Implementation Outline of the Emergency Medical Measure Plan

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Chapter 1: Primary emergency medical care

1. Objectives
1) The holiday and nighttime (after-hours) emergency care center operation aims to secure medical treatment for
local residents by establishing emergency centers that provide medical aid on holidays and at nighttime.
2) The primary pediatric emergency center operation aims to secure medical care for pediatric patients on holidays and at nighttime by collaborating with secondary emergency medical care facilities (e.g., pediatric emergency medical assistance services), in order to accept pediatric emergency patients.

2. Availability of subsidies
1) Subsidies shall be available for the development and maintenance of holiday and nighttime emergency care center facilities run by proprietors at clinics in response to requests from local government heads.
2) Subsidies shall be available for the costs of managing primary pediatric emergency centers operated by local governments, and for the costs of managing and developing facilities and equipment for primary pediatric emergency centers run by proprietors at clinics in response to a request from local government heads.

3. Service standards
1) "Medical care on holidays" refers to medical care provided on the following indicated days (A. through D.), from 8 AM to 6 PM. "Nighttime medical care" refers to medical care provided from 6 PM of that day to 8 AM of the following day.
A. Sundays
B. Holidays stipulated by the Act on National Holidays (Act No. 178 of July 20, 1948)
C. Year-end and New Year holidays (from December 29 to January 3)
D. Saturdays or other substitute rest days accompanying the five-day working week
2) Facilities and equipment
A. Holiday and nighttime emergency care centers
Holiday and nighttime emergency care centers shall be equipped with clinical departments and medical equipment as required.
B. Primary pediatric emergency medical care centers
Primary pediatric emergency medical care centers shall be equipped with clinical departments and medical equipment as required.
3) Information related to emergency medical care shall be provided to local residents.

Chapter 2: Secondary emergency medical care involving hospitalization

1. Objectives
1) The objective of groups of hospitals on rotational duty and joint-use hospitals (hereafter "management program for groups of hospitals on rotational duty") is to enable local governments to provide secondary emergency medical facilities via the rotational duty hospital system and joint-use hospital methods in accordance with the needs of the local community. The aim is to secure medical care for critical emergency patients who require hospital treatment during holidays and at nighttime, based on a smooth system of collaboration between primary emergency medical care facilities (i.e., holiday and nighttime emergency care centers, primary pediatric emergency centers, and on-call practitioners on

rotational duty), and organizations for transporting emergency patients.
2) The objective of major pediatric emergency care centers is for prefectural governments to establish major pediatric emergency care centers in accordance with the needs of the local community, and to secure medical care for critical emergency pediatric patients who require hospital treatment on holidays and at nighttime, based on a smooth system of collaboration between primary emergency medical care facilities (i.e., holiday and nighttime emergency care centers, primary pediatric emergency centers, and on-call practitioners on rotational duty), and organizations for transporting emergency pediatric patients.
3) The objective of the program to secure attending doctors and other medical personnel for helicopter ambulances and other such vehicles is to secure attending doctors to take the necessary emergency measures as soon as possible, within the vehicle, in response to local government requests, when transferring critical emergency patients by helicopter from remote islands or mountain villages.

2. Availability of subsidies
1) Management operation for hospital groups on rotational duty
A. Regional settings
As a general rule, regional settings shall be organized according to their medical district units. However, regions that do not easily fall into medical district units shall be classified by the prefectural governor and approved by the Minister of Health, Labour and Welfare.
B. Eligible hospitals
Eligible hospitals shall be those that are maintained and run by hospital proprietors at the request of a local government or local government heads, that have the appropriate number of beds, and that offer medical treatment in the form of secondary emergency medical care facilities, namely, securing medical personnel, such as doctors, in addition to beds designated for emergency medical care.
C. Application of subsidies
Subsidies shall be provided for facility and equipment development for groups of hospitals on rotational duty, and for operation fees and facility and equipment development for joint-use hospitals.
2) Major pediatric emergency care centers
A. Regional settings
As a general rule, regional settings shall be organized according to medical district units. However, regions that do not easily fall under multiple medical district units shall be classified by the prefectural governor and approved by the Minister of Health, Labour and Welfare.
B. Eligible hospitals
Eligible hospitals shall be those that are maintained and run by hospital proprietors at the request of a prefectural government or prefectural governor, that have the appropriate number of beds, and that offer medical treatment in the form of secondary emergency medical care facilities, namely, in securing medical personnel, such as pediatricians and nurses, in addition to beds designated for emergency pediatric medical care.
3) Program for securing attending doctors for a helicopter ambulance
This program shall include local government bodies that provide a helicopter service to transport emergency patients, with doctors on board.

3. Operational policies
1) Management program for groups of hospitals on rotational duty
A. Management program for groups of hospitals on rotational duty and joint-use type hospitals

This program shall maintain a medical care system on holidays and at nighttime in accordance with the circumstances of the local community in the following manner and, as a general rule, shall accept patients transferred from primary emergency medical care facilities.
A) Rotational duty hospital system
This system shall be conducted by having hospital groups within a region share responsibilities using a rotation system.
B) Joint-use type hospital system
Under this system, Japan Medical Association (JMA) hospitals are partially open on holidays and at nighttime and operations are conducted with the cooperation of local medical associations.
2) Major pediatric emergency care centers
Major pediatric emergency care centers shall always implement a medical care system on holidays and at nighttime, offering pediatric emergency medical care and, as a general rule, always accept severe pediatric emergency patients transferred from primary emergency medical care facilities and emergency transportation organizations.
3) Program to secure attending doctors and other medical personnel for helicopter ambulances and other such vehicles
Concerning the transportation of emergency patients via helicopter, the local government shall secure doctors to board the helicopter in accordance with the following procedure. As a general rule, one doctor should board the helicopter for the transportation of one emergency patient. However, depending on the symptoms of the emergency patient, one additional member (e.g., a nurse) may accompany the doctor on board.

4. Service standards
1) Rotational duty hospital system
A. Hospitals on duty on a given day shall secure the necessary medical treatment and designated hospital beds as are required of secondary emergency medical care facilities.
B. The medical care systems in hospitals on duty shall secure medical personnel such as doctors to respond to the acceptance of critical emergency patients outside of regular duty structures.
2) Joint-use hospital system
A. Hospitals shall secure the necessary medical treatment and designated hospital beds as are required of secondary emergency medical care facilities.
B. The medical care systems in hospitals on duty shall secure medical personnel such as doctors to respond to the acceptance of critical emergency patients outside of regular duty structures.
3) Major pediatric medical care center
A. Hospitals shall secure the necessary medical treatment and designated hospital beds as are required of secondary emergency pediatric medical care facilities.
B. The medical care system in hospitals on duty shall secure medical personnel such as pediatric doctors and nurses to respond at all times to the acceptance of critical emergency pediatric patients on holidays and at nighttime.
4) Program for securing attending doctors for helicopter ambulances
Local governments shall secure infrastructure so that doctors can easily accompany patients on helicopters.
5) Facilities and equipment
A. Groups of hospitals on rotational duty and joint-use hospital management operations
A) Facilities
Hospitals shall establish the necessary treatment departments (i.e., consultation rooms, treatment rooms, operating rooms, medicine administration rooms, X-ray rooms, and

inspection rooms) and designated hospital rooms for secondary emergency medical care facilities for patients requiring hospital treatment. Furthermore, if required, hospitals shall establish coronary care units (CCU) and stroke care units (SCU) for the acceptance of critical emergency patients suffering from heart disease and stroke.
B) Equipment
Hospitals shall be equipped with the necessary medical machines to enable medical treatment as are required by secondary emergency medical care facilities. In addition, if required, hospitals shall be equipped with the specialized medical equipment necessary for the treatment of critical emergency patients suffering from heart disease or stroke. Furthermore, if required, electrocardiogram reception devices shall be installed in secondary emergency medical care facilities that are central to the region in order to accurately ascertain the status of patients being transported, and to send specific instructions to doctors during transportation.
B. Major pediatric emergency care centers
A) Facilities
Major pediatric emergency care centers shall establish the necessary pediatric treatment departments (i.e., consultation rooms, treatment rooms, operating rooms, medicine administration rooms, X-ray rooms, and inspection rooms) and designate pediatric hospital rooms as are required by a secondary emergency medical care facility.
B) Equipment
Major pediatric emergency care centers shall be equipped with the necessary medical machines as are required by a secondary emergency medical care facility.

Chapter 3: Emergency critical care centers

1. Objectives
The objective of this operation is for prefectural governments to maintain emergency critical care centers to secure medical treatment for emergency patients in a critical condition, based on a smooth system of collaboration between primary emergency medical care facilities (i.e., holiday and nighttime emergency care centers and practitioners on rotational on-call duty), secondary emergency medical facilities (i.e., hospitals on rotational duty), and organizations that transfer emergency patients.

2. Availability of subsidies
Subsidies shall be available for emergency critical care centers maintained and run by hospital proprietors at the request of prefectural governors, based on prefectural government medical care plans, and recognized by the Minister of Health, Labour and Welfare.
Note that subsidies shall also be available for the installation of hospital beds designated for pediatric emergency medical care (i.e., intensive care units designated for pediatric care) for medical institutions with pediatric hospital wards and that are capable of accepting patients transferred from a wide area.

3. Operational policies
1) As a general rule, emergency critical care centers should accept all emergency patients in critical or serious condition and patients requiring multiple specialties, 24-hours a day.
2) The emergency critical care center is a supporting hospital for primary and secondary emergency medical care facilities. As a general rule, emergency critical care centers must accept emergency patients from these medical facilities and emergency transportation institutions 24-hours a day.

3) Concerning patients who have received appropriate emergency medical care and have been determined not to have a life-threatening condition, the emergency critical care center shall actively transfer such patients to the beds of an annex hospital or to the medical institutions that originally sent the patients, always securing the necessary hospital beds.
4) The emergency critical care center shall provide clinical training on emergency medical treatment to medical students, clinical trainees, doctors, nursing students, nurses, and emergency lifesaving technicians. Furthermore, it is desirable for emergency critical care centers to actively improve the medical skills of emergency medical treatment staff by taking such measures as temporarily dispatching doctors to pediatric emergency critical care centers, as well as providing support for this purpose.

4. Service standards
1) Emergency critical care centers shall possess an appropriate number of designated beds (in general, 20 beds or more; however, if the number of beds is between 10 and 20, care centers that were established before 2007, or that were established in 2008 but reached an agreement with the Japanese government in 2007, are exempt from this requirement), which are directly managed by emergency critical care center managers. Centers shall provide advanced medical treatment functions for all critical emergency patients, encompassing serious conditions and patients requiring multiple specialties, 24-hours a day.
2) Regional emergency critical care centers (emergency critical care centers that have 10 or more, but less than 20, designated beds) may be established in regions in which it would take some time (approximately 60 minutes or more) to access the closest emergency critical care center.
3) Emergency critical care centers (including regional emergency critical care centers) shall post the necessary staff members to secure a 24-hour consultation system.
A. Doctors
A) An emergency critical care center manager must possess such specialized knowledge and tertiary emergency medical care skills as will allow her/him to appropriately handle critical emergency patients who are critically ill, encompassing serious conditions and patients requiring multiple specialties, and must be a full-time doctor who has been objectively evaluated as possessing expertise in advanced emergency medical services and emergency medical education (e.g., consultants certified by the Japanese Association for Acute Medicine).
B) The emergency critical care center shall have an appropriate number of full-time doctors who hold clinical experience of a given period or more (approximately three years) in emergency medical education under the guidance of an appropriate medical advisor, and have been objectively evaluated as having expertise in specialist tertiary emergency medical treatment (e.g., a specialist certified by the Japanese Association for Acute Medicine).
C) In order to ensure its functioning as an emergency critical care center, the center shall be structured so as to secure doctors as required, from such departments as internal medicine, surgery, cardiology, neurosurgery, cardiovascular surgery, orthopedics, pediatrics, ophthalmology, otorhinology, anesthesiology, and psychiatry.
D) Internal medicine specialists and surgeons specializing in cardiology, as well as stroke-related surgeons and internal medicine specialists, shall be secured on a full-time basis as required.
E) Emergency critical care centers that have installed designated emergency pediatric hospital beds (pediatric-specialized intensive care units) must secure pediatric doctors who can handle the intensive care treatment of pediatric patients within the emergency critical care center or at a main hospital. (In the case of the main hospital, a system must be established in which necessary assistance can be received at all times.)

F) Full-time specialized doctors that can treat severe trauma shall be secured as required.
G) The emergency critical care center must always be in possession of the instruction system necessary for emergency lifesaving technicians.
B. Nurses and other medical personnel
A) The number of full-time nurses required for nursing critical emergency patients shall be of an appropriate number. Furthermore, an emergency critical care center that has established hospital beds designated for pediatric emergency care (a pediatric-designated intensive care unit) shall secure full-time nurses that can handle intensive care for pediatric emergency patients. (It is desirable for the full-time nurse to have been objectively evaluated as having expertise in specialized tertiary emergency medical treatment; e.g., Japanese Nursing Association-certified emergency nurses)
B) Specialists such as clinical radiologists and clinical laboratory technicians must always be secured.
C) Systems must be established to mobilize the necessary personnel to allow for the performance of emergency surgery.
4) Facilities and equipment
A. Facilities
A) A suitable number of hospital beds and intensive care units (ICU) directly managed by the emergency critical care center manager shall be designated.
Furthermore, in order to accept patients suffering from severe heart disease or stroke in critical periods, severe pediatric patients, and severe trauma patients, the facility shall install a coronary care unit (CCU), stroke care unit (SCU), pediatric emergency designated beds (pediatric designated intensive care unit), and severe trauma designated hospital rooms as required.
B) Designated consultation rooms (emergency resuscitation rooms), emergency laboratory rooms, radiography rooms, and surgery rooms shall be installed as required for an emergency critical care center.
C) A helicopter pad shall be installed at an appropriate location, according to requirements.
D) The facilities necessary for medical treatment shall be in an earthquake□resistant structure (including annexed hospitals).
B. Equipment
A) The facility shall be equipped with the medical equipment and other equipment required to treat severe burn patients in an emergency critical care center. Furthermore, it shall be equipped with the designated medical equipment required to treat patients with acute severe heart disease, emergency stroke, severe pediatric conditions, and severe trauma.
B) The facility shall own a physician-staffed ground ambulance as required.
C) In order to provide the necessary instruction to emergency lifesaving technicians, facilities shall be equipped with electrocardiogram reception devices, as required.
(Note) “Physician-staffed ground ambulance” refers to an ambulance equipped with medical equipment (e.g., patient monitoring equipment) that doctors and nurses board and that is dispatched to contact an ordinary ambulance transporting the patient.

Chapter 4: Advanced emergency critical care centers

1. Objectives
The objective of this service is for prefectural governments to implement advanced emergency critical care centers and to ensure medical treatment for patients with special illnesses in a system providing smooth, collaborative emergency medical care.

2. Availability of subsidies
An emergency critical care center, maintained and operated by hospital proprietors at the request of the prefectural governor based on the prefecture's medical care plan, and recognized as possessing a particularly advanced medical treatment function by the Minister of Health, Welfare and Labour, shall be eligible for subsidies.

3. Operational policies
An advanced emergency critical care center shall accept patients with special illnesses (i.e., extensive burns, severed fingers and extremities, and acute poisoning) among those patients interned in emergency critical care centers.

4. Service standards
1) An advanced emergency critical care center shall possess relatively advanced medical treatment capabilities in order to provide critical care to patients with special illnesses (i.e., extensive burns, severed fingers and extremities, and acute poisoning).
2) The advanced emergency critical care center shall post the personnel necessary to ensure 24-hour operation.
A. Doctors
Doctors shall adhere to a system that can handle regular advanced emergency critical care medical treatment. In particular, this means having the members necessary for surgery, such as anesthetists, on standby.
B. Nurses and other medical personnel
The personnel necessary to provide medical treatment to patients with special illnesses shall always be guaranteed. In particular, schemes for mobilizing the necessary personnel for surgery shall be prepared in advance.
3) Equipment
The medical equipment necessary for an advanced emergency critical care center shall be installed.

Chapter 5: Pediatric emergency critical care centers

1. Objectives
The objective of this operation is to ensure medical treatment for critical pediatric emergency patients by having the prefectural government maintain a pediatric emergency critical center, in support of pediatric emergency critical care centers.

2. Availability of subsidies
Subsidies shall be available for pediatric emergency critical care centers that are maintained and operated by hospital proprietors at the request of a prefectural government or prefectural governor, and that the Minister for Health, Labour and Welfare has approved as being suitable.

3. Operational policies
1) As a general rule, the pediatric emergency critical care center must accept all critical pediatric emergency patients 24-hours a day, regardless of the required specialties.
2) After having provided hyper-acute medical treatment to critical pediatric emergency patients, the pediatric emergency critical care center shall secure a structure that allows transfer of patients who require specialized medical treatment to another bed within the emergency critical care center, or to a bed in the main hospital providing intensive

treatment/specialized treatment during the acute phase (hereinafter, referred to as “pediatric intensive care unit bed”).
3) The pediatric emergency critical care center shall provide clinical education regarding pediatric emergency medical services to medical students, clinical trainees, doctors, nursing students, nurses, and emergency lifesaving technicians. Furthermore, the pediatric emergency critical care center should dispatch doctors and other professionals for a certain period to emergency critical care centers and other facilities, to undergo training, in order to actively improve the medical treatment skills of those in the pediatric emergency medical service. The pediatric emergency critical care center should support this endeavor.
4) The pediatric emergency critical care center shall tabulate the acceptance records of external patients (including records in which the center declined a request to accept a patient), treatment records, and other operational statuses for each year, and report them to the Regional Medical Care Planning Division, Health Policy Bureau, the Ministry of Health, Labour and Welfare.

4. Service standards
1) The pediatric emergency critical care center shall possess an appropriate number of designated beds (6 or more pediatric intensive care unit beds, including those in the main hospital) and provide “super acute period” medical treatment to all critical pediatric emergency patients 24-hours a day, along with the provision of advanced and specialized medical care to pediatric patients who have moved on from this phase.
2) The pediatric intensive care unit shall post the necessary personnel to ensure a 24-hour medical treatment system.
A. Doctors
The pediatric intensive care unit shall always guarantee full-time doctors and medical residents. Concerning full-time doctors, this should include at least one doctor who is qualified to provide guidance in pediatric intensive treatment. This can include an intensive care medical specialist certified by the Japanese Society of Intensive Care Medicine, a pediatric medical specialist certified by the Japan Pediatric Society, or an emergency medical specialist certified by the Japanese Association for Acute Medicine.
B. Nurses and other medical personnel
A) A pediatric intensive care unit shall, at all times, secure full-time nurses as required for nursing critical pediatric emergency patients at a ratio of 1 or more nurses per 2 patients (if necessary, 1 or more nurses per 1.5 patients). Furthermore, a critical intensive care certified nurse should preferably be employed to assume a leading position.
B) In addition to always securing clinical radiologists and clinical laboratory technicians within the hospital, the pediatric intensive care unit shall secure physiotherapists and clinical engineers within the hospital.
C) A pharmacist should preferably be secured within the pediatric intensive care unit.
D) A certified social worker should preferably be secured within the hospital.
3) A pediatric intensive care unit ward shall handle approximately 300 cases of hospitalization per year, of which a considerable number shall comprise hospitalization of emergency outpatients or transfers from other hospitals.
4) The pediatric emergency critical care center shall accept an appropriate number of patients via emergency transportation (includes the main hospital).
5) Facilities and equipment
A. Facilities
A) The pediatric intensive care unit shall have 6 or more dedicated pediatric intensive care unit beds and an independent nursing unit.
B) A designated consultation room (an emergency resuscitation room), as required by a

pediatric emergency critical care center, shall be installed. A system shall be established whereby priority is given to the center in using an emergency testing room, radiology room, and surgery room.
C) A helicopter pad shall be constructed in an appropriate location as required.
D) The facilities necessary for medical treatment shall be in an earthquake-proof structure (including annexed hospital).
B. Equipment
A) Centers shall be equipped with the necessary medical equipment for pediatric emergency critical care centers.
B) Facilities shall include a physician-staffed ground ambulance as required.

Chapter 6: Physician-staffed helicopter ambulance installation promotion program

1. Objectives
Based on the effect of the Act on Special Measures concerning Securing of Emergency Medical Care Using Helicopters for Emergency Medical Care (2007 Act No. 103), this program aims to station physician-staffed helicopter ambulances at emergency critical care centers under consignment, to improve the lifesaving rate of emergency patients, to improve wide-area emergency patient transportation systems, and to promote the nationwide installation of physician-staffed helicopter ambulances.

2. Availability of subsidies
1) Subsidies shall be made available for projects that are implemented both by prefectures or wide-area unions of municipal governments as stipulated by the Local Autonomy Law (1947 Act No. 67) Article 284, Clause 3 (herein, "cross-regional federations") and by emergency critical care centers at the request of prefectural governors or cross-regional federation heads, and that have been approved by the Minister for Health, Labour and Welfare.
2) Subsidies shall be available for projects that are installed in emergency care centers and implemented within these centers by prefectural governments or cross-regional federations respectively, and that have been approved by the Minister for Health, Labour and Welfare.

3. Operational policies
1) Projects shall establish a flight coordination committee that performs such duties as raising public awareness among local residents, and negotiating with the organizations involved in flying physician-staffed helicopter ambulances. Projects shall also implement services, negotiate on necessary matters related to their operation, and ensure that physician-staffed helicopter ambulances are operable, along with striving to earn the understanding and cooperation of local residents.
2) The members of the flight coordination committee shall comprise members of prefectural governments, municipal governments, local doctors' associations, fire departments, police departments, the Ministry of Land, Infrastructure and Transport, education committees, and other related government offices, as well as of the helicopter ambulance operation companies the helicopter ambulance base hospital, and other experts. Helicopter ambulance operations shall be conducted in close cooperation with these related institutions.
3) Concerning the running of the service, the physician-staffed helicopter ambulance vehicles themselves, helicopter pilots, technicians, and flight coordination managers should be deployed through consignment contracts undertaken with the helicopter operating companies.
4) Concerning the running of the service, doctors and nurses shall be secured to accompany patients on the helicopter ambulance (when the service is on consignment from a prefectural

government to an emergency critical care center, they shall be secured from the dispatching center), and doctors (and nurses when needed) must be on board when dispatching helicopters and transporting patients.
5) As a general rule, the dispatching of helicopters and transporting of patients shall be conducted according to judgments by doctors and helicopter pilots regarding requests made by fire services, medical institutions, or those whom the flight coordination committee have recognized as needing to give such judgments in accordance with the ordinance in partial amendment of the Aviation Law (2013 Ordinance of the Ministry of Land, Infrastructure, Transport and Tourism, No. 90).
6) The range of physician-staffed helicopter ambulance dispatches shall, as a general rule, be the entire prefectural region. This range may also include other prefectures as required; agreements may be concluded with adjacent prefectures and systems built for mutual assistance and collaborative flights (assisting prefectures that are in the process of introducing or have not yet introduced a physician-staffed helicopter ambulance).
7) Efforts must be made to secure communication between the physician-staffed helicopter ambulances and emergency critical care centers or ambulance services during flights.
8) Policies will be stipulated separately regarding the selection of a helicopter operating companies to be consigned for the flying of physician-staffed helicopter ambulances, and regarding wireless operations when securing communication via wireless means.
9) Safety shall be guaranteed, particularly when conducting flights after sunset or before sunrise (hereinafter, “nighttime flights”).
10) The term “nighttime flights” does not encompass short extended flights during twilight or dusk hours.
11) Reports shall be made annually to the Regional Medical Care Planning Division, Health Policy Bureau, the Ministry of Health, Labour and Welfare regarding cases in which flights have been halted for three consecutive days or more (excluding cases due to reasons of bad weather).

4. Service standards (these standards shall also be applied to the deploying center if the service is consigned by a prefectural government to an emergency critical care center)
1) Helicopter pads shall be located in places where emergency critical care center doctors are able to board immediately. Leading routes and methods for transferring patients into the emergency critical care center must also be secured.
2) There must be sufficient knowledge of physician-staffed helicopter ambulance emergency medical care.
3) Regions in which emergency critical care centers are established are those that show adequate efficacy in accordance with the aims of the project.
4) Hospitals in which emergency critical care centers operate should possess systems of cooperation for mobilizing all possible efforts in service of the project.
5) Cooperation between emergency critical care centers and institutions such as fire services should always have been close, and established for a long time.
6) This service shall not interfere with the operation of the emergency critical care center.
7) In the event that a nighttime flight is conducted, illumination equipment shall be installed at the helicopter pad used for the takeoff and landing of the physician-staffed helicopter ambulance.

(Note:) A “physician-staffed helicopter ambulance” is a helicopter equipped with the equipment and medical supplies required for emergency medical treatment, which emergency medical specialists and nurses board to travel to an emergency site. It is a specially designated helicopter that can provide lifesaving medical treatment to patients during transportation from the emergency site to a medical institution.

Chapter 7: Project for promoting acceptance of emergency lifesaving technicians for practical training in hospitals

1. Objectives
This program aims to promote the implementation of a system that conducts practical training for emergency lifesaving measures (e.g., cardiopulmonary resuscitation), to be undertaken by emergency (ambulance) crew members that hold the qualification of "emergency lifesaving technician." By this means, this program aims to advance and improve the quality of work conducted by emergency crew members holding this qualification.

2. Availability of subsidies
Subsidies shall be available for practical hospital training acceptance promotion projects for emergency lifesaving technician conducted by hospital proprietors (excluding emergency critical care centers) at the request of prefectural governments or prefectural governors.

3. Operational policies
The hospital's practical training of emergency crew members that hold the qualification of "emergency lifesaving technician" shall conduct practical hospital training with the following content:
1) Education for emergency crew members that hold the qualification of "emergency lifesaving technician," based on the Practice and Seminar Guidelines for Conducting Drug Administration as an Emergency Lifesaving Technician (issued by the MHLW Health Policy Bureau on March 10, 2005, No. 0310002).
2) Education for emergency crew members that hold the qualification of "emergency lifesaving technician," based on the Practice and Seminar Guideline for the Maintenance of Patient's Airway Using Endotracheal Tube by an Emergency Lifesaving Technician (issued by the MHLW Health Policy Bureau on March 23, 2004, No. 0323049).
3) Pre-operation education for emergency crew members that hold the qualification of "emergency lifesaving technician," based on the Implementation Guidelines of Pre-operation Education for Emergency Crew Members Qualified as Emergency Lifesaving Technicians (issued by the Fire and Disaster Management Agency on April 1, 1994, No. 42).
4) The re-education of emergency crew members that hold the qualification of "emergency lifesaving technician," based on the "Improvement and Reinforcement of Emergency Crew Member Education and Training" (issued by the Fire and Disaster Management Agency on April 8, 1985, No. 32), "Improvement and Reinforcement of Emergency Crew Member Education and Training, Including Courses for Qualifying as Crew" (issued by the Fire and Disaster Management Agency on May 18, 1993, No. 53), and the "Promoting Better Emergency Medical Work" (July 4, 2001, No. 204).

4. Service standards
1) Hospitals that provide practical training for emergency lifesaving technicians shall, as a general rule, have several doctors who are experts in emergency medical care (e.g., consultants certified by the Japanese Association for Acute Medicine, emergency medical specialists, or consultants certified by the Japanese Society of Anesthesiologists (previously "senior/leading doctors")).
2) Hospitals that provide practical training for emergency lifesaving technicians shall appoint a doctor who is an expert in emergency medical care within the hospital as a coordinator-doctor who shall mainly perform the following duties:
A. Confirming that emergency lifesaving technicians possess sufficient knowledge and skills

to receive practical training at the hospital;
B. Reporting on the implementation and confirmation of informed consent obtained from admitted patients to ethics committees;
C. Negotiating the securement of senior doctors in receiving hospital departments (e.g., negotiating consultation hours);
D. Negotiating instruction content for senior doctors (checking for overlaps and omissions);
E. Handling certification of practical training completion (overall evaluation of assessment results from each hospital department);
F. Negotiating with fire services on matters such as trainee acceptance periods;
G. Attending events such as the local medical control council.
3) Hospitals that conduct practical training for emergency lifesaving technicians shall implement systems for obtaining consent from patients and for securing safety.
4) Hospitals that conduct practical training for emergency lifesaving technicians shall provide an appropriate waiting area for trainees, as well as in which to conduct necessary orientation.

5. Equipment
Hospitals shall be equipped with medical equipment and other such equipment as is necessary for a hospital that conducts practical training for emergency lifesaving technicians.

Chapter 8: Pediatric intensive care unit implementation project

1. Objectives
This project aims to develop pediatric intensive care units and to secure appropriate medical services for critical pediatric patients.

2. Availibility of subsidies
Subsidies shall be available for pediatric intensive care units maintained by hospital proprietors in response to requests from prefectural governments, or a prefectural governor, and that have been approved by the Minister for Health, Labour and Welfare.

3. Service standards
1) Facilities
A pediatric intensive care unit shall have at least six beds and an independent nursing unit.
2) Equipment
A pediatric intensive care unit shall be equipped with such medical equipment as is necessary for a pediatric intensive care unit.

Chapter 9: Automated external defibrillator (AED) advocacy project for non-medical personnel

1. Objectives
This project aims to promote automated external defibrillators (hereinafter referred to as "AEDs") and offer relevant training programs to non-medical personnel, with the objective of contributing to improved rates of life-saving by providing cardiopulmonary resuscitation to people undergoing cardiopulmonary arrest when it is difficult to swiftly secure a medical practitioner. The project also aims to properly manage AEDs installed within respective prefectures.

2. Availability of subsidies
Subsidies shall be made available for practical training for non-medical personnel, programs related to the appropriate management of AEDs, and AED promotion projects conducted by prefectural governments (including consignments by prefectural governments).

3. Operational policies
1) There shall appropriate management of the AEDs installed within the prefecture, and construction of systems for the effective use of installed AEDs, such as requesting updates before consumable items expire.
2) Concerning the installation location of AEDs, the prefectural government shall provide information to local residents through avenues such as posting online information attained from the installation registration information provided by the Resuscitation Committee of the Japanese Foundation for Emergency Medicine, as well as information attained from independent research.
3) Efforts shall be made towards the spreading and promotion of cardiopulmonary resuscitation methods, including the use of AEDs, based on the guidelines entitled "Usage of Automated External Defibrillators (AEDs) by Non-Medical Personnel" (issued by the MHLW Health Policy Bureau on July 1, 2004, No. 0701001) and/or the "Implementation Guidelines for Promoting Dissemination and Awareness of First-aid Treatment" (March 30, 1993, issued by the Fire and Disaster Management Agency, No. 41).

4. Implementation standards
A council comprised of parties involved in the dissemination of AEDs within the prefecture (including consignments by prefectural governments) shall be installed, and shall select AED installation locations, hold instructor training seminars for disseminating AEDs and dissemination seminars for local residents, and gather information such as AED installed locations for the appropriate management of AEDs.

Chapter 10: Emergency medical information centers

(Wide-area disaster and emergency medical information system)

1. Objectives
This project aims for prefectural government to maintain emergency medical care information centers (a wide-area disaster and emergency medical information system) covering the entire prefectural area, as well as managing the computer network between prefectural centers and the backup center. Through these measures, this project aims for emergency medical care information centers to accurately acquire information from emergency medical care facilities during regular hours, to provide necessary information to medical care facilities, fire departments, and other relevant departments, and to ensure medical care for emergency patients based on a smooth system of collaboration. In the case of a disaster, emergency medical care information centers shall aim to secure the operation status of medical facilities, the status of members such as doctors and nurses, to secure basic living commodities (e.g., electricity), and to gather and provide comprehensive information on disaster-related medical care (e.g., the stock status of medical supplies).

2. Availability of subsidies
Subsidies shall be available for emergency medical care information centers (wide-area disaster and emergency medical information systems) maintained and operated by corporations consigned by a prefectural government or prefectural governor.

3. Operational policies

1) During regular times, these centers shall serve as an emergency medical information system in accordance with the circumstances in each prefecture. In other words, it shall gather information on holiday and nighttime emergency care centers, secondary emergency medical care facilities, emergency critical care centers, and other systems required for emergency medical services, and shall provide necessary information for medical facilities, local fire service headquarters, and so forth.
2) Centers shall coordinate with neighboring prefectures as required, to provide mutually accessible information, and shall plan for mutual coordination with the perinatal emergency care information system.
3) The medical institutions that participate in the emergency medical care information system shall strive to update emergency medical treatment information (e.g., regarding the capacity to accept emergency patients) as required for the smooth transportation of emergency patients. Matters that mainly contribute to providing information to residents shall be updated as required.
4) In order to provide assistance and rescue victims swiftly and precisely during times of disaster, centers shall serve as information systems to enable medical facilities, fire services, public health departments, and other administrative organs to ascertain the status of nationwide medical treatment facilities.
5) Information exchanged during the time of a disaster shall be shared nationwide.
6) Prefectural information centers shall coordinate with a backup center that can provide logistics support (hereinafter, "backup") in order for disaster/emergency medical service information to be disseminated across a wide area during times of disaster. Furthermore, in the event that a prefectural care center stops functioning during the time of a disaster, the backup center shall be able to directly perform the role of the prefectural care center in question.
7) Information registered during times of disaster shall be published online as necessary for effective use by citizens.
8) In order to engage in issues related to local emergency medical care and to construct a system in cooperation with medical/fire services and other related bodies, emergency medical care information center management committees shall be established in prefectural information centers, and shall coordinate with the prefectural medical control council to ensure appropriate functionality of the local emergency medical service system.

※Medical control council

A forum to address the maintenance of systems that ensure the quality of pre-hospital care by having doctors instruct, guide, advise, and examine the activities of emergency lifesaving technicians and other related professionals.

4. Operation details

1) Operation during regular times

A. Information collection duty (updated as required)

A) Availability of doctors by hospital department.
B) Availability of surgery and treatment procedures by hospital department.
C) Availability and state of beds of the hospital (by hospital department, by patient gender, and regarding special illness wards, e.g., intensive care units).
D) Other information that an emergency medical care information center operation committee recognizes as important.

B. Information provision/consultation operations:

Select appropriate acceptance facilities, provide confirmations and answers in response to queries from medical care facilities, fire service headquarters, and local residents.
C. Hosting emergency medical care information center operation committees.
2) Information gathering and provision operations during times of disaster
A. Medical facility status
B. Patient transfer requests
C. Medical supply stock status
D. The status of securement of basic living necessities (e.g., electricity)
E. Patient acceptance status

5. Service standards
1) Backup Center
A. A backup center shall be established in one location within Japan to store nationwide disaster/emergency medical care information.
B. The center shall operate 24-hours a day.
C. The center shall be located in an earthquake-proof building.
2) Prefectural center
A. A prefectural center shall be established to operate and register a wide-area disaster and emergency medical information system within each prefecture.
B. The center shall operate 24-hours a day.
C. Attention shall be paid to installation in an earthquake-proof building.
3) Terminal equipment
Terminal equipment for the information exchange of wide-area disaster and emergency medical information systems shall be located at medical facilities, public health departments, and other administrative organs.
4) Emergency medical information center operation committee
The members of the operation committee shall comprise those affiliated with such organizations as prefectural governments, municipalities, public health departments, medical district councils, fire services, local doctors' associations, and emergency critical care centers.

6. In the event that it is difficult to adhere to the above, those deemed appropriate following discussion with the Minister for Health, Labour and Welfare should be appointed.

Chapter 11: Project to strengthen emergency and perinatal emergency care information system

1. Objectives
This program aims to secure a smooth system for accepting emergency transported patients by attempting collaboration between the emergency medical information systems and perinatal emergency care information systems that prefectural governments operate, and by enhancing their functionality.

2. Availability of subsidies
Subsidies shall be available for emergency medical information systems and perinatal emergency information care systems, maintained and operated by a corporation consigned by the prefectural government or prefectural governor.

3. Service standards
In order to achieve coordination between the emergency medical information system and

perinatal medical emergency information system, and in order to enhance their functionality, one of the following items shall be implemented.

1) Input support and ability to display/view medical institutions' inpatient information as is necessary to establish a system for accepting emergency patients (e.g., by symptom, treatment, hospital department, and/or level of emergency), based on the Transport and Reception Implementation Standards of Injured Persons as regulated by the Fire Services Act, Article 35, Item 5 (2).
2) Coordination through integrated operations and mutual information referencing between emergency medical information systems and perinatal medical emergency information systems.
3) Mutual connections for performing mutual viewing of inpatient reception information (e.g., by symptom, treatment, hospital department, and/or level of emergency) for medical institutions beyond the local region.
4) An ICT-aided tool that swiftly selects the medical institution to which the emergency patient is to be transported.

4. In the event that it is difficult to adhere to the above, those deemed appropriate following discussion with the Minister for Health, Labour and Welfare should be appointed.

Chapter 12: Emergency patient discharge coordinator program

1. Objectives

This program designates medical personnel, such as nurses and certified social workers, who are well-acquainted with the circumstance of the region, as emergency patient discharge coordinators (hereinafter, referred to as "coordinators) by posting them within medical institutions, aiming for the smooth transfer of patients who are no longer in acute need, for effective utilization of hospital beds for emergency medical services, and also to reduce the burden on doctors.

2. Availability of subsidies

Subsidies shall be available for coordinators allocated by emergency critical care centers or secondary emergency medical care facilities (hereinafter, "emergency medical institutions") that a hospital proprietor, at the request of the prefecture (including consigned third-parties) or the prefectural governor, operates or maintains, and as deemed appropriate by the Minister for Health, Labour and Welfare.

3. Operational policies

Coordinators shall coordinate and negotiate within and between facilities to smoothly transfer emergency patients who are no longer in acute need to another hospital/bed within an emergency medical care facility.

4. Maintenance standards

Coordinators shall perform their duties by prioritizing coordination and negotiation, not only concerning the medical institution to which they are allocated or related medical institutions, but also between medical institutions within a wider area.

Chapter 13: Japan Poison Information Center information infrastructure maintenance program

1. Objective
The objective of this program is to enhance acute poisoning countermeasures by establishing a database of relevant information to allow the Japan Poison Information Center to swiftly provide information related to treatment methods for acute poisoning by chemical substances.

2. Availability of subsidies
Subsidies shall be available for the Japan Poison Information Center.

3. Operational policies
1) Collection and provision of the following types of information on acute poisoning triggered by chemicals:
A. Information on the names, components, and compositions of the causes of acute poisoning.
B. Information related to the names and contents of products that include the substance mentioned in A. above.
C. Information on the symptoms of acute poisoning and its treatment methods.
2) Organization and accumulation of the information gathered in 1).
3) Preparation of the basic data required to provide information on acute poisoning.
4) Securing a system in which doctors can receive appropriate guidance 24-hours a day.

Chapter 14: Emergency medical care system strengthening program

(1) Medical control system enhancement program
1. Objective
The objective of this program is for prefectural governments to post doctors who are familiar with local emergency medical services (hereinafter referred to as “MC doctors”) within the Medical Control Council (hereinafter referred to as “MC council”) to attempt to resolve difficult cases of emergency transport, and to establish a smooth emergency transport acceptance system. To do so, this program shall enhance the emergency medical systems of local communities through such measures as examining the standards related to transferring and receiving those with injuries or illnesses found in the Fire Service Act, based on a medical control system (hereinafter referred to as “implementation standards”), as well as training doctors to be knowledgeable in medical control.

2. Availability of subsidies
The organization responsible for this operation shall be the prefectural government (including consignments).

3. Operational policies
The prefectural government shall ascertain and analyze circumstances to maintain a system that allows for the enhancement and strengthening of local emergency medical systems through MC doctors. Through this, the prefectural government shall offer guidance and advice, and shall examine whether or not medical institutions are accepting emergency patients smoothly, based on the implementation standards examined mainly during MC councils.

4. Service standards

In order to appropriately fulfill the program objective, the prefectural government shall publicly share and publish information on the identities of MC doctors, as well as clarifying their roles, specific details of their duties, coordination systems with fire services, and other necessary matters, while considering the needs of the local region. The details of duties that are decided upon shall be disseminated in advance among related institutions, such as fire services and medical institutions.

During the hours in which MC doctors engage in program duties, they shall not engage in medical consultations and shall mainly be involved with the MC council, in order to negotiate with such institutions as local medical institutions, fire services, prefectural government, municipal government, and local doctors' associations. However, during all other hours, MC doctors may give consultations at their medical institutions (several MC doctors may be appointed and work in rotation depending on the needs of the region).

An MC doctor is a doctor who attends to emergency medical care and possesses the knowledge/experience necessary to oversee such duties as negotiating with relevant institutions, including emergency medical institutions, fire services, administrative organs (e.g., prefectural governments), and local doctors' associations, while taking into consideration the circumstances of local emergency medical services. As a general rule, they should be experienced doctors with five or more years of clinical history in emergency care, holding the qualification of a medical specialist or equivalent, with previous involvement in the local medical control council for two or more years, and with a history of providing instruction in seminars and providing emergency crew education to the local community, such as BLS, ACLS, JPTEC, and JATEC (it is also desirable for them to have attended (advanced-level) senior doctor training in the pre-hospital medical care system hosted by the Ministry of Health, Labour and Welfare).

5. Operation details

1) The ascertaining and analysis of various issues faced by emergency medical services within the local community:

By conducting field surveys and interviews with bodies such as medical institutions and fire services, the MC doctor shall ascertain and analyze the issues in relation to emergency medical care within the community and, if necessary, conduct reviews and improvements to patient transportation standards.

2) Instruction and advice to fire services and medical institutions

After validating the analysis conducted in 1), the MC doctor shall coordinate with bodies, such as the prefectural government, concerning necessary measures, and provide instruction and advice to fire services and medical institutions as necessary.

3) Securement and support of emergency medical institutions and backup hospitals

As well as negotiating with relevant institutions to secure emergency medical care institutions, the MC doctor shall closely coordinate among secondary emergency medical institutions performing assistance services with medical institutions that have difficulties transporting patients. Furthermore, for issues related to discharging emergency patients in particular, the situation should be ascertained in conjunction with professionals such as discharge coordinators or local medical care institutions, and a place in which to hold a conference to examine the issue should be established, while logistic support hospitals should be encouraged to accept patients.

4) Securement and negotiation of medical institutions to which patients will be transported/transferred

In the event that ambulance workers face difficulties selecting an institution to which to transport patients during holidays and after hours, it is desirable for the MC doctor her/himself to negotiate which medical institution will serve as the transportation destination,

in accordance with the needs of fire services and other relevant institutions.
5) Transmitting information related to emergency medical care
The council shall perform such duties as providing civic education through lifesaving training, awareness campaigns related to the appropriate usage of first-aid medical care, and awareness campaigns and promotion of AED installation and usage.
6) Holding liaison conferences
In addition to smoothly executing the above duties, the Council shall host liaison conferences to coordinate and negotiate with involved parties, as well as attend national medical control liaison conferences held across Japan.
7) Miscellaneous: The Council shall conduct other measures that are necessary for enhancing and strengthening emergency medical systems within the region.
8) If it is difficult to adhere to the above, the Council shall discuss the situation with the Minister of Health, Labour and Welfare in advance.

6. Miscellaneous
The prefectural government shall report the program implementation status to the Minister for Health, Labor, and
Welfare, as stipulated elsewhere.

(2) The program for helping medical institutions to accept patients in cases where determination of the transfer destination is difficult
1. Objective
The objective of this program is to resolve difficulties in transporting emergency patients and to construct smooth emergency transportation acceptance conditions in the region, by securing a medical institution that can accept, even if temporarily, emergency patients whose transfer destination cannot be determined for a prolonged time.

2. Availability of subsidies
Subsidies shall be available for the responsible organization of this program, namely a secondary emergency medical care facility maintained and operated by a medical institution proprietor that received a request from the local governing bodies or local governing body president (hereinafter, referred to as "accepting medical institutions," excluding standalone psychiatric medical institutions), and which have been deemed eligible and recognized by the Minister of Health, Labour and Welfare to be acceptable medical institutions in which to receive emergency patients whose transfer destination cannot be determined for a prolonged time.
Furthermore, receiving medical institutions that are to be considered eligible for subsidies shall be those
secondary emergency medical care facilities whose position has been clarified through the standards stipulated by the Fire Service Act, Article 35-5, Clause 2, Item 6, and also having formed an agreement between fire services and medical institutions related to the acceptance of injured or sick persons.

3. Operational policies
The accepting medical institution shall accept emergency patients in accordance with requests from fire services in the event that an emergency crew is having difficulty selecting the transfer destination for the emergency patient. Furthermore, this institution shall coordinate with MC doctors allocated by MC councils.

4. Service standards
1) Receiving medical institutions that always accept emergency patients
The receiving medical institution shall secure a system (e.g., the necessary empty beds) for the acceptance of emergency patients whose transfer destination cannot be determined for a prolonged period of time.
2) Receiving medical institutions that can accept emergency patients, even if temporarily
The receiving medical institution shall secure a system for the acceptance, even if temporarily, of emergency patients whose transfer destination within the region cannot be decided on for a prolonged period of time, depending on the reception status of emergency transportation in the region. In the event that a patient who was accepted temporarily has to be transferred to another institution, the cooperation of an MC doctor shall be requested, and the new transfer destination should be secured by following the rules stipulated in the region in advance.

Chapter 15: Trauma surgeon training program

1. Objective
The objective of this program is to train doctors (e.g., surgeons, emergency medical doctors) who can treat severe trauma caused by external factors (especially severe thoracic and abdominal trauma) by holding training to allow for the acquisition of knowledge and skills related to the surgical methods necessary for the appropriate treatment of severe physical injuries.

2. Availability of subsidies
Subsidies shall be available for the responsible organizations of this program, namely those organizations that have been selected in accordance with the Guidelines on Recruiting Organizations Conducting Trauma Surgeon Development Training Program

3. Operation details
1) The training content shall include classroom and training content for attaining the knowledge and skills related to the surgery treatment necessary for the appropriate handling of severe physical injury, which shall include the following matters:
A. Matters related to external injury strategies, based on cases and databases from overseas
B. Matters related to ethical aspects and psychological treatments concerning emergency treatments
C. Matters related to the knowledge and skills required for the treatment of external wounds (e.g., bullet wounds and bomb injuries)
D. Matters related to communication with medical team members
2) The target trainees are doctors (e.g., surgeons, emergency medical specialists) who have received external wound primary treatment training (i.e., Japan Advanced Trauma Evaluation and Care (JATEC) guidelines) and nurses who have received external wound primary nursing training (i.e., Japan Nursing Trauma Evaluation and Care (JNTEC)) and who, as a general rule, fulfill the following criteria:
A. Those who engage, or wish to engage, in the sharing of treatment strategies among all medical teams and in the provision of appropriate instructions to team members.
B. Surgeons who have sufficient experience in emergency external wound treatment, doctors who have engaged in surgical treatment for a given number of years, emergency physicians who have experienced a given number of abdominal injury surgery cases, and nurses who have a history of working in primary emergency treatment rooms or surgery rooms, as well as

experience assisting with surgery.

Chapter 16: Project to collect and analyze information on pediatric medical emergency telephone consultations

1. Objective
This program collects information (e.g., details of consultations) of pediatric telephone advice services conducted in prefectures (hereinafter referred to as "#8000 services") and analyzes evaluations of the health risks faced by children (e.g., illnesses and injuries) and the circumstances of home treatment. By this means, this program aims to improve and regionally equalize the quality of telephone advisors, as well as share analysis results with parents and guardians, to raise awareness of the occurrence of injuries and illnesses and their treatments.

2. Availability of subsidies
Subsidies shall be available for the responsible organizations of this program, namely organizations selected in accordance with the Guidelines on Recruiting Pediatric Telephone Advice Information Analysis Program.

3. Operation details
1) Information gathering
A. This program shall establish a system for gathering information (e.g., consultation details) in collaboration with operators who conduct #8000 services after having being commissioned by the prefectural government or the prefectural governor (hereinafter, referred to as "operators").
B. Data shall be collected from five operators or more in order to secure universality.
C. The information gathered shall be appropriate for information analysis, such as the information related to consultation details (e.g., symptoms, children's age, time when the call was received, and response time) for each case, and the responses of the telephone advisors.
2) Information analysis
A. The information analysis necessary for improving and regionally equalizing the quality of telephone advice by conducting such measures as analyzing the details of telephone advisors' responses for each major case, by operator.
B. Details, such as the causes of injuries/sickness, are to be analyzed by time range of consultation and by age, conducting the information analysis necessary to promote awareness of injuries and sickness (e.g., revealing the causes behind occurrences of emergency illness), as well as their treatment.
3) Usage of analysis results
A) Analysis results that are effective in improving and regionally equalizing the quality of telephone advisors are to be used effectively, such as by providing them to operators.
B) Analysis results that are effective in reducing domestic risks, such as of injuries and illness, are to be used effectively, such as by guardians who are assumed to use #8000 services.