located in the vicinity of bodies of water but which do not schedule over water flight and that are performed with multiengine helicopters having at least the capability to climb at greater than 50' per minute with one engine inoperative at 1000' AGL are more negatively impacted. The proposed changes, resultant additional costs, down time and weight are a significant burden and unnecessary considering the only time these operations are outside of gliding distance from shoreline are for instrument approaches, ATC procedures or special requirements, or on a rare occasion to cross an inland body of water to expedite transport of an ill or injured patient. If the FAA proposed changes are to provide additional safety on those flights operating offshore with intent and on more than an occasional basis, the blanket catch all is not necessary or beneficial to industry or the passenger.

After reviewing the 125/135 ARC Rotorcraft recommendation regarding this issue (Rotorcraft 21F), of which, the FAA states they agree with, the following changes are recommended to your proposal:

An "overwater operation" defined as a flight beyond autorotational distance from the shoreline, would require (1) An approved life preserver equipped with an approved survivor locator light for each occupant of the aircraft. The life preserver must be easily accessible to each seated occupant; and (2) One approved pyrotechnic signaling device.

An "Offshore Operation" definition would be created meaning: For rotorcraft, an overwater flight conducted more than 5 minutes flying time or 10 miles from the nearest shore, which may include an offshore takeoff, landing or external load operation to or from a helideck or vessel. Flights meeting this definition would require the enhanced safety equipment outlined in the proposed rule.

In addition, so as not to compromise the critical medical mission of the flight, patients being flown by helicopter air ambulance should be exempt from the patient safety equipment briefing and the requirement to wear a life preserver while flying over water.

Pilot Instrument rating

AAMS supports a rule which would require pilots engaged in commercial air ambulance operations to hold the appropriate instrument rating.

Pilot Training --Recovery from Inadvertent Flight into IMC.

The rule would require helicopter pilots to demonstrate recovery from an inadvertent IMC encounter and understand procedures for aircraft handling in flat-light, whiteout, and brownout conditions during initial certification and recurrent training.

AAMS supports this change. It would be appropriate for the FAA to allow simulators and appropriate flight training devices to be used in fulfilling this requirement.

National Transportation Board Recommendations

Night Visioning Imaging Systems

Although not addressed in the proposed rule, we would like to take this opportunity to express AAMS' support for the use of Night Vision Goggles (NVGs) along with HTAWS. We do not view NVG's and HTAWS as an either/or proposition. Both have safety benefits that can compliment one another. However, we note that many of the current FAA standards for NVIS are based upon outdated technology. AAMS would be pleased to work with the FAA to address modernization and expansion of NVG regulations.

HEMS Weather Tool:

AAMS agrees with the NTSB that the HEMS ADDS Weather Tool should be able to be used as an approved weather tool. We also support the use of additional resources in order to enhance the weather tool so that it can be a reliable source of information to be used in flight decision making. An enhanced weather tool would provide increased access to remote areas currently unavailable to HEMS due to poor weather reporting.

Data Collection:

AAMS also supports NTSB recommendation A-09-91 which calls for annual reporting of flights hours and number of flights flown, among other things. We agree that access to aggregate data regarding the air medical industry is sorely lacking. Appropriate data gathering is an important step in accessing the state of the industry and researching potentially beneficial risk mitigation strategies.

Autopilots:

AAMS supports the added safety benefits provided by autopilot technology and supports the continued development of such technology. However, further research, development, and industry collaboration is necessary before a regulatory requirement is considered.

Again, we appreciate the opportunity to comment on this proposed rule that offers many essential safety improvements for the air medical industry. As always, AAMS stands ready to assist the FAA in these and any other provisions affecting the industry. Please do not hesitate to call upon us if we can be of further assistance.

Sincerely,

Daniel Hankins, MD, FACEP
President
Association of Air Medical Services

Dawn M. Mancuso, CAE, MAM
Executive Director
Association of Air Medical Services