



Department of Defense

AD-A272 394 DIRECTIVE



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September 18, 1986
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ASD(HA)

SUBJECT: Emergency Medical Services

- References:
- (a) Accreditation Manual for Hospitals, Joint Commission on Accreditation of Hospitals, current issue
 - (b) Ambulatory Health Care Standards Manual, Joint Commission on Accreditation of Hospitals, current issue
 - (c) DoD Directive 6025.2, "DoD Nonphysician Health Care Providers," November 17, 1983
 - (d) through (h) see enclosure 1

A. PURPOSE

This Directive establishes policy, prescribes procedures, and assigns responsibilities for the administration and management of emergency medical services (EMS) in fixed DoD medical treatment facilities (MTFs). EMS administration and management requirements in this Directive complement the requirements for health care providers in references (a) through (h).

B. APPLICABILITY AND SCOPE

This Directive:

1. Applies to the Office of the Secretary of Defense (OSD) and the Military Departments.
2. Covers DoD military (Active Duty, Ready Reserve of the National Guard, and Reserve components) and civilian (Civil Services, foreign national hire, and contract) health care providers.
3. Covers all aspects of emergency medical and/or dental services including DoD health care providers and personnel providing emergency patient care in the emergency care area of the fixed MTF.

C. DEFINITIONS

The terms used in this Directive are defined in enclosure 2.

D. POLICY

It is DoD policy that:

1. Beneficiaries shall have access or referral to EMS for treatment of patient care emergencies. All MTFs shall have the capability to determine if a patient care emergency exists and to initiate life and limb saving measures before transporting the patient or providing definitive treatment.

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2. The EMS capability provided by MTFs shall be classified as Level I, II, or III in accordance with Joint Commission on Accreditation of Hospitals (JCAH) Standards, Accreditation Manual for Hospitals (reference (a)). In addition to JCAH physician requirements for Level III, a physician shall be in the MTF but does not have to remain in the emergency care area and shall be available immediately by two-way voice communication. Each MTF shall provide the highest EMS Level of care consistent with its overall capability according to JCAH Standards, Accreditation Manual for Hospitals (reference (a)), and this Directive.

3. Credentialing of health care providers for EMS practice shall be based on specific education, training, and experience requirements as stated in DoD Directive 6025.4 (reference (d)). The experience requirements for the EMS physician is 1 year of primary care or patient care speciality. This requirement also may be met at the entry level by a physician who has completed the first year of postgraduate training in a patient care speciality. This physician shall work under the supervision of an EMS physician for a minimum of 3 months.

4. The EMS shall be staffed with EMS physicians who have current certification in life support programs according to the specified Levels of this Directive. EMS nurses shall have current certification in Advanced Cardiac Life Support (ACLS). All EMS health care personnel working in an emergency care area shall have current certification in Basic Life Support (BLS). Technicians or hospital corpsmen working in EMS and/or assigned to ambulance duty shall have a minimum of Emergency Medical Technician-Ambulance (EMT-A) current certification from the National Registry for Emergency Medical Technicians (NREMT). EMT-Intermediate or EMT-Paramedic current certification as defined by the NREMT (reference (g)) also may fulfill this requirement.

5. Clinical privileges for providing patient care in an emergency care area shall be granted to physicians, dentists, nurse practitioners, and physician assistants. Physician supervision, responsibility, and accountability shall be required when nurse practitioners and physician assistants are diagnosing and treating patients in an emergency care area. Physician supervision, responsibility, and accountability also is required when EMT-A personnel are treating patients at the scene of an emergency or during emergency transport. Supervising of EMT-A personnel treating patients at the scene of an emergency may be by two-way voice communications. EMT-A personnel shall provide treatment only in accordance with protocols approved by the EMS physician supervisor.

6. Diagnostic and treatment protocols are to be used to provide basic guidelines for diagnosing and treating patient care emergencies, but should not replace clinical judgment. These protocols are not intended as rigid rules for the EMS health care provider, but rather as aids in avoiding errors of omission. Flow chart or checklist-type protocols in the EMS also serve as educational aids and provide a quick review for EMS health care providers. EMS health care providers should deviate from the established protocols when their clinical judgment so dictates.

7. Monitoring and evaluating the quality and appropriateness of emergency care services shall be an integral part of each MTF's quality assurance program.

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall monitor the implementation of this Directive.

2. The Secretaries of the Military Departments, or designees, shall ensure compliance with this Directive, and recommend changes or improvements in the program to the Secretary of Defense through ASD(HA).

3. The Surgeons General of the Military Departments shall ensure compliance with this Directive in their respective Military Department's MTFs.

F. PROCEDURES

1. Any eligible beneficiary with a stated or apparent patient care emergency arriving at a MTF emergency care area shall be evaluated, treated, and/or referred. It shall be the responsibility of a designated EMS health care provider or EMS nurse to determine which patients have a patient care emergency or to refer the patient to the appropriate area for care in the MTF. If referral to another facility is necessary, the patient shall be evaluated by a physician before transfer.

a. Patients who are ineligible for military health care services, but come to an MTF seeking emergency care shall be evaluated by an EMS physician and shall be treated if the physician determines that a patient care emergency exists. Referral or transport to an appropriate civilian treatment facility shall follow the written guidelines for transport and referral after physician evaluation (See paragraph F.1.c., below.)

b. Each Military Department shall direct its CONUS MTFs and outside of CONUS, when appropriate, to initiate written working agreements with the surrounding civilian medical treatment facilities. The working agreements shall specify the requirements for patient referral and transfer, the mutual support disaster plan, and the means of communication among facilities.

c. A written plan shall exist at each MTF for transporting or referring emergency patients for definitive treatment. The plan shall establish responsibility for the patient during transfer and set forth procedures for conveying pertinent patient care documents, which shall accompany the patient being transferred. The patient shall be transferred only on order of the physician and after the receiving hospital has consented to accept the patient.

2. The MTF commander shall designate the level of EMS to be provided in accordance with the JCAH standards (Accreditation Manual for Hospitals) (reference (a)) and the requirements of this Directive. Each MTF shall be responsive to the health care needs of the population served but the designated EMS level shall not exceed the personnel and equipment resources of the MTF (Accreditation Manual for Hospitals) (reference (a)).

a. In situations where the need for EMS or the availability of local resources does not justify or allow the establishment of Level I, II, or III EMS, the MTF commander shall provide alternative methods for emergency patient care, such as arrangements for initial first aid and transporting or referring patients to other facilities with emergency care services.

b. An MTF providing less than JCAH Level III EMS shall not use the word "emergency" to advertise its medical services capability. Information on the limited emergency treatment capability of such a service and the alternatives provided for emergency care shall be disseminated widely to the military beneficiaries served by that MTF. Signs indicating an emergency care area or emergency services capability shall be restricted to those MTFs that operate EMS at Level I, II, or III of the JCAH Standards (Accreditation Manual for Hospitals), under DoD Directive 6025.2 (reference (c)), and the requirements of this Directive.

c. Two health care personnel shall accompany each ambulance or helicopter when dispatched on an emergency. This may include any combination of physician, nurse anesthetist, nurse midwife, EMS nurse, critical care nurse, EMTs, or other health care personnel, if they are appropriately qualified. If the health care personnel are nonphysicians or do not have clinical privileges to provide emergency patient care, these individuals shall be under the direction of an EMS physician. Training of EMT-A personnel shall be in accordance with the basic Department of Transportation (DoT) EMT-A training course (reference (h)) or equivalent to it and accepted by NREMT (reference (g)). EMT-A personnel shall maintain current certification through the NREMT. Local and/or State requirements for ambulance services shall be met by each EMS.

3. The EMS clinical privileges for EMS health care providers shall define those patient care activities and procedures that providers can perform independently and those requiring consultation or supervision. Experience and training requirements for civilian or contract physicians employed as EMS staff shall be the same as active duty military EMS physicians. If a physician augments or is assigned temporarily to emergency room duty, he or she shall meet the same experience and training requirements as EMS physicians.

4. In EMS Level I, there shall be at least one full-time EMS physician on duty at all times. This physician shall maintain current certification in ACLS and Advanced Trauma Life Support (ATLS). In EMS Levels II there shall be one full-time EMS physician always on duty currently certified in ACLS. In EMS Level III, the EMS physician shall be available at all times in the MTF and by two-way voice communication. These physicians are to have current certification in ACLS. The Level III EMS physician is not limited to working in the emergency care area full-time, but may augment his or her practice with general medicine or other patient care speciality.

5. Nurse practitioners, physician assistants, EMS nurses, EMT-As, and other health care personnel (see paragraph F.2.c., above) in EMS may be used to augment physician services.

a. All EMS health care personnel shall receive orientation training (including current certification in BLS) before assignment in the EMS. The Military Departments shall encourage all EMS health care personnel to be ACLS certified, except those already required by this Directive.

b. The credentials file of nurse practitioners and physician assistants who work in EMS specifically shall include documentation of clinical privileges for EMS as required in DoD Directive 6025.4 (reference (d)).

c. The following types of patients shall be referred to an EMS physician by nurse practitioners and physician assistants:

- (1) Any patient requiring Schedule II controlled drugs.
- (2) Any patient requesting to see a physician.
- (3) Any patient having a life threatening problem.
- (4) Any patient having a multi-system injury.
- (5) Any patient having an unscheduled repeat visit for the same complaint.
- (6) Any patient having a problem beyond the scope of the nurse practitioner's or physician assistant's clinical privileges or clinical judgment.
- (7) When the nurse practitioner or physician assistant determines the need for referral.
- (8) When patient transport or referral to another facility is necessary.

d. In a Level I or Level II EMS using nurse practitioners or physician assistants, the EMS physician shall be present in the emergency care area at all times. In a Level III EMS, the nurse practitioner or physician assistant shall provide emergency services only if an EMS physician always is present in the MTF and immediately available by two-way voice communication.

e. The EMS physician should review the record of patients treated by nurse practitioners and physician assistants before the patients depart the emergency care area. Patients may be released from the emergency care area before this review only if the physician will be delayed in returning to the emergency care area and the patients would be inconvenienced unduly by having to wait. In these instances, the EMS physician shall review the patients' records within 8 hours of treatment.

f. All treatment by nonphysician health care providers and personnel during ambulance or helicopter dispatch shall be in accordance with protocols approved by the EMS physician. Treatment provided shall be documented at the accident scene and during transport. A designated EMS physician supervisor shall review all care provided by nonphysician personnel during ambulance or helicopter dispatch.

6. Written diagnostic and treatment protocols for patient care emergencies shall be employed by each Military Medical Department. The following components shall govern the scope and content of the required diagnostic and treatment protocols:

a. Protocol guidelines shall be developed or adopted and utilized in each Military Service to reflect nationally standardized protocols or the equivalent. Protocols may be supplemented locally but shall be concise and convey the essential diagnostic and therapeutic measures that may be rendered quickly by EMS health care providers whose primary expertise may not be emergency medicine.

b. Patient care emergencies requiring written diagnostic and treatment protocols shall include, but are not limited to: chest pain, shock, altered level of consciousness, multiple trauma, seizure, abdominal pain, fever, shortness of breath, major injuries to the extremities, injuries to the central nervous system, attempted suicide, rape, eye injuries, burns, gunshot and stab wounds, animal bites, poisoning, and child or spouse abuse (including sexual abuse). Each protocol, if applicable, shall address differences in treatment corresponding to patient sex and age; i.e., newborns, children, adolescents, or adults.

7. The MTF quality assurance program shall include EMS quality assurance activities.

a. The EMS quality assurance evaluation shall include monitoring and evaluating of all EMS health care. Occurrence screens specific to the EMS shall be a part of the EMS monitoring and evaluating process. Emergency services occurrence screening and quality assurance review results confirming provider error shall be documented in the provider's activity profile.

b. The JCAH requirement for an EMS Emergency Log (control register), as specified in the Accreditation Manual for Hospital (reference (a)), also shall be used for documenting the unit of assignment or duty station for active duty members. The logs shall be accessible in the MTF for at least 1 year and shall be retained for a total of 5 years.

G. EFFECTIVE DATE AND IMPLEMENTATION

1. This Directive is effective immediately, except for the following:

a. The effective date for EMS physicians to be assigned full-time to emergency care areas and to be certified currently in ACLS and/or ATLS shall be as soon as possible, but in no case more than 3 years from the date that this Directive is issued.

b. The effective date for EMS nurses to have current certification in ACLS shall be as soon as possible, but in no case more than 3 years from the date that this Directive is issued.

c. The effective date for two health care personnel to accompany each emergency ambulance or helicopter when dispatched on an emergency shall be as soon as possible, but in no case more than 3 years from the date that this Directive is issued.

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d. The effective date for EMT-A personnel to be certified by NREMT shall be as soon as possible, but in no case more than 3 years from the date that this Directive is issued.

2. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

William H. Taft, IV

William H. Taft, IV
Deputy Secretary of Defense

Enclosures - 2

1. References
2. Definitions

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REFERENCES, continued

- (d) DoD Directive 6025.4, "Credentialing of Health Care Providers,"
February 11, 1985
- (e) DoD Directive 6025.6, "Licensure of DoD Health Care Providers,"
July 18, 1985
- (f) DoD Directive 1125.1, "Utilization of Nursing Personnel," September 16,
1967
- (g) The National Registry of Emergency Medical Technicians, A-5/January 1985
- (h) U.S. Department of Transportation, Emergency Medical Technician-Ambulance:
National Standard Curriculum, current edition

DEFINITIONS

1. Emergency care area. The designated area in an MTF having the personnel and resources required to provide patient care emergency services at Level I, II, or III of care as defined by Accreditation Manual for Hospitals (reference (a)) and this Directive.
2. Emergency medical services (EMS). The resources-both personnel and facilities-that are available 24 hours a day to assess, treat, or refer for medical and/or dental treatment, an ill or injured person. The Level of EMS at a fixed MTF shall be classified as Level I, II, or III according to JCAH in the Accreditation Manual for Hospitals (reference (a)) and the additional requirements of this Directive.
3. EMS physician. A physician who is assigned to the emergency care area, has a minimum of 1 year experience in primary care or a patient care speciality such as, obstetrics/gynecology, pediatrics, family practice, general surgery, internal medicine, emergency medicine, or any combination of the above and has had this experience within the past 2 years. The physician also must be certified currently in ACLS and/or ATLS, depending on the JCAH designated Level of EMS. The physician's primary assignment or responsibility shall be to emergency medicine. The physician shall continue to gain and maintain proficiency in emergency medicine as well as pursue medical education in emergency medicine.
4. EMS health care providers. Physicians, dentists, nurse practitioners, and physician assistants granted clinical privileges to provide emergency patient care. This includes DoD military and civilian personnel.
5. EMS nurse. A registered nurse who is assigned to the emergency care area, has a minimum of 1 year of inpatient hospital experience, and is currently certified in ACLS.
6. EMT-A. Hospital corpsmen or technician who is assigned to the emergency care area and/or ambulance duty and are trained according to DOT curriculum or equivalent program approved by NREMT.
7. Fixed MTF. A permanently established land-based medical facility excluding ships, field units, and air-transportable hospitals.
8. Patient care emergency. A medical or dental condition threatening life, limb, or body functions or causing undue suffering to the patient.
9. Protocols. Written procedures providing basic guidelines for the management (diagnosis and treatment) of specific types of medical and dental patient care emergencies.