

## Military Emergency Medical Services

*This Policy Resource and Education Paper (PREP) is an explication of the ACEP policy statement  
“Military Considerations in Emergency Medical Services (EMS)”*

### Preamble

This policy resource and education paper (PREP) addresses the out-of-hospital care and emergency medical services (EMS) provided by the United States military services. Its intent is to address the in-garrison EMS systems for those living, working, or visiting on US military installations, and those EMS services regularly offered by the military to the community at large. This document outlines the essential components of the out-of-hospital and EMS systems that should be available on all military installations whether the system is operated by the uniformed services, other government agencies, or contractually by outside agencies. It applies to all elements of the EMS system including all forms of transportation, out of -hospital emergency medical care, and communications. It is not intended to address the wartime or operational medical system.

### System Organization

**“EMS System” Defined** An EMS system consists of those organizations, agencies, individuals, facilities, and equipment whose participation is required to ensure the timely and medically appropriate response to each request for out-of-hospital care and medical transportation. The focus of this PREP is not the operational/battlefield roles of EMS.

**Standards of Service** Military installation out-of-hospital services and EMS should, in all cases, meet or exceed the prevailing community standard for all aspects of EMS and out-of-hospital care. The military should establish standardized protocols employing best available evidence-based medicine principles. Protocols should be reviewed on a timely basis to ensure that current best practices are being implemented and sustained.

**Chain of Command** A clear chain of command should be responsible for ensuring compliance with all applicable federal requirements, applicable prevailing standards of care, and facilitating cooperation and mutual support with applicable civilian EMS organizations.

**Medical Direction** All military EMS systems must have a medical director with authority such that the installation EMS can successfully meet applicable clinical standards of care, operate within reasonable credentialing policies for clinical personnel, and with data-driven clinical operations. Accordingly, the medical director should be a licensed physician who has experience and training in out-of-hospital care and EMS, having completed formal education in medical oversight of EMS Medicine.

Physicians serving as indirect medical oversight (also commonly known as “on-line medical control”) should be knowledgeable with applicable clinical standards and capabilities as well as applicable operational responsibilities. Physicians attaining EMS Medicine subspecialty board certification should be integrally involved in the leadership of installation EMS systems whenever logistically possible. As this skillset is unique and specialized, EMS Medicine board-certified physicians should serve as consultants to

the installation-level medical directors and may be consultants for more than one installation simultaneously if serving in a regional capacity. The service Surgeon General should appoint service-specific consultants for Emergency Medical Services consistent with other medical specialties.

Clear responsibilities and authorities of all leadership positions in any installation EMS system are essential for effective and efficient clinically-related operations.

***Ambulance Services*** Emergency vehicles, ambulances, aircraft, and medical equipment must meet all applicable federal guidelines and standards, at a minimum, with adjustments as necessary based on technological advances and local operational requirements. All emergency vehicle operators must be trained in accordance with US Department of Transportation (DOT)-recommended guidelines or equivalent. The recognized entry level for EMS providers is Emergency Medical Technician (EMT). All personnel with patient care responsibilities must meet this minimum standard, regardless of installation location.

Personnel involved with specialty transports should receive additional courses of instruction commensurate with their responsibilities and in accordance with nationally recognized clinical education standards.

Air ambulances should meet or exceed accepted community standards for emergency air medical services. Personnel who support unique operations (eg, HazMat, tactical EMS) should receive additional, mission-specific training, particularly training that meets applicable DOD and OSHA requirements. All EMS personnel must be certified by the appropriate state or national organization (eg. NREMT) and maintain certification through approved continuing education as well as other requirements determined by the medical director in consultation with the chain of command.

***First Response Services*** A key component of EMS is first response. Installation safety agencies (eg, fire and police services) should participate as integral members of the installation EMS system. Installation safety agencies affiliated with the installation EMS system should ensure the availability of adequate equipment, communications, and trained personnel to provide safe extrication and first responder medical response, including automated external defibrillation, within the area of responsibility, while awaiting further EMS support. Specialized rescue teams (eg. HazMat, confined space, or urban search and rescue teams) should also be identified and affiliated with the installation EMS system, if not already integral to the system.

***Communications*** Installation EMS systems must have communications that ensure, at minimum, ease of access, ease of ability to accurately locate an incident, accurate and timely dispatch of responding clinical personnel, interagency abilities to communicate real-time during active incidents, and timely indirect medical oversight/”on-line medical control.”

Indirect medical oversight involves base hospital(s) having appropriate communications equipment to receive communications/consultations from EMS personnel and provide direct medical orders in return. Installation EMS system medical directors must also have appropriate communications equipment to provide real-time medical oversight, both direct and indirect.

All communications abilities must factor how governmental and civilian communications systems are regulated and favor common operational processes available to promote timely inter-agency communication, particularly in disasters and allowing installation EMS systems to communicate with applicable receiving civilian hospitals.

Enhanced 9-1-1 EMS access is a national goal and should be provided for all callers on the military installation. Communications personnel should be Emergency Medical Dispatcher (EMD) certified, or equivalent, and should have the capability and training to provide caller algorithmic interrogation, clinical-based priority dispatch, triage instructions, and pre-arrival medical instructions.

## **Operational Policies**

Chain of command for installation EMS systems should develop operational policies in accordance with federal and national standards. These should address both clinical situations, (eg. clinical treatment protocols and standing orders), and administrative operations that support clinical capabilities. Scope of services and responsibilities of affiliated agencies should be well defined. All affiliated EMS agencies within a geographical area's system, whether civilian or military, must cooperate and be willing to exchange resources in providing optimal clinical services. Optimal care of the patient must not be limited by installation boundaries. Therefore, the military EMS system must be fully integrated into the regional EMS system.

## **Human Resources and Education**

Adequate clinical and administrative staffing, using data-driven models, must be provided to meet anticipated demands meeting national and relevant community standards for system performance. Personnel assigned to EMS duty should have responsibilities and authorities that promote readily meeting such duty. As previously stated within this PREP, though repeated for emphasis in this section, the nationally recognized entry level for EMS personnel is the US DOT EMT. All EMS personnel are expected to attain and maintain this certification (or above, if applicable to their individual scope of practice) through completing approved education and other related requirements established by the installation EMS system medical director. EMS personnel must be certified by the appropriate national organization (ie, NREMT).

## **Facilities**

Military medical treatment facilities that receive ambulance patients should be properly accredited and meet applicable federal requirements for receiving patients transported by ambulance. If these facilities cannot provide appropriate levels of care to received patients, interfacility transfers must be arranged within applicable guidelines and regulations.

## **Public Information and Education**

An integral component of any optimal performing EMS system is public information and education. An installation EMS system should educate those living, working, and visiting the installation in matters regarding EMS, including the access and availability of EMS, CPR, hemorrhage control and other forms of critically important first aid, and injury/illness prevention.

## **Continuous Quality Improvement**

A continuous quality improvement (CQI) program is a fundamental part of any successful EMS system. The full support of the installation, its leaders, EMS system chain of command and credentialed EMS personnel is critical for the CQI program to effectively analyze and improve the system in its operations and clinical capabilities. All elements of the installation EMS system, including its affiliated first responders and its communications system, must be encompassed within the CQI program. The CQI program should

include clinically-related operational metrics and clinical treatment metrics identified by the installation EMS system medical director.

### **Disaster Management & Mass Casualty/Major Incident Planning**

Military out-of-hospital systems should be integrated into the disaster plans not only of the installation, but also of the local and regional communities. Full participation with local and regional partners in all-hazards approach meetings, disaster planning, and field exercises will promote optimal disaster mitigation. A thorough understanding of the National Response Framework and Incident Command System are essential for integration with civilian operations.

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