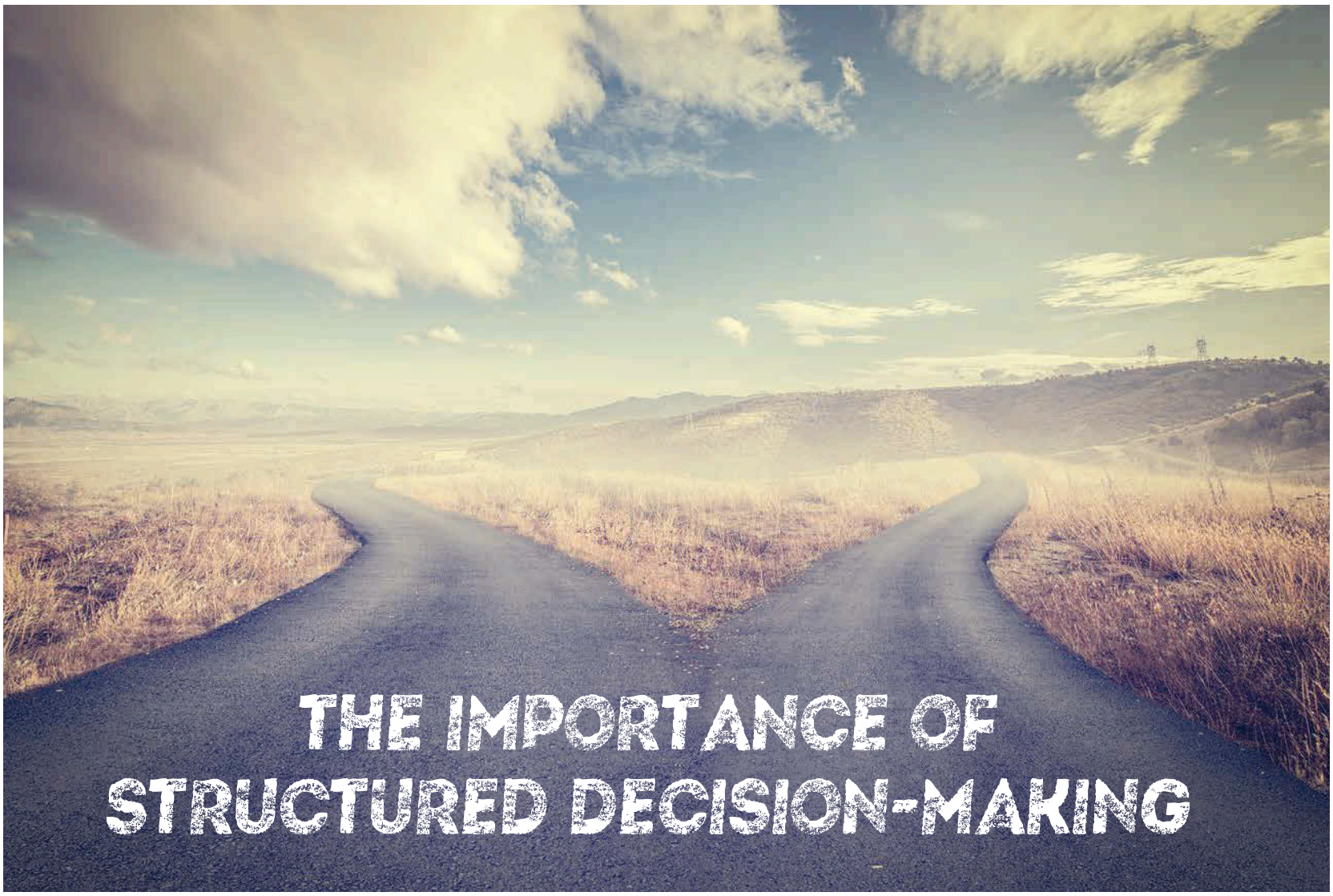

# THE IMPORTANCE OF STRUCTURED DECISION-MAKING

**When a patient ends up in hospital abroad, an assistance provider may subsequently need to enlist the repatriation services of an air ambulance company, a decision involving complex analysis and careful co-operation between all those involved. There are a multitude of motivations and factors that can influence such decision making – Femke van Iperen looks into the thought processes**

When it comes to making the decision to medically repatriate, said Dr Cai Glushak, International Medical Director and Chief Medical Officer at AXA Partners (formerly AXA Assistance), the assistance company's first question is: is the local care adequate or not, and can we get the patient out quickly? "Then follows a risk-benefit analysis," he said, "which usually means the risk of the patient having to stay where they are, versus flying them to a place of higher level of care. We usually opt for [the latter] when there is doubt."

**To repatriate or not to repatriate**

As Dr Glushak – who is also Professor of Emergency Medicine at the University of Chicago, US – explained, a medical reason would be one of the first and strongest motivations to evacuate a patient: "Those would be patients with medical conditions that are complex and unstable, so even if we manage to get them on a stretcher – on those commercial airlines that even take stretchers – their fragile condition may pose the potential to interrupt the flight. Or sometimes you will opt to repatriate somebody by air ambulance long before they will de-escalate enough to get home a simple way."

Another potential complication is that while medical infrastructure continues to improve worldwide, especially in some of the largest major cities, and the treatment being received may be adequate for the patient's immediate needs, it may not be possible for them to receive further treatment at the same quality level. For example, said Eva Kluge, Director of Sales and Business Development at Air Alliance Medflight, 'patients who need a long rehab in their native language after a stroke' or who 'need a long treatment that could lead to additional health risks (such as post-surgical complications for elderly patients)' may not be able to receive this longer-term care where they are, necessitating a repatriation. Clients may also, said Annina Auer, Manager of the operations control centre at Tyrol Air Ambulance (TAA), prefer to have surgery in their home country.

## ULTIMATELY ... PEOPLE SIMPLY WANT TO GET HOME WHEN THEY ARE ILL

When considering whether or not to repatriate, assistance providers must carefully balance the prospective costs of treatment at the location versus the costs of repatriation or other insurance coverage at home. However, cost is not always a determining factor, said Auer: "For almost all clients we work with, I've never had the impression that high hospital costs would lead to a medical indication for a transport." Rather, she said, it was more likely the requests of the family that will have a big impact.

The decision can also be driven, explained Kluge, by the 'evaluation of alternatives like regional transfer or commercial flight or ground transportation versus an air ambulance flight', or based on whether aeromedical transport is available within the transport window (this is usually no more than one or two days).

Ultimately, said Dr Glushak, people simply want to get home when they are ill: "No matter how high the level of medical care is, they are usually isolated, lack the usual support systems around them, and often the way the medical system works does not meet their expectations. This may not necessarily be a refletion on the expertise of the physician, or the available technology but [for example] patients may be upset about not getting regular meals,

help eating, or help getting out of bed to go to the bathroom if no family are present."

**Myriad challenges**

Whatever the motivation, once an assistance company decides to contract an air ambulance company to repatriate a patient, there are numerous challenges that may ensue. For starters, the complex interaction between all the departments and entities involved in the mission. "When our Operations Control Centre receives a flight confirmation, this complex interaction planning begins," said Auer. She went on to explain the process: "Does the flight and medical crew availability match the repatriation dates in accordance with already booked flights? Which of the flight doctors on duty is most suited for the patient? Are there restrictions from the maintenance department? Is a special crew qualification or a special authorisation required in order to land at a certain airport? Has a risk assessment been done? Is the patient fit to fly, are there any special medical requirements, is the patient overweight? Is the local ground ambulance accredited and does it meet the clients' and our expectations?"

Plus, as mentioned by Kluge during last year's International Travel & Health Insurance Conference in Barcelona, the relationship between underwriters, insurers and service providers tends to pose a 'natural conflict of interest and limited understanding of how the other operates'.

Dr Glushak agreed that a lack of mutual understanding can be an issue: "Not all insurance company representatives are trained in complex aeromedical principles that go into the delicate clinical decision about the safety of a medical flight, and they may look at it more from a business point of view to get this person home." By the same token, he often encounters treating physicians who are not familiar with aeromedical capabilities and risks around what can and cannot be done during a mission. "We often have to get the confidence of the treating physician first and explain and educate them on what is safe to do."

There can also be conflicting demands related to, for example, 'limitations on transports such as pilot duty time, crew visas, weather, permits and no-fly zones', said Kluge, and while doctors may have defined a particular, small window for a safe air ambulance transfer, with a patient fit to fly on that day, the required aircraft simply may not be available. As a result, she added, this can mean the whole process needs to be re-evaluated.

While Dr Glushak has generally found that reaching an agreement between all parties goes smoothly, 'it can be a bit of a challenge to reach agreement between the treating and accepting physicians at both ends as to the appropriate medical team and equipment', a decision that becomes even more contentious 'when a travel insurance policy stipulates, as they often do, that once the emergency condition has been managed the patient would have to accept transportation back home to resume medical care': "That may lead to some debate with the treating physician, or the patient, or both, if they are focussed on continuing routine care in the current location."

Another potential complication comes when trying to find an available bed in the hospital where the patient is to be taken, particularly in nationalised health systems where hospitals are typically fully loaded. Dr Glushak's own company has had to engage specialised 'bed finders' in some major Canadian cities. "Home medical providers may express sympathy, but there is no obligation to accept a patient," he said, adding this is a process of effective medical communication on both ends: "The sending and accepting physicians have to be fully comfortable that we can safely transfer the patient."

A lack of hospital beds can also put paid to an air ambulance mission, said Auer: "Most times, it is then too late to sell the aircraft for another flight and the aircraft is sitting on the ground for the whole day. Also, for most non-European countries, lead times for overflight and landing permissions or crew visa organisation have to be considered."

**Solutions provided**

There are, however, steps that involved parties can take to improve the decision-making process to repatriate a patient. First, it pays to have a structure in place. This is necessary, said Dr Glushak, to 'make a choice that is not the cheapest option, but the right one'.

Having structures in place beforehand also means everyone knows where they stand. As Kluge told the Air Ambulance Review: "Aviation is strongly process oriented. Every procedure is described and agreed upon beforehand, the same is done for medical matters. This helps to create routine and transfer knowledge to all team members. It also gives clear rules and responsibilities."

The use of data and reporting tools helps to make such structures particularly effective – for example, costing data based on past cases can be useful. "For flight quoting and planning," said Kluge, "we use a highly sophisticated learning IT system with an excellent reporting tool. Knowing the worldwide airport infrastructure we can clearly advise an alternative airport with better accessibility or lower fees, and it helps us to create reliable pricing and to avoid mistakes." It can also help, she added, if air ambulance and assistance companies inform clients about the precise route and the number of fuel stops on longer trips. "At the end of the day," she said, "the price of a flight is crucial, but in many cases, availability and speed are even more important."

To help improve the decision-making process, Dr Glushak's company will always look for highly qualified medical capability in an air ambulance company, with 'a background in and solid understanding of air medical principles and training, as well as acute medical care'. This applies to the assistance company's own staff as well: "They are always from a background in emergency or critical care medicine, and have had plenty of experience dealing with air ambulances. They have the ability to discuss things in an informed way with treating physicians, as well as with the air ambulance companies."

Kluge agreed: "All our medical staff needs to be proficient in current clinical practice and have experience with ICU and emergency medicine."

Key to success in the decision-making process is maintaining a high level of co-operation between all parties. For this, said Kluge: "It is essential that the assistance company will do a very good job in advance (prepare agreements with air ambulance providers, set service level agreements and payment terms and so on). Medical doctors in the assistance companies need to work closely with them and also have their decision structures in place." Her recommendation to achieve this, she told the Air Ambulance Review, 'is to create interdisciplinary task forces and [for assistance companies] to train with air operators'.

She also believes that it would benefit air ambulance teams to visit an assistance company for a day or so, in order to put themselves in their shoes: "Learning more facts and getting to know the other side better is beneficial for everybody and will create much better outcomes."

> IT [MIGHT] BENEFIT AIR AMBULANCE TEAMS TO VISIT AN ASSISTANCE COMPANY FOR A DAY OR SO, IN ORDER TO PUT THEMSELVES IN THEIR SHOES

And, finally, for a decision to be reached without too much struggle – and since many insurance companies reserve the right to agree to an air ambulance mission before the assistance company will send out the order – it is crucial, said Kluge, for an air ambulance company 'to present solid, conclusive and transparent facts to the insurer prior to a transportation', explaining any potential limitations such as pilot duty times in writing.

**An essential partnership**

Every mission, and its legal and other restrictions, is different and contains its own challenges. But key to every mission is the co-operation between all parties working together to make the repatriation a success. Said Kluge: "You need to combine experience, expertise and structured data in order to achieve the best results or decisions. The tricky part is to simulate the near future: 'what will happen if'?" This, she explained, 'requires a classical decision algorithm where doctors, assistance co-ordinators, case managers and network managers need to work closely together." ■