10A NCAC 13P .0101 ABBREVIATIONS

As used in this Subchapter, the following abbreviations mean:

(1) ACS: American College of Surgeons;

(2) AEMT: Advanced Emergency Medical Technician;

~~(2)~~(3) AHA: American Heart Association;

(4) ASTM: American Society for Testing and Materials;

~~(3) ATLS: Advanced Trauma Life Support;~~

~~(4) CA3: Clinical Anesthesiology Year 3;~~

(5) CAAHEP: Commission on Accreditation of Allied Health Education Programs;

~~(5) CRNA: Certified Registered Nurse Anesthetist;~~

~~(6)~~(6) CPR: Cardiopulmonary Resuscitation;

~~(7)~~ DOA: Dead on Arrival;

~~(8)~~(7) ED: Emergency Department;

~~(9)~~(8) EMD: Emergency Medical Dispatcher;

~~(10)~~ EMDPRS: Emergency Medical Dispatch Priority Reference System;

(9) EMR: Emergency Medical Responder;

~~(11)~~(10) EMS: Emergency Medical Services;

~~(12)~~(11) EMS-NP: EMS Nurse Practitioner;

~~(13)~~(12) EMS-PA: EMS Physician Assistant;

~~(14)~~(13) EMT: Emergency Medical Technician;

~~(15) EMT-I: EMT-Intermediate;~~

~~(16) EMT-P: EMT-Paramedic;~~

~~(17) ENT: Ear, Nose and Throat;~~

~~(18)~~(14) FAA: Federal Aviation Administration;

~~(19)~~(15) FAR: Federal Aviation Regulation;

~~(20)~~(16) FCC: Federal Communications Commission;

~~(21)~~(17) ~~GSC:~~ GCS: Glasgow Coma Scale;

~~(22)~~(18) ICD: International Classification of Diseases;

~~(23)~~(19) ISS: Injury Severity Score;

(20) ICU: Intensive Care Unit;

~~(24)~~(21) IV: Intravenous;

~~(25)~~(22) LPN: Licensed Practical Nurse;

~~(26)~~(23) MICN: Mobile Intensive Care Nurse;

~~(27) MR: Medical Responder;~~

~~(28)~~(24) NHTSA: National Highway Traffic Safety Administration;

~~(29)~~(25) OEMS: Office of Emergency Medical Services;

~~(30) OMF: Oral maxillofacial;~~

~~(31) OR: Operating Room;~~

~~(32) PGY2: Post Graduate Year 2;~~

~~(33) PGY4; Post Graduate Year 4;~~

~~(34)~~(26) PSAP: Public Safety Answering Point;

~~(35)~~(27) RAC: Regional Advisory Committee;

~~(36)~~(28) RFP: Request For Proposal;

~~(37)~~(29) RN: Registered Nurse;

~~(38)~~(30) SCTP: Specialty Care Transport Program;

~~(39)~~(31) SMARTT: State Medical Asset and Resource Tracking Tool;

~~(40)~~(32) STEMI: ST Elevation Myocardial Infarction;

~~(41)~~(33) TR: Trauma Registrar;

~~(42) TNC: Trauma Nurse Coordinator;~~

~~(43)~~(34) TPM: Trauma Program Manager; and

~~(44)~~(35) US DOT: United States Department of Transportation.

10A NCAC 13P .0102 DEFINITIONS

The following definitions apply throughout this Subchapter:

~~(1) "Advanced Trauma Life Support" means the course sponsored by the American College of Surgeons.~~

~~(2)~~(1) "Affiliated EMS Provider" means the firm, corporation, agency, organization, or association identified to a specific county EMS system as a condition for EMS Provider Licensing as required by Rule ~~.0204(a)(1)~~ .0204(b)(1) of this Subchapter.

~~(3)~~(2) "Affiliated Hospital" means a non-Trauma Center hospital that is owned by the Trauma Center or there exists a contract or other agreement to allow for the acceptance or transfer of the Trauma Center's patient population to the non-Trauma Center hospital.

~~(4)~~(3) "Affiliation" means a reciprocal agreement and association that includes active participation, collaboration and involvement in a process or system between two or more parties.

(4) "Alternative Practice Setting" means a clinical environment not affiliated with or under the oversight of the EMS System or EMS System Medical Director, that utilizes a physician licensed by the North Carolina Medical Board for the provision of medical oversight and review of medical care provided by EMS professionals and who is affiliated with the practice setting in which the EMS professional shall function.

(5) "Air Medical Ambulance" means an aircraft configured and medically equipped to transport patients by air. The patient care compartment of air medical ambulances shall be staffed by medical crew members approved for the mission by the medical director.

(6) "Air Medical Program" means a SCTP or EMS System utilizing rotary-wing or fixed-wing aircraft configured and operated to transport patients.

(7) "Assistant Medical Director" means a physician, EMS-PA, or EMS-NP who assists the medical director with the medical aspects of the management of an EMS System or EMS SCTP.

~~(8) "Attending" means a physician who has completed medical or surgical residency and is either eligible to take boards in a specialty area or is boarded in a specialty.~~

~~(9) "Board Certified, Board Certification, Board Eligible, Board Prepared, or Boarded" means approval by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, or the Royal College of Physicians and Surgeons of Canada unless a further sub-specialty such as the American Board of Surgery or Emergency Medicine is specified.~~

~~(10)~~(8) "Bypass" means the transport of an emergency medical services patient from the scene of an accident or medical emergency past an emergency medical services receiving facility for the purposes of accessing a facility with a higher level of care, or a hospital of its own volition reroutes a patient from the scene of an accident or medical emergency or referring hospital to a facility with a higher level of care.

~~(11)~~(9) "Contingencies" mean conditions placed on a trauma center's designation that, if unmet, can result in the loss or amendment of a hospital's designation.

~~(12)~~(10) "Convalescent Ambulance" means an ambulance used on a scheduled basis solely to transport patients having a known non-emergency medical condition. Convalescent ambulances shall not be used in place of any other category of ambulance defined in this Subchapter.

~~(13) "Clinical Anesthesiology Year 3" means an anesthesiology resident having completed two clinical years of general anesthesiology training. A pure laboratory year shall not constitute a clinical year.~~

~~(14)~~(11) "Deficiency" means the failure to meet essential criteria for a trauma center's designation as specified in Section .0900 of this Subchapter, that can serve as the basis for a focused review or denial of a trauma center designation.

~~(15)~~(12) "Department" means the North Carolina Department of Health and Human Services.

~~(16)~~(13) "Diversion" means the hospital is unable to accept a pediatric or adult patient due to a lack of staffing or resources.

~~(17) "E-Code" means a numeric identifier that defines the cause of injury, taken from the ICD.~~

~~(18)~~(14) "Educational Medical Advisor" means the physician responsible for overseeing the medical aspects of approved EMS educational programs in continuing education, basic, and advanced EMS educational institutions.

~~(19)~~(15) "EMS Care" means all services provided within each EMS System by its associated EMS agencies and personnel that relate to the dispatch, response, treatment, and disposition of any patient ~~that would require the submission of System Data to the OEMS,~~ resulting in the collection of data used by the EMS system in the performance of peer review, quality management, and the development of continuing education programs for affiliated EMS personnel.

~~(20)~~(16) "EMS Educational Institution" means any agency credentialed by the OEMS to offer EMS educational programs.

~~(21)~~(17) "EMS Nontransporting Vehicle" means a motor vehicle operated by a licensed EMS provider dedicated and equipped to move medical equipment and EMS personnel functioning within the scope of practice of ~~EMT-I or EMT-P~~ AEMT or Paramedic to the scene of a request for assistance. EMS nontransporting vehicles shall not be used for the transportation of patients on the streets, highways, waterways, or airways of the state.

~~(22)~~(18) "EMS Peer Review Committee" means a committee as defined in G.S. ~~131E-144(a)(6b).~~ 131E-155(6b).

~~(23)~~(19) "EMS Performance Improvement Toolkits" mean one or more reports generated from the state EMS data system analyzing the EMS service delivery, personnel performance, and patient care provided by an EMS system and its associated EMS agencies and personnel. Each EMS toolkit focuses on a topic of care such as trauma, cardiac arrest, EMS response times, stroke, STEMI (heart attack), and pediatric care.

~~(24)~~(20) "EMS Provider" means those entities defined in G.S. 131E-155 (13a) that hold a current license issued by the Department pursuant to G.S. 131E-155.1.

~~(25)~~(21) "EMS System" means a coordinated arrangement of local resources under the authority of the county government (including all agencies, personnel, equipment, and facilities) organized to respond to medical emergencies and integrated with other health care providers and networks including public health, community health monitoring activities, and special needs populations.

~~(26) "EMS System Peer Groups" are defined as:~~

~~(a) Urban EMS System means greater than 200,000 population;~~

~~(b) Suburban EMS System means from 75,001 to 200, 000 population;~~

~~(c) Rural EMS System means from 25,001 to 75,000 population; and~~

~~(d) Wilderness EMS System means 25,000 or less.~~

~~(27)~~(22) "Essential Criteria" means those items listed in Rules .0901, .0902, and .0903 of this Subchapter that are the minimum requirements for the respective level of trauma center designation (I, II, or III).

~~(28)~~(23) "Focused Review" means an evaluation by the OEMS of a trauma center's corrective actions to remove contingencies that are a result of deficiencies placed upon it following a renewal site visit.

~~(29)~~(24) "Ground Ambulance" means an ambulance used to transport patients with traumatic or medical conditions or patients for whom the need for specialty care or emergency or non-emergency medical care is anticipated either at the patient location or during transport.

~~(30)~~(25) "Hospital" means a licensed facility as defined in G.S. 131E-176.

~~(31)~~(26) "Immediately Available" means the physical presence of the health professional or the hospital resource within the trauma center to evaluate and care for the trauma patient without delay.

~~(32)~~(27) "Inclusive Trauma System" means an organized, multi-disciplinary, evidence-based approach to provide quality care and to improve measurable outcomes for all defined injured patients. EMS, hospitals, other health systems and clinicians shall participate in a structured manner through leadership, advocacy, injury prevention, education, clinical care, performance improvement and research resulting in integrated trauma care.

~~(33)~~(28) "Infectious Disease Control Policy" means a written policy describing how the EMS system will protect and prevent its patients and EMS professionals from exposure and illness associated with contagions and infectious disease.

~~(34)~~(29) "Lead RAC Agency" means the agency (comprised of one or more Level I or II trauma centers) that provides staff support and serves as the coordinating entity for trauma planning in a region.

~~(35)~~(30) "Level I Trauma Center" means a hospital as defined by Item ~~(30)~~ (25) of this Rule that has the capability of providing leadership, research, and total care for every aspect of injury from prevention to rehabilitation.

~~(36)~~(31) "Level II Trauma Center" means a hospital as defined by Item ~~(30)~~ (25) of this Rule that provides trauma care regardless of the severity of the injury but may not be able to provide the same comprehensive care as a Level I trauma center and does not have trauma research as a primary objective.

~~(37)~~(32) "Level III Trauma Center" means a hospital as defined by Item ~~(30)~~ (25) of this Rule that provides prompt assessment, resuscitation, emergency operations, and stabilization, and arranges for hospital transfer as needed to a Level I or II trauma center.

~~(38)~~(33) "Licensed Health Care Facility" means any health care facility or hospital as defined by Item ~~(30)~~ (25) of this Rule licensed by the Department of Health and Human Services, Division of Health Service Regulation.

~~(39)~~(34) "Medical Crew Member" means EMS personnel or other health care professionals who are licensed or registered in North Carolina and are affiliated with a SCTP.

~~(40)~~(35) "Medical Director" means the physician responsible for the medical aspects of the management of an EMS System, or SCTP, or Trauma Center.

~~(41)~~(36) "Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of an EMS System, or SCTP. Medical Oversight includes physician direction of the initial education and continuing education of EMS personnel or medical crew members; development and monitoring of both operational and treatment protocols; evaluation of the medical care rendered by EMS personnel or medical crew members; participation in system or program evaluation; and directing, by two-way voice communications, the medical care rendered by the EMS personnel or medical crew members.

~~(42) "Mid-level Practitioner" means a nurse practitioner or physician assistant who routinely cares for trauma patients.~~

~~(43) "Model EMS System" means an EMS System that is recognized and designated by the OEMS for meeting and mastering quality and performance indicator criteria as defined by Rule .0202 of this Subchapter.~~

~~(44)~~(37) "Off-line Medical Control" means medical supervision provided through the EMS System Medical Director or SCTP Medical Director who is responsible for the day to day medical care provided by EMS personnel. This includes EMS personnel education, protocol development, quality management, peer review activities, and EMS administrative responsibilities related to assurance of quality medical care.

~~(45)~~(38) "Office of Emergency Medical Services" means a section of the Division of Health Service Regulation of the North Carolina Department of Health and Human Services located at ~~701 Barbour Drive,~~ 1201 Umstead Drive, Raleigh, North Carolina 27603.

~~(46)~~(39) "On-line Medical Control" means the medical supervision or oversight provided to EMS personnel through direct communication in person, via radio, cellular phone, or other communication device during the time the patient is under the care of an EMS professional. ~~The source of on-line medical control is typically a designated hospital's emergency department physician, EMS nurse practitioner, or EMS physician assistant.~~

~~(47)~~(40) "Operational Protocols" means the administrative policies and procedures of an EMS System or that provide guidance for the day-to-day operation of the system.

~~(48)~~(41) "Participating Hospital" means a hospital that supplements care within a larger trauma system by the initial evaluation and assessment of injured patients for transfer to a designated trauma center if needed.

~~(49)~~(42) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.

~~(50) "Post Graduate Year Two" means any surgery resident having completed one clinical year of general surgical training. A pure laboratory year shall not constitute a clinical year.~~

~~(51) "Post Graduate Year Four" means any surgery resident having completed three clinical years of general surgical training. A pure laboratory year shall not constitute a clinical year.~~

(43) "Practicing Trauma Center" means a hospital as defined by Item (25) of this Rule authorized by the Department to temporarily provide the services of a Level I, Level II or Level III trauma center during the period of application pending trauma center designation.

~~(52) "Promptly Available" means the physical presence of health professionals in a location in the trauma center within a short period of time, that is defined by the trauma system (director) and continuously monitored by the performance improvement program.~~

~~(53)~~(44) "Regional Advisory Committee (RAC)" means a committee comprised of a lead RAC agency and a group representing trauma care providers and the community, for the purpose of regional trauma planning, establishing, and maintaining a coordinated trauma system.

~~(54)~~(45) "Request for Proposal (RFP)" means a state document that must be completed by each hospital as defined by Item ~~(30)~~ (25) of this Rule seeking initial or renewal trauma center designation.

(46) "Significant Failure to Comply" means a degree of non-compliance determined by the Department to exceed the ability of the local EMS System, to correct. warranting enforcement action pursuant to Section .1500 of this Subchapter.

~~(55)~~(47) "State Medical Asset and Resource Tracking Tool (SMARTT)" means the Internet web-based program used by the OEMS both daily in its operations and during times of disaster to identify, record and monitor EMS, hospital, health care and sheltering resources statewide, including facilities, personnel, vehicles, equipment, pharmaceutical and supply caches.

~~(56)~~(48) "Specialty Care Transport Program" means a program designed and operated for the ~~provision of specialized medical care and transportation of critically ill or injured patients between health care facilities and for patients who are discharged from a licensed health care facility to their residence that require specialized medical care during transport which exceeds the normal capability of the local EMS System.~~ transportation of a patient by ground or air requiring specialized interventions, monitoring and staffing by a paramedic who has received additional training as determined by the program medical director beyond the minimum training prescribed by the OEMS, or by one or more other healthcare professional(s) qualified for the provision of specialized care based on the patient's condition.

~~(57)~~(49) "Specialty Care Transport Program Continuing Education Coordinator" means a Level I EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.

(50) "Stretcher" means any wheeled or portable device capable of transporting a person in a recumbent position and may only be used in an ambulance vehicle permitted by the Department.

~~(58)~~(51) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

~~(59)~~(52) "System Continuing Education Coordinator" means the Level I EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.

~~(60)~~(53) "System Data" means all information required for daily electronic submission to the OEMS by all EMS Systems using the EMS data set, data dictionary, and file format as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost.

~~(61) "Transfer Agreement" means a written agreement between two agencies specifying the appropriate transfer of patient populations delineating the conditions and methods of transfer.~~

~~(62)~~(54) "Trauma Center" means a hospital as defined by Item ~~(30)~~ (25) of this Rule designated by the State of North Carolina and distinguished by its ability to immediately manage, on a 24-hour basis, the severely injured patient or those at risk for severe injury.

~~(63)~~(55) "Trauma Center Criteria" means essential criteria to define Level I, II, or III trauma centers.

~~(64)~~(56) "Trauma Center Designation" means a process of approval in which a hospital as defined by Item ~~(30)~~ (25) of this Rule voluntarily seeks to have its trauma care capabilities and performance evaluated by experienced on-site reviewers.

~~(65)~~(57) "Trauma Diversion" means a trauma center of its own volition declines to accept an acutely injured pediatric or adult patient due to a lack of staffing or resources.

~~(66)~~(58) "Trauma Guidelines" mean standards for practice in a variety of situations within the trauma system.

~~(67)~~(59) "Trauma Minimum Data Set" means the basic data required of all hospitals for submission to the trauma statewide database.

~~(68)~~(60) "Trauma Patient" means any patient with an ~~ICD-9-CM discharge diagnosis 800.00-959.9 excluding 905-909 (late effects of injury), 910.0-924 (blisters, contusions, abrasions, and insect bites), and 930-939 (foreign bodies).~~ ICD-CM discharge diagnosis as defined in the North Carolina Trauma Registry Data Dictionary.

~~(69)~~(61) "Trauma Program" means an administrative entity that includes the trauma service and coordinates other trauma related activities. It must also include the trauma medical director, trauma program manager/trauma coordinator, and trauma registrar. This program's reporting structure shall give it the ability to interact with at least equal authority with other departments providing patient care.

~~(70)~~(62) "Trauma Registry" means a disease-specific data collection composed of a file of uniform data elements that describe the injury event, demographics, pre-hospital information, diagnosis, care, outcomes, and costs of treatment for injured patients collected and electronically submitted as defined by the OEMS.

~~(71) "Trauma Service" means a clinical service established by the medical staff that has oversight of and responsibility for the care of the trauma patient.~~

~~(72) "Trauma Team" means a group of health care professionals organized to provide coordinated and timely care to the trauma patient.~~

~~(73)~~(63) "Treatment Protocols" means a document approved by the medical directors of ~~both~~ the local EMS System, Specialty Care Transport Program, or Trauma Center and the OEMS specifying the diagnostic procedures, treatment procedures, medication administration, and patient-care-related policies that shall be completed by EMS personnel or medical crew members based upon the assessment of a patient.

~~(74)~~(64) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.

~~(75)~~(65) "Water Ambulance" means a watercraft specifically configured and medically equipped to transport patients.

10A NCAC 13P .0103 MANUALS AND BULLETINS

Pursuant to G.S. 150B-2(8a)(c), the Department may issue non-binding manuals, bulletins, or both, to show the agency's interpretation of the provisions of these rules and regulations. These manuals, bulletins, or both shall be consistent with and reflect the policies contained in these rules and regulations.

10A NCAC 13P .0201 EMS SYSTEM REQUIREMENTS

(a) County governments shall establish EMS Systems. Each EMS System shall have:

(1) a defined geographical service area for the EMS System. The minimum service area for an EMS System shall be one county. There may be multiple EMS Provider service areas within the service area of an EMS System. The highest level of care offered within any EMS Provider service area must be available to the citizens within that service area 24 hours per day;

(2) a defined scope of practice for all EMS personnel, functioning in the EMS System, within the parameters set forth by the North Carolina Medical Board pursuant to G.S. 143-514;

(3) written policies and procedures describing the dispatch, coordination and oversight of all responders that provide EMS care, specialty patient care skills and procedures as defined in Rule .0301(a)(4) of this Subchapter, and ambulance transport within the system;

(4) at least one licensed EMS Provider;

(5) a listing of permitted ambulances to provide coverage to the service area 24 hours per day;

(6) personnel credentialed to perform within the scope of practice of the system and to staff the ambulance vehicles as required by G.S. 131E-158. There shall be a written plan for the use of credentialed EMS personnel for all practice settings used within the system;

(7) written policies and procedures specific to the utilization of the EMS System's EMS Care data for the daily and on-going management of all EMS System resources;

(8) a written Infectious Disease Control Policy as defined in Rule ~~.0102(33)~~ .0102(28) of this Subchapter and written procedures which are approved by the EMS System medical director that address the cleansing and disinfecting of vehicles and equipment that are used to treat or transport patients;

(9) a listing of ~~facilities~~ resources that will provide online medical direction for all EMS Providers operating within the EMS System;

(10) an EMS communication system that provides for:

(A) public access ~~using the emergency telephone number~~ to emergency services by dialing 9-1-1 within the public dial telephone network as the primary method for the public to request emergency assistance. This number shall be connected to the ~~emergency communications center or~~ PSAP with immediate assistance available such that no caller

will be instructed to hang up the telephone and dial another telephone number. A person calling for emergency assistance shall not be required to speak with more than two persons to request emergency medical assistance;

(B) ~~an emergency communications system~~ a PSAP operated by public safety telecommunicators with training in the management of calls for medical assistance available 24 hours per day;

(C) dispatch of the most appropriate emergency medical response unit or units to any caller's request for assistance. The dispatch of all response vehicles shall be in accordance with a written EMS System plan for the management and deployment of response vehicles including requests for mutual aid; and

(D) two-way radio voice communications from within the defined service area to the ~~emergency communications center or~~ PSAP and to facilities where patients are routinely transported. The ~~emergency communications system~~ PSAP shall maintain all required FCC radio licenses or authorizations;

(11) written policies and procedures for addressing the use of SCTP and Air Medical Programs within the system;

(12) a written continuing education program for all credentialed EMS personnel, under the direction of a System Continuing Education Coordinator, developed and modified based on feedback from system EMS Care data, review, and evaluation of patient outcomes and quality management peer reviews, that follows the ~~guidelines of the:~~ criteria defined in Rule .0501 of this Subchapter;

~~(A) "US DOT NHTSA First Responder Refresher: National Standard Curriculum" for MR personnel;~~

~~(B) "US DOT NHTSA EMT Basic Refresher: National Standard Curriculum" for EMT personnel;~~

~~(C) "EMT P and EMT I Continuing Education National Guidelines" for EMT I and EMT P personnel; and~~

~~(D) "US DOT NHTSA Emergency Medical Dispatcher: National Standard Curriculum" for EMD personnel.~~

~~These documents are incorporated by reference in accordance with G.S. 150B 21.6, including subsequent amendments and additions. These documents are available from NHTSA, 400 7th Street, SW, Washington, D.C. 20590, at no cost;~~

(13) written policies and procedures to address management of the EMS System that includes:

(A) triage and transport of all acutely ill and injured patients with time-dependent or other specialized care issues including trauma, stroke, STEMI, burn, and pediatric patients that may require the by-pass of other licensed health care facilities and which are based upon the expanded clinical capabilities of the selected healthcare facilities;

(B) triage and transport of patients to facilities outside of the system;

(C) arrangements for transporting patients to appropriate facilities when diversion or bypass plans are activated;

(D) reporting, monitoring, and establishing standards for system response times using data provided by the OEMS;

(E) weekly updating of the SMARTT EMS Provider information;

(F) a disaster plan; ~~and~~

(G) a mass-gathering plan;

(H) a mass-casualty plan;

(I) a plan on how EMS personnel shall report suspected child abuse pursuant to G.S. 7B-302;

(J) a plan on how EMS personnel shall report suspected abuse of the elderly or disabled pursuant to G.S. 108A-102; and

(K) a plan on how each responding agency is to maintain a current roster of its personnel providing EMS care within the county under the provider number issued pursuant to Paragraph (c) of this Rule, in the OEMS credentialing and information database.

(14) affiliation as defined in Rule .0102(3) of this Subchapter with the trauma RAC as required by Rule .1101(b) of this Subchapter; and

(15) medical oversight as required by Section .0400 of this Subchapter.

(b) Each EMS System that utilizes emergency medical dispatching agencies applying the principles of EMD or offering EMD services, procedures, or programs to the public shall have:

(1) a defined service area for each agency;

(2) adequate personnel within each agency, credentialed in accordance with the requirements of Section .0500 of this Subchapter, to ensure continuous EMD services to the citizens within that service area are available 24 hours per day; and

(3) EMD responsibilities in special situations, such as disasters, mass-casualty incidents, or situations requiring referral to specialty hotlines.

(c) The EMS System must obtain provider numbers from the OEMS for each responding agency that provides EMS Care within the county.

~~(b)~~(d) An application to establish an EMS System shall be submitted by the county to the OEMS for review. When the system is comprised of more than one county, only one application shall be submitted. The proposal shall demonstrate that the system meets the requirements in Paragraph (a) of this Rule. System approval shall be granted for a period of six years. Systems shall apply to OEMS for reapproval.

10A NCAC 13P .0203 SPECIAL SITUATIONS

Upon application of citizens in North Carolina, the North Carolina Medical Care Commission shall approve the furnishing and providing of programs within the scope of practice of EMD, EMR, EMT, ~~EMT I,~~ AEMT or ~~EMT P~~ Paramedic in North Carolina by persons who have been approved to provide these services by an agency of a state

adjoining North Carolina or federal jurisdiction. This approval shall be granted where the North Carolina Medical Care Commission concludes that the requirements enumerated in Rule .0201 of this Subchapter cannot be reasonably obtained by reason of lack of geographical access.

10A NCAC 13P .0204 EMS PROVIDER LICENSE REQUIREMENTS

(a) Any firm, corporation, agency, organization or association that provides non-transportation emergency medical services at the AEMT or Paramedic level shall be licensed as an EMS Provider by meeting and continuously maintaining the criteria defined in Paragraph (b) of this Rule.

~~(a)~~(b) Any firm, corporation, agency, organization or association that provides emergency medical transportation services shall be licensed as an EMS Provider by meeting and continuously maintaining the following criteria:

(1) Be affiliated as defined in Rule .0102(3) of this Subchapter with each EMS System where there is to be a physical base of operation or where the EMS Provider will provide point-to-point patient transport within the system;

(2) Present an application for a permit for any ambulance and non-transporting vehicle that will be in service as required by G.S. 131E-156;

(3) Submit a written plan detailing how the EMS Provider will furnish credentialed personnel;

(4) Where there are franchise ordinances pursuant to G.S 153A-250 in effect that cover the proposed service areas of each EMS system of operation, show the affiliation as defined in Rule .0102(3) of this Subchapter with each EMS System, as required by Subparagraph ~~(a)(1)~~ (b)(1) of this Rule, by being granted a current franchise to operate, or present written documentation of impending receipt of a franchise, from each county. In counties where there is no franchise ordinance in effect, present a signature from each EMS System representative authorizing the EMS Provider to affiliate as defined in Rule .0102(3) of this Subchapter and as required by ~~Paragraph (a)(1)~~ Subparagraph (b)(1) of this Rule;

(5) Provide systematic, periodic inspection, repair, cleaning, and routine maintenance of all EMS responding ground vehicles and maintain records available for inspection by the OEMS which verify compliance with this Subparagraph;

(6) Collect and within 24 hours electronically submit to the OEMS EMS Care data that uses the EMS data set and data dictionary as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost.

(7) Develop and implement written operational protocols for the management of equipment, supplies and medications and maintain records available for inspection by the OEMS which verify compliance with this Subparagraph. These protocols shall include a methodology:

(A) to assure that each vehicle contains the required equipment and supplies on each response;

(B) for cleaning and maintaining the equipment and vehicles; and

(C) to assure that supplies and medications are not used beyond the expiration date and stored in a temperature controlled atmosphere according to manufacturer's specifications.

~~(b)~~(c) In addition to the general requirements detailed in Paragraph (a) of this Rule, if providing fixed-wing air medical services, affiliation as defined in Rule .0102(3) of this Subchapter with a hospital as defined in Rule ~~.0102(30)~~ .0102(25) of this Subchapter is required to ensure the provision of peer review, medical director oversight and treatment protocol maintenance.

~~(c)~~(d) In addition to the general requirements detailed in Paragraph (a) of this Rule, if providing rotary-wing air medical services, affiliation as defined in Rule .0102(3) of this Subchapter with a Level I or Level II Trauma Center as defined in Rules ~~.0102(29)~~ .0102(30) and ~~(30)~~ (31) of this Subchapter designated by the OEMS is required to ensure the provision of peer review, medical director oversight and treatment protocol maintenance. Due to the geographical barriers unique to the County of Dare, the Medical Care Commission exempts the Dare County EMS System from this Paragraph.

~~(d)~~(e) An EMS Provider may renew its license by presenting documentation to the OEMS that the Provider meets the criteria found in Paragraphs (a) through (c) of this Rule.

(f) Air Medical Programs are exempt from the requirements detailed in Subparagraphs (b)(1) and (b)(4) of this Rule.

10A NCAC 13P .0209 AIR MEDICAL AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

To be permitted as an Air Medical Ambulance, an aircraft shall meet the following requirements:

(1) Configuration of the aircraft patient care compartment does not compromise the ability to provide appropriate care or prevent performing in-flight emergency patient care procedures as approved by the program medical director.

(2) The aircraft has on board patient care equipment and supplies as defined in the treatment protocols for the program. The equipment and supplies shall be clean, in working order, and secured in the aircraft.

(3) There is installed in the aircraft an internal voice communication system to allow for communication between the medical crew and flight crew.

(4) The medical director designates the combination of medical equipment specified in Item (2) of this Rule that is carried on a mission based on anticipated patient care needs.

(5) The name of the EMS Provider is permanently displayed on each side of the aircraft.

(6) The aircraft is equipped with a two-way voice radio licensed by the FCC capable of operation on any frequency required to allow communications with public safety agencies such as fire

departments, police departments, ambulance and rescue units, hospitals, and local government agencies within the service area.

(7) In addition to equipment required by applicable air worthiness certificates and Federal Aviation Regulations (FAA Part 91 or 135), any rotary-wing aircraft permitted has the following functioning equipment to help ensure the safety of patients, crew members and ground personnel, patient comfort, and medical care:

(a) Global Positioning System;

(b) an external search light that can be operated from inside the aircraft;

(c) survival gear appropriate for the service area and the number, age and type of patients;

(d) permanently installed environmental control unit (ECU) capable of both heating and cooling the patient compartment of the aircraft; and

(e) capability to carry at least a 220 pound patient load and transport at least 60 nautical miles or nearest Trauma Center non-stop without refueling.

(8) The availability of one pediatric restraint device to safely transport pediatric patients and children under 40 pounds in the patient compartment of the air medical ambulance.

(9) The aircraft has no structural or functional defects that may adversely affect the patient, or the EMS personnel.

(10) A copy of the patient care treatment protocols, either paper or electronic, carried aboard the aircraft.

10A NCAC 13P .0214 EMS NONTRANSPORTING VEHICLE PERMIT CONDITIONS

(a) An EMS provider shall apply to the OEMS for an EMS Nontransporting Vehicle Permit prior to placing such vehicle in service.

(b) The Department shall issue a permit for a vehicle following verification of compliance with applicable laws and rules.

(c) Only one EMS Nontransporting Vehicle Permit shall be issued for each vehicle.

(d) EMS Nontransporting Vehicle Permits ~~shall not~~ may be ~~transferred.~~ transferred to allow for fleet rotation.

(e) The EMS Nontransporting Vehicle Permit shall be posted as designated by the OEMS inspector.

(f) Vehicles that are not owned or leased by the EMS Provider are ineligible for permitting.

10A NCAC 13P .0216 WEAPONS AND EXPLOSIVES FORBIDDEN

(a) Weapons, whether lethal or non-lethal, ~~as defined by the local county district attorney's office,~~ and explosives shall not be worn or carried aboard an ambulance or EMS nontransporting vehicle within the State of North Carolina when the vehicle is operating in any patient treatment or transport capacity or is available for such function.

(b) Conducted electrical weapons and chemical irritants such as mace, pepper (oleoresin capsicum) spray and tear gas are considered weapons for the purpose of this Rule.

~~(b)~~(c) This Rule shall apply whether or not such weapons and explosives are concealed or visible.

~~(c)~~(d) This Rule shall not apply to duly appointed law enforcement officers.

~~(d)~~(e) Safety flares are authorized for use on an ambulance with the following restrictions:

(1) These devices are not stored inside the patient compartment of the ambulance; and

(2) These devices shall be packaged and stored so as to prevent accidental discharge or ignition.

10A NCAC 13P .0219 STAFFING FOR MEDICAL AMBULANCE/EVACUATION BUS VEHICLES

Medical Ambulance/Evacuation Bus Vehicles are exempt from the requirements of G.S. 131E-158(a). The EMS System Medical Director shall determine the combination and number of EMT, ~~EMT-Intermediate,~~ AEMT or ~~EMT-Paramedic~~ Paramedic personnel that are sufficient to manage the anticipated number and severity of injury or illness of the patients transported in the Medical Ambulance/Evacuation Bus vehicle.

10A NCAC 13P .0221 PATIENT TRANSPORTATION BETWEEN HOSPITALS

(a) For the purpose of this Rule, hospital means those facilities as defined in Rule ~~.0102(30)~~ .0102(25) of this Subchapter.

(b) Every ground ambulance when transporting a patient between hospitals shall be occupied by all of the following;

(1) one person who holds a credential issued by the OEMS as ~~a Medical Responder~~ an emergency medical responder or higher who is responsible for the operation of the vehicle and rendering assistance to the patient caregiver when needed; and

(2) at least one of the following who is responsible for the medical aspects of the mission:

(A) ~~Emergency Medical Technician;~~ emergency medical technician;

(B) ~~EMT-Intermediate;~~ advanced EMT;

(C) ~~EMT-Paramedic;~~ paramedic;

(D) nurse practitioner;

(E) physician;

(F) physician assistant;

(G) registered nurse; or

(H) respiratory therapist.

(c) Information must be provided to the OEMS by the licensed EMS provider:

(1) describing the intended staffing pursuant to Rule ~~.0204(a)(3)~~ .0204(b)(3) of this Section; and

(2) showing authorization pursuant to Rule ~~.0204(a)(4)~~ .0204(b)(4) of this Section by the county in which the EMS provider license is issued to use the staffing in paragraph (b) of this Rule.

(d) Ambulances used for patient transports between hospitals must contain all medical equipment, supplies, and medications approved by the medical director, based on the treatment protocols.

10A NCAC 13P .0222 TRANSPORT OF STRETCHER BOUND PATIENTS

(a) Any person transported on a stretcher as defined in Rule .0102(50) of this Subchapter meets the definition of patient as defined in G.S. 131E-155 (16).

(b) Stretchers may only be utilized for patient transport in an ambulance permitted by the Department in accordance with G.S. 131E-156 and Rule .0211 of this Section.

(c) The Medical Care Commission exempts wheeled chair devices used solely for the transportation of mobility impaired persons in non-permitted vehicles configured solely for the use of wheeled chair devices from the definition of stretcher in Rule .0102(50) of this Subchapter.

10A NCAC 13P .0223 REQUIRED DISCLOSURE AND REPORTING INFORMATION

(a) Applicants for initial and renewal EMS Provider licensing must disclose the following background information:

(1) any prior name(s) used for providing emergency medical services in North Carolina or any other state;

(2) any felony criminal charges and convictions, under Federal or State law, and any civil actions taken against the applicant or any of its owners or officers in North Carolina or any other state;

(3) any misdemeanor or felony conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;

(4) any misdemeanor or felony conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of EMS care or service;

(5) any current and prior investigations and their outcomes for alleged Medicare, Medicaid, and insurance fraud, and tax evasion or fraud;

(6) any revocation or suspension of accreditation; and

(7) any revocation or suspension by any State licensing authority of a license to provide EMS.

(b) Within 30 days of occurrence, a Licensed EMS provider must disclose any changes in the background information defined in Paragraph (a) of this Rule that was provided to the OEMS in its most recent initial or renewal application.

10A NCAC 13P .0301 SPECIALTY CARE TRANSPORT PROGRAM CRITERIA

(a) EMS Providers seeking designation to provide specialty care transports shall submit an application for program approval to the OEMS at least 60 days prior to field implementation. The application shall document that the program has:

(1) a defined service area that identifies the specific transferring and receiving facilities in which the program is intended to service;

(2) written policies and procedures implemented for medical oversight meeting the requirements of Section .0400;

(3) service continuously available on a 24 hour per day basis;

(4) the capability to provide the patient care skills and procedures as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost;

(5) a written continuing education program for EMS personnel, under the direction of the Specialty Care Transport Program Continuing Education Coordinator, developed and modified based on feedback from program data, review and evaluation of patient outcomes, and quality management review that follows the ~~guidelines of the:~~ criteria defined in Rule .0501 of this Subchapter;

~~(A) "US DOT NHTSA EMT Basic Refresher: National Standard Curriculum" for EMT personnel; and~~

~~(B) "EMT P and EMT I Continuing Education National Guidelines" for EMT I and EMT P personnel.~~

~~These documents are incorporated by reference in accordance with G.S. 150B 21.6, including subsequent amendments and additions. These documents are available from NHTSA, 400 7th Street, SW, Washington, D.C. 20590, at no cost;~~

(6) a communication system that will provide two-way voice communications for transmission of patient information to medical crew members anywhere in the service area of the program. The SCTP medical director shall verify that the communications system is satisfactory for on-line medical direction;

(7) medical crew members that have all completed training regarding:

(A) operation of the EMS communications system used in the program; and

(B) the medical and patient safety equipment specific to the program. This training shall be conducted every six months;

(8) written operational protocols for the management of equipment, supplies and medications. These protocols include:

(A) a listing of all standard medical equipment, supplies, and medications for all vehicles used in the program based on the treatment protocols and approved by the medical director; and

(B) a methodology to assure that each ground vehicle and aircraft contains the required equipment, supplies and medications on each response; and

(9) written policies and procedures specifying how EMS Systems will dispatch and utilize the ground ambulances and aircraft operated by the program.

(b) When transporting patients, staffing for the ground ambulance and aircraft used in the SCTP shall be approved by the SCTP medical director as medical crew members, using any of the following appropriate for the condition of the patient:

(1) ~~EMT-Paramedic;~~ Paramedic;

(2) nurse practitioner;

(3) physician;

(4) physician assistant;

(5) registered nurse; and

(6) respiratory therapist.

(c) Specialty Care Transport Programs as defined in Rule ~~.0102(56)~~ .0102(48) of this Subchapter are exempt from the staffing requirements defined in G.S. 131E-158(a).

(d) Specialty Care Transport Program approval are valid for a period to coincide with the EMS Provider License, not to exceed six years. Programs shall apply to the OEMS for reapproval.

10A NCAC 13P .0302 AIR MEDICAL SPECIALTY CARE TRANSPORT PROGRAM CRITERIA FOR LICENSED EMS PROVIDERS USING ROTARY-WING AIRCRAFT

(a) In addition to the general requirements of Specialty Care Transport Programs in Rule .0301 of this Section, Air Medical Programs using rotary-wing aircraft shall document that the program has:

(1) Medical crew members that have all completed training regarding:

(A) Altitude physiology; and

(B) The operation of the EMS communications system used in the program;

(2) Written policies and procedures for transporting patients to appropriate facilities when diversion or bypass plans are activated;

(3) Written policies and procedures specifying how EMS Systems will dispatch and utilize aircraft operated by the program;

(4) Written triage protocols for trauma, stroke, STEMI, burn, and pediatric patients reviewed and approved by the OEMS medical director;

(5) Written policies and procedures specifying how EMS Systems will receive the Specialty Care Transport Services offered under the program when the aircraft are unavailable for service; and

(6) Written policies and procedures specifying how mutual aid assistance will be obtained from both in-state and bordering out-of-state air medical programs.

~~(6) A copy of the Specialty Care Transport Program patient care treatment protocols.~~

(b) All patient response, re-positioning and mission flight legs must be conducted under FAA part 135 regulations.

10A NCAC 13P .0403 RESPONSIBILITIES OF THE MEDICAL DIRECTOR FOR EMS SYSTEMS

(a) The Medical Director for an EMS System is responsible for the following:

(1) ensuring that medical control is available 24 hours a day;

(2) the establishment, approval and annual updating of adult and pediatric treatment protocols;

(3) EMD programs, the establishment, approval, and annual updating of the EMDPRS;

(4) medical supervision of the selection, system orientation, continuing education and performance of all EMS personnel;

(5) medical supervision of a scope of practice performance evaluation for all EMS personnel in the system based on the treatment protocols for the system;

(6) the medical review of the care provided to patients;

(7) providing guidance regarding decisions about the equipment, medical supplies, and medications that will be carried on all ambulances and EMS nontransporting vehicles operating within the system;

(8) keeping the care provided up to date with current medical practice; and

(9) developing and implementing an orientation plan for all hospitals within the EMS system that use MICN, EMS-NP, or EMS-PA personnel to provide on-line medical direction to EMS personnel, which includes:

(A) a discussion of all EMS System treatment protocols and procedures;

(B) an explanation of the specific scope of practice for credentialed EMS personnel, as authorized by the approved EMS System treatment protocols as required by Rule .0405 of this Section;

(C) a discussion of all practice settings within the EMS System and how scope of practice may vary in each setting;

(D) a mechanism to assess the ability to effectively use EMS System communications equipment including hospital and prehospital devices, EMS communication protocols, and communications contingency plans as related to on-line medical direction; and

(E) the successful completion of a scope of practice performance evaluation which verifies competency in Parts (A) through (D) of this Subparagraph and which is administered under the direction of the medical director.

(b) Any tasks related to Paragraph (a) of this Rule may be completed, through written delegation, by assisting physicians, physician assistants, nurse practitioners, registered nurses, EMD's, or ~~EMT-P's.~~ Paramedics.

(c) The Medical Director may suspend temporarily, pending due process review, any EMS personnel from further participation in the EMS System when it is determined the activities or medical care rendered by such personnel are detrimental to the care of the patient, constitute unprofessional conduct, or result in non-compliance with credentialing requirements. If during the due process review it is determined further action is necessary, the Medical Director may:

(1) restrict the EMS personnel's scope of practice pending successful completion of remediation on the identified deficiencies;

(2) continue the suspension pending successful completion of remediation on the identified deficiencies; or

(3) permanently revoke the EMS personnel's participation in the EMS System.

10A NCAC 13P .0409 EMS PEER REVIEW COMMITTEE FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) The EMS Peer Review Committee for a Specialty Care Transport Program shall:

(1) be composed of membership as defined in G.S. 131E-155(6b);

(2) appoint a physician as chairperson;

(3) meet at least quarterly;

(4) analyze program data to evaluate the ongoing quality of patient care and medical direction within the program;

(5) use information gained from program data analysis to make recommendations regarding the content of continuing education programs for medical crew members;

(6) review adult and pediatric treatment protocols of the Specialty Care Transport Programs and make recommendations to the medical director for changes;

(7) establish and implement a written procedure to guarantee due process reviews for medical crew members temporarily suspended by the medical director;

(8) record and maintain minutes of committee meetings throughout the approval period of the Specialty Care Transport Program;

(9) establish and implement EMS system performance improvement guidelines that meet or exceed the statewide standard as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost; and

(10) adopt written guidelines that address:

~~(a)~~(A) structure of committee membership;

~~(b)~~(B) appointment of committee officers;

~~(c)~~(C) appointment of committee members;

~~(d)~~(D) length of terms of committee members;

~~(e)~~(E) frequency of attendance of committee members;

~~(f)~~(F) establishment of a quorum for conducting business; and

~~(g)~~(G) confidentiality of medical records and personnel issues.

(b) County government representation is not required for committee membership for approved Air Medical Programs.

10A NCAC 13P .0501 EDUCATIONAL PROGRAMS

(a) An educational program approved by the OEMS to qualify credentialed EMS personnel to perform within their scope of practice shall be offered ~~by an EMS educational institution.~~ by:

(1) an approved North Carolina EMS educational institution;

(2) an EMS educational institution in another state where the education/credentialing requirements have been approved for legal recognition by the Department; or

(3) an EMD educational institution where the education/credentialing requirements have been approved for legal recognition by the Department.

(b) Educational programs approved to qualify EMS personnel for credentialing shall meet the educational ~~objectives~~ content of ~~the:~~ the "US DOT NHTSA National EMS Education Standards" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. This document is available from NHTSA, 400 7th Street, SW, Washington, D.C. 20590, at no cost.

~~(1) "US DOT NHTSA First Responder: National Standard Curriculum" for MR personnel;~~

~~(2) "US DOT NHTSA EMT-Basic: National Standard Curriculum" for EMT personnel;~~

~~(3) "US DOT NHTSA EMT-Paramedic: National Standard Curriculum" for EMT-I and EMT-P personnel. For EMT-I personnel, the educational objectives shall be limited to the following:~~

~~(A) Module 1: Preparatory~~

~~SECTION~~	~~TITLE~~	~~LESSON OBJECTIVES~~
~~1-1~~	~~EMS Systems / Roles & Responsibilities~~	~~1-1.1 - 1-1.46~~
~~1-2~~	~~The Well Being of the Paramedic~~	~~1-2.1 - 1-2.46~~
~~1-4~~	~~Medical / Legal Issues~~	~~1-4.1 - 1-4.35~~
~~1-5~~	~~Ethics~~	~~1-5.1 - 1-5.11~~
~~1-6~~	~~General Principles of Pathophysiology~~	~~1-6.3; 1-6.5 - 1-6.9; 1-6.13 - 1-6.16; 1-6.19 - 1-6.25; 1-6.27 - 1-6.31~~
~~1-7~~	~~Pharmacology~~	~~1-7.1 - 1-7.31~~
~~1-8~~	~~Venous Access / Medication Administration~~	~~1-8.1 - 1-8.8; 1-8.10 - 1-8.17; 1-8.19 - 1-8.34; 1-8.36 - 1-8.38; 1-8.40 - 1-8.43~~
~~1-9~~	~~Therapeutic Communications~~	~~1-9.1 - 1-9.21~~

~~(B) Module 2: Airway~~

~~SECTION~~	~~TITLE~~	~~LESSON OBJECTIVES~~
~~2-1~~	~~Airway Management & Ventilation~~	~~2-1.1 - 2-1.10; 2-1.12 - 2-1.40; 2-1.42 - 2-1.64;~~

		~~2-1.69;~~ ~~2-1.73 – 2-1.89;~~ ~~2-1.93 – 2-1.103;~~ ~~2-1.104a-d;~~ ~~2-1.105 – 2-1.106;~~ ~~2-1.108~~

~~(C) Module 3: Patient Assessment~~

~~SECTION~~	~~TITLE~~	~~LESSON OBJECTIVES~~
~~3-2~~	~~Techniques of Physical Examination~~	~~3-2.1 – 3-2.88~~

~~(D) Module 4: Trauma~~

~~SECTION~~	~~TITLE~~	~~LESSON OBJECTIVES~~
~~4-2~~	~~Hemorrhage and Shock~~	~~4-2.1 – 4-2.54~~
~~4-4~~	~~Burns~~	~~4-4.25 – 4-4.30;~~ ~~4-4.80 – 4-4.81~~

~~(E) Module 5: Medical~~

~~SECTION~~	~~TITLE~~	~~LESSON OBJECTIVES~~
~~5-1~~	~~Pulmonary~~	~~5-1.2 – 5-1.7;~~ ~~5-1.10bcdefjk – 5-1.14~~
~~5-2~~	~~Cardiology~~	~~5-2.1 – 5-2.5;~~ ~~5-2.8;~~ ~~5-2.11 – 5-2.12;~~ ~~5-2.14;~~ ~~5-2.29 – 5-2.30;~~ ~~5-2.53;~~ ~~5-2.65 – 5-2.68;~~ ~~5-2.70;~~ ~~5-2.72 – 5-2.73;~~

		5-2.75 – 5-2.77; 5-2.79 – 5-2.81; 5-2.84 – 5-2.89; 5-2.91 – 5-2.95; 5-2.121 – 5-2.125; 5-2.128 – 5-2.133; 5-2.150; 5-2.159; 5-2.162; 5-2.165; 5-2.168; 5-2.179 – 5-2.180; 5-2.184; 5-2.193 – 5-2.194; 5-2.201; 5-2.205ab; 5-2.206 – 5-2.207
5-3	Neurology	5-3.11 – 5-3.17; 5-3.82 – 5-3.83
5-4	Endocrinology	5-4.8 – 5-4.48
5-5	Allergies and Anaphylaxis	5-5.1 – 5-5.19
5-8	Toxicology	5-8.40 – 5-8.56; 5-8.62

(F) Module 7: Assessment Based Management

SECTION	TITLE	LESSON OBJECTIVES
7-1	Assessment Based Management	7-1.1 – 7-1.19 (objectives 7-1.12 and 7-1.19 include only abefhklo)

(4) "US DOT NHTSA Emergency Medical Dispatcher: National Standard Curriculum" for EMD personnel; and

(5) "National Guidelines for Educating EMS Instructors" for EMS Instructors.

These documents are incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. These documents are available from NHTSA, 400 7th Street, SW, Washington, D.C. 20590, at no cost.

(c) Educational programs approved to qualify EMD personnel for credentialing shall conform with the "ASTM F1258 – 95(2006): Standard Practice for Emergency Medical Dispatch" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. This document is available from ASTM International, 100 Barr Harbor Drive, PO Box C700, West Conshohocken, PA, 19428-2959 USA, at a cost of forty dollars ($40.00) per copy.

(d) Instructional methodology courses approved to qualify Level I EMS instructors shall conform with the "US DOT NHTSA 2002 National Guidelines for Educating EMS Instructors" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. This document is available from NHTSA, 400 7th Street, SW, Washington, D.C. 20590, at no cost.

~~(c) Educational programs approved to qualify EMS personnel for renewal of credentials shall follow the guidelines of the:~~

~~(1) "US DOT NHTSA First Responder Refresher: National Standard Curriculum" for MR personnel;~~

~~(2) "US DOT NHTSA EMT Basic Refresher: National Standard Curriculum" for EMT personnel;~~

~~(3) "EMT P and EMT I Continuing Education National Guidelines" for EMT I and EMT P personnel;~~

~~(4) "US DOT NHTSA Emergency Medical Dispatcher: National Standard Curriculum" for EMD personnel;~~

~~(5) "US DOT NHTSA EMT Intermediate Refresher: National Standard Curriculum" for EMT I personnel; and~~

~~(6) "US DOT NHTSA EMT Paramedic Refresher: National Standard Curriculum" for EMT P personnel.~~

~~These documents are incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. These documents are available from NHTSA, 400 7th Street, SW, Washington, D.C. 20590, at no cost.~~

(e) Continuing educational programs approved to qualify EMS personnel for renewal of credentials must be approved by demonstrating the ability to assess competency in the skills and medications for the level of application as defined by the North Carolina Medical Board pursuant to G.S. 143-514. These programs must offer an educational experience designed to enhance the practice of emergency medical services through:

(1) enrichment of knowledge;

(2) development or change of attitudes; or

(3) acquisition or improvement of skills.

(f) Refresher courses must comply with the requirements defined in Rule .0513 of this Subchapter.

10A NCAC 13P .0502 INITIAL CREDENTIALING REQUIREMENTS FOR ~~MR,~~ EMR, EMT, ~~EMT-I, EMT-P,~~ AEMT, PARAMEDIC, AND EMD

(a) In order to be credentialed as an ~~MR,~~ EMR, EMT, ~~EMT-I, EMT-P,~~ AEMT, or Paramedic, ~~or EMD,~~ individuals shall:

(1) Be at least 18 years of age.

(2) Successfully complete an approved educational program as defined in Rule .0501(b) of this Section for their level of application. ~~If the educational program was completed over one year prior to application, applicants shall submit evidence of completion of continuing education during the past year. This continuing education shall be based on the educational objectives in Rule .0501(c) of this Section consistent with their level of application and approved by the OEMS.~~

(3) Successfully complete a scope of practice performance evaluation which uses performance measures based on the cognitive, psychomotor, and affective educational objectives in Rule .0501(b) of this Section and which are consistent with their level of application and approved by the OEMS. This evaluation must be completed no more than one year prior to examination. This evaluation shall be conducted ~~under the direction of the educational medical advisor or~~ by a Level I or Level II EMS Instructor credentialed at or above the level of application or under the direction of the primary credentialed EMS instructor or educational medical advisor for the approved educational program. ~~and designated by the educational medical advisor, and may be included within the educational program or conducted separately. If the evaluation was completed over one year prior to application, applicants must repeat the evaluation and submit evidence of successful completion during the previous year.~~

(4) ~~Successfully~~ Within three months from their course graded date as reflected in the OEMS credentialing database, complete the first attempt to successfully complete a written examination administered by the OEMS or a written examination approved by OEMS as equivalent to the examination administered by OEMS. A maximum of three attempts within nine months shall be allowed except as defined in Paragraph (a)(4)(A) of this Rule. This examination may be taken at age 17; however, the EMS credential will not be issued until the applicant has reached the age of 18 as required in paragraph (a)(1) of this Rule.

(A) If the individual fails to satisfy this requirement, the individual may continue eligibility for examination for an additional three attempts within the following nine months by submitting to the OEMS:

(i) evidence the individual has repeated a course specific scope of practice evaluation as defined in paragraph (a)(3) of this rule; and

(ii) evidence of successful completion of a refresher course as defined in Rule .0513 of this Section for the level of application; or

(iii) evidence of a minimum of eight hours course specific remediation on each examination topic that revealed a deficiency below an average of 70% in their three previous written examination attempts.

(B) If unable to successfully complete the written examination requirement after six attempts within an 18 month period following course grading date as reflected in the OEMS credentialing database, the educational program becomes invalid and the individual may

only become eligible for credentialing by repeating the requirements detailed in Rule .0501of this Section.

(5) Submit to a criminal background history check pursuant to G.S. 131E-159(g) as defined in Rule .0511 of this Section.

(6) Submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).

(7) Disclose any criminal history to the EMS System and EMS System Medical Director.

(8) Be a resident of North Carolina or affiliated with an EMS provider approved by the Department.

(b) An individual seeking credentialing as an EMR, EMT, AEMT or Paramedic may qualify for initial credentialing under the legal recognition option defined in G.S. 131E-159(c).

(c) In order to be credentialed as an EMD, individuals shall:

(1) Be at least 18 years of age.

(2) Successfully complete the educational requirements defined in Rule .0501(c) of this Section.

(3) Successfully complete, within one year prior to application, an AHA CPR course or a course determined by the OEMS to be equivalent to the AHA CPR course, including infant, child, and adult CPR.

(4) Submit to a criminal background history check pursuant to G.S. 131E-159(g) as defined in Rule .0511 of this Section.

(5) Submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).

(7) Disclose any criminal history to the EMS System and EMS System Medical Director.

(8) Possess an EMD credential pursuant to G.S. 131E-159(d).

~~(b) EMD applicants shall successfully complete, within one year prior to application, an AHA CPR course or a course determined by the OEMS to be equivalent to the AHA CPR course, including infant, child, and adult CPR.~~

(d) Pursuant to G.S. 131E-159(h), the Department shall not issue an EMS credential for any person listed on the Department of Justice, Sex Offender and Public Protection Registry.

10A NCAC 13P .0503 TERM OF CREDENTIALS FOR EMS PERSONNEL

Credentials for EMS Personnel shall be valid for a period ~~of~~ not to exceed four years.

10A NCAC 13P .0504 RENEWAL OF CREDENTIALS FOR ~~MR,~~ EMR, EMT, ~~EMT-I, EMT-P,~~ AEMT, PARAMEDIC, AND EMD

(a) ~~MR,~~ EMR, EMT, ~~EMT-I, EMT-P,~~ AEMT, and Paramedic, ~~and EMD~~ applicants shall renew credentials by meeting the following criteria:

(1) presenting documentation to the OEMS or an approved EMS educational institution as defined in Rule .0603 or .0605 of this Subchapter that they have successfully completed an approved educational program as described in Rule ~~.0501(c)~~ .0501(e) or (f) of this Section;

(2) submit to a criminal background history check pursuant to G.S. 131E-159(g) as defined in Rule .0511 of this Section;

(3) submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s); and

(4) be a resident of North Carolina or affiliated with an EMS provider approved by the Department.

(b) EMD applicants shall renew credentials by presenting documentation to the OEMS that they hold a valid EMD credential issued in accordance with G.S. 131E-159(d).

(c) Upon request, an EMS professional may renew at a lower credentialing level by meeting the requirements defined in paragraph (a) of this Rule. To restore the credential held at the higher level, the individual must meet the requirements defined in Rule .0512 of this Section.

(d) EMS credentials may not be renewed through a local continuing education program more than 90 days prior to the date of expiration.

(e) An individual may renew an EMS credential under the legal recognition option defined in G.S. 131E-159(c).

(f) Pursuant to G.S. 150B-3(a), if an applicant makes a timely and sufficient application for renewal, the EMS credential does not expire until a decision on the credential is made by the Department. If the application is denied, the credential shall remain effective until the last day for applying for judicial review of the Department's order.

(g) Pursuant to G.S. 131E-159(h), the Department shall not renew the EMS credential for any person listed on the North Carolina Department of Justice, Sex Offender and Public Protection Registry.

10A NCAC 13P .0506 PRACTICE SETTINGS FOR EMS PERSONNEL

(a) Credentialed EMS Personnel may function in the following practice settings in accordance with the protocols approved by the medical director of the EMS System or Specialty Care Transport Program with which they are affiliated, and by the OEMS:

(1) at the location of a physiological or psychological illness or injury including transportation to an appropriate treatment facility if required;

(2) at public or community health facilities in conjunction with public and community health initiatives;

(3) in hospitals and clinics;

(4) in residences, facilities, or other locations as part of wellness or injury prevention initiatives within the community and the public health system; and

(5) at mass gatherings or special events.

(b) Individuals functioning in an approved alternative practice setting as defined in Rule .0102(4) of this Subchapter consistent with the areas identified in Paragraphs (a)(2) thru (4) of this Rule that are not affiliated with an EMS System shall:

(1) be under the medical oversight of a physician licensed by the North Carolina Medical Board that is associated with the practice setting in which the individual will function; and

(2) be restricted to performing within the scope of practice as defined by the North Carolina Medical Board pursuant to G. S. 143-514 for the individuals level of EMS credential.

(c) Individuals holding a valid EMR or EMT credential that are not affiliated with an approved first responder program or EMS agency and that do not administer medications or utilize advanced airway devices are approved to function as a member of an industrial or corporate first aid safety team without medical oversight or EMS System affiliation.

10A NCAC 13P .0507 CREDENTIALING REQUIREMENTS FOR LEVEL I EMS INSTRUCTORS

(a) Applicants for credentialing as a Level I EMS Instructor shall:

(1) be currently credentialed by the OEMS as an EMT, ~~EMT I, EMT P, or EMD;~~ AEMT, or Paramedic;

(2) have three years experience at the scope of practice for the level of application;

(3) within one year prior to application, successfully complete an evaluation which demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule .0501(b) of this Section consistent with their level of application and approved by the OEMS:

(A) For a credential to teach at the EMT level, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application; and

(B) For a credential to teach at the ~~EMT I~~ AEMT or ~~EMT P~~ Paramedic levels, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical ~~advisor; and~~ advisor.

~~(C) For a credential to teach at the EMD level, this evaluation shall be conducted under the direction of the educational medical advisor or a Level I EMS Instructor credentialed at the EMD level designated by the educational medical advisor;~~

(4) have 100 hours of teaching experience at the level of application in an approved EMS educational program or an EMS educational program approved by OEMS as equivalent to an approved program;

(5) successfully complete an educational program as described in Rule ~~.0501(b)(5)~~ .0501(d) of this Section;

(6) within one year prior to application, attend an OEMS Instructor workshop sponsored by the OEMS; and

(7) have a high school diploma or General Education Development certificate.

(b) An individual seeking credentialing for Level I EMS Instructor may qualify for initial credentialing under the legal recognition option defined in G.S. 131E-159(c).

~~(b)~~(c) The credential of a Level I EMS Instructor shall be valid for a period not to exceed four years, unless any of the following occurs:

(1) the OEMS imposes an administrative action against the instructor credential; or

(2) the instructor fails to maintain a current EMT, ~~EMT-I, EMT-P, or EMD~~ AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

10A NCAC 13P .0508 CREDENTIALING REQUIREMENTS FOR LEVEL II EMS INSTRUCTORS

(a) Applicants for credentialing as a Level II EMS Instructor shall:

(1) be credentialed by the OEMS as an EMT, ~~EMT-I, EMT-P, or EMD;~~ AEMT, or Paramedic;

(2) have completed post-secondary level education equal to or exceeding an Associate Degree;

(3) within one year prior to application, successfully complete an evaluation which demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule .0501(b) of this Section consistent with their level of application and approved by the OEMS:

(A) For a credential to teach at the EMT level, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application; and

(B) For a credential to teach at the ~~EMT-I~~ AEMT or ~~EMT-P~~ Paramedic level, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical advisor;

~~(C) For a credential to teach at the EMD level, this evaluation shall be conducted under the direction of the educational medical advisor or a Level I EMS Instructor credentialed at the EMD level designated by the educational medical advisor;~~

(4) have two years teaching experience as a Level I EMS Instructor at the level of application or a teaching experience approved as equivalent by the OEMS;

(5) successfully complete the "EMS Education Administration Course" conducted by a North Carolina Community College; and

(6) within one year of application, attend an OEMS Instructor workshop sponsored by the OEMS;

(b) An individual seeking credentialing for Level II EMS Instructor may qualify for initial credentialing under the legal recognition option defined in G.S. 131E-159(c).

~~(b)~~(c) The credential of a Level II EMS Instructor is valid for a period not to exceed four years, unless any of the following occurs:

(1) The OEMS imposes an administrative action against the instructor credential; or

(2) The instructor fails to maintain a current EMT, ~~EMT-I, EMT-P, or EMD~~ AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

10A NCAC 13P .0510 RENEWAL OF CREDENTIALS FOR LEVEL I AND LEVEL II EMS INSTRUCTORS

(a) Level I and Level II EMS Instructor applicants shall renew credentials by presenting documentation to the OEMS that they:

(1) are credentialed by the OEMS as an EMT, ~~EMT I,~~ AEMT or ~~EMT-P, or EMD;~~ Paramedic;

(2) successfully completed, within one year prior to application, a scope of practice performance evaluation which use performance measures based on the cognitive, psychomotor, and affective educational objectives in Rule .0501(b) of this Subchapter consistent with their level of application and approved by the OEMS:

(A) To renew a credential to teach at the EMT level, this evaluation shall be conducted under the direction of a Level II EMS Instructor credentialed at or above the level of application; and

(B) To renew a credential to teach at the ~~EMT I~~ AEMT or ~~EMT-P~~ Paramedic level, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical ~~advisor; and~~ advisor.

~~(C) To renew a credential to teach at the EMD level, this evaluation shall be conducted under the direction of the educational medical advisor or a Level I EMS Instructor credentialed at the EMD level designated by the educational medical advisor.~~

(3) completed 96 hours of EMS instruction at the level of application; and

(4) completed ~~40~~ 24 hours of educational professional development as defined by the educational ~~institution.~~ institution that provides for:

(A) enrichment of knowledge;

(B) development or change of attitude; or

(C) acquisition or improvement of skills; and

(5) within one year prior to renewal application, attend an OEMS Instructor workshop sponsored by the OEMS.

(b) An individual may renew a Level I or Level II EMS Instructor credential under the legal recognition option defined in G.S. 131E-159(c).

~~(b)~~(c) The credential of a Level I or Level II EMS Instructor is valid for a period not to exceed four years, unless any of the following occurs:

(1) the OEMS imposes an administrative action against the instructor credential; or

(2) the instructor fails to maintain a current EMT, ~~EMT I, EMT-P, or EMD~~ AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

10A NCAC 13P .0511 CRIMINAL HISTORIES

(a) The criminal background histories for all individuals who apply for EMS credentials, seek to renew EMS credentials, or hold EMS credentials shall be reviewed pursuant to G.S. 131E-159(g).

(b) In addition to Paragraph (a) of this Rule, the OEMS shall carry out the following for all EMS Personnel whose primary residence is outside North Carolina, individuals who have resided in North Carolina for 60 months or less, and individuals under investigation who may be subject to administrative enforcement action by the Department under the provisions of Rule .1507 of this Subchapter:

(1) obtain a signed consent form for a criminal history check;

(2) obtain fingerprints on an SBI identification card or live scan electronic fingerprinting system at an agency approved by the North Carolina Department of Justice, State Bureau of Investigation;

(3) obtain the criminal history from the Department of Justice; and

(4) collect any non-refundable processing fees from the individual identified in Paragraph (a) or (b) as required by the Department of Justice pursuant to G.S. 114-19.21 prior to conducting the criminal history background check.

(c) An individual who makes application for renewal of a current EMS credential or advancement to a higher level EMS credential who has previously submitted a criminal background history required under the criteria contained in Paragraph (b) of this Rule for residing in North Carolina for 60 months or less but has continuously resided in North Carolina since submission of the criminal background check may be exempt from the residency requirements of Paragraph (b) of this Rule.

~~(c)~~(d) An individual is not eligible for initial or renewal of EMS credentials if the applicant refuses to consent to any criminal history check as required by G.S. 131E-159(g). Since payment is required before the fingerprints may be processed by the State Bureau of Investigation, failure of the applicant or credentialed EMS personnel to pay the required fee in advance shall be considered a refusal to consent for the purposes of issuance or retention of an EMS credential.

10A NCAC 13P .0512 REINSTATEMENT OF LAPSED EMS CREDENTIAL

(a) EMS personnel that were eligible for renewal of an EMS credential prior to expiration may submit documentation to the OEMS following expiration and receive a renewed EMS credential with an expiration date no more than four years from the date of their lapsed credential.

(b) An individual with a lapsed North Carolina EMS credential is eligible for reinstatement through the legal recognition option defined in G.S. 131E-159(c) and Rule .0502 of this Subchapter.

(c) EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed up to 24 months, must:

(1) be ineligible for legal recognition as defined in Paragraph (b) of this Rule;

(2) be a resident of North Carolina or affiliated with a licensed North Carolina EMS Provider;

(3) at the time of application, present evidence that renewal education requirements were met prior to expiration and a minimum of 2 hours of continuing education per month following expiration or

successfully complete a refresher course at the level of application taken following expiration of the credential;

(4) successfully complete an OEMS administered written examination for the individuals level of credential application;

(5) undergo a criminal history check performed by the OEMS; and

(6) submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).

(d) EMR and EMT applicants for reinstatement of an EMS credential, lapsed more than 24 months, must:

(1) be ineligible for legal recognition as defined in Paragraph (b) of this Rule;

(2) meet the provisions for initial credentialing as defined in Rule .0502 of this Section; and

(5) undergo a criminal history check performed by the OEMS.

(e) AEMT and Paramedic applicants for reinstatement of an EMS credential, lapsed between 24 and 48 months, must:

(1) be ineligible for legal recognition as defined in Paragraph (b) of this Rule;

(2) be a resident of North Carolina or affiliated with a licensed North Carolina EMS Provider;

(3) present evidence of successful completion of a refresher course at the level of application taken following expiration of the credential;

(4) successfully complete an OEMS administered written examination for the individuals level of credential application;

(5) undergo a criminal history check performed by the OEMS; and

(6) submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).

(f) AEMT and Paramedic applicants for reinstatement of an EMS credential, lapsed more than 48 months, must:

(1) be ineligible for legal recognition as defined in Paragraph (b) of this Rule;

(2) meet the provisions for initial credentialing as defined in Rule .0502 of this Section; and

(3) undergo a criminal history check performed by the OEMS; and

(g) EMD applicants shall renew a lapsed credential by meeting the requirements for initial credentialing as defined in Rule .0502 of this Section.

(h) Pursuant to G.S. 131E-159(h), the Department shall not issue or renew the EMS credential for any person listed on the Department of Justice, Sex Offender and Public Protection Registry.

10A NCAC 13P .0513 REFRESHER COURSES

(a) Approved EMS educational institutions as defined in Rule .0603 of this Subchapter may develop refresher courses for the renewal or reinstatement of EMS credentials.

(b) The application for approval of a refresher course shall include:

(1) course objectives, content outline and time allocation;

(2) teaching methodologies for measuring the student's abilities to perform at their level of application;

(3) plan for evaluation of student competencies and ability to practice safe delivery of emergency medical care; and

(4) the method to be used to conduct a technical scope of practice evaluation for students seeking reinstatement of a lapsed EMS credential for their level of application.

(c) EMR, EMT, AEMT and paramedic refresher courses developed for the renewal of an EMS credential or reinstatement of an EMS credential as defined in Rule .0512 of this Section must meet the following criteria:

(1) application for approval of a refresher course shall be completed and submitted by the approved EMS educational institution at least 30 days prior to the expected date of enrollment and shall include evidence of complying with the rules for refresher courses.

(A) Refresher course approval shall be for a period not to exceed two years.

(B) Any changes in curriculum shall be approved by the OEMS prior to implementation.

(2) course curricula must:

(A) meet the National Registry of Emergency Medical Technicians' recertification requirements, incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. This document is available from the National Registry of Emergency Medical Technicians, Rocco V. Morando Building, 6610 Busch Blvd., P.O. Box 29233, Columbus, Ohio 43229, at no cost; and

(B) demonstrate the ability to assess student knowledge and competency in the skills and medications as defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the proposed level of EMS credential application.

(3) The administrative responsibility for developing and implementing the refresher course shall be vested in the EMS educational institution's credentialed Level II EMS instructor.

~~**10A NCAC 13P .0601 CONTINUING EDUCATION EMS EDUCATIONAL INSTITUTION REQUIREMENTS**~~

~~(a) Continuing Education EMS Educational Institutions shall be credentialed by the OEMS to provide EMS continuing education programs.~~

~~(b) Continuing Education EMS Educational Institutions shall have:~~

~~(1) at least a Level I EMS Instructor as program coordinator. The program coordinator shall hold a Level I EMS Instructor credential at a level equal to or greater than the highest level of continuing education program offered in the EMS System or Specialty Care Transport Program;~~

~~(2) a continuing education program consistent with the EMS System or Specialty Care Transport Program continuing education plan for EMS personnel:~~

~~(A) In an EMS System, the continuing education programs for EMD, EMT I, and EMT P shall be reviewed and approved by the medical director of the EMS System.~~

(B) In a Model EMS System, the continuing education program shall be reviewed and approved by the system continuing education coordinator and medical director.

(C) In a Specialty Care Transport Program, the continuing education program shall be reviewed and approved by Specialty Care Transport Program Continuing Education Coordinator and the medical director;

(3) access to instructional supplies and equipment necessary for students to complete educational programs as defined in Rule .0501(c) of this Subchapter;

(4) educational programs offered in accordance with Rule .0501(c) of this Subchapter;

(5) an Educational Medical Advisor if offering educational programs that have not been reviewed and approved by a medical director of an EMS System or Specialty Care Transport Program. The Educational Medical Advisor shall meet the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost; and

(6) written educational policies and procedures describing the delivery of educational programs, the record keeping system detailing student attendance and performance, and the selection and monitoring of EMS instructors.

(c) An application for credentialing as a Continuing Education EMS Educational Institution shall be submitted to the OEMS for review. The application shall demonstrate that the applicant meets the requirements in Paragraph (b) of this Rule.

(d) Continuing Education EMS Educational Institution credentials are valid for a period of four years.

10A NCAC 13P .0602 BASIC EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) Basic EMS Educational Institutions may offer MR, EMT, and EMD courses for which they have been credentialed by the OEMS.

(b) For initial courses, Basic EMS Educational Institutions shall have:

(1) at least a Level I EMS Instructor as lead course instructor for MR and EMT courses. The lead course instructor must be credentialed at a level equal to or higher than the course offered;

(2) at least a Level I EMS Instructor credentialed at the EMD level as lead course instructor for EMD courses;

(3) a lead EMS educational program coordinator. This individual may be either a Level II EMS Instructor credentialed at or above the highest level of course offered by the institution, or a combination of staff who cumulatively meet the requirements of the Level II EMS Instructor referenced in this Subparagraph. These individuals may share the responsibilities of the lead EMS educational coordinator. The details of this option shall be defined in the educational plan required in Subparagraph (b)(5) of this Rule. Basic EMS Educational Institutions offering only

~~EMD courses may meet this requirement with a Level I EMS Instructor credentialed at the EMD level;~~

~~(4) an Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost;~~

~~(5) written educational policies and procedures describing the delivery of educational programs, the record keeping system detailing student attendance and performance; and the selection and monitoring of EMS instructors; and~~

~~(6) access to instructional supplies and equipment necessary for students to complete educational programs as defined in Rule .0501(b) of this Subchapter.~~

~~(c) For EMS continuing education programs, Basic EMS Educational Institutions shall meet the requirements defined in Paragraphs (a) and (b) of Rule .0601 of this Section.~~

~~(d) An application for credentialing as a Basic EMS Educational Institution shall be submitted to the OEMS for review. The proposal shall demonstrate that the applicant meets the requirements in Paragraphs (b) and (c) of this Rule.~~

~~(e) Basic EMS Educational Institution credentials are valid for a period of four years.~~

10A NCAC 13P .0603 ~~ADVANCED~~ APPROVED EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) ~~Advanced~~ Approved EMS Educational Institutions may offer all EMS educational programs for which they have been credentialed by the OEMS.

(b) For initial courses, ~~Advanced~~ Approved EMS Educational Institutions shall have:

(1) at least a Level I EMS Instructor as lead course instructor for ~~MR~~ EMR and EMT ~~courses.~~ initial courses. The lead course instructor must be credentialed at a level equal to or higher than the course offered;

~~(2) at least a Level I EMS Instructor credentialed at the EMD level as lead course instructor for EMD courses;~~

~~(3)~~(2) a Level II EMS Instructor as lead instructor for ~~EMT-I~~ AEMT and ~~EMT-P~~ Paramedic initial courses. The lead course instructor must be credentialed at a level equal to or higher than the course offered;

~~(4)~~(3) a lead EMS educational program coordinator. This individual may be either a Level II EMS Instructor credentialed at or above the highest level of course offered by the institution, or a combination of staff who cumulatively meet the requirements of the Level II EMS Instructor referenced in this Subparagraph. These individuals may share the responsibilities of the lead EMS

educational coordinator. The details of this option shall be defined in the educational plan required in Subparagraph ~~(b)(6)~~ (b)(5) of this Rule;

~~(5)~~(4) an Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost;

~~(6)~~(5) written educational policies and procedures ~~describing the delivery of educational programs, the record keeping system detailing student attendance and performance; and the selection and monitoring of EMS instructors; and~~ to include each of the following:

(A) the secure delivery of educational programs;

(B) the secure delivery of cognitive and psychomotor examinations;

(C) the exam item validation process utilized for the development of validated cognitive examinations;

(D) the record-keeping system detailing student attendance and performance;

(E) the selection and monitoring of EMS instructors;

(F) the selection and monitoring of all in-state and out-of-state clinical education and field internship sites;

(G) the selection and monitoring of all approved clinical education and field internship preceptors,

(H) the initial and continuing education component of a standardized EMS preceptor program approved by the OEMS;

(I) the evaluation of faculty by their students, including the frequency of the evaluations;

(J) the evaluation of preceptors by their students, including the frequency of the evaluations;

(K) the evaluation of the program's courses or components by their students, including the frequency of the evaluations;

(L) the evaluation of the clinical education and field internship sites by their students, including the frequency of the evaluations;

(M) the evaluation of graduates and employers completed within six months following program completion;

(N) completion of an annual analysis of the program's strengths, weaknesses, opportunities, and threats, to identify any correctable deficiencies, and the provision of a corrective action plan for the enhancement of the program to the OEMS no later than the annual anniversary date of the program's approval; and

~~(7)~~(6) access to instructional supplies and equipment necessary for students to complete educational programs as defined in Rule .0501(b) of this Subchapter.

(c) For refresher courses, the Approved EMS Educational Institution shall:

(1) meet the requirements defined in Paragraphs (a) and (b) of this Rule; and

(2) meet at a minimum the educational program requirements as defined in Rule .0513 of this Subchapter,

~~(c)~~(d) For EMS continuing education programs, ~~Advanced~~ Approved EMS Educational Institutions ~~shall meet the requirements defined in Paragraphs (a) and (b) of Rule .0601 of this Section.~~ shall have:

(1) a Level I EMS Instructor as course coordinator. The course coordinator must be credentialed at a level equal to or higher than the course offered;

(2) an Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost;

(3) written educational policies and procedures to include each of the following:

(A) the secure delivery of educational programs;

(B) the secure delivery of cognitive and psychomotor examinations;

(C) the exam item validation process utilized for the development of validated cognitive examinations;

(D) the record-keeping system detailing student attendance and performance;

(E) the selection and monitoring of EMS instructors;

(F) the selection and monitoring of all in-state and out-of-state clinical education and field internship sites;

(G) the selection and monitoring of all approved clinical education and field internship preceptors,

(H) the continuing education component of an EMS preceptor program;

(I) the evaluation of faculty by their students, including the frequency of the evaluations;

(J) the evaluation of preceptors by their students, including the frequency of the evaluations;

(K) the evaluation of the program's courses or components by their students, including the frequency of the evaluations;

(L) the evaluation of the clinical education and field internship sites by their students, including the frequency of the evaluations;

(M) completion of an annual analysis of the program's strengths, weaknesses, opportunities, and threats, to identify any correctable deficiencies, and the provision of a corrective action plan for the enhancement of the program to the OEMS no later than the annual anniversary date of the program's approval; and

(4) access to instructional supplies and equipment necessary for students to complete educational programs as defined in Rule .0501(e) of this Subchapter.

(5) meet at a minimum the educational program requirements as defined in Rule .0501(e) of this Subchapter; and

(6) offer continuing education programs consistent with the services offered by the EMS System, Operational EMS Program and Specialty Care Transport Program.

(e) Approved EMS Educational Institutions may choose to credential offering any combination of the courses and programs defined in paragraphs (b) through (d) of this Rule.

(f) Upon request, the Approved EMS Educational Institution must provide records as defined in Paragraphs (b) through (e) of this Rule in order to verify compliance with educational program requirements and student eligibility for credentialing.

~~(d)~~(g) An application for credentialing as an ~~Advanced~~ Approved EMS Educational Institution shall be submitted to the OEMS for review. The applicant may choose any or all of the service types defined in Paragraphs (b) through (e) of this Rule. ~~The~~ Based upon the services selected to be offered, the application shall demonstrate that the applicant meets the requirements ~~in Paragraphs (b) and (c)~~ of this Rule.

~~(e)~~(h) ~~Advanced~~ Unless accredited in accordance with Rule .0605 of this Subchapter, Approved Educational Institution credentials are valid for a period ~~of~~ not to exceed four years.

10A NCAC 13P .0605 ACCREDITED EMS EDUCATIONAL INSTITUTION REQUIREMENTS

(a) EMS Educational Institutions who already possess accreditation by the CAAHEP may be credentialed by the OEMS by presenting:

(1) an application for credentialing;

(2) evidence to the OEMS of current CAAHEP accreditation;

(3) a copy of the self study;

(4) a copy of the executive analysis; and

(5) documentation reflecting compliance with Rule .0603 (b)(1) thru (b)(4) of this Section.

(b) For EMS Educational Institutions undergoing the accreditation process, the Educational Institution:

(1) the OEMS staff must be notified prior to the CAAHEP site visit; and

(2) upon accreditation, present the information presented in paragraph (a) of the Rule.

(c) Accredited EMS Educational Institutions may offer initial and renewal educational programs for EMS personnel as defined in Rule .0501 of this Subchapter.

(d) EMS Educational Institutions maintaining CAAHEP accreditation shall renew credentials no more than 12 months prior to expiration by providing the information detailed in paragraph (a) of this Rule.

(e) EMS Educational Institutions that fail to maintain CAAHEP accreditation will be subject to the credentialing and renewal standards defined in Rule .0603 of this Section.

(f) Accredited EMS Educational Institution credentials are valid for a period not to exceed five years.

10A NCAC 13P .0901 LEVEL I TRAUMA CENTER APPLICATION CRITERIA

To receive designation as a Level I Trauma Center, a hospital ~~shall have the following:~~ shall:

(1) ~~A~~ Have a trauma program and a trauma service that have been operational for at least 12 months prior to application for designation;

(2) ~~Membership~~ For at least 12 months prior to submitting a RFP, membership in and inclusion of all trauma patient records in the North Carolina Trauma ~~Registry for at least 12 months prior to submitting a Request for Proposal;~~ Registry, in accordance with the North Carolina Trauma Registry Data Dictionary, which is incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available upon request by contacting the OEMS at 2707 Mail Service Center, Raleigh, NC 27699-2707, at no cost; and

(3) Meet the verification criteria as defined in the "American College of Surgeons: Resources for Optimal Care of the Injured Patient" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available online at www.facs,org or from the American College of Surgeons, Post Office Box 92425, Chicago, Illinois 60675-2425, at a cost of twenty dollars ($20.00) per copy.

~~(3) A trauma medical director who is a board certified general surgeon. The trauma medical director must:~~

~~(a) Have a minimum of three years clinical experience on a trauma service or trauma fellowship training;~~

~~(b) Serve on the center's trauma service;~~

~~(c) Participate in providing care to patients with life threatening or urgent injuries;~~

~~(d) Participate in the North Carolina Chapter of the ACS Committee on Trauma as well as other regional and national trauma organizations;~~

~~(e) Remain a provider in the ACS' ATLS Course and in the provision of trauma related instruction to other health care personnel; and~~

~~(f) Be involved with trauma research and the publication of results and presentations;~~

~~(4) A full time TNC/TPM who is a registered nurse, licensed by the North Carolina Board of Nursing;~~

~~(5) A full time TR who has a working knowledge of medical terminology, is able to operate a personal computer, and has the ability to extract data from the medical record;~~

~~(6) A hospital department/division/section for general surgery, neurological surgery, emergency medicine, anesthesiology, and orthopaedic surgery, with designated chair or physician liaison to the trauma program for each;~~

~~(7) Clinical capabilities in general surgery with separate posted call schedules. One shall be for trauma, one for general surgery and one back up call schedule for trauma. In those instances where a physician may simultaneously be listed on more than one schedule, there must be a defined back up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. If a trauma surgeon is simultaneously on call at more than one hospital, there shall be a defined, posted trauma surgery back up call schedule composed of surgeons credentialed to serve on the trauma panel;~~

~~(8) A trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:~~

~~(a) An in-house trauma attending or PGY4 or senior general surgical resident. The trauma attending participates in therapeutic decisions and is present at all operative procedures.~~

~~(b) An emergency physician who is present in the Emergency Department 24 hours per day who is either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine). Emergency physicians caring only for pediatric patients may, as an alternative, be boarded or prepared in pediatric emergency medicine. Emergency physicians must be board certified within five years after successful completion of a residency in emergency medicine and serve as a designated member of the trauma team to ensure immediate care for the injured patient until the arrival of the trauma surgeon;~~

~~(c) Neurosurgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, unless there is either an in-house attending neurosurgeon, a PGY2 or higher in-house neurosurgery resident or an in-house trauma surgeon or emergency physician as long as the institution can document management guidelines and annual continuing medical education for neurosurgical emergencies. There must be a specified back-up on the call schedule whenever the neurosurgeon is simultaneously on call at a hospital other than the trauma center;~~

~~(d) Orthopaedic surgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, unless there is either an in-house attending orthopaedic surgeon, a PGY2 or higher in-house orthopaedic surgery resident or an in-house trauma surgeon or emergency physician as long as the institution can document management guidelines and annual continuing medical education for orthopaedic emergencies. There must be a specified written back-up on the call schedule whenever the orthopaedist is simultaneously on call at a hospital other than the trauma center;~~

~~(e) An in-house anesthesiologist or a CA3 resident as long as an anesthesiologist on call is advised and promptly available if requested by the trauma team leader; and~~

~~(f) Registered nursing personnel trained in the care of trauma patients;~~

~~(9) A written credentialing process established by the Department of Surgery to approve mid-level practitioners and attending general surgeons covering the trauma service. The surgeons must have board certification in general surgery within five years of completing residency;~~

~~(10) Neurosurgeons and orthopaedists serving the trauma service who are board certified or eligible. Those who are eligible must be board certified within five years after successful completion of the residency;~~

~~(11) Written protocols relating to trauma management formulated and updated to remain current;~~

~~(12) Criteria to ensure team activation prior to arrival, and trauma attending arrival within 15 minutes of the arrival of trauma and burn patients that include the following conditions:~~

~~(a) Shock;~~

~~(b) Respiratory distress;~~

~~(c) Airway compromise;~~

~~(d) Unresponsiveness (GSC less than nine) with potential for multiple injuries;~~

~~(e) Gunshot wound to neck, chest or abdomen;~~

~~(f) Patients receiving blood to maintain vital signs; and~~

~~(g) ED physician's decision to activate;~~

~~(13) Surgical evaluation, based upon the following criteria, by the trauma attending surgeon who is promptly available:~~

~~(a) Proximal amputations;~~

~~(b) Burns meeting institutional transfer criteria;~~

~~(c) Vascular compromise;~~

~~(d) Crush to chest or pelvis;~~

~~(e) Two or more proximal long bone fractures; and~~

~~(f) Spinal cord injury.~~

~~A PGY4 or higher surgical resident, a PGY3 or higher emergency medicine resident, a nurse practitioner or physician's assistant, who is a member of the designated surgical response team, may initiate the evaluation;~~

~~(14) Surgical consults for patients with traumatic injuries, at the request of the ED physician, will conducted by a member of the trauma surgical team. Criteria for the consults include:~~

~~(a) Falls greater than 20 feet;~~

~~(b) Pedestrian struck by motor vehicle;~~

~~(c) Motor vehicle crash with:~~

~~(i) Ejection (includes motorcycle);~~

~~(ii) Rollover;~~

~~(iii) Speed greater than 40 mph; or~~

~~(iv) Death of another individual in the same vehicle; and~~

~~(d) Extremes of age, less than five or greater than 70 years.~~

~~A senior surgical resident may initiate the evaluation;~~

~~(15) Clinical capabilities (promptly available if requested by the trauma team leader, with a posted on-call schedule), that include individuals credentialed in the following:~~

~~(a) Cardiac surgery;~~

~~(b) Critical care;~~

~~(c) Hand surgery;~~

~~(d) Microvascular/replant surgery, or if service is not available, a transfer agreement must exist;~~

~~(e) Neurosurgery (The neurosurgeon must be dedicated to one hospital or a back up call schedule must be available. If fewer than 25 emergency neurosurgical trauma operations are done in a year, and the neurosurgeon is dedicated only to that hospital, then a published back up call list is not necessary);~~

~~(f) Obstetrics/gynecologic surgery;~~

~~(g) Opthalmic surgery;~~

~~(h) Oral maxillofacial surgery;~~

~~(i) Orthopaedics (dedicated to one hospital or a back up call schedule must be available);~~

~~(j) Pediatric surgery;~~

~~(k) Plastic surgery;~~

~~(l) Radiology;~~

~~(m) Thoracic surgery; and~~

~~(n) Urologic surgery;~~

~~(16) An Emergency Department that has:~~

~~(a) A designated physician director who is board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);~~

~~(b) 24 hour per day staffing by physicians physically present in the ED such that:~~

~~(i) At least one physician on every shift in the ED is either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) to serve as the designated member of the trauma team to ensure immediate care until the arrival of the trauma surgeon. Emergency physicians caring only for pediatric patients may, as an alternative, be boarded in pediatric emergency medicine. All emergency physicians must be board certified within five years after successful completion of the residency;~~

~~(ii) All remaining emergency physicians, if not board certified or prepared in emergency medicine as outlined in Subitem (16)(b)(i) of this Rule, are board certified, or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine, with each being board certified within five years after successful completion of a residency; and~~

~~(iii) All emergency physicians practice emergency medicine as their primary specialty.~~

~~(c) Nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;~~

~~(d) Equipment for patients of all ages to include:~~

~~(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, pocket masks, and oxygen);~~

~~(ii) Pulse oximetry;~~

~~(iii) End-tidal carbon dioxide determination equipment;~~

~~(iv) Suction devices;~~

~~(v) Electrocardiograph oscilloscope defibrillator with internal paddles;~~

~~(vi) Apparatus to establish central venous pressure monitoring;~~

~~(vii) Intravenous fluids and administration devices that include large bore catheters and intraosseous infusion devices;~~

~~(viii) Sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, thoracostomy, peritoneal lavage, and central line insertion;~~

~~(ix) Apparatus for gastric decompression;~~

~~(x) 24 hour per day x-ray capability;~~

~~(xi) Two-way communication equipment for communication with the emergency transport system;~~

~~(xii) Skeletal traction devices, including capability for cervical traction;~~

~~(xiii) Arterial catheters;~~

~~(xiv) Thermal control equipment for patients;~~

~~(xv) Thermal control equipment for blood and fluids;~~

~~(xvi) A rapid infuser system;~~

~~(xvii) A dosing reference and measurement system to ensure appropriate age related medical care;~~

~~(xviii) Sonography; and~~

~~(xix) A doppler;~~

~~(17) An operating suite that is immediately available 24 hours per day and has:~~

~~(a) 24 hour per day immediate availability of in-house staffing;~~

~~(b) Equipment for patients of all ages that includes:~~

~~(i) Cardiopulmonary bypass capability;~~

~~(ii) Thermal control equipment for patients;~~

~~(iii) Thermal control equipment for blood and fluids;~~

~~(iv) 24 hour per day x-ray capability including c-arm image intensifier;~~

~~(v) Endoscopes and bronchoscopes;~~

~~(vi) Craniotomy instruments;~~

~~(vii) The capability of fixation of long bone and pelvic fractures; and~~

~~(viii) A rapid infuser system;~~

~~(18) A postanesthetic recovery room or surgical intensive care unit that has:~~

~~(a) 24 hour per day in house staffing by registered nurses;~~

~~(b) Equipment for patients of all ages that includes:~~

~~(i) The capability for resuscitation and continuous monitoring of temperature, hemodynamics, and gas exchange;~~

~~(ii) The capability for continuous monitoring of intracranial pressure;~~

~~(iii) Pulse oximetry;~~

~~(iv) End tidal carbon dioxide determination capability;~~

~~(v) Thermal control equipment for patients; and~~

~~(vi) Thermal control equipment for blood and fluids;~~

~~(19) An intensive care unit for trauma patients that has:~~

~~(a) A designated surgical director for trauma patients;~~

~~(b) A physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital as long as this physician is not the sole physician on call for the Emergency Department;~~

~~(c) Ratio of one nurse per two patients on each shift;~~

~~(d) Equipment for patients of all ages that includes:~~

~~(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators, and pocket masks);~~

~~(ii) An oxygen source with concentration controls;~~

~~(iii) A cardiac emergency cart;~~

~~(iv) A temporary transvenous pacemaker;~~

~~(v) Electrocardiograph oscilloscope defibrillator;~~

~~(vi) Cardiac output monitoring capability;~~

~~(vii) Electronic pressure monitoring capability;~~

~~(viii) A mechanical ventilator;~~

~~(ix) Patient weighing devices;~~

~~(x) Pulmonary function measuring devices;~~

~~(xi) Temperature control devices; and~~

~~(xii) Intracranial pressure monitoring devices.~~

~~(e) Within 30 minutes of request, the ability to perform blood gas measurements, hematocrit level, and chest x ray studies;~~

~~(20) Acute hemodialysis capability;~~

~~(21) Physician directed burn center staffed by nursing personnel trained in burn care or a transfer agreement with a burn center;~~

(22) Acute spinal cord management capability or transfer agreement with a hospital capable of caring for a spinal cord injured patient;

(23) Radiological capabilities that include:

(a) 24 hour per day in house radiology technologist;

(b) 24 hour per day in house computerized tomography technologist;

(c) Sonography;

(d) Computed tomography;

(e) Angiography;

(f) Magnetic resonance imaging; and

(g) Resuscitation equipment that includes airway management and IV therapy;

(24) Respiratory therapy services available in house 24 hours per day;

(25) 24 hour per day clinical laboratory service that must include:

(a) Analysis of blood, urine, and other body fluids, including micro sampling when appropriate;

(b) Blood typing and cross matching;

(c) Coagulation studies;

(d) Comprehensive blood bank or access to community central blood bank with storage facilities;

(e) Blood gases and pH determination; and

(f) Microbiology;

(26) A rehabilitation service that provides:

(a) A staff trained in rehabilitation care of critically injured patients;

(b) Functional assessment and recommendations regarding short and long term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable;

(c) In house rehabilitation service or a transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;

(d) Physical, occupational, speech therapies, and social services; and

(e) Substance abuse evaluation and counseling capability;

(27) A performance improvement program, as outlined in the North Carolina Chapter of the American College of Surgeons Committee on Trauma document "Performance Improvement Guidelines for North Carolina Trauma Centers," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. This performance improvement program must include:

(a) The state Trauma Registry whose data is submitted to the OEMS at least weekly and includes all the center's trauma patients as defined in Rule .0102(68) of this Subchapter

who are either diverted to an affiliated hospital, admitted to the trauma center for greater than 24 hours from an ED or hospital, die in the ED, are DOA or are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital);

(b) Morbidity and mortality reviews including all trauma deaths;

(c) Trauma performance committee that meets at least quarterly and includes physicians, nurses, pre-hospital personnel, and a variety of other healthcare providers, and reviews policies, procedures, and system issues and whose members or designee attends at least 50 percent of the regular meetings;

(d) Multidisciplinary peer review committee that meets at least quarterly and includes physicians from trauma, neurosurgery, orthopaedics, emergency medicine, anesthesiology, and other specialty physicians, as needed, specific to the case, and the trauma nurse coordinator/program manager and whose members or designee attends at least 50 percent of the regular meetings;

(e) Identification of discretionary and non-discretionary audit filters;

(f) Documentation and review of times and reasons for trauma related diversion of patients from the scene or referring hospital;

(g) Documentation and review of response times for trauma surgeons, neurosurgeons, anesthesiologists or airway managers, and orthopaedists. All must demonstrate 80 percent compliance.

(h) Monitoring of trauma team notification times;

(i) Review of pre-hospital trauma care that includes dead on arrivals; and

(j) Review of times and reasons for transfer of injured patients;

(28) An outreach program that includes:

(a) Transfer agreements to address the transfer and receipt of trauma patients;

(b) Programs for physicians within the community and within the referral area (that include telephone and on-site consultations) about how to access the trauma center resources and refer patients within the system;

(c) Development of a Regional Advisory Committee as specified in Rule .1102 of this Subchapter;

(d) Development of regional criteria for coordination of trauma care;

(e) Assessment of trauma system operations at the regional level; and

(f) ATLS;

(29) A program of injury prevention and public education that includes:

(a) Epidemiology research that includes studies in injury control, collaboration with other institutions on research, monitoring progress of prevention programs, and consultation with researchers on evaluation measures;

~~(b) Surveillance methods that includes trauma registry data, special Emergency Department and field collection projects;~~

~~(c) Designation of a injury prevention coordinator; and~~

~~(d) Outreach activities, program development, information resources, and collaboration with existing national, regional, and state trauma programs.~~

~~(30) A trauma research program designed to produce new knowledge applicable to the care of injured patients that includes:~~

~~(a) An identifiable institutional review board process;~~

~~(b) Educational presentations that must include 12 education/outreach presentations offered outside the trauma center over a three-year period; and~~

~~(c) 10 peer reviewed publications over a three-year period that could come from any aspect of the trauma program; and~~

~~(31) A written continuing education program for staff physicians, nurses, allied health personnel, and community physicians that includes:~~

~~(a) A general surgery residency program;~~

~~(b) 20 hours of Category I or II trauma-related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years for all attending general surgeons on the trauma service, orthopedists, and neurosurgeons, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center. Continuing education based on the reading of content such as journals or other continuing medical education documents is not considered education outside of the trauma center;~~

~~(c) 20 hours of Category I or II trauma-related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years for all emergency physicians, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center or visiting lecturers or speakers from outside the trauma center. Continuing education based on the reading of content such as journals or other continuing medical education documents is not considered education outside of the trauma center;~~

~~(d) ATLS completion for general surgeons on the trauma service and emergency physicians. Emergency physicians, if not boarded in emergency medicine, must be current in ATLS;~~

~~(e) 20 contact hours of trauma-related continuing education (beyond in-house in-services) every two years for the TNC/TPM;~~

~~(f) 16 hours of trauma registry related or trauma related continuing education every two years, as deemed appropriate by the trauma nurse coordinator/program manager for the trauma registrar;~~

~~(g) At least an 80 percent compliance rate for 16 hours of trauma related continuing education (as approved by the TNC/TPM)every two years related to trauma care for RN's and LPN's in transport programs, Emergency Departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the TNC/TPM; and~~

~~(h) 16 hours of trauma related continuing education every two years for mid-level practitioners routinely caring for trauma patients.~~

10A NCAC 13P .0902 LEVEL II TRAUMA CENTER CRITERIA

To receive designation as a Level II Trauma Center, a hospital ~~shall have the following:~~ shall:

(1) ~~A~~ Have a trauma program and a trauma service that have been operational for at least 12 months prior to application for designation;

(2) ~~Membership~~ For at least 12 months prior to submitting a RFP, membership in and inclusion of all trauma patient records in the North Carolina Trauma ~~Registry for at least 12 months prior to submitting a Request for Proposal;~~ Registry, in accordance with the North Carolina Trauma Registry Data Dictionary, which is incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available online upon request by contacting the OEMS at 2707 Mail Service Center, Raleigh, NC 27699-2707, at no cost; and

(3) Meet the verification criteria as defined in the "American College of Surgeons: Resources for Optimal Care of the Injured Patient" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available online at www.facs,org or from the American College of Surgeons, Post Office Box 92425, Chicago, Illinois 60675-2425, at a cost of twenty dollars ($20.00) per copy.

~~(3) A trauma medical director who is a board certified general surgeon. The trauma medical director must:~~

~~(a) Have at least three years clinical experience on a trauma service or trauma fellowship training;~~

~~(b) Serve on the center's trauma service;~~

~~(c) Participate in providing care to patients with life-threatening urgent injuries;~~

~~(d) Participate in the North Carolina Chapter of the ACS' Committee on Trauma as well as other regional and national trauma organizations; and~~

~~(e) Remain a provider in the ACS' ATLS and in the provision of trauma related instruction to other health care personnel;~~

~~(4) A full time trauma nurse coordinator TNC/TPM who is a registered nurse, licensed by the North Carolina Board of Nursing;~~

~~(5) A full time TR who has a working knowledge of medical terminology, is able to operate a personal computer, and has the ability to extract data from the medical record;~~

(6) A hospital department/division/section for general surgery, neurological surgery, emergency medicine, anesthesiology, and orthopedic surgery, with designated chair or physician liaison to the trauma program for each;

(7) Clinical capabilities in general surgery with separate posted call schedules. One shall be for trauma, one for general surgery and one back up call schedule for trauma. In those instances where a physician may simultaneously be listed on more than one schedule, there must be a defined back up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. If a trauma surgeon is simultaneously on call at more than one hospital, there shall be a defined, posted trauma surgery back up call schedule composed of surgeons credentialed to serve on the trauma panel;

(8) A trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:

(a) A trauma attending or PGY4 or senior general surgical resident. The trauma attending participates in therapeutic decisions and is present at all operative procedures.

(b) An emergency physician who is present in the Emergency Department 24 hours per day who is either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practices emergency medicine as his primary specialty. This emergency physician if prepared or eligible must be board certified within five years after successful completion of the residency and serves as a designated member of the trauma team to ensure immediate care for the injured patient until the arrival of the trauma surgeon;

(c) Neurosurgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, as long as there is either an in house attending neurosurgeon; a PGY2 or higher in house neurosurgery resident; or in house emergency physician or the on call trauma surgeon as long as the institution can document management guidelines and annual continuing medical education for neurosurgical emergencies. There must be a specified back up on the call schedule whenever the neurosurgeon is simultaneously on call at a hospital other than the trauma center;

(d) Orthopaedic surgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, as long as there is either an in house attending orthopaedic surgeon; a PGY2 or higher in house orthopaedic surgery resident; or in house emergency physician or the on call trauma surgeon as long as the institution can document management guidelines and annual continuing medical education for orthopaedic emergencies. There must be a

~~specified back up on the call schedule whenever the orthopaedic surgeon is simultaneously on-call at a hospital other than the trauma center; and~~

~~(c) An in-house anesthesiologist or a CA3 resident unless an anesthesiologist on call is advised and promptly available after notification or an in-house CRNA under physician supervision, practicing in accordance with G.S. 90-171.20(7)c, pending the arrival of the anesthesiologist;~~

~~(9) A credentialing process established by the Department of Surgery to approve mid-level practitioners and attending general surgeons covering the trauma service. The surgeons must have board certification in general surgery within five years of completing residency;~~

~~(10) Neurosurgeons and orthopaedists serving the trauma service who are board certified or eligible. Those who are eligible must be board certified within five years after successful completion of the residency;~~

~~(11) Written protocols relating to trauma care management formulated and updated to remain current;~~

~~(12) Criteria to ensure team activation prior to arrival, and attending arrival within 20 minutes of the arrival of trauma and burn patients that include the following conditions:~~

~~(a) Shock;~~

~~(b) Respiratory distress;~~

~~(c) Airway compromise;~~

~~(d) Unresponsiveness (GCS less than nine with potential for multiple injuries;~~

~~(e) Gunshot wound to neck, chest or abdomen;~~

~~(f) Patients receiving blood to maintain vital signs; and~~

~~(g) ED physician's decision to activate;~~

~~(13) Surgical evaluation, based upon the following criteria, by the health professional who is promptly available:~~

~~(a) Proximal amputations;~~

~~(b) Burns meeting institutional transfer criteria;~~

~~(c) Vascular compromise;~~

~~(d) Crush to chest or pelvis;~~

~~(e) Two or more proximal long bone fractures; and~~

~~(f) Spinal cord injury;~~

~~(14) Surgical consults, based upon the following criteria, by the health professional who is promptly available:~~

~~(a) Falls greater than 20 feet;~~

~~(b) Pedestrian struck by motor vehicle;~~

~~(c) Motor vehicle crash with:~~

~~(i) Ejection (includes motorcycle);~~

~~(ii) Rollover;~~

~~(iii) Speed greater than 40 mph; or~~

~~(iv) Death of another individual in the same vehicle; or~~

~~(d) Extremes of age, less than five or greater than 70 years;~~

~~(15) Clinical capabilities (promptly available if requested by the trauma team leader, with a posted on-call schedule), that include individuals credentialed in the following:~~

~~(a) Critical care;~~

~~(b) Hand surgery;~~

~~(c) Neurosurgery (The neurosurgeon must be dedicated to one hospital or a back up call schedule must be available. If fewer than 25 emergency neurosurgical trauma operations are done in a year, and the neurosurgeon is dedicated only to that hospital, then a published back up call list is not necessary.);~~

~~(d) Obstetrics/gynecologic surgery;~~

~~(e) Opthalmic surgery;~~

~~(f) Oral maxillofacial surgery;~~

~~(g) Orthopaedics (dedicated to one hospital or a back up call schedule must be available);~~

~~(h) Plastic surgery;~~

~~(i) Radiology;~~

~~(j) Thoracic surgery; and~~

~~(k) Urologic surgery;~~

~~(16) An Emergency Department that has:~~

~~(a) A physician director who is board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);~~

~~(b) 24 hour per day staffing by physicians physically present in the Emergency Department who:~~

~~(i) Are either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine). These emergency physicians must be board certified within five years after successful completion of a residency;~~

~~(ii) Are hospital designated members of the trauma team; and~~

~~(iii) Practice emergency medicine as their primary specialty;~~

~~(c) Nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;~~

~~(d) Equipment for patients of all ages that includes:~~

~~(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, pocket masks, and oxygen);~~

~~(ii) Pulse oximetry;~~

~~(iii) End-tidal carbon dioxide determination equipment;~~

~~(iv) Suction devices;~~

~~(v) An electrocardiograph-oscilloscope-defibrillator with internal paddles;~~

~~(vi) An apparatus to establish central venous pressure monitoring;~~

~~(vii) Intravenous fluids and administration devices that include large bore catheters and intraosseous infusion devices;~~

~~(viii) Sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, thoracostomy, peritoneal lavage, and central line insertion;~~

~~(ix) An apparatus for gastric decompression;~~

~~(x) 24-hour-per-day x-ray capability;~~

~~(xi) Two-way communication equipment for communication with the emergency transport system;~~

~~(xii) Skeletal traction devices, including capability for cervical traction;~~

~~(xiii) Arterial catheters;~~

~~(xiv) Thermal control equipment for patients;~~

~~(xv) Thermal control equipment for blood and fluids;~~

~~(xvi) A rapid infuser system;~~

~~(xvii) A dosing reference and measurement system to ensure appropriate age-related medical care;~~

~~(xviii) Sonography; and~~

~~(xix) A Doppler;~~

~~(17) An operating suite that is immediately available 24 hours per day and has:~~

~~(a) 24-hour-per-day immediate availability of in-house staffing;~~

~~(b) Equipment for patients of all ages that includes:~~

~~(i) Thermal control equipment for patients;~~

~~(ii) Thermal control equipment for blood and fluids;~~

~~(iii) 24-hour-per-day x-ray capability, including c-arm image intensifier;~~

~~(iv) Endoscopes and bronchoscopes;~~

~~(v) Craniotomy instruments;~~

~~(vi) The capability of fixation of long bone and pelvic fractures; and~~

~~(vii) A rapid infuser system;~~

~~(18) A postanesthetic recovery room or surgical intensive care unit that has:~~

~~(a) 24-hour-per-day in-house staffing by registered nurses;~~

~~(b) Equipment for patients of all ages to include:~~

~~(i) Capability for resuscitation and continuous monitoring of temperature, hemodynamics, and gas exchange;~~

~~(ii) Capability for continuous monitoring of intracranial pressure;~~

~~(iii) Pulse oximetry;~~

~~(iv) End-tidal carbon dioxide determination capability;~~

~~(v) Thermal control equipment for patients; and~~

~~(vi) Thermal control equipment for blood and fluids;~~

~~(19) An intensive care unit for trauma patients that has:~~

~~(a) A hospital designated surgical director of trauma patients;~~

~~(b) A physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital as long as this physician is not the sole physician on call for the Emergency Department;~~

~~(c) Ratio of one nurse per two patients on each shift;~~

~~(d) Equipment for patients of all ages that includes:~~

~~(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, and pocket masks);~~

~~(ii) An oxygen source with concentration controls;~~

~~(iii) A cardiac emergency cart;~~

~~(iv) A temporary transvenous pacemaker;~~

~~(v) Electrocardiograph-oscilloscope-defibrillator;~~

~~(vi) Cardiac output monitoring capability;~~

~~(vii) Electronic pressure monitoring capability;~~

~~(viii) A mechanical ventilator;~~

~~(ix) Patient weighing devices;~~

~~(x) Pulmonary function measuring devices;~~

~~(xi) Temperature control devices; and~~

~~(xii) Intracranial pressure monitoring devices; and~~

~~(e) Within 30 minutes of request, the ability to perform blood gas measurements, hematocrit level, and chest x-ray studies;~~

~~(20) Acute hemodialysis capability or utilization of a transfer agreement;~~

~~(21) Physician-directed burn center staffed by nursing personnel trained in burn care or a transfer agreement with a burn center;~~

~~(22) Acute spinal cord management capability or transfer agreement with a hospital capable of caring for a spinal cord injured patient;~~

~~(23) Radiological capabilities that include:~~

~~(a) 24 hour per day in-house radiology technologist;~~

~~(b) 24 hour per day in-house computerized tomography technologist;~~

(c) Sonography;

(d) Computed tomography;

(e) Angiography; and

(f) Resuscitation equipment that includes airway management and IV therapy;

(24) Respiratory therapy services available in-house 24 hours per day;

(25) 24-hour-per-day clinical laboratory service that must include:

(a) Analysis of blood, urine, and other body fluids, including micro-sampling when appropriate;

(b) Blood typing and cross-matching;

(c) Coagulation studies;

(d) Comprehensive blood bank or access to a community central blood bank with storage facilities;

(e) Blood gases and pH determination; and

(f) Microbiology;

(26) A rehabilitation service that provides:

(a) A staff trained in rehabilitation care of critically injured patients;

(b) For trauma patients, functional assessment and recommendation regarding short- and long-term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable;

(c) In-house rehabilitation service or a transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;

(d) Physical, occupational, speech therapies, and social services; and

(e) Substance abuse evaluation and counseling capability;

(27) A performance improvement program, as outlined in the North Carolina Chapter of the American College of Surgeons Committee on Trauma document "Performance Improvement Guidelines for North Carolina Trauma Centers," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. This performance improvement program must include:

(a) The state Trauma Registry whose data is submitted to the OEMS at least weekly and includes all the center's trauma patients as defined in Rule .0102(68) of this Subchapter who are either diverted to an affiliated hospital, admitted to the trauma center for greater than 24 hours from an ED or hospital, die in the ED, are DOA or are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital);

(b) Morbidity and mortality reviews that include all trauma deaths;

(c) Trauma performance committee that meets at least quarterly and includes physicians, nurses, pre-hospital personnel, and a variety of other healthcare providers, and reviews

~~policies, procedures, and system issues and whose members or designee attends at least 50 percent of the regular meetings;~~

~~(d) Multidisciplinary peer review committee that meets at least quarterly and includes physicians from trauma, neurosurgery, orthopaedics, emergency medicine, anesthesiology, and other specialty physicians, as needed, specific to the case, and the TNC/TPM and whose members or designee attends at least 50 percent of the regular meetings;~~

~~(e) Identification of discretionary and non-discretionary audit filters;~~

~~(f) Documentation and review of times and reasons for trauma related diversion of patients from the scene or referring hospital;~~

~~(g) Documentation and review of response times for trauma surgeons, neurosurgeons, anesthesiologists or airway managers, and orthopaedists. All must demonstrate 80 percent compliance;~~

~~(h) Monitoring of trauma team notification times;~~

~~(i) Review of pre-hospital trauma care to include dead on arrivals; and~~

~~(j) Review of times and reasons for transfer of injured patients;~~

~~(28) An outreach program that includes:~~

~~(a) Transfer agreements to address the transfer and receipt of trauma patients;~~

~~(b) Programs for physicians within the community and within the referral area (that include telephone and on-site consultations) about how to access the trauma center resources and refer patients within the system;~~

~~(c) Development of a Regional Advisory Committee as specified in Rule .1102 of this Subchapter;~~

~~(d) Development of regional criteria for coordination of trauma care; and~~

~~(e) Assessment of trauma system operations at the regional level;~~

~~(29) A program of injury prevention and public education that includes:~~

~~(a) Designation of an injury prevention coordinator; and~~

~~(b) Outreach activities, program development, information resources, and collaboration with existing national, regional, and state trauma programs; and~~

~~(30) A written continuing education program for staff physicians, nurses, allied health personnel, and community physicians that includes:~~

~~(a) 20 hours of Category I or II trauma-related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years for all attending general surgeons on the trauma service, orthopaedics, and neurosurgeons, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center or visiting lecturers or speakers from outside the trauma center. Continuing education based on the reading of content such as journals or other~~

~~continuing medical education documents is not considered education outside of the trauma center;~~

~~(b) 20 hours of Category I or II trauma related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years for all emergency physicians, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center or visiting lecturers or speakers from outside the trauma center. Continuing education based on the reading of content such as journals or other continuing medical education documents is not considered education outside of the trauma center;~~

~~(c) ATLS completion for general surgeons on the trauma service and emergency physicians. Emergency physicians, if not boarded in emergency medicine, must be current in ATLS.~~

~~(d) 20 contact hours of trauma related continuing education (beyond in house in services) every two years for the TNC/TPM;~~

~~(e) 16 hours of trauma registry related or trauma related continuing education every two years, as deemed appropriate by the TNC/TPM, for the trauma registrar;~~

~~(f) at least 80 percent compliance rate for 16 hours of trauma related continuing education (as approved by the TNC/TPM)every two years related to trauma care for RN's and LPN's in transport programs, Emergency Departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator/program manager; and~~

~~(g) 16 contact hours of trauma related continuing education every two years for mid level practitioners routinely caring for trauma patients.~~

10A NCAC 13P .0903 LEVEL III TRAUMA CENTER CRITERIA

To receive designation as a Level III Trauma Center, a hospital ~~shall have:~~ shall:

(1) ~~A~~ Have a trauma program and a trauma service that have been operational for at least 12 months prior to application for designation;

(2) ~~Membership~~ For at least 12 months prior to submitting a RFP, membership in and inclusion of all trauma patient records in the North Carolina Trauma ~~Registry for at least 12 months prior to submitting a Request for Proposal;~~ Registry, in accordance with the North Carolina Trauma Registry Data Dictionary, which is incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available online upon request by contacting the OEMS at 2707 Mail Service Center, Raleigh, NC 27699-2707, at no cost; and

(3) Meet the verification criteria as defined in the "American College of Surgeons: Resources for Optimal Care of the Injured Patient" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available online at

www.facs,org or from the American College of Surgeons, Post Office Box 92425, Chicago, Illinois 60675-2425, at a cost of twenty dollars ($20.00) per copy.

~~(3) A trauma medical director who is a board certified general surgeon. The trauma medical director must:~~

~~(a) Serve on the center's trauma service;~~

~~(b) Participate in providing care to patients with life threatening or urgent injuries;~~

~~(c) Participate in the North Carolina Chapter of the ACS' Committee on Trauma; and~~

~~(d) Remain a provider in the ACS' ATLS Course in the provision of trauma related instruction to other health care personnel;~~

~~(4) A hospital designated trauma nurse coordinator TNC/TPM who is a registered nurse, licensed by the North Carolina Board of Nursing;~~

~~(5) A TR who has a working knowledge of medical terminology, is able to operate a personal computer, and has the ability to extract data from the medical record;~~

~~(6) A hospital department/division/section for general surgery, emergency medicine, anesthesiology, and orthopaedic surgery, with designated chair or physician liaison to the trauma program for each;~~

~~(7) Clinical capabilities in general surgery with a written posted call schedule that indicates who is on call for both trauma and general surgery. If a trauma surgeon is simultaneously on call at more than one hospital, there must be a defined, posted trauma surgery back up call schedule composed of surgeons credentialed to serve on the trauma panel. The trauma service director shall specify, in writing, the specific credentials that each back up surgeon must have. These must state that the back up surgeon has surgical privileges at the trauma center and is boarded or eligible in general surgery (with board certification in general surgery within five years of completing residency);~~

~~(8) Response of a trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:~~

~~(a) A trauma attending whose presence at the patient's bedside within 30 minutes of notification is documented and who participates in therapeutic decisions and is present at all operative procedures;~~

~~(b) An emergency physician who is present in the ED 24 hours per day who is either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine and practices emergency medicine as his primary specialty. This emergency physician if prepared or eligible must be board certified within five years after successful completion of the residency and serve as a hospital designated member of the trauma team to ensure immediate care for the trauma patient until the arrival of the trauma surgeon; and~~

~~(c) An anesthesiologist who is on-call and promptly available after notification by the trauma team leader or an in-house CRNA under physician supervision, practicing in accordance with G.S. 90-171.20(7)e, pending the arrival of the anesthesiologist within 30 minutes of notification;~~

~~(9) A credentialing process established by the Department of Surgery to approve mid-level practitioners and attending general surgeons covering the trauma service. The surgeons must have board certification in general surgery within five years of completing residency;~~

~~(10) Board certification or eligibility of orthopaedists and neurosurgeons (if participating),with board certification within five years after successful completion of residency;~~

~~(11) Written protocols relating to trauma care management formulated and updated. Activation guidelines shall reflect criteria that ensures patients receive timely and appropriate treatment including stabilization, intervention and transfer. Documentation of effectiveness of variances from activation criteria addressed in Items (12), (13), and (14) of this Rule must be available for review;~~

~~(12) Criteria to ensure team activation prior to arrival of trauma and burn patients that include the following conditions:~~

~~(a) Shock;~~

~~(b) Respiratory distress;~~

~~(c) Airway compromise;~~

~~(d) Unresponsiveness (GSC less than nine) with evidence for multiple injuries;~~

~~(e) Gunshot wound to neck, or torso; or~~

~~(f) ED physician's decision to activate;~~

~~(13) Trauma Treatment Guidelines based on facility capabilities that ensure surgical evaluation or appropriate transfer, based upon the following criteria, by the health professional who is promptly available:~~

~~(a) Proximal amputations;~~

~~(b) Burns meeting institutional transfer criteria;~~

~~(c) Vascular compromise;~~

~~(d) Crush to chest or pelvis;~~

~~(e) Two or more proximal long bone fractures;~~

~~(f) Spinal cord injury; and~~

~~(g) Gunshot wound to the head;~~

~~(14) Surgical consults or appropriate transfers determined by Trauma Treatment Guidelines based on facility capabilities, based upon the following criteria, by the health professional who is promptly available:~~

~~(a) Falls greater than 20 feet;~~

~~(b) Pedestrian struck by motor vehicle;~~

~~(c) Motor vehicle crash with:~~

~~(i) Ejection (includes motorcycle);~~

~~(ii) Rollover;~~

~~(iii) Speed greater than 40 mph; or~~

~~(iv) Death of another individual in the same vehicle; and~~

~~(d) Extremes of age, less than five or greater than 70 years;~~

~~(15) Clinical capabilities (promptly available if requested by the trauma team leader, with a posted on-call schedule) that include individuals credentialed in the following:~~

~~(a) Orthopaedics;~~

~~(b) Radiology; and~~

~~(c) Neurosurgery, if actively participating in the acute resuscitation and operative management of patients managed by the trauma team;~~

~~(16) An Emergency Department that has:~~

~~(a) A physician director who is board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);~~

~~(b) 24 hour per day staffing by physicians physically present in the Emergency Department who:~~

~~(i) Are either board certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) or board certified or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine. These emergency physicians must be board certified within five years after successful completion of a residency;~~

~~(ii) Are designated members of the trauma team to ensure immediate care to the trauma patient; and~~

~~(iii) Practice emergency medicine as their primary specialty;~~

~~(c) Nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;~~

~~(d) Resuscitation equipment for patients of all ages that includes:~~

~~(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, pocket masks, and oxygen);~~

~~(ii) Pulse oximetry;~~

~~(iii) End-tidal carbon dioxide determination equipment;~~

~~(iv) Suction devices;~~

~~(v) An Electrocardiograph oscilloscope defibrillator with internal paddles;~~

~~(vi) Apparatus to establish central venous pressure monitoring;~~

~~(vii) Intravenous fluids and administration devices that include large bore catheters and intraosseous infusion devices;~~

~~(viii) Sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, thoracostomy, peritoneal lavage, and central line insertion;~~

~~(ix) Apparatus for gastric decompression;~~

~~(x) 24 hour per day x-ray capability;~~

~~(xi) Two way communication equipment for communication with the emergency transport system;~~

~~(xii) Skeletal traction devices;~~

~~(xiii) Thermal control equipment for patients;~~

~~(xiv) Thermal control equipment for blood and fluids;~~

~~(xv) A rapid infuser system;~~

~~(xvi) A dosing reference and measurement system to ensure appropriate age related medical care; and~~

~~(xvii) A Doppler;~~

~~(17) An operating suite that has:~~

~~(a) Personnel available 24 hours a day, on call, and available within 30 minutes of notification unless in house;~~

~~(b) Age specific equipment that includes:~~

~~(i) Thermal control equipment for patients;~~

~~(ii) Thermal control equipment for blood and fluids;~~

~~(iii) 24 hour per day x-ray capability, including c-arm image intensifier;~~

~~(iv) Endoscopes and bronchoscopes;~~

~~(v) Equipment for long bone and pelvic fracture fixation; and~~

~~(vi) A rapid infuser system;~~

~~(18) A postanesthetic recovery room or surgical intensive care unit that has:~~

~~(a) 24 hour per day availability of registered nurses within 30 minutes from inside or outside the hospital;~~

~~(b) Equipment for patients of all ages that includes:~~

~~(i) The capability for resuscitation and continuous monitoring of temperature, hemodynamics, and gas exchange;~~

~~(ii) Pulse oximetry;~~

~~(iii) End tidal carbon dioxide determination;~~

~~(iv) Thermal control equipment for patients; and~~

~~(v) Thermal control equipment for blood and fluids;~~

~~(19) An intensive care unit for trauma patients that has:~~

~~(a) A trauma surgeon who actively participates in the committee overseeing the ICU;~~

~~(b) A physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital (which may be a physician who is the sole physician on call for the ED);~~

~~(c) Equipment for patients of all ages that includes:~~

~~(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators and pocket masks);~~

~~(ii) An oxygen source with concentration controls;~~

~~(iii) A cardiac emergency cart;~~

~~(iv) A temporary transvenous pacemaker;~~

~~(v) An electrocardiograph-oscilloscope-defibrillator;~~

~~(vi) Cardiac output monitoring capability;~~

~~(vii) Electronic pressure monitoring capability;~~

~~(viii) A mechanical ventilator;~~

~~(ix) Patient weighing devices;~~

~~(x) Pulmonary function measuring devices; and~~

~~(xi) Temperature control devices; and~~

~~(d) Within 30 minutes of request, the ability to perform blood gas measurements, hematocrit level, and chest x-ray studies;~~

~~(20) Acute hemodialysis capability or utilization of a written transfer agreement;~~

~~(21) Physician-directed burn center staffed by nursing personnel trained in burn care or a written transfer agreement with a burn center;~~

~~(22) Acute spinal cord management capability or transfer agreement with a hospital capable of caring for a spinal cord injured patient;~~

~~(23) Acute head injury management capability or transfer agreement with a hospital capable of caring for a head injury;~~

~~(24) Radiological capabilities that include:~~

~~(a) Radiology technologist and computer tomography technologist available within 30 minutes of notification or documentation that procedures are available within 30 minutes;~~

~~(b) Computed Tomography;~~

~~(c) Sonography; and~~

~~(d) Resuscitation equipment that includes airway management and IV therapy;~~

~~(25) Respiratory therapy services on call 24 hours per day;~~

~~(26) 24 hour per day clinical laboratory service that must include:~~

~~(a) Analysis of blood, urine, and other body fluids, including micro sampling when appropriate;~~

~~(b) Blood typing and cross matching;~~

~~(c) Coagulation studies;~~

~~(d) Comprehensive blood bank or access to a community central blood bank with storage facilities;~~

~~(e) Blood gases and pH determination; and~~

~~(f) Microbiology;~~

~~(27) In house rehabilitation service or transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;~~

~~(28) Physical therapy and social services;~~

~~(29) A performance improvement program, as outlined in the North Carolina Chapter of the American College of Surgeons Committee on Trauma document "Performance Improvement Guidelines for North Carolina Trauma Centers," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. This performance improvement program must include:~~

~~(a) The state Trauma Registry whose data is submitted to the OEMS at least weekly and includes all the center's trauma patients as defined in Rule .0102(68) of this Subchapter who are either diverted to an affiliated hospital, admitted to the trauma center for greater than 24 hours from an ED or hospital, die in the ED, are DOA or are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital);~~

~~(b) Morbidity and mortality reviews including all trauma deaths;~~

~~(c) Trauma performance committee that meets at least quarterly and includes physicians, orthopaedics and neurosurgery if participating in trauma service, nurses, pre-hospital personnel, and a variety of other healthcare providers, and reviews policies, procedures, and system issues and whose members or designee attends at least 50 percent of the regular meetings;~~

~~(d) Multidisciplinary peer review committee that meets at least quarterly and includes physicians from trauma, emergency medicine, and other specialty physicians as needed specific to the case, and the trauma nurse coordinator/program manager and whose members or designee attends at least 50 percent of the regular meetings;~~

~~(e) Identification of discretionary and non-discretionary audit filters;~~

~~(f) Documentation and review of times and reasons for trauma-related diversion of patients from the scene or referring hospital;~~

~~(g) Documentation and review of response times for trauma surgeons, airway managers, and orthopaedists. All must demonstrate 80 percent compliance;~~

~~(h) Monitoring of trauma team notification times;~~

~~(i) Documentation (unless in-house) and review of Emergency Department response times for anesthesiologists or airway managers and computerized tomography technologist;~~

~~(j) Documentation of availability of the surgeon on call for trauma, such that compliance is 90 percent or greater where there is no trauma surgeon back up call schedule;~~

~~(k) Trauma performance and multidisciplinary peer review committees may be incorporated together or included in other staff meetings as appropriate for the facility performance improvement rules;~~

~~(l) Review of pre hospital trauma care including dead on arrivals; and~~

~~(m) Review of times and reasons for transfer of injured patients;~~

~~(30) An outreach program that includes:~~

~~(a) Transfer agreements to address the transfer and receipt of trauma patients; and~~

~~(b) Participation in a RAC;~~

~~(31) Coordination or participation in community prevention activities; and~~

~~(32) A written continuing education program for staff physicians, nurses, allied health personnel, and community physicians that includes:~~

~~(a) 20 hours of Category I or II trauma related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years for all attending general surgeons on the trauma service, orthopaedists, and neurosurgeons if participating in trauma service, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center or visiting lecturers or speakers from outside the trauma center. Continuing education based on the reading of content such as journals or other continuing medical education documents is not considered education outside of the trauma center;~~

~~(b) 20 hours of Category I or II trauma related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education)every two years for all emergency physicians, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center or visiting lecturers or speakers from outside the trauma center. Continuing education based on the reading of content such as journals or other continuing medical education documents is not considered education outside of the trauma center;~~

~~(c) ATLS completion for general surgeons on the trauma service and emergency physicians. Emergency physicians, if not boarded in emergency medicine, must be current in ATLS;~~

~~(d) 20 contact hours of trauma related continuing education (beyond in house in services) every two years for the TNC/TPM;~~

~~(e) 16 hours of trauma registry related or trauma related continuing education every two years, as deemed appropriate by the TNC/TPM, for the trauma registrar;~~

~~(f) At least an 80 percent compliance rate for 16 hours of trauma related continuing education (as approved by the trauma nurse coordinator/program manager) every two years related to trauma care for RN's and LPN's in transport programs, Emergency~~

~~Departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the trauma nurse coordinator/program manager; and~~

~~(g) 16 hours of trauma related continuing education every two years for mid-level practitioners routinely caring for trauma patients.~~

10A NCAC 13P .0904 INITIAL DESIGNATION PROCESS

(a) For initial Trauma Center designation, the hospital shall request a consult visit by OEMS and have the consult within one year prior to submission of ~~the RFP.~~ a RFP using form DHHS/DHSR/EMS 4919, incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. Copies of this form can be obtained from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina, 27699-2707, at no cost.

(b) A hospital interested in pursuing Trauma Center designation shall submit a letter of intent 180 days prior to the submission of an RFP to the OEMS. The letter shall define the hospital's primary trauma catchment area. Simultaneously, Level I or II applicants shall also demonstrate the need for the Trauma Center designation by submitting one original and three copies of documents that include:

(1) The population to be served and the extent to which the population is underserved for trauma care with the methodology used to reach this conclusion;

(2) Geographic considerations to include trauma primary and secondary catchment area and distance from other Trauma Centers; and

(3) Evidence the Trauma Center will admit at least 1200 trauma patients yearly or show that its trauma service will be taking care of at least 240 trauma patients with an Injury Severity Score (ISS) greater than or equal to 15 yearly. ~~This~~ These criteria shall be met without compromising the quality of care or cost effectiveness of any other designated Level I or II Trauma Center sharing all or part of its catchment area or by jeopardizing the existing Trauma Center's ability to meet this same 240-patient minimum.

(c) The hospital must be actively participating in the state Trauma Registry and submit data to the OEMS at least weekly and include all the Trauma Center's trauma patients as defined in Rule ~~.0102(68)~~ .0102(60) of this Subchapter who are either diverted to an affiliated hospital, admitted to the Trauma Center for greater than 24 hours from an ED or hospital, die in the ED, are DOA or are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital) a minimum of 12 months prior to application.

(d) OEMS shall review the regional Trauma Registry data, from both the applicant and the existing trauma center(s), and ascertain the applicant's ability to satisfy the justification of need information required in Subparagraphs (b)(1) through (3) of this Rule. Simultaneously, the applicant's primary RAC shall be notified by the OEMS of the application and be provided the regional data as required in Subparagraphs (b)(1) through (3) of this Rule submitted by the applicant for review and comment. The RAC shall be given a minimum of 30 days to submit any concerns in writing for OEMS' consideration. If no comments are received, OEMS shall proceed.

(e) OEMS shall notify the hospital in writing of its decision to allow submission of an RFP. The RAC shall also be notified by the OEMS so that any necessary changes in protocols can be considered.

(f) OEMS shall notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for initial designation to allow for comment.

(g) Hospitals desiring to be considered for initial trauma center designation shall complete and submit ~~one paper copy with signatures and an electronic copy of the RFP~~ an electronic copy of the completed RFP with signatures to the OEMS at least 90 days prior to the proposed site visit date.

(h) For Level I, II, and III applicants, the RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in Rules .0901, .0902, or .0903 of this Section.

(i) If OEMS does not recommend a site visit based upon failure to comply with Rules .0901, .0902, or ~~.0903,~~ .0903 of this Section, the reasons shall be forwarded to the hospital in writing within 30 days of the decision. The hospital may reapply for designation within six months following the submission of an updated RFP. If the hospital fails to respond within six months, the hospital shall reapply following the process outlined in Paragraphs (a) through (h) of this Rule.

(j) If the OEMS recommends the hospital for a site visit, the OEMS shall notify the hospital within 30 days and the site visit shall be conducted within six months of the recommendation. The site visit date shall be mutually agreeable to the hospital and the OEMS.

(k) Any in-state reviewer for a Level I or II visit (except the OEMS representatives) shall be from outside the ~~planning region~~ local or adjacent RAC, unless mutually agreed upon by the OEMS and the trauma center seeking designation, in which the hospital is located. The composition of a Level I or II state site survey team shall be as follows:

(1) One ~~out of state~~ out of state trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be designated the primary reviewer;

(2) One emergency physician who works in a designated trauma center, is a member of the American College of Emergency ~~Physicians,~~ Physicians or American Academy of Emergency Medicine, and is boarded in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);

(3) One in-state trauma surgeon who is a member of the North Carolina Committee on Trauma;

(4) One ~~out of state~~ out of state trauma ~~nurse coordinator/program manager and one in-state trauma nurse coordinator/program manager; and~~ program manager who is licensed to practice as an RN in North Carolina or equivalent license from another state; and

(5) OEMS Staff.

(l) All site team members for a Level III visit shall be from in-state, and ~~all~~ (except for the OEMS representatives) shall be from outside the ~~planning region~~ local or adjacent RAC in which the hospital is located. The composition of a Level III state site survey team shall be as follows:

(1) One Fellow of the ACS, who is a member of the North Carolina Committee on Trauma and shall be designated the primary reviewer;

(2) One emergency physician who currently works in a designated trauma center, is a member of the North Carolina College of Emergency ~~Physicians,~~ Physicians or American Academy of

Emergency Medicine, and is boarded in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);

(3) A trauma ~~nurse coordinator/program manager; and~~ program manager who is licensed to practice as an RN in North Carolina; and

(4) OEMS Staff.

(m) On the day of the site visit the hospital shall make available all requested patient medical charts.

(n) The ~~lead researcher~~ primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team at the summary conference. A written consensus report shall be completed, to include a peer review report, by the primary reviewer and submitted to OEMS within 30 days of the site visit.

(o) The report of the site survey team and the staff recommendations shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting ~~which is more than 45 days~~ following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center designation be approved or denied.

(p) All criteria defined in Rule .0901, .0902, or .0903 of this Section shall be met for initial designation at the level requested. Initial designation shall not be granted if deficiencies exist.

(q) Hospitals with a deficiency(ies) shall be given up to 12 months to demonstrate compliance. Satisfaction of deficiency(ies) may require an additional site visit. If compliance is not demonstrated within the time period, to be defined by OEMS, the hospital shall submit a new application and updated RFP and follow the process outlined in Paragraphs (a) through (h) of this Rule.

(r) The final decision regarding Trauma Center designation shall be rendered by the OEMS.

(s) The OEMS shall notify the hospital in writing, of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(t) If a trauma center changes its trauma program administrative structure (such that the trauma service, trauma medical director, trauma ~~nurse coordinator/program~~ program manager or trauma registrar are relocated on the hospital's organizational chart) at any time, it shall notify OEMS of this change in writing within 30 days of the occurrence.

(u) Initial designation as a trauma center is valid for a period of three years.

10A NCAC 13P .0905 RENEWAL DESIGNATION PROCESS

(a) Hospitals may utilize one of two options to achieve Trauma Center renewal:

(1) Undergo a site visit conducted by OEMS to obtain a four-year renewal designation; or

(2) Undergo a verification visit arranged by the ACS, in conjunction with OEMS, to obtain a ~~four-year~~ three-year renewal designation.

(b) For hospitals choosing Subparagraph (a)(1) of this Rule:

(1) Prior to the end of the designation period, the OEMS shall forward to the hospital an RFP for completion using form DHHS/DHSR/EMS 4919, incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. Copies of this form can be obtained from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina, 27699-2707, at no cost. The hospital shall, within 10 days of receipt of the RFP, define for OEMS the Trauma Center's trauma primary catchment area. Upon this notification, OEMS shall notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for renewal to allow for comment.

(2) Hospitals shall complete and submit ~~one paper copy and~~ an electronic copy of the RFP to the OEMS ~~and the specified site surveyors~~ at least 30 days prior to the site visit. The RFP shall include information that supports compliance with the criteria contained in Rule .0901, .0902, or .0903 of this Section as it relates to the Trauma Center's level of designation.

(3) All criteria defined in Rule .0901, .0902, or .0903 of this Section, as relates to the Trauma Center's level of designation, shall be met for renewal designation.

(4) A site visit shall be conducted within 120 days prior to the end of the designation period. The site visit shall be scheduled on a date mutually agreeable to the hospital and the OEMS.

(5) The composition of a Level I or II site survey team shall be ~~the same as that specified in Rule .0904(k) of this Section.~~ as follows:

(a) one out-of-state trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be designated the primary reviewer;

(b) out-of-state, or in-state if mutually agreed upon by the OEMS and the trauma center seeking designation, emergency physician who currently works in a designated trauma center, is a member of the American College of Emergency Physicians or the American Academy of Emergency Medicine, and is boarded in emergency medicine (by the American Board of Emergency Physicians or the American Osteopathic Board of Emergency Medicine), and has membership in the North Carolina College of Emergency Physicians if from in-state only;

(c) out-of-state trauma surgeon, or if in-state only, must be a member of the North Carolina Committee on Trauma;

(d) one out-of-state, or in-state if mutually agreed upon by the OEMS and trauma center seeking designation, trauma program manager who is licensed to practice as an RN in North Carolina or equivalent license from another state; and

(e) OEMS staff.

(6) The composition of a Level III site survey team shall be the same as that specified in Rule .0904(l) of this Section.

(7) On the day of the site visit the hospital shall make available all requested patient medical charts.

(8) The primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team at the summary conference. A written consensus report shall be completed, to include a peer review report, by the primary reviewer and submitted to OEMS within 30 days of the site visit.

(9) The report of the site survey team and a staff recommendation shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting which is more than 30 days following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center renewal be approved; approved with a contingency(ies) due to a deficiency(ies) requiring a focused review; approved with a contingency(ies) not due to a deficiency(ies) requiring a consultative visit; or denied.

(10) Hospitals with a deficiency(ies) have up to 10 working days prior to the State EMS Advisory Council meeting to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this period prior to the State EMS Advisory Council meeting, the hospital, instead of a four-year renewal, shall be given 12 months by the OEMS to demonstrate compliance and undergo a focused review, that may require an additional site visit. The hospital shall retain its Trauma Center designation during the focused review period. If compliance is demonstrated within the prescribed time period, the hospital shall be granted its designation for the four-year period from the previous designation's expiration date. If compliance is not demonstrated within the time period, as specified by OEMS, the Trauma Center designation shall not be renewed. To become redesignated, the hospital shall submit an updated RFP and follow the initial applicant process outlined in Rule .0904 of this Section.

(11) The final decision regarding trauma center renewal shall be rendered by the OEMS.

(12) The OEMS shall notify the hospital of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(13) Hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 days following receipt of the written final decision on the trauma recommendations.

~~(13)~~(14) The four-year renewal date that may be eventually granted shall not be extended due to the focused review period.

(c) For hospitals choosing Subparagraph (a)(2) of this Rule:

(1) At least six months prior to the end of the Trauma Center's designation period, the trauma center must notify the OEMS of its intent to undergo an ACS verification visit. It must simultaneously define in writing to the OEMS its trauma primary catchment area. Trauma Centers choosing this option must then comply with all the ACS' verification procedures, as well as any additional state criteria as outlined in Rule .0901, .0902, or .0903, as apply to their level of designation.

(2) When completing the ACS' documentation for verification, the Trauma Center must ensure access to the ACS on-line PRQ (pre-review questionnaire) to OEMS. The Trauma Center must simultaneously complete any documents supplied by OEMS ~~to verify compliance with additional North Carolina criteria (i.e., criteria that exceed the ACS criteria)~~ and forward these to OEMS and the ACS.

(3) The OEMS shall notify the Board of County Commissioners within the trauma center's trauma primary catchment area of the Trauma Center's request for renewal to allow for comments.

(4) The Trauma Center must make sure the site visit is scheduled to ensure that the ACS' final written report, accompanying medical record reviews and cover letter are received by OEMS at least 30 days prior to a regularly scheduled State Emergency Medical Services Advisory Council meeting to ensure that the Trauma Center's state designation period does not terminate without consideration by the State Emergency Medical Services Advisory Council.

~~(5) The composition of the Level I or Level II site team must be as specified in Rule .0904(k) of this Section, except that both the required trauma surgeons and the emergency physician may be from out of state. Neither North Carolina Committee on Trauma nor North Carolina College of Emergency Physician membership is required of the surgeons or emergency physician, respectively, if from out of state. The date, time, and all proposed site team members of the site visit team must be submitted to the OEMS for review at least 45 days prior to the site visit. The OEMS shall approve the site visit schedule if the schedule does not conflict with the ability of attendance by required OEMS staff. The OEMS shall approve the proposed site team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site team member associated with the site visit.~~

(5) Any in-state review for a hospital choosing Subparagraph (a)(2) of this Rule, except for the OEMS staff, shall be from outside the local or adjacent RAC in which the hospital is located.

(6) The composition of a Level I or II state site survey team for hospitals choosing Subparagraph (a)(2) of this Rule shall be as follows:

(A) one out-of-state trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be designated the primary reviewer;

(B) out-of-state, or in-state if mutually agreed upon by the OEMS and the trauma center seeking designation, emergency physician who currently works in a designated trauma center, is a member of the American College of Emergency Physicians or the American Academy of Emergency Medicine, and is boarded in emergency medicine (by the American Board of Emergency Physicians or the American Osteopathic Board of Emergency Medicine), and has membership in the North Carolina College of Emergency Physicians if from in-state only;

(C) out-of-state trauma surgeon, or if in-state only, must be a member of the North Carolina Committee on Trauma;

(D) one out-of-state, or in-state if mutually agreed upon by the OEMS and trauma center seeking designation, trauma program manager; and

(E) OEMS staff.

(7) The date, time, and all proposed site team members of the site visit team must be submitted to the OEMS for review at least 45 days prior to the site visit. The OEMS shall approve the site visit schedule if the schedule does not conflict with the ability of attendance by required OEMS staff. The OEMS shall approve the proposed site team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site team member associated with the site visit.

~~(6) The composition of the Level III site team must be as specified in Rule .0904(l) of this Section, except that the trauma surgeon, emergency physician, and trauma nurse coordinator/program manager may be from out of state. Neither North Carolina Committee on Trauma nor North Carolina College of Emergency Physician membership is required of the surgeon or emergency physician, respectively, if from out of state. The date, time, and all proposed site team members of the site visit team must be submitted to the OEMS for review at least 45 days prior to the site visit. The OEMS shall approve the site visit schedule if the schedule does not conflict with the ability of attendance by required OEMS staff. The OEMS shall approve the proposed site team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site team member associated with the site visit.~~

(8) The composition of a Level III state site survey team for hospitals choosing Subparagraph (a)(2) of this Rule shall be as follows:

(A) one in-state trauma surgeon who is a Fellow of the ACS, who is a member of the North Carolina Committee on Trauma, who shall be designated the primary reviewer;

(B) one-in-state or out-of-state emergency physician who currently works in a designated trauma center, is a member of the American College of Emergency Physicians or American Academy of Emergency Medicine, and is boarded in emergency medicine (by the American Board of Emergency Physicians or the American Osteopathic Board of Emergency Medicine), and has membership in the North Carolina College of Emergency Physicians if from in-state only;

(C) one in-state or out-of-state trauma program manager; and

(D) OEMS staff.

(9) The date, time, and all proposed site team members of the site visit team must be submitted to the OEMS for review at least 45 days prior to the site visit. The OEMS shall approve the site visit schedule if the schedule does not conflict with the ability of attendance by required OEMS staff. The OEMS shall approve the proposed site team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site team member associated with the site visit.

~~(7)~~(10) All state Trauma Center criteria must be met as defined in Rules .0901, .0902, and .0903 of this Section, for renewal of state designation. An ACS' verification is not required for state designation. An ACS' verification does not ensure a state designation.

~~(8)~~(11) ACS reviewers shall complete the state designation preliminary reporting form immediately prior to the post conference meeting. This document and the ACS final written report and supporting documentation described in Subparagraph (c)(4) of this Rule shall be used to generate a staff summary of findings report following the post conference meeting for presentation to the NC EMS Advisory Council for redesignation.

~~(9)~~(12) The final written report issued by the ACS' verification review committee, the accompanying medical record reviews (from which all identifiers may be removed), and cover letter must be forwarded to OEMS within 10 working days of its receipt by the Trauma Center seeking renewal.

~~(10)~~(13) The OEMS shall present its summary of findings report to the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting. The State EMS Advisory Council shall recommend to the Chief of the OEMS that the request for Trauma Center renewal be approved; approved with a contingency(ies) due to a deficiency(ies) requiring a focused review; approved with a contingency(ies) not due to a deficiency(ies); or denied.

~~(11)~~(14) The OEMS shall notify the hospital in writing of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(15) The final decision regarding trauma center designation shall be rendered by the OEMS.

~~(12)~~(16) Hospitals with contingencies, as the result of a deficiency(ies), as determined by OEMS, have up to 10 working days prior to the State EMS Advisory Council meeting to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this time period prior to the State EMS Advisory Council meeting, the hospital, instead of a ~~four-year~~ three-year renewal, may undergo a focused review (to be conducted by the OEMS) whereby the Trauma Center is given 12 months by the OEMS to demonstrate compliance. Satisfaction of contingency(ies) may require an additional site visit. The hospital shall retain its Trauma Center designation during the focused review period. If compliance is demonstrated within the prescribed time period, the hospital shall be granted its designation for the ~~four-year~~ three-year period from the previous designation's expiration date. If compliance is not demonstrated within the time period, as specified by OEMS, the Trauma Center designation shall not be renewed. To become redesignated, the hospital shall submit a new RFP and follow the initial applicant process outlined in Rule .0904 of this Section.

(17) Hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 days following receipt of the written final decision on the trauma recommendations.

(18) The three-year renewal date that may be eventually granted shall not be extended due to the focused review period.

(d) If a Trauma Center currently using the ACS' verification process chooses not to renew using this process, it must notify the OEMS at least six months prior to the end of its state trauma center designation period of its intention to exercise the option in Subparagraph (a)(1) of this Rule. Upon notification, the OEMS shall extend the designation for one additional year to ensure consistency with hospitals using Subparagraph (a)(1) of this Rule.

(e) Renewal shall be for a period not to exceed four years. If the hospital chose the option in Subparagraph (a)(2) of this Rule, the renewal shall coincide with the three-year designation period of the ACS verification.

10A NCAC 13P .0906 PRACTICING TRAUMA CENTER STATUS CRITERIA

(a) Hospitals applying for initial Level I, Level II or Level III trauma center designation that are not included in an EMS system's triage and transport plan as required by Rule .0201(a)(13)(A) of this Subchapter may be eligible for interim practicing trauma center status as defined in Rule .0102(44) of this Subchapter.

(b) In order to be eligible for interim practicing trauma center status, a hospital must demonstrate trauma system organizational structure through submission of a partial RFP prior to approval of this status by the OEMS using form DHHS/DHSR/EMS 4918, incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions, Copies of this form can be obtained from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina, 27699-2707, at no cost.

(c) Upon authorization to begin services as a practicing trauma center, the OEMS shall notify the EMS systems and participating hospitals in the practicing trauma center's catchment area and recommend each to revise their triage and transport plans to include the services of the practicing trauma center.

(d) In order to maintain practicing trauma center status, the hospital must continue to pursue trauma center designation as evidenced by continued submission of trauma registry data, consultation visit by the OEMS, submission of a complete RFP using form DHHS/DHSR/EMS 4919, incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions, and designation site visit as required in Rule .0904 of this Section. Copies of this form can be obtained from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina, 27699-2707, at no cost.

(e) Once all designation criteria have been met for the level of application as defined in Rule .0904 of this Section, the practicing trauma center status will end and the hospital will receive the Level I, Level II or Level III trauma center designation valid for a period of three years from the date of designation.

(f) If not successful in achieving initial designation by OEMS within one year of the date of approval of practicing trauma center status, the practicing hospital may apply for a one time extension, not to exceed an additional 12 months as a practicing trauma center.

(g) Failure to successfully achieve initial designation by the OEMS within one year of the date of approval of practicing trauma center status will result in the withdrawal of the practicing trauma center status by the OEMS and the EMS systems and participating hospitals in the hospital's catchment area will be notified by the OEMS of this action.

(h) Hospitals may not re-apply for practicing trauma center status for a five year period from the date that practicing status is withdrawn.

10A NCAC 13P .1101 STATE TRAUMA SYSTEM

(a) The state trauma system consists of regional plans, policies, guidelines and performance improvement initiatives by the RACs to create an Inclusive Trauma System monitored by the OEMS.

(b) Each hospital and EMS System shall affiliate as defined in Rule .0102(3) of this Subchapter and participate with the RAC that includes the Level I or II Trauma Center in which the majority of trauma patient referrals and transports occur. Each hospital and EMS System shall submit to the OEMS upon request patient transfer patterns from data sources that support the choice of their primary RAC affiliation. Each RAC shall include at least one Level I or II Trauma Center.

(c) The OEMS shall notify each RAC of its hospital and EMS System membership.

(d) Each hospital and each EMS System must update and submit its RAC affiliation information to the OEMS no later than July 1 of each year. RAC affiliation may only be changed during this annual update and only if supported by a change in the majority of transfer ~~patterns.~~ patterns to a Level I or Level II Trauma Center. Documentation detailing these new transfer patterns must be included in the request to change affiliation. If no change is made in RAC affiliation, notification of continued affiliation shall be provided to the OEMS in writing.

10A NCAC 13P .1102 REGIONAL TRAUMA SYSTEM PLAN

(a) A Level I or II Trauma Center shall facilitate development of and provide RAC staff support that includes the following:

(1) The trauma medical director(s) from the lead RAC agency;

(2) Trauma nurse coordinator(s) or program manager(s) from the lead RAC agency; and

(3) An individual to coordinate RAC activities.

(b) The RAC membership shall include the following:

(1) The trauma medical director(s) and the trauma nurse coordinator(s) or program manager(s) from the lead RAC agency;

(2) If on staff, an outreach coordinator(s), injury prevention coordinator(s) or designee(s), as well as a RAC registrar or designee(s) from the lead RAC agency;

(3) A senior level hospital administrator;

(4) An emergency physician;

(5) A representative from each EMS system participating in the RAC;

(6) A representative from each hospital participating in the RAC;

(7) Community representatives; and

(8) An EMS System physician involved in medical oversight.

(c) The RAC shall develop ~~and submit~~ a plan within one year of notification of the RAC ~~membership, or for existing RACs within six months of the implementation date of this rule, to the OEMS~~ membership containing:

(1) Organizational structure to include the roles of the members of the system;

(2) Goals and objectives to include the orientation of the providers to the regional system;

(3) RAC membership list, rules of order, terms of office, meeting schedule (held at a minimum of two times per year);

(4) Copies of documents and information required by the OEMS as defined in Rule .1103 of this Section;

(5) System evaluation tools to be utilized;

(6) Written documentation of regional support for the plan; and

(7) Performance improvement activities to include utilization of patient care data.

(d) The RAC shall ~~submit to the OEMS~~ prepare an annual progress report no later than July 1 of each year that assesses compliance with the regional trauma system plan and specifies any updates to the plan. This report shall be made available to the OEMS for review upon request.

(e) Upon OEMS' receipt of a letter of intent for initial Level I or II Trauma Center designation pursuant to Rule .0904(b) of this Subchapter, the applicant's RAC shall be provided the applicant's data from OEMS to review and comment.

(f) The RAC has 30 days to comment on the request for initial designation.

(g) The OEMS shall notify the RAC of the OEMS approval to submit an RFP so that necessary changes in protocols can be considered.

10A NCAC 13P .1401 CHEMICAL ADDICTION OR ABUSE TREATMENT PROGRAM REQUIREMENTS

(a) The OEMS shall provide a treatment program for aiding in the recovery and rehabilitation of EMS personnel subject to disciplinary action for being unable to perform as credentialed EMS personnel with reasonable skill and safety to patients and the public by reason of use of alcohol, drugs, chemicals, or any other type of ~~material and who are recommended by the EMS Disciplinary Committee pursuant to G.S. 143-519.~~ material.

(b) This program requires:

(1) an initial assessment by a healthcare professional specialized in chemical dependency ~~affiliated with~~ approved by the treatment program;

(2) a treatment plan developed for the individual using the findings of the initial assessment;

(3) random body fluid screenings;

(4) the individual attend three self-help recovery meetings each week for the first year of participation, and two each week for the remainder of participation in the treatment program;

(5) monitoring of the individual for compliance with the treatment program; and

(6) written progress reports available for review by the ~~EMS Disciplinary Committee:~~ OEMS:

(A) upon completion of the initial assessment by the treatment program;

(B) upon request by the ~~EMS Disciplinary Committee~~ OEMS throughout the individual's participation in the treatment program;

(C) upon completion of the treatment program;

(D) of all body fluid screenings showing chain of custody;

(E) by the therapist or counselor assigned to the individual during the course of the treatment program; and

(F) listing attendance at self-help recovery meetings.

10A NCAC 13P .1402 PROVISIONS FOR PARTICIPATION IN THE CHEMICAL ADDICTION OR ABUSE TREATMENT PROGRAM

Individuals ~~recommended by the EMS Disciplinary Committee~~ authorized by the OEMS to enter the Treatment Program defined in Rule .1401 of this Section may participate if:

(1) the individual acknowledges, in writing, the actions which violated the performance requirements found in this Subchapter;

(2) the individual has not been charged or convicted of diverting chemicals for the purpose of sale or distribution or dealing or selling illicit drugs;

(3) the individual is not under investigation or subject to pending criminal charges by law enforcement;

(4) the individual ceases in the direct delivery of any patient care and surrenders all EMS credentials until either the individual is eligible for issuance of an encumbered EMS credential pursuant to Rule .1403 of this Section, or has successfully completed the treatment program established in Rule .1401 of this Section; and

(5) the individual agrees to accept responsibility for all costs including assessment, treatment, monitoring, and body fluid screening.

10A NCAC 13P .1403 CONDITIONS FOR RESTRICTED PRACTICE WITH LIMITED PRIVILEGES

(a) In order to assist in determining eligibility for an individual to return to restricted practice with limited privileges, the OEMS shall create a standing Reinstatement Committee that shall consist of at least the following members:

(1) One physician licensed by the North Carolina Medical Board, representing EMS Systems who will serve as Chair of this committee;

(2) One specialist trained in chemical addiction or abuse therapy; and

(3) The OEMS staff member responsible for managing the Chemical Addiction or Abuse Treatment Program.

~~(a)~~(b) Individuals who have surrendered their EMS credential as a condition of entry into the treatment program may be reviewed by ~~the EMS Disciplinary Committee to determine if a recommendation to~~ the OEMS Reinstatement Committee for issuance of an encumbered EMS credential is warranted.

~~(b)~~(c) In order to obtain an encumbered credential with limited privileges, an individual must:

(1) be compliant for a minimum of 90 consecutive days with the treatment program described in Paragraph (b) of Rule .1402 of this Section;

(2) be recommended in writing for review by the individual's treatment counselor;

(3) be interviewed by the ~~EMS Disciplinary Committee;~~ OEMS Re-entry/Reinstatement Committee; and

(4) be recommended in writing by the ~~EMS Disciplinary Committee~~ OEMS Re-entry/Reinstatement Committee for issuance of an encumbered EMS credential. The ~~EMS Disciplinary Committee~~ OEMS Re-entry/Reinstatement Committee shall detail in their recommendation ~~to the OEMS~~ all restrictions and limitations to the individual's practice privileges.

~~(c)~~(d) The individual must agree to sign a consent agreement with the OEMS which details the practice restrictions and privilege limitations of the encumbered EMS credential, and which contains the consequences of failure to abide by the terms of this agreement.

~~(d)~~(e) The individual shall be issued the encumbered credential within 10 business days following execution of the consent agreement described in Paragraph ~~(c).~~ (d).

10A NCAC 13P .1405 FAILURE TO COMPLETE THE CHEMICAL ADDICTION OR ABUSE TREATMENT PROGRAM

Individuals who fail to complete the treatment program, upon review ~~and recommendation~~ by the ~~North Carolina EMS Disciplinary Committee to the~~ OEMS, are subject to revocation of their EMS credential.

10A NCAC 13P .1502 LICENSED EMS PROVIDERS

(a) The Department shall deny an initial or renewal EMS Provider license for any of the following reasons:

(1) significant failure to comply with the applicable licensing requirements as found in this Subchapter;

(2) making false statements or representations to the Department or willfully concealing information in connection with an application for licensing;

(3) tampering with or falsifying any record used in the process of obtaining an initial license or in the renewal of a license;

(4) disclosing information as defined in Rule .0224 of this Subchapter determined by the Department to disqualify the applicant from licensing.

~~(a)~~(b) The Department shall amend any EMS Provider license by reducing it from a full license to a provisional license whenever the Department finds that:

(1) the licensee failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article;

(2) there is a reasonable probability that the licensee can remedy the licensure deficiencies within a reasonable length of time; and

(3) there is a reasonable probability that the licensee will be able thereafter to remain in compliance with the licensure rules for the foreseeable future.

~~(b)~~(c) The Department shall give the licensee written notice of the amendment of the EMS Provider license. This notice shall be given personally or by certified mail and shall set forth:

(1) the length of the provisional EMS Provider license;

(2) the factual allegations;

(3) the statutes or rules alleged to be violated; and

(4) notice of the EMS provider's right to a contested case hearing on the amendment of the EMS Provider license.

~~(c)~~(d) The provisional EMS Provider license is effective immediately upon its receipt by the licensee and shall be posted in a location at the primary business location of the EMS Provider, accessible to public view, in lieu of the full license. The provisional license remains in effect until the Department:

(1) restores the licensee to full licensure status; or

(2) revokes the licensee's license.

~~(d)~~(e) The Department shall revoke or suspend an EMS Provider license whenever the Department finds that the licensee:

(1) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article and it is not reasonably probable that the licensee can remedy the licensure deficiencies within 12 months or less;

(2) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article and, although the licensee may be able to remedy the deficiencies, it is not reasonably probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future;

(3) failed to comply with the provision of G.S. 131E, Article 7, and the rules adopted under that article that endanger the health, safety or welfare of the patients cared for or transported by the licensee;

(4) obtained or attempted to obtain an ambulance permit, EMS nontransporting vehicle permit, or EMS Provider license through fraud or misrepresentation;

(5) repeated deficiencies placed on the EMS Provider License in previous compliance site visits;

(6) failed to provide emergency medical care within the defined EMS service area in a timely manner as determined by the EMS System;

(7) failed to disclose or report information in accordance with Rule .0224 of this Subchapter;

(8) owner or any officer or agent is convicted in any court of a crime involving fiduciary misconduct or a conviction of a felony the Department deems to place the public at risk;

~~(7)~~(9) altered, destroyed, attempted to destroy, withheld or delayed release of evidence, records, or documents needed for a complaint investigation; or

~~(8)~~(10) continues to operate within an EMS System after a Board of County Commissioners has terminated its affiliation with the licensee.

~~(e)~~(f) The issuance of a provisional EMS Provider license is not a procedural prerequisite to the revocation or suspension of a license pursuant to Paragraph ~~(d)~~(e) of this Rule.

10A NCAC 13P .1505 EMS EDUCATIONAL INSTITUTIONS

(a) The Department shall deny the initial or renewal credential, without first allowing a focused review, of an EMS Educational Institution for any of the following reasons:

(1) significant failure to comply with the provisions of Section .0600 of this Subchapter;

(2) attempting to obtain a EMS Educational Institution designation through fraud or misrepresentation; or

~~(3) endangerment to the health, safety, or welfare of patients cared by students of the EMS Educational Institution; or~~

~~(4)~~(3) repetition of deficiencies placed on the EMS Educational Institution in previous compliance site visits.

(b) When a EMS Educational Institution is required to have a focused review, it must demonstrate compliance with the provisions of Section .0600 of this Subchapter within 12 months or less.

(c) The Department will revoke an EMS Educational Institution credential at any time or deny a request for renewal of credential, whenever the Department finds that the EMS Educational Institution has failed to comply with the provisions of Section .0600 of this Subchapter; and:

(1) it is not probable that the EMS Educational Institution can remedy the deficiencies within 12 months or less;

(2) although the EMS Educational Institution may be able to remedy the deficiencies, it is not probable that the EMS Educational Institution shall be able to remain in compliance with credentialing rules for the foreseeable future;

(3) failure to produce records upon request as defined in Rule .0603 (f) of this Subchapter;

~~(3)~~(4) the EMS Educational Institution failed to meet the requirements of a focused review;

~~(4)~~(5) the failure to comply endangered the health, safety, or welfare of patients cared for as part of an EMS educational program; or

~~(5)~~(6) the EMS Educational Institution altered, destroyed or attempted to destroy evidence needed for a complaint investigation.

(d) The Department shall give the EMS Educational Institution written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:

(1) the factual allegations;

(2) the statutes or rules alleged to be violated; and

(3) notice of the EMS Educational Institution 's right to a contested case hearing on the revocation of the credential.

(e) Focused review is not a procedural prerequisite to the revocation of a credential pursuant to Paragraph (c) of this Rule.

(f) An EMS Educational Institution may voluntarily withdraw its credential for a maximum of one year by submitting a written request. This request shall include the reasons for withdrawal and a plan for resolution of the deficiencies. To reactivate the credential, the institution shall provide to the Department written documentation of

compliance. Voluntary withdrawal does not affect the original expiration date of the EMS Educational Institution's credential.

(g) If the institution fails to resolve the issues which resulted in a voluntary withdrawal within one year, the Department shall revoke the EMS Educational Institution credential.

(h) In the event of a revocation or voluntary withdrawal, the Department shall provide written notification to all EMS Systems within the EMS Educational Institution's defined service area. The Department shall provide written notification to all EMS Systems within the EMS Educational Institution's defined service area if, and when, the voluntary withdrawal reactivates to full credential.

(i) When an accredited EMS Educational Institution as defined in Rule .0605 of this Subchapter has administrative action taken against its accreditation, the OEMS shall determine if the cause for action is sufficient for revocation of the EMS Educational Institution credential or imposing a focused review pursuant to Paragraph (b) of this Rule.

10A NCAC 13P .1507 EMS PERSONNEL CREDENTIALS

(a) An EMS credential which has been forfeited under G.S.15A-1331A may not be reinstated until the person has successfully complied with any and all court's requirements, has petitioned the Department for reinstatement, has successfully completed the disciplinary process subject to appearing before the EMS Disciplinary Committee with established Department reinstatement approval.

(b) The Department ~~shall~~ amend, deny, suspend, or revoke the credentials of EMS personnel for significant failure to comply with any of the ~~following reasons:~~ following:

(1) failure to comply with the applicable performance and credentialing requirements as found in this Subchapter;

(2) making false statements or representations to the Department or willfully concealing information in connection with an application for credentials;

(3) making false statements or representations, willfully concealing information, or failing to respond within a reasonable period of time and in a reasonable manner to inquiries from the Department during a complaint investigation;

(4) tampering with or falsifying any record used in the process of obtaining an initial EMS credential or in the renewal of an EMS credential;

(5) in any manner or using any medium, engaging in the stealing, manipulating, copying, reproducing or reconstructing of any written EMS credentialing examination questions or scenarios;

(6) cheating or assisting others to cheat while preparing to take or when taking a written EMS credentialing examination;

(7) altering an EMS credential, using an EMS credential that has been altered or permitting or allowing another person to use his or her EMS credential for the purpose of alteration. Altering includes changing the name, expiration date or any other information appearing on the EMS credential;

(8) unprofessional conduct, including a failure to comply with the rules relating to the proper function of credentialed EMS personnel contained in this Subchapter or the performance of or attempt to perform a procedure that is detrimental to the health and safety of any person or that is beyond the scope of practice of credentialed EMS personnel or EMS instructors;

(9) being unable to perform as credentialed EMS personnel with reasonable skill and safety to patients and the public by reason of illness; use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality;

(10) conviction in any court of a crime involving moral turpitude, a conviction of a felony, a conviction requiring registering on a sex offender registry, or conviction of a crime involving the scope of practice of credentialed EMS personnel;

(11) by false representations obtaining or attempting to obtain money or anything of value from a patient;

(12) adjudication of mental incompetence;

(13) lack of competence to practice with a reasonable degree of skill and safety for patients including a failure to perform a prescribed procedure, failure to perform a prescribed procedure competently or performance of a procedure that is not within the scope of practice of credentialed EMS personnel or EMS instructors;

(14) performing as ~~an EMT-I, EMT-P, or EMD~~ credentialed EMS personnel in any EMS System in which the individual is not affiliated and authorized to function;

(15) performing or authorizing the performance of procedures or administration of medications detrimental to a student or individual;

(16) willful delay or failure to respond when on-duty and dispatched to a call for EMS assistance;

~~(15)~~(17) testing ~~positive~~ positive, whether for-cause or at random, through urine, blood, or breath sampling, for any substance, legal or illegal, that ~~has impaired~~ is likely to impair the physical or psychological ability of the credentialed EMS personnel to perform all required or expected functions while on duty;

~~(16)~~(18) failure to comply with G.S. 143-518 regarding the use or disclosure of records or data associated with EMS Systems, Specialty Care Transport Programs, Alternative Practice Settings, or patients;

~~(17)~~(19) refusing to consent to any criminal history check required by G.S. 131E-159;

~~(18)~~(20) abandoning or neglecting a patient who is in need of care, without making reasonable arrangements for the continuation of such care;

~~(19)~~(21) falsifying a patient's record or any controlled substance records;

~~(20)~~(22) harassing, abusing, or intimidating a ~~patient~~ patient, student, by-stander, or OEMS staff, either ~~physically or verbally;~~ physically, verbally, or in writing;

~~(21)~~(23) engaging in any activities of a sexual nature with a patient including kissing, fondling or touching while responsible for the care of that individual;

~~(22)~~(24) any criminal arrests that involve charges which have been determined by the Department to indicate a necessity to seek action in order to further protect the public pending adjudication by a court;

~~(23)~~(25) altering, destroying or attempting to destroy evidence needed for a complaint investigation;

~~(24)~~(26) as a condition to the issuance of an encumbered EMS credential with limited and restricted practices for persons in the chemical addiction or abuse treatment program; ~~or~~

(27) unauthorized possession of lethal or non-lethal weapons, chemical irritants to include mace, pepper (oleoresin capsicum) spray and tear gas, or explosives while in the performance of providing emergency medical services;

(28) failure to provide EMS care records to the licensed EMS provider for submission to the OEMS as required by Rule .0204 of this Subchapter; or

~~(25)~~(29) continuing to provide EMS care after local suspension of practice privileges by the local EMS System; or

(30) representing or allowing others to represent that the credentialed EMS personnel has a credential that the credentialed EMS personnel does not in fact have.

(c) Pursuant to the provisions of S.L. 2011-37, any person listed on the North Carolina Department of Justice Sex Offender and Public Protection Registry shall be denied initial or renewal EMS credentials.

(d) Pursuant to the provisions of G.S. 50-13.12, upon notification by the court, the Department shall immediately revoke an individual's EMS credential until the Department has been notified by the court evidence has been obtained of compliance with a child support order.

~~(d)~~(e) When a person who is credentialed to practice as an EMS professional is also credentialed in another jurisdiction and that other jurisdiction takes disciplinary action against the person, the Department shall summarily impose the same or lesser disciplinary action upon receipt of the other jurisdiction's action. The EMS professional may request a hearing before the EMS Disciplinary Committee. At the hearing the issues shall be limited to:

(1) whether the person against whom action was taken by the other jurisdiction and the Department are the same person;

(2) whether the conduct found by the other jurisdiction also violates the rules of the Medical Care Commission; and

(3) whether the sanction imposed by the other jurisdiction is lawful under North Carolina law.

(f) The OEMS shall provide written notification to the EMS professional within five business days after information has been entered into the National Practitioner Data Bank and the Healthcare Integrity and Protection Integrity Data Bank.

10A NCAC 13P .1510 PROCEDURES FOR VOLUNTARY SURRENDING OR MODIFYING THE LEVEL OF AN EMS CREDENTIAL

(a) An individual who holds a valid North Carolina EMS credential may request to voluntarily surrender the credential to the OEMS by completing the following:

(1) providing, in writing, a letter expressing the individual's desire to surrender the credential and explaining in detail the circumstances surrounding the request; and

(2) returning the pocket credential and wall certificate to the OEMS immediately upon notification the request has been approved.

(b) An individual who holds a valid North Carolina EMS credential may request to voluntarily modify the current credentialing level from a higher level to a lower level by the OEMS by completing the following:

(1) providing, in writing, a letter expressing the individual's desire to lower their current level and explaining in detail the circumstances surrounding the request;

(2) stating the desired level of credentialing; and

(3) returning the pocket credential and wall certificate to the OEMS immediately upon notification the request has been approved.

(c) The OEMS shall provide a written response to the individual within 10 working days following receipt of the request either approving or denying the request. This response shall detail the reason(s) for approval or denial.

(d) If, at a future date, the individual seeks to restore the credential to the previous status, the individual must:

(1) wait a minimum of six months from the date the action was taken;

(2) provide, in writing, a letter expressing the individual's desire to restore the previous credential;

(3) provide evidence of continuing education at a minimum of 2 hours per month at the level of the EMS credential being sought; and

(4) undergo a National Criminal History background check.

(e) If the Department denies the individual's request for restoration of the previous EMS credential, the Department shall provide in writing the reason(s) for denial and inform the individual of the procedures for contested hearing as defined in Rule .1509 of this Section.

10A NCAC 13P .1511 PROCEDURES FOR QUALIFYING FOR AN EMS CREDENTIAL FOLLOWING ENFORCEMENT ACTION

(a) Any individual who has been subject to denial, suspension, revocation or amendment of an EMS credential must submit in writing to the OEMS a request for review to determine eligibility for credentialing.

(b) Factors to be considered by the Department when determining eligibility shall include:

(1) Reason for administrative action, including but not limited to:

(A) Criminal History;

(B) Patient Care;

(C) Substance Abuse; and

(D) Failure to meet credentialing requirements.

(2) Length of time since the administrative action was taken.

(3) Any mitigating or aggravating factors relevant to obtaining a valid EMS credential.

(c) In order to be considered for eligibility, the individual must:

(1) wait a minimum of thirty-six months following administrative action before seeking review; and

(2) undergo a national criminal history background check. If the individual has been charged or convicted of a misdemeanor or felony in this or any other state or country within the previous 36 months, the thirty-six month waiting period will begin from the date of the latest charge or conviction.

(d) If determined to be eligible, the Department shall grant authorization for the individual to begin the process for EMS credentialing as defined in Rule .0502 of this Subchapter.

(e) Prior to enrollment in an EMS educational program, the individual must disclose the prior administrative action taken against the individual's credential in writing to the EMS educational institution.

(f) Individuals who have undergone administrative action against their EMS credential are not eligible for legal recognition as defined in G.S. 131E-159(d) or issuance of a temporary EMS credential as defined in G.S. 131E-159(e).

(g) For a period of ten years following restoration of the EMS credential, the individual must disclose the prior administrative action taken against the individual's credential to every EMS System, Medical Director, EMS Provider, and EMS Educational Institution in which the individual is affiliated and provide a letter to the OEMS from each verifying disclosure.

(h) If the Department determines the individual is ineligible for EMS credentialing, the Department shall provide in writing the reason(s) for denial and inform the individual of the procedures for contested hearing as defined in Rule .1509 of this Section.