GOVERNOR'S COUNCIL ON EMERGENCY MEDICAL SERVICES

REPORT TO THE GOVERNOR

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Summary

The Governor's Council on Emergency Medical Services was established by Governor Thomas H. Kean, pursuant to Executive Order 146 (Appendix 1), on September 5, 1986. The Council was charged with recommending an overall policy direction that would enable New Jersey to provide a comprehensive network of emergency medical services. The thirty-three members of the Council included a broad spectrum of viewpoints and expertise. In addition to the co-chairpersons, the Commissioner of Health and the Superintendent of the State Police, and a variety of State Officials and Legislators, the membership (Appendix 2) was specified to include, among others, the President of the New Jersey State First Aid Council, the President of the Medical Transport Association of New Jersey, the Chairperson of the Emergency Medical Service Committee of the Medical Society of New Jersey, the President of the New Jersey Chapter of the American Heart Association; representatives from the New Jersey Trauma Centers, the New Jersey Burn Center, New Jersey Hospital Association and the New Jersey Spinal Cord Center; an EMT-A, and a paramedic; a representative of the New Jersey Emergency Nurses Association, and representatives of the Health Care Financing Administration, and the insurance industry. The creation of the Council gave the state emergency services community a historic opportunity to reorganize and upgrade the provision of these services in New Jersey.

As a result of a grant from the Robert Wood Johnson Foundation, the Council was able to retain the services of a panel of emergency medical service experts from outside New Jersey to assist in designing and describing the ideal EMS system. The panel consisted of the following persons:

Alasdair Conn, M.D.	- Trauma Surgeon and Executive Medical Director, Boston Med-Flight Helicopter Consortium;
Mary Elizabeth Michos, R.N.	- Director, Emergency Medical Services, Montgomery County, Maryland; Captain, Montgomery County Fire Service; and Training Officer, Fire Academy;
Ronald D. Stewart, M.D.	- Director, Center for Emergency Medicine of Western Pennsylvania; and Chief, Division of Emergency Medicine, University of Pittsburgh.

On May 6, 1987, the Council submitted its Phase I Report to the Governor. This report documented the consensus of the major emergency care providers, services and specialty care centers, and volunteers from the First Aid Council--and indicated their commitment to assisting in modernizing and centralizing the New Jersey system.

The Council members brought many divergent viewpoints and provisions to their initial Phase I deliberations; nevertheless, with the assistance of the Office of the Public Advocate, they were able to reach consensus on eight key recommendations that addressed: federal reimbursement criteria, standard response times, minimum

training standards, minimum vehicle and equipment standards, uniform reporting, triage and dispatch protocols and emergency medical services coordinating areas. The text of these recommendations are included in the Report on pp. 5-16. Significantly, the Council affirmed its determination to preserve the volunteer component of the state's system, because they believe it to be in the best interest of the citizens of New Jersey.

The Council has continued its deliberations over the past several months. The Council agreed that public forums should be held throughout the State in order to obtain comments on the Phase I Report and the Final Report to Governor Kean. The forums were also crucial for obtaining input from all EMS providers and the public at large on the process. Other procedural changes included the Council's decision to combine the Staff/Response/Operations, Structure and Design of State EMS and Communications Subcommittees into one Field Operations Subcommittee (Appendix 3). In addition, all plenary council meetings were opened to the public, and a new Public Information and Education Subcommittee was established.

The Final Report of the Governor's Council on EMS pursuant to the Executive Order addresses the integral components of a coordinated comprehensive statewide EMS system. It provides continuity from the recommendations that were presented from Phase I; and in addition offers a policy direction for developing and implementing a pre-hospital care delivery system that will be among the best in the nation.

Progress Update

Federal Reimbursement Criteria - Negotiations were successful with the federal government and third party payers to assure a payment mechanism for MICU providers after the MICU waiver expired October 31, 1987. A transition from the prior method of reimbursement was overseen by the Finance Subcommittee.

Training - A uniform training standard, the EMT-A (a national curriculum developed by the U.S. DOT in conjunction with the National Highway Traffic Safety Administration) has been implemented for over eighty percent of all volunteer Basic Life Support providers. In an unprecedented move, the New Jersey State First Aid Council independently voted to amend its training by-laws, which previously endorsed the Eight Point Training Program. In order to achieve a uniform standard for basic life support personnel, the Department of Health agreed to "grandfather" the 8 Point trained volunteers, as of November 1, 1987, as EMT-As. At the close of the "grandfathering" period, over 6,400 volunteers were certified as EMT-As.

Resource Assessment Survey - A survey instrument has been developed and is presently being disseminated throughout the state. This survey will assist in determining current resources and resource needs and will also assist in enhancing the coordination of services among the local providers.

Study of Response to Cardiac Arrest - The Council received a study performed by Rutgers University, Bureau of Economic Research on "Responding to Cardiac Arrest, An Analysis of a Cardiac Arrest Questionnaire." The study was funded by the Robert Wood Johnson Foundation, and consisted of an analysis of MICU responses to 2,200 cardiac arrests due to heart disease and pulmonary edema in which resuscitation was attempted. In summary, the findings were that: (1) MICU response time, the presence of a witness and the time CPR and defibrillation began made a significant difference in the survival rate, and (2) sex, race and gender did not significantly effect the survival rate.

Trauma - The Ad Hoc Committee on Trauma, an advisory committee to the Commissioner of Health, was established to address trauma system development, including triage protocols and trauma data collection. The Advisory Committee recently recommended to the Commissioner of Health and the EMS Council the implementation of the American College of Surgeons' triage protocols in the State of New Jersey. A schematic design can be found in Appendix 6.

Ambulance Diversion - The Commissioner of Health established an Ad Hoc Diversion Task Force to define the problem of hospital diversion and to propose recommendations to alleviate the problem. The Task Force presented a report to the Council, including a recommendation that hospitals develop diversion and by-pass policies, using standard terminology, for divert, critical care divert and medical/surgical divert. The report can be found in Appendix 7.

Public Information and Education - An EMS Network newsletter was published in June 1988 and disseminated to approximately 20,000 members of the EMS community and the interested public. The newsletter, which is funded by a grant from the State Department of Health will keep both EMS providers and the general public abreast of those local, regional and statewide activities that are ongoing throughout the State. In addition, a videotape has been produced in cooperation with the Health Information Network on New Jersey's EMS system. The videotape featured a simulated emergency and discussions by Joseph Imbesi, D.O., Chairman of the MICU Advisory Committee, C. Clayton Griffin, M.D., Chairman, Governor's Council on EMS Steering Committee, and Mickey McCabe, Chairman of the Council's Public Information and Education Subcommittee.

MEDEVAC - An aeromedical component was developed to complement the existing ground system. Once fully operational, helicopters and trained aeromedical crews will be positioned in both north and south Jersey and readily available to transport patients to trauma centers and other hospital facilities. The University Hospital in Newark and Cooper Hospital in Camden have been designated Level I trauma centers and, as such, are staffed around the clock by specialists in emergency care.

The REMCS and Gloucester County Communications were designated as regional centers to dispatch both in state and out-of-state aeromedical services.

As all of these initiatives indicate, the work for a comprehensive and cohesive EMS system has just begun. Perhaps the most significant success of this effort to date, however, has been the establishment of an environment within which a thorough analysis of our prehospital care delivery has been accomplished and which solutions have been developed with consensus of all providers.

Reimbursement - The Post Medicare MICU Waiver

The New Jersey Medicare MICU Part B Coverage waiver that was granted by the Health Care Financing Administration (HCFA) expired on October 31, 1987. HCFA required beginning November 1, 1987 that Advanced Life Support services be reimbursed in accordance with the Medicare rules and regulations applicable to transportation services. The Department of Health, with the assistance of the Finance Subcommittee for the Governor's Council on Emergency Medical Services worked together with the major third party payers (Medicare, Medicaid, and Blue Cross) in resolving the post waiver reimbursement issues.

Medicare, Medicaid and other third party payers agreed to continue reimbursement to the MICU provider hospitals for the provision of Advanced Life Support (ALS) services. However, one of the major changes in reimbursement is that Medicare will limit their payment to eighty percent (80%) of the MICU charge regardless if a patient is admitted to a hospital. Medicare patients will now receive a bill for the twenty percent (20%) co-insurance payment. The reason for this is that Medicare reimbursment for Advanced Life Support services are regulated under their Part B outpatient coverage program. The HCFA regulations on ALS reimbursement can be obtained from Blue Cross and Blue Shield of New Jersey (Medicare Part A Intermediary or Pennsylvania Blue Shield (Part B Carrier).

Hospital billing procedures have also been modified in order to submit MICU claims to the various third party payers effective November 1, 1987. Medicare, Medicaid and other third party payers have agreed to modify their payment systems in order to accommodate the hospitals changes in submitting MICU claims. As a result, hospitals were notified by the various payers as to the specific billing instructions in order to ensure that all MICU claims are processed correctly and that the facility receives the appropriate amount of reimbursement.

Recent statistics indicate that there were 87,929 completed ALS runs. Medicare and Medicaid represent approximately fifty-five percent (55%) of the total completed ALS runs. Blue Cross represents approximately thirteen (13%).

As a result of the loss of the HCFA waiver, MICU hospital providers were confronted with issues regarding the future reimbursement of Advanced Life Support services. The Department of Health, in cooperation with the Finance Subcommittee and the entire Governor's Council on Emergency Medical Services recognized the importance of resolving these issues, in order that MICU hospital providers could continue their effort in providing MICU services to the Citizens of New Jersey on a statewide basis.

RECOMMENDATIONS

Introduction

The following recommendations have been approved by consensus by the Governor's Council on Emergency Medical Services. The recommendations are divided into six areas: Public Information and Education, Field Operations, Training, Data/ Quality Assurance, Finance and System Development.

All recommendations are typed in **BOLD** print. In response to questions and comments raised by the public, the Council has provided a statement of intent, to clarify selected recommendations.

FIELD OPERATIONS

Primary Objective - To provide the public with an optimal level of statewide emergency medical services.

The successful implementation of emergency medical services field operations consists of four major components including communications, dispatch, transportation and the provision of services. Coordination is a critical factor that occurs through a variety of efficient networks that operate at all levels throughout the State.

Efficiency of the system also relies on the availability of guidelines to assist the providers in communicating to and from the scene, and on what to do at the scene. The New Jersey State Department of Health in collaboration with the New Jersey State First Aid Council, the New Jersey State Police, the New Jersey Hospital Association and several other agencies has established guidelines for BLS treatment and also for coordinated communications. The optimal goal is to assure that every citizen and visitor to New Jersey will receive quality emergency care as promptly as possible.

RECOMMENDATION #1:

Establish response times for each of the following levels of EMS providers:

A. First Responder
B. BLS Squads
C. MICU/ALS Units

All citizens should have access to all aspects of emergency medical services within an acceptable time frame. Such time frames should be established and administered by the local governing body in accordance with nationally recognized standards for EMS.

The intent is to ensure that all citizens receive timely Emergency Medical Services.

RECOMMENDATION #2:

Require all ambulances to meet appropriate uniform vehicle and equipment standards.

The intent is to ensure that all appropriate equipment be available for patient care. The equipment standards will be promulgated either through the New Jersey Department of Health or the New Jersey State First Aid Council.

RECOMMENDATION #3:

Establish appropriate dispatch criteria, protocols and quality assurance review.

The intent is to ensure dispatch of the appropriate level of care and transport for all patients.

RECOMMENDATION #4:

Establish appropriate basic life support, advanced life support and treatment and triage protocols for all patients, to include the following specialty classifications of patients: trauma, spinal cord injury, burns, neonatal and pediatrics.

The intent is to assist all providers in the delivery of field treatment and transport to the appropriate facility for all patients.

RECOMMENDATION #5:

Establish local, multi-county and statewide emergency medical service coordinating areas for all aspects of emergency medical care.

Coordinating areas will provide a networking mechanism which will assist all EMS providers. This mechanism will help to identify the needs and resources of local communities, meet nationally recognized standards and provide an avenue for assistance in identifying funding sources. In addition these areas will facilitate communications among EMS providers to include technical and medical support.

RECOMMENDATION #6:

Develop and implement planning criteria for ALS, trauma services and all other critical care services.

RECOMMENDATION #7:

Develop efficient critical care inter-hospital transfer services, including maternal and neonatal transport.

The intent is to assure the provision of adequate transport with appropriate level of personnel for patients requiring inter-hospital transport.

RECOMMENDATION #8:

Promote the implementation of the enhanced 911 system.

The intent is to improve statewide access into our EMS system.

RECOMMENDATION #9:

Develop a comprehensive pediatric emergency medical service system to include pediatric trauma centers, pediatric rehabilitative facilities, required pediatric equipment for ambulance and MICU's, and specialized pediatric emergency care training for all levels of EMS providers.

The Council recognizes that pediatric emergency medical services are inadequate and provided in a fragmented fashion in New Jersey. In order to appropriately care for the special needs of children, special attention is required to address this important issue.

RECOMMENDATION #10:

Designate responsibility to local governments for assuring adequate EMS services in their communities.

The intent is to ensure that accountability for EMS will occur at the local municipal level. Without accountability there is no assurance of the adequate provision of EMS to all citizens.

TRAINING

Primary Objective - Assure an adequate supply of trained EMS providers.

The availability of highly qualified, well trained EMS personnel is a very important component of New Jersey's EMS System. Trained personnel help to assure the best possible care for emergency patients. Statewide training standards have been in place for advanced life support personnel (i.e. paramedics) for the past 13 years. More recently through the deliberations of the Council, the EMT-A standard was recommended and accepted as the statewide training standard for all BLS providers.

Training programs for basic life support (BLS), intermediate life support (ILS) and advance life support (ALS) are on-going, and are planned to meet the EMS personnel needs that will serve to enhance the quality of care delivered to the EMS patient.

In addition, the Council has given special attention to the need for First Responder training for citizens, that can effect a reduction in further injury to an emergency patient, if a trained witness is present at the scene.

RECOMMENDATION #11:

Establish minimum training standards/certification for the following categories of service: EMS Dispatcher, First Responder, Basic Life Support, EMT Defibrillation, Intermediate Life Support, Advanced Life Support and MICU Base Station Physician.

A. Require EMS dispatchers to have Uniform EMS dispatcher training.

The specialized nature of EMS dispatching requires that standardized training be implemented in order to ensure appropriate and timely utilization of the EMS system.

B. Require First Responders to maintain current training certification.

First responders are those persons, who by virtue of their role are the first official responder to the scene of a medical emergency. First responders whether policemen, fire fighters, school nurses, lifeguards, etc., should maintain the appropriate level of training require by their position.

C. Require all drivers of emergency medical service vehicles to successfully complete emergency vehicle driver training.

To provide education concerning laws pertaining to emergency vehicles and to provide training with regard to the specific situations encountered while driving emergency vehicles.

D. The minimum Basic Life Support training will be Emergency Medical Technician-A provided that:

i. New Jersey State First Aid Council continues to act as one of the providers of this training; and

ii. New Jersey State First Aid Council personnel will be certified as testers within this program by the Office of Emergency Medical Services; and

iii. There can be a variety of mechanisms for delivering this curriculum including modular training; and

iv. There will be a program of certifying current "five/eight pointers" as Emergency Medical Technician-As with appropriate and acceptable standards for recertification.

v. A single practical and written testing program is in place for new Emergency Medical Technician-As with testing by a neutral, third party (i.e., not the course instructor.)

To maintain EMT-A as the minimum training requirement for BLS personnel and to make that training easily accessible to the providers through a variety of mechanisms, some of which have already been initiated.

E. When EMT-Defibrillation legislation is enacted in New Jersey the training requirements should follow nationally accepted training standards.

All EMT-Defibrillation students should be trained to national standard.

F. **The EMT-Intermediate program currently exists as an approved demonstration project in five counties. The Council reserves its recommendations pending final evaluation of the project.**

G. **EMT-Paramedic training requirements should continue to meet Department of Transportation standards.**

H. **Require MICU Base Station Physicians to complete MICU Base Station training.**

Base Station Physicians should complete appropriate training.

RECOMMENDATION #12:

Implement the EMT-A standard, statewide as the minimum level of training for all providers of BLS on any ambulance by 1990.

The intent is to ensure full compliance with the minimum training within an appropriate time frame.

RECOMMENDATION #13:

Develop and implement an EMT certification for non-affiliated squad members.

The intent is to facilitate compliance with minimum training standards for non-New Jersey State First Aid Council members with the appropriate levels of training.

RECOMMENDATION #14:

Support legislation to establish the EMT-D level of pre-hospital care and develop and implement a statewide EMT-D training program.

EMT-D has been clearly shown to have a positive effect on the survival rate of cardiac arrest victims.

RECOMMENDATION #15:

Uniform EMS dispatch criteria should be promulgated by Department of Health, Office of Emergency Medical Services to all agencies in New Jersey responsible for the dispatch of EMS units.

The intent is to identify the Office of Emergency Medical Services as the responsible agency to promulgate and disseminate dispatch criteria.

RECOMMENDATION #16:

Organized pediatric emergency care training curriculum should be incorporated into the ALS and BLS training programs.

The Council recognizes the special needs of pediatric patients and the need to incorporate appropriate training in the BLS and ALS training curriculum.

RECOMMENDATION #17:

A. **Develop a comprehensive MICU training program that consists of three concurrent, integrated components (i.e. didactic and clinical instruction and practical application).**

The intent is to enhance the currently existing Paramedic Medical Training Program.

B. **Establish an EMS Management Training Program for EMS supervisors and administrators.**

The intent is to provide an additional level of training in order to enhance the performance of EMS managers.

RECOMMENDATION #18:

A. **Develop MICU Base Station training for all physicians who operate a MICU console.**

B. **Establish that emergency room directors be held responsible for physicians receiving this training.**

C. **Require the Department of Health supply the mechanism by which that training is made available, working in cooperation with emergency rooms and MICU coordinators.**

The intent is to ensure that physicians receive appropriate Base Station Training.

RECOMMENDATION #19:

All emergency department nurses should complete an orientation program which follows the Emergency Nurses Association's core curriculum (including practical application of MAST, KED, and other appropriate pre-hospital care equipment). in addition, all emergency department nurses should be certified in Basic Life Support upon employment and certified in advanced Cardiac Life Support within one year. It is further recommended that trauma nurse training, following the TNCC program curriculum, be provided within one year for emergency nurses.

RECOMMENDATION #20:

Require CPR as a necessary course for high school graduates.

RECOMMENDATION #21:

Encourage statewide citizen participation in CPR and basic first aid courses.

RECOMMENDATION #22:

Establish a Statewide Training Advisory Council.

The intent is to establish a Council comprised of people with training expertise from all levels of EMS providers. Training of EMS providers must stay current with standards of care. The Council should periodically review current training curriculum and recommend appropriate changes when necessary.

DATA/QUALITY ASSURANCE

Primary Objective - Develop a comprehensive information base and data system with a standardized quality assurance mechanism.

Data collection, analysis and evaluation will support and improve the overall planning efforts for maintaining a comprehensive and coordinated EMS system. Uniform run reports have been developed by the Data Reporting and Quality Assurance Subcommittee in order to assure peer review at the BLS level, as well as the ALS level of care. The need to compile data on trauma and other critical injuries, serves a primary role in evaluating existing resources, and in establishing future planning criteria.

RECOMMENDATION #23:

Field Triage protocols should be established for all patients. There should be a uniform reporting system for emergency care, including: basic life support, intermediate care, advanced life support, emergency department care, and all aspects of the New Jersey Emergency Medical Services Systems should be operated under appropriate medical direction with a system of concurrent and retrospective quality assurance review.

A. **All BLS providers should have a medical advisor. This medical advisor should be involved in all Quality Assurance. The advisor and the BLS providers should have a mutually agreeable relationship. When a BLS provider is unable to find an appropriate medical advisor, the local medical society should implement a designation responsibility for a medical advisor. For example: as part of a hospital staff responsibility.**

   Under the guidance of this medical advisor each BLS provider will be responsible for developing its own Quality Assurance program. The results will be transmitted to the BLS provider's corresponding regional coordinating council.

B. **Since it has been show that the routine, appropriate and timely, recording information protects rather than exposes the BLS provider from litigation, all runs should be recorded in a complete and timely manner and documented on a uniform reporting system in a timely and complete manner.**

These records will provide a vehicle for Quality Assurance, continuing education, and documentation of the needs of the BLS provider for example: personnel, equipment, etc.

C. **All run sheets should be evaluated on a regular basis after implementation to assess usefulness, appropriateness and adequacy of charting.**

RECOMMENDATION #24:

Develop and implement standardized statewide ALS and BLS run reporting systems.

RECOMMENDATION #25:

Develop and implement a peer review and quality assurance system with appropriate medical direction for all levels of emergency medical service providers.

RECOMMENDATION #26:

Utilize the data reporting system to develop and integrate an EMS registry.

PUBLIC INFORMATION AND EDUCATION

Primary Objective - Promote public awareness and education on accessing and utilizing the EMS system.

Each year, more than three million New Jersey residents and visitors require emergency medical care. The patients who range in age from the newborn to the elderly, experience a wide variety of traumatic, medical, and surgical emergencies. The "new generation" of mobile intensive care units, trauma centers, MEDEVAC, and other dedicated critical care services have the potential to save the lives of many seriously ill or injured individuals.

Throughout the Council's deliberations there has been increasing awareness of the need for a statewide public information and education program on New Jersey's emergency medical care services. The Council has determined that this process must not be limited to the local squads, but must be broadened to encompass all providers (including the medical profession), legislators and the consumer.

Through its on-going activities, the primary goal of the Public Education and Information Subcommittee has been not only to educate, but also to heighten community expectation for accessing and receiving quality emergency care.

RECOMMENDATION #27:

A. **Develop, publish and distribute a monthly EMS system newsletter. - develop a statewide logo.**

B. **Develop and produce film/videotape materials on the EMS system.**

C. **Annually promote the sponsorship of a statewide EMS symposium and participation in the observation of national EMS week.**

The intent is to identify and unite all facets of New Jersey's pre-hospital EMS system for purposes of integration and teamwork as well as exchange of information and continuing education in all levels of care. To enhance the spirit of cooperation among all providers.

RECOMMENDATION #28:

Develop and implement a statewide public information and education program on accessing the local EMS system.

The intent is to ensure that all citizens know how to access the EMS system correctly.

RECOMMENDATION #29:

Develop and implement a statewide education program for citizens on what to do until the ambulance arrives.

The intent is to improve awareness of EMS in New Jersey and to help the citizens understand their role in the system.

RECOMMENDATION #30:

Develop and distribute educational materials about the EMS system for medical professionals and government officials.

RECOMMENDATION #31:

Establish a mechanism to identify and clarify pending legislation and to communicate that information to the leadership in the EMS Community and other interested parties in an effort to provide expert testimony and support of EMS issues.

RECOMMENDATION #32:

Initiate and implement recruitment campaigns for all levels of EMS providers through the statewide newsletter, the annual EMS symposium and through the EMS Coordinating areas. Encourage citizens to participate in local volunteer EMS services.

FINANCE

Primary Objective - Develop adequate and on-going methods of reimbursement for all levels of emergency medical services.

A sophisticated system of emergency medical care such as the one found in New Jersey, needs on-going funding to maintain itself. The impetus for much of the Council's initial deliberations focused on the continuation of reimbursement for MICU services, given the loss of the Medicare waiver. The Council's Phase I recommendations were successful in meeting federal criteria for continuing funding under Medicare rules. The Finance Subcommittee has identified the following reimbursement issues still under review and proposed recommendations accordingly. They include MICU Uncompensated Care, reimbursement for Basic Life Support services, and the Medicare co-payment.

In regard to MICU uncompensated care, the Department of Health has made a commitment to reimburse MICU hospitals reasonable costs associated with treating the indigent population. The Department is currently reviewing a proposal from the New Jersey Hospital Association in addition to evaluating cost data relating to MICU services. A recommendation from the Department is expected in the very near future.

Reimbursement for Basic Life Support (BLS) services is an issue that will require further study. One of the major problems is that costs associated with BLS have not been collected in the past. As a result it is very difficult to evaluate what the reasonable amount of reimbursement would be to develop a mechanism to begin collecting data relating to BLS services.

The Medicare Co-Payment involves the 20% of the total MICU charge that is not reimbursed under the Medicare principle of reimbursement. However this will impact on those Medicare patients that do not have supplemental coverage. Blue Cross has agreed to pay for the remaining 20% of the charge, as long as the patient has Blue Cross coverage. This issue will require further study in order to determine the impact on reimbursement.

RECOMMENDATION #33:

Federal reimbursement criteria for advanced life support should be met in New Jersey by combining the use of both Mobile Intensive Care Units and the volunteer/proprietary Basic Life Services. Transportation of an advanced life support patient shall be provided by either of the following procedures:

A. Transportation in a Basic Life Support ambulance which has been specially equipped to accommodate Advanced Life Support medical and communications equipment, certified by the Department of Health as Advanced Life Support capable, with certified MICU paramedics on board, and a patient who requires care which would qualify for Advanced Life Support reimbursement under federal guidelines.

B. Transportation in a MICU ambulance which has been specially equipped with medical and communications equipment, certified by the Department of Health as an Advanced Life Support Ambulance, containing certified MICU paramedics and a patient who requires care which would qualify for advanced life support reimbursement under federal guidelines.

RECOMMENDATION #34:

A. Explore ongoing methods of EMS funding/support.

Alternative sources of funding beyond third party reimbursement should continue to be explored. Other sources of revenue, such as casino revenue, State lottery funds, and additional taxes, should be evaluated. In addition, consideration must be given to the necessary legislation required to provide for additional funding for EMS.

B. Explore reimbursement methods for BLS services.

Basic Life Support (BLS) services must continue to be made available in all areas of the State of New Jersey. BLS services are being provided by proprietary and municipal ambulance providers in areas of the state that are not covered by volunteer squads. There is a concern about the adequacy of the payment rates and insurance coverage for BLS services being rendered by proprietary and municipal providers. Inadequate insurance reimbursement could hinder future access to this service for all New Jersey residents. Therefore, the issue of BLS reimbursement may need to be explored further if access is threatened.

C. Explore reimbursement methods for uncompensated care for MICU.

In order to continue to provide MICU services to all New Jersey citizens, charity care reimbursement must be provided.

Alternatives for Reimbursement for MICU Charity Care

1. Alternative Source of Funding - This would include having charity care reimbursed from alternate sources, such as State taxes, casino revenue, lottery revenue, or general treasury funds. This method would maintain reimbursement outside of the Chapter 83 hospital reimbursement system. This approach satisfies the concerns raised by the finance sub-committee members.

2. Department of Health Proposal - This approach would limit the MICU provider to a reasonable rate for charity care runs. This method would utilize the uncompensated care trust fund for charity care. However, MICU services would be outside of the Chapter 83 hospital reimbursement system.

3. Department of Health Regulate MICU Services - This approach would require the Department of Health to monitor MICU costs and charges for all of the MICU providers. The MICU costs would be included under the Chapter 83 reimbursement system. This would also include reimbursement for MICU Charity Care and Bad Debt.

Summary

Alternative 1 is the only method in which general consensus was reached by the members of the committee. The New Jersey Hospital Association would support alternatives 1 and 2. Federal regulations preclude Medicare and Medicaid participation in alternative 2 or 3. Blue Cross finds that alternative 2 is inconsistant with the Chapter 83 regulations. However, they would support alternatives 1 and 3.

SYSTEM DEVELOPMENT

Primary Objective - To maintain an on-going EMS advisory group to succeed the Governor's Council on EMS.

In accordance with Executive Order #146, the term of the Governor's Council on Emergency Medical Services will expire December 30, 1988. In order to encourage and promote continuous, positive dialogue among all providers of EMS care at all levels of the State, an advisory committee should be established that will be:

1) advisory to the Commissioner of Health and
2) responsible for the coordination and implementation of a five year EMS System Plan.

RECOMMENDATIONS #35:

Establish a Statewide Advisory Council on EMS.

APPENDICES

STATE OF NEW JERSEY
EXECUTIVE DEPARTMENT

EXECUTIVE ORDER NO. 146

WHEREAS, major initiatives relating to drunk driving, mandatory seat belt usage, improved highways, increased law enforcement, and a continual upgrading of the acute care network, have resulted in a reduction in fatal accidents in New Jersey; and

WHEREAS, the recent initiation of helicopter services to bring persons more quickly to life saving procedures is a significant addition to the State's emergency medical services programs; and

WHEREAS, it is our intention to use these beginnings and to build in New Jersey the most comprehensive network of emergency medical services for persons with emergency needs;

NOW, THEREFORE, I, THOMAS H. KEAN, Governor of the State of New Jersey, by virtue of the authority vested in me by the Constitution and by the Statutes of the State, do hereby ORDER AND DIRECT:

A. There is hereby created a Governor's Council on Emergency Medical Services, hereafter referred to as the Council.

B. The Council shall consist of 33 members to be appointed by the Governor:

1. The Commissioner of Health, who shall also serve as Co-Chairperson of the Council;
2. The Superintendent of the State Police, Department of Law and Public Safety, who shall also serve as Co-Chairperson of the Council;
3. The Attorney General, or his designated representative;
4. The Commissioner of Human Services, or his designated representative from the Division of Medical Assistance;
5. The Deputy Commissioners of Health;
6. The Director of the Office of Emergency Health Services, Department of Health;
7. A representative from the New Jersey State Police, Aviation Bureau;
8. A representative from the Office of Highway Safety, Department of Law and Public Safety;

9. The Chairperson of the Mobile Intensive Care Advisory Committee;
10. Four members of the Legislature, two Senators, one of each political party, and two Assembly persons, one of each political party, appointed by the Governor upon the recommendation of the President of the Senate and the Speaker of the General Assembly;
11. The President of the New Jersey State First Aid Council;
12. The President of the New Jersey Medical Transportation Association;
13. One representative from the New Jersey Hospital Association;
14. The Chairperson of the Emergency Medical Services Committee, Medical Society of New Jersey;
15. One representative from the American College of Emergency Physicians (New Jersey Chapter);
16. One representative from the National Disaster Medical System;
17. The Chairperson of the New Jersey Chapter, American Heart Association;
18. One representative from each of the designated New Jersey Trauma Centers;
19. One representative from the designated New Jersey Burn Center;
20. One representative from the designated New Jersey Spinal Cord Center;
21. A physician specialist from a related service;
22. A New Jersey certified Emergency Medical Technician;
23. A New Jersey certified Paramedic;
24. One public member;
25. One representative from the New Jersey Emergency Nurses Association;
26. The Medical Director of the New Jersey Poison Information and Education System;
27. The New Jersey representative of the Health Care Financing Administration;
28. One representative of the private insurance industry.

C. All members shall serve, without compensation, at the pleasure of the Governor. Council vacancies shall be filled by the Governor as necessary.

D. The Council shall be charged with the following responsibilities:

1. Recommend an overall policy direction for a comprehensive, coordinated, statewide emergency medical services system in New Jersey, including issues such as financing, training, communications, staffing and management, and administration;

2. Utilize consultants with national expertise to look for innovative and other efficient methods of providing emergency care;

E. The Council shall convene as soon hereafter as is practicable. The Council shall submit to the Governor a State Plan on Emergency Medical Services that will make maximum utilization of existing resources and will ensure the coordination of the state volunteer/private sector efforts. This State Plan shall be submitted to the Governor no later than November 30, 1988 and the Council shall terminate 30 days thereafter.

F. Resources for the staffing of this Council shall be the responsibility of the Department of Health and the Department of Law and Public Safety, Division of State Police. The Department of Health shall provide the Executive Secretary for the Council.

G. This ORDER shall take effect immediately.

GIVEN, under my hand and seal
this 5th day of September
in the year of Our Lord
one thousand nine hundred
and eighty-six, and of the
Independence of the United
States, the two hundred and
eleventh.

/s/ Thomas H. Kean

GOVERNOR

[seal]

Attest:

/s/ Michael R. Cole

Chief Counsel

Governor's Council on Emergency Medical Services

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2. **Training**

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Facilitator

NJ Dept. of the Public Advocate
Center for Public Dispute Resolution

Thomas A. Fee, Esq.
Staff Attorney/Mediator

This entire issue has many sub-issues and a variety of interested parties, each with concerns and interests specific to their organizations and constituencies. To help facilitate the Council's work and to encourage collaborative problem solving, the State Department of Health and the New Jersey State Police sought assistance from the Center for Public Dispute Resolution of the Public Advocate's Office. The Center's representatives have been involved as third-party neutrals who have guided the process of the Council since its inception. The Council's final report to the Governor is a result of reasoned thought, a collaborative process and consensus.

The Governor's Council, Colonel Pagano, and Dr. Coye wish to express their sincere appreciation to Commissioner Alfred A. Slocum and Thomas Fee.

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AGREEMENTS IN PRINCIPLE

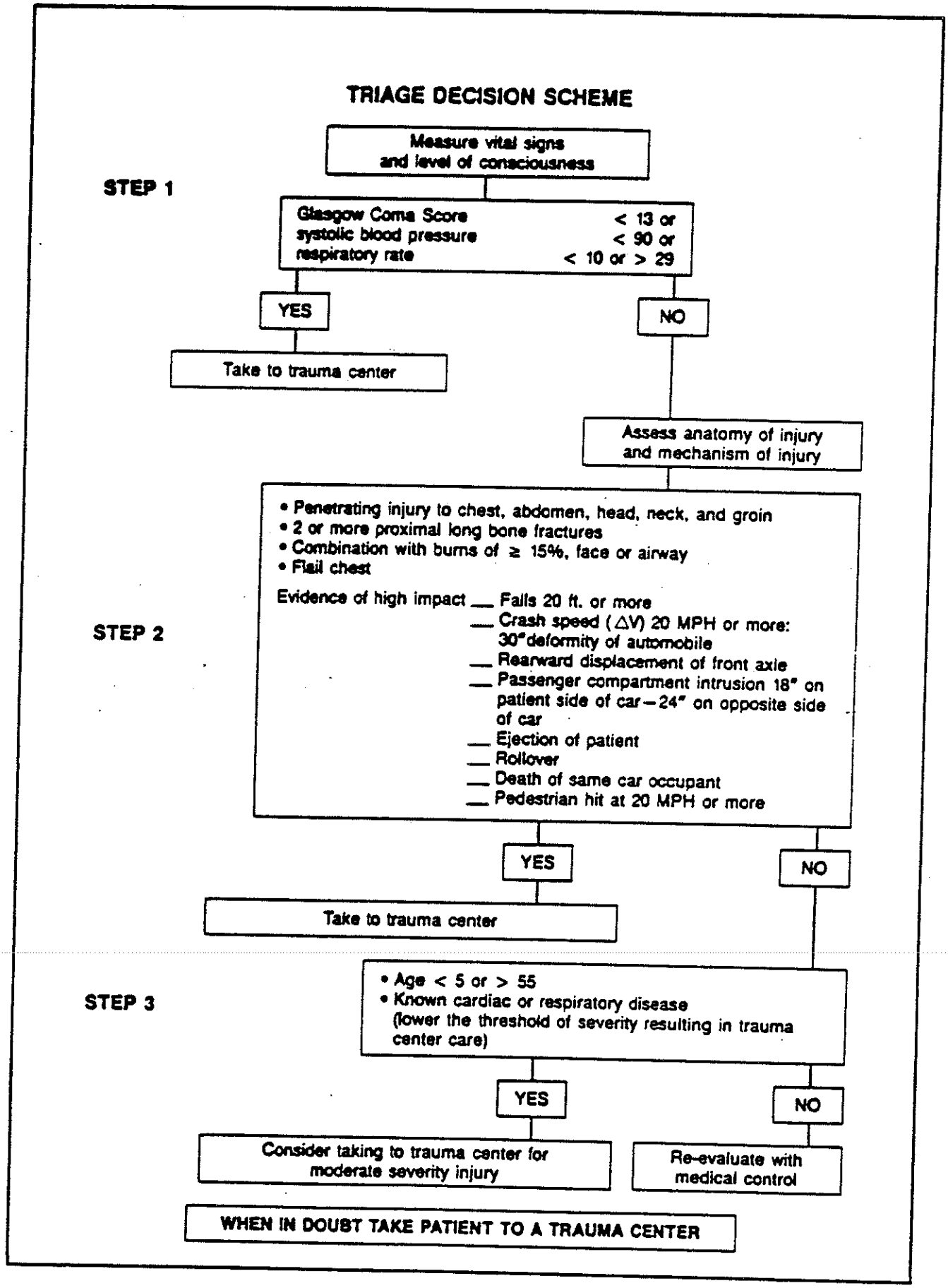
The Council investigated the issues surrounding reimbursement of MICU/ALS runs, as defined by the Health Care Financing Administration. One of the goals of the Governor's Emergency Medical Services Council is to establish a reimbursement mechanism that can be implemented with the least disruption of the current New Jersey Emergency Medical Services system.

The New Jersey State First Aid Council, the New Jersey Department of Health and the Governor's Council on Emergency Medical Services agree that New Jersey has a unique system in which pre-hospital care is delivered with the heavy participation of volunteers. Preservation of this basic volunteer system is in the best interest of the citizens of New Jersey.

The current mechanism of advanced life support service transport, either by MICU or BLS, will be acceptable if agreed upon response times can be met and quality assurance standards can be maintained.

It is agreed that MICU will transport only if: (1) there is no mechanism for BLS transport within the community (not squad-by-squad), (2) response times and quality assurance standards cannot be met and maintained, or (3) the community requests it.

No system will be acceptable without a system of accountability which is universal, consistent, enforceable, well defined, agreed upon and implemented. Of primary importance, is the tracking and maintaining of quality care, not the mechanism of transport.



Committee on Trauma of the American College of Surgeons, Hospital and Prehospital Resources for Optimal Care of the Injured Patient and Appendices A through J. February 1987. p. 38. Used with the permission of the American College of Surgeons.

REPORT OF THE DIVERSION TASK FORCE

SUBMITTED TO THE NEW JERSEY STATE DEPARTMENT OF HEALTH

MAY 1988

This report identifies and addresses the following issues concerning the problem of patient diversion:

- There is a lack of a standard definition of the term diversion.
- There is a misuse/abuse of emergency departments.
- There is a lack of specific data about diversion.
- There is a lack of hospital planning and procedures in cases of bypass and diversion.
- There are procedures which hospitals should follow which might prevent or alleviate the need for declaring a bypass or diversion.
- There is a lack of effective working agreements between hospitals and the pre-hospital emergency care system.
- There is a lack of coordinated communication.
- There is a lack of trained health care providers.

The task force members reached agreement by consensus on the following recommendations:

I. There is a lack of a standard definition of the term diversion.

To correct this deficiency:

A. Standard definitions should be developed, adopted and used statewide. The recommended definitions include:

BYPASS: The Emergency Department is overwhelmed and cannot accept any additional transported patients. Bypass designation is limited to a maximum of two hours. After this period of time, it is either continued or discontinued.

DIVERSION: The hospital is unable to admit safely any additional patients requiring critical care or medical/surgical care. This designation consists of 3 categories:

Total Care Divert (ICU) - no admitting beds
Critical Care Divert (ICU), (CCU)
Medical/Surgical Divert (M/S)

Diversion implies that a hospital can treat and release patients.

B. Terms such as "closed" should not be used. Patients should not be turned away at the door of the emergency department.

II. There is misuse/abuse of emergency departments by medical practitioners.

Common practices which dilute the efforts of emergency department resources from their primary purpose during a period of diversion include:

Critically ill patients arriving at the emergency department: Patients on occasion are instructed by their physicians to drive themselves or have untrained family members drive them to the emergency room. The practitioner knows that the hospital is on divert status, yet he also realizes that the emergency department staff will accept that patient and admit them. This practice frustrates the attempts of the emergency department personnel to properly treat and stabilize this critically ill patient as there is a lack of functional beds, equipment, or personnel.

Noncritical patients arriving at the emergency department: Frequently, individuals having no primary care provider or unable to reach their primary care provider seek care at the emergency department. These individuals take time and effort away from critically ill patients needing specialized services.

Nursing home residents transported to the emergency department: Frequently, nursing homes unable to provide definitive, on-site medical care, send their residents to emergency departments for evaluation.

To correct this misuse/abuse:

A. Primary care providers and attending physicians in the community should be educated with regard to the problem of diversion and be requested to cooperate and participate in the planning of solutions. This educational process can be developed and disseminated through local medical societies, professional societies and hospital medical staff meetings. Hospitals should appoint a liaison between the hospital administration and medical staff to be responsible for professional staff involvement.

B. Physician information should include the responsibility of educating their patients on the bypass and diversion problem. Patients and physicians should be advised of the availability of pre-hospital EMS services and how to access these services in their community and region. They should be aware of the problems which may be caused by trying to circumvent normal pre-hospital EMS protocols.

C. Physicians and their medical societies should be requested to aid in a public informational campaign. Emphasis on adhering to EMS protocols will provide a higher standard of care.

D. Hospitals should develop a public informational campaign aimed at informing the public on the primary purpose of the emergency departments and the illnesses and accidents most appropriate for its use.

E. EMS systems should also develop a public information campaign designed to inform the public of the appropriate methods to access the EMS system and when to use it.

F. Hospitals should communicate with the nursing homes in their region and develop a plan for transferring nursing home patients. Nursing homes should inform and alert their nursing and medical staff of the plan and require their compliance.

G. Nursing homes should review their policies concerning types of care which are appropriate for a nursing home. These policies should include, but not be limited to, those for IVs, emergency and acute patient care.

III. There is a lack of specific data about diversion.

To correct this deficiency:

A. Hospitals should collect information to determine the scope of the problem. The information needed includes:

1. The date and time when bypass and/or diversion situations occur.

2. The length of time the bypass or diversion is in effect.

3. The number and types of patients admitted to the Emergency Department during the bypass and diversion.

4. The number of patients transferred during bypass and diversion.

5. The number of patients (estimated) who went elsewhere because of the bypass or diversion instructions to the pre-hospital EMS system.

6. The origin of the patients coming to the Emergency Department during the time in study.

B. This information should be reported to the Office of Emergency Medical Services.

IV. There is a lack of hospital planning and procedures in cases of bypass and diversion.

To correct this deficiency hospitals should:

A. Develop a policy and procedure for managing bypass and diversion, based on the standard definitions. This policy and procedure should include:

1. Identification of a person designated by the hospital to declare that the hospital is on bypass or divert.

2. The criteria within the hospital for declaring a bypass or diversion.

3. Agreements to abide by the time limits for bypass and diversion. Bypass should be limited to a maximum of two hours and should be reevaluated and renewed for an additional two hours. Diversion can be declared for a maximum of four hours. If there is a need for a longer diversion, it can be extended in four-hour intervals; however, all affected parties should receive a diversion status update every four hours.

4. The communication channels, both within the hospital and externally, to notify affected parties (including pre-hospital services) of the status of the situation.

5. A quality assurance/accountability mechanism for information collected regarding the bypass or diversion.

B. Develop a plan for handling the excess patients while waiting to go on divert.

C. Meet with other hospitals in a given geographic area to develop a system for distribution of patients during crisis periods. This plan could include:

rotation - All hospitals on divert status agree to accept one additional patient on a rotational basis.

catchment area - All hospitals on divert status shall accept patients from a specific geographical area.

patient base - All hospitals on divert status will accept patients that have been hospitalized or that have their personal physician on the staff of the divert hospital.

V. There are procedures which hospitals should follow which might prevent or alleviate the need for declaring a bypass or diversion.

To prevent or alleviate bypass and diversion, hospitals should consider:

A. Evaluating the total time patients spend in the Emergency Department and seek ways to expedite treatment. This might include finding more effective and/or efficient use of ancillary services or establishing a "fast track" room for minor emergencies.

B. Evaluating the staffing pattern of the Emergency Department and assuring that the appropriate number and type of staff are available. Care rendered to patients admitted to the hospital,

but; held in the emergency department should be at the same standard of care as is rendered to hospitalized patients in the hospital proper.

C. Developing a policy for transferring patients to the most appropriate level of care within the hospital. This should include criteria for transfer of patients from critical care areas to regular patient floors.

D. Developing a policy so that patients are discharged throughout the day, thus providing more efficient utilization of beds.

E. Developing a policy in cooperation with nursing homes so that necessary admissions and readmissions can be handled throughout the day. This policy could relieve the bed shortages in some situations.

F. Encouraging discharge planning, including utilization of hospice and home health care services, when appropriate.

G. Evaluate the ongoing hospital patient census and diagnosis, to determine if there is a need to increase/decrease the number of critical care beds.

VI. There is a lack of effective working agreements between hospitals and the pre-hospital emergency care system.

To correct this situation:

A. Hospitals should meet with pre-hospital emergency medical services which operate in the hospital's geographic area to agree on patterns of transport in order to assure expeditious patient movement.

B. Once these agreements are reached, other agencies involved should be informed of these agreements. The parties to be notified should include:

local police
existing dispatch centers
local practitioners
sending institutions (e.g., nursing homes)
others

C. Mutual aid agreements should be reexamined and strengthened. Provisions for mutual aid should be agreed in the event the pre-hospital emergency care system is involved in bypass and diversion.

D. Pre-hospital providers should always communicate with the receiving hospitals (generally by radio) prior to arrival with a patient.

VII. There is a lack of coordinated communication.

Because of the multiplicity of municipal dispatch centers and localized communication, there is a lack of coordinated communication between patients, the pre-hospital EMS system and hospitals.

To correct this deficiency:

A. Encourage establishment of enhanced 911.

B. Encourage establishment of regional communication systems for coordination, dispatching and tracking of all levels of hospital EMS.

C. Develop a mechanism for hospitals to advise dispatch centers of the Emergency Department and in-hospital bed availability status so that this information can be passed on to the pre-hospital transport personnel as early possible.

D. Encourage pre-hospital health care providers to access bed status information daily.

E. Encourage the use of radio communication between the ambulance and the hospital at the earliest possible convenience.

VIII. There is a lack of trained health care providers:

The nursing shortages adversely effect the diversion problem as hospitals at times have beds and do not have nurses to staff these units. The EMT shortages adversely affect the diversion problem. Pre-hospital transporters often overload the nearest hospital due to lack of personnel. Ambulances that are short staffed do not want to leave the immediate area. This practice often prevents patients from being transported to other hospitals, a little more distant, that have the capability to admit and treat the patient appropriately.

To correct this deficiency:

A. Encourage a statewide program to entice students into the profession of nursing.

B. Encourage a statewide program to appeal to citizens to train as EMTs and join volunteer squads.

C. Encourage municipalities to explore having proprietary ambulance services in areas where the volunteer squads cannot provide 24 hour service.

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EMERGENCY MEDICAL SERVICES (EMS) GLOSSARY

Advanced Life Suport (ALS) Services - Implementation of the Fifteen Components (see below) of an EMS system to a level of capability which provides both non-invasive (basic life support) and invasive (intravenous lines, drug therapy, etc.) emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Vehicles are staffed by Mobile Intensive Care Paramedics (MICPs) and/or Mobile Intensive Care Nurses (MICNs), providing on-site, prehospital mobile intensive care under medical direction via two-way voice and/or telemetry. Examples of ALS care include care at the basic life support level plus administration of selected medications, drugs and solutions, intravenous therapy, cardiac defibrillation, and use of specialized techniques, procedures and equipment.

Basic Life Support (BLS) Services - Implementation of the 15 components of an EMS system to a level of capability which provides prehospital non-invasive emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Examples of BLS care include identifying patients with possible illness or injury and assessing those problems, controlling bleeding, bandaging wounds, splinting fractures, administering oxygen, giving cardio-pulmonary resuscitation (CPR), administering basic poisoning antidotes (e.g., Syrup of Ipecac), and maintaining an open airway.

Cardiopulmonary Resuscitation (CPR) - A combined, coordinated effort to artificially restore or maintain normal respiration and circulation functions (from "cardio" (heart) and "pulmonary" (lungs)).

Critical Care Divert - The hospital is unable to admit cardiac patients or severely injured patients to its critical care units.

Critical Care Units (Centers) - Sophisticated treatment facilities in large medical centers and hospitals that provide advanced definitive care for the most critically ill and injured patients. The units are available for the diagnosis and care of specific patient problems, including major trauma, critical burns, spinal cord injuries, poisoning, acute cardiac problems, high risk infant care, and behavioral emergencies.

Divert Status - The hospital is unable to admit safely any additional patients requiring critical care or medical/surgical care. The designation consists of three categories: total care divert, critical care divert, and medical/surgical divert. Diversion implies that a hospital can treat and release patients; terms such as "closed" should not be used.

Emergency Medical Services (EMS) - Services utilized in responding to an individual's perceived need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury.

EMS Personnel - Key individual EMS providers. This includes physicians, emergency and critical care nurses, Emergency Medical Technicians, Paramedics, EMT-Intermediates, other volunteer rescue squad personnel, central dispatchers, telephonic screeners, first responders (police, fire), project administrators, medical directors, medical consultants, and system coordinators.

EMS System - A system which provides for the arrangement of personnel, facilities, and equipment for the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions (occurring as a result of the patient's condition or because of natural or manmade disasters).

EMS System Coordination - Ensuring the system's integration from the point of the first responder's identification of the emergency through communications coordination, transportation (primary and secondary), the hospital, and critical care facilities and/or links to rehabilitation centers (if needed).

Emergency Medical Technician-Ambulance (EMT-A or EMT) - A person trained in emergency medical care in accordance with national standards (i.e. basic 110-hour course). The EMT provides emergency medical services at the basic life support level.

Emergency Medical Technician - Defibrillator (EMT-D) - An emergency medical technican who has been certified to perform cardiac defibrillation, according to rules and regulations adopted by the Commissioner of Health. Legislation is pending to create this level of prehospital emergency medical care provider in New Jersey. (Note--A defibrillator is a device whch counteracts uncoordinated contractions within the heart muscle by applying electrical impulses to the heart).

Emergency Medical Technician-Intermediate (EMT-I) - An EMT who has received additional training in specific advanced life support techniques in an approved training program accredited by the Commissioner of Health. Once certified by the Department of Health, the EMT-I is qualified to render limited services (e.g., cardiac defibrillation, administration of selected intravenous fluids for fluid replacement) which are generally considered to be advanced life support, in addition to providing care at the basic life support level.

Fifteen Components - Necessary elements to properly operate an EMS system. These include: adequate manpower, appropriate training, communications, transportation, facilities, critical care units, interfaces with public safety agencies (e.g., fire and police), consumer participation, access to care, patient transfer, coordinated patient recordkeeping, public information and education, review and evaluation, disaster planning and mutual aid.

Five Point Training Program - Training program for basic life support personnel provided by the New Jersey State First Aid Council consisting of modules relating to various skills. Additional modules were developed which, when added to the program, resulted in the program being named the Eight Point Training Program.

Health Care Financing Administration (HCFA) - The Health Care Financing Administration (HCFA) is the Federal agency which regulates Federal expenditures for Medicare and Medicaid. Located within the US Department of Health and Human Services, the agency has the authority to permit waiver of certain payment regulations for the purpose of demonstrating innovative approaches to the delivery of health services.

Health Care Administration Board (HCAB) - The body which has responsibility for approving final promulgation of all New Jersey State Department of Health regulations in the areas encompassed by the New Jersey Health Care Facilities Planning Act of 1971. It is the appeals board for the certificate of need process.

Medical Control Center - The base station in the hospital where the physician receives radio and telemetry communications from the EMS personnel. The physician in turn provides medical direction.

Medical Direction - Directions and advice provided by physicians from a centrally designated medical facility which is staffed by appropriately trained EMS personnel who utilize regional treatment and triage protocols. Facility staff supply professional support through radio and/or telephone communication for on-site and intransit BLS and ALS services given by field personnel.

Medical Directors - Physicians employed at regional, area or local levels to direct and to administer the medical portion of EMS programs.

Medical/Surgical Divert - The hospital is unable to admit patients to its medical/surgical units.

Mobile Intensive Care Paramedic (MICP) or Paramedic - Persons trained in advanced life support care in accordance with national standards and certified by the Commissioner of the New Jersey State Department of Health. The New Jersey paramedic training program requires 200 classroom hours and 400 clinical and field hours (combined) of training beyond the EMT level.

New Jersey State First Aid Council - An organization of volunteer ambulance first aid squads whose purpose is to enunciate policy directions and provide support for squads, such as training for personnel, dissemination of information, and advocacy.

Non-affiliated Provider - Any volunteer first aid or rescue squad which is not a member of the New Jersey State First Aid Council.

Paramedic - See Mobile Intensive Care Paramedic.

State of New Jersey Emergency Medical Communications Plan (JEMS Plan): - A coordinated communications plan, endorsed by major agencies and organizations within the state, to assure well-planned and integrated emergency medical services communications systems for access to all components in the most effective way possible.

Telemetry - Specialized electronic communication which transmits an electrocardiogram from the location of the patient to the medical control center in the hospital.

Transfer Agreements - Formal arrangements between hospitals and physicians concerning acceptance and procedures for interhospital transfer of critical patients. Included in these agreements are such things as prior physician consultation, treatment protocols, transportation arrangements and equipment, health professionals who will accompany the patient, and necessary records.

Transfer Protocols - Prearranged regionwide plans for transferring specific critical patients to appropriate, designated treatment facilities.

Trauma Center - Specialized critical care service with resources to treat victims of serious injury. These are categorized from Level I (highest) to Level III (lowest).

Treatment Protocols - Written uniform treatment and care plans for emergency and critical patients. These treatment plans must be approved and signed by appropriate physicians and/or medical groups.

Triage Protocols - Regionwide plans for identifying, selecting and transporting specific critical patients to appropriate, designated treatment facilities.