EMS Glossary

I. Governance & Leadership (The "Structure")

These roles define who is legally and operationally responsible for the service.

- **EMS Medical Director:** A board-certified physician who provides the "delegated practice" authority for the agency. In the eyes of the law, every medical act performed by a responder is an extension of this doctor's license. Without a Medical Director, an agency cannot legally treat patients.
    - **Standing Orders (Protocols):**
        - **The Definition:** Written instructions signed by the Medical Director that allow EMTs and Paramedics to perform specific medical acts (like giving medication) without calling a doctor first.
        - **Policy Note**: These orders define the "Standard of Care" for your community.
- **Agency Director (Chief / Manager):** The executive leader responsible for the day-to-day operations, budgeting, staffing, and compliance of the EMS service. They bridge the gap between clinical needs and fiscal reality.
- **Agency Board (Board of Directors / Commissioners):** The governing body that oversees the agency's long-term strategy, approves major expenditures, and sets high-level policy. They are the ultimate "fiduciary" authority, ensuring the agency remains solvent and serves the public interest.

II. Clinical Care Levels (The "Who")

These definitions determine the level of medical intervention your community receives.

- **EMR (Emergency Medical Responder):** The first tier of professional care. Typically used by police or fire departments to arrive in 3–5 minutes to provide life-saving basics (CPR, AED, bleeding control). **Policy Note:** They stabilize the patient but cannot transport them to a hospital.
- **EMT (Emergency Medical Technician):** The standard for **Basic Life Support (BLS)**. They provide non-invasive care and are the minimum certification required to staff an ambulance.

- **Paramedic:** The highest level of pre-hospital care, providing **Advanced Life Support (ALS)**. They perform invasive procedures (IVs, intubation, EKG interpretation) and administer potent medications. **Policy Note:** This level is more expensive to staff but is required for critical emergencies like heart attacks or trauma.

III. Staffing & Compensation

These terms define how personnel are paid and how the "seats" in the ambulance are filled.

- **Paid Staff (Career):** Full-time or part-time employees who receive an hourly wage or salary. They provide the most predictable coverage but require the highest budget for wages and benefits.
- **Paid Volunteer (Stipend):** Individuals who are not full employees but receive a flat fee (stipend) for a 12- or 24-hour shift to cover their time.
- **Pay-Per-Call Volunteer:** Responders who receive a small payment only when they physically respond to an emergency.
- **Volunteer:** Responders who work without any financial compensation. **Policy Note:** While "free," a volunteer system requires significant investment in recruitment and retention to remain reliable.
- **Roster:** The total list of personnel affiliated with the agency.
- **Schedule:** The actual hour-by-hour plan showing who is on duty. **Policy Note:** A large *roster* does not guarantee a full *schedule*.

IV. System Health & Performance (The "Results")

Use these terms to evaluate if the service is meeting the needs of the public.

- **Reliability:** The guarantee that an ambulance is available to respond **24/7/365**. A "Reliable" system ensures that when 911 is called, a unit is ready to go immediately without delay.
- **Sustainability:** The ability of the agency to maintain its performance over time with current funding and personnel. **Policy Note:** If staff are working excessive overtime to stay "reliable," the system is likely "unsustainable" and headed for a collapse.

- **Run Time:** The total time an ambulance is "tied up" with a call, from dispatch until it is cleaned, restocked, and ready for the next patient.
- **Response Time:** The minutes and seconds between the 911 dispatch and the ambulance arriving at the patient's side.
- **Mutual Aid Agreement:** A formal, legal contract between agencies to assist one another during extraordinary events (e.g., a multi-car crash or a natural disaster). It includes specific protocols for when one agency must notify the other that they have reached maximum capacity.
- **Automatic Aid:** A technology-driven dispatch protocol where the closest unit is sent across jurisdictional lines regardless of which town it "belongs" to. This is used to shave seconds off response times for critical calls.
- **Coverage Gap (The "Empty Station"):** A failure of the local system where a vehicle is physically present but cannot respond because there are no qualified personnel to staff it. This is a staffing failure, not a volume issue.
- **Mutual Aid "Leaning":** When an agency consistently utilizes a neighbor's ambulance for routine calls because its own unit is frequently "out of service" or unstaffed. This creates a hidden tax on the neighboring community's resources.

V. Operational Risk Factors

These terms represent "red flags" for policy makers.

- **Dropped/Scratched Call:** When an agency is dispatched to an emergency but has to refuse it because no staff or vehicles are available. This creates significant legal and safety liability.
- **Wall Time (Offload Delay):** Time spent by an ambulance crew waiting at a hospital for a bed to become available. During this time, the ambulance is "out of service" for your community.
- **Churn (Turnover):** The rate at which staff leave the agency. High churn increases costs due to constant retraining and background checks.

VI. Transporting vs. Non-Transporting Agencies

1. Transporting Agency (The "Ambulance Provider")

- **The Definition:** An agency licensed to provide patient care *and* transport that patient to a medical facility in a specialized vehicle (ambulance).
    - **The Model:** These agencies bear the cost of expensive vehicles, fuel, and "Wall Time" at hospitals.
    - **Fiscal Reality:** They can bill insurance (Medicare, Medicaid, Private) for the transport. In many systems, the revenue from these bills helps offset the cost of the personnel.
    - **Policy Note:** Being a transporting agency requires a higher level of logistical complexity but provides more control over the "patient's journey" and potential revenue.

2. Non-Transporting Agency (The "First Responder" or "Fly-Car")

- **The Definition:** An agency that provides on-scene medical care but **does not** have the legal authority or equipment to move the patient to the hospital. Examples include many Fire Departments and Police "First Responder" units.
    - **The Model:** They often arrive faster because they are stationed more densely in a community. Once a transporting ambulance arrives, the non-transporting crew "hands off" the patient.
    - **Fiscal Reality:** In most states, **non-transporting agencies cannot bill insurance.** They are almost entirely funded by tax dollars or subsidies.
    - **Policy Note:** These agencies are vital for **Reliability** (getting to the patient in 4 minutes), but they rely on a second agency (the transporting one) to actually finish the call.

3. Intercept (ALS Intercept)

- **The Definition:** A specific scenario where a **Non-Transporting ALS unit** (with a Paramedic) meets a **Transporting BLS ambulance** (with EMTs) on the way to the hospital.
    - **The Role:** The Paramedic jumps onto the BLS ambulance to provide advanced care for the remainder of the trip.
    - **Policy Note:** This is an efficient way to spread a few expensive Paramedics across a large rural area.