STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
801 BIGGS DRIVE, RALEIGH NC 27603
EDGERTON BUILDING
CONFERENCE ROOM – 026A
OR
TEAMS Video Conference: Click here to join the meeting
OR
Dial-IN: 1-984-204-1487 / Passcode: 553 484 783#

AGENDA

I. Meeting Opens – Roll Call

II. Chairman's Comments……..……..…….……Dr. John Meier

III. Public Meeting Statement……..……..……..……Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement……..…….Dr. John Meier
The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. Resolution of Appreciation for Retiring Member……..Dr. John Meier

- John A. Fagg, M.D. **(See Exhibit A/1)**

VI. North Carolina Board of Ethics Letter……..……Dr. John Meier

North Carolina Board of Ethics Letter was received for the following newly appointed member:

- Pascal Udekwu, M.D. (**See Exhibit A/2**)

VII. Approval of Minutes (Action Items)……..…….……...……..Dr. John Meier

- **May 19, 2023** (Medical Care Commission Quarterly Meeting) (**See Exhibit A**)
- **May 31, 2023** (Executive Committee) **(See Exhibit B/1)**
- **August 2, 2023** (Executive Committee) (**See Exhibit B/2**)

VIII. Bond Program Activities……...……Geary W. Knapp

A. Quarterly Report on Bond Program (**See Exhibit B**)

B. Notices & Non-Action Items & Technical Rule Changes

June 6, 2023 – EveryAge Series 2023B (Refunding Taxable Series 2021C)

- Par Value Outstanding: $28,630,000
- Series 2023B is a tax-exempt bond

July 12, 2023 – UMRH Series 2023 (Refunding Taxable Series 2021B)

- Par Value Outstanding: $78,665,000
- Series 2023 is a tax-exempt bond

IX. Bond Market Update…….Geary W. Knapp

X. Adult Care Update……..…….Megan Lamphere

XI. Old Business (Discuss Rules, Fiscal Note, & Comments Submitted) (Action Items)

A. Rules for Adoption

1. **Medical Care Commission Rules**…….....…….Nadine Pfeiffer

   Amendment of one rule

   - Rule: 10A NCAC 13A.0201

   (**See Exhibits C thru C/2**)

2. **Adult Care Home/Family Care Home Rules**……...…N. Pfeiffer & M. Lamphere

   Readoption of 4 rules following Periodic Review of rules (Phase 4); Amendment of one rule.

   - Rules: 10A NCAC 13F.0702, .1307 & 10A NCAC 13G .0504, .0705, .1301

   (**See Exhibits C/3 thru C/5**)

XII. New Business (Discuss Rules & Fiscal Note) (Action Items)

A. Rules for Initiating Rulemaking Approval

1. Emergency Medical Services & Trauma Rules.....N. Pfeiffer & T. Mitchell

Amendment of 25 rules

- Rules: 10A NCAC 13P .0101, .0102, .0201, 0207, .0216 - .0218, .0221, .0224, .0301, .0401 - .0404, .0407, .0410, 0502, .0503, .0512, .0601, .0602, .0904, .0905, .1505, .1507

(**See Exhibits D thru D/2**)

2. Nursing Pool Licensure Rules……..…….N. Pfeiffer & Azzie Conley

Amendments in response to rulemaking petition granted by MCC

- Rules: 10A NCAC 13L.0301, 0302

(**See Exhibits D/3 thru D/4**)

XIII. Refunding of Commission Bond Issues (Action Item)…….……Geary W. Knapp

Recommended:

WHEREAS the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until November 3, 2023 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and November 3, 2023. Refunding projects may include non-Commission debt, and non-material, routine capital improvement expenditures.

XIV. Meeting Adjournment

STATE OF NORTH CAROLINA
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809 RUGGLES DRIVE, RALEIGH NC 27603
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Dial-IN: 1-984-204-1487 / Passcode: 183 430 637#

May 19, 2023 (Friday)
9:00 a.m.

Minutes

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Kathy G. Barger Paul R.G. Cunningham, M.D. Bryant C. Foriest Linwood B. Hollowell, III Ashley H. Lloyd, D.D.S. David C. Mayer, M.D. Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Timothy D. Weber, RPH Jeffrey S. Wilson	Sally B. Cone John A. Fagg, M.D. Eileen C. Kugler, RN, MSN, MPH, FNP Karen E. Moriarty Lisa A. Tolnitch, M.D.
DIVISION OF HEALTH SERVICE REGULATION STAFF Mark Payne, Director, DHSR/Secretary, MCC Emery Milliken, Deputy Director, DHSR Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Kimberly Randolph, Attorney General's Office Jeff Harms, Acting Construction Chief, DHSR Nadine Pfeiffer, Rules Review Manager, DHSR	

Megan Lamphere, Chief, ACLS Libby Kinsey, Assistant Chief, ACLS Shalisa Jones, Policy Coordinator, ACLS Tom Mitchell, Chief, OEMS David Ezzell, HPP Operations Manager, OEMS Kimberly Clement, HPP Program Manager, OEMS Crystal Abbott, Auditor, MCC Alice Creech, Executive Assistant, MCC **OTHERS PRESENT** Dr. Sandra Greene, Cecil G. Sheps Center for Health Services Research Jillian Riley, Planned Parenthood Susanna Birdsong, Planned Parenthood	

II. Chairman's Comments……..……..…….……Dr. John Meier

Dr. Meier welcomed Members and emphasized our role is about the patient and citizens of North Carolina.

III. Public Meeting Statement…….…….……..……Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement……..…….Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. North Carolina Board of Ethics Letters……Dr. John Meier

North Carolina Board of Ethics Letters were received for the following newly appointed member:

- Timothy D. Weber, RPh (**See Exhibit A/1**)

VI. Approval of Minutes (Action Items)……..……..……...……..Dr. John Meier

- **February 10, 2023** (Medical Care Commission Quarterly Meeting) (**See Exhibit A**)
- **February 28, 2023** (Executive Committee) (**See Exhibit B/1**)
- **March 22, 2023** (Executive Committee) (**See Exhibit B/2)**
- **April 19, 2023** (Executive Committee) (**See Exhibit B/3**)
- **May 3, 2023** (Executive Committee) (**See Exhibit B/4**)

COMMISSION ACTION: *A motion was made to approve the minutes by Mr. Joe Crocker, seconded by Dr. Robert Schaaf, and unanimously approved.*

VII. Bond Program Activities……...……Geary W. Knapp

A. Quarterly Report on Bond Program (See Exhibit B)

B. Notices & Non-Action Items & Technical Rule Changes

April 3, 2023 – Aldersgate Series 2023 (Refunding Taxable Series 2021A)

- Par Value Outstanding: $25,665,000
- Series 2023 is a tax-exempt bond

VIII. NC Hospital Discharge Data Presentation……Dr. Sandra Greene

See **EXHIBIT D for the presentation*

IX. OEMS Presentation……..……..Tom Mitchell

See **EXHIBIT E for the presentation*

X. Bond Project (Action Item)

A. Mobile Disaster Hospital (DHSR)……...……Geary W. Knapp

Resolution: The Commission grants preliminary approval to a project for the North Carolina Office of Emergency Medical Services (NCOEMS) to provide funds in the amount of **$620,000** for upgrades to the North Carolina Mobile Disaster Hospital. The upgrades are necessary to maintain operational capabilities and ensure readiness for deployment of the Mobile Disaster Hospital. The specific use of the funds is as follows:

- $340,000 – Two 264kW, 800-amp generators
- $100,000 – One transfer switch
- $130,000 – DLX Quick Deploy Soft-Sided Structures
- $50,000 – Eight Hill Rom ED Stretchers

Tentative approval is given with the understanding that NCOEMS accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.
2. The project will continue to be developed pursuant to all applicable North Carolina purchasing guidelines.
3. The project must, in all respects, meet the requirements of G.S. § 131A (Health Care Facilities Finance Act).
4. The Executive Committee of the Commission is delegated the authority to approve the final expenditure of funds for this project and may approve the expenditure of such greater amount as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

COMMISSION ACTION: *A motion was made to approve the upgrades of the OEMS Mobile Disaster Hospital by Dr. Robert Schaaf, seconded by Mr. Bryant Foriest, and unanimously approved.*

See **EXHIBIT F for presentation*

XI. New Business (Discuss Rules & Fiscal Note) (Action Items)

A. Rules for Initiating Rulemaking Approval

1. Adult Care Home/Family Care Home Rules….N. Pfeiffer & M. Lamphere

11 total rules – Readoption of 9 rules following Periodic Review of rules (Phase 5), Amendment of 2 rules

- Rules: 10A NCAC 13F .0703, .0704, .1103, .1104, .1106 & 10A NCAC 13G .0702, .0703, .0704, .1102, .1103, .1106

(See **Exhibits C thru C/3**)

COMMISSION ACTION: *A motion was made to approve the Adult Care/Family Care Home Rules by Ms. Kathy Barger, seconded by Mr. Bryant Foriest, and unanimously approved.*

XII. Refunding of Commission Bond Issues (Action Item)……Geary W. Knapp

Recommended:

WHEREAS the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until August 11, 2023 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and August 11, 2023. Refunding projects may include non-Commission debt, and non-material, routine capital improvement expenditures.

COMMISSION ACTION: *A motion was made to authorize its Executive Committee to approve projects involving the refunding of existing debt between this date and August 11, 2023 by Mr. Joe Crocker, seconded by Dr. John Meier, and unanimously approved.*

XIII. Meeting Adjournment

There being no further business the meeting was adjourned at 11:33 a.m.

Respectfully Submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

THE NORTH CAROLINA MEDICAL CARE COMMISSION RESOLUTION OF APPRECIATION

JOHN ANDERSON FAGG, M.D.

WHEREAS, John A. Fagg M.D. was a member of the North Carolina Medical Care Commission from November 25, 2003 until June 26, 2023; and

WHEREAS, Dr. Fagg served with a devotion of interest far beyond the call of duty with the highest integrity, graciousness, and efficiency; and

WHEREAS, during Dr. Fagg's tenure, the Medical Care Commission assisted many hospitals and other health care facilities with tax exempt bond financing; and

WHEREAS, during Dr. Fagg's tenure, significant program rules were revised and/or adopted to ensure the quality of health services to the people of North Carolina; and

WHEREAS, the Commission will miss Dr. Fagg's tenacity in posing questions to all; and

WHEREAS, in addition to his intelligence the Commission will miss his quick wit, camaraderie, and caring interest of healthcare, and the citizens of North Carolina;

NOW, THEREFORE, BE IT RESOLVED that the North Carolina Medical Care Commission does hereby record its great appreciation for the services of Dr. Fagg;

BE IT RESOLVED, FURTHER, that this resolution be recorded in the permanent minutes of the Commission;

Resolved this the 11th day of August, 2023.

_____
John J. Meier, IV, M.D.
Chairman

ATTEST:

_____
S. Mark Payne, Secretary

STATE ETHICS COMMISSION

POST OFFICE BOX 27685
RALEIGH, NC 27611
PHONE: 919-814-3600

Via Email

June 27, 2023

The Honorable Roy A. Cooper III
Governor of North Carolina
20301 Mail Service Center
Raleigh, North Carolina 27699-0301

Re: Evaluation of Statement of Economic Interest Filed by Dr. Pascal Udekwu
Prospective Appointee to the North Carolina Medical Care Commission

Dear Governor Cooper:

Our office has received **Dr. Pascal Udekwu's** 2023 Statement of Economic Interest as a prospective appointee to the **North Carolina Medical Care Commission (the "Commission")**. We have reviewed it for actual and potential conflicts of interest pursuant to Chapter 138A of the North Carolina General Statutes ("N.C.G.S."), also known as the State Government Ethics Act (the "Act").

Compliance with the Act and avoidance of conflicts of interest in the performance of public duties are the responsibilities of every covered person, regardless of this letter's contents. This letter, meanwhile, is not meant to impugn the integrity of the covered person in any way. This letter is required by N.C.G.S. § 138A-28(a) and is designed to educate the covered person as to potential issues that could merit particular attention. Advice on compliance with the Act is available to certain public servants and legislative employees under N.C.G.S. § 138A-13.

We did not find an actual conflict of interest but found the potential for a conflict of interest. The potential conflict identified does not prohibit service on this entity.

The North Carolina Medical Care Commission was created to adopt statewide plans for the construction and maintenance of public and private hospitals, medical centers, and related facilities, including the approval of projects in the amounts of grants-in-aid from funds by both federal and state governments. The Commission is charged with administering the Health Care Facilities Finance Act (N.C.G.S. Chapter 131A) and issues bonds pursuant thereto. In addition, the Commission has the authority to adopt rules, regulations, and standards for the different types of hospitals to be licensed, the operation of nursing homes, the inspection, licensure, and operation of adult care homes, including personnel requirements of staff employed in adult care homes. The Commission also adopts rules providing for the accreditation of facilities that perform mammography and other procedures.

The Act establishes ethical standards for certain public servants and prohibits public servants from: (1) using their positions for their financial benefit or for the benefit of their extended family or business, N.C.G.S. § 138A-31; and (2) participating in official actions from which they or certain associated persons might receive a reasonably foreseeable financial benefit, N.C.G.S. § 138A-36(a). The Act also requires public servants to take appropriate steps to remove themselves from proceedings in which their impartiality might reasonably be questioned due to a familial, personal, or financial relationship with a participant in those proceedings. N.C.G.S. § 138A-36(c).

Dr. Udekwu would fill the role of a member nominated by the North Carolina Medical Society. He is employed by WakeMed Health and Hospitals. As such, he has the potential for a conflict of interest and should exercise appropriate caution in the performance of his public duties should issues involving WakeMed Health and Hospitals come before the Commission for official action.

In addition to the conflicts standards noted above, the Act prohibits public servants from accepting gifts from (1) a lobbyist or lobbyist principal, (2) a person or entity that is seeking to do business with the public servant's agency, is regulated or controlled by that agency, or has financial interests that might be affected by their official actions, or (3) anyone in return for being influenced in the discharge of their official responsibilities. N.C.G.S. § 138A-32. Exceptions to the gifts restrictions are set out in N.C.G.S. § 138A-32(e).

When this letter cites an actual or potential conflict of interest under N.C.G.S. § 138A-24(e), the conflict must be recorded in the minutes of the applicable board and brought to the membership's attention by the board's chair as often as necessary to remind all members of the conflict and to help ensure compliance with the Act. N.C.G.S. § 138A-15(c).

Finally, the Act mandates that all public servants attend an ethics and lobbying education presentation. N.C.G.S. § 138A-14. Please review the attached document for additional information concerning this requirement.

Please contact our office if you have any questions concerning our evaluation or the ethical standards governing public servants under the Act.

Sincerely,

Mary Roerden

Mary Roerden, SEI Unit
State Ethics Commission

cc: Dr. Pascal Udekwu
Attachment: Ethics Education Guide

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 4th Quarter FYE 2023)

Program Measures	FYE 2022 Ending: 6/30/2022	FYE 2023 Ending: 6/30/2023
Outstanding Debt	**$5,062,795,270**	**$4,676,200,334**
Outstanding Series	**117**[1]	**114**[1]

Detail of Program Measures	Ending: 6/30/2022	Ending: 6/30/2023
Outstanding Debt per Hospitals and Healthcare Systems	$3,560,138,783	$3,212,486,549
Outstanding Debt per CCRCs	$1,502,656,487	$1,463,713,786
Outstanding Debt per Other Healthcare Service Providers	$0	$0
Outstanding Debt Total	**$5,062,795,270**	**$4,676,200,334**
Outstanding Series per Hospitals and Healthcare Systems	59	51
Outstanding Series per CCRCs	58	63
Outstanding Series per Other Healthcare Service Providers	0	0
Series Total	**117**	**114**
Number of Hospitals and Healthcare Systems with Outstanding Debt	11	10
Number of CCRCs with Outstanding Debt	18	19
Number of Other Healthcare Service Providers with Outstanding Debt	0	0
Facility Total	29	29

Note 1: For FYE 2023, NCMCC has closed 13 **Bond Series**. Out of the closed Bond Series: 5 were conversions, 5 were new money projects, 0 combination of new money project and refunding, and 3 were refundings. The Bond Series outstanding from FYE 2022 to current represents all new money projects, refundings, conversions, and redemptions.

GENERAL NOTES: Facility Totals represent a parent entity total and do not represent each individual facility owned/managed by the parent entity. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities. The following parent entities represent the current "other healthcare service providers" with outstanding NC MCC debt: NONE AT THIS TIME

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 4th Quarter FYE 2023)

Program Measures	FYE 2022 Ending: 6/30/2022	FYE 2023 Ending: 6/30/2023
Total PAR Amount of Debt Issued	**$28,681,980,327**	**$28,995,305,288**
Total Project Debt Issued (excludes refunding/conversion proceeds) [1]	**$13,517,222,552**	**$13,523,822,513**
Total Series Issued	**694**	**708**

Detail of Program Measures		Ending: 6/30/2022	Ending: 6/30/2023
PAR Amount of Debt per Hospitals and Healthcare Systems		$22,868,969,855	$23,116,044,855
PAR Amount of Debt per CCRCs		$5,438,715,242	$5,504,965,203
PAR Amount of Debt per Other Healthcare Service Providers		$374,295,230	$374,295,230
	Par Amount Total	**$28,681,980,327**	**$28,995,305,288**
Project Debt per Hospitals and Healthcare Systems		$10,273,019,674	$10,273,019,674
Project Debt per CCRCs		$2,997,188,964	$3,003,788,925
Project Debt per Other Healthcare Service Providers		$247,013,915	$247,013,915
	Project Debt Total	**$13,517,222,552**	**$13,523,822,513**
Series per Hospitals and Healthcare Systems		428	433
Series per CCRCs		227	236
Series per Other Healthcare Service Providers		39	39
	Series Total	**694**	**708**
Number of Hospitals and Healthcare Systems issuing debt		99	99
Number of CCRCs issuing debt		41	41
Number of Other Healthcare Service Providers issuing debt		46	46
	Facility Total	186	186

Note 1: Project Debt excludes bond proceeds that directly refunded prior NCMCC outstanding issues and conversion par amounts. Project Debt is an accumulation of all new project money, issuance costs (including issuance costs for refundings/conversions (if any)), and refundings of non-NCMCC debt.

GENERAL NOTES: Facility Totals represent each individual facility and <u>do not</u> represent parent entity totals. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE

MAY 31, 2023
11:30 A.M.

Members of the Executive Committee Present:

John J. Meier, IV, M.D., Chairman
Kathy G. Barger
Sally B. Cone
Bryant C. Foriest
Jeffrey S. Wilson

Members of the Executive Committee Absent:

Joseph D. Crocker, Vice-Chairman
Linwood B. Hollowell, III

Members of Staff Present:

Geary W. Knapp, JD, CPA, Assistant Secretary, MCC
Kathy C. Larrison, Auditor, MCC
Alice S. Creech, Executive Assistant, MCC

Others Present:

Alice Adams, Robinson Bradshaw & Hinson, PA
Allen Robertson, Robinson Bradshaw & Hinson, PA
Jennifer Temple, Atrium Health Wake Forest Baptist
Andy Zukowski, ECU Health
Brian Dunn, ECU Health

1. Purpose of Meeting

To approve certain modifications of the existing Bank-Bought Rate Period for the Commission's Health Care Facilities Revenue Bonds (Wake Forest Baptist Obligated Group), Series 2012D in connection with the cessation of LIBOR, and to consider a resolution providing for the waiver of certain reporting provisions included in the 2015 Loan Agreement with University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health and Pitt County Memorial Hospital, Incorporated d/b/a ECU Health Medical Center.

2. Resolution of the North Carolina Medical Care Commission authorizing a supplemental Trust Agreement and certain other action for the purpose of modifying certain terms of the North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (Wake Forest Baptist Obligated Group), Series 2012D.

Executive Committee Action: *A motion was made to approve the Supplemental Trust Agreement by Ms. Kathy Barger, seconded by Mr. Bryant Foriest, and unanimously approved.*

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina, and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to lend the same to any public or nonprofit agency for the purpose of providing funds to pay all or any part of the cost of health care facilities; and

WHEREAS, North Carolina Baptist Hospital (the "Borrower") is a North Carolina nonprofit corporation and a "nonprofit agency" within the meaning and intent of the Act, which owns and operates (in certain cases through controlled affiliates) health care facilities located in the City of Winston-Salem, North Carolina and other locations in the State of North Carolina; and

WHEREAS, the Commission has heretofore issued its Health Care Facilities Revenue Bonds (Wake Forest Baptist Obligated Group), Series 2012D (the "Series 2012D Bonds") pursuant to a Trust Agreement, dated as of December 1, 2012 (the "Trust Agreement"), between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "Bond Trustee"); and

WHEREAS, the Commission has heretofore loaned the proceeds of the Series 2012D Bonds to the Borrower pursuant to a Loan Agreement, dated as of December 1, 2012, between the Commission and the Borrower; and

WHEREAS, the Series 2012D Bonds are currently held by Truist Commercial Equity, Inc., as successor to BB&T Community Holdings Co. (the "Holder") and bear interest in the Bank-Bought Rate Period (as defined in the Trust Agreement) at the LIBOR Index Rate (as defined in the Trust Agreement); and

WHEREAS, the interest rate applicable to the Series 2012D Bonds is based upon LIBOR and, in contemplation of the cessation of LIBOR on June 30, 2023, the Holder has offered to modify the Series 2012D Bonds to provide for, in the manner as described herein, the replacement of LIBOR with a SOFR based interest rate; and

WHEREAS, the Borrower has determined to accept such offer and has requested that the Commission and the Bond Trustee amend the Trust Agreement for the purpose of modifying the terms of the Series 2012D Bonds as hereinabove described; and

WHEREAS, Section 1202 of the Trust Agreement provides for the execution of such trust agreements supplemental thereto with the consent of the Holders (as defined in the Trust Agreement) of not less than a majority of the aggregate principal amount of the Series 2012D Bonds then Outstanding (as defined in the Trust Agreement); and

WHEREAS, there has been presented to the officers and staff of the Commission (i) a draft of a Supplemental Trust Agreement amending the Trust Agreement, dated as of June 1, 2023 (the "Supplemental Trust Agreement"), between the Commission and the Bond Trustee, and (ii) a draft of an Allonge to the Series 2012D Bonds (the "Allonge"), modifying the terms of the Series 2012D Bonds in a tenor consistent with this Resolution; and

WHEREAS, the Holder, as the sole Holder of the Series 2012D Bonds, has indicated its willingness to give its consent to the terms and provisions of the Supplemental Trust Agreement and the Allonge; and

WHEREAS, the Commission has determined that the public will best be served by the amendment of the Trust Agreement and the modification of the terms of the Series 2012D Bonds in a tenor consistent with this Resolution;

NOW, THEREFORE, THE EXECUTIVE COMMITTEE OF THE NORTH CAROLINA MEDICAL CARE COMISISON DOES HEREBY RESOLVE, as follows:

Section 1. The form, terms and provisions of the Supplemental Trust Agreement are hereby approved in all respects, and the Chairman, Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose and the Secretary or the Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Supplemental Trust Agreement in substantially the form presented to the officers and staff of the Commission, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 2. The form, terms and provisions of the Allonge set forth in the Supplemental Trust Agreement are hereby approved in all respects and the Chairman, Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose and the Secretary or the Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature, and to deliver to the Bond Trustee for authentication on behalf of the Commission, the Allonge in definitive form, which shall be in substantially the form set forth in the Supplemental Trust Agreement, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and

appropriate; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 3. Upon its execution, the Allonge shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Allonge and deliver the Allonge to the Holder of the Series 2012D Bonds in accordance with the Trust Agreement and the Supplemental Trust Agreement.

Section 4. The Chairman, the Vice Chairman, any member of the Commission designated in writing by the Chairman of the Commission for such purpose, the Secretary and the Assistant Secretary of the Commission are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments, including delivery of the Allonge to the Holder, as they, with the advice of counsel, may deem necessary or appropriate to effect the amendment of the Trust Agreement and the modification of the terms of the Series 2012D Bonds as set forth in the Supplemental Trust Agreement and the Allonge.

Section 5. This Resolution shall take effect immediately upon its passage.

3. Resolution of the North Carolina Medical Care Commission Approving the Waiver of Certain Reporting Provisions for the North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (Vidant Health), Series 2015.

Executive Committee Action: *A Motion was made to approve the waiver by Ms. Sally Cone, seconded by Mr. Bryant Foriest, and unanimously approved with the recusal of Ms. Kathy Barger.*

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended, to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities; and

WHEREAS, pursuant to Trust Agreements, dated as of as of April 1, 2015, October 1, 2019, March 1, 2021 and June 1, 2022, between the Commission and the bond trustee named therein, the Commission has heretofore issued multiple series of its bonds for the benefit of University Health Systems of Eastern Carolina, Inc. d/b/a ECU Health (the "Parent Corporation") and Pitt County Memorial Hospital, Incorporated d/b/a ECU Health Medical Center (the "Corporation" and, together with the Parent Corporation, the "Corporations");

WHEREAS, the Commission loaned the proceeds of such bonds to the Corporations pursuant to Loan Agreements, dated as of April 1, 2015, October 1, 2019, March 1, 2021 and June 1, 2022 (collectively, the "Loan Agreements"), between the Commission and the Corporations;

WHEREAS, Section 5.03(e) of Loan Agreement, dated as of April 1, 2015 (the "2015 Loan Agreement"), between the Commission and the Corporations, relating to the Commission's Health Care Facilities Revenue Bonds (Vidant Health), Series 2015 (the "Series 2015 Bonds"), includes

a covenant requiring the Corporations to file certain materials with the Commission if the Coverage Ratio (as defined in 2015 Loan Agreement) at the end of each fiscal year is not greater than 2.0;

WHEREAS, Section 5.03(e) of the 2015 Loan Agreement provides that the Commission or the Executive Committee of the Commission may waive the requirements of Section 5.03(e) of the 2015 Loan Agreement at any time without notice to or consent of the Holders (as defined in the 2015 Loan Agreement);

WHEREAS, the Commission no longer includes the covenant set forth in Section 5.03(e) of the 2015 Loan Agreement as part of its programmatic requirements for new bond issues, and the other Loan Agreements with the Corporations do not include this covenant;

WHEREAS, the Corporations have requested that the Commission waive the requirements set forth in Section 5.03(e) of the 2015 Loan Agreement;

NOW THEREFORE, BE IT RESOLVED by the Executive Committee of the North Carolina Medical Care Commission as follows:

Section 1. Capitalized terms used in this resolution and not defined herein shall have the meanings given such terms in the 2015 Loan Agreement.

Section 2. The provisions of the Section 5.03(e) of the 2015 Loan Agreement are hereby waived. Such waiver is effective with the reporting requirements for the fiscal year ended September 30, 2022 and shall remain in effect until the Series 2015 Bonds are no longer outstanding unless such waiver is otherwise revoked by resolution of the Commission or the Executive Committee of the Commission.

Section 3. The Chairman, the Vice Chairman, any member of the Commission designated by resolution of the Commission or in writing by the Chairman, the Secretary and any Assistant Secretary of the Commission are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver such documents, certificates, undertakings, agreements or other instruments as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the provisions of this resolution.

Section 4. This resolution shall take effect immediately upon its adoption.

4. Adjournment

There being no further business, the meeting was adjourned at 11:54 a.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE
CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE
AUGUST 2, 2023
11:30 A.M.

Members of the Executive Committee Present:

John J. Meier, IV, M.D., Chairman
Joseph D. Crocker, Vice-Chairman
Kathy G. Barger
Bryant C. Foriest
Linwood B. Hollowell, III

Members of the Executive Committee Absent:

Sally B. Cone
Jeffrey S. Wilson

Members of Staff Present:

S. Mark Payne, Director, DHSR/Secretary, MCC
Geary W. Knapp, JD, CPA, Assistant Secretary, MCC
Crystal Watson-Abbott, Auditor, MCC
Kathy C. Larrison, Auditor, MCC
Alice S. Creech, Executive Assistant, MCC

Others Present:

Alice Adams, Robinson Bradshaw & Hinson, P.A.
Jon Mize, Womble Bond Dickinson (US) LLP

1. Purpose of Meeting

To approve an amendment to the Master Trust Indenture of Arbor Acres United Methodist Retirement Community, Inc.

2. Resolution of the North Carolina Medical Care Commission Approving Amendment to Arbor Acres United Methodist Retirement Community, Inc.'s Master Trust Indenture.

Executive Committee Action: A motion was made to approve the amendment to the Master Trust Indenture by Mr. Joe Crocker, seconded by Mrs. Kathy Barger, and unanimously approved.

WHEREAS, Arbor Acres United Methodist Retirement Community, Inc. ("Arbor Acres") has entered into a Master Trust Indenture, dated as of March 1, 2002 (as amended and supplemented, the "Master Indenture"), between Arbor Acres and Branch Banking and Trust Company, succeeded to by Truist Bank (the "Master Trustee"); and

WHEREAS, the North Carolina Medical Care Commission (the "Commission"), a commission of the Department of Health and Human Services of the State of North Carolina, has previously issued bonds for the benefit of Arbor Acres in 2010, 2016 and 2021 (collectively, the "Bonds") and loaned the proceeds thereof to Arbor Acres; and

WHEREAS, all of the Bonds are currently owned by Truist Bank or an affiliate thereof ("Truist"); and

WHEREAS, the Corporation desires to amend the Master Indenture to increase the amount of cash and investments allowed to be transferred pursuant to Section 3.08(b) of the Master Indenture (the "MTI Amendment") and Truist has agreed to consent to the MTI Amendment; and

WHEREAS, pursuant to Section 6.02 of the Master Indenture, the Commission and the Local Government Commission of North Carolina must also consent to the MTI Amendment; and

WHEREAS, the MTI Amendment is set forth in the Supplemental Indenture for Amendment to Master Indenture, to be dated as of August 1, 2023 or thereafter (the "2023 Supplement"), between Arbor Acres and the Master Trustee; and

WHEREAS, a copy of the 2023 Supplement containing the MTI Amendment has been presented to the staff of the Commission; and

WHEREAS, Arbor Acres has requested the Commission to consent to the MTI Amendment; and

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE as follows:

Section 1. The MTI Amendment is hereby approved and consented to.

Section 2. The Chairman, Vice Chairman, Secretary, and any Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are each hereby authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments as they, with the advice of counsel, may deem necessary or appropriate to reflect the Commission's consent to the MTI Amendment, including but not limited to the 2023 Supplement.

Section 3. This Resolution shall take effect immediately upon its passage.

3. Adjournment

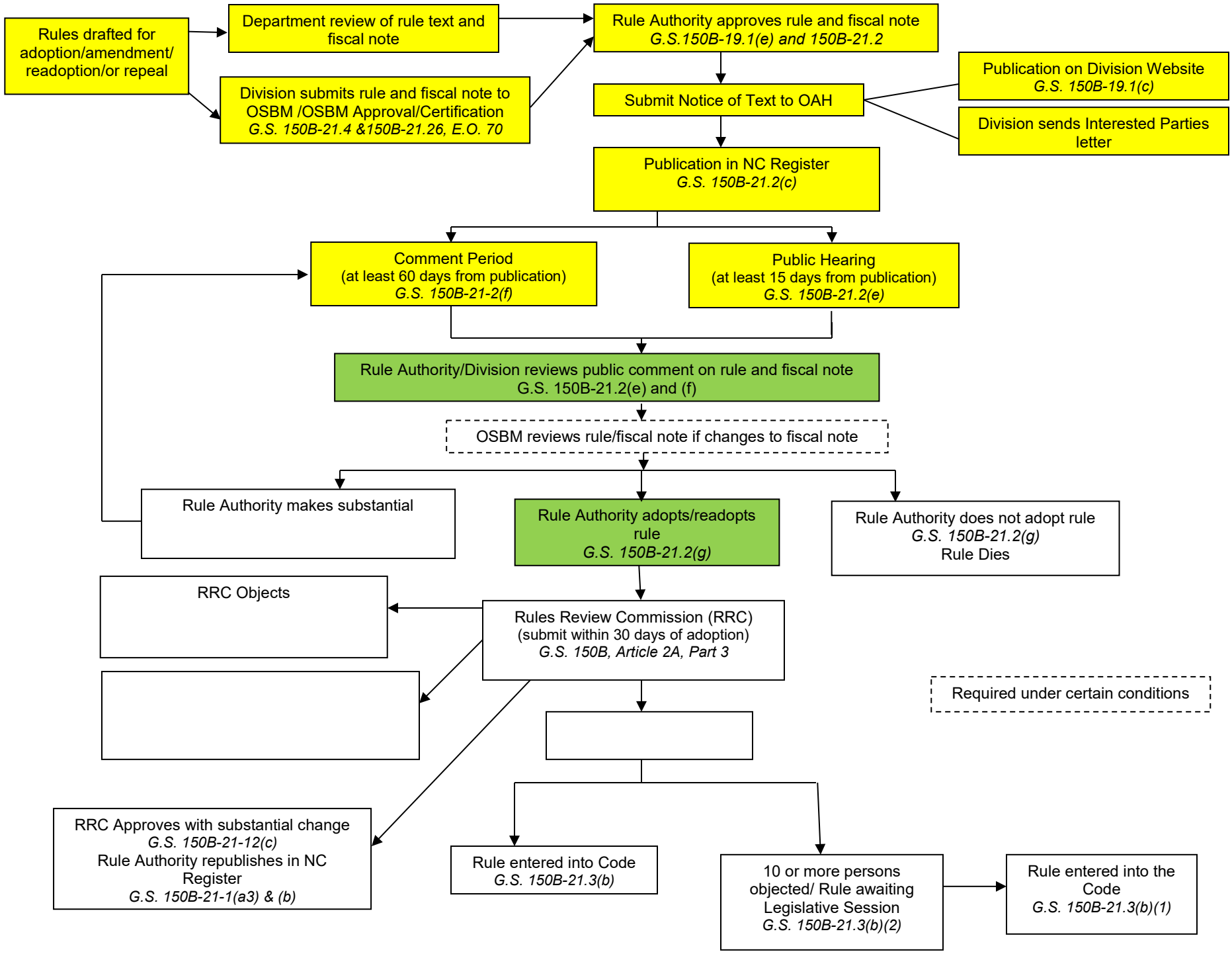
There being no further business, the meeting was adjourned at 11:39 a.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

Process for Medical Care Commission to Adopt/Readopt Rule

Exhibit C



10A NCAC 13A .0201 is amended as published in 37:18 NCR 1873-1874 as follows:

SECTION .0200 - RULEMAKING

10A NCAC 13A .0201 PETITIONS

(a) Any person wishing to submit a petition requesting the adoption, ~~amendment~~ amendment, or repeal of a rule by the North Carolina Medical Care Commission shall ~~address~~ submit the petition addressed to Office of the Director, Division of Health Service Regulation, 2701 Mail Service Center, Raleigh, North Carolina, 27699-2701.

(b) The petition shall contain the following information:

(1) ~~either a draft of~~ the text of the proposed ~~rule or a summary of its contents~~ rule(s) for adoption or amendment and the statutory authority for the agency to promulgate the ~~rule;~~ rule(s);

~~(2) reason for proposal;~~

~~(3)~~(2) a statement of the effect on existing rules or orders;

~~(4) any data supporting the proposal;~~

~~(5)~~(3) a statement of the effect of the proposed ~~rule~~ rule(s) on existing practices in the area involved, ~~including cost factors,~~ if known; and

~~(6) names of those most likely to be affected by the proposed rule, with addresses, if known;~~

~~(7)~~(4) the name(s) and address(es) of petitioner(s).

(c) The petitioner may include the following information within the request:

(1) documents and any data supporting the petition;

(2) a statement of the reasons for adoption of the proposed rule(s), amendment or the repeal of an existing rule(s);

(3) a statement explaining the costs and computation of the cost factors, if known; and

(4) a description, including the names and addresses, if known, of those most likely to be affected by the proposed rule(s).

~~(c)~~(d) The ~~Chairman of the~~ North Carolina Medical Care ~~Commission will determine,~~ Commission, based on a ~~study~~ review of the facts stated in the petition, ~~whether the public interest will be served by granting the petition. He will consider all the contents of the submitted petition, plus any additional information he deems relevant.~~ shall consider the following in the determination to grant the petition:

(1) whether the North Carolina Medical Care Commission has authority to adopt the rule(s);

(2) the effect of the proposed rule(s) on existing rules, programs and practices;

(3) probable costs and cost factors of the proposed rule(s);

(4) the impact of the rule on the public and the regulated entities; and

(5) whether the public interest will be served by granting the petition.

~~(d) Within 30 days of submission of the petition, the Chairman will render a final decision. If the decision is to deny the petition, the Chairman will notify the petitioner in writing, stating the reasons for the denial. If the decision is to~~

~~approve the petition, the Chairman will initiate a rulemaking proceeding by issuing a rulemaking notice, as provided in these rules.~~

(e) Petitions that do not contain the information required by Paragraph (b) of this Rule shall be returned to the petitioner by the Chairman of the North Carolina Medical Care Commission.

History Note: *Authority G.S. 143B-165; 150B-20;*
Eff. February 1, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, ~~2015.~~ 2015;
Amended Eff. October 1, 2023.

Fiscal Impact Analysis
Permanent Rule Amendment without Substantial Economic Impact

Rulemaking Authority Proposing Rule Change:
North Carolina Medical Care Commission

Agency Contact Persons
Nadine Pfeiffer, DHSR Rules Review Manager – (919) 855-3811
Emery Milliken, Deputy Director, Health Service Regulation – (919) 855-3958

Impact Summary

Federal Government:	No
State Government:	Yes, minimal
Local Government:	No
Private Entities:	Yes, minimal
Substantial Impact:	No

N.C. Administrative Code Citations and Titles of Rule Change
**See proposed text in the Appendix*

10A NCAC 13A .0201 Petitions (Amendment)

Authorizing Statutes
N.C. G.S. 143B-165
N.C. G.S. 150B-20

Background and Rationale for Rule Amendment
The rulemaking procedures in Subchapter 10A NCAC 13A apply to the rulemaking authority of the North Carolina Medical Care Commission (Commission) granted by G.S. 143B-165. Rules are required in the N.C. Administrative Code pursuant to G.S. 150B-20 for the procedure for submitting a rule petition to an Agency and the procedure an Agency follows in considering a rulemaking petition. There are 1717 rules the Division of Health Service Regulation (DHSR) has jurisdiction over in the N.C. Administrative Code. Of that number, the Commission has rulemaking authority for 736 rules. The remaining 981 rules are under the rulemaking authority of the Director, DHSR through Directive II-24 from the Department of Health and Human Services, the N.C. Radiation Protection Commission, the N.C. Social Services Commission, and the N.C. Mental Health Commission.

As discussed in the fiscal analysis, this rule is proposed for amendment to provide clarity, remove ambiguity, remove language restating statute, and make technical changes to the text.

Rules Summary

Rule .0201 – Petitions

The Agency is proposing to amend this rule to revise, update and clarify the procedure for the requirements for a rule petition submission and for rule petition approval by the Commission. The rule has been reorganized to identify items the petitioner may include in the petition but are not required to submit. The requirement for the timeframe of rendering of a final decision by the Commission Chairman of a petition submission was removed because it is governed by statute in G.S. 150B-20. In addition, other language restating the requirements in G.S. 150B-20 has been removed. By clarifying the requirements for rule petition submission and rule petition approval in the proposed rule, it removes the ambiguity in the rule for the submission of rule petitions to the Office of the Director, DHSR for rulemaking by the Commission.

Fiscal Impact to State Government and the Regulated Community

The proposed rule is clarifying the process for Medical Care Commission rulemaking petitions. The factors listed in the proposed rule have been used in consideration of rule petition approvals and are not new in the determination used to grant a rule petition. As such, there will be no change to the quality of review or the outcome of petitions.

In the last five years (10/1/18 -10/1/22), there have been two rule petitions submitted to DHSR for the rulemaking authority of the Commission, both of them submitted in the year 2022. In clarifying the requirements for petition submission in the proposed rule amendment, no additional requirements were added for the petitioner to address. Of the optional items listed in the rule, it is up to the discretion of the petitioner to include any or all the items listed the submitted petition for Commission consideration. Clarifying the determination factors for granting the petition enables a fair and equitable process for the Commission to consider petitions submitted. Petitioners and Commissioners may receive an incremental benefit in the form of time savings from the petition submission requirements being easier to understand.

The proposed rule shifts the responsibility for a petition determination from solely that of the Commission Chair to that of the entire Commission. In theory, this change has the potential to make the petition process more burdensome in that it requires a determination from the full Commission rather than just the Chair. It could also produce a benefit in that it will enable more transparency and diverse input from Commission members. However, costs and benefits associated with this change would be realized only if the Chair discontinues the current practice of deferring petition determinations to the entire Commission. This appears to be a discretionary outcome; as such, these potential costs and benefits may not be realized.

There will be no change in the amount of time for a petition determination by the Commission because according to G.S. 150B-20, a decision must be made within 120 days of receipt of a petition. The Commission holds regularly scheduled quarterly meetings, and as business needs arise, may hold special meetings in between the quarterly meetings. In the last five years, the petition determination decisions have been accommodated on the Commission meeting agendas for one regularly scheduled quarterly meeting and one special Commission meeting.

Impact Summary

As measured from the baseline conditions, there are no quantifiable economic costs or benefits associated with the proposed rule amendments. The amendments are for the purpose of providing clarity and consistency with Statute. While these amendments will not result in a change to the

baseline regulatory condition, they could have a positive economic impact to the regulated community and the State agency in terms of time savings. These impacts are expected to be negligible. The amendments could also result in a potential cost to the Commission, but such a cost would be realized only if the Commission Chair discontinues the current practice of deferring petition determinations to the full Commission. This appears to be a discretionary outcome; as such, this potential cost may not be realized.

Appendix: Proposed Rule Text

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

SECTION .0200 - RULEMAKING

10A NCAC 13A .0201 PETITIONS

(a) Any person wishing to submit a petition requesting the adoption, ~~amendment~~ amendment, or repeal of a rule by the North Carolina Medical Care Commission shall ~~address~~ submit the petition addressed to Office of the Director, Division of Health Service Regulation, 2701 Mail Service Center, Raleigh, North Carolina, 27699-2701.

(b) The petition shall contain the following information:

(1) ~~either a draft of~~ the text of the proposed ~~rule or a summary of its contents~~ rule(s) for adoption or amendment and the statutory authority for the agency to promulgate the ~~rule;~~ rule(s);

~~(2) reason for proposal;~~

~~(3)~~(2) a statement of the effect on existing rules or orders;

~~(4) any data supporting the proposal;~~

~~(5)~~(3) a statement of the effect of the proposed ~~rule~~ rule(s) on existing practices in the area involved, ~~including cost factors,~~ if known; and

~~(6) names of those most likely to be affected by the proposed rule, with addresses, if known;~~

~~(7)~~(4) the name(s) and address(es) of petitioner(s).

(c) The petitioner may include the following information within the request:

(1) documents and any data supporting the petition;

(2) a statement of the reasons for adoption of the proposed rule(s), amendment or the repeal of an existing rule(s);

(3) a statement explaining the costs and computation of the cost factors, if known; and

(4) a description, including the names and addresses, if known, of those most likely to be affected by the proposed rule(s).

~~(c)~~(d) The ~~Chairman of the~~ North Carolina Medical Care ~~Commission will determine,~~ Commission, based on a ~~study~~ review of the facts stated in the petition, ~~whether the public interest will be served by granting the petition. He will consider all the contents of the submitted petition, plus any additional information he deems relevant.~~ shall consider the following in the determination to grant the petition:

(1) whether the North Carolina Medical Care Commission has authority to adopt the rule(s);

(2) the effect of the proposed rule(s) on existing rules, programs and practices;

(3) probable costs and cost factors of the proposed rule(s);

(4) the impact of the rule on the public and the regulated entities; and

(5) whether the public interest will be served by granting the petition.

~~(d) Within 30 days of submission of the petition, the Chairman will render a final decision. If the decision is to deny the petition, the Chairman will notify the petitioner in writing, stating the reasons for the denial. If the decision is to approve the petition, the Chairman will initiate a rulemaking proceeding by issuing a rulemaking notice, as provided in these rules.~~

(e) Petitions that do not contain the information required by Paragraph (b) of this Rule shall be returned to the petitioner by the Chairman of the North Carolina Medical Care Commission.

History Note: *Authority G.S. 143B-165; 150B-20;*
Eff. February 1, 1976;
Readopted Eff. December 19, 1977;
Amended Eff. November 1, 1989;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, ~~2015.~~ 2015;
Amended Eff. October 1, 2023.

10A NCAC 13F .0702 is readopted as published in 37:18 NCR 1874-1882 as follows:

10A NCAC 13F .0702 DISCHARGE OF RESIDENTS

~~(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.~~

~~(b) The discharge of a resident shall be based on one of the following reasons:~~

~~(1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(3) the safety of other individuals in the facility is endangered;~~

~~(4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;~~

~~(5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or~~

~~(6) the discharge is mandated under G.S. 131D-2(a1).~~

~~(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:~~

~~(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or~~

~~(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.~~

~~(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:~~

~~(1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;~~

~~(2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;~~

~~(3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or~~

~~(4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.~~

~~(e) The facility shall assure the following requirements for written notice are met before discharging a resident:~~

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand-delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand-delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.

(3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.

(4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) notifying staff in the county department of social services responsible for placement services;

(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;

(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and

(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a copy of the resident's current physician orders;

(D) a list of the resident's current medications;

(E) the resident's current medications;

(F) a record of the resident's vaccinations and TB screening;

(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:

(A) the regional long term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities.

~~(g) If an appeal hearing is requested:~~

~~(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and~~

~~(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.~~

~~(h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14 day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period.. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.~~

~~(i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician documented level of care change for the resident, the discharge requirements in this Rule apply.~~

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (h) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident initiated by the facility shall be based on one of the following reasons under G.S. 131D-4.8:

(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner;

(2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner;

(3) the safety of the resident or other individuals in the facility is endangered;

(4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner;

(5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident’s contract after receiving written notice of warning of discharge for failure to pay; or

(6) the discharge is mandated under G.S. 131D-2.2(a).

(c) The facility shall assure the following requirements for written notice are met before discharging a resident:

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated.

(3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's current physician's orders, including medication order;

(4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge.

(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or

(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(e) The following shall be documented in the resident record and shall be made available upon request to potential discharge locations:

(1) The reason for discharge to include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

(A) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;

(B) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;

(C) written notices of warning of discharge for failure to pay the costs of services and accommodations; or

(D) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2.2(a)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility; and

(2) any known intervention of law enforcement with the resident due to threatening behavior or violence toward self or others.

(f) The facility shall document contacts with possible discharge locations and responses and make available this documentation, upon request, to the resident, legal representative, the individual identified upon admission to receive a discharge notice on behalf of the resident and the adult care home resident discharge team if convened. For the purposes of this rule, "the individual identified upon admission to receive a discharge notice on behalf of the resident" may be the same person as the resident's legal representative or responsible person as identified in the resident's record.

(g) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary;

(2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination; and

(A) If at the time of the discharge notice the discharge destination is unknown or is not appropriate for the resident, the facility shall contact the local adult care home resident discharge team to assist with placement; and

(B) The facility shall inform the resident and the resident's legal representative of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team: and

(3) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a list of referrals to licensed health professionals, including mental health;

(D) a copy of the resident's current physician orders;

(E) a list of the resident's current medications;

(F) the resident's current medications; and

(G) a record of the resident's vaccinations and TB screening;

(4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule:

(A) the regional long-term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities;

(5) providing the resident, responsible party or legal representative and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.

(h) If an appeal hearing is requested:

(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (d) of this Rule.

(i) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.

(j) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: *Authority G.S. 131D-2.1; 131D-2.16; 131D-4.5; ~~131D-4.5;~~ 131D-21; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, ~~2004.~~ 2004:
Readopted Eff. October 1, 2023.

10A NCAC 13F .1307 is readopted as published in 37:18 NCR 1874-1882 as follows:

10A NCAC 13F .1307 SPECIAL CARE UNIT RESIDENT PROFILE AND CARE PLAN

In addition to the requirements in Rules ~~13F~~ .0801 and ~~13F~~ .0802 of this Subchapter, the facility shall assure the following:

(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.

(2) The resident care plan as required in Rule ~~13F~~ .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, ~~2000.~~ 2000;
Readopted Eff. October 1, 2023.

10A NCAC 13G .0504 is amended as published in 37:18 NCR 1874-1882 as follows:

10A NCAC 13G .0504 COMPETENCY EVALUATION AND VALIDATION FOR LICENSED HEALTH PROFESSIONAL SUPPORT TASKS

(a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task.

(b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.

~~(b)~~ (c) Evaluation and validation of competency shall be performed by the following licensed health professionals in accordance with his or her North Carolina occupational licensing laws:

(1) A registered nurse shall validate the competency of staff who perform any of the personal care tasks specified in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter;

(2) In lieu of a registered nurse, a licensed respiratory care practitioner may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19), and (21) of Rule .0903 of this Subchapter;

(3) In lieu of a registered nurse, a licensed pharmacist may validate the competency of staff who perform the personal care tasks specified in Subparagraph (a)(8) and (11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter; and

(4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (a)(27) of Rule .0903 of this Subchapter.

~~(c)~~ (d) If a physician certifies that care can be provided to a resident in a family care home on a temporary basis in accordance with G.S. 131D-2.2(a), the facility shall ensure that the staff performing the care task(s) authorized by the physician are competent to perform the task(s) in accordance with Paragraphs ~~(a)~~ (b) and ~~(b)~~ (c) of this Rule. For the purpose of this Rule, "temporary basis" means a length of time as determined by the resident's physician to meet the care needs of the resident and prevent the resident's relocation from the family care home.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004;
Readopted Eff. October 1, ~~2022.~~ 2022;
Amended Eff. October 1, 2023.

10A NCAC 13G .0705 is readopted as published in 37:18 NCR 1874-1882 as follows:

10A NCAC 13G .0705 DISCHARGE OF RESIDENTS

~~(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.~~

~~(b) The discharge of a resident shall be based on one of the following reasons:~~

~~(1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(3) the safety of other individuals in the facility is endangered;~~

~~(4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;~~

~~(5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or~~

~~(6) the discharge is mandated under G.S. 131D-2(a1).~~

~~(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:~~

~~(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or~~

~~(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.~~

~~(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:~~

~~(1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;~~

~~(2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;~~

~~(3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or~~

~~(4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.~~

~~(e) The facility shall assure the following requirements for written notice are met before discharging a resident:~~

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand-delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand-delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.

(3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.

(4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) notifying staff in the county department of social services responsible for placement services;

(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;

(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and

(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a copy of the resident's current physician orders;

(D) a list of the resident's current medications;

(E) the resident's current medications; and

(F) a record of the resident's vaccinations and TB screening.

(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:

(A) the regional long term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities.

~~(g) If an appeal hearing is requested:~~

~~(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and~~

~~(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.~~

~~(h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14 day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.~~

~~(i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician documented level of care change for the resident, the discharge requirements in this Rule apply.~~

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (j) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident initiated by the facility shall be based on one of the following reasons under G.S. 131D-4.8:

(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner;

(2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner;

(3) the safety of the resident or other individuals in the facility is endangered;

(4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner;

(5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after receiving written notice of warning of discharge for failure to pay; or

(6) the discharge is mandated under G.S. 131D-2.2(a).

(c) The facility shall assure the following requirements for written notice are met before discharging a resident:

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated.

(3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's current physician's orders, including medication order;

(4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge.

(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or

(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(e) The following shall be documented in the resident record and shall be made available upon request to potential discharge locations:

(1) The reason for discharge to include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

(A) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;

(B) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;

(C) written notices of warning of discharge for failure to pay the costs of services and accommodations; or

(D) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2.2(a)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility; and

(2) any known intervention of law enforcement with the resident due to threatening behavior or violence toward self or others.

(f) The facility shall document contacts with possible discharge locations and responses and make available this documentation, upon request, to the resident, legal representative, the individual identified upon admission to receive a discharge notice on behalf of the resident and the adult care home resident discharge team if convened. For the purposes of this rule, "the individual identified upon admission to receive a discharge notice on behalf of the resident" may be the same person as the resident's legal representative or responsible person as identified in the resident's record.

(g) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary;

(2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination; and

(A) If at the time of the discharge notice the discharge destination is unknown or is not appropriate for the resident, the facility shall contact the local adult care home resident discharge team to assist with placement; and

(B) The facility shall inform the resident and the resident's legal representative of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team: and

(3) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a list of referrals to licensed health professionals, including mental health;

(D) a copy of the resident's current physician orders;

(E) a list of the resident's current medications;

(F) the resident's current medications; and

(G) a record of the resident's vaccinations and TB screening;

(4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule:

(A) the regional long-term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities.

(5) providing the resident, responsible party or legal representative and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.

(h) If an appeal hearing is requested:

(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (d) of this Rule.

(i) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.

(j) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: *Authority G.S. 131D-2.1; 131D-2.16; 131D-4.8; 131D-4.5; 131D-21; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. April 1, 2001;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2023.

10A NCAC 13G .1301 is readopted as published in 37:18 NCR 1874-1882 as follows:

SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and ~~which~~ that restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;

(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;

(3) the least restrictive restraint that would provide safety;

(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.

(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;

(6) applied correctly according to the manufacturer's instructions and the physician's order; and

(7) used in conjunction with alternatives in an effort to reduce restraint use.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact.

(c) In addition to the requirements in Rule ~~13F~~ .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.

(2) The assessment shall include consideration of the following:

(A) medical symptoms that warrant the use of a restraint;

(B) how the medical symptoms affect the resident;

(C) when the medical symptoms were first observed;

(D) how often the symptoms occur;

(E) alternatives that have been provided and the resident's response; and

(F) the least restrictive type of physical restraint that would provide safety.

(3) The care plan shall include the following:

(A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;

(B) the type of restraint to be used; and

(C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

(1) The order shall indicate:

(A) the medical need for the restraint;

(B) the type of restraint to be used;

(C) the period of time the restraint is to be used; and

(D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases.

(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days.

(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.

(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.

(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.

(6) The restraint order shall be kept in the resident’s record.

(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:

(1) restraint alternatives that were provided and the resident's response;

(2) type of restraint that was used;

(3) medical symptoms warranting restraint use;

(4) the time the restraint was applied and the duration of restraint use;

(5) care that was provided to the resident during restraint use; and

(6) behavior of the resident during restraint use.

(f) Physical restraints shall be applied only by staff who have received training according to Rule .0506 of this Subchapter and been validated on restraint use according to Rule .0504 of this Subchapter.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2023.

DHSR Adult Care Licensure Section
Fiscal Impact Analysis
Permanent Rule Readoption and Amendment without Substantial Economic Impact

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Shalisa Jones, Regulatory Analyst, (704) 589-6214

Impact:

Federal Government:	No
State Government:	No
Local Government:	No
Private Entities:	Yes
Substantial Impact:	No

Titles of Rule Changes and N.C. Administrative Code Citation

Rule Readoptions (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0702 Discharge Of Residents
10A NCAC 13F .1307 Special Care Unit Resident Profile And Care Plan
10A NCAC 13G .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks
10A NCAC 13G .0705 Discharge Of Residents
10A NCAC 13G .1301 Use Of Physical Restraints And Alternatives

Authorizing Statutes: 131D-2.1; 131D-2.16; 131D-4.5;143B-165

Introduction and Background

The agency is proposing changes to update the Discharge of Residents rule language to be consistent with the existing requirements in N.C. Gen. Stat. 131D-4.8 that were established in 2011, to reformat the rule to be in a more chronological order, and to ensure the requirements are clear and unambiguous. Technical changes were also made to include additional documentation requirements for discharge preparation. The proposed changes will generate minimal costs and/or benefits for adult care homes and family care homes. The proposed changes will have limited fiscal impact on facilities as most changes have no substantial costs associated and some are already required in statute.

The proposed changes will have no impact on the Adult Care Licensure Section. The agency does not anticipate any additional impact on state government or local government (i.e. county Departments of Social Services who monitor and conduct complaint investigations in adult care homes and family care homes) beyond their current job requirements to implement, monitor, or regulate the proposed amendments.

Under the authority of G.S. 150B-21.3A, Periodic review of existing rules. The North Carolina Medical Care Commission and Rule Review Commission approved the Subchapter reports with classifications for the rules under 10A NCAC 13F Licensing of Adult Care Homes of Seven or More Beds and 10 NCAC 13G Licensing of Family Care Homes. The rules were classified in the reports as necessary with substantive public interest. Rules 10A NCAC 13F .0702 and 13G .0705 are being presented for readoption with substantive changes. The following rules were identified for readoption without substantive changes:10A NCAC 13F .1307 and 13G .1301. Rule 13G .0504, has been amended for clarity and it doesn't affect the fiscal analysis. This rule was part of the fiscal analysis in the package for the Phase 3 readoption rules.

Rules Summary and Anticipated Fiscal Impact

10A NCAC 13F .0702 and 13G .0705 Discharge of Residents: These rules outline facilities' requirements and procedures for a proper and safe discharge of residents. These rules were modified to update the language and to be consistent with the existing requirements in N.C. Gen. Stat. 131D-4.8. Technical changes were also made to this rule to be consistent with current rule writing styles. Revisions were also made to include additional documentation requirements for discharge preparation.

1. Paragraphs (b), (c), and (g) include language consistent with N.C. Gen. Stat. 131D-4.8. The current statute also identifies "the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident" as an additional individual involved in the discharge process, the language was updated to include this individual, and a definition was also included to provide clarity. The proposed changes also include additional requirements in (g)(2)(A) and (g)(2)(B), as outlined in the statute, requiring the facility to request to convene the adult care home resident discharge team to assist with placement if the discharge location is unknown, as well as the facility requirement to inform the resident and/or their representative of their right to request the Long Term Care Ombudsman to serve as a member of the adult care home resident discharge team. The resident discharge team may be led by county Adult Home Specialists who are employed by the local department social services to monitor adult and family care homes or a staff person from the Local Management Entity/Managed Care Organization (LME/MCO).

Facilities have been required to meet the requirements of 131D-4.8. since 2011; the proposed rule amendments will better align the rule with the existing statute. Updating the rule to align with the statute provides clarity for regulated providers and the public and alleviates facilities of the burden of referencing both the rule and the statute. According to 2022 facility license renewal data, there are 553 adult care homes and 535 family care homes operating in North Carolina. Review of the data provided by the North Carolina Division of Health Service Regulation; Adult Care Licensure Section reveals a substantial amount of discharges completed annually in facilities (Table 1). While facility-initiated discharges are represented in Table 1, it is important to note that this data is inclusive of the total number of discharges reported to the agency annually, which also includes resident-initiated discharges and resident hospitalizations that resulted in a level of care change resulting in the resident not returning to the facility. Therefore, the total number of discharges represented in Table 1 would not need to meet the requirements of the proposed rule.

Table 1. Number of Annual Discharges by Facility Type

Year	Facility Type		Total
	Adult Care Home	Family Care Home	
2019	9,678	662	10,340
2020	9,927	584	10,511
2021	8,402	504	8,906

2022	7,027	481	7,508

Source: Division of Health Service Regulation Enterprise Licensing Database, Adult Care Home & Family Care Home License Renewal Data

2. The agency proposes that facilities also document any known intervention of law enforcement with the resident due to threatening behavior or violence toward self or others and make this information available to potential discharge locations upon request. The agency also proposes the facility document contacts with possible discharge locations and responses and make the documentation available to the resident, or legal representative upon request.

Rationale: The rules as currently written do not require facilities to document information regarding the resident interactions with law enforcement or threatening or violent behaviors which often results in the receiving facility being unaware of this information prior to admission. The intent of this proposed change was to allow the receiving facility to be informed upon request of the resident's known intervention involving law enforcement. This would enable the receiving facility to make a determination as to whether admission of a resident would cause potential harm or disruption to the current residents, and to plan for how to address behaviors and potential future law enforcement interaction should the facility choose to admit the resident. This information would be documented by staff and would only be available upon request of the receiving facility. This will require facility staff to spend a small amount of time to document resident interactions with law enforcement. This additional time is expected to be minimal and will be performed by existing staff as part of their regular job duties.

These rules as currently written do not require facilities to document their efforts to find another placement during the discharge process. The proposed rule language now includes this documentation and also makes it available upon request to the resident to show the efforts done to find another placement. This requirement displays the effort of facilities actions to find a safe discharge location. This will require facility staff to spend a small amount of time to document their efforts to find another placement for a resident. This additional time is expected to be minimal and will be performed by existing staff as part of their regular job duties.

3. These rules as currently written provide a mailing address for copies of The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form. The proposed language removes the mailing address and provides an updated internet address where the forms can be found at no cost.

Fiscal Impact: There are no additional costs to implement the changes included to align with G.S. 131D-4.8 as facilities have been required to comply since 2011. There will be no additional costs with including the documentation of any known intervention of law enforcement with the resident due to threatening behavior or violence toward self or others. This information is already documented as required in section 13F .1212/13G. 1213 Reporting of Incidents and Accidents. Facilities will have minimal impact due to the additional time it will require for existing staff to document potential discharge locations and responses. The impact is expected to be minimal as staff are already documenting reasons for discharge and any additional information as indicated in Paragraph (e).

Appendix

10A NCAC 13F .0702 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0702 DISCHARGE OF RESIDENTS

~~(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.~~

~~(b) The discharge of a resident shall be based on one of the following reasons:~~

~~(1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(3) the safety of other individuals in the facility is endangered;~~

~~(4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;~~

~~(5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or~~

~~(6) the discharge is mandated under G.S. 131D-2(a1).~~

~~(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:~~

~~(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or~~

~~(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.~~

~~(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:~~

~~(1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;~~

~~(2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;~~

~~(3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or~~

~~(4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.~~

~~(e) The facility shall assure the following requirements for written notice are met before discharging a resident:~~

~~(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is~~

dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand-delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.

(3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.

(4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) notifying staff in the county department of social services responsible for placement services;

(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;

(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and

(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a copy of the resident's current physician orders;

(D) a list of the resident's current medications;

(E) the resident's current medications;

(F) a record of the resident's vaccinations and TB screening;

(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:

(A) the regional long-term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities.

(g) If an appeal hearing is requested:

(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.

(h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period..

~~Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.~~

~~(i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.~~

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (h) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident initiated by the facility shall be based on one of the following reasons under G.S. 131D-4.8:

(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner;

(2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner;

(3) the safety of the resident or other individuals in the facility is endangered;

(4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner;

(5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after receiving written notice of warning of discharge for failure to pay; or

(6) the discharge is mandated under G.S. 131D-2.2(a).

(c) The facility shall assure the following requirements for written notice are met before discharging a resident:

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated.

(3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's current physician's orders, including medication order;

(4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge.

(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or

(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(e) The following shall be documented in the resident record and shall be made available upon request to potential discharge locations:

(1) The reason for discharge to include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

(A) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;

(B) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;

(C) written notices of warning of discharge for failure to pay the costs of services and accommodations; or

(D) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2.2(a)(4) and as disclosed in the resident contract signed upon the resident’s admission to the facility; and

(2) any known intervention of law enforcement with the resident due to threatening behavior or violence toward self or others.

(f) The facility shall document contacts with possible discharge locations and responses and make available this documentation, upon request, to the resident, legal representative, the individual identified upon admission to receive a discharge notice on behalf of the resident and the adult care home resident discharge team if convened. For the purposes of this rule, “the individual identified upon admission to receive a discharge notice on behalf of the resident” may be the same person as the resident’s legal representative or responsible person as identified in the resident’s record.

(g) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary;

(2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination; and

(A) If at the time of the discharge notice the discharge destination is unknown or is not appropriate for the resident, the facility shall contact the local adult care home resident discharge team to assist with placement; and

(B) The facility shall inform the resident and the resident's legal representative of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team: and

(3) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a list of referrals to licensed health professionals, including mental health;

(D) a copy of the resident's current physician orders;

(E) a list of the resident's current medications;

(F) the resident's current medications; and

(G) a record of the resident's vaccinations and TB screening;

(4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule:

(A) the regional long-term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities;

(5) providing the resident, responsible party or legal representative and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.

(h) If an appeal hearing is requested:

(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (d) of this Rule.

(i) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.

(j) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: *Authority G.S. 131D-2.1; 131D-2.16; 131D-4.5; ~~131D-4.5;~~ 131D-21; 143B-165;*
Eff. January 1, 1977;

Readopted Eff. October 31, 1977;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, ~~2004.~~ 2004:
Readopted Eff. October 1, 2023.

10A NCAC 13F .1307 is proposed for readoption without substantive changes as follows:

10A NCAC 13F .1307 SPECIAL CARE UNIT RESIDENT PROFILE AND CARE PLAN

In addition to the requirements in Rules ~~13F~~ .0801 and ~~13F~~ .0802 of this Subchapter, the facility shall assure the following:

(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.

(2) The resident care plan as required in Rule ~~13F~~ .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.6; 131D-8; 143B-165;*
Temporary Adoption Eff. December 1, 1999;
Eff. July 1, ~~2000.~~ 2000;
Readopted Eff. October 1, 2023.

10A NCAC 13G .0504 is proposed for amendment as follows:

10A NCAC 13G .0504 COMPETENCY EVALUATION AND VALIDATION FOR LICENSED HEALTH PROFESSIONAL SUPPORT TASKS

(a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task.

(b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.

~~(b)~~ (c) Evaluation and validation of competency shall be performed by the following licensed health professionals in accordance with his or her North Carolina occupational licensing laws:

(1) A registered nurse shall validate the competency of staff who perform any of the personal care tasks specified in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter;

(2) In lieu of a registered nurse, a licensed respiratory care practitioner may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (11), (16), (18), (19), and (21) of Rule .0903 of this Subchapter;

(3) In lieu of a registered nurse, a licensed pharmacist may validate the competency of staff who perform the personal care tasks specified in Subparagraph (a)(8) and (11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter; and

(4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (a)(27) of Rule .0903 of this Subchapter.

~~(c)~~ (d) If a physician certifies that care can be provided to a resident in a family care home on a temporary basis in accordance with G.S. 131D-2.2(a), the facility shall ensure that the staff performing the care task(s) authorized by the physician are competent to perform the task(s) in accordance with Paragraphs ~~(a)~~ (b) and ~~(b)~~ (c) of this Rule. For the purpose of this Rule, "temporary basis" means a length of time as determined by the resident's physician to meet the care needs of the resident and prevent the resident's relocation from the family care home.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. September 1, 2003;
Eff. July 1, 2004;
Readopted Eff. October 1, ~~2022.~~ 2022;
Amended Eff. October 1, 2023.

10A NCAC 13G .0705 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0705 DISCHARGE OF RESIDENTS

~~(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (g) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.~~

~~(b) The discharge of a resident shall be based on one of the following reasons:~~

~~(1) the discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(2) the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility as documented by the resident's physician, physician assistant or nurse practitioner;~~

~~(3) the safety of other individuals in the facility is endangered;~~

~~(4) the health of other individuals in the facility is endangered as documented by a physician, physician assistant or nurse practitioner;~~

~~(5) failure to pay the costs of services and accommodations by the payment due date according to the resident contract after receiving written notice of warning of discharge for failure to pay; or~~

~~(6) the discharge is mandated under G.S. 131D-2(a1).~~

~~(c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:~~

(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or

(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(d) The reason for discharge shall be documented in the resident's record. Documentation shall include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

(1) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;

(2) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;

(3) written notices of warning of discharge for failure to pay the costs of services and accommodations; or

(4) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2(a1)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility.

(e) The facility shall assure the following requirements for written notice are met before discharging a resident:

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Medical Assistance, 2505 Mail Service Center, Raleigh, NC 27699-2505.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative on the same day the Adult Care Home Notice of Discharge is dated.

(3) Failure to use and simultaneously provide the specific forms according to Subparagraphs (e)(1) and (e)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge unless the facility has been previously notified of a change in the forms and been provided a copy of the latest forms by the Department of Health and Human Services.

(4) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) notifying staff in the county department of social services responsible for placement services;

(2) explaining to the resident and responsible person or legal representative why the discharge is necessary;

(3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and

(4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a copy of the resident's current physician orders;

~~(D) a list of the resident's current medications;~~

~~(E) the resident's current medications; and~~

~~(F) a record of the resident's vaccinations and TB screening.~~

~~(5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule:~~

~~(A) the regional long term care ombudsman; and~~

~~(B) the protection and advocacy agency established under federal law for persons with disabilities.~~

~~(g) If an appeal hearing is requested:~~

~~(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and~~

~~(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (c) of this Rule.~~

~~(h) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.~~

~~(i) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.~~

(a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (j) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy.

(b) The discharge of a resident initiated by the facility shall be based on one of the following reasons under G.S. 131D-4.8:

(1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner;

(2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner;

(3) the safety of the resident or other individuals in the facility is endangered;

(4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner;

(5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident’s contract after receiving written notice of warning of discharge for failure to pay; or

(6) the discharge is mandated under G.S. 131D-2.2(a).

(c) The facility shall assure the following requirements for written notice are met before discharging a resident:

(1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from the Division of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms.

(2) A copy of the Adult Care Home Notice of Discharge with a copy of the Adult Care Home Hearing Request Form shall be hand delivered, with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home Notice of Discharge is dated.

(3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's current physician's orders, including medication order;

(4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the discharge. Failure to use the latest version of these forms shall not invalidate the discharge.

(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

(d) The notices of discharge and appeal rights as required in Paragraph (c) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when:

(1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or

(2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist.

(e) The following shall be documented in the resident record and shall be made available upon request to potential discharge locations:

(1) The reason for discharge to include one or more of the following as applicable to the reasons under Paragraph (b) of this Rule:

(A) documentation by physician, physician assistant or nurse practitioner as required in Paragraph (b) of this Rule;

(B) the condition or circumstance that endangers the health or safety of the resident being discharged or endangers the health or safety of individuals in the facility, and the facility's action taken to address the problem prior to pursuing discharge of the resident;

(C) written notices of warning of discharge for failure to pay the costs of services and accommodations; or

(D) the specific health need or condition of the resident that the facility determined could not be met in the facility pursuant to G.S. 131D-2.2(a)(4) and as disclosed in the resident contract signed upon the resident's admission to the facility; and

(2) any known intervention of law enforcement with the resident due to threatening behavior or violence toward self or others.

(f) The facility shall document contacts with possible discharge locations and responses and make available this documentation, upon request, to the resident, legal representative, the individual identified upon admission to receive a discharge notice on behalf of the resident and the adult care home resident discharge team if convened. For the purposes of this rule, "the individual identified upon admission to receive a discharge notice on behalf of the resident" may be the same person as the resident's legal representative or responsible person as identified in the resident's record.

(g) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by:

(1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary;

(2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination; and

(A) If at the time of the discharge notice the discharge destination is unknown or is not appropriate for the resident, the facility shall contact the local adult care home resident discharge team to assist with placement; and

(B) The facility shall inform the resident and the resident's legal representative of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team: and

(3) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:

(A) a copy of the resident's most current FL-2;

(B) a copy of the resident's most current assessment and care plan;

(C) a list of referrals to licensed health professionals, including mental health;

(D) a copy of the resident's current physician orders;

(E) a list of the resident's current medications;

(F) the resident's current medications; and

(G) a record of the resident's vaccinations and TB screening;

(4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule:

(A) the regional long-term care ombudsman; and

(B) the protection and advocacy agency established under federal law for persons with disabilities.

(5) providing the resident, responsible party or legal representative and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.

(h) If an appeal hearing is requested:

(1) the facility shall provide to the resident or legal representative or the resident and the responsible person, and the Hearing Unit copies of all documents and records that the facility intends to use at the hearing at least five working days prior to the scheduled hearing; and

(2) the facility shall not discharge the resident before the final decision resulting from the appeal has been rendered, except in those cases of discharge specified in Paragraph (d) of this Rule.

(i) If a discharge is initiated by the resident or responsible person, the administrator may require up to a 14-day written notice from the resident or responsible person which means the resident or responsible person may be charged for the days of the required notice if notice is not given or if notice is given and the resident leaves before the end of the required notice period. Exceptions to the required notice are cases in which a delay in discharge or transfer would jeopardize the health or safety of the resident or others in the facility. The facility's requirement for a notice from the resident or responsible person shall be established in the resident contract or the house rules provided to the resident or responsible person upon admission.

(j) The discharge requirements in this Rule do not apply when a resident is transferred to an acute inpatient facility for mental or physical health evaluation or treatment and the adult care facility's bed hold policy applies based on the expected return of the resident. If the facility decides to discharge a resident who has been transferred to an acute inpatient facility and there has been no physician-documented level of care change for the resident, the discharge requirements in this Rule apply.

History Note: *Authority G.S. 131D-2.1; 131D-2.16; 131D-4.8; 131D-4.5; 131D-21; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. April 1, 2001;
Temporary Amendment Eff. July 1, 2003;
Amended Eff. July 1, ~~2004.~~ 2004;
Readopted Eff. October 1, 2023.

10A NCAC 13G .1301 is proposed for readoption without substantive changes as follows:

SECTION .1300 - USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

10A NCAC 13G .1301 USE OF PHYSICAL RESTRAINTS AND ALTERNATIVES

(a) A family care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and ~~which~~ that restricts freedom of movement or normal access to one's body, shall be:

(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;

(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;

(3) the least restrictive restraint that would provide safety;

(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.

(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;

(6) applied correctly according to the manufacturer's instructions and the physician's order; and

(7) used in conjunction with alternatives in an effort to reduce restraint use.

Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

(b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use.

Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact.

(c) In addition to the requirements in Rule ~~13F~~ .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements:

(1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend.

(2) The assessment shall include consideration of the following:

(A) medical symptoms that warrant the use of a restraint;

(B) how the medical symptoms affect the resident;

(C) when the medical symptoms were first observed;

(D) how often the symptoms occur;

(E) alternatives that have been provided and the resident's response; and

(F) the least restrictive type of physical restraint that would provide safety.

(3) The care plan shall include the following:

(A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained;

(B) the type of restraint to be used; and

(C) care to be provided to the resident during the time the resident is restrained.

(d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule:

(1) The order shall indicate:

(A) the medical need for the restraint;

(B) the type of restraint to be used;

(C) the period of time the restraint is to be used; and

(D) the time intervals the restraint is to be checked and released, but no longer than every 30 minutes for checks and two hours for releases.

(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days.

(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.

(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.

(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.

(6) The restraint order shall be kept in the resident's record.

(e) All instances of the use of physical restraints and alternatives shall be documented by the facility in the resident's record and include the following:

(1) restraint alternatives that were provided and the resident's response;

(2) type of restraint that was used;

(3) medical symptoms warranting restraint use;

(4) the time the restraint was applied and the duration of restraint use;

(5) care that was provided to the resident during restraint use; and

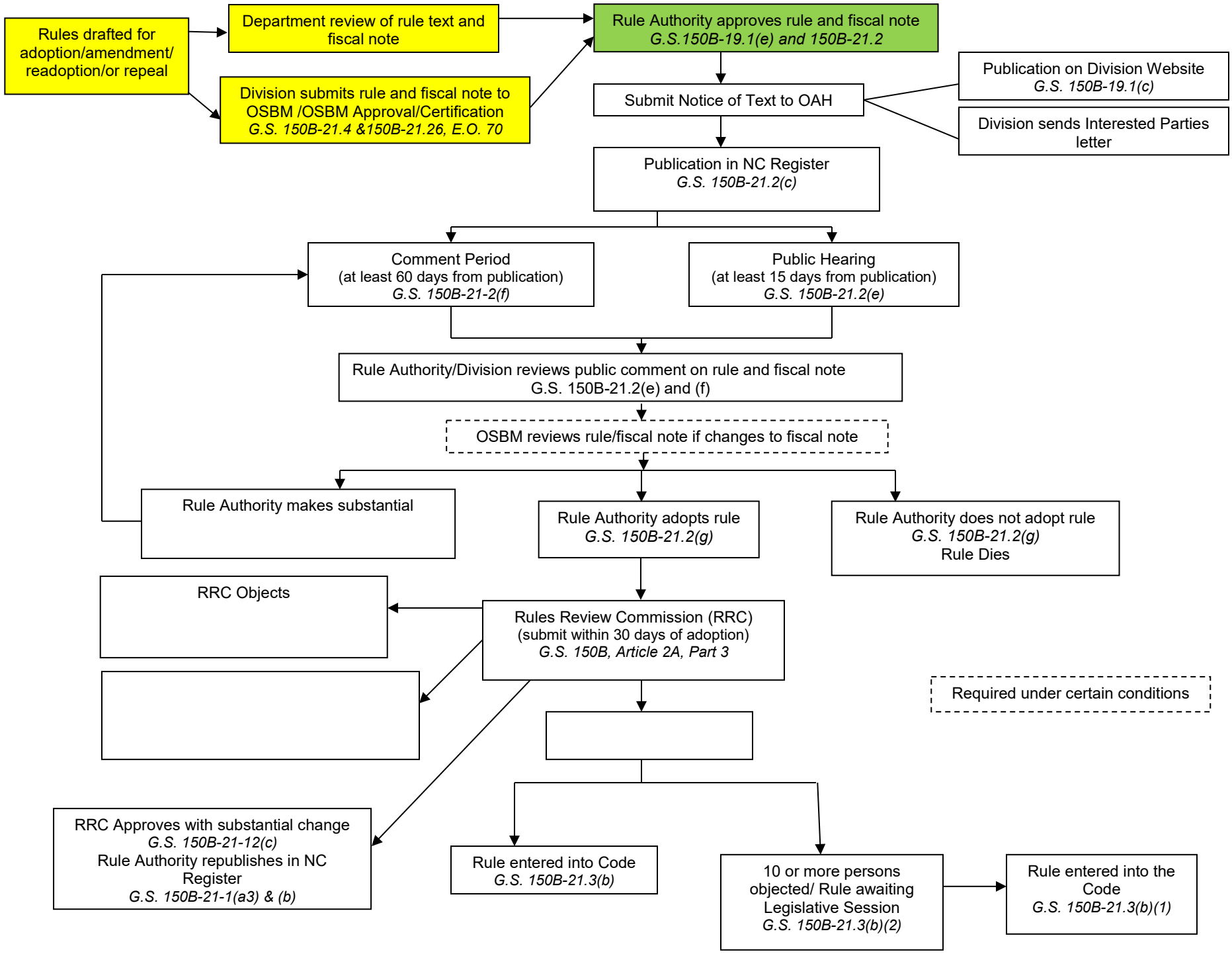
(6) behavior of the resident during restraint use.

(f) Physical restraints shall be applied only by staff who have received training according to Rule .0506 of this Subchapter and been validated on restraint use according to Rule .0504 of this Subchapter.

History Note: *Authority G.S. 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, ~~2005.~~ 2005;
Readopted Eff. October 1, 2023.

Process for Medical Care Commission to Initiate Rulemaking

Exhibit D



10A NCAC 13P .0101 is proposed for amendment as follows:

SUBCHAPTER 13P – EMERGENCY MEDICAL SERVICES AND TRAUMA RULES

SECTION .0100 – DEFINITIONS

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;
(3) AHA: American Heart Association;
(4) ASTM: American Society for Testing and Materials;
(5) CAAHEP: Commission on Accreditation of Allied Health Education Programs;
(6) CPR: Cardiopulmonary Resuscitation;
(7) ED: Emergency Department;
(8) EMD: Emergency Medical Dispatcher;
(9) EMDPRS: Emergency Medical Dispatch Priority Reference System
~~(9)~~(10) EMR: Emergency Medical Responder;
~~(10)~~(11) EMS: Emergency Medical Services;
~~(11)~~(12) EMS-NP: EMS Nurse Practitioner;
~~(12)~~(13) EMS-PA: EMS Physician Assistant;
~~(13)~~(14) EMT: Emergency Medical Technician;
~~(14)~~(15) FAA: Federal Aviation Administration;
~~(15)~~(16) FCC: Federal Communications Commission;
~~(16)~~(17) ICD: International Classification of Diseases;
~~(17)~~(18) ISS: Injury Severity Score;
~~(18) MICN: Mobile Intensive Care Nurse;~~
(19) NHTSA: National Highway Traffic Safety Administration;
(20) OEMS: Office of Emergency Medical Services;
(21) OR: Operating Room;
(22) PSAP: Public Safety Answering Point;
(23) RAC: Regional Advisory Committee;
(24) RFP: Request For Proposal;
(25) SCTP: Specialty Care Transport Program;
(26) SMARTT: State Medical Asset and Resource Tracking Tool;
(27) STEMI: ST Elevation Myocardial Infarction; and
(28) US DOT: United States Department of Transportation.

History Note: *Authority G.S. 143-508(b);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

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 with a specific county EMS system as a condition for EMS Provider Licensing as required by Rule .0204 of this Subchapter.

(2) "Affiliated Hospital" means a non-trauma center hospital that is owned by the Trauma Center ~~or there is~~ or a hospital with 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 practice setting that utilizes credentialed EMS personnel that may not be affiliated with or under the oversight of 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 a practice setting utilizing credentialed EMS personnel or medical crew members.

(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~~ by a hospital of its own volition ~~reroutes~~ to reroute 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~~ 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~~ System plan.

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

(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.

(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.

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

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

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

(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.

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

(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.

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

~~(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.~~

~~(21)~~(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.

~~(22)~~(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.

~~(23)~~(22) "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.

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

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

~~(26)~~(25) "Hospital" means a licensed facility as defined in G.S. 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.

~~(27)~~(26) "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)~~(27) "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)~~(28) "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)~~(29) "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)~~(30) "Level II Trauma Center" means a hospital that provides trauma care regardless of the severity of the injury, but may lack the comprehensive care as a Level I trauma center, and does not have trauma research as a primary objective.

~~(32)~~(31) "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)~~(32) "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.

~~(34)~~(33) "Medical Director" means the physician responsible for the medical aspects of the management of a practice setting utilizing credentialed EMS personnel or medical crew members, or a Trauma Center.

~~(35)~~(34) "Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of 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.

~~(36)~~(35) "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)~~(36) "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.

~~(38)~~(37) "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.

~~(39)~~(38) "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.

~~(40)~~(39) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.

~~(41)~~(40) "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 planning, establishing, and maintaining a coordinated trauma system.

~~(42)~~(41) "Request for Proposal" means a State document that must be completed by each hospital seeking initial or renewal trauma center designation.

(42) "Specialized Ambulance Protocol Summary (SAPS) means a document listing of all standard medical equipment, supplies, and medications, approved by the Specialty Care or Air Medical Program 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.

(43) "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.

~~(44) "State Medical Asset and Resource Tracking Tool" means the Internet web-based program used by the OEMS both in its daily operations and during times of disaster to identify, record, and monitor EMS, hospital, health care, and sheltering resources statewide, including facilities, personnel, vehicles, equipment, and pharmaceutical and supply caches.~~

~~(45)~~(44) "Specialty Care Transport Program" means a program designed and operated for the 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.

~~(46)~~(45) "Specialty Care Transport Program Continuing Education Coordinator" means a ~~Level II~~ Level I EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.

~~(47)~~(46) "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.

~~(48)~~(47) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

~~(49)~~(48) "System Continuing Education Coordinator" means the Level II EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.

~~(50)~~(49) "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~~ OEMS at https://oems.nc.gov at no cost.

~~(51)~~(50) "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.

~~(52)~~(51) "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, 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~~ OEMS online at ~~https://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html~~ https://oems.nc.gov/wp-content/uploads/2022/10/datadictionary.pdf at no cost.

~~(53)~~(52) "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.

~~(54)~~(53) "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://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html~~ online at https://oems.nc.gov/wp-content/uploads/2022/10/datadictionary.pdf at no cost.

~~(55)~~(54) "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.

~~(56)~~(55) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.

~~(57)~~(56) "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;
Amended Eff. April 1, 2024; July 1, 2021; September 1, 2019; July 1, 2018.

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

SECTION .0200 – EMS SYSTEMS

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 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 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 bypass 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)~~(E) a disaster plan;

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

~~(H)~~(G) a mass-casualty plan;

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

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

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

~~(L)~~(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; and

(L) a plan on how each licensed hospital facility will use and maintain two-way radio communication for receiving in coming patient from EMS providers;

(14) affiliation as defined in Rule .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~~ week, and a written policy describing how the agency will maintain a roster of credentialed EMD personnel in the OEMS credentialing and information database; and

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

(4) EMD medical oversight as required in Section .0400 of this Subchapter.

(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;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0207 is proposed for amendment as follows:

10A NCAC 13P .0207 GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) To be permitted as a Ground Ambulance, a vehicle shall have:

(1) a patient compartment that meets the following interior dimensions:

(A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and

(B) the height is at least 48 inches over the patient area, measured from the approximate center of the floor, exclusive of cabinets or equipment;

(2) patient care equipment and supplies 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.~~ Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) other equipment that includes:

(A) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge; and

(B) the availability of one pediatric restraint device to safely transport pediatric patients and children under 40 pounds in the patient compartment of the ambulance;

(4) the name of the EMS Provider permanently displayed on each side of the vehicle;

(5) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(6) emergency warning lights and audible warning devices mounted on the vehicle as required by ~~G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards.~~ G.S. 20-25. All warning devices shall function properly;

(7) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(8) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has ~~sufficient~~ the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device ~~mounted~~ in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(9) permanently installed heating and air conditioning systems; and

(10) a copy of the EMS System patient care treatment protocols.

(b) Ground ambulances ~~shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.~~ permitted by the OEMS that do not back up the 911 EMS System shall be exempt from requirements for two-way radio communications as defined in Subparagraph (8) of this Rule. A two-way radio or radiotelephone device such as a cellular telephone shall be available to summon emergency assistance.

(c) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0216 is proposed for amendment as follows:

10A NCAC 13P .0216 WEAPONS AND EXPLOSIVES FORBIDDEN

(a) Weapons, whether lethal or non-lethal, and explosives shall not be worn or carried aboard an ambulance or EMS non-transporting 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 shall be considered weapons for the purpose of this Rule.

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

(d) If any weapon is found to be in the possession of a patient or person accompanying the patient during transportation, the weapon shall be safely secured in accordance with the weapons policy as set forth in ~~Rule .0201(a)(13)(I)~~ Rule .0201 of this Section.

(e) Weapons authorized for use by EMS personnel attached to a law enforcement tactical team in accordance with the weapons policy as set forth in ~~Rule .0201(a)(13)(I)~~ Rule .0201 of this Section may be secured in a locked, dedicated compartment or gun safe mounted within the ambulance or non-transporting vehicle for use when dispatched in support of the law enforcement tactical team, but are not to be worn or carried open or concealed by any EMS personnel in the performance of normal EMS duties under any circumstances.

(f) This Rule shall not apply to duly appointed law enforcement officers.

(g) 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.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. April 1, 2024.

10A NCAC 13P .0217 is proposed for amendment as follows:

10A NCAC 13P .0217 MEDICAL AMBULANCE/EVACUATION BUS: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Medical Ambulance/Evacuation bus is a multiple passenger vehicle configured and medically equipped for emergency and non-emergency transport of at least three stretcher bound patients with traumatic or medical conditions.

(b) To be permitted as a Medical Ambulance/Evacuation Bus, a vehicle shall have:

(1) a non-light penetrating sliding curtain installed behind the driver from floor-to-ceiling and from side-to-side to keep all light from the patient compartment from reaching the driver's area during vehicle operation at night;

(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data ~~Collection," which is incorporated 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.~~ Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) ~~five-pound~~ five-pound fire extinguishers mounted in a quick release bracket located inside the patient compartment at the front and rear of the vehicle that are either a dry chemical or all-purpose type and have pressure gauges;

(4) monitor alarms installed inside the patient compartment at the front and rear of the vehicle to warn of unsafe buildup of carbon monoxide;

(5) the name of the EMS provider permanently displayed on each side of the vehicle;

(6) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(7) emergency warning lights and audible warning devices mounted on the vehicle as required by ~~G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards.~~ G.S.20-125. All warning devices shall function properly;

(8) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(9) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has ~~sufficient~~ the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device ~~mounted~~ in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(10) permanently installed heating and air conditioning systems; and

(11) a copy of the EMS System patient care treatment protocols.

(c) A Medical Ambulance/Evacuation Bus shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.

(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

(e) The EMS System medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.

(f) The ambulance permit for this vehicle shall remain in effect for two years unless any of the following occurs:

(1) ~~The~~ the Department imposes an administrative sanction which specifies permit expiration;

(2) ~~The~~ the EMS Provider closes or goes out of business;

(3) ~~The~~ the EMS Provider changes name or ownership; or

(4) ~~Failure~~ failure to comply with the applicable Paragraphs of this Rule.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Eff. July 1, 2011;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0218 is proposed for amendment as follows:

10A NCAC 13P .0218 PEDIATRIC SPECIALTY CARE GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Pediatric Specialty Care Ground Ambulance is an ambulance used to transport only those patients 18 years old or younger with traumatic or medical conditions or for whom the need for specialty care or emergency or non-emergency medical care is anticipated during an inter-facility or discharged patient transport.

(b) To be permitted as a Pediatric Specialty Care Ground Ambulance, a vehicle shall have:

(1) a patient compartment that meets the following interior dimensions:

(A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and

(B) the height is at least 48 inches over the patient area, measured from the center of the floor, exclusive of cabinets or equipment;

(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data ~~Collection," which is incorporated 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.~~ Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge;

(4) the name of the EMS Provider permanently displayed on each side of the vehicle;

(5) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(6) emergency warning lights and audible warning devices mounted on the vehicle as required by ~~G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards.~~ G.S. 20-125. All warning devices shall function properly;

(7) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(8) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has ~~sufficient~~ the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device ~~mounted~~ in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(9) permanently installed heating and air conditioning systems; and

(10) a copy of the EMS System patient care treatment protocols.

(c) Pediatric Specialty Care Ground ambulances shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.

(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

(e) The Specialty Care Transport Program medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.

(f) The ambulance permit for this vehicle shall remain in effect for two years unless any of the following occurs:

(1) ~~The~~ the Department imposes an administrative sanction which specifies permit expiration;

(2) ~~The~~ the EMS Provider closes or goes out of business;

(3) ~~The~~ the EMS Provider changes name or ownership; or

(4) ~~Failure~~ failure to comply with the applicable paragraphs of this Rule.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Eff. July 1, 2011;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0221 is proposed for amendment as follows:

10A NCAC 13P .0221 PATIENT TRANSPORTATION BETWEEN HOSPITALS

(a) For the purpose of this Rule, hospital means those facilities as defined in ~~Rule .0102(25)~~ Rule .0102 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 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 individuals as determined by the transferring physician to manage the anticipated severity of injury or illness of the patient who is responsible for the medical aspects of the mission:

(A) emergency medical technician;

(B) advanced EMT;

(C) paramedic;

(D) nurse practitioner;

(E) physician;

(F) physician assistant;

(G) registered nurse; or

(H) respiratory therapist.

(c) Information shall be provided to the OEMS by the licensed EMS provider in the application:

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

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

(d) Ambulances used for patient transports between hospitals shall contain all medical equipment, supplies, and medications approved by the Medical Director, based upon the NCCEP treatment protocol guidelines. These protocol guidelines set forth in Rules .0405 and .0406 of this Subchapter are available online at no cost at ~~www.nccems.org.~~ https://oems.nc.gov.

History Note: *Authority G.S. 131E-155.1; 131E-158(b); 143-508(d)(1); 143-508(d)(8);*
Eff. July 1, 2012;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; September 1, 2019.

10A NCAC 13P .0224 is proposed for amendment as follows:

10A NCAC 13P .0224 GROUND AMBULANCE VEHICLE MANUFACTURING STANDARDS

(a) In addition to the terms defined in Rule .0102 of this Subchapter, the following definitions apply to this Rule:

(1) "Remounted" means a ground ambulance patient compartment module that has been removed from its original chassis and mounted onto a different chassis.

(2) "Refurbished" means upgrading or repairing an existing ground ambulance patient care module or chassis that may not involve replacement of the chassis.

(b) "Ground ambulances" as defined in Rule .0102 of this Subchapter manufactured after July 1, ~~2018,~~ 2018, or remounted after July 1, 2025, that are based and operated in North Carolina shall meet one of the following manufacturing standards:

(1) the Commission on Accreditation of Ambulance Services (CAAS) "Ground Vehicle Standard for ~~Ambulances" (GVS v.1.0),~~ Ambulances, which is incorporated herein by reference including all subsequent amendments and editions. This document is available online at no cost at www.groundvehiclestandard.org; or

(2) the National Fire Protection Association (NFPA) 1917-2016 "Standard for Automotive Ambulances," which is incorporated herein by reference including all subsequent amendments and editions. This document is available for purchase online at www.nfpa.org for a cost of ~~fifty-two dollars ($52.00).~~ seventy-eight dollars ($78.00).

(c) The following shall be exempt from the criteria set forth in Paragraph (b) of this Rule:

(1) ambulances owned and operated by an agency of the United States government;

(2) ambulances manufactured prior to July 1, 2018;

(3) ambulances remounted prior to July 1, 2025;

~~(3)~~(4) "convalescent ambulances" as defined in Rule .0102 of this Subchapter;

~~(4)~~(5) ~~remounted or~~ refurbished ambulances; or

~~(5)~~(6) Medical Ambulance/Evacuation/Bus as set forth in Rule .0217 of this Section.

(d) Effective July 1, 2018, the National Highway Traffic Safety Administration (NHTSA) KKK-A-1822F-Ambulance Manufacturing Standard shall no longer meet the manufacturing standards for new ground ambulances as set forth in Paragraph (b) of the Rule.

(e) Ground ambulances that do not meet the criteria set forth in this Rule shall be ineligible for permitting as set forth in Rule .0211 of this Section.

History Note: *Authority G.S. 131E-156; 131E-157; 143-508(d)(8);*
Eff. January 1, ~~2018.~~ 2018;
Amended Eff. April 1, 2024.

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

SECTION .0300 – SPECIALTY CARE TRANSPORT PROGRAMS

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 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;"

(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 Specialized Ambulance Protocol Summary document 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 and aircraft 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 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 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;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0401 is proposed for amendment as follows:

SECTION .0400 - MEDICAL OVERSIGHT

10A NCAC 13P .0401 COMPONENTS OF MEDICAL OVERSIGHT FOR EMS SYSTEMS

Each EMS System shall have the following components in place to assure medical oversight of the system:

(1) a medical director for adult and pediatric patients appointed, either directly or by written delegation, by the county responsible for establishing the EMS System. Systems may elect to appoint one or more assistant medical directors. The medical director and assistant medical directors shall meet the criteria 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;~~ Collection;"

(2) written treatment protocols for adult and pediatric patients for use by EMS personnel;

(3) for systems providing EMD service, an EMDPRS approved by the medical director;

(4) an EMS Peer Review Committee; and

(5) written procedures for use by EMS personnel to obtain on-line medical direction. On-line medical direction shall:

(a) be restricted to medical orders that fall within the scope of practice of the EMS personnel and within the scope of approved system treatment protocols;

(b) be provided only by a physician, ~~MICN,~~ EMS-NP, or EMS-PA. Only physicians may deviate from written treatment protocols; and

(c) be provided by a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0402 is proposed for amendment as follows:

10A NCAC 13P .0402 COMPONENTS OF MEDICAL OVERSIGHT FOR SPECIALTY CARE TRANSPORT PROGRAMS

Each Specialty Care Transport Program shall have the following components in place to assure Medical Oversight of the system:

(1) a medical director. The administration of the SCTP shall appoint a medical director following the criteria for medical directors of Specialty Care Transport Programs 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.~~ Collection." The program administration may elect to appoint one or more assistant medical directors;

(2) treatment protocols for adult and pediatric patients for use by medical crew members;

(3) an EMS Peer Review Committee; and

(4) a written protocol for use by medical crew members to obtain on-line medical direction. On-line medical direction shall:

(a) be restricted to medical orders that fall within the scope of practice of the medical crew members and within the scope of approved program treatment protocols;

(b) be provided only by a physician, ~~MICN,~~ EMS-NP, or EMS-PA. Only physicians may deviate from written treatment protocols; and

(c) be provided by a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0403 is proposed for amendment as follows:

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 as set forth in Rule .0401(5) of this Section is available 24 hours a day, seven days a week;

(2) the establishment, approval, and annual updating of adult and pediatric treatment ~~protocols;~~ protocols as set forth in Rule .0405 of this Section;

(3) EMD programs, the establishment, approval, and annual updating of the ~~Emergency Medical Dispatch Priority Reference System;~~ EMDPRS, including subsequent editions published by the EMDPRS program utilized by the EMS System;

(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) determining the combination and number of EMS personnel sufficient to manage the anticipated number and severity of injury or illness of the patients transported in Medical Ambulance/Evacuation Bus Vehicles defined in Rule .0219 of this Subchapter; and

(9) keeping the care provided up-to-date with current medical ~~practice; and~~ practice.

~~(10) 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. This plan shall include:~~

~~(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 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 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 completion of a scope of practice performance evaluation that verifies competency in Parts (A) through (D) of this Subparagraph and that is administered under the direction of the Medical Director.~~

(b) Any tasks related to Paragraph (a) of this Rule may be completed, through the Medical Director's written delegation, by assisting physicians, physician assistants, nurse practitioners, registered nurses, EMDs, or paramedics. The EMS System Medical Director may delegate physician medical oversight for a licensed EMS provider at the EMT level of service that does not back up the emergency 911 EMS System. Any decision delegating medical oversight for a licensed provider shall comply with the EMS System franchise requirements in Rule .0204 of this Subchapter. Medical oversight delegated for a licensed EMS provider shall meet the following requirements:

(1) a medical director for adult and pediatric patients. The medical director and assistant medical directors shall meet the criteria defined in "The North Carolina College of Emergency Physicians: Standards for Medical Oversight and Collection;"

(2) treatment protocols must be adopted in their original form from the standard adult and pediatric treatment protocols as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;" and

(3) establish an agency peer review committee that meets quarterly. The agency peer review committee minutes shall be reported to the EMS System peer review committee.

(c) The Medical Director may suspend temporarily, pending review, any EMS personnel from further participation in the EMS System when he or she determines that the individual's actions are detrimental to the care of the patient, the individual committed unprofessional conduct, or the individual failed to comply with credentialing requirements. During the review process, the Medical Director may:

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

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

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

History Note: *Authority G.S. 143-508(b); 143-508(d)(3); 143-508(d)(7);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. April 1, 2024.

10A NCAC 13P .0404 is proposed for amendment as follows:

10A NCAC 13P .0404 RESPONSIBILITIES OF THE MEDICAL DIRECTOR FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) The medical director for a Specialty Care Transport Program is responsible for the following:

(1) ~~The~~ the establishment, approval, and updating of adult and pediatric treatment ~~protocols;~~ protocols as set forth in Rule .0406 of this Section;

(2) ~~Medical~~ medical supervision of the selection, program orientation, continuing education, and performance of medical crew members;

(3) ~~Medical~~ medical supervision of a scope of practice performance evaluation for all medical crew members in the program based on the treatment protocols for the program;

(4) ~~The~~ the medical review of the care provided to patients;

(5) ~~Keeping~~ keeping the care provided up to date with current medical practice; and

(6) approving the Specialized Ambulance Protocol Summary (SAPS) document listing of all medications, equipment, and supplies for all Specialty Care level ground vehicles and aircraft permitted by the OEMS;

~~(6)~~(7) ~~In~~ in air medical programs, determination and specification of the medical equipment required in ~~Item (2) of~~ Rule .0209 of this Subchapter that is carried on a mission based on anticipated patient care needs.

(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, or medical crew members.

(c) The medical director may suspend temporarily, pending due process review, any medical crew members from further participation in the Specialty Care Transport Program when it is determined the activities or medical care rendered by such personnel may be detrimental to the care of the patient, constitute unprofessional conduct, or result in non-compliance with credentialing requirements. During the review process, the medical director may:

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

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

(3) permanently revoke the EMS personnel's participation in the Specialty Care Transport Program.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0407 is proposed for amendment as follows:

10A NCAC 13P .0407 REQUIREMENTS FOR EMERGENCY MEDICAL DISPATCH PRIORITY REFERENCE SYSTEM

(a) EMDPRS used by an EMD within an approved EMD program shall:

(1) be approved by the OEMS Medical Director and meet or exceed the statewide standard for EMDPRS 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~~ Collection;"

(2) not exceed the EMD scope of practice defined by the North Carolina Medical Board pursuant to G.S. ~~143-514.~~ 143-514;

(3) have a written plan how the agency is to maintain a current roster of EMD personnel in the OEMS credentialing and information database;

(4) have a written plan how the emergency medical dispatching agency applying the principles of EMD or offering EMD services, procedures, or program will comply with subsequent editions and compliance standards defined by the EMDPRS program and the EMS System.

(5) participate and report compliance data at EMS System peer review meetings.

(b) An EMDPRS developed locally shall be reviewed and updated annually and submitted to the OEMS Medical Director for approval. Any change in the EMDPRS shall be submitted to the OEMS Medical Director for review and approval at least 30 days prior to the implementation of the change.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
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.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0410 is proposed for amendment as follows:

10A NCAC 13P .0410 COMPONENTS OF MEDICAL OVERSIGHT FOR AIR MEDICAL PROGRAMS

~~(a) In addition to the terms defined in Rule .0102 of this Subchapter, the following definition applies to this Rule: "Specialized Ambulance Protocol Summary (SAPS) form" means a document completed by the Medical Director of the Air Medical Program that contains a listing of all medications, equipment, and supplies.~~

~~(b)~~(a) Licensed EMS providers seeking to offer rotary-wing or fixed-wing air medical program services within North Carolina shall receive approval from the OEMS prior to beginning operation.

~~(c)~~(b) Licensed EMS providers seeking to offer multiple air medical programs under separate medical oversight processes as set forth in Paragraph ~~(d)~~ (c) of this Rule shall make application for each program and receive approval from the OEMS as set forth in Paragraph ~~(b)~~ (a) of this Rule.

~~(d)~~(c) Each Air Medical Program providing services within North Carolina shall meet the following requirements for the provision of medical oversight:

(1) a Medical Director as set forth in Rules .0402 and .0404 of this Section;

(2) treatment protocols approved by the OEMS, to be utilized by the provider as required by Rule .0406 of this Section;

(3) a peer review committee as required by Rule .0409 of this Section;

(4) notify all North Carolina EMS Systems where services will be provided to enable each EMS System to include the provider in their EMS System plan, as set forth in Rule .0201 of this Subchapter;

(5) all aircrafts used within North Carolina shall comply with Rule .0209 of this Subchapter;

(6) populate and maintain a roster in the North Carolina database for all air medical crew members, Medical Directors, and staff identified by the program to serve as primary and secondary administrative contacts;

(7) all medical crew members operating in North Carolina shall maintain a North Carolina license or credential in accordance with the rules and regulations of the ~~appropriate~~ respective state licensing or credentialing body;

(8) active membership in each Trauma RAC containing the majority of hospitals where the program transports patients for admission;

(9) submit patient care data ~~into the PreHospital Medical Information System (PreMIS)~~ electronically, within 24 hours, to the OEMS EMS care database as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Collection" for all interstate and intrastate transports as set forth in Rule .0204 of this Subchapter;

(10) provide information regarding procedures performed during transport within North Carolina to OEMS for quality management review as required by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"

(11) submit peer review materials to the receiving hospital's peer review committee for each patient transported for admission; and

(12) a method providing for the coordinated dispatch of resources between air medical programs for scene safety, ensuring that only the number of air medical resources needed respond to the incident location are provided, and ~~arrange~~ arranging for the receiving hospital to prepare for the incoming patient.

~~(e)~~(d) In addition to the requirements set forth in Paragraph ~~(d)~~ (c) of this Rule, Air Medical Program whose base of operation is outside of North Carolina who operate fixed-wing or rotary-wing air medical programs within the State shall meet the following requirements for the provision of medical oversight:

(1) submit to the OEMS all existing treatment protocols utilized by the program in the state that it is based for comparison with North Carolina standards as set forth in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," and make any modifications identified by the OEMS to comply with the standards as set forth in Subparagraph ~~(d)(2)~~ (c)(2) of this Rule;

(2) all aircrafts used within North Carolina shall comply with Rule .0209 of this Subchapter, to be conducted at a location inside North Carolina at a time agreed upon by the Department and the Air Medical Program;

(3) submit written notification to the Department within three business days of receiving notice of any arrests or regulatory investigations for the diversion of drugs or patient care issues involving a North Carolina credentialed or licensed medical crew member; and

(4) any medical crew member suspended by the Department shall be barred from patient contact when operating in North Carolina until such time as the case involving the medical crew member has been adjudicated or resolved as set forth in Rule .1507 of this Subchapter;

~~(d)~~(e) Significant failure to comply with the criteria set forth in this Rule shall result in revocation of the Air Medical Program as set forth in Rule .1503 of this Subchapter.

History Note: *G.S. 131E-155.1; 131E-156; 131E-157(a); 131E-161; 143-508(d)(8);*
Eff. January 1, ~~2018.~~ 2018;
Amended Eff. April 1, 2024.

10A NCAC 13P .0502 is proposed for amendment as follows:

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

(a) In order to be credentialed by the OEMS as an EMR, EMT, AEMT, or Paramedic, individuals shall:

(1) Be at least 18 years of age. An examination may be taken at age 17; however, the EMS credential shall not be issued until the applicant has reached the age of 18.

(2) Complete an approved educational program as set forth in Rule .0501 of this Section for their level of application.

(3) Complete a scope of practice performance evaluation that uses performance measures based on the cognitive, psychomotor, and affective educational objectives set forth in Rule .0501 of this Section and that is consistent with their level of application, and approved by the OEMS. This scope of practice evaluation shall be completed no more than one year prior to examination. This evaluation shall be conducted 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.

(4) Within 90 days from their course graded date as reflected in the OEMS credentialing database, complete a written examination administered by the OEMS. If the applicant fails to register and complete a written examination within the 90-day period, the applicant shall obtain a letter of authorization to continue eligibility for testing from his or her EMS Educational Institution's program coordinator to qualify for an extension of the 90-day requirement set forth in this Paragraph. If the EMS Educational Institution's program coordinator declines to provide a letter of authorization, the applicant shall be disqualified from completing the credentialing process. Following a review of the applicant's specific circumstances, OEMS staff will determine, based on professional judgment, if the applicant qualifies for EMS credentialing eligibility. The OEMS shall notify the applicant in writing within 10 business days of the decision.

(A) a maximum of three attempts within six months shall be allowed.

(B) if unable to pass the written examination requirement after three attempts, the educational program shall become invalid and the individual may only become eligible for credentialing by repeating the requirements set forth in Rule .0501 of this Section.

(5) Individuals applying to OEMS for legal recognition, who completed initial educational courses through an OEMS approved North Carolina educational institution, shall complete a written examination administered by the OEMS.

~~(5)~~(6) Submit to a criminal background history check as set forth in Rule .0511 of this Section.

~~(6)~~(7) Submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).

(b) An individual seeking credentialing as an EMR, EMT, AEMT, or Paramedic may qualify for initial credentialing under the legal recognition option set forth in G.S. 131E-159(c). Individuals seeking credentialing as an AEMT or Paramedic shall submit documentation that the credential being used for application is from an educational program meeting the requirements as set forth in Rule .0501 of this Section.

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

(1) be at least 18 years of age;

(2) complete the educational requirements set forth in Rule .0501 of this Section;

(3) ~~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;~~ possess a valid CPR card;

(4) submit to a criminal background history check 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); and

(6) possess an EMD nationally recognized credential pursuant to G.S. 131E-159(d).

(d) Pursuant to G.S. 131E-159(h), the Department shall not issue an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159(a); 131E-159(b); 131E-159(g); 131E-159(h); 143-508(d)(3); 143B-952;*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0503 is proposed for amendment as follows:

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

~~Credentials for EMS Personnel~~ EMR, AEMT, Paramedic, and Instructor credentials shall be valid for a period of four years, and the EMD credential shall be valid for a period of two years, barring any delay in expiration as set forth in ~~Rule .0504(f)~~ Rule .0504 of this Section.

History Note: *Authority G.S. 131E-159(a);*
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;
Amended Eff. April 1, 2024; January 1, 2017.

10A NCAC 13P .0512 is proposed for amendment as follows:

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

(a) EMS personnel enrolled in an OEMS approved continuing education program as set forth in Rule .0601 of this Subchapter and who were eligible for renewal of an EMS credential prior to expiration, may request the EMS educational institution submit documentation of the continuing education record to the OEMS. OEMS shall renew the EMS credential to be valid for four years from the previous expiration date.

(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 Section.

(c) EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed up to ~~36 months,~~ 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c);

(2) be a resident of North Carolina or affiliated with a North Carolina EMS ~~Provider;~~ provider or employed with an alternative practice setting in compliance with Rule .0506 of this Section;

(3) at the time of application, present evidence that renewal education requirements were met prior to expiration or complete a refresher course at the level of application taken following expiration of the credential;

(4) complete an OEMS administered written examination for the individual's level of credential application;

(5) undergo a criminal history check performed by the ~~OEMS; and~~ OEMS as defined in Rule .0511 of this Section; and

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

(d) EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed more than ~~36 months,~~ 12 months shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c); ~~and~~

~~(2) meet the provisions for initial credentialing set forth in Rule .0502 of this Section.~~

(2) be a resident of North Carolina, affiliated with a North Carolina EMS Provider, or employed with an alternative practice setting in compliance with Rule .0506 of this Section;

(3) at the time of application, complete a refresher course at the level of application taken following expiration of the credential;

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

(5) undergo a criminal history check performed by the OEMS as defined in Rule .0511 of this Section; and

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

(e) EMT, AEMT, and Paramedic applicants for reinstatement of an EMS Instructor Credential, lapsed up to 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c);

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

(3) at the time of application, present evidence that renewal requirements were met prior to expiration or within six months following the expiration of the Instructor credential.

(f) EMT, AEMT, and Paramedic applicants for reinstatement of an EMS Instructor credential, lapsed greater than 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c); and

(2) meet the requirements for initial Instructor credentialing set forth in Rules .0507 and .0508 of this Section. Degree requirements that were not applicable to EMS Instructors initially credentialed prior to July 1, 2021 shall be required for reinstatement of a lapsed credential.

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

(h) Pursuant to G.S. 131E-159(h), the Department shall not issue or renew an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159; 143-508(d)(3); 143B-952;*
Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0601 is proposed for amendment as follows:

SECTION .0600 – EMS EDUCATIONAL INSTITUTIONS AND PROGRAMS

10A NCAC 13P .0601 CONTINUING EDUCATION EMS EDUCATIONAL PROGRAM REQUIREMENTS

(a) Continuing Education EMS Educational Programs shall be credentialed by the OEMS to provide only EMS continuing education. An application for credentialing as an approved EMS continuing education program shall be submitted to the OEMS for review.

(b) Continuing Education EMS Educational Programs shall have:

(1) at least a Level I EMS Instructor as program coordinator and 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, Specialty Care Transport Program, or Agency;

(2) a continuing education program shall be consistent with the services offered by the EMS System, Specialty Care Transport Program, or Agency;

(A) In an EMS System, the continuing education programs shall be reviewed and approved by the system continuing education coordinator and Medical Director;

(B) 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; and

(C) In an Agency not affiliated with an EMS System or Specialty Care Transport Program, the continuing education program shall be reviewed and approved by the Agency Program Medical Director;

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

(A) the delivery of educational programs in a manner where the content and material is delivered to the intended audience, with a limited potential for exploitation of such content and material;

(B) the record-keeping system of student attendance and performance;

(C) the selection and monitoring of EMS instructors; and

(D) student evaluations of faculty and the program's courses or components, and the frequency of the evaluations;

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

(5) meet the educational program requirements as defined in Rule .0501 of this Subchapter;

(6) Upon request, the approved EMS continuing education program shall provide records to the OEMS in order to verify compliance and student eligibility for credentialing; and

(7) approved education program credentials are valid for a period not to exceed four years.

(c) Program coordinators shall attend an OEMS Program Coordinator workshop annually. A listing of scheduled OEMS Program Coordinator Workshops is available at https://emspic.org. Newly appointed program coordinators who have not attended an OEMS Program Coordinator Workshop within the past year shall attend a workshop within one year of appointment as the program coordinator.

(d) Assisting physicians delegated by the EMS System Medical Director as authorized by Rule .0403 of this Subchapter or SCTP Medical Director as authorized by Rule .0404 of this Subchapter for provision of medical oversight of continuing education programs ~~must~~ shall meet the Education Medical Advisor criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight."

History Note: *Authority G.S. 143-508(d)(4); 143-508(d)(13);*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0602 is proposed for amendment as follows:

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

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

(1) EMS Educational Institutions shall complete a minimum of two initial courses at the highest level educational program approved for the Educational Institution's credential approval period.

(2) EMS Educational Institutions that do not complete two initial courses for each educational program approved shall be subject to action as set forth in Rule .1505 of this Subchapter.

(b) For initial courses, Basic EMS Educational Institutions shall meet all of the requirements for continuing EMS educational programs defined in Rule .0601 of this Section and shall have:

(1) ~~at least~~ a Level I or higher EMS Instructor as each lead course instructor for all courses. The lead course instructor must be credentialed at a level equal to or higher than the course and shall meet the lead instructor responsibilities ~~under Standard III~~ of the CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services ~~Professions.~~ Professions as set forth in Rule .0501 of this Subchapter. The lead instructor shall:

(A) perform duties assigned under the direction and delegation of the program director.

(B) assist in coordination of the didactic, lab, clinical, and field internship instruction.

(2) a lead EMS educational program coordinator. This individual shall be a Level II EMS Instructor credentialed at or above the highest level of course offered by the ~~institution,~~ institution. Newly appointed program coordinators who have not attended an OEMS Program Coordinator Workshop with the past year shall attend a workshop within one year of appointment as the program coordinator; and:

(A) have EMS or related allied health education, training, and experience;

(B) be knowledgeable about methods of instruction, testing, and evaluation of students;

(C) have field experience in the delivery of pre-hospital emergency care;

(D) have academic training and preparation related to emergency medical services, at least equivalent to that of a paramedic; and

(E) be knowledgeable of current versions of the National EMS Scope of Practice and National EMS Education Standards as defined by USDOT NHTSA National EMS, evidence-informed clinical practice, and incorporated by Rule .0501 of this ~~Section;~~ Subchapter;

(3) a lead EMS educational program coordinator responsible for the following:

(A) the administrative oversight, organization, and supervision of the program;

(B) the continuous quality review and improvement of the program;

(C) the long-range planning on ongoing development of the program;

(D) evaluating the effectiveness of the instruction, faculty, and overall program;

(E) the collaborative involvement with the Education Medical Advisor;

(F) the training and supervision of clinical and field internship preceptors; and

(G) the effectiveness and quality of fulfillment of responsibilities delegated to another qualified individual;

(4) written educational policies and procedures that include:

(A) the written educational policies and procedures set forth in Rule .0601 of this Section;

(B) the delivery of cognitive and psychomotor examinations in a manner that will protect and limit the potential for exploitation of such content and material;

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

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

(E) the selection and monitoring of all educational institutionally approved clinical education and field internship preceptors;

(F) utilization of EMS preceptors providing feedback to the student and EMS program;

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

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

(I) completion of an annual evaluation of the program to identify any correctable deficiencies;

(J) the program annually assesses goals and learning domains that include how program staff identify and respond to changes in the needs or expectations of the community's interests; and

(K) an advisory committee representing all practice settings utilizing EMS personnel, including clinical preceptor sites, shall assist the program to monitor community needs and expectations and provide guidance to revise goals and responsiveness to change. The advisory committee shall meet no less than annually.

(5) 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" who is responsible for the following;

(A) medical oversight of the program;

(B) collaboration to provide appropriate and updated educational content for the program curriculum;

(C) establishing minimum requirements for program completion;

(D) oversight of student evaluation, monitoring, and remediation as needed;

(E) ensuring entry level competence;

(F) ensuring interaction of physician and students; 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) For initial courses, Advanced Educational Institutions shall meet all requirements set forth in Paragraph (b) of this Rule, Standard III of the CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions shall apply, and;

(1) The faculty must be knowledgeable in course content and effective in teaching their assigned subjects, and capable through academic preparation, training, and experience to teach the courses or topics to which they are assigned.

(2) A faculty member to assist in teaching and clinical coordination in addition to the program coordinator.

(d) The educational institution shall notify the OEMS within 10 business days of a change to the program coordinator or Medical Advisor position. The educational institution shall submit the change to the OEMS as an addendum to the approved Educational Institution application within 30 days of the effective date of the position change.

~~(d)~~(e) Basic and Advanced EMS Educational Institution credentials shall be valid for a period of four years, unless the institution is accredited in accordance with Rule .0605 of this Section.

History Note: *Authority G.S. 143-508(d)(4); 143-508(d)(13);*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

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

10A NCAC 13P .0904 INITIAL DESIGNATION PROCESS

(a) For initial Trauma Center ~~designation,~~ designation or changing the level of 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 or more trauma patients 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 of this Subchapter, and submit data weekly to the OEMS ~~weekly a minimum~~ of 12 months or more prior to application that includes all the Trauma Center's trauma patients as defined in Rule .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 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 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~~ no later than 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.~~ days. The hospital and the OEMS shall agree on the date of the site visit.

(k) Except for OEMS representatives, ~~any in-state reviewer~~ reviewers 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;~~ surgeon;

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

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

~~(6)~~(5) OEMS Staff.

(l) All site team members for a Level III ~~visit shall be from in-state, and,~~ visit 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~~ ACS 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,~~ center 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 nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes;~~ manager; and

(4) OEMS Staff.

(m) ~~On the day of the site visit, the~~ 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 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;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0905 is proposed for amendment as follows:

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 by the ACS, in conjunction with the OEMS, to obtain a 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. The hospital shall, within 10 business days of receipt of the RFP, define for OEMS the Trauma Center's trauma primary catchment area.

(2) hospitals shall complete and submit 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 of this Section as it relates to the Trauma Center's level of designation.

(3) all criteria defined in Rule .0901 of this Section, as it 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 hospital and the OEMS shall agree on the date of the site visit.

(5) the composition of a Level I or II site survey team shall be the same as that specified in ~~Rule.0904(k)~~ Rule .0904 of this Section.

(6) the composition of a Level III site survey team shall be the same as that specified in ~~Rule .0904(l)~~ Rule .0904 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. The primary reviewer shall complete and submit to the OEMS a written consensus report within 30 days of the site visit.

(9) the report of the site survey team and a staff recommendation shall be reviewed by the NC 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 NC Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center renewal be:

(A) approved;

(B) approved with a contingency(ies) due to a deficiency(ies) requiring a focused review;

(C) approved with a contingency(ies) not due to a deficiency(ies) requiring a consultative visit; or

(D) denied.

(10) hospitals with a deficiency(ies) shall have up to 10 business days prior to the NC Emergency Medical Services 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 NC Emergency Medical Services Advisory Council meeting, the hospital shall be given 12 months by the OEMS to demonstrate compliance and undergo a focused review that may require an additional site visit. The need for an additional site visit is on a case-by-case basis based on the type of deficiency. 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 12 month time period, 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 in writing of the NC Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the NC Emergency Medical Services Advisory Council meeting.

(13) hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 business days following receipt of the written final decision on the trauma recommendations.

(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 shall notify the OEMS of its intent to undergo an ACS verification visit. It shall simultaneously define in writing to the OEMS its trauma primary catchment area. Trauma Centers choosing this option shall then comply with all the ACS' verification procedures, as well as any additional state criteria as defined in Rule .0901 of this Section, that apply to their level of designation.

(2) when completing the ACS' documentation for verification, the Trauma Center shall ensure access to the ACS on-line PRQ (pre-review questionnaire) to OEMS. The Trauma Center shall simultaneously complete any documents supplied by OEMS and forward these to the OEMS.

(3) the Trauma Center shall 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 NC Emergency Medical Services Advisory Council meeting to ensure that the Trauma Center's state designation period does not terminate without consideration by the NC Emergency Medical Services Advisory Council.

(4) 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.

(5) the composition of a Level I, II, or III 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 the primary reviewer;

(B) one ~~out-of-state~~ emergency physician who 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;

(C) one ~~out-of-state~~ trauma program ~~manager with an equivalent license from another state;~~ manager; and

(D) OEMS staff.

(6) the date, time, and all proposed members of the site visit team shall 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 visit team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site visit team member associated with the site visit.

(7) all state Trauma Center criteria shall be met as defined in Rule .0901 of this Section for renewal of state designation. ACS' verification is not required for state designation. ACS' verification does not ensure a state designation.

(8) The ACS final written report and supporting documentation described in Subparagraph (c)(4) of this Rule shall be used to generate a report following the post conference meeting for presentation to the NC Emergency Medical Services Advisory Council for renewal designation.

(9) the final written report issued by the ACS' verification review committee, the accompanying medical record reviews from which all identifiers shall be removed and cover letter shall be forwarded to OEMS within 10 business days of its receipt by the Trauma Center seeking renewal.

(10) the OEMS shall present its summary of findings report to the NC Emergency Medical Services Advisory Council at its next regularly scheduled meeting. The NC Emergency Medical Services Advisory Council shall recommend to the Chief of the OEMS that the request for Trauma Center renewal be:

(A) approved;

(B) approved with a contingency(ies) due to a deficiency(ies) requiring a focused review;

(C) approved with a contingency(ies) not due to a deficiency(ies); or

(D) denied.

(11) the OEMS shall send the hospital written notice of the NC Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the NC Emergency Medical Services Advisory Council meeting.

(12) the final decision regarding trauma center designation shall be rendered by the OEMS.

(13) hospitals with contingencies as the result of a deficiency(ies), as determined by OEMS, shall have up to 10 business days prior to the NC Emergency Medical Services Advisory Council meeting to

provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this time period, the hospital, may undergo a focused review to be conducted by the OEMS whereby the Trauma Center shall be given 12 months by the OEMS to demonstrate compliance. Satisfaction of contingency(ies) may require an additional site visit. The need for an additional site visit is on a case-by-case basis based on the type of deficiency. 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 three-year period from the previous designation's expiration date. If compliance is not demonstrated within the 12 month time period, 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.

(14) hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 business days following receipt of the written final decision on the trauma recommendations.

(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.

History Note: *Authority G.S. 131E-162; 143-508(d)(2);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. April 1, 2009; January 1, 2009; January 1, 2004;
Readoption Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

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:~~ Institution. An Educational Institution denied initial designation shall not be eligible to reapply to the OEMS for two years. Reasons for denial are:

(1) significant failure to comply with the provisions of Sections .0500 and .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 Sections .0500 and .0600 of this Subchapter within six months or less.

(d) The Department shall amend, suspend, or 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 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 six 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 of this Subchapter;

(4) the EMS Educational Institution failed to meet the requirements of a focused review within six 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 action taken on the Institution designation. 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. April 1, 2024; July 1, 2021; July 1, 2018; January 1, 2017.

10A NCAC 13P .1507 is proposed for amendment as follows:

10A NCAC 13P .1507 EMS PERSONNEL CREDENTIALS

(a) Any EMS credential that has been forfeited under G.S. 15A-1331.1 may not be reinstated until the person has complied with the court's requirements, has petitioned the Department for reinstatement, has completed the disciplinary process, and has received Department reinstatement approval.

(b) The Department shall amend, deny, suspend, or revoke the credentials of EMS personnel for any of the following:

(1) significant 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 concealing information in connection with an application for credentials;

(3) making false statements or representations, concealing information, or failing to respond 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 significant failure to comply with the rules relating to the 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 that will compromise skill and safety, use of alcohol, drugs, chemicals, or any other type of material, or by reason of any physical impairment;

(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 theft or false representations, obtaining or attempting to obtain, money or anything of value from a patient, EMS Agency, or educational institution;

(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 a 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) delay or failure to respond when on-duty and dispatched to a call for EMS assistance;

(17) testing positive, whether for-cause or at random, through urine, blood, or breath sampling, for any substance, legal or illegal, that is likely to impair the physical or psychological ability of the credentialed EMS personnel to perform all required or expected functions while on duty;

(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;

(19) refusing to consent to any criminal history check required by G.S. 131E-159;

(20) abandoning or neglecting a patient who is in need of care, without making arrangements for the continuation of such care;

(21) falsifying a patient's record or any controlled substance records;

(22) harassing, abusing, or intimidating a patient, student, ~~bystander,~~ EMS personnel, other allied healthcare personnel, student, educational institution staff, members of the public, or OEMS staff, either physically, verbally, or in writing;

(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;

(24) any criminal arrests that involve charges that 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;

(25) altering, destroying, or attempting to destroy evidence needed for a complaint investigation being conducted by the OEMS;

(26) significant failure to comply with 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;

(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) significant failure to comply to provide EMS care records to the licensed EMS provider for submission to the OEMS as required by Rule .0204 of this Subchapter;

(29) continuing to provide EMS care after local suspension of practice privileges by the local EMS System, Medical Director, or Alternative Practice Setting;

(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;

(31) diversion of any medication requiring medical oversight for credentialed EMS personnel; ~~or~~

(32) filing a knowingly false complaint against an individual, EMS Agency, or educational ~~institution.~~ institution; or

(33) failure to comply with educational requirements defined in Sections .0500 and .0600 of this Subchapter.

(c) Pursuant to the provisions of G.S. 131E-159(h), the OEMS shall not issue an EMS credential for any person listed on the North Carolina Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when the registration would have been required by law.

(d) Pursuant to the provisions of G.S. 50-13.12, upon notification by the court, the OEMS shall revoke an individual's EMS credential until the Department has been notified by the court that evidence has been obtained of compliance with a child support order. The provisions of G.S. 50-13.12 supersede the requirements of Paragraph (f) of this Rule.

(e) When a person who is credentialed to practice as an EMS professional is also credentialed in another jurisdiction and the 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 N.C. 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 of the amendment, denial, suspension, or 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 have been violated; and

(3) notice of the individual's right to a contested hearing, set forth in Rule .1509 of this Section, on the revocation of the credential.

(g) 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.

(h) The EMS System Administrator, Primary Agency Contact, Medical Director, Educational Institution Program Coordinator, or Medical Advisor shall notify the OEMS of any violation listed in Paragraph (b) of this ~~Rule.~~ Rule within 30 days of discovery of the violation or upon completion of the internal agency or EMS system investigation.

History Note: *Authority G.S. 131E-159; 143-508(d)(10); 143-519;*
Eff. January 1, 2013;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

DHHS
Fiscal Impact Analysis of Permanent Rule Amendment without Substantial Economic Impact

Agencies Proposing Rule Change
North Carolina Medical Care Commission
Division of Health Service Regulation
Office of Emergency Medical Services

Contact Persons
Nadine Pfeiffer, DHSR Rule Making Manager – (919) 855-3811
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Impact Summary

State Government:	**Yes**
Local Government:	**Yes**
Private Entities:	**Yes**
Substantial Impact:	**No**

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Appendix A: EMS and Trauma Rules 10A NCAC 13P proposed for revision

Authorizing Statutes
The following statutes are cited in the statutory authority of the rules under revision by the MCC.

G.S. 131E-155	Definitions
G.S. 131E-156	Permit Required to Operate Ambulance
G.S. 131E-157	Standards for Equipment; Inspection of Equipment and Supplies Required for Ambulances
G.S. 131E-158	Credentialed Personnel Required; Temporary Waiver of Requirements During an Emergency
G.S. 131E-159	Credentialing Requirements
G.S. 131E-162	Statewide Trauma System
G.S. 143-508	Department of Health and Human Services to Establish Program; Rules and Regulations of North Carolina Medical Care Commission
G.S. 143-509	Powers and Duties of Secretary
G.S. 143-517	Ambulance Support; Free Enterprise

G.S. 143-518	Confidentiality of Patient Information
G.S. 143-519	Emergency Medical Services Disciplinary Committee
G.S. 143B-952	Criminal Records Checks of EMS Personnel

Titles of Rule Changes and Related Statutory Citations affected by amendment to the General Statues of the State of North Carolina.

To support the proposed revisions to the 10A NCAC 13P EMS and Trauma rules, the Office of Emergency Medical Services (OEMS) is recommending §131E-155 be changed to remove "mobile intensive care nurse" from the definitions. This reference is obsolete. The rules being updated to reflect the proposed change to the statutory language directly related to this change are as follows:

10A NCAC 13P

Section .0100 – Definitions

- .0101- Abbreviations

Section .400 Medical Oversight

- .0401 – Components of Medical Oversight for EMS Systems
- .0402 – Components of Medical Oversight for Specialty Care Transport Programs

Titles of Rule Changes Proposed for Amendment

The following rules reflect the changes needed to update obsolete or unnecessary standards, clarify ambiguous language, incorporate changes in the healthcare delivery models, recognize new technologies, and to provide all regulated entities and the public the most efficient and effective structure for services regulated for emergency medical and trauma systems. The Medical Care Commission meeting for initial approval of the proposed rules is scheduled for August 11, 2023. These Rules are identified as follows:

10A NCAC 13P *(See proposed text of these rules in Appendix A)*

Section .0100 – Definitions

- .0101– Abbreviations (Amend)
- .0102 – Definitions (Amend)

Section .0200 – EMS Systems

- .0201 – EMS System Requirements (Amend)
- .0207 – Ground Ambulance: Vehicle and Equipment Requirements (Amend)
- .0216 – Weapons and Explosives Forbidden (Amend)
- .0217 – Medical Ambulance/Evacuation Bus: Vehicle and Equipment Requirements (Amend)
- .0218 – Pediatric Specialty Care Ground Ambulance: Vehicle and Equipment Requirements (Amend)
- .0221 – Patient Transportation Between Hospitals (Amend)
- .0224 – Ground Ambulance Manufacturing Standards (Amend)

Section .0300 – Specialty Care Transport Programs

- .0301 – Specialty Care Transport Program Criteria (Amend)

Section .0400 – Medical Oversight

- .0401 – Components of Medical Oversight for EMS Systems (Amend)
- .0402 – Components of Medial Oversight for Specialty Care Transport Programs (Amend)
- .0403 – Responsibilities of the Medical Director for EMS Systems (Amend)
- .0404 – Responsibilities of the Medical Director for Specialty Care Transport Programs (Amend)
- .0407 – Requirements for Emergency Medical Dispatch Priority Reference System (Amend)
- .0410 – Components of Medical Oversight for Air Medical Programs (Amend)

Section .0500 – EMS Personnel

- .0502 – Initial Credentialing Requirements for EMR, EMT, AEMT, Paramedic, and EMD (Amend)
- .0503 – Term of Credentials for EMS Personnel (Amend)
- .0512 – Reinstatement of Lapsed Credential (Amend)

Section .0600 – EMS Educational Institutions and Programs

- .0601 – Continuing Education EMS Educational Program Requirements (Amend)
- .0602 – Basic and Advanced EMS Educational Institution Requirements (Amend)

Section .0900 Trauma Center Standards and Approval

- .0904 – Initial Designation Process (Amend)
- .0905 – Renewal Designation Process (Amend)

Section .1500 Denial, Suspension, Amendment, or Revocation

- .1505 – EMS Educational Institutions (Amend)
- .1507 – EMS Personnel Credentials (Amend)

Summary of Revisions and Anticipated Impacts

Rules .0101 – Abbreviations and .0102 Definitions

Rules .0101 and .0102 are being amended to update terminology that is used throughout the rules. There is no impact associated with these amendments other than improved clarity.

Rule .0201 – EMS System Requirements

The proposed amendments to Rule .0201 and associated impacts are as follows:

Delete outdated reference to updating of SMARTT EMS provider information that is no longer a part of the OEMS database. The change also moves the documentation of how each hospital will

use and maintain two-way radio communications for incoming EMS providers from Rule .0403 – Responsibilities of the Medical Director for EMS System into this Rule. The OEMS staff review for approving and auditing of the EMS System Plan require all documents be available for review. This will streamline the development, update, and review of the respective EMS System Plan. The amendment also adds language for strengthening EMS System oversight of the EMD agency, particularly the agency roster in the OEMS database. This will address a common issue of rosters not being updated in a timely manner to reflect the current roster of credentialed EMD personnel. Adding this requirement to EMS System Plan, not just at the agency level, should strengthen compliance.

The primary impact associated with this rule is the potential for incremental improvements to compliance from the increased clarity of the requirements for document review and maintaining EMD personnel rosters.

Rules .0207 – Ground Ambulance: Vehicle and Equipment Requirements, .0217 – Medical Ambulance/Evacuation Bus: Vehicle and Equipment Requirements, and **.0218 – Pediatric Specialty Care Ground Ambulance: Vehicle and Equipment Requirements**

The proposed amendments to Rules .0207, .0217, and .0218 and associated impacts are as follows:

Remove Radio Mounting Requirement

Remove the requirement for a "mounted" radio device in the patient compartment of a ground ambulance. Since these rules were last updated, portable two-way communication technology has improved and is now considered sufficient for EMS personnel to communicate with the hospital from the ambulance. This change would apply to both 911 Emergency ambulances and Non-Emergency transport vehicles. 911 Emergency ambulances would still be required to have a radio control device in the rear patient compartment, but it would not need to be mounted (i.e., it could be portable). 911 Emergency ambulances would still be required to have a mounted two-way radio in the cab.

The potential future cost savings to agencies from this change will be in the form of avoided costs from not having to purchase and reinstall the radios as they replace existing radios, or not having to purchase a new radio or pay for reinstallation of an existing radio in a new ambulance. The potential savings will be available to state, county government. and private licensed EMS agencies.

EMS agencies may choose to phase out the ambulance mounted rear radios as they age out or the ambulances are replaced. The majority of new ambulances and virtually all remounts are purchased to replace vehicles that have either reached the end of the project life cycle, or a very few replacing those involved in accidents which repair costs exceed the value of the vehicle. Although the OEMS does not have a means to predict how many agencies will choose to replace mounted radios with portable technology, we expect it is likely to occur more frequently as portable technology continues to improve and become more affordable.

As far as installation costs, OEMS reached out to a Raleigh area communications company for an estimate. They estimated the cost for installation (labor only) of the radio component at $450 in the front cab and patient compartment and $350 for installation in the cab only. Cost for cables,

antenna, faceplates, and connects were not included. Not including the costs for the radio itself and other related equipment costs, OEMS estimates the minimum potential cost savings (avoided costs) for non-emergency ambulances is $450 per vehicle. For the EMS 911 ambulances, the savings would be $100 per vehicle as the rear mounted radio is not required. Avoided costs will be greater if purchase of new cables and other related equipment would have been required for installation. Potential minimum avoided costs associated with the proposed rule change are summarized for non-emergency agencies (Table 1) and 911 emergency agencies (Table 2).

Table 1: Potential Minimum Cost Savings (Avoided Costs) to Non-Emergency Agencies from Revisions to Radio Mounting Requirement

Non-Emergency Agency Type	Number of Ambulances currently in operation*	Estimated Minimum Cost Savings per Vehicle	Sub-Total Potential Cost Savings by Agency Type
State owned and operated	6	$450	$2,700
Local Government Owned	0	$450	$0
Privately owned and operated (Hospitals, For-Profit Non-Hospital Agencies, Volunteer agencies)	160	$450	$72,000
Total Potential Minimum Cost Savings†			$74,700

** The non-emergency (medical transport/convalescent) ambulance numbers were obtained from the OEMS Continuum database. These ambulances are permitted at the EMT level.*

† Savings would occur over an unknown number of years.

Table 2: Potential Minimum Cost Savings (Avoided Costs) to 911 Emergency Agencies from Revisions to Radio Mounting Requirement

911 Emergency and SCTP Agency Type	Number of Ambulances currently in operation*	Estimated Minimum Cost Savings per Vehicle	Sub-Total Potential Cost Savings by Agency Type
State owned and operated	0	$100	$0
Local Government Owned	624	$100	$62,400
Privately owned and operated (Hospitals, For-Profit Non-Hospital Agencies, Volunteer agencies)	570	$100	$57,000
Total Potential Minimum Cost Savings†			$119,400

**The 911 and Specialty Care Transport (SCTP) ambulance numbers include only vehicles in-service, ready for frontline use at various levels (EMT, AEMT, Paramedic, Specialty Care).*
† Savings would occur over an unknown number of years.

Remove Two-way Radio Requirement – non-emergency transport only

Remove the requirement for two-way radios on ambulances of agencies that only provide "convalescent" or non-emergency transport that do not back up the 911 EMS System. In place of the requirement for a two-way radio, the change will allow either a two-way radio or a radiotelephone device be available. The reason for having one of these devices is for ambulance personnel to have a reliable way to request emergency assistance if needed.

Based on manufacturer recommendations (Motorola), two-way radios generally have a long lifespan and do not need replacement frequently. Although the rules do not require replacement of radios on a fixed schedule, most agencies have a budget plan to replace their radios on a fixed schedule (8 to 10 years is a common schedule). Any cost savings from the proposed rule change will be spread out over many years as existing radios gradually age out. It is possible some agencies will elect to replace existing radios with new radios or install existing radios into new ambulances even when it is no longer required. OEMS has no way of projecting this number.

If an agency providing non-emergency transport chooses not to install new or used two-way radios and instead relies on radiotelephone devices, it is reasonable to assume they would do so as a means to save on costs. There are too many unknown variables to estimate the likely cost savings in this scenario. In any case, cost savings (in the form of avoided costs) would occur over an unknown number of years.

Rules .0216 – Weapons and Explosives Forbidden and .0221 – Patient Transportation Between Hospitals

Rules .0216 and .0221 are being amended with minor technical changes only. There is no impact associated with these changes other than improved clarity.

Rule .0224 Ground Ambulance Vehicle Manufacturing Standards

The proposed amendments to Rule .0224 and associated impacts are as follows:

Rule .0224 was first adopted on January 1, 2018 to establish a minimum manufacturing standard for all ground ambulances for the transport of emergent and non-emergent patients in North Carolina. In order to ensure ambulances operating in North Carolina are safe and reliable, the Office of Emergency Medical Services (OEMS) determined that the minimum manufacturing standard for North Carolina must be either the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Manufacturing Standard, CAAS GVS v.1.0[1] or the National Fire Protection Association (NFPA) 1917-2016 Standard for Automotive Ambulances.[2] In 2018 those were the only two American National Standards Institute (ANSI) accredited "standards developers" issuing new ambulance manufacturing standards in the United States. Since the original adoption of this rule, both accrediting agencies have implemented subsequent standards to include ambulance "remounts."

In the proposed rule amendment, the addition of the "remount" standards is to align the rule with updates to the CAAS and NFPA standards and provide a reasonable timeframe for agencies to comply. Due to recent supply chain challenges for ambulance vehicle chassis, EMS agencies may currently have contractual agreements with vendors that may extend well over a year or 18 months before the unit is ready for delivery.

Any costs or benefits associated with the remount standards would occur as a result of the change to the CAAS and NFPA standards themselves, and not to the proposed rule amendments. These standards already apply to the regulated community as the current rule includes "all subsequent amendments and editions" for both accrediting agencies.

Rule .0301 – Specialty Care Transport Program Criteria

The proposed amendments to Rule .0301 and associated impacts are as follows:

Clarify that the listing of all required equipment, supplies, and medications approved by the medical director must be documented on a "Specialized Ambulance Protocol Summary" form provided by the OEMS. The document specifies OEMS required equipment, supplies, and

[1] A copy of the updated CAAS GVS v.3.0 *"Ground Vehicle Standard for Ambulances"* may be obtained online without cost at www.groundvehiclestandard.org/.
[2] A copy of the NFPA 1917-2016 *"Automotive Ambulance Standard"* may be obtained online at www.nfpa.org for a cost of $78.00.

medications and the optional equipment, supplies, and medications approved by the program medical director. The "SAPS" document is used by OEMS staff to inspect the vehicle or aircraft to issue a permit as required by NC G.S. 131E-156. "Aircraft" was added to clarify the aircraft is under the SCTP and must meet the requirements listed on the respective agency SCTP "SAPS" document. The OEMS has been utilizing the "SAPS" document for several years and the regulated programs are already in compliance. As such, there will no be no impact associated with the proposed amendments.

Rules .0401 – Components of Medical Oversight for EMS Systems and .0402 – Components of Medical Oversight for Specialty Care Transport Programs

The proposed amendments to Rules .0401 and .0402 and associated impacts are as follows:

Delete obsolete language regarding MICN (Mobile Intensive Care Nurse) and a minor technical change. EMS systems and Specialty Care Transport Programs no longer use Registered Nurses in the MICN role. There is no impact associated with these changes other than improved clarity.

Rule .0403 – Responsibilities of the Medical Director for EMS Systems

The proposed amendments to Rule .0403 and associated impacts are as follows:

Clarify that EMDPRS updates include subsequent editions as published used by the respective EMS System. The current rule requires that the Medical Director for the EMS System update the EMDPRS on an annual basis. This proposed change simply clarifies that the most current version of the EMDPRS must be utilized. As compared to the regulatory baseline, this change will not impose any new requirements or result in any additional workload. The increased rule clarity could result in better compliance with the protocol update requirements which could ultimately lead to incremental improvements in delivery of emergency services to the public.

Due to protocol advancement during recent years, standing orders have been expanded. On-line medical control is far less frequent. On-line medical control is provided by system designated hospital Emergency Department physician, EMS-PA, EMS NP, or by contacting the System Medical Director, or Assistant Medical Director.

Add an option for the EMS System Medical Director to delegate Medical Oversight of a licensed non-emergency EMS agency to the agency medical director. These agencies are franchised to provide "non-emergency" ambulance transport within the EMS System. This would be an option only for those agencies that do not back up the emergency 911 EMS System. The rule also proposes requirements regarding qualifications of the delegated medical director, treatment protocols, and a peer review process. It should be noted that the delegation option will not supersede local franchise requirements for Medical Oversight.

Many "non-emergency" ambulance transport agencies provide services in multiple counties. Each of the counties have protocols specific to their respective EMS system which require EMS personnel employed by these agencies to be familiar with each EMS system's protocols and Medical Director. The option to delegate medical oversight to non-emergency EMC providers

will allow an EMC System to focus more of their staff resources on the more urgent 911 EMS components rather than on providing non-emergency transportation. OEMS cannot predict how many EMS Systems will elect to delegate medical oversight at the agency level. Presumably, an EMC System would only choose to delegate if they believe it will be beneficial to them as far as cost or time savings or improved delivery of services. OEMS believes that companies that have multiple EMS Systems across counties are likely to derive the most benefit from this option.

OEMS cannot estimate the cost associated with delegation of medical oversight. Contracts for services vary for accessibility and an agreed upon number of hours per week or month. The vast majority of the "non-emergency" transport agencies are private entities whose funding is based on fee for transport services. Franchise requirements in some county EMS systems include agency level medical oversight for the non-emergency services. Other EMS systems may appoint the agency Medical Director as an Assistant Medical Director for the EMS system with the sole responsibility for medical oversight of that agency.

Requiring the non-emergency agencies to conduct peer review and report information to the EMS System peer review committee will provide feedback back to the EMS System to validate the agencies are maintaining OEMS compliance as well as local franchise requirements. As compared to the regulatory baseline, this change will result in minimal additional costs to the agencies in the form of time spent conducting the focused peer review and preparing reports. Rule .0408 already requires a peer review committee, a quarterly review, and reporting, so the addition of the focused peer review specific to Rule .0403 will not require agencies to form a new peer review committee or to change the frequency of ongoing reviews. Rather, the inclusion of this requirement in Rule .0403 will serve as a prompt for the System committee to focus on particular elements related to delegated medical oversight.

The agency medical director will determine agency staff required for the peer review committee and criteria for focused review. The focused review will provide opportunities to improve criteria specific to the level of care and services provided by the non-emergency agency. Examples of focused review may include patient suctioning, management of patients transported in home ventilators, patient encounters resulting in request for 911 EMS response, areas of documentation, and safe patient transfer to mention a few. The impact should be minimal as reports should be available through agency data and quarterly meetings are projected to be an hour or less.

Rule .0404 - Responsibilities of the Medical Director for Specialty Care Transport Programs

The proposed amendments to Rule .0404 and associated impacts are as follows:

Clarify specific responsibilities of the SCTP Medical Director and minor technical changes. Clarification includes specific reference for compliance to Rule .0406 Requirements for Adult and Pediatric Treatment Protocols for Specialty Care Transport Programs and the addition of the SAPS document to detail medications, equipment, and supplies on the vehicles and aircraft. The SAPS document is the tool OEMS personnel use to conduct permitting and compliance inspections. Disciplinary action by the medical director has been added to mirror language in Rule .0403 Responsibilities of the Medical Director for EMS Systems. There is no impact associated with these changes other than improved clarity.

Rule .0407 – Requirements for Emergency Medical Dispatch Priority Reference System

The proposed amendments to Rule .0407 and associated impacts are as follows:

Clarify that certain components of the existing performance measure requirements be incorporated into a written plan, including how the agency will maintain a current roster of EMD personnel and how the dispatching agency will comply with updates to compliance standards defined by EMDPRS. EMD personnel credentialed by the OEMS are required to be entered into the OEMS credentialing and information database. Agencies providing EMDPRS must also be listed in the database and maintain a "current" roster all credentialed personnel. OEMS audits of EMS systems and EMD agencies have identified concerns regarding failure to keep rosters and credential staff information up to date. EMD agencies consistently have a high turnover rate of EMD personnel and often administrative staff. Documenting the roster requirement under Rule .0201 - EMS System Requirements, in this Rule should enhance oversight at the EMS system level and the EMD agency level.

EMD participation in the EMS system peer review has been defined in the "North Carolina College of Emergency Physicians: Standard for Medical Oversight and Data Collection Performance Improvement" document. The addition of the proposed language to this rule clarifies and strengthens peer review compliance requirements for EMD centers.

The primary impact associated with changes to this rule is the potential for incremental improvements to compliance as a result of the increased clarity of the requirements for maintaining rosters and staying up to date with EMSPRS program requirements, including peer review requirements.

Rule .0410 Components of Medical Oversight for Air Medical Programs

The proposed amendments to Rule .0410 and associated impacts are as follows:

Paragraph (a) is proposed to be deleted since the Specialized Ambulance Protocol Summary was moved to Rule .0102 Definitions.

Paragraph (c)(9) referenced the PreHospital Medical Information System (PreMIS) which is outdated. Language added clarifies the electronic submission requirements as defined in Rule .0204 EMS Licensed Provider Requirements. Agencies are already compliant with the updated data system.

There is no impact associated with these changes other than improved clarity.

Rule .0502 – Initial Paramedic Credentialing Requirements for EMR, EMT, AEMT, Paramedic and EMD

The proposed amendments to Rule .0502 and associated impacts are as follows:

Streamlines and updates terminology regarding qualifications for being credentialed to provide CPR instructions to 911 callers. The change in paragraph (c)(3) is based on updates to CPR training for the public, which are already required in practice. EMD personnel provide CPR instructions to 911 callers, which for the public is "hands only" and no mouth-to-mouth breaths. As compared to the regulatory baseline, the change to the term "valid CPR card" will not result in any changes to existing procedures. EMD personnel will continue to comply with EMDPRS recommended CPR training.

Add a requirement that individuals seeking legal recognition (the OEMS internal process for applying for reciprocity) for an EMR, EMT, AEMT, or Paramedic credential and who completed initial courses through an approved NC educational institution must complete a written examination administered by the OEMS. The OEMS written examination is online and available at designated centers throughout the United States.

Under the current rule, applicants for initial credentialing who have completed an initial education course in North Carolina and fail the OEMS written examination may currently take the National Registry examination and apply for legal recognition for an initial OEMS credential. This proposed change would not apply to individuals who are seeking reciprocity but have not taken coursework at a NC institution. Those individuals would continue to have the option to take either the NC exam or the national exam.

The OEMS strongly believes maintaining an accredited credentialing examination allows more efficient cost of credentialing at all levels. The process also allows credential term of EMS credentials of four years versus two years for National Registry. Maintaining a state examination allows better oversight of the educational curriculum to focus skills within the scope of practice for EMS personnel in North Carolina. Maintaining the state exam also allows the OEMS to better assist students/applicants by approving accommodation requests locally rather than being determined by the National Registry.

The proposed change related to reciprocity could result in some modest cost savings for applicants who would have otherwise chosen to take the national exam. The total cost savings to an applicant would vary due to 1) how many attempts taken to pass the OEMS exam versus how many attempts it would have taken to pass the National Registry exam and 2) which credential they are seeking. OEMS written examinations (all levels) cost $68. National Registry cost is EMT $104, AEMT $144, Paramedic $160. Those applicants seeking credentialing as a Paramedic would potentially see the largest cost savings ($160 for national exam versus $68 for OEMS exam). The OEMS examination may be taken at any Meazured Learning approved testing site nationwide, so there would not be a cost difference as far as location. In 2022, a total of 1,394 applicants were approved for legal recognition. OEMS does not have data on how many of those had completed their coursework in NC and then taken the National Registry rather than the OEMS exam.

Table 3: Calendar Year 2022 OEMS Legal Recognition Applicants Approved

Advanced EMT	36
Emergency Medical Responder	7
EMT	555
Paramedic	253
Emergency Medical Dispatcher	543
Total	1,394

While the OEMS cannot predict the number of students that will apply for the National Registry examination and then seek reciprocity, there is likely to be some cost savings to students due to the lower cost of the OEMS examination. The OEMS does not receive any funds from the examination fees. The fees go to Meazured Learning.

Table 4: Calendar Year 2022 OEMS Written Examinations

Totals Examinations	5,863	Includes carry over initial testers completing courses in late 2021, and 2nd and 3rd time testers who initially tested in 2021
Students from qualified through OEMS approved teaching institutions in 2022	4,319	Passed 1st Attempt 3,128 Passed 2nd or 3rd Attempt 494

Rule .0503 - Terms of Credentials for EMS Personnel

The proposed amendments to Rule .0503 and associated impacts are as follows:

Revise the state EMD credential renewal period from four years to two years to align with the National EMD credential renewal period. NCOEMS credentials will continue to be valid for four years. Changing the NC EMD credential to two years to coincide with national credentials should streamline the process and avoid confusion for EMD personnel and respective EMD agency administration. The OEMS administrative staff will be processing EMD reciprocity application every two years versus the current four-year time frame. Considerable time is spent to swiftly process expired credentials routinely.

Table 5 compares the OEMS cost to process EMD applicants for a North Carolina credential. Based on the Continuum database, 2,039 EMD personnel are on an agency roster. The general assumption is an average percentage number of credentialed EMD personnel would be renewed per year (e.g., 50% of 2,039 personnel renewed each year under proposed 2-year certification period). Most EMD centers have a significant amount of turnover, therefore based on "roster" numbers, the figure should remain consistent even with new applicants. The estimated total time to process an EMD application by OEMS staff is approximately ten minutes. The total compensation for an Administrative Officer 2 was estimated at $37.34 per hour.[3] Once the

[3] Total compensation was estimated using NC OSHR Total Compensation Calculator and was based on the salary + benefits of an Administrative Officer 2 with 8 years of experience.

background check is completed by the North Carolina SBI, the credential is approved. As a result of the proposed change to the certification period from four years to two years, OEMS is likely to spend about twice as much time processing applications, with an increased opportunity cost of about $3,174 per year. This workload will be absorbed into existing staff's regular duties and will not require additional expenditures other than time.

Table 5: Estimated Annual Opportunity Cost to OEMS to Process EMD Applicants

Certification Period	Applicants per year	Time to Process One Application *(Minutes)*	Time to Process All Applications per year *(Hours)*	Total Employee Hourly Compensation Estimate	Total Annual Processing Cost*
4 year (current)	510	10 Min	85 Hrs	$37.34	$3,174
2 year (proposed)	1020	10 Min	170 Hrs	$37.34	$6,348

**Total Annual Processing Cost is an opportunity cost rather than a direct cost.*

Rule .0512 – Reinstatement of Lapsed EMS Credential

The proposed amendments to Rule .0512 and associated impacts are as follows:

Clarify that EMS personnel affiliated with an alternative practice setting, as defined in Rule .0102 of this Subchapter, in North Carolina are also eligible for reinstatement. This aligns with current practice; as such, there should not be an impact from this change other than from improved rule clarity.

Replace the requirement for repeating initial credentialing course with a requirement to complete a refresher course and pass an OEMS written exam. This change is in response to public feedback that questioned the benefit of repeating initial educational requirements. OEMS agrees that a refresher course and examination is sufficient to help ensure the quality of applicants' preparation. However, this relaxation of the educational requirement needs to be accompanied by shortening the duration of the allowable lapse. OEMS believes changing the timeframe to 12 months for previously meeting all continuing education requirements for renewal prior to expiring would be more appropriate to validate compliance with up-to-date medical care.

Under the proposed rule, the refresher course and written exam would apply to those whose credentials have lapsed more than 12 months. For applicants whose credentials have lapsed for less than 12 months, they would retain the opportunity to present other evidence that continuing education requirements were met prior to the expiration date or complete a refresher course and complete a written exam. In 2022, 58 individuals with expired credentials completed a refresher course/examination. OEMS assumes that the number of individuals completing refresher courses may increase as a result of the proposed rule changes, but there is no way to predict by how much.

Given the current staffing challenges facing EMS providers and considering that multiple other licenses/certifications issued by the State require the appropriate fee and educations updates to be reinstated, the OEMS feels this change may encourage EMS personnel to re-enter the profession by providing a more reasonable opportunity than repeating the entire education program. The hiring processes and orientation programs, performance improvement, and Medical Oversight of EMS providers provide additional educational guidance to target specific needs for successful integration back into the agency work force.

The criminal history check is required for reinstatement of credentials for those with lapses of greater than 12 months. As compared to the regulatory baseline, this is not a new requirement as it was already part of the coursework process to get reinstatement. As such, this change will not impact the regulated community as compared to the baseline.

Rule .0601 – Continuing Education EMS Educational Program Requirements

The proposed amendments to Rule .0601 and associated impacts are as follows:

Clarify the time frame for newly appointed program coordinators requirements to attend an OEMS Program Coordinator Workshop. The current rule already requires program coordinators to attend a workshop annually. The proposed change simply clarifies that this requirement applies to newly appointed coordinators as well. There will be no impact associated with the proposed amendments other than improved clarity and incremental improvements to compliance.

Rule .0602 - Basic and Advanced EMS Educational Institution Requirements

The proposed amendments to Rule .0602 and associated impacts are as follows:
Clarify the time frame for newly appointed program coordinators requirements to attend an OEMS Program Coordinator Workshop. The current rule already requires program coordinators to attend a workshop annually. The proposed change simply clarifies that this requirement applies to newly appointed coordinators as well.

Language has also been added to the written educational policies and procedures requirements to align the educational program evaluation and community needs with accreditation requirements.

Paragraph (d) was added to clarify required timelines for reporting changes of the program coordinator or medical advisor to the OEMS.

Impacts associated with these changes include improved clarity which could result in incremental improvements to compliance with accreditation requirements.

Rule .0904 – Initial Designation Process

The proposed amendments to Rule .0904 and associated impacts are as follows:

Proposed amendments include technical changes, clarification, and specific changes to survey team members. Language was added to clarify a designated trauma center applying to change

levels is considered an "initial designation." Survey team member requirements have been changed to delete any references to in or out of state, which clarifies ACS verification. Individual surveyor team members descriptions have been amended to be less restrictive but still maintain the integrity of the team and provide better consistency for Level II survey team members.

These changes may potentially have a small future impact on the reimbursement costs for out-of-state team members. However, the estimate is unquantifiable due to there have not be any new trauma centers since 2019. OEMS is aware of one potential trauma center that may upgrade, but no timeline has been established at this time.

Rule .0905 – Renewal Designation Process

The proposed amendments to Rule .0905 and associated impacts are as follows:

Proposed amendments include technical changes and removing out-of-state requirements for survey team members. The OEMS feels there are qualified individuals throughout the state who can fill the surveyor requirements for renewal site visits. Amending the OEMS site visit team requirements will provide a more efficient pool of surveyors and eliminate scheduling challenges posed by out-of-state surveyors. The option of the OEMS site visit offers a four-year renewal designation versus a three-year with the ACS verification.

Rule .1505 - EMS Educational Institutions

The proposed amendments to Rule .1505 and associated impacts are as follows:

Prohibit an Educational Institution from reapplying for designation for two years after being denied initial designation. This change addresses an issue OEMS staff has encountered with the lack of quality of some EMS Educational Institution applications. OEMS receives applications that are incomplete or from startup educational institutions that do not have the equipment, resources, or clinical affiliations to qualify. The addition of a two-year prohibition on reapplying should result in a time savings for OEMS staff. Staff estimate that a typical well-documented application review takes about 8 to 16 hours to thoroughly review. The time processing the application depends on the level of the institution (continuing education, basic, or advanced) and the quality of the application. Poor quality and incomplete applications often require more time spent communicating about the shortcomings with the applicant. Reducing the number of poor-quality applications is estimated to save OEMS staff as much as an additional 16 to 24 hours per application. Some applicants may not complete the application process for approval even after numerous reviews that required either returning the application or consistently requesting additional information or supporting documents. The added language added will enhance the OEMS ability to consistently approve and reinforce high quality educational institutions for the benefit of potential students and our regulated public.

Rule .1507 EMS Personnel Credentials

The proposed amendments to Rule .1507 and associated impacts are as follows:

Clarify that the Department can amend, deny, suspend, or revoke credentials of an EMC personnel for harassing, abusing, or intimidating EMS personnel, other allied healthcare personnel, students, educational institution staff, and members of the public. Currently, the rule uses the more general terms "bystanders" and "OEMS staff." These changes are proposed because of recommendations from the EMS Disciplinary Committee, OEMS Compliance staff, EMS System administrators, and medical directors. Ongoing complaints, investigations, and interviews identified a need to list more specifically the persons that could be considered "bystanders" or "OEMS staff."

Another challenge has been clarity for acting on EMS instructor credentials for credentialed instructors who have consistently failed to comply with educational requirements that potentially impact the institution. The addition of (b)(33) provides the avenue to take appropriate action on the individual instructor that failed to comply with requirements and not the institution. Investigations from the OEMS regarding instructor failure to comply with course requirements result in action on the institution and do not hold the instructor accountable. This addition will allow action on the specific instructor's credential for failure to comply with course requirements without unnecessarily penalizing the institution itself.

Lastly, a reporting timeline for violations is proposed to be added at the request of numerous EMS System administrators and agency leaders. The reason for this is that many county or employer management, legal, and human resources staff require a timeline. The OEMS compliance personnel have been challenged by organizational legal and administrative personnel failing to provide documents to staff conducting complaint investigations. Without a required timeline to report violations some agencies/organizations have stated they do not feel obligated to provide personnel or other internal documents for the investigation process.

Impacts associated with these changes include improved clarity which could result in incremental improvements to compliance with accreditation requirements.

Conclusion

The proposed revisions to the EMS and trauma rules will delete obsolete elements, align the rules with current national and state standards, increase clarity, increase flexibility in key areas of management and credentialing, and strengthen documentation and peer review processes. Overall, the proposed changes should result in improved compliance, additional recruitment potential, higher quality EMS credential applications, and ultimately, a higher quality of care for the citizens of North Carolina. As proposed, the revisions could result in opportunity costs to OEMS of approximately $3,174 per year from additional time spent processing EMS credential applications. There is also likely to be cost savings in the form of avoided costs of at least $74,700 to non-emergency agencies and $119,400 to 911 emergency agencies from revisions to radio mounting requirements. These savings would be spread across all agencies and an unknown number of years.

APPENDIX A

10A NCAC 13P .0101 is proposed for amendment as follows:

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;

(3) AHA: American Heart Association;

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

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

(6) CPR: Cardiopulmonary Resuscitation;

(7) ED: Emergency Department;

(8) EMD: Emergency Medical Dispatcher;

(9) EMDPRS: Emergency Medical Dispatch Priority Reference System

~~(9)~~(10) EMR: Emergency Medical Responder;

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

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

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

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

~~(14)~~(15) FAA: Federal Aviation Administration;

~~(15)~~(16) FCC: Federal Communications Commission;

~~(16)~~(17) ICD: International Classification of Diseases;

~~(17)~~(18) ISS: Injury Severity Score;

~~(18) MICN: Mobile Intensive Care Nurse;~~

(19) NHTSA: National Highway Traffic Safety Administration;

(20) OEMS: Office of Emergency Medical Services;

(21) OR: Operating Room;

(22) PSAP: Public Safety Answering Point;

(23) RAC: Regional Advisory Committee;

(24) RFP: Request For Proposal;

(25) SCTP: Specialty Care Transport Program;

(26) SMARTT: State Medical Asset and Resource Tracking Tool;

(27) STEMI: ST Elevation Myocardial Infarction; and

(28) US DOT: United States Department of Transportation.

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Amended Eff. January 1, 2009; January 1, 2004;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

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 with a specific county EMS system as a condition for EMS Provider Licensing as required by Rule .0204 of this Subchapter.

(2) "Affiliated Hospital" means a non-trauma center hospital that is owned by the Trauma Center ~~or there is~~ or a hospital with 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 practice setting that utilizes credentialed EMS personnel that may not be affiliated with or under the oversight of 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 a practice setting utilizing credentialed EMS personnel or medical crew members.

(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~~ by a hospital of its own volition ~~reroutes~~ to reroute 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~~ 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~~ System plan.

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

(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.

(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.

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

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

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

(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.

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

(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.

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

~~(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.~~

~~(21)~~(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.

~~(22)~~(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.

~~(23)~~(22) "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.

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

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

~~(26)~~(25) "Hospital" means a licensed facility as defined in G.S. 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.

~~(27)~~(26) "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)~~(27) "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)~~(28) "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)~~(29) "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)~~(30) "Level II Trauma Center" means a hospital that provides trauma care regardless of the severity of the injury, but may lack the comprehensive care as a Level I trauma center, and does not have trauma research as a primary objective.

~~(32)~~(31) "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)~~(32) "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.

~~(34)~~(33) "Medical Director" means the physician responsible for the medical aspects of the management of a practice setting utilizing credentialed EMS personnel or medical crew members, or a Trauma Center.

~~(35)~~(34) "Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of 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.

~~(36)~~(35) "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)~~(36) "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.

~~(38)~~(37) "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.

~~(39)~~(38) "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.

~~(40)~~(39) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.

~~(41)~~(40) "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 planning, establishing, and maintaining a coordinated trauma system.

~~(42)~~(41) "Request for Proposal" means a State document that must be completed by each hospital seeking initial or renewal trauma center designation.

(42) "Specialized Ambulance Protocol Summary (SAPS) means a document listing of all standard medical equipment, supplies, and medications, approved by the Specialty Care or Air Medical Program 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.

(43) "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.

~~(44) "State Medical Asset and Resource Tracking Tool" means the Internet web-based program used by the OEMS both in its daily operations and during times of disaster to identify, record, and monitor EMS, hospital, health care, and sheltering resources statewide, including facilities, personnel, vehicles, equipment, and pharmaceutical and supply caches.~~

~~(45)~~(44) "Specialty Care Transport Program" means a program designed and operated for the 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.

~~(46)~~(45) "Specialty Care Transport Program Continuing Education Coordinator" means a ~~Level II~~ Level I EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.

~~(47)~~(46) "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.

~~(48)~~(47) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

~~(49)~~(48) "System Continuing Education Coordinator" means the Level II EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.

~~(50)~~(49) "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~~ OEMS at https://oems.nc.gov at no cost.

~~(51)~~(50) "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.

~~(52)~~(51) "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, 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~~ OEMS online at ~~https://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html~~ https://oems.nc.gov/wp-content/uploads/2022/10/datadictionary.pdf at no cost.

~~(53)~~(52) "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.

~~(54)~~(53) "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://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html~~ online at https://oems.nc.gov/wp-content/uploads/2022/10/datadictionary.pdf at no cost.

~~(55)~~(54) "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.

~~(56)~~(55) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.

~~(57)~~(56) "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;
Amended Eff. April 1, 2024; July 1, 2021; September 1, 2019; 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 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 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 bypass 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)~~(E) a disaster plan;

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

~~(H)~~(G) a mass-casualty plan;

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

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

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

~~(L)~~(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; and

(L) a plan on how each licensed hospital facility will use and maintain two-way radio communication for receiving in coming patient from EMS providers;

(14) affiliation as defined in Rule .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~~ week, and a written policy describing how the agency will maintain a roster of credentialed EMD personnel in the OEMS credentialing and information database; and

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

(4) EMD medical oversight as required in Section .0400 of this Subchapter.

(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;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0207 is proposed for amendment as follows:

10A NCAC 13P .0207 GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) To be permitted as a Ground Ambulance, a vehicle shall have:

(1) a patient compartment that meets the following interior dimensions:

(A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and

(B) the height is at least 48 inches over the patient area, measured from the approximate center of the floor, exclusive of cabinets or equipment;

(2) patient care equipment and supplies 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.~~ Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) other equipment that includes:

(A) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge; and

(B) the availability of one pediatric restraint device to safely transport pediatric patients and children under 40 pounds in the patient compartment of the ambulance;

(4) the name of the EMS Provider permanently displayed on each side of the vehicle;

(5) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(6) emergency warning lights and audible warning devices mounted on the vehicle as required by ~~G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards.~~ G.S. 20-25. All warning devices shall function properly;

(7) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(8) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has ~~sufficient~~ the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device ~~mounted~~ in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(9) permanently installed heating and air conditioning systems; and

(10) a copy of the EMS System patient care treatment protocols.

(b) Ground ambulances ~~shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.~~ permitted by the OEMS that do not back up the 911 EMS System shall be exempt from requirements for two-way radio communications as defined in Subparagraph (8) of this Rule. A two-way radio or radiotelephone device such as a cellular telephone shall be available to summon emergency assistance.

(c) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0216 is proposed for amendment as follows:

10A NCAC 13P .0216 WEAPONS AND EXPLOSIVES FORBIDDEN

(a) Weapons, whether lethal or non-lethal, and explosives shall not be worn or carried aboard an ambulance or EMS non-transporting 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 shall be considered weapons for the purpose of this Rule.

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

(d) If any weapon is found to be in the possession of a patient or person accompanying the patient during transportation, the weapon shall be safely secured in accordance with the weapons policy as set forth in ~~Rule .0201(a)(13)(I)~~ Rule .0201 of this Section.

(e) Weapons authorized for use by EMS personnel attached to a law enforcement tactical team in accordance with the weapons policy as set forth in ~~Rule .0201(a)(13)(I)~~ Rule .0201 of this Section may be secured in a locked, dedicated compartment or gun safe mounted within the ambulance or non-transporting vehicle for use when dispatched in support of the law enforcement tactical team, but are not to be worn or carried open or concealed by any EMS personnel in the performance of normal EMS duties under any circumstances.

(f) This Rule shall not apply to duly appointed law enforcement officers.

(g) 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.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. April 1, 2024.

10A NCAC 13P .0217 is proposed for amendment as follows:

10A NCAC 13P .0217 MEDICAL AMBULANCE/EVACUATION BUS: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Medical Ambulance/Evacuation bus is a multiple passenger vehicle configured and medically equipped for emergency and non-emergency transport of at least three stretcher bound patients with traumatic or medical conditions.

(b) To be permitted as a Medical Ambulance/Evacuation Bus, a vehicle shall have:

(1) a non-light penetrating sliding curtain installed behind the driver from floor-to-ceiling and from side-to-side to keep all light from the patient compartment from reaching the driver's area during vehicle operation at night;

(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data ~~Collection," which is incorporated 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.~~ Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) ~~five-pound~~ five-pound fire extinguishers mounted in a quick release bracket located inside the patient compartment at the front and rear of the vehicle that are either a dry chemical or all-purpose type and have pressure gauges;

(4) monitor alarms installed inside the patient compartment at the front and rear of the vehicle to warn of unsafe buildup of carbon monoxide;

(5) the name of the EMS provider permanently displayed on each side of the vehicle;

(6) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(7) emergency warning lights and audible warning devices mounted on the vehicle as required by ~~G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards.~~ G.S.20-125. All warning devices shall function properly;

(8) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(9) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has ~~sufficient~~ the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device ~~mounted~~ in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(10) permanently installed heating and air conditioning systems; and

(11) a copy of the EMS System patient care treatment protocols.

(c) A Medical Ambulance/Evacuation Bus shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.

(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

(e) The EMS System medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.

(f) The ambulance permit for this vehicle shall remain in effect for two years unless any of the following occurs:

(1) ~~The~~ the Department imposes an administrative sanction which specifies permit expiration;

(2) ~~The~~ the EMS Provider closes or goes out of business;

(3) ~~The~~ the EMS Provider changes name or ownership; or

(4) ~~Failure~~ failure to comply with the applicable Paragraphs of this Rule.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Eff. July 1, 2011;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0218 is proposed for amendment as follows:

10A NCAC 13P .0218 PEDIATRIC SPECIALTY CARE GROUND AMBULANCE: VEHICLE AND EQUIPMENT REQUIREMENTS

(a) A Pediatric Specialty Care Ground Ambulance is an ambulance used to transport only those patients 18 years old or younger with traumatic or medical conditions or for whom the need for specialty care or emergency or non-emergency medical care is anticipated during an inter-facility or discharged patient transport.

(b) To be permitted as a Pediatric Specialty Care Ground Ambulance, a vehicle shall have:

(1) a patient compartment that meets the following interior dimensions:

(A) the length, measured on the floor from the back of the driver's compartment, driver's seat or partition to the inside edge of the rear loading doors, is at least 102 inches; and

(B) the height is at least 48 inches over the patient area, measured from the center of the floor, exclusive of cabinets or equipment;

(2) patient care equipment and supplies as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data ~~Collection," which is incorporated 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.~~ Collection." The equipment and supplies shall be clean, in working order, and secured in the vehicle;

(3) one fire extinguisher mounted in a quick release bracket that is either a dry chemical or all-purpose type and has a pressure gauge;

(4) the name of the EMS Provider permanently displayed on each side of the vehicle;

(5) reflective tape affixed to the vehicle such that there is reflectivity on all sides of the vehicle;

(6) emergency warning lights and audible warning devices mounted on the vehicle as required by ~~G.S. 20-125 in addition to those required by Federal Motor Vehicle Safety Standards.~~ G.S. 20-125. All warning devices shall function properly;

(7) no structural or functional defects that may adversely affect the patient, the EMS personnel, or the safe operation of the vehicle;

(8) an operational two-way radio that:

(A) is mounted to the ambulance and installed for safe operation and controlled by the ambulance driver;

(B) has ~~sufficient~~ the range, radio frequencies, and capabilities to establish and maintain two-way voice radio communication from within the defined service area of the EMS System to the emergency communications center or PSAP designated to direct or dispatch the deployment of the ambulance;

(C) is capable of establishing two-way voice radio communication from within the defined service area to the emergency department of the hospital(s) where patients are routinely transported and to facilities that provide on-line medical direction to EMS personnel;

(D) is equipped with a radio control device ~~mounted~~ in the patient compartment capable of operation by the patient attendant to receive on-line medical direction; and

(E) is licensed or authorized by the FCC;

(9) permanently installed heating and air conditioning systems; and

(10) a copy of the EMS System patient care treatment protocols.

(c) Pediatric Specialty Care Ground ambulances shall not use a radiotelephone device such as a cellular telephone as the only source of two-way radio voice communication.

(d) Communication instruments or devices such as data radio, facsimile, computer, or telemetry radio shall be in addition to the mission dedicated dispatch radio and shall function independently from the mission dedicated radio.

(e) The Specialty Care Transport Program medical director shall designate the combination of medical equipment as required in Subparagraph (b)(2) of this Rule that is carried on a mission based on anticipated patient care needs.

(f) The ambulance permit for this vehicle shall remain in effect for two years unless any of the following occurs:

(1) ~~The~~ the Department imposes an administrative sanction which specifies permit expiration;

(2) ~~The~~ the EMS Provider closes or goes out of business;

(3) ~~The~~ the EMS Provider changes name or ownership; or

(4) ~~Failure~~ failure to comply with the applicable paragraphs of this Rule.

History Note: *Authority G.S. 131E-157(a); 143-508(d)(8);*
Eff. July 1, 2011;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;

Amended Eff. April 1, 2024.

10A NCAC 13P .0221 is proposed for amendment as follows:

10A NCAC 13P .0221 PATIENT TRANSPORTATION BETWEEN HOSPITALS

(a) For the purpose of this Rule, hospital means those facilities as defined in ~~Rule .0102(25)~~ Rule .0102 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 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 individuals as determined by the transferring physician to manage the anticipated severity of injury or illness of the patient who is responsible for the medical aspects of the mission:

(A) emergency medical technician;

(B) advanced EMT;

(C) paramedic;

(D) nurse practitioner;

(E) physician;

(F) physician assistant;

(G) registered nurse; or

(H) respiratory therapist.

(c) Information shall be provided to the OEMS by the licensed EMS provider in the application:

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

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

(d) Ambulances used for patient transports between hospitals shall contain all medical equipment, supplies, and medications approved by the Medical Director, based upon the NCCEP treatment protocol guidelines. These protocol guidelines set forth in Rules .0405 and .0406 of this Subchapter are available online at no cost at ~~www.ncems.org.~~ https://oems.nc.gov.

History Note: *Authority G.S. 131E-155.1; 131E-158(b); 143-508(d)(1); 143-508(d)(8);*
Eff. July 1, 2012;
Readopted Eff. January 1, 2017;

Amended Eff. April 1, 2024; September 1, 2019.

10A NCAC 13P .0224 is proposed for amendment as follows:

10A NCAC 13P .0224 GROUND AMBULANCE VEHICLE MANUFACTURING STANDARDS

(a) In addition to the terms defined in Rule .0102 of this Subchapter, the following definitions apply to this Rule:

(1) "Remounted" means a ground ambulance patient compartment module that has been removed from its original chassis and mounted onto a different chassis.

(2) "Refurbished" means upgrading or repairing an existing ground ambulance patient care module or chassis that may not involve replacement of the chassis.

(b) "Ground ambulances" as defined in Rule .0102 of this Subchapter manufactured after July 1, ~~2018,~~ 2018, or remounted after July 1, 2025, that are based and operated in North Carolina shall meet one of the following manufacturing standards:

(1) the Commission on Accreditation of Ambulance Services (CAAS) "Ground Vehicle Standard for ~~Ambulances" (GVS v.1.0),~~ Ambulances, which is incorporated herein by reference including all subsequent amendments and editions. This document is available online at no cost at www.groundvehiclestandard.org; or

(2) the National Fire Protection Association (NFPA) 1917-2016 "Standard for Automotive Ambulances," which is incorporated herein by reference including all subsequent amendments and editions. This document is available for purchase online at www.nfpa.org for a cost of ~~fifty-two dollars ($52.00).~~ seventy-eight dollars ($78.00).

(c) The following shall be exempt from the criteria set forth in Paragraph (b) of this Rule:

(1) ambulances owned and operated by an agency of the United States government;

(2) ambulances manufactured prior to July 1, 2018;

(3) ambulances remounted prior to July 1, 2025;

~~(3)~~(4) "convalescent ambulances" as defined in Rule .0102 of this Subchapter;

~~(4)~~(5) ~~remounted or~~ refurbished ambulances; or

~~(5)~~(6) Medical Ambulance/Evacuation/Bus as set forth in Rule .0217 of this Section.

(d) Effective July 1, 2018, the National Highway Traffic Safety Administration (NHTSA) KKK-A-1822F-Ambulance Manufacturing Standard shall no longer meet the manufacturing standards for new ground ambulances as set forth in Paragraph (b) of the Rule.

(e) Ground ambulances that do not meet the criteria set forth in this Rule shall be ineligible for permitting as set forth in Rule .0211 of this Section.

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

Amended Eff. April 1, 2024.

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 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;"

(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 Specialized Ambulance Protocol Summary document 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 and aircraft 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 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 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;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0401 is proposed for amendment as follows:

10A NCAC 13P .0401 COMPONENTS OF MEDICAL OVERSIGHT FOR EMS SYSTEMS

Each EMS System shall have the following components in place to assure medical oversight of the system:

(1) a medical director for adult and pediatric patients appointed, either directly or by written delegation, by the county responsible for establishing the EMS System. Systems may elect to appoint one or more assistant medical directors. The medical director and assistant medical directors shall meet the criteria 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;~~ Collection;"

(2) written treatment protocols for adult and pediatric patients for use by EMS personnel;

(3) for systems providing EMD service, an EMDPRS approved by the medical director;

(4) an EMS Peer Review Committee; and

(5) written procedures for use by EMS personnel to obtain on-line medical direction. On-line medical direction shall:

(a) be restricted to medical orders that fall within the scope of practice of the EMS personnel and within the scope of approved system treatment protocols;

(b) be provided only by a physician, ~~MICN,~~ EMS-NP, or EMS-PA. Only physicians may deviate from written treatment protocols; and

(c) be provided by a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0402 is proposed for amendment as follows:

10A NCAC 13P .0402 COMPONENTS OF MEDICAL OVERSIGHT FOR SPECIALTY CARE TRANSPORT PROGRAMS

Each Specialty Care Transport Program shall have the following components in place to assure Medical Oversight of the system:

(1) a medical director. The administration of the SCTP shall appoint a medical director following the criteria for medical directors of Specialty Care Transport Programs 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.~~ Collection." The program administration may elect to appoint one or more assistant medical directors;

(2) treatment protocols for adult and pediatric patients for use by medical crew members;

(3) an EMS Peer Review Committee; and

(4) a written protocol for use by medical crew members to obtain on-line medical direction. On-line medical direction shall:

(a) be restricted to medical orders that fall within the scope of practice of the medical crew members and within the scope of approved program treatment protocols;

(b) be provided only by a physician, ~~MICN,~~ EMS-NP, or EMS-PA. Only physicians may deviate from written treatment protocols; and

(c) be provided by a system of two-way voice communication that can be maintained throughout the treatment and disposition of the patient.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0403 is proposed for amendment as follows:

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 as set forth in Rule .0401(5) of this Section is available 24 hours a day, seven days a week;

(2) the establishment, approval, and annual updating of adult and pediatric treatment ~~protocols;~~ protocols as set forth in Rule .0405 of this Section;

(3) EMD programs, the establishment, approval, and annual updating of the ~~Emergency Medical Dispatch Priority Reference System;~~ EMDPRS, including subsequent editions published by the EMDPRS program utilized by the EMS System;

(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) determining the combination and number of EMS personnel sufficient to manage the anticipated number and severity of injury or illness of the patients transported in Medical Ambulance/Evacuation Bus Vehicles defined in Rule .0219 of this Subchapter; and

(9) keeping the care provided up-to-date with current medical ~~practice; and~~ practice.

~~(10) 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. This plan shall include:~~

~~(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 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 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 completion of a scope of practice performance evaluation that verifies competency in Parts (A) through (D) of this Subparagraph and that is administered under the direction of the Medical Director.~~

(b) Any tasks related to Paragraph (a) of this Rule may be completed, through the Medical Director's written delegation, by assisting physicians, physician assistants, nurse practitioners, registered nurses, EMDs, or paramedics. The EMS System Medical Director may delegate physician medical oversight for a licensed EMS provider at the EMT level of service that does not back up the emergency 911 EMS System. Any decision delegating medical oversight for a licensed provider shall comply with the EMS System franchise requirements in Rule .0204 of this Subchapter. Medical oversight delegated for a licensed EMS provider shall meet the following requirements:

(1) a medical director for adult and pediatric patients. The medical director and assistant medical directors shall meet the criteria defined in "The North Carolina College of Emergency Physicians: Standards for Medical Oversight and Collection;"

(2) treatment protocols must be adopted in their original form from the standard adult and pediatric treatment protocols as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;" and

(3) establish an agency peer review committee that meets quarterly. The agency peer review committee minutes shall be reported to the EMS System peer review committee.

(c) The Medical Director may suspend temporarily, pending review, any EMS personnel from further participation in the EMS System when he or she determines that the individual's actions are detrimental to the care of the patient, the individual committed unprofessional conduct, or the individual failed to comply with credentialing requirements. During the review process, the Medical Director may:

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

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

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

History Note: *Authority G.S. 143-508(b); 143-508(d)(3); 143-508(d)(7);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009; January 1, 2004;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. April 1, 2024.

10A NCAC 13P .0404 is proposed for amendment as follows:

10A NCAC 13P .0404 RESPONSIBILITIES OF THE MEDICAL DIRECTOR FOR SPECIALTY CARE TRANSPORT PROGRAMS

(a) The medical director for a Specialty Care Transport Program is responsible for the following:

(1) ~~The~~ the establishment, approval, and updating of adult and pediatric treatment ~~protocols;~~ protocols as set forth in Rule .0406 of this Section;

(2) ~~Medical~~ medical supervision of the selection, program orientation, continuing education, and performance of medical crew members;

(3) ~~Medical~~ medical supervision of a scope of practice performance evaluation for all medical crew members in the program based on the treatment protocols for the program;

(4) ~~The~~ the medical review of the care provided to patients;

(5) ~~Keeping~~ keeping the care provided up to date with current medical practice; and

(6) approving the Specialized Ambulance Protocol Summary (SAPS) document listing of all medications, equipment, and supplies for all Specialty Care level ground vehicles and aircraft permitted by the OEMS;

~~(6)~~(7) ~~In~~ in air medical programs, determination and specification of the medical equipment required in ~~Item (2) of~~ Rule .0209 of this Subchapter that is carried on a mission based on anticipated patient care needs.

(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, or medical crew members.

(c) The medical director may suspend temporarily, pending due process review, any medical crew members from further participation in the Specialty Care Transport Program when it is determined the activities or medical care

rendered by such personnel may be detrimental to the care of the patient, constitute unprofessional conduct, or result in non-compliance with credentialing requirements. During the review process, the medical director may:

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

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

(3) permanently revoke the EMS personnel's participation in the Specialty Care Transport Program.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. January 1, 2009;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0407 is proposed for amendment as follows:

10A NCAC 13P .0407 REQUIREMENTS FOR EMERGENCY MEDICAL DISPATCH PRIORITY REFERENCE SYSTEM

(a) EMDPRS used by an EMD within an approved EMD program shall:

(1) be approved by the OEMS Medical Director and meet or exceed the statewide standard for EMDPRS 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~~ Collection;"

(2) not exceed the EMD scope of practice defined by the North Carolina Medical Board pursuant to G.S. ~~143-514.~~ 143-514;

(3) have a written plan how the agency is to maintain a current roster of EMD personnel in the OEMS credentialing and information database;

(4) have a written plan how the emergency medical dispatching agency applying the principles of EMD or offering EMD services, procedures, or program will comply with subsequent editions and compliance standards defined by the EMDPRS program and the EMS System.

(5) participate and report compliance data at EMS System peer review meetings.

(b) An EMDPRS developed locally shall be reviewed and updated annually and submitted to the OEMS Medical Director for approval. Any change in the EMDPRS shall be submitted to the OEMS Medical Director for review and approval at least 30 days prior to the implementation of the change.

History Note: *Authority G.S. 143-508(b); 143-509(12);*
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.~~ 2016;
Amended Eff. April 1, 2024.

10A NCAC 13P .0410 is proposed for amendment as follows:

10A NCAC 13P .0410 COMPONENTS OF MEDICAL OVERSIGHT FOR AIR MEDICAL PROGRAMS

~~(a) In addition to the terms defined in Rule .0102 of this Subchapter, the following definition applies to this Rule: "Specialized Ambulance Protocol Summary (SAPS) form" means a document completed by the Medical Director of the Air Medical Program that contains a listing of all medications, equipment, and supplies.~~

~~(b)~~(a) Licensed EMS providers seeking to offer rotary-wing or fixed-wing air medical program services within North Carolina shall receive approval from the OEMS prior to beginning operation.

~~(c)~~(b) Licensed EMS providers seeking to offer multiple air medical programs under separate medical oversight processes as set forth in Paragraph ~~(d)~~ (c) of this Rule shall make application for each program and receive approval from the OEMS as set forth in Paragraph ~~(b)~~ (a) of this Rule.

~~(d)~~(c) Each Air Medical Program providing services within North Carolina shall meet the following requirements for the provision of medical oversight:

(1) a Medical Director as set forth in Rules .0402 and .0404 of this Section;
(2) treatment protocols approved by the OEMS, to be utilized by the provider as required by Rule .0406 of this Section;
(3) a peer review committee as required by Rule .0409 of this Section;
(4) notify all North Carolina EMS Systems where services will be provided to enable each EMS System to include the provider in their EMS System plan, as set forth in Rule .0201 of this Subchapter;
(5) all aircrafts used within North Carolina shall comply with Rule .0209 of this Subchapter;
(6) populate and maintain a roster in the North Carolina database for all air medical crew members, Medical Directors, and staff identified by the program to serve as primary and secondary administrative contacts;
(7) all medical crew members operating in North Carolina shall maintain a North Carolina license or credential in accordance with the rules and regulations of the ~~appropriate~~ respective state licensing or credentialing body;

(8) active membership in each Trauma RAC containing the majority of hospitals where the program transports patients for admission;

(9) submit patient care data ~~into the PreHospital Medical Information System (PreMIS)~~ electronically, within 24 hours, to the OEMS EMS care database as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Collection" for all interstate and intrastate transports as set forth in Rule .0204 of this Subchapter;

(10) provide information regarding procedures performed during transport within North Carolina to OEMS for quality management review as required by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;"

(11) submit peer review materials to the receiving hospital's peer review committee for each patient transported for admission; and

(12) a method providing for the coordinated dispatch of resources between air medical programs for scene safety, ensuring that only the number of air medical resources needed respond to the incident location are provided, and ~~arrange~~ arranging for the receiving hospital to prepare for the incoming patient.

~~(e)~~(d) In addition to the requirements set forth in Paragraph ~~(d)~~ (c) of this Rule, Air Medical Program whose base of operation is outside of North Carolina who operate fixed-wing or rotary-wing air medical programs within the State shall meet the following requirements for the provision of medical oversight:

(1) submit to the OEMS all existing treatment protocols utilized by the program in the state that it is based for comparison with North Carolina standards as set forth in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," and make any modifications identified by the OEMS to comply with the standards as set forth in Subparagraph ~~(d)(2)~~ (c)(2) of this Rule;

(2) all aircrafts used within North Carolina shall comply with Rule .0209 of this Subchapter, to be conducted at a location inside North Carolina at a time agreed upon by the Department and the Air Medical Program;

(3) submit written notification to the Department within three business days of receiving notice of any arrests or regulatory investigations for the diversion of drugs or patient care issues involving a North Carolina credentialed or licensed medical crew member; and

(4) any medical crew member suspended by the Department shall be barred from patient contact when operating in North Carolina until such time as the case involving the medical crew member has been adjudicated or resolved as set forth in Rule .1507 of this Subchapter;

~~(d)~~(e) Significant failure to comply with the criteria set forth in this Rule shall result in revocation of the Air Medical Program as set forth in Rule .1503 of this Subchapter.

History Note: *G.S. 131E-155.1; 131E-156; 131E-157(a); 131E-161; 143-508(d)(8);*
Eff. January 1, ~~2018.~~ 2018;

Amended Eff. April 1, 2024.

10A NCAC 13P .0502 is proposed for amendment as follows:

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

(a) In order to be credentialed by the OEMS as an EMR, EMT, AEMT, or Paramedic, individuals shall:

(1) Be at least 18 years of age. An examination may be taken at age 17; however, the EMS credential shall not be issued until the applicant has reached the age of 18.

(2) Complete an approved educational program as set forth in Rule .0501 of this Section for their level of application.

(3) Complete a scope of practice performance evaluation that uses performance measures based on the cognitive, psychomotor, and affective educational objectives set forth in Rule .0501 of this Section and that is consistent with their level of application, and approved by the OEMS. This scope of practice evaluation shall be completed no more than one year prior to examination. This evaluation shall be conducted 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.

(4) Within 90 days from their course graded date as reflected in the OEMS credentialing database, complete a written examination administered by the OEMS. If the applicant fails to register and complete a written examination within the 90-day period, the applicant shall obtain a letter of authorization to continue eligibility for testing from his or her EMS Educational Institution's program coordinator to qualify for an extension of the 90-day requirement set forth in this Paragraph. If the EMS Educational Institution's program coordinator declines to provide a letter of authorization, the applicant shall be disqualified from completing the credentialing process. Following a review of the applicant's specific circumstances, OEMS staff will determine, based on professional judgment, if the applicant qualifies for EMS credentialing eligibility. The OEMS shall notify the applicant in writing within 10 business days of the decision.

(A) a maximum of three attempts within six months shall be allowed.

(B) if unable to pass the written examination requirement after three attempts, the educational program shall become invalid and the individual may only become eligible for credentialing by repeating the requirements set forth in Rule .0501 of this Section.

(5) Individuals applying to OEMS for legal recognition, who completed initial educational courses through an OEMS approved North Carolina educational institution, shall complete a written examination administered by the OEMS.

~~(5)~~(6) Submit to a criminal background history check as set forth in Rule .0511 of this Section.

~~(6)~~(7) Submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).

(b) An individual seeking credentialing as an EMR, EMT, AEMT, or Paramedic may qualify for initial credentialing under the legal recognition option set forth in G.S. 131E-159(c). Individuals seeking credentialing as an AEMT or Paramedic shall submit documentation that the credential being used for application is from an educational program meeting the requirements as set forth in Rule .0501 of this Section.

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

(1) be at least 18 years of age;

(2) complete the educational requirements set forth in Rule .0501 of this Section;

(3) ~~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;~~ possess a valid CPR card;

(4) submit to a criminal background history check 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); and

(6) possess an EMD nationally recognized credential pursuant to G.S. 131E-159(d).

(d) Pursuant to G.S. 131E-159(h), the Department shall not issue an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159(a); 131E-159(b); 131E-159(g); 131E-159(h); 143-508(d)(3); 143B-952;*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0503 is proposed for amendment as follows:

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

~~Credentials for EMS Personnel~~ EMR, AEMT, Paramedic, and Instructor credentials shall be valid for a period of four years, and the EMD credential shall be valid for a period of two years, barring any delay in expiration as set forth in ~~Rule .0504(f)~~ Rule .0504 of this Section.

History Note: *Authority G.S. 131E-159(a);*
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;
Amended Eff. April 1, 2024; January 1, 2017.

10A NCAC 13P .0512 is proposed for amendment as follows:

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

(a) EMS personnel enrolled in an OEMS approved continuing education program as set forth in Rule .0601 of this Subchapter and who were eligible for renewal of an EMS credential prior to expiration, may request the EMS educational institution submit documentation of the continuing education record to the OEMS. OEMS shall renew the EMS credential to be valid for four years from the previous expiration date.

(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 Section.

(c) EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed up to ~~36 months,~~ 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c);

(2) be a resident of North Carolina or affiliated with a North Carolina EMS ~~Provider;~~ provider or employed with an alternative practice setting in compliance with Rule .0506 of this Section;

(3) at the time of application, present evidence that renewal education requirements were met prior to expiration or complete a refresher course at the level of application taken following expiration of the credential;

(4) complete an OEMS administered written examination for the individual's level of credential application;

(5) undergo a criminal history check performed by the ~~OEMS; and~~ OEMS as defined in Rule .0511 of this Section; and

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

(d) EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed more than ~~36 months,~~ 12 months shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c); ~~and~~

~~(2) meet the provisions for initial credentialing set forth in Rule .0502 of this Section.~~

(2) be a resident of North Carolina, affiliated with a North Carolina EMS Provider, or employed with an alternative practice setting in compliance with Rule .0506 of this Section;

(3) at the time of application, complete a refresher course at the level of application taken following expiration of the credential;

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

(5) undergo a criminal history check performed by the OEMS as defined in Rule .0511 of this Section; and

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

(e) EMT, AEMT, and Paramedic applicants for reinstatement of an EMS Instructor Credential, lapsed up to 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c);

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

(3) at the time of application, present evidence that renewal requirements were met prior to expiration or within six months following the expiration of the Instructor credential.

(f) EMT, AEMT, and Paramedic applicants for reinstatement of an EMS Instructor credential, lapsed greater than 12 months, shall:

(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c); and

(2) meet the requirements for initial Instructor credentialing set forth in Rules .0507 and .0508 of this Section. Degree requirements that were not applicable to EMS Instructors initially credentialed prior to July 1, 2021 shall be required for reinstatement of a lapsed credential.

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

(h) Pursuant to G.S. 131E-159(h), the Department shall not issue or renew an EMS credential for any person listed on the Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159; 143-508(d)(3); 143B-952;*
Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0601 is proposed for amendment as follows:

10A NCAC 13P .0601 CONTINUING EDUCATION EMS EDUCATIONAL PROGRAM REQUIREMENTS

(a) Continuing Education EMS Educational Programs shall be credentialed by the OEMS to provide only EMS continuing education. An application for credentialing as an approved EMS continuing education program shall be submitted to the OEMS for review.

(b) Continuing Education EMS Educational Programs shall have:

(1) at least a Level I EMS Instructor as program coordinator and 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, Specialty Care Transport Program, or Agency;

(2) a continuing education program shall be consistent with the services offered by the EMS System, Specialty Care Transport Program, or Agency;

(A) In an EMS System, the continuing education programs shall be reviewed and approved by the system continuing education coordinator and Medical Director;

(B) 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; and

(C) In an Agency not affiliated with an EMS System or Specialty Care Transport Program, the continuing education program shall be reviewed and approved by the Agency Program Medical Director;

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

(A) the delivery of educational programs in a manner where the content and material is delivered to the intended audience, with a limited potential for exploitation of such content and material;

(B) the record-keeping system of student attendance and performance;

(C) the selection and monitoring of EMS instructors; and

(D) student evaluations of faculty and the program's courses or components, and the frequency of the evaluations;

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

(5) meet the educational program requirements as defined in Rule .0501 of this Subchapter;

(6) Upon request, the approved EMS continuing education program shall provide records to the OEMS in order to verify compliance and student eligibility for credentialing; and

(7) approved education program credentials are valid for a period not to exceed four years.

(c) Program coordinators shall attend an OEMS Program Coordinator workshop annually. A listing of scheduled OEMS Program Coordinator Workshops is available at https://emspic.org. Newly appointed program coordinators who have not attended an OEMS Program Coordinator Workshop within the past year shall attend a workshop within one year of appointment as the program coordinator.

(d) Assisting physicians delegated by the EMS System Medical Director as authorized by Rule .0403 of this Subchapter or SCTP Medical Director as authorized by Rule .0404 of this Subchapter for provision of medical oversight of continuing education programs ~~must~~ shall meet the Education Medical Advisor criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight."

History Note: *Authority G.S. 143-508(d)(4); 143-508(d)(13);*

Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

10A NCAC 13P .0602 is proposed for amendment as follows:

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

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

(1) EMS Educational Institutions shall complete a minimum of two initial courses at the highest level educational program approved for the Educational Institution's credential approval period.

(2) EMS Educational Institutions that do not complete two initial courses for each educational program approved shall be subject to action as set forth in Rule .1505 of this Subchapter.

(b) For initial courses, Basic EMS Educational Institutions shall meet all of the requirements for continuing EMS educational programs defined in Rule .0601 of this Section and shall have:

(1) ~~at least~~ a Level I or higher EMS Instructor as each lead course instructor for all courses. The lead course instructor must be credentialed at a level equal to or higher than the course and shall meet the lead instructor responsibilities ~~under Standard III~~ of the CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services ~~Professions.~~ Professions as set forth in Rule .0501 of this Subchapter. The lead instructor shall:

(A) perform duties assigned under the direction and delegation of the program director.

(B) assist in coordination of the didactic, lab, clinical, and field internship instruction.

(2) a lead EMS educational program coordinator. This individual shall be a Level II EMS Instructor credentialed at or above the highest level of course offered by the ~~institution,~~ institution. Newly appointed program coordinators who have not attended an OEMS Program Coordinator Workshop with the past year shall attend a workshop within one year of appointment as the program coordinator; and:

(A) have EMS or related allied health education, training, and experience;

(B) be knowledgeable about methods of instruction, testing, and evaluation of students;

(C) have field experience in the delivery of pre-hospital emergency care;

(D) have academic training and preparation related to emergency medical services, at least equivalent to that of a paramedic; and

(E) be knowledgeable of current versions of the National EMS Scope of Practice and National EMS Education Standards as defined by USDOT NHTSA National EMS, evidence-informed clinical practice, and incorporated by Rule .0501 of this ~~Section;~~ Subchapter;

(3) a lead EMS educational program coordinator responsible for the following:

(A) the administrative oversight, organization, and supervision of the program;

(B) the continuous quality review and improvement of the program;

(C) the long-range planning on ongoing development of the program;

(D) evaluating the effectiveness of the instruction, faculty, and overall program;

(E) the collaborative involvement with the Education Medical Advisor;

(F) the training and supervision of clinical and field internship preceptors; and

(G) the effectiveness and quality of fulfillment of responsibilities delegated to another qualified individual;

(4) written educational policies and procedures that include:

(A) the written educational policies and procedures set forth in Rule .0601 of this Section;

(B) the delivery of cognitive and psychomotor examinations in a manner that will protect and limit the potential for exploitation of such content and material;

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

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

(E) the selection and monitoring of all educational institutionally approved clinical education and field internship preceptors;

(F) utilization of EMS preceptors providing feedback to the student and EMS program;

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

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

(I) completion of an annual evaluation of the program to identify any correctable deficiencies;

(J) the program annually assesses goals and learning domains that include how program staff identify and respond to changes in the needs or expectations of the community's interests; and

(K) an advisory committee representing all practice settings utilizing EMS personnel, including clinical preceptor sites, shall assist the program to monitor community needs and expectations and provide guidance to revise goals and responsiveness to change. The advisory committee shall meet no less than annually.

(5) 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" who is responsible for the following;

(A) medical oversight of the program;

(B) collaboration to provide appropriate and updated educational content for the program curriculum;

(C) establishing minimum requirements for program completion;

(D) oversight of student evaluation, monitoring, and remediation as needed;

(E) ensuring entry level competence;

(F) ensuring interaction of physician and students; 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) For initial courses, Advanced Educational Institutions shall meet all requirements set forth in Paragraph (b) of this Rule, Standard III of the CAAHEP Standards and Guidelines for the Accreditation of Educational Programs in the Emergency Medical Services Professions shall apply, and;

(1) The faculty must be knowledgeable in course content and effective in teaching their assigned subjects, and capable through academic preparation, training, and experience to teach the courses or topics to which they are assigned.

(2) A faculty member to assist in teaching and clinical coordination in addition to the program coordinator.

(d) The educational institution shall notify the OEMS within 10 business days of a change to the program coordinator or Medical Advisor position. The educational institution shall submit the change to the OEMS as an addendum to the approved Educational Institution application within 30 days of the effective date of the position change.

~~(d)~~(e) Basic and Advanced EMS Educational Institution credentials shall be valid for a period of four years, unless the institution is accredited in accordance with Rule .0605 of this Section.

History Note: *Authority G.S. 143-508(d)(4); 143-508(d)(13);*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

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

10A NCAC 13P .0904 INITIAL DESIGNATION PROCESS

(a) For initial Trauma Center ~~designation,~~ designation or changing the level of 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 or more trauma patients 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 of this Subchapter, and submit data weekly to the OEMS ~~weekly a minimum~~ of 12 months or more prior to application that includes all the Trauma Center's trauma patients as defined in Rule .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 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 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~~ no later than 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.~~ days. The hospital and the OEMS shall agree on the date of the site visit.

(k) Except for OEMS representatives, ~~any in-state reviewer~~ reviewers 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;~~ surgeon;

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

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

~~(6)~~(5) OEMS Staff.

(l) All site team members for a Level III ~~visit shall be from in-state, and,~~ visit 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~~ ACS 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,~~ center 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 nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes;~~ manager; and

(4) OEMS Staff.

(m) ~~On the day of the site visit, the~~ 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 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;
Amended Eff. April 1, 2024; July 1, 2018.

10A NCAC 13P .0905 is proposed for amendment as follows:

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 by the ACS, in conjunction with the OEMS, to obtain a 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. The hospital shall, within 10 business days of receipt of the RFP, define for OEMS the Trauma Center's trauma primary catchment area.

(2) hospitals shall complete and submit 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 of this Section as it relates to the Trauma Center's level of designation.

(3) all criteria defined in Rule .0901 of this Section, as it 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 hospital and the OEMS shall agree on the date of the site visit.

(5) the composition of a Level I or II site survey team shall be the same as that specified in ~~Rule.0904(k)~~ Rule .0904 of this Section.

(6) the composition of a Level III site survey team shall be the same as that specified in ~~Rule .0904(l)~~ Rule .0904 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. The primary reviewer shall complete and submit to the OEMS a written consensus report within 30 days of the site visit.

(9) the report of the site survey team and a staff recommendation shall be reviewed by the NC 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 NC Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center renewal be:

(A) approved;

(B) approved with a contingency(ies) due to a deficiency(ies) requiring a focused review;

(C) approved with a contingency(ies) not due to a deficiency(ies) requiring a consultative visit; or

(D) denied.

(10) hospitals with a deficiency(ies) shall have up to 10 business days prior to the NC Emergency Medical Services 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 NC Emergency Medical Services Advisory Council meeting, the hospital shall be given 12 months by the OEMS to demonstrate compliance and undergo a focused review that may require an additional site visit. The

need for an additional site visit is on a case-by-case basis based on the type of deficiency. 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 12 month time period, 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 in writing of the NC Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the NC Emergency Medical Services Advisory Council meeting.

(13) hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 business days following receipt of the written final decision on the trauma recommendations.

(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 shall notify the OEMS of its intent to undergo an ACS verification visit. It shall simultaneously define in writing to the OEMS its trauma primary catchment area. Trauma Centers choosing this option shall then comply with all the ACS' verification procedures, as well as any additional state criteria as defined in Rule .0901 of this Section, that apply to their level of designation.

(2) when completing the ACS' documentation for verification, the Trauma Center shall ensure access to the ACS on-line PRQ (pre-review questionnaire) to OEMS. The Trauma Center shall simultaneously complete any documents supplied by OEMS and forward these to the OEMS.

(3) the Trauma Center shall 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 NC Emergency Medical Services Advisory Council meeting to ensure that the Trauma Center's state designation period does not terminate without consideration by the NC Emergency Medical Services Advisory Council.

(4) 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.

(5) the composition of a Level I, II, or III 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 the primary reviewer;

(B) one ~~out-of-state~~ emergency physician who 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;

(C) one ~~out-of-state~~ trauma program ~~manager with an equivalent license from another state;~~ manager; and

(D) OEMS staff.

(6) the date, time, and all proposed members of the site visit team shall 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 visit team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site visit team member associated with the site visit.

(7) all state Trauma Center criteria shall be met as defined in Rule .0901 of this Section for renewal of state designation. ACS' verification is not required for state designation. ACS' verification does not ensure a state designation.

(8) The ACS final written report and supporting documentation described in Subparagraph (c)(4) of this Rule shall be used to generate a report following the post conference meeting for presentation to the NC Emergency Medical Services Advisory Council for renewal designation.

(9) the final written report issued by the ACS' verification review committee, the accompanying medical record reviews from which all identifiers shall be removed and cover letter shall be forwarded to OEMS within 10 business days of its receipt by the Trauma Center seeking renewal.

(10) the OEMS shall present its summary of findings report to the NC Emergency Medical Services Advisory Council at its next regularly scheduled meeting. The NC Emergency Medical Services Advisory Council shall recommend to the Chief of the OEMS that the request for Trauma Center renewal be:

(A) approved;

(B) approved with a contingency(ies) due to a deficiency(ies) requiring a focused review;

(C) approved with a contingency(ies) not due to a deficiency(ies); or

(D) denied.

(11) the OEMS shall send the hospital written notice of the NC Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the NC Emergency Medical Services Advisory Council meeting.

(12) the final decision regarding trauma center designation shall be rendered by the OEMS.

(13) hospitals with contingencies as the result of a deficiency(ies), as determined by OEMS, shall have up to 10 business days prior to the NC Emergency Medical Services Advisory Council meeting to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this time period, the hospital, may undergo a focused review to be conducted by the OEMS whereby the Trauma Center shall be given 12 months by the OEMS to demonstrate compliance. Satisfaction of contingency(ies) may require an additional site visit. The need for an

additional site visit is on a case-by-case basis based on the type of deficiency. 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 three-year period from the previous designation's expiration date. If compliance is not demonstrated within the 12 month time period, 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.

(14) hospitals with a deficiency(ies) shall submit an action plan to the OEMS to address the deficiency(ies) within 10 business days following receipt of the written final decision on the trauma recommendations.

(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.

History Note: *Authority G.S. 131E-162; 143-508(d)(2);*
Temporary Adoption Eff. January 1, 2002;
Eff. April 1, 2003;
Amended Eff. April 1, 2009; January 1, 2009; January 1, 2004;
Readoption Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

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:~~ Institution. An Educational Institution denied initial designation shall not be eligible to reapply to the OEMS for two years. Reasons for denial are:

(1) significant failure to comply with the provisions of Sections .0500 and .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 Sections .0500 and .0600 of this Subchapter within six months or less.

(d) The Department shall amend, suspend, or 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 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 six 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 of this Subchapter;

(4) the EMS Educational Institution failed to meet the requirements of a focused review within six 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 action taken on the Institution designation. 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. April 1, 2024; July 1, 2021; July 1, 2018; January 1, 2017.

10A NCAC 13P .1507 is proposed for amendment as follows:

10A NCAC 13P .1507 EMS PERSONNEL CREDENTIALS

(a) Any EMS credential that has been forfeited under G.S. 15A-1331.1 may not be reinstated until the person has complied with the court's requirements, has petitioned the Department for reinstatement, has completed the disciplinary process, and has received Department reinstatement approval.

(b) The Department shall amend, deny, suspend, or revoke the credentials of EMS personnel for any of the following:

(1) significant 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 concealing information in connection with an application for credentials;

(3) making false statements or representations, concealing information, or failing to respond 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 significant failure to comply with the rules relating to the 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 that will compromise skill and safety, use of alcohol, drugs, chemicals, or any other type of material, or by reason of any physical impairment;

(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 theft or false representations, obtaining or attempting to obtain, money or anything of value from a patient, EMS Agency, or educational institution;

(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 a 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) delay or failure to respond when on-duty and dispatched to a call for EMS assistance;

(17) testing positive, whether for-cause or at random, through urine, blood, or breath sampling, for any substance, legal or illegal, that is likely to impair the physical or psychological ability of the credentialed EMS personnel to perform all required or expected functions while on duty;

(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;

(19) refusing to consent to any criminal history check required by G.S. 131E-159;

(20) abandoning or neglecting a patient who is in need of care, without making arrangements for the continuation of such care;

(21) falsifying a patient's record or any controlled substance records;

(22) harassing, abusing, or intimidating a patient, student, ~~bystander,~~ EMS personnel, other allied healthcare personnel, student, educational institution staff, members of the public, or OEMS staff, either physically, verbally, or in writing;

(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;

(24) any criminal arrests that involve charges that 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;

(25) altering, destroying, or attempting to destroy evidence needed for a complaint investigation being conducted by the OEMS;

(26) significant failure to comply with 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;

(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) significant failure to comply to provide EMS care records to the licensed EMS provider for submission to the OEMS as required by Rule .0204 of this Subchapter;

(29) continuing to provide EMS care after local suspension of practice privileges by the local EMS System, Medical Director, or Alternative Practice Setting;

(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;

(31) diversion of any medication requiring medical oversight for credentialed EMS personnel; ~~or~~

(32) filing a knowingly false complaint against an individual, EMS Agency, or educational ~~institution.~~ institution; or

(33) failure to comply with educational requirements defined in Sections .0500 and .0600 of this Subchapter.

(c) Pursuant to the provisions of G.S. 131E-159(h), the OEMS shall not issue an EMS credential for any person listed on the North Carolina Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration if committed at a time when the registration would have been required by law.

(d) Pursuant to the provisions of G.S. 50-13.12, upon notification by the court, the OEMS shall revoke an individual's EMS credential until the Department has been notified by the court that evidence has been obtained of compliance with a child support order. The provisions of G.S. 50-13.12 supersede the requirements of Paragraph (f) of this Rule.

(e) When a person who is credentialed to practice as an EMS professional is also credentialed in another jurisdiction and the 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 N.C. 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 of the amendment, denial, suspension, or 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 have been violated; and

(3) notice of the individual's right to a contested hearing, set forth in Rule .1509 of this Section, on the revocation of the credential.

(g) 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.

(h) The EMS System Administrator, Primary Agency Contact, Medical Director, Educational Institution Program Coordinator, or Medical Advisor shall notify the OEMS of any violation listed in Paragraph (b) of this ~~Rule.~~ Rule within 30 days of discovery of the violation or upon completion of the internal agency or EMS system investigation.

History Note: *Authority G.S. 131E-159; 143-508(d)(10); 143-519;*
Eff. January 1, 2013;
Readopted Eff. January 1, 2017;
Amended Eff. April 1, 2024; July 1, 2021.

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

SECTION .0300 - ADMINISTRATION

10A NCAC 13L .0301 WRITTEN POLICIES AND PROCEDURES

(a) The nursing pool shall have written administrative and personnel policies to govern the services that it provides. These policies shall include those concerning patient care, personnel, training and orientation, supervision, employee evaluation, and organizational structure.

(b) At the option of the licensee, written policies and procedures may address other services not subject to the Nursing Pool Licensure Act. The Division shall not require separate policies and procedures if the premises from which nursing pool services are offered also offers additional temporary nursing services not subject to licensure.

(c) Policies shall provide that no reprisal action shall be taken against any employee who reports instances of patient rights violations or patient abuse, ~~neglect~~ neglect, or exploitation to the appropriate governmental authority.

(d) The nursing pool shall retain all administrative records for five years and shall make these records available to the Division upon request. Administrative records shall include:

(1) documents evidencing control and ownerships, such as corporation or partnership papers;

(2) policies and procedures governing the operation of the agency;

(3) minutes of the agency's professional and administrative staff meetings;

(4) reports of complaints, inspections, reviews, and corrective actions taken related to licensure; and

(5) contracts and agreements to which the agency is a party.

History Note: *Authority G.S. 131E-154.4;*
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, ~~2015.~~ 2015;
Amended Eff. April 1, 2024.

10A NCAC 13L .0302 is proposed for amendment as follows:

10A NCAC 13L .0302 PERSONNEL RECORDS

(a) A nursing pool shall maintain a personnel record on each individual.

(b) Each individual's personnel record shall include:

(1) A legible copy of ~~a current~~ an unexpired license verification to practice nursing as a registered nurse or a licensed practical nurse or ~~a current~~ an unexpired Nurse Aide I or Nurse Aide II ~~Listing Card issued by the North Carolina Board of Nursing.~~ listing verification.

(2) A completed job application with employment history, training, ~~education and continuing education.~~ education, continuing education, and identification data including name, address, and telephone number.

(3) Results of reference checks.

(4) Performance evaluations ~~at least~~ annually. The annual performance evaluation shall include feedback from the health care facility of the on-site performance of contracted nursing personnel.

(c) Personnel records shall be maintained for one year after termination from agency employment.

History Note: *Authority G.S. 131E-154.4;*
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, ~~2015.~~ 2015;
Amended Eff. April 1, 2024.

Fiscal Impact Analysis of Permanent Rule Amendment without Substantial Economic Impact

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Agency:	North Carolina Medical Care Commission Division of Health Service Regulation Acute Care Licensure and Certification Section	
Rule Citation(s):	10A NCAC 13L .0301 Written Policies and Procedures 10A NCAC 13L .0302 Personnel Records (see rule text in Appendix A)	
Agency Contact:	Nadine Pfeiffer, DHSR Rules Review Manager – 919-855-3811 Azzie Conley, Section Chief, Acute and Home Care Licensure & Certification – 919-855-4646 Greta Hill, Assistant Section Chief, Acute and Home Care Licensure & Certification – 919-855-4635	
Rulemaking Authority:	G.S. 131E-154.4	
Impact Summary:	State Government: Local Government: Private Entities: Substantial Impact:	No Impact No Impact Yes No Impact

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Introduction and Purpose

In response to a Petition for Rulemaking regarding North Carolina Nursing Pool agencies and pursuant to N.C. General Statute150B-20(c), N.C. General Statute section 131E-154.1 to 154.8 the Department of Health and Human Services proposes to amend existing rules set forth at 10A NCAC 13L Rules Governing the Licensure of Nursing Pools.

This fiscal analysis addresses two rules proposed for amendment. The rule amendments require a retention period for records and require a policy for annually assessing the performance of nursing personnel assigned to health care facilities. In addition, technical and formatting revisions have been made and rule language has been amended to be consistent with updated terminology.

Currently, there are 436 Nursing Pool agencies that are licensed to provide nursing personnel to North Carolina facilities. A Nursing Pool is any person, firm, corporation, partnership, or association engaged for hire in the business of providing or procuring temporary employment for nursing personnel in health care facilities. It should be noted that many of these Nursing Pool agencies are headquartered outside of North Carolina but provide personnel to North Carolina healthcare facilities. All of these agencies are privately owned. Nursing personnel includes nurses, nursing assistants, nurse aides, and orderlies. Nursing personnel shortages exacerbated during the COVID-19 pandemic resulted in health care facilities relying on Nursing Pools to provide staff for the care of patients and residents. The increase in the use of nursing pools resulted in a rise in the percentage of nursing care being provided by nursing personnel from nursing pools and caused health care facilities to prioritize improvements to regulation of Nursing

Pool agencies. There are numerous states currently engaged in the process of enhancing regulation of nursing pool agencies including Connecticut, Iowa, Illinois, Louisiana, Oregon, Ohio, and Pennsylvania.

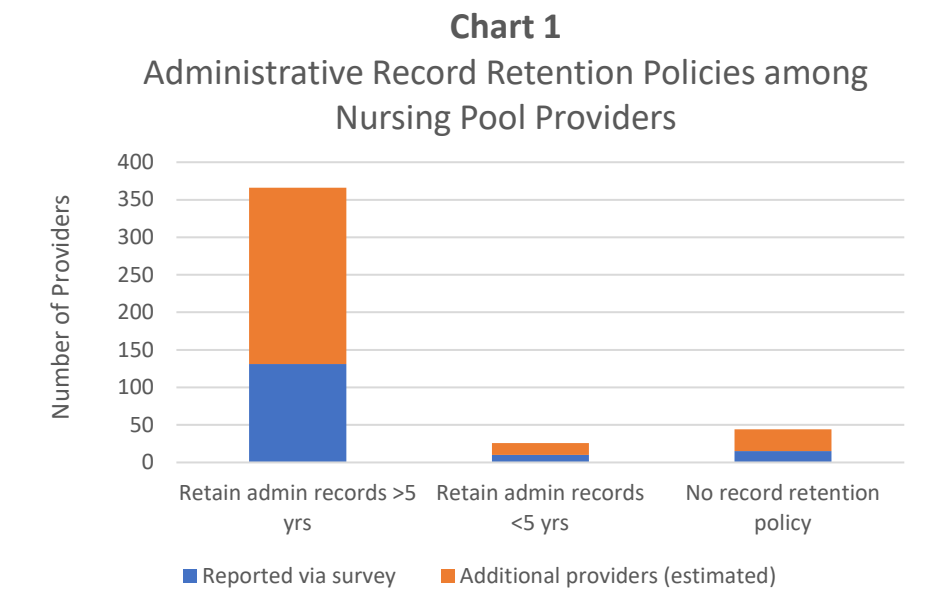
Description of Proposed Rules and Anticipated Fiscal Impact

Rule 10A NCAC 13L .0301- Written Policies and Procedures

The agency is proposing to amend this rule with substantive changes. This rule establishes the criteria for written policies and procedures. The agency is amending the rule to require the nursing pool to retain administrative records for a period of five years. The change will list the type of administrative documents the nursing pool must keep and how long they must keep them.

In September 2022, DHSR surveyed 436 Nursing Pool providers to inquire about their retention period policy for administrative documents. 156 Nursing Pool providers responded to the survey (about 36% of total providers). Of those, 141 (about 90% of respondents) reported they already have an established retention period for administrative documents that is written in the contract, policies and procedures, or both.

The vast majority of providers with an existing retention policy reported having a retention period of five to ten years. Only 10 providers (about 6% of survey respondents) reported having a retention period of less than the proposed five years. 15 providers (about 10% of survey respondents) reported that they did not have any established retention period. In the absence of survey responses from all 436 Nursing Pool providers, we assumed that the relative proportions of responding providers with and without retention policies was representative of the total population of providers. Using this assumption, we estimated that about 366 of the 436 licensed NC providers will already be compliant with the proposed retention requirement, 26 will need to increase their existing requirement to meet or exceed five years, and 44 will need to adopt a new retention policy.



A review of other states' regulations for nursing pools revealed no retention period requirement at all (as of September 2022).

For the majority of Nursing Pool providers licensed in North Carolina, adding the proposed requirement for a five-year retention period should have no additional impact on their existing record keeping practice. For the relatively small proportion of Nursing Pool providers that currently have either no retention period or a retention period of less than five years, they will be required to revise their policies and procedures to comply. There should be no fiscal impact to these providers other than a minimal one-time expenditure of time to revise their contract and policies/ procedures documentation and establish an internal process for keeping these records.

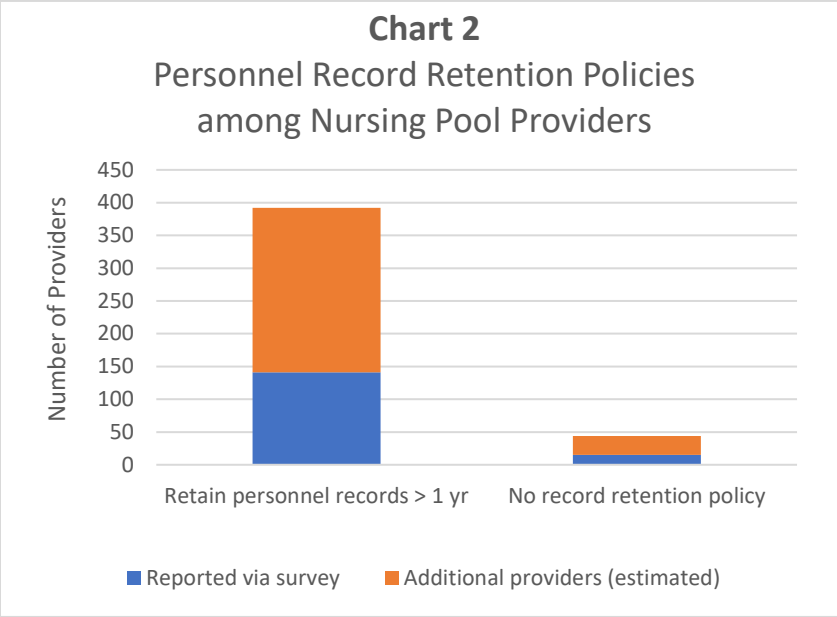
Rule 10A NCAC 13L .0302 - Personnel Records

The agency is proposing to amend this rule with substantive changes. This rule establishes the criteria for Nursing Pool personnel records and the content of personnel records. The current rule requires a completed job application and an annual performance evaluation for each individual employee. The agency is updating the rule to clarify the identification data to be included on the job application. This change will ensure the nursing pool gathers consistent data on all applicants. This change will not result in any impacts to Nursing Pool providers as this is already standard practice.

In addition, the agency is proposing a new requirement that will make it mandatory that the annual performance evaluation include feedback from the health care facility for assigned nursing personnel. This change should enable the Nursing Pool providers to better assess the satisfaction of the health care facility with each assigned nursing personnel's services, and competencies. Nursing Pool nursing personnel are evaluated after every assignment in the general areas of adaptability, communication, dependability, punctuality, documentation, overall clinical skills and job performance. Nursing Pool agencies obtain feedback from Clinical Site Managers via various methods such as periodic phone calls, emails, site visits, and customer surveys. The method used to collect feedback is determined by agency policy. Adding this requirement would improve the quality of nursing care, improve patient/customer experience, and help Nursing Pools address issues as they arise and prevent future issues that could lead to poor and unsafe care for patients.

Lastly, the agency is amending the rule to require the nursing pool to retain personnel records for a period of one year after termination. The change will establish a minimum for how long the nursing pool must keep employee files after termination. The U.S Equal Employment Opportunity Commission (EEOC) requires employers to retain personnel records for one year from the date of termination. Guidelines may vary from state to state but they complement and mirror federal requirements.

According to the 2022 survey by DHSR, about 90% of the Nursing Pool providers who responded indicated they already have a policy to retain personnel records for at least one year. Providers reported personnel record retention periods that varied from one to seven years. About 10% of survey respondents reported having no personnel record retention policy. A review by DHSR of other states' regulations for nursing pools reveals no retention period requirements for personnel records at all.



For the majority of Nursing Pool providers licensed in North Carolina, adding the proposed requirement for a one-year retention period for personnel records should have no additional impact on their existing record keeping practice. For the relatively small proportion of Nursing Pool providers that currently have no retention period for personnel records, they will be required to revise their policies and procedures to comply. There should be no fiscal impact to these providers other than a minimal one-time expenditure of time to revise their contracts and policies/procedures documentation and establish an internal process for keeping these records. The exact cost will vary and depends on the method the Nursing Pool agency chooses to retain files (manual/digital). We can assume the cost of retaining a paper document is more than a digital document.

Summary

The proposed amendments should result in minimal costs to a small number of currently licensed Nursing Pool providers in the form of time spent revising policies and procedures and implementing new internal record retention processes. Ultimately, the goal of the proposed changes is to benefit the patient community by promoting consistency in regulation among Nursing Pool providers and strengthening the existing evaluation processes for nursing personnel employed by these providers. These small, but meaningful, improvements will help to assure quality care, improve patient safety, and provide accountability for Nursing Pool agencies.

Appendix A

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

SECTION .0300 - ADMINISTRATION

10A NCAC 13L .0301 WRITTEN POLICIES AND PROCEDURES

(a) The nursing pool shall have written administrative and personnel policies to govern the services that it provides. These policies shall include those concerning patient care, personnel, training and orientation, supervision, employee evaluation, and organizational structure.

(b) At the option of the licensee, written policies and procedures may address other services not subject to the Nursing Pool Licensure Act. The Division shall not require separate policies and procedures if the premises from which nursing pool services are offered also offers additional temporary nursing services not subject to licensure.

(c) Policies shall provide that no reprisal action shall be taken against any employee who reports instances of patient rights violations or patient abuse, ~~neglect~~ neglect, or exploitation to the appropriate governmental authority.

(d) The nursing pool shall retain all administrative records for five years and shall make these records available to the Division upon request. Administrative records shall include:

(1) documents evidencing control and ownerships, such as corporation or partnership papers;

(2) policies and procedures governing the operation of the agency;

(3) minutes of the agency's professional and administrative staff meetings;

(4) reports of complaints, inspections, reviews, and corrective actions taken related to licensure; and

(5) contracts and agreements to which the agency is a party.

History Note: *Authority G.S. 131E-154.4;*
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, ~~2015.~~ 2015;
Amended Eff. April 1, 2024.

10A NCAC 13L .0302 is proposed for amendment as follows:

10A NCAC 13L .0302 PERSONNEL RECORDS

(a) A nursing pool shall maintain a personnel record on each individual.

(b) Each individual's personnel record shall include:

(1) A legible copy of ~~a current~~ an unexpired license verification to practice nursing as a registered nurse or a licensed practical nurse or ~~a current~~ an unexpired Nurse Aide I or Nurse Aide II ~~Listing Card issued by the North Carolina Board of Nursing.~~ listing verification.

(2) A completed job application with employment history, training, ~~education and continuing education.~~ education, continuing education, and identification data including name, address, and telephone number.

(3) Results of reference checks.

(4) Performance evaluations ~~at least~~ annually. The annual performance evaluation shall include feedback from the health care facility of the on-site performance of contracted nursing personnel.

(c) Personnel records shall be maintained for one year after termination from agency employment.

History Note: *Authority G.S. 131E-154.4;*
Eff. January 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. June 20, ~~2015.~~ 2015;
Amended Eff. April 1, 2024.