

Aeromedical Tasking Schema

Do we need an ATS for Prehospital and Retrieval Medicine?

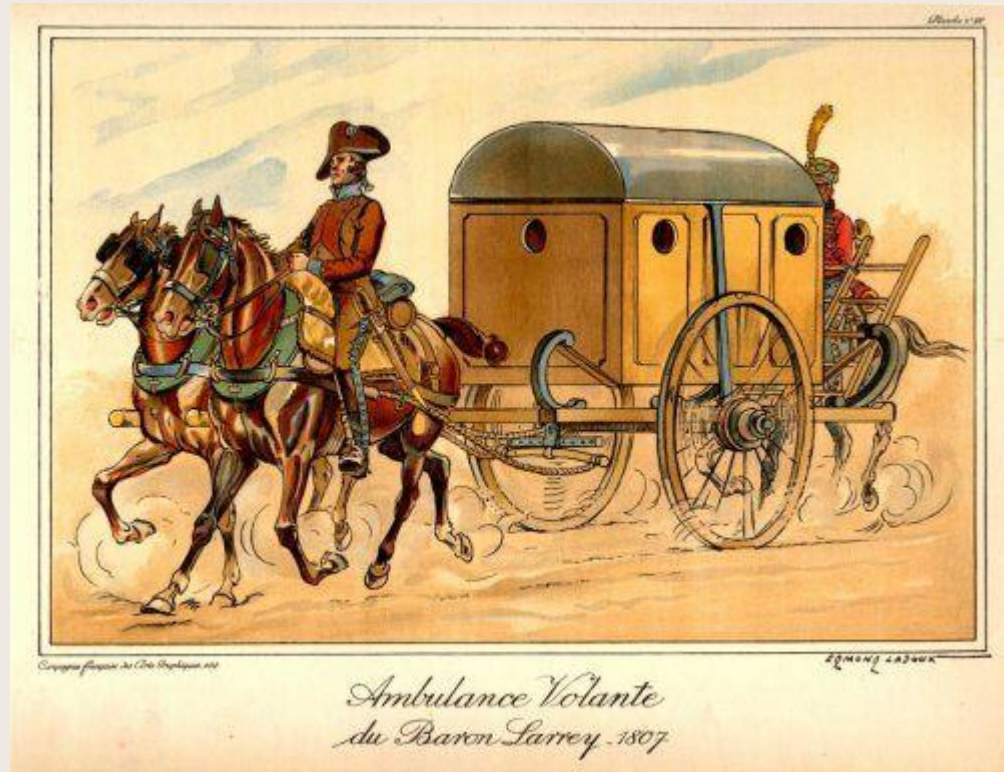
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Where have we come from?

Ambulance Volante

> Napoleon in 1792



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Where have we come from?

From War to Civilian

- > Ambulance Corps & Pre-hospital Care
- > 1869: US civilian ambulance service
- > Aeromedical transport after WW1



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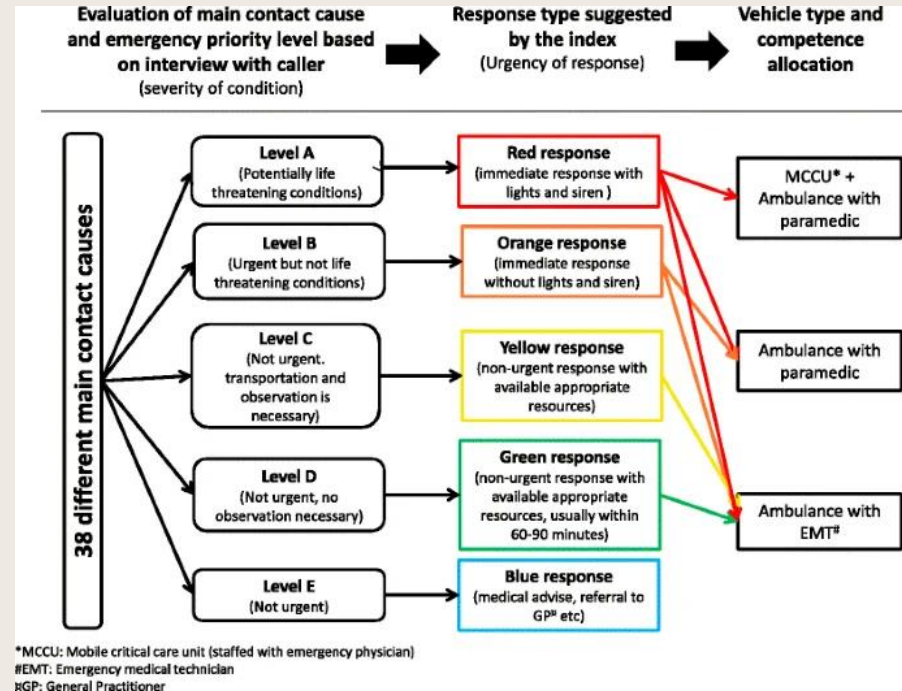



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Prehospital Triage

Road Transport

- > Differently applied in different countries.
- > Lack sensitivity and specificity
- > Not applicable for hospital use
- > Many systems are validated only for trauma triage.
- > **Assumption:**
Relatively consistent time to arrival



Hospital Triage

Emergency Departments

- > Australasian Triage score (2000)
- > Canadian Triage Assessment Scale
- > Manchester Triage System

Assumptions:

1. Triage category = same window
2. All patients receive the same quality of care

Australasian Triage Scale Category	Response Time	Category Description	Clinical Indicators
Category 1 (RED)	Seen Immediately	Life Threatening Conditions	Cardiac/Respiratory Arrest Immediate risk of airway, respiratory rate < 10/min, Extreme Respiratory Distress. BP less than 80 in adult. Severe shock in child/infant GCS scale less than 9 Prolonged seizure IV overdose Severe behavioral disorder
Category 2 (ORANGE)	Seen within 10 minutes	Imminently life threatening, time sensitive treatment needed, or Severe pain.	Airway risk (stridor) Circulatory Compromise (HR less than 50 or greater than 150, Hypotension, severe blood loss, poor perfusion). Chest pain likely cardiac related Suspected sepsis, Febrile Neutropenia, Fever with lethargy Acute Stroke GCS less than 13 Suspected Tetanicus/Torsion High Risk History (toxic ingestion, venomous bite, pain suggesting PE, AAA, ectopic pregnancy).
Category 3 (GREEN)	Seen within 30 minutes	Potentially life threatening, situational urgency, or severe pain	Severe Hypertension, Moderate blood loss Moderate Shortness of breath Vomiting Dehydration Seizure (post ictal), Head Injury with LOC (now alert) Physiologically stable suspected sepsis Severe pain Limb injury consisting of limb deformity or severe laceration, altered sensation, absent pulse. Potential child abuse Behavioral/Psychiatric patient very distressed, risk of self-harm, potentially aggressive.
Category 4 (BLUE)	Seen within 60 minutes	Potentially serious condition, situational urgency or complex case	Mild Hemorrhage Foreign Body Aspiration without respiratory distress Chest injury without rib pain or respiratory distress Minor head injury without LOC Moderate pain Vomiting or diarrhea without dehydration Inflammation or foreign body in eye without vision changes Minor limb trauma (ankle sprain, fracture, uncomplicated laceration with normal vital signs) Swollen, erythematous joint Semi Urgent mental health problems with no immediate risk to personnel.
Category 5 (white)	Seen within 120 minutes	Less urgent or Clinical/Administrative problems	Minimal pain with no risk factors Low risk history Minor symptoms of illness Minor symptoms of low risk condition Abrasions or minor laceration Scheduled revisit Immunizations Patient with chronic psychiatric symptoms in social crisis.

Evolution of Principles

Where we've ended up so far....

1. Treating the **sickest first**
2. Evacuating them to the **most appropriate care facility in priority order**
3. **Maximising the use of our available resources** for maximum patient benefit
4. Aiming for **minimum time to definitive treatment**

Aeromedical Triage

USA

- > Air Medical Prehospital Triage (AMPT) score
- > For primary trauma patients most likely to benefit from HEMS compared with ground EMS
- > Potentially cost effective in trauma
- > Not validated in medical patients

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Development and Validation of the Air Medical Prehospital Triage (AMPT) Score for Helicopter Transport of Trauma Patients

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JAMA Surgery | Original Investigation

Comparing the Air Medical Prehospital Triage Score With Current Practice for Triage of Injured Patients to Helicopter Emergency Medical Services: A Cost-effectiveness Analysis

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IMPORTANCE Little evidence exists to guide helicopter emergency medical services (HEMS) triage, and current practice is inefficient. The Air Medical Prehospital Triage (AMPT) score was developed to identify patients most likely to benefit from HEMS compared with ground EMS. To our knowledge, no studies have evaluated the potential effect on costs and outcomes of a more targeted HEMS triage strategy, such as the AMPT score.

OBJECTIVE To evaluate the cost-effectiveness of current practice compared with the AMPT score for HEMS scene triage of trauma patients.

DESIGN, SETTING, AND PARTICIPANTS A cost-effectiveness Markov model was developed for the US health care system to compare current practice with the AMPT score as HEMS scene triage strategies from the health care system perspective over a patient lifetime horizon. A base case was estimated using national data of patient characteristics from the National Trauma Databank from 2007 to 2012. Model inputs, including demographic information, health care costs, survival, and utility estimates, were derived from literature and national

 Invited Commentary
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 Supplemental content

 CME Quiz at
jamanetwork.com/learning

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Aeromedical Triage

Australia - fixed wing

- > No national agreed model
- > **Priority system for urgency**
- > **Acuity and Crew:** senior clinician discretion

Air Response		
<u>Code</u>	<u>Description</u>	<u>Dispatch goal</u>
Priority 1	Any pre-hospital mission (RW) Immediate threat to life or limb Clinical management outside skills of local hospital for life-threatening problem	Immediate
Priority 2	Other urgent conditions Condition of patient likely to overwhelm the local hospital (but not yet doing so)	< 3 hours
Priority 3	Acute but not life-threatening pathology	< 12 hours
Priority 4	Moving patient for a planned procedure	Routine; within agreed timeframe
Priority 5	Normal emergency	'Backloads'

Excerpt from NETS 2016 tasking guideline

*A focus on **dispatch times**
may result in inequitable **time to definitive care***

*A focus on **urgency** may underestimate **acuity**,
resulting in inequitable **quality of care**.*

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Time to Definitive Care

(aka Wild Boars principle)

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Time to Definitive Care

(aka Wild Boars principle)

- > Current priority levels are "*time to doors closed*"
- > extrapolated from the ED metric of "*maximum time to cubicle*" or "*time to CT scan*" or "*time to needle*"
- > Fundamental paradigm shift of "*time to definitive care*"

Time to Definitive Care

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- > Fundamental paradigm shift of "*time to definitive care*"
- > TDC May range from 30 mins for a metro HEMS task to 7 hours for a regional FW task.

$$\begin{aligned} \text{TDC} &= \\ &\text{flight time} \\ &+ \\ &\text{scene time} \\ &+ \\ &\text{road time} \\ &+ \\ &\text{ramp time} \end{aligned}$$

Time to Definitive Care

(aka Wild Boars principle)

- > **Future focus:**
Could data analysis determine a validated aeromedical triage priority (ATP) algorithm that takes TDC into account?
eg **ATP = Clinical priority category / TDC**

Time to Definitive Care

(aka Wild Boars principle)

> *Future focus:*

Could data analysis determine a validated aeromedical triage priority (ATP) algorithm that takes TDC into account?

eg $ATP = \text{Clinical priority category} / TDC$

- > *While TDC could be based on averages, ideally TDC would be dynamic based on AI determination of current weather, crew availability, ambulance delays and ramping; with agile patient prioritisation based on queuing theory and real-time data.*

Case example:

- Remote stroke <4 hours from onset in remote community; TDC 3.5 hours to tertiary hospital by FW.
ATP: ED Cat 2 / 3.5h = 0.57
- Multitrauma primary MVA with head injury, TDC 1.5h.
ATP: ED Cat 1 / 1.5h = 0.67
- This algorithm prioritises the stroke slightly above the MVA in this scenario
- Both have brain cells that need saving, but the distance of the stroke patient elevates his priority.

The Priority = Acuity misconception

- > **Crewing is often determined for aeromedical flights aligned with the urgency of the task.**
 - => P1 = doctor,
 - => P2 = flight nurse (+/- doctor)
 - => P3 = flight nurse/paramedic.
- > **An aeromedical tasking schema that identifies both urgency and acuity may bring consistency across states and territories**

*A P2, time critical stroke
- may be low acuity
- may also be the highest priority task*

*A P3, non-time critical psych patient may require a critical care team for ketamine infusion or intubation/ventilation
- high acuity
- low priority*

Aeromedical Clinical Tasking Guideline



1 Executive Summary – Tasking Priorities – Timing and Acuity

Response Priority	Acuity	Clinical Criteria	Recommended Tasking Crew
1 or 2 45 mins	Critical Speciality	<p>Requires Special Operations Team / rotary extraction</p> <p>Requires ECMO/IABP</p> <p>Paediatric Trauma <12 years of age meeting the following state-wide criteria for level 1/2 trauma:</p> <ul style="list-style-type: none"> Any primary paediatric trauma direct from incident Mechanism of injury including MVC ≥ 60km/hr or vehicle severely damaged: ejection from a vehicle or death of an occupant; pedestrian struck at ≥ 30km/hr; cyclist (pedal or motor) struck or fall from at ≥ 30km/hr; prolonged extrication time (≥ 30mins); fall > 2m (age < 2 years – fall from > 2 times the child's body height); fall from or kicked by a horse (or other large animal); handlebar (or other significant blunt injury) to the abdomen; hanging / Traumatic Asphyxiation; gunshot wound (GSW); drowning; other significant mechanism of injury Pattern of injury including airway compromise (including intubation or attempted intubation); flail chest or subcutaneous emphysema; significant haemorrhage; abdominal guarding; severe pain or distention; penetrating injury to head, neck or torso; pelvic fractures; spinal injury; femur fracture plus one other long bone fracture; amputation or severe crush, proximal to the wrist or ankle or ischaemic limbs; burns > 20% BSA and/or inhalational burns; high voltage electrical injury (>1000volts) Abnormal physiology including abnormal respiratory function (compromise of airway and/or breathing; respiratory distress; cyanosis; saturations < 90%); abnormal heart rate and/or blood pressure; GCS ≤ 13 <p>Paediatric Medical ICU <12 years of age</p> <p>Premature or critical neonate</p> <p>Obstetric</p> <ul style="list-style-type: none"> Impending premature delivery < 37/40, ≥ 25/40 with viable pregnancy (see Pre-Term Labour Tasking Guideline) 	<p>MedSTAR (SA) or hospital specialist (NT)</p> <p>+RFDSCO Midwife for Obstetric</p>
	High	<p>Trauma > 12 years of age with the following mechanism (aligned with state-wide level 1/2 trauma)</p> <ul style="list-style-type: none"> Any primary trauma direct from incident Any secondary retrieval with ejection from a vehicle or death of an occupant; pedestrian struck at ≥ 30km/hr; Cyclist (pedal or motor) struck or fall from at ≥ 30km/hr; prolonged extrication time (≥ 30 mins); fall > 3m; Trauma in the pregnant patient with gestation > 20 weeks; fall from or kicked by a horse (or other large animal); hanging / Traumatic Asphyxiation; gunshot wound (GSW); drowning <p>Trauma > 12 years with significant physiology or injury profile:</p> <ul style="list-style-type: none"> RR <10 or >30; HR <50 or >120; SBP <100; GCS <13 Any secondary retrieval with airway compromise; flail chest; subcutaneous emphysema; ongoing uncontrolled significant haemorrhage; penetrating injury to head, neck or torso; major pelvic fractures; spinal injury with neurological signs; femur fracture plus one other long bone fracture; amputation or severe crush, proximal to the wrist or ankle; burns >20% BSA and/or inhalational burns; high voltage electrical injury (>1000volts) <p>Trauma > 55 years of age with:</p> <ul style="list-style-type: none"> High speed MVA; SBP < 110 (in presence of significant injury); injury to 2 or more separate body areas (with clear evidence of haematoma, active bleeding, laceration or fracture); long bone fracture/open fracture (proximal to wrist/ankle - excluding isolated h/NOFs); anticoagulated <p>Cardiorespiratory</p> <ul style="list-style-type: none"> Cardiac arrhythmia with hypotension (SBP <80) Pen-arrest; adult or paediatric Cardiorespiratory arrest; paediatric Any primary retrieval with chest pain not assessed by a doctor at referring site Any STEMI Cardiogenic shock <p>Neurological</p> <ul style="list-style-type: none"> persistently decreased GCS < 13, or AVPU of P or U Status epilepticus <p>Mental Health / Behavioural Disturbance</p> <ul style="list-style-type: none"> Sedative infusion (e.g. ketamine) required due to purple/red RASS score <p>Obstetric</p> <ul style="list-style-type: none"> Impending premature delivery < 37/40, ≥ 25/40 with viable pregnancy (see Preterm Labour Tasking Guideline) Post-partum haemorrhage with MEWS > 3 Eclamptic seizure <p>Snake Bite with Collapse or Evidence of Neurotoxicity</p> <p>Time Critical Surgical Lesion</p> <ul style="list-style-type: none"> Potential threatened airway <p>Other Medical Emergencies</p>	<p>Critical Care retrieval team (RFDs/MRACC Critical Care Credentialed Doctor + Flight Nurse)</p>
45 min	High (continued)	<p>Cardiorespiratory</p> <ul style="list-style-type: none"> Cardiac arrhythmia with hypotension (SBP <80) Pen-arrest; adult or paediatric Cardiorespiratory arrest; paediatric Any primary retrieval with chest pain not assessed by a doctor at referring site Any STEMI Cardiogenic shock <p>Neurological</p> <ul style="list-style-type: none"> persistently decreased GCS < 13, or AVPU of P or U Status epilepticus <p>Mental Health / Behavioural Disturbance</p> <ul style="list-style-type: none"> Sedative infusion (e.g. ketamine) required due to purple/red RASS score <p>Obstetric</p> <ul style="list-style-type: none"> Impending premature delivery < 37/40, ≥ 25/40 with viable pregnancy (see Preterm Labour Tasking Guideline) Post-partum haemorrhage with MEWS > 3 Eclamptic seizure <p>Snake Bite with Collapse or Evidence of Neurotoxicity</p> <p>Time Critical Surgical Lesion</p> <ul style="list-style-type: none"> Potential threatened airway <p>Other Medical Emergencies</p>	<p>Critical Care retrieval team (RFDs/MRACC Critical Care Credentialed Doctor + Flight Nurse)</p>
	Low	<p>Cardiorespiratory</p> <ul style="list-style-type: none"> Unstable Angina (-) troponin, no pain currently <p>Neurological - Persistent GCS 13-14, or V on AVPU</p> <ul style="list-style-type: none"> Headache with neurological signs Suspected stroke within treatment window with mild symptoms <p>Acute behavioural disturbance requiring minimal sedation</p> <ul style="list-style-type: none"> RASS score may not be purple/red <p>Obstetric - High Risk Labour</p> <ul style="list-style-type: none"> Short cervix; meconium liquor; foetal distress, no antenatal care, fever, extreme prematurity (23 to 24+6 weeks) <p>Time Critical Surgical Lesion</p> <ul style="list-style-type: none"> Testicular torsion 	<p>Critical Care Credentialed Doctor + Flight Nurse</p>
	Medium	<p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise 	<p>Critical Care Credentialed Doctor + Flight Nurse</p>
3 3 hrs	Low	<p>Trauma – Fully evaluated by referring doctor; normal vital signs, pain controlled</p> <p>Infection - Responsive to treatment and MEWS <4</p> <p>Cardiorespiratory</p> <ul style="list-style-type: none"> NSTEMI (+) troponin, pain free for 12 hours, no arrhythmia, no failure, no GTN infusion Unstable Angina (-) troponin, no pain currently <p>Neurological - Any persisting new-onset neurology</p> <p>Acute behavioural disturbance requiring minimal sedation</p> <ul style="list-style-type: none"> RASS score may not be purple/red <p>Renal - Missed dialysis with K+ of 6-7 and no ECG changes</p> <p>Obstetric - Abdominal pain in early pregnancy; Uncomplicated labour of which birth is not imminent</p>	<p>Single Flight Nurse</p>
	Medium	<p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise 	<p>Single Flight Nurse</p>
4 or 5 6 to 12 hrs	Medium	<p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise 	<p>RFDS/MRACC Dr + Flight Nurse, or 2 Flight Nurses</p>
	Medium	<p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise 	<p>RFDS/MRACC Dr + Flight Nurse, or 2 Flight Nurses</p>

Aeromedical Clinical Tasking Guideline



45 min	Medium	<ul style="list-style-type: none"> Missed dialysis with systemic compromise and inability to render temporising treatment (e.g. BiPAP, calcium gluconate, GTN) Sepsis shock Status Asthmaticus CVA with concern for significant/evolving pathology impacting airway or GCS Significant suspected Pulmonary Embolus 	<p>RFDS/MRACC doctor (including GP/Registrar) + Flight Nurse Or 2 Flight Nurses (High Acuity Skills)</p> <p>(Single Flight Nurse should only be tasked by exception)</p>
		<p>Trauma – MEWS/REWS ≥ 4 but not meeting above criteria with low chance of deterioration</p> <p>Sepsis – MEWS/REWS ≥ 4, pH < 7.2 or Lactate > 4 with low little systemic compromise; inability to treat beyond antibiotics at site</p> <p>Cardiorespiratory</p> <ul style="list-style-type: none"> NSTEMI (+) or (-) troponin plus pain within 12 hours, any arrhythmia, heart failure or pain on GTN infusion <p>Fluid overload with significant pulmonary oedema</p> <p>Renal - Missed dialysis with ECG changes or K+ > 7.0.</p> <p>Neurological</p> <ul style="list-style-type: none"> CVA with moderate symptoms requiring urgent transfer Seizure in non-epileptic <p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise (see Transport Acutely Agitated/Mental Health Patient Guideline) <p>Snake bite</p> <p>Time Critical Surgical Lesion</p> <ul style="list-style-type: none"> Bleeding diathesis Limb fracture or dislocation requiring reduction Ex-premature paediatrics with intercurrent illness Other medical emergencies GI bleeding with systemic compromise (e.g. tachycardia) Newly diagnosed or highly suspected severe metabolic disturbance- e.g. DKA 	<p>RFDS/MRACC doctor (including GP/Registrar) + Flight Nurse Or 2 Flight Nurses (High Acuity Skills)</p> <p>(Single Flight Nurse should only be tasked by exception)</p>
3 3 hrs	Low	<p>Cardiorespiratory</p> <ul style="list-style-type: none"> NSTEMI (+) troponin, pain free for 12 hours, no arrhythmia, no failure, stable GTN infusion Unstable Angina (-) troponin, no pain currently <p>Neurological - Persistent GCS 13-14, or V on AVPU</p> <ul style="list-style-type: none"> Headache with neurological signs Suspected stroke within treatment window with mild symptoms <p>Acute behavioural disturbance requiring minimal sedation</p> <ul style="list-style-type: none"> RASS score may not be purple/red <p>Obstetric - High Risk Labour</p> <ul style="list-style-type: none"> Short cervix; meconium liquor; foetal distress, no antenatal care, fever, extreme prematurity (23 to 24+6 weeks) <p>Time Critical Surgical Lesion</p> <ul style="list-style-type: none"> Testicular torsion 	<p>Single Flight Nurse (consider upgrading to 2 clinicians if evolving acuity and risk of deterioration)</p>
		<p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise 	<p>RFDS/MRACC Dr + Flight Nurse, or 2 Flight Nurses</p>
4 or 5 6 to 12 hrs	Medium	<p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise 	<p>RFDS/MRACC Dr + Flight Nurse, or 2 Flight Nurses</p>
		<p>Acute behavioural disturbance requiring sedation</p> <ul style="list-style-type: none"> RASS score purple/red due to requirement for ongoing intermittent sedation or potential for airway compromise 	<p>RFDS/MRACC Dr + Flight Nurse, or 2 Flight Nurses</p>



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The Priority = Acuity misconception

... and the Binary acuity fallacy

- > Retrieval team vs. LAMR
- > Emerg vs. non-emerg
- >



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The Priority = Acuity misconception

... and the Binary acuity fallacy

- > Retrieval team vs. LAMR
- > Emerg vs. non-emerg
- > *Acuity is a spectrum*
- > Patient safety risks evolve due to
 - patient factors
 - austerity factors



The Priority = Acuity misconception

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- > Retrieval team vs. LAMR
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 - patient factors
 - austerity factors
 - is there a missing middle **MAMR**



The Priority = Acuity misconception

... and the Binary acuity fallacy

- > Retrieval team vs. LAMR
- > Emerg vs. non-emerg
- > *Acuity is a spectrum*
- > Patient safety risks evolve due to
 - > - patient factors
 - > - austerity factors
 - > - is there a missing middle **MAMR**

What if there was an acuity scoring system? Considering eg:

- **Level of referring assessment**
(3= bystander, 1= clinician, 0 =Clinician + labs/imaging)
- **Evolution of illness/injury**
(3 = requires airway/titrated drug infusion; 2 = acute/evolving, may not have peaked; 1= subacute/improving, likely has peaked; 0= stable)
- **Distance from crew augmentation**
(2 = >1.5 hrs; 1 = 45 min-1.5 hours; 0=<45 min).
- **ACUITY SCORE:**
7-8 = retrieval team
4-6 = 2 clinicians
0-3 = single clinician

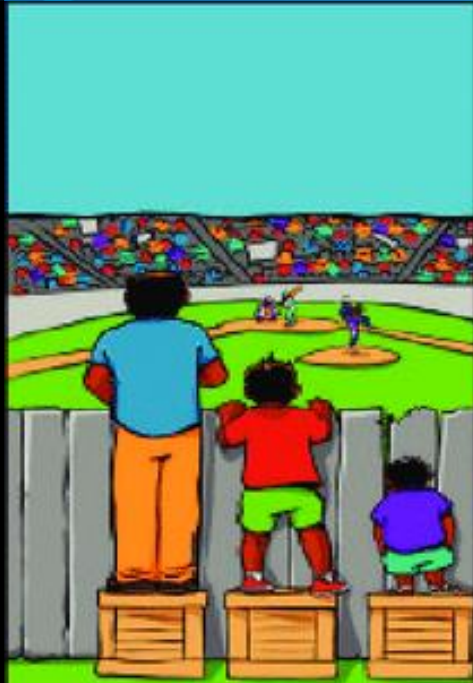
Should we, as a unique aeromedical community, consider

1. Redefining aeromedical urgency and consider time to definitive care rather than time to dispatch?
2. Redefining aeromedical acuity from a patient-centred risk perspective - better aligning crew mix with surety of assessment, phase of the clinical condition and time in austerity?



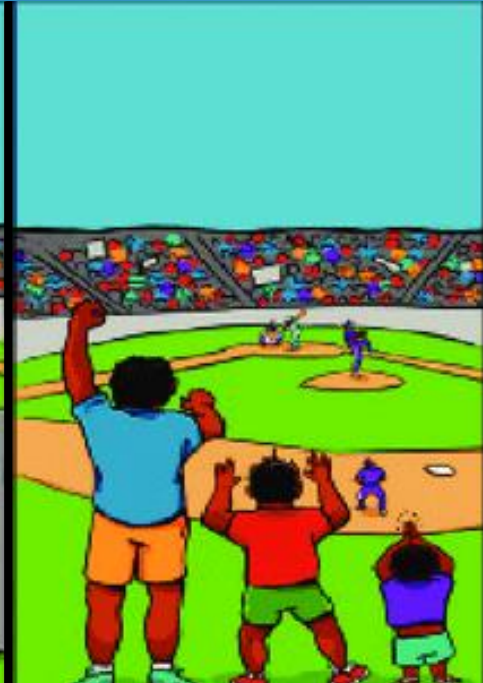
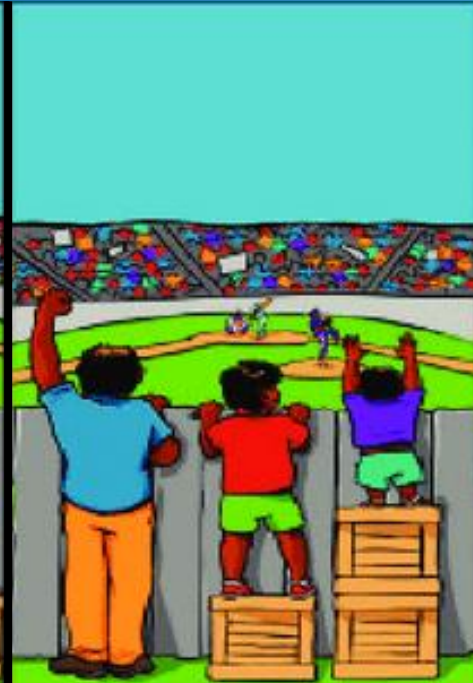
PREVIOUSLY

No aeromedicine



EQUALITY

P1-7 response times



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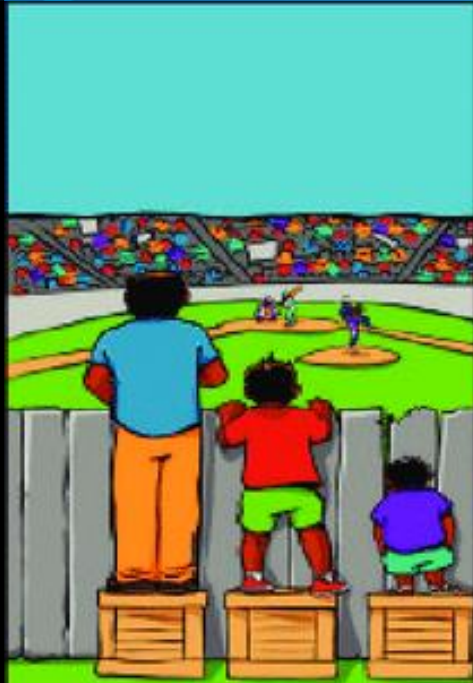



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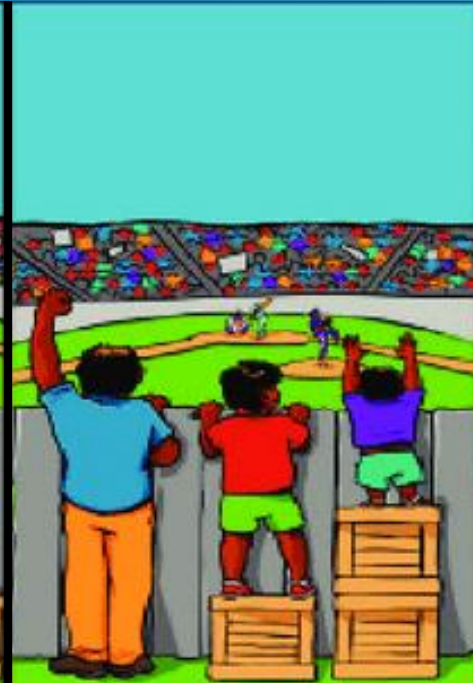
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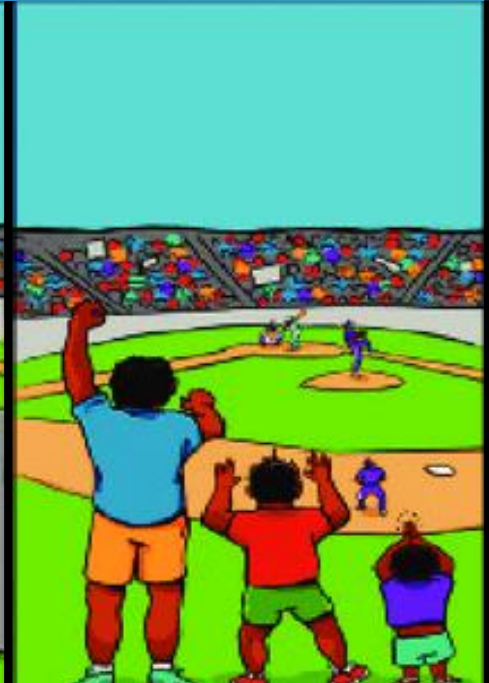
EQUALITY

P1-7 response times



EQUITY

TDC + risk stratified crew



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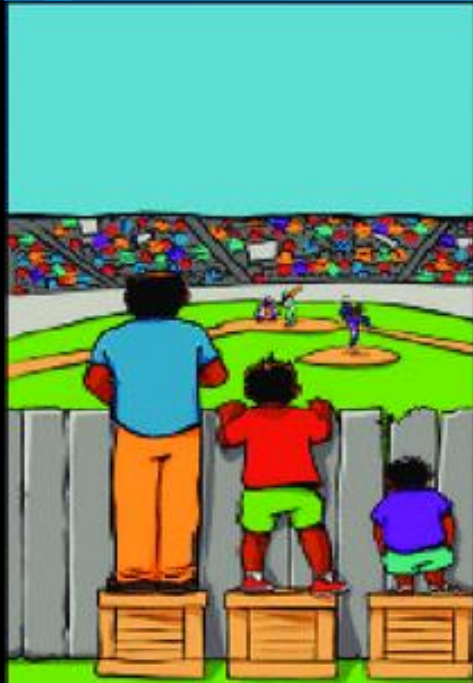



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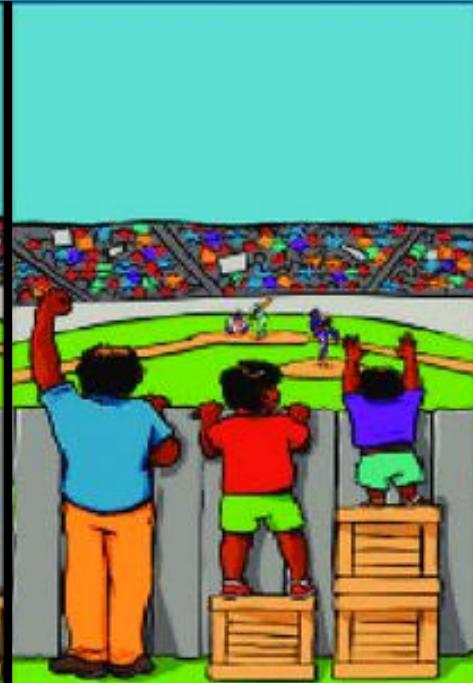
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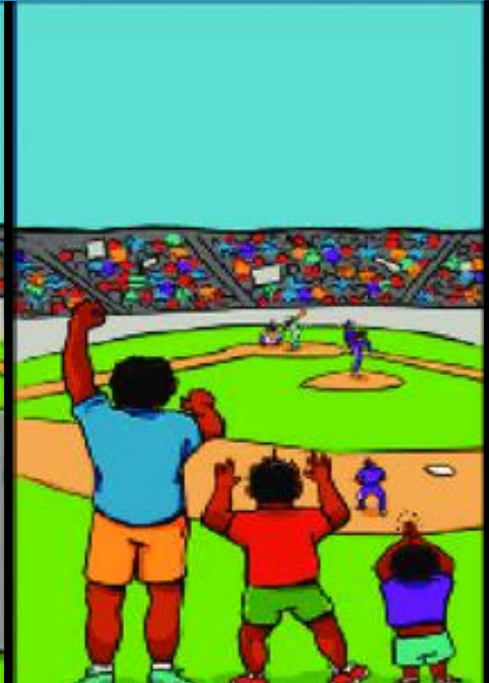
EQUALITY

P1-7 response times



EQUITY

TDC + risk stratified crew



JUSTICE

Critical Care <1h for all

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