NC DEPARTMENT OF HEALTH AND HUMAN SERVICES

ROY COOPER • Governor
KODY H. KINSLEY • Secretary
MARK PAYNE • Director, Division of Health Service Regulation

MEMORANDUM

DATE: September 15, 2023

TO: Interested Parties

FROM: Nadine Pfeiffer, Rule Review Manager

RE: Proposed Amendment of Emergency Medical Services and Trauma Rules
10A NCAC 13P

G.S. 150B-21.2 requires a rule-making body to notify certain individuals of its intent to adopt a permanent rule. It also requires notification of the date, time and location of the public hearing on the rule and any fiscal note that has been prepared in connection with the proposed rule. The rules are being amended for regulated entities for emergency medical services and trauma systems.

The North Carolina Medical Care Commission has submitted form OAH 0300 to the Codifier of Rules, Office of Administrative Hearings, indicating their intent to proceed with the following rule-making actions:

> Amend the following 25 Emergency Medical Services and Trauma 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, and .1507.

In accordance with G.S. 150B-21.4, approval of the fiscal note was received for these rules from the Office of State Budget and Management on July 3, 2023.

The proposed rule text is attached to this memo and were published in today's September 15, 2023 edition of the N.C. Register which can be found at the Office of Administrative Hearings web site at https://www.oah.nc.gov/rules-division/north-carolina-register.

A public hearing is scheduled for November 8, 2023 at 2:00 p.m. in Room 131, Wright Building, 1201 Umstead Drive, Raleigh, NC 27603. The building is in the Dorothea Dix Park. Ms. Nadine Pfeiffer, DHSR Rule-Review Manager, is accepting public comments on these rules and fiscal note from September 15, 2023 through November 14, 2023, close of business. Comments will also be accepted in person at the public hearing. The proposed effective date of these rules is April 1, 2024.

A copy of the proposed rules, fiscal note, and instructions for submitting comment can be found at the Division of Health Service Regulation web site at https://info.ncdhhs.gov/dhsr/ruleactions.html.

Please feel free to contact the Office of Emergency Medical Services at (919) 855-3750 should you have questions related to this memorandum or the proposed rule and fiscal note.

Enclosures

cc: John Meier, IV, MD, Chair, N.C. Medical Care Commission
Mark Payne, Director, Health Service Regulation
Emery Milliken, Deputy Director, DHSR
Raj Premakumar, Deputy General Counsel, DHHS
Tom Mitchell, Chief, OEMS
Wally Ainsworth, Regional Manager, OEMS
Chuck Lewis, Assistant Chief, OEMS

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. 20-125. 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.

(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; and

~~(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; and

(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.

~~(c)~~(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.