



DEPARTMENT OF THE NAVY
BUREAU OF MEDICINE AND SURGERY
7700 ARLINGTON BOULEVARD
FALLS CHURCH, VA 22042

IN REPLY REFER TO
BUMEDINST 6320.80A
BUMED-M3
4 May 2016

BUMED INSTRUCTION 6320.80A

From: Chief, Bureau of Medicine and Surgery

Subj: EMERGENCY MEDICINE CARE GUIDELINES

Ref: (a) BUMEDINST 6010.30
(b) BUMEDINST 6550.10B
(c) MANMED Chapter 9, Section III
(d) Emergency Medical Treatment and Active Labor Act (EMTALA)
(e) MANMED Chapter 16
(f) SECNAV M-5210.1 of January 2012
(g) BUMEDINST 6010.17B
(h) American College of Emergency Physicians Policy Statement on Emergency Department Planning and Resource Guidelines, April 2014
(i) BUMEDINST 1500.15E

Encl: (1) Navy Medical Treatment Facilities with Emergency Departments
(2) Training Requirements for Emergency Department Personnel

1. Purpose. To issue guidance concerning organization, staffing, professional qualifications of personnel assigned, and triage procedures mandated for the safe and efficient operation of emergency departments (EDs); to complement the requirements for health care providers in references (a) through (i); and to detail accepted procedures for documenting emergency care and treatment given to patients at naval medical treatment facilities (MTF). This is a complete revision and should be read in its entirety.

2. Cancellation. BUMEDINST 6320.80 and S/N 0510-LD-057-1030.

3. Applicability. Applies only to MTFs with an ED. All other MTFs must meet Joint Commission standards for acute and urgent care.

4. Records. MTFs are encouraged to use electronic, dictated, or template-based documentation systems for ED care that include, at a minimum, the information required by reference (e). Records must be maintained per reference (f), Part III, Chapter 6.

5. Policy. Beneficiaries must have access to emergency medical care. MTFs must have the capability to determine if an emergency medical condition exists and have procedures in place to either provide emergency medical care or arrange expeditious transport (per applicable laws and community standards) to the nearest appropriate ED.

6. ED Capability

a. For Continental United States (CONUS) MTFs, an ED offers comprehensive emergency care 24 hours per day with at least one emergency physician on duty in the emergency care area. Specialty coverage by members of the medical staff or by senior-level residents for medical, surgical, orthopedic, obstetrical, gynecological, pediatric, and anesthesiology services will be available within 60 minutes. MTFs that qualify as ST segment elevation myocardial infarction (STEMI) receiving centers will also have cardiology available within 60 minutes. Coverage will either be in-house, or by telephone or pager according to the individual MTF medical staff bylaws. For an MTF to have an ED, the hospital must have the capability to manage a variety of acute medical conditions and have on staff a privileged mental health provider for the evaluation of psychiatric disorders. This capability will include intensive care capability or the ability to stabilize and prepare for transport. For patients who exceed the hospital's ability to definitively care for them after stabilization and resuscitation to the best of the facility's capability, expeditious transfer to an appropriate facility will be accomplished per reference (d) and applicable laws. Reference (d) is available at: www.cms.gov/emtala/.

b. For outside Continental United States (OCONUS) MTFs, EDs may be staffed by physicians from alternate specialties, such as a sole family medicine provider, or a combination of internal medicine for adult patients and pediatrics for pediatric patients. The medical director/senior medical officer of these EDs should be a board-certified or board-eligible emergency medicine provider.

c. The MTF commanding officer (CO), with the assistance of the emergency medicine (EM) specialty leader, must inform the Chief, Bureau of Medicine and Surgery (BUMED) about the emergency care capabilities (or lack thereof) of each MTF as defined in this instruction. Each MTF must be responsive to the health care needs of the population served. MTFs without a designated ED must provide alternative methods of meeting emergency medical requirements. Such arrangements may include establishing an urgent care center that will provide for initial first aid and transportation or referral of patients to other facilities with an ED. Enclosure (1) is a list of MTFs that contain an ED. Requests to change ED status must be submitted to Chief, BUMED at least 60 days prior to the anticipated change.

d. An MTF without an ED as defined above cannot use the word "emergency" when advertising its medical and health care services. Information that emergency medical care is not available at the MTF and that alternatives are available for emergency care must be widely disseminated to the beneficiaries served by the MTF. Signs indicating an emergency care area or emergency care capabilities may only be displayed at an MTF that operates an ED.

e. EDs should be sufficiently designed and equipped to effectively treat the wide range of medical conditions encompassed by the scope of emergency medicine, per reference (h).

7. Organization of the ED

a. The ED department head (DH) must be designated in writing by the CO. The ED DH must direct the care provided in the ED per reference (h). The ED DH must:

(1) Possess competence in management and administration of the clinical services in the ED.

(2) Be knowledgeable about emergency medical services (EMS) operations and the regional EMS network.

(3) Be responsible for assessing and making recommendations to the MTF's credentialing body related to qualifications of emergency physicians.

(4) Ensure that the ED staff is adequately qualified and appropriately educated.

b. The DH may serve as the ED medical director. Alternatively, the ED medical director may be a physician appointed by the ED DH. The ED medical director must:

(1) Be certified by the American Board of Emergency Medicine (ABEM), the American Osteopathic Board of Emergency Medicine (AOBEM), or possess comparable qualifications as established through the privilege delineation policy.

(2) Be responsible for mentoring and guiding providers within the ED.

(3) Advise the ED DH on recommended training for ED providers.

8. Staffing

a. The ED must have a permanently assigned staff. The staff must include an adequate number of physicians, registered nurses (RNs), hospital corpsmen, and support staff qualified to manage all types and volumes of patients, as described in reference (h). Other personnel such as physician assistants (PAs), nurse practitioners (NPs), and independent duty corpsmen (IDCs) may also be assigned. Medical clerks should be assigned to handle both ED administrative tasks that directly affect patient care (order entry, result retrieval, managing patient data) and for standard ED administrative tasks common to all hospital departments. Manning levels for each ED are recommended to be coordinated with both the specialty leader for emergency medicine and for emergency nursing per current standards of care. COs are encouraged to work closely with the specialty leaders to accommodate additional training and operational requirements. It is expected that in many MTFs the emergency clinicians (or staff) will be a mix of military and civilian staff.

b. Clinical privileges for physicians, PAs, NPs, and a scope of practice for the IDCs assigned to the ED must be compatible with the capabilities of the facility and based on demonstrated competence. The ED DH must ensure criteria stated in references (a) and (g) are used in recommending privileges be granted to ED providers.

c. Training requirements for all emergency medicine health care personnel (to include providers, nurses, corpsmen, and their civilian equivalents) are contained in enclosure (2).

d. Physician Staff

(1) Emergency physicians must be permanently and exclusively assigned to the ED unless obviated by command priorities. Physicians must possess current emergency medicine board certification by either ABEM or AOBEM or have completed an accredited emergency medicine residency program. The on-duty emergency physician must review and co-sign medical records for all patients treated in collaboration with on-duty non-emergency medicine physicians as appropriate.

(2) All interns and residents assigned to the ED must be under the direct supervision of an emergency physician.

(3) Civilian or contract physicians employed as emergency physicians must meet the same training requirements as active duty emergency physicians.

(4) Any physician assigned temporarily to clinical duties in the ED as an emergency physician must meet the same training requirements as the emergency physicians permanently assigned to that ED. Any non-emergency medicine provider assigned to the ED will practice within his or her scope of privileges only.

(5) Non-emergency physicians (e.g., general medical officers) may be assigned as emergency physician extenders, but must not work in the ED as the sole provider at CONUS facilities, and must practice under the supervision of a privileged emergency physician at all times. They must follow the same requirements for chart co-signature as listed for physician extenders in paragraph 8e(3)(c) below. It is highly recommended that patients meeting any of the criteria listed in 8e(3)(a)(1) through 8e(3)(a)(8) have active patient care supervision by the on-duty emergency physician.

(6) Staff coverage for an ED is on a 24-hour-a-day basis, 7 days a week. Facilities providing only acute care services must have a privileged provider available during all designated working hours.

e. Non Physician Staff

(1) Non-emergency medicine physician assistants (Non-EMPAs), NPs, IDCs, and other health care personnel may augment physician services in the ED, following guidance established in references (a) through (c).

(2) The non-physicians who work in the ED must have supplemental clinical privileges for specific emergency medicine skills if appropriate to their training and documented level of competence. Utilization guidelines for NPs are provided in reference (b).

(3) Non-EMPAs must successfully pass the National Commission on Certification of PAs.

(a) NPs, Non-EMPAs, and IDCs must refer patient management to the on-duty emergency physician any patient who:

- (1) Requires schedule II controlled drugs (IDC or PA without narcotic prescribing privileges).
- (2) Requests to see a physician.
- (3) Has a life-threatening condition.
- (4) Has a multi-system injury.
- (5) Has an unscheduled repeat visit for the same complaint.
- (6) Has a problem beyond the scope of their clinical privileges.
- (7) In their judgment requires emergency physician referral.
- (8) Requires transport/referral to another facility.

(b) When NPs, Non-EMPAs, or IDCs are working in the ED, the on-duty emergency physician must be immediately accessible (in the ED) for collaboration as needed.

(c) The on-duty emergency physician must review and co-sign medical records for all patients treated in collaboration as appropriate. Collaboration is defined as any active discussion of patient management or disposition. Patients in which no collaboration occurred will not require a physician co-signature of the medical record.

(4) EMPAs

(a) EMPAs must be dedicated exclusively to the ED and not available to be reassigned (pulled) to support other clinical areas unless obviated by command priorities.

(b) Reference (a) requires PAs to have a “physician collaborator,” assigned in writing by the ED DH. Consultation with the collaborating physician requires flexibility due to the nature of shift work and scheduling within the department. When an EMPA’s collaborating physician is not available during a clinical shift, the emergency physician on duty in the ED must fulfill that role.

(1) Consultation may include, but is not limited to, discussion of the case during the course of treatment or following disposition of the case.

(2) Records are not required to be counter-signed prior to discharging the patient from the ED.

(c) The EMPA must ensure timely collaboration with the on-duty emergency physician for any patient who:

(1) Requests to see a physician;

(2) Has a condition beyond the scope of their clinical privileges or clinical judgment; and/or

(3) Requires transport/referral to another facility.

Note: Patients meeting the above categories require a separate physician medical note, physician addendum to the PA record, or (at a minimum) medical note/record co-signature by the physician.

(d) An EMPA must carry both emergency medicine and primary care privileges as per reference (a).

(e) A senior EMPA may be assigned by the ED DH or his or her designee to supervise and mentor the other EMPAs as well as non-EMPAs to ensure continuity of care across the specialty; the PA specialty leader may be consulted as necessary. Topics may include but are not limited to:

(1) Standards of practice.

(2) Clinical and administrative responsibilities.

(3) Special qualifications.

(4) Limitations in scope of practice.

(f) Civilian or contract EMPAs must meet the same training requirements as active duty EMPAs.

(g) Any EMPA assigned temporarily to clinical duties in the ED must meet the same training requirements as the EMPAs permanently assigned to that ED.

(h) The on-duty emergency physician must review and co-sign medical records for all patients treated in collaboration as appropriate. Collaboration is defined as any active discussion of patient management or disposition. Cases in which no collaboration occurred will not require a physician co-signature of the medical record.

(5) RN Staff

(a) Permanently assigned RNs are required in EDs, and at least 25 percent of the active duty nursing staff assigned to the ED should hold a 1945S emergency nursing subspecialty code.

(b) The RN responsible for the direct supervision of emergency nursing care for the ED must meet at least one of the following criteria: (1) have a master's degree in either emergency trauma nursing or critical care nursing; (2) be a certified emergency nurse and/or; (3) have a minimum of 2 years of emergency nursing experience and possess a nursing subspecialty code of 1945S.

(c) It is strongly recommended that RNs assigned to the ED obtain moderate sedation certification within 6 months of their initial assignment.

(d) It is recommended that civilian or contract nurses employed as ED nurses must meet the same training requirements as active duty ED nurses, as allowable by current contract.

(6) Hospital Corpsmen/Nursing Support Staff

(a) It is recommended that all hospital corpsmen have 1 year of patient care experience elsewhere in a hospital prior to assignment in the ED. This experience will have ideally been obtained in an intensive care unit, critical care, or inpatient setting. In addition, it is strongly recommended that hospital corpsmen successfully complete one or all of the following courses: Pre-hospital Trauma Life Support, Advanced Trauma Life Support (ATLS), Tactical Combat Casual Care (TCCC), and/or Advanced Cardiac Life Support (ACLS).

(b) General duty hospital corpsmen, E-5 or below, identified to be working in the ED and ordered to OCONUS locations that do not have an approved emergency medical training (EMT)-Basic training program must have received EMT-Basic training and will have passed the EMT-Basic certification exam before detaching their CONUS duty station.

(c) Civilian or contract ED nursing support personnel (licensed practical nurses, nurse technicians, and medical assistants) must meet the minimum equivalent training requirements for active duty hospital corpsmen.

(7) Consultants. Specialty consultants are staff physicians or senior residents who must respond within 30 minutes if in-house and 60 minutes if taking "home call," unless superseded by a specific MTF policy. Physician clinical specialty services must provide and maintain an accurate up-to-date duty roster of specialty consultants, specified by name, and posted in the ED or available electronically. An MTF with residency programs will post the on-call residents, plus the credentialed staff consultants. Specialty consultants must be available and report to the ED when requested by the medical officer on duty. A method of communication that is simple, rapid, and efficient must be maintained by the specialty consultants at all times to ensure expeditious access by the ED providers and staff.

9. Triage and Transfer Protocols

a. Any person presenting for evaluation to a MTF ED must receive a triage evaluation on arrival and subsequent medical screening examination to determine if an emergency medical

condition exists, per reference (d). The on-duty emergency physician is ultimately responsible for determining which patients are appropriate for MTF ED evaluation and treatment or require referral and/or transport to a clinic or other health care facility.

b. Patients ineligible for military health care services presenting to a MTF for emergency care must receive an appropriate medical screening examination per reference (d). If the on-duty emergency physician determines an emergency medical condition exists, and it is clinically inadvisable to transfer the patient to a non-military treatment facility, the patient must be treated and admitted to the MTF, as necessary.

c. Patients who have received a medical screening examination and are appropriate for discharge from the MTF ED may be referred back to their primary care provider or suitable clinic for care. Medical screening examinations must conform to reference (d).

d. Each MTF will maintain an emergency referral policy to ensure timely and safe disengagement and transport of all patients to a definitive treatment facility when appropriate. The policy must establish responsibility for the patient during transfer and set forth procedures for conveying patient care information as outlined in reference (d). The patient must be transferred only on the order of the physician and only after the consent of a receiving hospital and accepting physician. Patients who cannot be admitted to the MTF must be disengaged to a non-military medical facility per reference (d) and current BUMED medical care eligibility guidance. The MTF CO will provide proper resources to assist the ED in identifying accepting physicians and hospitals. It is recommended that bed management personnel or an established transfer center be utilized for this process when available. All transfers must comply with the Federal statute governing transfer of patients to other health care facilities, as well as applicable State statutes.

10. ED Policies and Procedures

a. Written diagnostic, treatment, and administrative protocols must provide basic guidelines for diagnosing and treating medical emergencies. Each ED DH must adopt protocols as deemed necessary in their MTF to reflect the standards of practice. Protocols must be concise and convey the essential diagnostic and therapeutic measures to be rendered quickly by emergency medical providers. Protocols are intended as aids in preventing errors of omission, particularly when treating infrequent or high-risk conditions. All Navy EDs will adhere to clinical protocols developed and disseminated by the Specialty Leader/Emergency Medicine Working Group for Navy-wide use, as these protocols represent the current evidence-based standard of care. Local resource limitations may require modification of these protocols which can be discussed with, and approved by, the EM specialty leader.

b. Individual DHs are encouraged to develop clinical pathways in conjunction with their consultants as appropriate for their institutions.

11. Quality Assessment and Improvement (QA&I). To ensure optimal patient care, an ED QA&I program must be formally maintained and focus on objective measurements of ED

efficiency, patient safety, and quality of care provided, as dictated by local instructions and directives. The EM community has adopted an official dashboard with consistent/standardized metrics based on industry-based key performance indicators. ED's having access to this dashboard should actively use this tool as the foundation of their QA&I program. In addition, a mechanism for patient feedback, per local hospital policy, must be integrated into this process.

12. Education. All personnel assigned to the ED must be prepared adequately for the responsibilities of patient care. Each ED must establish a written orientation program to inform assigned ED staff of policies, procedures, equipment, and patient care responsibilities related to each individual's level of participation in providing emergency care.

13. Emergency Medical Services. EDs must be involved in the integrated pre-hospital emergency care system in their area. The emergency physicians may, by protocol and/or memorandum of understanding/agreement, be the medical control for the emergency medical system, have oversight functions, or operate the emergency medical system.

14. Action

a. COs of MTFs must:

(1) Commit the necessary resources, including manpower, funds, and equipment to ensure that required emergency medical care as outlined in this instruction is available.

(2) To the extent possible, integrate health care resources with local, State, and other Federal health care facilities so unnecessary duplication of emergency services may be prevented.

(3) Ensure that personnel assigned to the ED are sufficient in number and professionally competent through demonstrated skills and knowledge.

(4) Ensure support services and backup personnel are readily available.

(5) Ensure adequate education and training opportunities to meet recertification and registration requirements. Mandate personnel participate in these programs.

(6) Maintain ongoing public information programs to keep local commands and beneficiaries aware of the availability and alternative sources of emergency health care by utilizing all appropriate modes of communication (to include but not limited to: staff meetings, health care consumer councils, spouse club presentations, newsletters, welcome-aboard packages, and orientation programs on base radio and television stations).

(7) Be responsible for all military emergency medical care including ambulance services under command jurisdiction. Maintain liaison with emergency medical systems providing pre-hospital care for enrolled populations and eligible patients.

(8) Provide regular reports of compliance with this instruction to regional commanders.

b. Navy Medicine Regional Commanders will:

(1) Monitor MTF compliance with this instruction.

(2) Ensure that the required emergency services are maintained.

15. Records. Records created as a result of this instruction, regardless of media and format, must be managed per SECNAV M-5210.1 of January 2012.

16. Reports. The reports required in paragraph 14a(8) are exempt from reports control per SECNAV M-5214.1 of December 2005, part IV, paragraph 7k.



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NAVY MEDICAL TREATMENT FACILITIES WITH EMERGENCY DEPARTMENTS

Navy Medicine East

Naval Medical Center Portsmouth
Naval Hospital Camp Lejeune
Naval Hospital Jacksonville
U.S. Naval Hospital, Naples, Italy
U.S. Naval Hospital, Sigonella, Italy
U.S. Naval Hospital, Rota, Spain
U.S. Naval Hospital, Guantanamo Bay, Cuba

Navy Medicine West

Naval Medical Center San Diego
Naval Hospital Camp Pendleton
Naval Hospital Twenty-Nine Palms
U.S. Naval Hospital Yokosuka, Japan
U.S. Naval Hospital Okinawa, Japan
U.S. Naval Hospital Guam

TRAINING REQUIREMENTS FOR EMERGENCY DEPARTMENT PERSONNEL

PROVIDER TYPE	BLS	ACLS	ATLS	PALS^Z	TNCC or ATCN
Physician	X	X	X	X	
Physician Assistant	X	X	X	X	
Nurse Practitioner	X	X		X	X*
Nurse	X	X		X	X*
Independent Duty Corpsman	X				
Corpsman or Technician	X				

* - Required only for NC Officers with 1945 (emergency medicine) and 1960 (critical care) subspecialty codes.

^Z - Neonatal Resuscitation Program (NRP) is recommended but not required for providers who take PALS.

Reference: BUMEDINST 1500.15E.