10A NCAC 13P .0102 is proposed for amendment as follows:

10A NCAC 13P .0102 DEFINITIONS

In addition to the definitions in G.S. 131E-155, the following definitions apply throughout this Subchapter:

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

(2) "Affiliated Hospital" means a non-trauma center hospital that is owned by the Trauma Center or there is 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.

(3) "Affiliate" or "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~~ a practice setting that utilizes credentialed EMS personnel that may not be affiliated with or under the oversight of ~~the~~ an EMS System or EMS System Medical Director.

(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 SCTP.

(8) "Bypass" means a decision made by the patient care technician to transport a patient from the scene of an accident or medical emergency past a 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.

(9) "Community Paramedicine" means an EMS System utilizing credentialed personnel who have received additional training as determined by the EMS system Medical Director to provide knowledge and skills for the community needs beyond the 911 emergency response and transport operating guidelines defined in the EMS system plan.

~~(9)~~ (10) "Contingencies" mean conditions placed on a designation that, if unmet, may result in the loss or amendment of a designation.

~~(10)~~ (11) "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.

~~(11)~~ (12) "Deficiency" means the failure to meet essential criteria for a designation that can serve as the basis for a focused review or denial of a designation.

~~(12)~~ (13) "Department" means the North Carolina Department of Health and Human Services.

~~(13)~~ (14) "Diversion" means the hospital is unable to accept a patient due to a lack of staffing or resources.

~~(14)~~ (15) "Educational Medical Advisor" means the physician responsible for overseeing the medical aspects of approved EMS educational programs.

~~(15)~~ (16) "EMS Care" means all services provided within each EMS System by its affiliated EMS agencies and personnel that relate to the dispatch, response, treatment, and disposition of any patient.

~~(16)~~ (17) "EMS Educational Institution" means any agency credentialed by the OEMS to offer EMS educational programs.

~~(17)~~ (18) "EMS Non-Transporting 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 an 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.

~~(18)~~ (19) "EMS Peer Review Committee" means a committee as defined in G.S. 131E-155(6b).

~~(19)~~ (20) "EMS Performance Improvement Self-Tracking and Assessment of Targeted Statistics" means 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 Performance Improvement Self-Tracking and Assessment of Targeted Statistics focuses on a topic of care such as trauma, cardiac arrest, EMS response times, stroke, STEMI (heart attack), and pediatric care.

~~(20)~~ (21) "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.

~~(21)~~ (22) "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.

~~(22)~~ (23) "Essential Criteria" means those items that are the requirements for the respective level of trauma center designation (I, II, or III), as set forth in Rule .0901 of this Subchapter.

~~(23)~~ (24) "Focused Review" means an evaluation by the OEMS of corrective actions to remove contingencies that are a result of deficiencies following a site visit.

~~(24)~~ (25) "Ground Ambulance" means an ambulance used to transport patients with traumatic or medical conditions or patients for whom the need for specialty ~~care~~ care, ~~or emergency~~ emergency, or non-emergency medical care is anticipated either at the patient location or during transport.

~~(25)~~ (26) "Hospital" means a licensed facility as defined in G.S. ~~131E-176.~~ 131E-176 or an acute care in-patient diagnostic and treatment facility located within the State of North Carolina that is owned and operated by an agency of the United States government.

~~(26)~~ (27) "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.

~~(27)~~ (28) "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.

~~(28)~~ (29) "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.

~~(29)~~ (30) "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.

~~(30)~~ (31) "Level I Trauma Center" means a hospital that has the capability of providing guidance, research, and total care for every aspect of injury from prevention to rehabilitation.

~~(31)~~ (32) "Level II Trauma Center" means a hospital that provides trauma care regardless of the severity of the ~~injury~~ injury, but may lack the comprehensive care as a Level I trauma ~~center~~ center, and does not have trauma research as a primary objective.

~~(32)~~ (33) "Level III Trauma Center" means a hospital that provides assessment, resuscitation, emergency operations, and stabilization, and arranges for hospital transfer as needed to a Level I or II trauma center.

~~(33)~~ (34) "Licensed Health Care Facility" means any health care facility or hospital licensed by the Department of Health and Human Services, Division of Health Service Regulation.

~~(34)~~ (35) "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.

~~(35)~~ (36) "Medical Director" means the physician responsible for the medical aspects of the management of ~~an EMS System, Alternative Practice Setting, SCTP,~~ a practice setting utilizing credentialed EMS personnel or medical crew members, or a Trauma Center.

~~(36)~~ (37) "Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of ~~an EMS System, Alternative Practice Setting, or SCTP.~~ a practice setting utilizing credentialed EMS personnel or medical crew members. 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.

(38) “Mobile Integrated Healthcare” means utilizing credentialed personnel who have received additional training as determined by the Alternative Practice Setting medical director to provide knowledge and skills for the healthcare provider program needs.

~~(37)~~ (39) "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.

~~(38)~~ (40) "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 1201 Umstead Drive, Raleigh, North Carolina 27603.

~~(39)~~ (41) "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.

~~(40)~~ (42) "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.

~~(41)~~ (43) "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.

~~(42)~~ (44) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.

~~(43)~~ (45) "Regional Advisory Committee" 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.

~~(44)~~ (46) "Request for Proposal" means a State document that must be completed by each hospital seeking initial or renewal trauma center designation.

~~(45)~~ (47) "Significant Failure to Comply" means a degree of non-compliance determined by the OEMS during compliance monitoring to exceed the ability of the local EMS System to correct, warranting enforcement action pursuant to Section .1500 of this Subchapter.

~~(46)~~ (48) "State Medical Asset and Resource Tracking Tool" means the Internet web-based program used by the OEMS both ~~daily~~ in its daily operations and during times of disaster to identify, ~~record~~ record, and monitor EMS, hospital, health ~~care~~ care, and sheltering resources statewide, including facilities, personnel, vehicles, equipment, and pharmaceutical and supply caches.

~~(47)~~ (49) "Specialty Care Transport Program" means a program designed and operated for the transportation of a patient by ground or air requiring specialized interventions, ~~monitoring~~ 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.

~~(48)~~ (50) "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.

~~(49)~~ (51) "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.

~~(50)~~ (52) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

~~(51)~~ (53) "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.

~~(52)~~ (54) "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 herein by reference 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 online at www.ncems.org at no cost.

~~(53)~~ (55) "Trauma Center" means a hospital designated by the State of North Carolina and distinguished by its ability to manage, on a 24-hour basis, the severely injured patient or those at risk for severe injury.

~~(54)~~ (56) "Trauma Center Criteria" means essential criteria to define Level I, II, or III trauma centers.

~~(55)~~ (57) "Trauma Center Designation" means a process of approval in which a hospital voluntarily seeks to have its trauma care capabilities and performance evaluated by experienced on-site reviewers.

~~(56)~~ (58) "Trauma Diversion" means a trauma center of its own volition declines to accept an acutely injured patient due to a lack of staffing or resources.

~~(57)~~ (59) "Trauma Guidelines" mean standards for practice in a variety of situations within the trauma system.

~~(58)~~ (60) "Trauma Minimum Data Set" means the basic data required of all hospitals for submission to the Trauma Registry.

~~(59)~~ (61) "Trauma Patient" means any patient with an ICD-CM discharge diagnosis as defined in the "North Carolina Trauma Registry Data Dictionary," incorporated herein 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 online at https://www.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html at no cost.

~~(60)~~ (62) "Trauma Program" means an administrative entity that includes the trauma service and coordinates other trauma-related activities. It shall 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 in the hospital providing patient care.

~~(61)~~ (63) "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. The elements of the Trauma Registry can be accessed at https://www.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html at no cost.

~~(62)~~ (64) "Treatment Protocols" means a document approved by the Medical Directors of the local EMS System, Specialty Care Transport Program, Alternative Practice Setting, 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.

~~(63)~~ (65) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.

~~(64)~~ (66) "Water Ambulance" means a watercraft specifically configured and medically equipped to transport patients.

History Note: *Authority G.S. 131E-155(6b); 131E-162; 143-508(b), 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-508(d)(4); 143-508(d)(5); 143-508(d)(6); 143-508(d)(7); 143-508(d)(8); 143-508(d)(13); 143-518(a)(5);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2018.

10A NCAC 13P .0201 is proposed for amendment as follows:

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 an EMS System. The highest level of care offered within any EMS Provider service area shall be available to the citizens within that service area 24 hours a day, seven days a week;

(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 set forth in Rule ~~.0301(a)(4)~~ .0301 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 a day, seven days a week;

(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(28)~~ .0102 of this Subchapter and written procedures that 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 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 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 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) a PSAP operated by public safety telecommunicators with training in the management of calls for medical assistance available 24 hours a day, seven days a week;

(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 PSAP and to facilities where patients are transported. The 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 resources utilized 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 EMS Care system data, review, and evaluation of patient outcomes and quality management peer reviews, that follows the criteria set forth in Rule .0501 of this Subchapter;

(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 that 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 identified facilities when diversion or bypass plans are activated;

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

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

(F) a disaster plan;

(G) a mass-gathering ~~plan;~~ plan that includes how the provision of EMS standby coverage for the public-at-large will be provided;

(H) a mass-casualty plan;

(I) a weapons plan for any weapon as set forth in Rule .0216 of this Section;

(J) a plan on how EMS personnel shall report suspected child abuse pursuant to G.S. 7B-301;

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

(L) 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)~~ .0102 of this Subchapter with a 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) appropriate personnel within each agency, credentialed in accordance with the requirements set forth in Section .0500 of this Subchapter, to ensure EMD services to the citizens within that service area are available 24 hours per day, seven days a week; and

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

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

(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 no more than 90 days prior to expiration.

History Note: *Authority G.S. 131E-155(1); 131E-155(6); 131E-155(7); 131E-155(8); 131E-155(9); 131E-155(13a); 131E-155(15); 143-508(b); 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-508(d)(5); 143-508(d)(8); 143-508(d)(9); 143-508(d)(10); 143-508(d)(13); 143-517; 143-518;*
Temporary Adoption Eff. January 1, 2002;
Eff. August 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2018.

10A NCAC 13P .0222 is proposed for amendment as follows:

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

(a) Any person transported on a stretcher as defined in Rule ~~.0102(49)~~ .0102 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 OEMS 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 from the definition of stretcher.

History Note: *Authority G.S. 131E-156; 131E-157; 143-508(d)(8);*
Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2018.

10A NCAC 13P .0301 is proposed for amendment as follows:

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 the program is intended to service;

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

(3) ~~Service~~ service available on a 24 hour a day, seven days a week 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;"~~ Collection";

(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 upon feedback from program data, review and evaluation of patient outcomes, and quality management review that follows the criteria set forth in Rule .0501 of this Subchapter;

(6) a communication system that provides 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 completed training conducted every six months regarding:

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

(B) the medical and patient safety equipment specific to the program;

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

(A) a listing of all standard medical equipment, supplies, and medications, approved by the Medical Director as sufficient to manage the anticipated number and severity of injury or illness of the patients, for all vehicles used in the program based on the treatment protocols and approved by the OEMS; and

(B) a methodology to ensure 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 as determined by the transferring

physician who is responsible for the medical aspects of the mission to manage the anticipated severity of injury or illness of the patient:

(1) paramedic;

(2) nurse practitioner;

(3) physician;

(4) physician assistant;

(5) registered nurse; or

(6) respiratory therapist.

(c) SCTP as defined in Rule ~~.0102(47)~~ .0102 of this Subchapter are exempt from the staffing requirements defined in G.S. 131E-158(a).

(d) SCTP approval is valid for a period to coincide with the EMS Provider License that is issued by OEMS and is valid for six years. Programs shall apply to the OEMS for ~~reapproval.~~ reapproval no more than 90 days prior to expiration.

History Note: *Authority G.S. 131E-155.1(b); 131E-158; 143-508;*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2004;
Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;
Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2018.

10A NCAC 13P .0505 is proposed for amendment as follows:

10A NCAC 13P .0505 SCOPE OF PRACTICE FOR EMS PERSONNEL

EMS Personnel educated in approved programs, credentialed by the OEMS, and ~~affiliated with an approved EMS System~~ functioning under physician medical oversight may perform acts and administer intravenous fluids and medications as allowed by the North Carolina Medical Board pursuant to G.S. 143-514.

History Note: *Authority G.S. 143-508(d)(6); 143-514;*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. July 1, 2018.

10A NCAC 13P .0506 is proposed for amendment as follows:

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 OEMS and by the Medical Director of the EMS System or Specialty Care Transport Program with which they are affiliated:

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

(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.~~ events; and

(6) community paramedicine programs.

(b) Individuals functioning in an alternative practice setting as defined in Rule ~~.0102(4)~~ .0102 of this Subchapter consistent with the areas identified in Subparagraphs ~~(a)(2)~~ (a)(1) through ~~(a)(4)~~ (a)(5) 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 where 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 individual's 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.

History Note: *Authority G.S. 143-508(d)(7);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2018; January 1, 2017.

10A NCAC 13P .0904 is proposed for amendment as follows:

10A NCAC 13P .0904 INITIAL DESIGNATION PROCESS

(a) For initial Trauma Center designation, the hospital shall request a consult visit by OEMS and the consult shall occur within one year prior to submission of the RFP.

(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 that 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~~ annually or show that its trauma service will be taking care of at least 240 trauma patients with an ISS greater than or equal to 15 yearly. 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 shall be participating in the State Trauma Registry as defined in Rule ~~.0102(61)~~ .0102 of this Subchapter, and submit data to the OEMS weekly a minimum of 12 months prior to application that includes all the Trauma Center's trauma patients as defined in Rule ~~.0102(59)~~ .0102 of this Subchapter who are:

(1) diverted to an affiliated hospital;

(2) admitted to the Trauma Center for greater than 24 hours from an ED or hospital;

(3) die in the ED;

(4) are DOA; or

(5) are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital).

(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)~~ Paragraph (b) of this Rule. The OEMS shall notify the applicant's primary RAC of the application and provide the regional data submitted by the applicant in ~~Subparagraphs (b)(1) through (3)~~ Paragraph (b) of this Rule for review and comment. The RAC shall be given 30 days to submit written comments to the OEMS.

(e) OEMS shall notify the respective Board of County Commissioners in the applicant's primary catchment area of the request for initial designation to allow for comment during the same 30 day comment period.

(f) OEMS shall notify the hospital in writing of its decision to allow submission of an RFP. If approved, the RAC and Board of County Commissioners in the applicant's primary catchment area shall also be notified by the OEMS that an RFP will be submitted.

(g) Once the hospital is notified that an RFP will be accepted, the hospital shall complete and submit an electronic copy of the completed RFP with signatures to the OEMS at least 45 days prior to the proposed site visit date.

(h) The RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in Rule .0901 of this Section.

(i) If OEMS does not recommend a site visit based upon failure to comply with Rule .0901 of this Section, the OEMS shall send the written reasons to the hospital 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 after review of the RFP, 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 hospital and the OEMS shall agree on the date of the site visit.

(k) Except for OEMS representatives, any in-state reviewer for a Level I or II visit shall be from outside the local or adjacent RAC, unless mutually agreed upon by the OEMS and the trauma center seeking designation where 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 trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be the primary reviewer;

(2) one in-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 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) for Level I designation, one out-of-state trauma program manager with an equivalent license from another state;

(5) for Level II designation, one in-state program manager who is licensed to practice ~~professional~~ nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes; and

(6) OEMS Staff.

(l) All site team members for a Level III visit shall be from in-state, and, except for the OEMS representatives, shall be from outside the local or adjacent RAC where the hospital is located. The composition of a Level III state site survey team shall be as follows:

(1) one trauma surgeon who is a Fellow of the ACS, who is a member of the North Carolina Committee on Trauma and shall be 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 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 trauma program manager who is licensed to practice ~~professional~~ nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes; and

(4) OEMS Staff.

(m) On the day of the site visit, the hospital shall make available all requested patient medical charts.

(n) The primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team. The primary reviewer shall complete and submit to the OEMS a written consensus report 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 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 of this Section shall be met for initial designation at the level requested.

(q) Hospitals with a deficiency(ies) resulting from the site visit shall be given up to 12 months to demonstrate compliance. Satisfaction of deficiency(ies) may require an additional site visit. The need for an additional site visit ~~is~~ shall be determined on a case-by-case basis based on the type of deficiency. If compliance is not demonstrated within the time period set 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 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 shall be valid for a period of three years.

History Note: *Authority G.S. 131E-162; 143-508(d)(2);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2018.

10A NCAC 13P .1502 is proposed for amendment as follows:

10A NCAC 13P .1502 LICENSED EMS PROVIDERS

(a) The OEMS shall deny an initial or renewal EMS Provider license for any of the following reasons:

(1) significant failure to comply, as defined in Rule ~~.0102(45)~~ .0102 of this Subchapter, with the applicable licensing requirements in Rule .0204 of this Subchapter;

(2) making false statements or representations to the OEMS 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; or

(4) disclosing information as defined in Rule .0223 of this Subchapter that is determined by OEMS ~~staff~~ staff, based upon review of documentation, to disqualify the applicant from licensing.

(b) The Department shall amend any EMS Provider license by amending it to reduce the license 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 probability that the licensee can take corrective measures to resolve the issue of non-compliance with Rule .0204 of this Subchapter, and be able ~~thereafter~~ to remain in compliance within a reasonable length of time determined by OEMS staff on a case-by-case basis; and

(3) there is a probability, determined by OEMS staff using their professional judgment, based upon analysis of the licensee's ability to take corrective measures to resolve the issue of non-compliance with the licensure rules, that the licensee will be able thereafter to remain in compliance with the licensure rules.

(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 duration 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, as set forth in Rule .1509 of this Subchapter, on the amendment of the EMS Provider license.

(d) The provisional EMS Provider license is effective 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. Pursuant to G.S. 131E-155.1(d), the provisional license remains in effect until the Department:

(1) restores the licensee to full licensure status; or

(2) revokes the licensee's license.

(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 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 probable that the licensee will be able to remain in compliance with licensure rules;

(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) continues to repeat the same deficiencies placed on the licensee in previous compliance site visits;

(6) has recurring failure to provide emergency medical care within the defined EMS service area in a manner as determined by the EMS System;

(7) failed to disclose or report information in accordance with Rule .0223 of this Subchapter;

(8) was deemed by OEMS to place the public at risk because the ~~owner~~ owner, ~~or~~ any ~~officer~~ officer, or agent was convicted in any court of a crime involving fiduciary misconduct or a conviction of a felony;

(9) altered, destroyed, attempted to destroy, withheld, or delayed release of evidence, records, or documents needed for a complaint investigation being conducted by the OEMS; or

(10) continues to operate within an EMS System after a Board of County Commissioners ~~has~~ terminated its affiliation with the licensee, resulting in a violation of the licensing requirement set forth in Rule ~~.0204(a)(1)~~ .0204 of this Subchapter.

(f) The Department shall give the EMS Provider 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 Provider's right to a contested case hearing, as set forth in Rule .1509 of this Section, on the revocation of the EMS Provider's license.

(g) The issuance of a provisional EMS Provider license is not a procedural prerequisite to the revocation or suspension of a license pursuant to Paragraph (e) of this Rule.

History Note: *Authority G.S. 131E-155.1(d); 143-508(d)(10);*
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2018; January 1, 2017.

10A NCAC 13P .1505 is proposed for amendment as follows:

10A NCAC 13P .1505 EMS EDUCATIONAL INSTITUTIONS

(a) For the purpose of this Rule, "focused review" means an evaluation by the OEMS of an educational institution's corrective actions to remove contingencies that are a result of deficiencies identified in the initial or renewal application process.

(b) The Department shall deny the initial or renewal designation, 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; or

(2) attempting to obtain an EMS Educational Institution designation through fraud or misrepresentation.

(c) When an EMS Educational Institution is required to have a focused review, it shall demonstrate compliance with the provisions of Section .0600 of this Subchapter within 12 months or less.

(d) The Department shall revoke an EMS Educational Institution designation at any time whenever the Department finds that the EMS Educational Institution has significant failure to comply, as defined in Rule ~~.0102(45)~~ .0102 of this Subchapter, 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 as determined by OEMS staff based upon analysis of the educational institution's ability to take corrective measures to resolve the issue of non-compliance with Section .0600 of this Subchapter;

(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;

(3) failure to produce records upon request as required in Rule .0601(b)(6) of this Subchapter;

(4) the EMS Educational Institution failed to meet the requirements of a focused review within 12 months, as set forth in Paragraph (c) of this Rule;

(5) the failure to comply endangered the health, safety, or welfare of patients cared for as part of an EMS educational program as determined by OEMS staff in their professional judgment based upon a complaint investigation, in consultation with the Department and Department of Justice, to verify the results of the investigations are sufficient to initiate enforcement action pursuant to G.S. 150B; or

(6) the EMS Educational Institution altered, destroyed, or attempted to destroy evidence needed for a complaint investigation.

(e) The Department shall give the EMS Educational Institution written notice of revocation and denial. 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, set forth in Rule .1509 of this Section, on the revocation of the designation.

(f) Focused review is not a procedural prerequisite to the revocation of a designation as set forth in Rule .1509 of this Section.

(g) If determined by the educational institution that suspending its approval to offer EMS educational programs is necessary, the EMS Educational Institution may voluntarily surrender its credential without explanation by submitting a written request to the OEMS stating its intention. The voluntary surrender shall not affect the original expiration date of the EMS Educational Institution's designation. To reactivate the designation:

(1) the institution shall provide OEMS written documentation requesting reactivation; and

(2) the OEMS shall verify the educational institution is compliant with all credentialing requirements set forth in Section .0600 of this Subchapter prior to reactivation of the designation by the OEMS.

(h) If the institution fails to resolve the issues that resulted in a voluntary surrender, the Department shall revoke the EMS Educational Institution designation.

(i) In the event of a revocation or voluntary surrender, 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 when the voluntary surrender reactivates to full credential.

(j) 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 of action is sufficient for revocation of the EMS Educational Institution designation or imposing a focused review pursuant to Paragraphs (b) and (c) of this Rule is warranted.

History Note: *Authority G.S. 143-508(d)(4); 143-508(d)(10);*
Eff. January 1, 2013;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2018; January 1, 2017.