STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603 EDGERTON BUILDING
CONFERENCE ROOM - 026A
Or
Via Microsoft Teams: Click here to join the meeting
Or
Via Teleconference: 1-984-204-1487 / Passcode: 597 021 567#

Friday, May 14, 2021

9:00 a.m.

AGENDA

I. Meeting Opens – Roll Call

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

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

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

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

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

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

- **February 11-12, 2021 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**

- **February 22, 2021 (Executive Committee Meeting)** – To approve an Amended and Restated Master Trust Indenture for the Appalachian Regional Hospital System Obligated Group. **(See Exhibit B/1)**

- **March 4, 2021 (Executive Committee Meeting) –** To approve (1) amendments to Hugh Chatham Memorial Hospital, Inc.'s Series 2015 Trust Agreement, and authorize (2) the sale and issuance of Series 2021A revenue refunding bonds for Vidant Health. **(See Exhibit B/2)**

- **March 10, 2021 (Medical Care Commission Meeting)** – To approve temporary rules for Adult Care Homes & Family Care Homes. **(See Exhibit A/1)**

- **April 12, 2021 (Executive Committee Meeting)** – To approve (1) amendments to Novant Health's Master Trust Indenture and (2) grant preliminary approval for a Lutheran Services for the Aging, Inc refunding. **(See Exhibit B/3)**

- **April 29, 2021 (Executive Committee Meeting)** – To approve amendments to Hugh Chatham Memorial Hospital, Inc.'s Series 2008 Trust Agreement. **(See Exhibit B/4)**

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

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

B. The following notices and non-action items were received by the Executive Committee:

April 1, 2021 – Appalachian Regional Health System, Series 2018 (Conversion)
- Par Value: $29,515,000
- Taxable Bonds converted to Tax-Exempt Bonds
- Bank Purchaser: PNC Bank

April 2, 2021 – Hugh Chatham Memorial Hospital, Series 2015 (Conversion)
- New interest rate for Medium-Term Period

April 7, 2021 – Cone Health Series 2011A (Redemption)
- Par Value Outstanding: $16,310,000
- Funds provided by: Private bank loan

May 3, 2021 – Hugh Chatham Memorial Hospital, Series 2008 (Conversion)
- New LIBOR Index Rate
- New Holding Period: April 30, 2031
- New Bank Holder: First National Bank of Pennsylvania

VII. Bond Projects (Action Items)

A. Arbor Acres United Methodist Retirement Community (Winston-Salem)…….G. Knapp

Compliance Summary:

- **<u>No Violation of MCC Compliance policy</u>**

1) Does Organization have a formal post tax issuance compliance policy?

   Yes

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?

   David Matthews, CFO

3) What is the Organization's compliance monitoring plan?

The Bond Compliance Officer will review these practices and procedures and consult with bond counsel and/or Borrower's outside counsel regarding any revisions that are necessary and appropriate:

- **Annually, in connection with the preparation of Schedule K to Form 990; and**
- **Promptly, after**
  - **the issuance of any additional bonds by the Issuer for the benefit of the Borrower,**
  - **the establishment of a refunding or defeasance escrow for any bonds issued by the Issuer for the benefit of the Borrower, or**
  - **the retirement of a bond issue issued by the Issuer for the benefit of the Borrower.**

The Bond Compliance Officer shall propose any such revisions to the Borrower's chief executive officer for review and approval. If these practices and procedures are revised, the Bond Compliance Officer shall distribute the revised version of these practices and procedures to all relevant officers, employees and counsel.

4) How will the Organization report compliance deficiencies to leadership and the Board?

Board is notified on an annual basis of any deficiencies and leadership is made aware on a timely basis.

Selected Application Information:

1) Information from FYE 2020 (12/31 Year End) Audit of Arbor Acres:

Net Income	$ 2,758,790
Operating Revenue	$ 37,906,122
Operating Expenses	$ 35,874,031
Net Cash provided by Operating Activities	$ 9,621,465
Change in Net Assets	$ 4,806,877
Unrestricted Cash	$ 3,574,579
Change in Cash	$ 284,992

2) Ratings:

Fitch – BBB+ Outlook Stable

3) Community Benefits (FYE 2019):

Per N.C.G.S § 105 – 5.76% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $1,874,868

4) Long-Term Debt Service Coverage Ratios:

Actual FYE 2020	2.78
Forecasted FYE 2021	3.04
Forecasted FYE 2022	3.26
Forecasted FYE 2023	3.67
Forecasted FYE 2024	2.87

5) Transaction Participants:

Bond Counsel:	Robinson, Bradshaw, & Hinson, P.A.
Underwriter:	B.C. Ziegler and Company
Underwriter Counsel:	Parker Poe Adams & Bernstein LLP
Accountant (AUP Forecast):	Dixon Hughes Goodman LLP
Bank Purchaser:	Truist Bank
Bank Counsel:	Moore & Van Allen, PLLC
Trustee:	TBD
Trustee Counsel:	TBD

6) Other Information:

(a) Board diversity

Male:	11
Female:	8
Total:	19

Caucasian:	15
African American:	4
	19

(b) Diversity of residents

Male:	171	Caucasian:	513
Female:	348	Asian/American Indian:	6
Total:	519	Total:	519

(c) Fee Schedule & MCC Bond Sale Approval Policy (See Exhibit E)

Resolution: The Commission grants preliminary approval for the Arbor Acres United Methodist Retirement Community, Inc. project to (1) provide funds to be used, together with other available funds, to ***refund*** the $28,473,682.10 NC Medical Care Commission **Series 2010** bonds, outstanding in the amount of $23,935,000, (2) provide funds to be used, together with other available funds, to ***refund*** the $13,159,000 NC Medical Care Commission **Series 2016** bonds, outstanding in the amount of $9,706,000, (3) provide funds to be used, together with other available funds, to refund a private taxable loan, outstanding in the amount of $7,915,332, and (4) provide funds to ***construct*** the following:

- 56 New Independent Living Apartments (1 Building)

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$ 99,000,000
Total Sources	**$ 99,000,000**

ESTIMATED USES OF FUNDS

Construction Contracts	$ 45,444,949
Construction Contingency (1% of Construction Contracts)	2,643,409
Low Voltage	997,133
Construction Monitor	265,000
Entitlements	190,537
Architect Fees	2,390,549
Refund Series 2010, Series 2016, and Private Loan	40,731,148
Termination of Interest Rate Swaps	2,870,996
Swap Advisor	30,000
Furniture/Fixtures/Art	324,407
Marketing	900,000
Bond Interest during Construction	1,143,822
Underwriter Discount/Placement Fee	339,300
Accountant Fee	20,000
Corporation Counsel	80,000
Bond Counsel	95,000
Rating Agency	75,000
Trustee Fee & Counsel	12,500
Printing Cost	7,500
Local Government Commission	8,750
Underwriter Counsel	55,000
Placement Agent	165,000
Bank Origination	110,000
Bank Counsel	50,000
Survey/Title/Insurance	50,000
Total Uses	**$ 99,000,000**

Tentative approval is given with the understanding that the governing board of Arbor Acres United Methodist Retirement Community accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Final financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is:

1.	Financially feasible	✓	Yes	_____	No	_____ N/A
2.	Construction and related costs are reasonable	✓	Yes	_____	No	_____ N/A

B. Plantation Village (Wilmington)……...…….……...……G. Knapp

Compliance Summary:

- **No Violation of MCC Compliance policy**

1) Does Organization have a formal post tax issuance compliance policy?

No

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?

Cara Arrans, Director of Finance

3) What is the Organization's compliance monitoring plan?

Adhere to tax certificate and loan documents and follow reporting requirements and covenants with monthly, quarterly, and annual procedures.

4) How will the Organization report compliance deficiencies to leadership and the Board?

Any deficiencies in compliance will be noted in writing to the Executive Director with a follow-up report to the Board of Directors.

Selected Application Information:

1) Information from FYE 2020 (12/31 Year End) Audit of Plantation Village:

Net Income	$ 4,335,549
Operating Revenue	$ 18,386,893
Operating Expenses	$ 15,664,833
Net Cash provided by Operating Activities	$ 6,608,734
Change in Net Assets	$ 2,067,790
Unrestricted Cash	$ 9,227,510
Change in Cash	$ 148,483

2) Ratings:

Rating Anticipated

3) Community Benefits (FYE 2020):

Per N.C.G.S § 105 – 2.75% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $98,600

4) Long-Term Debt Service Coverage Ratios:

Actual FYE 2020	4.50
Forecasted FYE 2021	9.52
Forecasted FYE 2022	5.63
Forecasted FYE 2023	6.44
Forecasted FYE 2024	5.27
Forecasted FYE 2024	1.85

5) Transaction Participants:

Bond Counsel:	Robinson, Bradshaw, & Hinson, P.A.
Underwriter:	Herbert J. Sims & Co., Inc.
Underwriter Counsel:	TBD
Accountant (AUP Forecast):	Dixon Hughes Goodman LLP
Bank Purchaser:	TBD
Bank Counsel:	TBD
Trustee:	TBD
Trustee Counsel:	TBD

6) Other Information:

(a) Board diversity

Male:	7
Female:	7
Total:	14

Caucasian:	13
African American:	1
	14

(b) Diversity of residents

Male:	96
Female:	190
Total:	286

Caucasian:	284
Female:	2
Total:	286

(c) Fee Schedule & MCC Bond Sale Approval Policy (See Exhibit F)

Resolution: The Commission grants preliminary approval for the Plantation Village, Inc. project to provide funds to be used, together with other available funds, to (1) refund private taxable construction loan, which is currently outstanding in the amount of $12,500,000, and to (2) ***construct*** and ***renovate*** the following:

- 4 buildings consisting of 44 Independent Living Apartments
  - 3 buildings will contain 12 Independent Living Apartments
  - 1 building will contain 8 Independent Living Apartments
- Renovate dining facilities; bistro; pub/bar; arts and crafts room; game room; marketplace; private dining; board room; cinema/classroom
- Relocate maintenance facilities; hobby shop; dog park; gardens

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$ 87,618,535
Total Sources	**$ 87,618,535**

ESTIMATED USES OF FUNDS

Construction Contracts	$ 50,442,365
Construction Contingency (1% of Construction Contracts)	464,438
Architect Fees	3,236,651
Land Acquisition Costs (Survey/Legal/Engineering) Fees	48,000
Utility Development	406,723
Refund Private Taxable Construction Loan	12,500,000
Moveable Equipment	306,000
Survey, Tests, Insurance	838,832
Consultant Fees (Zoning/Marketing/Legal/Design)	5,256,991
DHSR Reimbursables (G.S. § 131-E-267)	25,000
Bond Interest during Construction	7,907,070
Debt Service Reserve Fund	4,917,375
Underwriter Discount/Placement Fee	606,340
Feasibility Study Fee	150,000
Accountant Fee	30,000
Corporation Counsel	100,000
Bond Counsel	150,000
Rating Agency	85,000
Trustee Fee & Counsel	4,000
Printing Cost	10,000
Local Government Commission	8,750
Underwriter Counsel	125,000
Total Uses	**$ 87,618,535**

Tentative approval is given with the understanding that the governing board of Plantation Village, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Final financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall

constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is:

1.	Financially feasible	✓	Yes	_____	No	_____ N/A
2.	Construction and related costs are reasonable	✓	Yes	_____	No	_____ N/A

VIII. Old Business (Discuss Rules, Fiscal Note, and Comments submitted) **(Action Items)**

A. Rules for Adoption

1. Adult Care Home/FCH Rules……..…….Nadine Pfeiffer & Megan Lamphere

   Readoption of 4 rules following Periodic Review & Amendment of 1 rule – Phase 2 (Total of 5 rules)
   - Rules: 10A NCAC 13F .0403, .0406; 10NCAC 13G.0402, .0403, .0405
     (See Exhibits C thru C/3)

2. Emergency Medical Services and Trauma Rules…..….Nadine Pfeiffer & Tom Mitchell

   Amendment of 21 rules for education and credentialing
   - Rules: 10A NCAC 13P .0101, .0102, .0222, .0501, .0502, .0504, .0507, .0508, .0510, .0512, .0601, .0602, .0905, .1101, .1401, .1403, .1404, .1405, .01505, .1507, and .1511
     (See Exhibits C/4 thru C/6)

IX. New Business (Discuss Rules & Fiscal Note) **(Action Item)**

A. Rules for Initiating Rulemaking Approval

1. Adult Care Home/Family Care Home Rules…….…Nadine Pfeiffer & Megan Lamphere

   Readoption of 4 rules following Periodic Review, Amendment of 1 rule – Phase 2.5 (Total of 5 rules)
   - Rules: 10A NCAC 13F .0405, .0509, .1213; 10A NCAC 13G .0509, .1214
     (See Exhibits D thru D/3)

X. Appointment of Executive Committee Member (Action Item).....……..Dr. John Meier

The Chairman will appoint a member to serve out Mr. Al Lockamy's term on the Executive Committee, which will end on December 31, 2021.

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

<u>Recommended</u>:

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

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

WHEREAS, the Commission will not meet again until August 13, 2021 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and August 13, 2021.

XII. Meeting Adjournment

EXHIBIT A

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL CARE COMMISSION PLANNING SESSION
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE RALEIGH, NORTH CAROLINA 27603
CONFERENCE ROOM #026A – EDGERTON BUILDING
OR
MICROSOFT TEAMS VIDEO LINK: Click here to join the meeting
OR
DIAL-IN: 1-984-204-1487 PASSCODE: 240 553 921#

THURSDAY, FEBRUARY 11, 2021
3:00 P.M.

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
CONFERENCE ROOM - #026A - EDGERTON BUILDING
OR
MICROSOFT TEAM VIDEO LINK: Click here to join the meeting
OR
DIAL-IN: 1-984-204-1487 PASSCODE: 671 316 429#
Friday, February 12, 2021
9:00

FRIDAY, FEBRUARY 12, 2021
9:00 A.M.

MINUTES

I. MEETING ATTENDANCE – MCC PLANNING SESSION – FEBRUARY 11, 2021

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman	Anita L. Jackson, M.D.
Joseph D. Crocker, Vice-Chairman	Karen E. Moriarty
Kathy G. Barger	
Sally B. Cone	
Paul R.G. Cunningham, M.D.	
John A. Fagg, M.D.	
Bryant C. Foriest	
Linwood B. Hollowell, III	
Eileen C. Kugler, RN, MSN, MPH, FNP	
Ashley H. Lloyd, D.D.S.	
Albert F. Lockamy, Jr., RPh	
Stephen T. Morton	
Robert E. Schaaf, M.D.	
Neel G. Thomas, M.D.	
Jeffrey S. Wilson	

DIVISION OF HEALTH SERVICE REGULATION STAFF Mark Payne, DHSR Director/MCC Secretary Emery Milliken, DHSR Deputy Director Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Jeff Harms, Acting DHSR Construction Chief Tammy Sylvester, DHSR Construction Action Bethany Burgon, Attorney General's Office Kimberly Randolph, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR Jana Busick, Chief, Healthcare Personnel Registry Jammie Johnson, Healthcare Personnel Registry Beverly Speroff, Assistant Chief, Nursing Home Licensure Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC	

COMMISSION ACTION: *The Medical Care Commission held its planning meeting on Thursday, February 11, 2021 to review rules, have a presentation on CCRC Financial Feasibility* **(See Exhibit E)***, and a presentation on the MCC Process Review* **(See Exhibit F)**. *The agenda was referred without action to the Medical Care Commission meeting on Friday, February 12, 2021.*

II. MEETING ATTENDANCE – MCC PLANNING SESSION – FEBRUARY 12, 2021

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Kathy G. Barger Sally B. Cone Paul R.G. Cunningham, M.D. John A. Fagg, M.D. Bryant C. Foriest Linwood B. Hollowell, III Eileen C. Kugler, RN, MSN, MPH, FNP Ashley H. Lloyd, D.D.S. Albert F. Lockamy, Jr., RPh Karen E. Moriarty Stephen T. Morton Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Jeffrey S. Wilson **DIVISION OF HEALTH SERVICE REGULATION STAFF** Mark Payne, DHSR Director/MCC Secretary Emery Milliken, DHSR Deputy Director Geary W. Knapp, JD, CPA, Assistant Secretary, MCC	Anita L. Jackson, M.D.

Jeff Harms, Acting DHSR Construction Chief Bethany Burgon, Attorney General's Office Kimberly Randolph, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR Jana Busick, Chief, Healthcare Personnel Registry Jammie Johnson, Healthcare Personnel Registry Beverly Speroff, Assistant Chief, Nursing Home Licensure Tom Mitchell, Chief, Office of Emergency Medical Services Chuck Lewis, Office of Emergency Medical Services Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC **OTHERS PRESENT** Paul Billow, Womble Bond Dickinson (US), LLP Jon Mize, Womble Bond Dickinson (US), LLP David Hughes, Vidant Health John Cheney, Ponder & Co. Bradley Dills, Ponder & Co. Anita Holt, The Forest at Duke Karen Henry, The Forest at Duke Tad Melton, Ziegler Jennifer Wimmer, State Treasurer's Office	

III. Chairman's Comment……...Dr. John Meier

Dr. Meier thanked everyone for taking time out of their busy schedules to take part in the meeting today. He discussed the information and side effects of the COVID-19 Moderna and Pfizer vaccines with the Commission.

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

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

V. Ethics Statement…….Dr. John Meier

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

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

- **November 12-13, 2020 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**

- **December 9, 2020 (Full Commission Emergency Conference Call)** – To approve temporary rulemaking for Adult Care Home & Family Care Home Rules. **(See Exhibit A-1)**

- **January 21, 2021 (Executive Committee Conference Call)** – To approve the final sale of bonds for CaroMont Health. **(See Exhibit B-1)**

COMMISSION ACTION: *Motion was made to approve the minutes by Mr. Joe Crocker, seconded by Mr. Al Lockamy, and unanimously approved.*

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

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

VIII. Bond Projects (Action Items)

1. Vidant Health (Greenville)……Geary W. Knapp

Resolution: The Commission grants preliminary approval to a transaction for Vidant Health to (1) provide funds, to be used, together with other available funds, to advance refund, on a *taxable* basis, the callable portion of the North Carolina Medical Care Commission $297,100,000 Health Care Facilities Revenue Bonds, Series 2015, outstanding callable portion as of the date of the refunding in the amount of $101,920,000 and (2) enter a forward purchase agreement that allows the exchange of the taxable refunding bonds for *tax-exempt* bonds within 90 days of the first optional call date (7/1/2025) of the Series 2015 Bonds. The intent of the proposed Bond Issue is to take advantage of the low interest rate environment and to enter into a forward agreement with established terms for the exchange of the taxable bonds for tax-exempt bonds. The proposed transaction in its entirety will result in an estimated NPV savings of $10,700,000. The proposed transaction is in accordance with an application received as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$123,780,000
Total Sources of Funds	**$123,780,000**

ESTIMATED USES OF FUNDS

Escrow Amount to refund Series 2015	$123,373,750
Financial Advisor Fee	165,000
Verification Agent Fee	3,000
Escrow Agent Fee	3,000
Local Government Commission Fee	8,750
Trustee Fee	8,000
Trustee Counsel	6,000
Corporation Counsel	62,500
Bank Purchaser Counsel	60,000
Bond Counsel	90,000
Total Uses	**$123,780,000**

Tentative approval is given with the understanding that the governing board of Vidant Health accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Final financial feasibility must be determined prior to the issuance of bonds.

3. The project must, in all respects, meet requirements of G.S. § 13lA (Health Care Facilities Finance Act).

4. The Executive Committee of the Commission is delegated the authority to approve the issuance or conversion of bonds for this project and may approve the issuance or conversion of such greater amount principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

5. The bonds or notes shall be sold or converted in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its patients.

6. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

7. The borrower will provide the Commission annually a copy of Schedule H of the IRS form 990 to demonstrate community benefits provided by the borrower.

8. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

9. All health care facilities and services directly or indirectly owned or controlled by the health care organization, including physician practices, shall be available to Medicare and Medicaid patients with no limitations imposed as a result of the source of reimbursement.

Based on information furnished by applicant, the project is:

1.	Financially feasible	✓	Yes	_____	No	_____	N/A
2.	Construction and related costs are reasonable	_____	Yes	_____	No	✓	N/A

(See Exhibit G for Selected Application Information)

COMMISSION ACTION: *A motion for preliminary approval of the project was made by Mr. Joe Crocker, seconded by Mr. Bryant Foriest, and unanimously approved with the recusals of Mrs. Kathy Barger, Dr. John Meier, and Dr. John Fagg.*

2. Forest at Duke (Durham)……..Geary W. Knapp

Resolution: The Commission grants preliminary approval for The Forest at Duke, Inc. project to provide funds to be used, together with other available funds, to ***construct*** a new healthcare facility building that includes the following:

5-Story 90 Licensed Bed Health Care Facility (110,000 square feet)

- "Small House" Model
- House = 10 Private Rooms w/bathroom designed around common spaces and support areas
- House total will be 9 Houses (90 Licensed Beds)

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$ 57,575,000
Total Sources	**$ 57,575,000**

ESTIMATED USES OF FUNDS

Construction Contracts	39,582,115
Construction Contingency (1% of Construction Contracts)	395,821
Architect Fees	2,383,602
Architect's Reimbursables	50,000
Moveable Equipment	1,710,000
Survey, Tests, Insurance	154,038
Consultant Fees (Landscape/Kitchen/3rd Party Commissioning)	399,300
DHSR Reimbursables (G.S. § 131-E-267)	30,000
Bond Interest during Construction	6,523,307
Debt Service Reserve Fund	5,146,300
Underwriter Discount/Placement Fee	574,700
Feasibility Study Fee	115,000
Accountant Fee	20,000
Corporation Counsel	75,000
Bond Counsel	95,000
Rating Agency	75,000
Trustee Fee & Counsel	11,250
Bank Counsel	45,000
Printing Cost	7,500
Local Government Commission	8,750
Underwriter Counsel & Blue Sky Fee	75,000
Bank Fee	25,000
Appraisal/Survey/Title Fee	73,317
Total Uses	**$ 57,575,000**

Tentative approval is given with the understanding that the governing board of The Forest at Duke, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

3. Final financial feasibility must be determined prior to the issuance of bonds.

4. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

5. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

6. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

7. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

8. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

9. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is:

1.	Financially feasible	✓	Yes	_____	No	_____ N/A
2.	Construction and related costs are reasonable	✓	Yes	_____	No	_____ N/A

(See Exhibit H and Exhibit I for Selected Application Information and Presentation)

COMMISSION ACTION: *A motion for preliminary approval of the project was made by Dr. Paul Cunningham, seconded by Dr. Robert Schaaf, and unanimously approved with the recusal of Dr. John Meier.*

IX. Old Business (Discuss Rules, fiscal note, and comments submitted)

1. Rules for Adoption (Action Item)

1. Healthcare Personnel Registry Rule…….....…….Nadine Pfeiffer & Jana Busick

Amendment of 1 following emergency and temporary rulemaking for nurse aide reciprocity
- Rule: 10A NCAC 13O .0301
  (See Exhibits C thru C-2)

COMMISSION ACTION: *Motion was made to approve the Healthcare Personnel Registry Rule by Mrs. Eileen Kugler, seconded by Mr. Joe Crocker, and unanimously approved.*

X. New Business (Discuss Rules & Fiscal Note)

1. Rules for Initiating Rulemaking Approval (Action Items)

1. Hospice Licensing Construction Rules .....…Nadine Pfeiffer & Jeff Harms

Readoption of 13 rules following Periodic Review & 3 rule amendments
- Rules: 10A NCAC 13K.1109, .1112 -.1116, .1201, and .1204 - .1212
  (See Exhibits D thru D-2)

COMMISSION ACTION: *A motion was made to approve the Hospice Licensing Rules by Mr. Bryant Foriest, seconded by Mrs. Eileen Kugler, and unanimously approved.*

2. Nursing Home Licensing Rules…….Nadine Pfeiffer, Jeff Harms, & Beverly Speroff

Amendment of one rule for technical changes
- Rule: 10A NCAC 13D .2001
  (See Exhibit D-3)

COMMISSION ACTION: *Motion was made to approve the Nursing Home Licensing Rules by Mr. Bryant Foriest, seconded by Mr. Joe Crocker, and unanimously approved.*

XI. Mobile Disaster Hospital Update……Tom Mitchell & Geary W. Knapp

Mr. Geary Knapp gave a background of the Mobile Disaster Hospital to the Commission and Mr. Tom Mitchell gave a PowerPoint presentation on the history of the Mobile Disaster Hospital to the Commission.

(See Exhibit J)

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

Recommended:

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

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could

result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until May 14, 2021 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and to amend previously approved projects to include refunding components only between this date and May 14, 2021.

COMMISSION ACTION: *Motion was made to authorize the Executive Committee to approve projects involving the refunding of existing Commission debt between this date and May 14, 2021 by Mrs. Kathy Barger, seconded by Mr. Joe Crocker, and unanimously approved.*

XIII. Meeting Adjournment – There being no further business the meeting was adjourned at 11:45 a.m.

Respectfully Submitted

Geary W. Knapp, JD, CPA
Assistant Secretary

EXHIBIT A/1

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION EMERGENCY TELECONFERENCE MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
EDGERTON BUILDING
CONFERENCE ROOM - 026A
Via Microsoft TEAMS video-conference (Click here to join the meeting)
Or
Dial-in: +1 984-204-1487 (ID#: 184704620#)

March 10, 2021
11:30 A.M.
MINUTES

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Kathy G. Barger Sally B. Cone John A. Fagg, M.D. Bryant C. Foriest Linwood B. Hollowell, III Anita L. Jackson, M.D. Eileen C. Kugler, RN, MSN, MPH, FNP Ashley H. Lloyd, D.D.S. Karen E. Moriarty Stephen T. Morton Neel G. Thomas, M.D. Jeffrey S. Wilson DIVISION OF HEALTH SERVICE REGULATION STAFF Mark Payne, DHSR Director/MCC Secretary Emery Milliken, DHSR Deputy Director Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Nadine Pfeiffer, Rules Review Manager, DHSR Jeff Harms, Acting Chief, DHSR Construction Section Megan Lamphere, Chief, Adult Care Licensure Section Libby Kinsey, Assistant Chief, Adult Care Licensure Section Tichina Hamer, Director of Programs, Adult Care Licensure Section Bethany Burgon, Attorney General's Office Kimberly Randolph, Attorney General's Office Alice Creech, Executive Assistant, MCC OTHERS PRESENT Jeff Horton, NC Senior Living Association Frances Messer, NC Assisted Living Association Jim Wrenn, Hopper Hicks & Wrenn, PLLC	Paul R.G. Cunningham, M.D. Albert F. Lockamy, RPh Robert E. Schaaf, M.D.

II. Public Meeting Statement.....Dr. John Meier

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

III. Ethics Statement.....Dr. John Meier

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

IV. New Business

A. Rules for Initiating Rulemaking Approval (Discuss rules & fiscal note)

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

Permanent adoption of four rules for infection prevention policies and procedures, communicable disease reporting

- Rules: 10A NCAC 13F .1801, .1802, .1701 & .1702 (See Exhibits A thru A/3)

COMMISSION ACTION: Motion was made to approve the Adult Care & Family Care Homes Rules as presented by Mr. Joe Crocker, seconded by Mr. Stephen Morton, and approved with Mrs. Karen Moriarty opposing.

COMMISSION ACTION: Motion was made to approve the fiscal note by Mrs. Eileen Kugler, seconded by Mr. Bryant Foriest, and approved with Mrs. Karen Moriarty and Mr. Stephen Morton opposing.

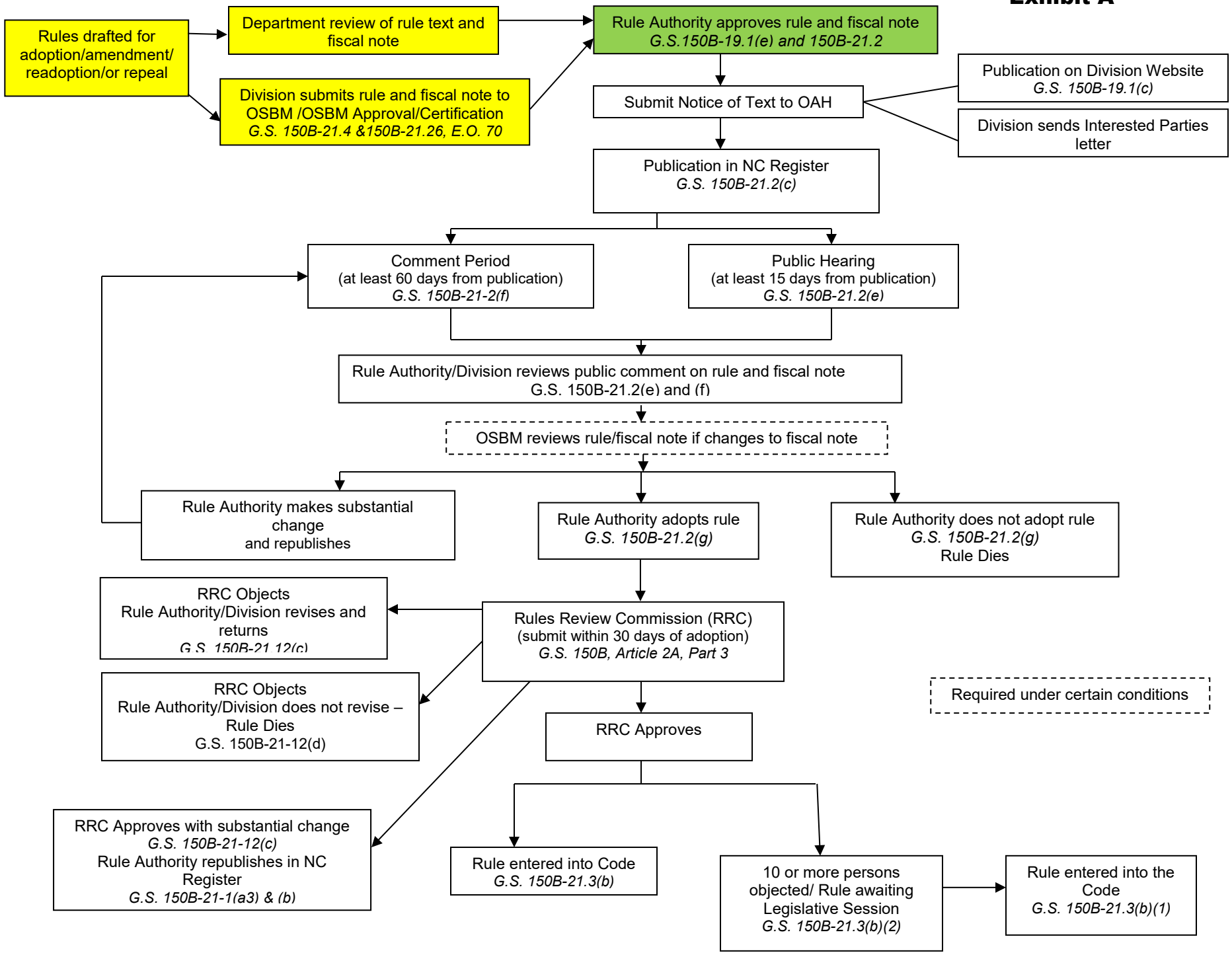
V. Meeting Adjournment – There being no further business the meeting was adjourned at 1:00 p.m.

Respectfully Submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

Process for Medical Care Commission to Initiate Rulemaking

Exhibit A



10A NCAC 13F .1801 is proposed for adoption as follows:

SECTION .1800 - INFECTION PREVENTION AND CONTROL

10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

(b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following:

(1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including:

(A) respiratory hygiene and cough etiquette;

(B) environmental cleaning and disinfection;

(C) reprocessing and disinfection of reusable resident medical equipment;

(D) hand hygiene;

(E) accessibility and proper use of personal protective equipment (PPE); and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions:

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section:

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the residents.

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the North Carolina Department of Health and Human Services or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020;~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13F .1802 is proposed for adoption as follows:

10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall inform the residents and their representative(s) and staff within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change;

(3) provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and

(4) provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

History Note: *Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13G .1701 is proposed for adoption as follows:

SECTION .1700 - INFECTION PREVENTION AND CONTROL

10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

(b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following:

(1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including:

(A) respiratory hygiene and cough etiquette;

(B) environmental cleaning and disinfection;

(C) reprocessing and disinfection of reusable resident medical equipment;

(D) hand hygiene;

(E) accessibility and proper use of personal protective equipment (PPE); and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions:

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1702 of this Section:

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the residents.

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the North Carolina Department of Health and Human Services or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020;~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13G .1702 is proposed for adoption as follows:

10A NCAC 13G .1702 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall inform the residents and their representative(s) and staff within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change;

(3) provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and

(4) provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

History Note: *Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. October 1, 2021.

DHSR Adult Care Licensure Section
Fiscal Impact Analysis
Permanent Rule Adoption with Substantial Economic Impact

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Tichina Hamer, Director of Programs, (919) 855-3782

Impact:

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

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

Rule Adoption (*See proposed text of these rules in Appendix)*

10A NCAC 13G .1701	Infection Prevention and Control Program
10A NCAC 13G .1702	Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak
10A NCAC 13F .1801	Infection Prevention and Control Program
10A NCAC 13F .1802	Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak

Authorizing Statutes: G.S. 131D-2.16; G.S. 131D-4.4; 143B-165

Introduction:

In North Carolina, assisted living facilities are defined by law as "adult care homes." There are over 1100 licensed adult cares homes licensed by the Adult Care Licensure Section (ACLS) and approximately 39,000 licensed beds. There are two main categories of Adult Care Homes (ACHs)—family care homes and adult care homes. Family care homes (FCHs) are facilities with a licensed capacity of two to six residents. Due to the facility's licensed capacity, the number of staff working at the facility may be limited to one to two staff per shift depending upon the assessed needs of the residents. Staff may also be live-in staff.

Adult care homes are larger facilities with a licensed capacity of seven or more residents. Currently, 14% of licensed adult care homes have a licensed capacity of 100 or more residents.[1] The facility with the highest capacity has 201 beds. The majority of licensed adult care facilities

[1] (2020 Adult Care Homes data from Long Term Care Safety Initiative System)

have a capacity between 60-99 residents (47%).[1] These facilities can receive a special designation as a Special Care Unit licensed to serve residents with certain diagnoses, such as Alzheimer's disease or dementia. Forty-two percent of adult care facilities have licensed special care units.[2] Facilities are required to provide sufficient staff to provide care and supervision based on the facility's census and assessed needs of the residents. Residents admitted to adult care homes (and family care homes) must be at least 18 years old. Based on the 2020 ACLS Facility License Renewal data, 61% of the resident population was at least 65 years old. Residents ages 75 and older make up 63% of the total resident population. Almost 20% of residents are over the age of 85.

Most of the rules for both types of ACHs are the same with the primary exception of staffing and physical plant requirements since they serve the same population based on need for care and services. From this point onward in this report, the term "adult care home (ACH)" refers in general to both types of facilities—adult care homes and family care homes.

Adult care homes provide 24-hour care and services for residents who need assistance with various tasks such as personal care, medication administration, food and nutrition services, health care referral, housekeeping and laundry, social and recreational activities, and supervision for safety. These services are provided based on a resident's assessed needs. Most residents require assistance with personal care tasks such as bathing, dressing, feeding, toileting and ambulation with devices such as a wheelchair or walker. Assessed health care needs may include wound care, medication administration through injections, use of oxygen and collecting and testing fingerstick blood samples. These assessed needs, along with others referenced in 10A NCAC 13F .0903 and 10A NCAC 13G .0903, are considered "licensed health professional support (LHPS)" tasks and require a registered nurse to assess each resident who requires these tasks on a quarterly basis, provide guidance to the staff on caring for the resident, and identify any issues unable to be assessed by the facility's unlicensed staff and need to be communicated to the resident's physician.

Adult care homes employ unlicensed staff to provide personal care, administer medications and supervise residents. Regulations require staff to be at least 18 years old, have a high school diploma or general education degree (GED), and no substantiated listing on the Healthcare Personnel Registry for findings such as resident abuse, neglect and misappropriation of property. ACHs may employ individuals with no work history and no prior work experience in a healthcare setting.

Staff hired in positions that involve providing direct care to residents, such as Personal Care Aides or Medication Aides, are required by General Statutes and rules, at a minimum, to attend classroom training and have certain skills validated by a registered nurse who observes staff performing the tasks.

The purpose of licensure rules is to establish the minimum standards for adult care homes to ensure the health, safety and well-being of residents. For adult care homes in particular, licensure rules establish requirements for training unlicensed individuals who are caring for a vulnerable population with medical and cognitive impairments that place them at greater risk for abuse, neglect, exploitation, harm or even death.

[2] Data from Adult Care Homes 2020 Facility License Renewal Applications

The Need for Infection Control Rules:

Although there are several reasons why infection control rules are needed for ACHs, the primary reasons are: the unique vulnerabilities of a congregate living setting, the health conditions and age of residents, and the limitations of unlicensed staff who provide care to the residents in these settings. But most obviously, in settings where hands-on health care services are being provided to people, basic infection prevention and control practices protect people by reducing the transmission of disease and can potentially save lives.

First, ACHs are congregate living settings where residents share dining room space during meals, living room space for activities, bathrooms and share living space with another resident as roommates. Residents freely move throughout the facility to visit other residents. While residents are encouraged to interact and talk with each other during activities and dining, infectious diseases, including but not limited to, influenza, norovirus, and coronavirus, can quickly spread among residents due to the close contact with each other, as well as among roommates.

Second, residents in ACHs are at greater risk of experiencing complications and negative outcomes from exposure to various communicable diseases and bloodborne pathogens. Individuals who live in ACHs typically have physical disabilities, chronic illness, mental or behavioral health conditions, or a combination of these conditions. Residents have a range of medical and cognitive diagnoses which includes diabetes, hypertension, obesity, heart disease, stroke, chronic obstructive pulmonary disease (COPD), and dementia. In an article published by Healio, Dr. Keith Kaye reveals, "older adults become more susceptible to infections due to several factors. As people get older, it is more frequent that they have comorbid conditions, such as diabetes, renal insufficiency and arthritis. Many comorbid conditions, both the number and type of comorbid conditions, predispose people to infections".[3]

Individuals move into ACHs for assistance because of these various needs and conditions. Staff in facilities provide this personal, close contact care to many residents throughout the day. Staff are within close proximity to residents and other staff members for prolonged periods of time and touching many of the same surfaces and reusing various equipment to carry out their work. All of these factors make transmission of viruses and communicable diseases more likely to occur in this environment, and sound infection prevention and control practices are critical to maintaining the health and safety of residents and staff.

Another challenge in these congregate living settings is the difficulty in effectuating some recommended environmental controls when there is an outbreak. ACHs typically serve as a resident's home for the long term, and therefore, facilities have limited space and room availability to properly quarantine, isolate, and cohort residents if they become ill. This can make it hard for facilities to manage an outbreak once a virus has entered a facility.

[3] (Healio News, 2011) "Comorbidities, metabolic changes make elderly more susceptible to infection"

North Carolina Public Health Communicable Disease Outbreak Report Summary for 2015-2018[4] revealed 73% of reported communicable disease outbreaks were from the state's long-term care facilities, including nursing homes and adult care homes. Over this 4-year span, communicable disease repots in long-term care facilities have doubled. Of all the reports from every setting, 49% were respiratory causes with influenza being 93% of those illnesses reported; 41% were gastrointestinal causes with norovirus being 80% of those types of illnesses reported; and 10% of reports were related to other causes such as scabies.

Generally, the most common communicable disease is influenza, or "the flu." The influenza virus can be spread between residents, staff and visitors. The Centers for Disease Control and Prevention (CDC) estimates, in recent years, "that between 70 percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older, and between 50 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in this age group".[5] The flu, for example, can worsen certain medical conditions, such as diabetes, by raising a person's blood sugar or increase the risk of serious complications.[6]

Worst Case Scenario: A Global Pandemic – COVID-19 and Its Impact on ACHs

Congregate living settings present unique challenges in infection control of communicable diseases. The coronavirus pandemic has hit long-term care residents particularly hard. "Since the start of the pandemic, 100,033 residents and staff at long-term care facilities have died from COVID-19 as of November 24, 2020."[7] In North Carolina, residential care facilities account for 10,493 case, 743 deaths, and there have been 273 outbreaks.[8] This represents over 1/10th of the total deaths in North Carolina.[9] There have been 20,978 cases, 2,280 deaths, and 303 outbreaks at nursing homes. As this data shows, highly communicable diseases can be especially deadly in congregate living situations, which is why infection control practices are an essential part of care of residents in adult and family care homes. The pandemic has highlighted and enhanced a need that previously existed which was to improve the quality of policies and training around IPC.

COVID-19 represents a worst-case scenario for assisted living settings and the impact of a communicable disease. COVID-19, is a new coronavirus that "spreads through respiratory droplets or small particles, such as those in aerosols, produced when an infected person coughs, sneezes, sings, talks, or breathes".[10] COVID-19, has killed more than 500,000 people as a result of the infection in 2020-2021, in comparison to the flu which 22,000 people

[4] Outbreak Report Summary: 2015-2018, NC DHHS Epidemiology Communicable Disease Reports. Data retrieved 1/7/2021. https://epi.dph.ncdhhs.gov/cd/figures/aggregate_outbreak_data_2015_2018.pdf
[5] (CDC, 2020) Seasonal Influenza (Flu) Who is at High Risk for Complications
[6] (WedMD.com) "6 Health Problems to Watch For"
[7] Kaiser Family Foundation, "COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff," https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/.
[8] Outbreaks and Clusters, NC DHHS COVID Dashboard. Data retrieved 1/7/2021. https://covid19.ncdhhs.gov/dashboard/ outbreaks-and-clusters
[9] NCDHHS' COVID-19 Response. Data retrieved 12/17/2020. https://covid19.ncdhhs.gov/
[10] (CDC, 2021)Frequently Asked Questions https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Basics

died in 2019-2020. The flu is also a communicable disease spread through similar mode of transmission as COVID-19.

Although infectious diseases occur in both nursing homes and ACHs, unlike nursing homes, ACHs do not have the advantage of being staffed with licensed health care professionals. ACHs are not required to have a registered nurse on duty or onsite to provide clinical assessment and monitoring of residents' conditions or to oversee unlicensed personnel and implementation of infection control measures. ACHs also do not have medical directors to direct or guide facility infection prevention and control programs. In a recent survey conducted by the Division of Health Service Regulation Adult Care Licensure Section, 59% of facilities reported they do not employ a registered nurse on duty. Therefore, for the safety of residents and staff and to prevent and reduce the spread of communicable diseases in ACHs, well-defined regulations requiring comprehensive infection prevention and control policies and procedures are warranted to ensure unlicensed staff have guidelines and proper training to prevent and limit spread the spread of communicable diseases and bloodborne pathogens.

Administrators are responsible for the overall operation of the facility and often develop the policies and procedures that direct how staff are to respond to and handle incidents and accidents, emergencies and infection control. As part of improving the quality of care and services and the overall management of the facility, administrators may earn continuing education credits towards their biennial re-certification for course work related to infection control.

Facility staff have many and varied duties within ACHs, depending on the facility. They are responsible for performing multiple tasks for residents which include administering medications, meal preparation, assistance with activities of daily living, housekeeping and laundry, nutrition and food services, and ensuring safety. The lack of ongoing staff education related to infection prevention and control and the facility's policies and procedures on implementing these critical measures contributes to the increased rates of transmission of communicable diseases in this setting. Research from Walden University, studied the impact of hospital-acquired infections (HAIs) on staff and associated costs to patients and staff.[11] (Debesai, 2019) This research focused on "reprocessing medical devices to prevent HAIs".[11] The research reveals that the CDC and the Food and Drug Administration issued a health advisory that focused on ensuring adequate training for personnel involved in reprocessing medical devices to prevent HAIs", which recommended training "upon hire and at least one year after the initial hiring date".[11] This research drew a correlation between staff training and infection control measures which reduced HAIs by 70% "when employees and providers were aware of infections and had adequate training in infection prevention".[11] It was noted in the report that healthcare workers should adhere to the standards and wearing PPE.[11] Although the research was focus on HAIs, the conclusion can be drawn that providing training to adult care facility staff routinely on how to use PPE and staff adherence to wearing PPE may prevent or reduce the spread of infectious diseases.

As mentioned previously, staff working in ACHs have frequent and direct contact with residents and do not have clinical training or backgrounds. The most common qualifications that employees

[11] (Debesai, Strategies Healthcare Managers Use to Reduce, 2019)
https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=7694&context=dissertations

of adult care homes have are completion of personal care aide training and medication aide certificates. Personal care aides must complete 80 hours of training and competency evaluation completed by a registered nurse. Personal Care aides receive basic training in infection control and universal precautions. Medication aides are unlicensed staff who administer medications to residents independently and not under the supervision of a licensed professional. N.C. Gen. Stat. § 131D-4.5B requires medication aides to complete 15 hours of training, one-time clinical skills evaluation by a registered nurse, and pass an exam. Medication aides, as part of their training, are evaluated by a registered nurse on infection control skills related to administering medications.

Lastly, based on infectious outbreak data and recent and past compliance data, there is a need for the state licensing agency to have the clear authority to enforce regulations with infection prevention and control standards and guidance for the protection of residents. Providers are required to report to public health officials per N.C. Gen. Stat. §131D-4.4B, but not required to implement written strategies that would reduce the risk of spreading infectious diseases to other residents. Current rules are vague and, as evidenced by the COVID-19 pandemic, detailed requirements are needed to promote better understanding and prevention of communicable diseases and bloodborne pathogens and implementation of safe practices to prevent harm and transmission of illness. The proposed rules ensure that basic infection prevention and control standards of care are applied consistently adult in care facilities across the state. The rules set forth clearly defined minimum requirements of IPC and provide ACLS the ability enforcement those requirements, and as a result will reduce the transmission of infectious diseases.

III. Baseline

Adult care homes have been required to comply with basic infection control standards related to bloodborne pathogens since January 1, 2012, based on N.C. Gen. Stat. § 131D-4.4A. The statute requires ACHs to develop written infection control policies consistent with CDC guidelines to prevent the spread of blood borne pathogens. The statute also requires providers to monitor the facility's compliance with IC policies and update the policies as necessary to prevent transmission. The facility is required to have a staff person on-site who is knowledgeable of the CDC infection control guidelines.

Since the adoption of current rules in 2005, facilities have been required to maintain infection control policies in accordance with 10A NCAC 13F .1211 and 13G .1211; however, the rules as written provide no specific criteria indicating what should be included in the IC policies and procedures nor measures facilities should take if there is a suspected communicable disease case or outbreak.

Although current general statutes and rules both address infection control and staff training, these requirements are limited. In 2018 and 2019, N.C. Gen. Stat. § 131D-4.4A was cited 40 times against adult care homes for reasons including medication aides using a single glucometer for multiple residents, and not following infection control policies. In the seven months prior to COVID-19 (September 2019– March 2020), 48 citations were issued to adult care homes for failure to provide training to medication aides which includes infection control training.

Infection prevention and control emergency rules were implemented effective October 23, 2020 through December 30, 2020. Since the implementation of the emergency rules, 13F .1801 and 13G

.1701, ACLS identified non-compliance in both adult care and family care homes related infection prevention and control. As a result, of the 56 facilities surveyed, adult care facilities were cited at a rate of 48.6% for non-compliance with rule 13F .1801, and family care homes were cited for non-compliance with rule 13G .1701 at a rate of 68.4%. However, these rates are based on surveys that were done primarily as a response to complaints received by the licensing agency and do not represent the overall population of adult care homes and family care homes that are expected to need to implement additional infection control procedures above those that they normally do.

Review of Proposed Rules: Infection Prevention and Control Program 10A NCAC 13F .1801 and 13G .1701

The proposed permanent rules were developed to give ACHs specific requirements to address in infection prevention and control policies and procedures and compel facilities to implement recommendations from the CDC, NCDHHS and the local health department when necessary for the health and safety of residents and staff. The rules are the minimum standards that facilities should have as part of the written IPC policies and procedures. The requirement for facilities to have IPC policies and procedures is not a new standard. Providers are currently required to comply with N.C. Gen. Stat. 131D-4.4A and 10A NCAC 13F/13G .1211 which requires infection control policies dealing specifically with bloodborne pathogens to be consistent with CDC guidelines.

It should be noted that the proposed rules apply to any communicable disease that may impact residents living at ACHs irrespective of a global pandemic. The focus of implementation of the rules will be addressed from the perspective of "normal" or "non-pandemic" events with diseases that typically impact ACHs each year, such as the influenza, norovirus and bloodborne pathogens. While COVID-19 has certainly had an incredible impact on ACHs this past year and cannot be discounted, it is not a typical or common occurrence in these facilities and will be addressed separately at the conclusion of this report.

Proposed Rule 13F .1801(a)/13G .1701(a)
The rule requires providers to establish and implement IPC programs and IC policies in accordance with CDC guidelines. It should be noted that this rule is not a new requirement. ACHs are currently required to comply with N.C. Gen. Stat. 131D-4.4A and 10A NCAC 13F/13G .1211 which require ACHs to have infection control policies and infection control policies related to bloodborne pathogens to be consistent with CDC guidelines. The proposed rule was added to provide clarity regarding the minimum requirements of the ACH's infection control policy and present a cohesive set of rules, making it easier for providers to access and follow and improve consistency across the state.

Proposed Rule 13F .1801(b)/13G .1701(b)
Rules (b)(1) through (b)(4) provide define the areas that are to be included in a facilities' IPC policies and procedures. These areas are the very basic foundation of infection prevention and control in a long-term care congregate living setting. The rule directs providers to assure that the policies and procedures developed are consistent with CDC guidelines. This rule provides the CDC website where providers can locate the latest information and resources, including toolkits, where are available at no cost, for provider to address the components listed in rule (b)(1)(a-f), which

requires providers, at a minimum, to address standard and transmission-based precautions. The IPC policies and procedures should specifically address the following:

- respiratory hygiene and coughing etiquette,
- environmental cleaning and disinfection,
- reprocessing and disinfection of reusable resident medical equipment;
- hand hygiene;
- accessibility and proper use of personal protective equipment (PPE);
- types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions.

The CDC website provides detailed information and some toolkits for providers to reference regarding each item required to be included in the IPC policies and procedures. These are basic, evidence-based practices employed in all health care settings to prevent the spread of illness between residents and staff. It should be noted providers are currently required to comply with U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) regulations when occupational hazards are assessed by facilities. While OSHA requirements are focused on worker safety, there are some of these requirements that overlap with the proposed rules for resident safety. Also, to assist their members with implementation of this requirement, the N.C. Senior Living Association and N.C. Assisted Living Association collaborated to develop a template of policies and procedures and have provided those to their member facilities. Providers are required to have IPC policies and procedures. Any fiscal impact of updating the policies is expected to be due to ensuring that the ACH's policies discuss the minimum infection control standards. As the providers have templates and CDC information readily available, the time needed to do this should be minimal.

Rule (b)(2) requires providers to ensure policies address when and how to notify the local health department for suspected reportable communicable disease or outbreak. Providers have been required to report communicable outbreaks since 2011, when N.C. Gen. Stat. § 131D-4.4B was established. ACHs should have a procedure for staff to follow when there is a suspected or confirmed reportable communicable disease condition. Staff should be aware of what these conditions are and how and where to report. In accordance with the law, the Department established the process for ACHs to report suspected communicable disease outbreaks to local health departments by telephone within 24 hours of when the outbreak reasonably suspected to exist. There is no additional burden on facilities. ACHs will need to ensure that this process is included in their policies and procedures.

Rule (b)(3) provides guidance to ACH providers of common considerations or steps to take to mitigate and reduce the spread of a suspected or known outbreak of a communicable disease. The measures listed in the rule, including isolating infected residents, limiting or stopping group activities or communal dining, conduct screenings of staff, residents and visitors, and limit visitation are measures commonly issued in CDC guidance for long term care facilities to prevent further spread and are typically included in the recommendations given by local health departments to facilities when there is an outbreak. These measures listed in the rule can be critical to preventing

further spread when implemented in a timely manner. These standard measures are not new and are ordinarily included in CDC guidance for influenza and norovirus outbreaks in LTC settings, and are also recommended protections against COVID-19 and other diseases. This rule requires the ACHs to update current IPC policies and procedures to include these measures to be considered by staff when there is illness identified in the facility.

Rule (b)(4) requires ACHs to update current IPC policies and procedures by developing a plan to address potential staffing shortages due to an illness or an outbreak. Planning for staffing issues during an outbreak is critical as oftentimes staff also fall ill or so do their family members for whom they may have personal obligations to care for. This rule compels ACHs to coordinate staff and provide procedures for facility managers and supervisors on how to ensure there is adequate staffing to meet the needs of the residents during an outbreak. Examples may include contacting a staffing agency, using staff from a sister facility or developing a pool of on-call staff. ACHs are currently required to meet staffing requirements according to 10A NCAC 13F .0600 and 13G .0600. Therefore, the impact of this rule is updating the IPC policies and procedures to reflect staffing strategies.

Rule (c) requires ACHs to implement IPC policies and procedures when a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat. The rule is to help prevent and mitigate the spread of communicable diseases within the facility and has a direct impact on the health and safety of residents. The rule requires ACHs to follow more specific written guidance or directives when issued from the local health department or NCDHHS in response to what may be occurring in our state, in the ACHs' geographic area, or the facility itself. It is important to note that while state and local public health agencies follow guidance issued by the CDC, these agencies may also have recommendations specific to the facility, the area impacted by the infectious disease, resources available, or other factors. The rule directs facilities to follow CDC guidance, but to follow the guidance and recommendation of state and local public health officials is there is more specific guidance provided. This rule resolves any conflict between sources of guidance and requires ACHs to follow public health guidance.

Rule (d) requires ACHs to provide annual IPC training to all staff. The intent is to ensure all staff working at ACHs know and understand the facility's policies and procedures for IPC to protect residents and staff and prevent the transmission of communicable diseases and bloodborne pathogens. Per existing rule (13F/G .1211) and law (GS 131D-4.4A(b)(4)), all staff are required to be trained within 30 days of hire on the facility's policies and procedures to ensure they are able to implement these practices as they carry out their duties. The requirement for this training to be conducted annually is a new requirement and will have a fiscal impact on facilities to provide this training each year.

Rule (e) requires ACHs to ensure IPC policies and procedures are readily accessible for facility staff for reference and guidance. This is a current requirement according to 13F .1211 and 13G .1211, therefore there is no fiscal impact.

Review of Proposed Rules: 10A NCAC 13F .1802/.1702 Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak

Rule (a) requires ACHs to report suspected or confirmed reportable communicable diseases in accordance with rules adopted by the Commission for Public Health. Since 2011, ACHs have been required to report suspected communicable disease outbreaks based on N.C. Gen. Stat. § 131D-4.4B.

Rule (b) requires ACHs to notify residents, staff and family members within 24 hours following confirmation by the local health department of a communicable disease outbreak. This is a new requirement. The intent of providing notification to residents, staff and family members within 24 hours is to mitigate the risk and spread of a confirmed communicable disease outbreak and ensure residents, staff and families are kept informed of outbreaks in the facility without sharing confidential information. Having awareness of a confirmed communicable disease outbreak prepares staff and residents for the implementation of IPC policies and procedures and keeps families abreast of possible changes in visitation.

The facility has discretion regarding how individuals are notified, such as by email, text message, or other means. If the ACH does not have an email account, letters or flyers may be considered as notification. Information to be shared may be how many residents or staff are infected, and any changes to facility policies such as visitation.

Fiscal Impact

Time Required to Update Policies and Procedures

Rules 10A NCAC 13F .1801 and 13G .1701 require ACHs to make updates to current IPC policies and procedures. The fiscal impact is based on the administrator, who is responsible for the management and operations of the facility, updating the IPC policies and procedures using the CDC resources available at no cost.

Based on a previous survey conducted by ACLS, the average administrator's salary is approximately $55,542. On average, salary and wages account for 70% of private industry worker compensation costs for employers, with benefits accounting for 30%.[12] Using this ratio, benefits would cost an additional $23,766 for a total annual cost of $79,218 and hourly cost of $38.08. Although the actual amount of time needed to update IPC policies is unknown, estimating 5 hours of research using information provided by the CDC and policy development, the cumulative cost of the administrator's time is estimated $190.40. It is also unknown how many adult care homes whose policies would need to be updated to match the proposed rules versus those whose policies would already meet the requirements. Potentially if CDC guidance changes again in the future, there would be additional time needed to update the procedures but it is unknown when this might happen and how much time would be needed. Although ACH administrators serve as administrator for multiple facilities and use the same policies, the total cost of $214,771 is based on each one administrator per facility.

Time Required to Provide Staff Training

There is a fiscal impact to provide annual training to staff as it is currently not required. The estimated cost is based on the number of staff required in accordance with the facility's licensed capacity, environmental services staff and food service for adult care homes. Medication aides

[12] Employer Costs for Employee Compensation – June 2020. BLS. https://www.bls.gov/news.release/pdf/ecec.pdf

and personal care aides' average hourly rate ranges between $10-$12 per hour or $24,480 annually.[13,14] Considering the employee's compensation and benefits for a total salary of $34,972, the cost of providing annual infection prevention and control training to direct care staff and auxiliary support staff, such as custodians and dietary staff, the estimated cost would be $18.25 per hour of training per staff. The number of staff varies as it is based on the company's operational structure and facility census. Based on minimum staffing chart and the average licensed capacity of 60 residents in facilities, the estimated cost of training 30 adult care employees and 5 family care home employees is approximately $365,380.00.

Time for ACLS Staff to Spend on Enforcement of these Rules

Review of infection prevention and control practices is currently part of the ACLS survey process. The review for compliance with infection control has been part of the survey process prior to the implementation of N.C. Gen. Stat. § 131D-4.4A. Observing infection prevention and control measures includes observing medication administration, personal care, feeding assistance and the use of PPE. Non-compliance identified requires ACLS staff to document findings in a written format. There is no change in the process for ACLS staff and no additional surveyors will need to be hired to enforce these rules. The proposed rules merely provide clarification and authority to appropriately enforce non-compliance identified. The average staff hourly rate with benefits is $44.26. The amount of time spent on enforcement includes observations, interviewing staff and residents, record reviews and documenting non-compliance. The average number of staff per survey is approximately 3 for adult care homes and 1 for family care homes. Although there is no data for the amount of time spent solely on reviewing compliance with infection control during for non-pandemic surveys, the estimated cost of enforcement is $265.56 for three hours spent conducting the survey process. Based on the number of surveys referenced in Table 2, the estimated cost is $32,132.76.

Time Required to Notify Resident or Representatives

It is anticipated that this requirement will have a minimal impact on ACHs. With technology today, communicating information to large groups of people can be simplified by using tools like email, phone messaging systems, or texting apps. The expectations of this rule is that ACHs notify residents and their responsible person, as well as their staff, when they become aware that there is a communicable disease outbreak in the facility. ACHs may send these groups an email or text providing notice of an outbreak at the facility. Based on ACLS data, 99% of licensed facilities reporting having an email address. Based on the average licensed capacity of 60 residents for facilities, adult care providers could create an email distribution list of families, residents, and/or staff for purposes of sharing information such as outbreaks or other emergencies. The estimated cost for an administrator to spend 15 minutes drafting and sending an email to comply with the rule to notify families and staff is an approximate total of $9.52 for each weekly notification.

[13] Personal care aide salary in North Carolina (careerexplorer.com)
[14] Medication Aide Salary in North Carolina (indeed.com)

Cost to Comply with CDC Guidance

There is a fiscal impact to implement Rule .1801(c) and .1701(c). The cost is based on the requirement of the facility to comply with CDC guidance. Under normal circumstances, outside of a global pandemic, most facilities' current practice is to adhere to CDC guidance and OSHA regulations, such as the cost to practice hand hygiene, cleaning and disinfecting surfaces and equipment, purchasing the necessary PPE, and paper products for food service. The cost to implement this rule comes from the increase in complying with CDC guidelines (primarily PPE) from the subset of the adult care homes who do not currently comply with CDC guidance. Implementation of these new requirements will have a positive impact on ACHs ability to carry out appropriate infection prevention and control practices. As the regulations require specific measures to be a part of a facility's policies and procedures, and for staff to be trained annually on those procedures, it serves to impress upon the facility and staff the importance of taking these precautions. In addition, the regulations set forth the expectation that "guidance" or "recommendations" from the CDC, NCDHHS or the local health department are not optional and shall be followed to the greatest extent possible. The agencies are the subject matter experts on infectious disease and best practices for preventing or stopping the spread of illnesses that can be harmful to long-term care residents. They have expertise of not only how to utilize standard and transmission-based precautions, but also can assist facilities with implementing environmental controls to ensure the daily operations of the facility are not contributing to the spread of illness. The rules also clarify procedures for when there seems to be different recommendations coming from these various agencies. While all of these agencies base their recommendations off of CDC protocols, NCDHHS and local health departments may provide direction to ACHs that is more specific and geared toward a facility's unique situation, such as the resident population, local community factors, staffing issues, facility layout, etc. Given that these rules provide more concrete and specific direction to ACHs than current regulations, it is reasonable to believe that it will be easier for ACHs to implement infection prevention and control measures, follow recommendations given by public health experts, and be better prepared when there is an outbreak of an illness.

Facilities routinely purchase PPE for staff for regular infection prevention, such as gloves, to assist residents with hands-on tasks such as eating, bathing and toileting. Providers will need to supply additional PPE required when there is an outbreak of a communicable disease that is above the baseline of normal PPE usage. There is minimal data to determine the baseline of normal PPE usage in ACHs. Due to the pandemic, NCDHHS assisted providers with purchasing PPE. Based on daily burn rate data provided for gloves, in December 2020, facilities who requested PPE reported a daily burn rate as follows: as follows:

Gloves	217 pairs
Goggles	15
N-95 masks	13
"Procedural" Masks	45
Gowns	37

However, the rate of PPE usage will be dependent upon the residents and their specific conditions and any infectious diseases that residents may have at certain times, so the rate of PPE

usage will fluctuate based on these conditions. Although the size of the adult care homes that requested PPE varied greatly (capacity of 60-120), the December 2020 data reflects the adult care homes that requested PPE had an average licensed capacity of 82 residents. Family care homes licensed capacity a maximum of 6 residents.

The chart below represents some current vendors' prices for PPE.

Type of PPE	Supplier	Average Cost/Unit
Goggles	RB Medical Supply	$5.75
Facemask	RB Medical Supply	$7.00 (box of 50)
Nonsterile, disposable patient isolation gowns	Grainger	$1.44
Nonsterile gloves	Grainger	$17.50 (box of 100)
N95 respirators	RB Medical Supply	92.50 (box of 50)

Based on these prices, the average daily cost of PPE for the average PPE burn rate above would total $207.86. However, many times goggles can be reused, so this estimate would overstate the total cost and provides a conservative estimate. This amount also reflects December 2020 usage, which was during one of the largest COVID-19 case surges and before mass vaccination in congregate living situations. In general, the overall cost of PPE would be lower without the impact of COVID-19.

Cost of Provider Violations

There is also a cost incurred by facilities as a result of violations cited by ACLS for noncompliance with implementing IPC procedures. In accordance with N.C. Gen. Stat. § 131D-34, civil penalty amounts vary based on the type of penalty and license type. The initial violation for a Type A1 for a family care home may range from $500 to $20,000, and an adult care may range from $1,000 to $20,000. Factors surrounding the violation cited will impact the penalty amount imposed. As COVID-19 became more prevalent in ACH facilities, complaints regarding infection control increased as well as the amount of non-compliance identified for failure to comply with infection control measures.

Based on ACLS data (Table 2), surveys conducted between May 2020 and October 2020, found 41% of facilities surveyed during this period were non-compliant with infection prevention and control measures. Of the facilities cited, 94% of non-compliance identified were violations. The potential cost of violations is estimated at $25,500.

(Table 2)

ACLS Survey Data – Compliance with Infection Control May 2020-October 2020	
Number of Surveys May-October 2020	**121**
Number of facilities – infection control - compliant	**71**
Number of facilities – infection control non-compliant	**50**
• Adult Care facilities	34
• Family Care facilities	16

Number of facilities cited for violations (A1, A2, UA, B, UB)	**47**
Number of facilities cited for standard deficiencies	**3**

In 2020, violations cited for infection control included lack of staff training, lack of supplies for norovirus, and failure to wear proper PPE.

Fiscal Impact of COVID-19 on Proposed Rules

Currently, during the COVID-19 global pandemic, ACHs have incurred additional costs particularly for PPE (face shields, larger gown supply, thermometers) in which ACHs have received additional financial support through the passage of appropriations and temporary increased Medicaid rates.

As a result of COVID-19 and its deadly impact, the N.G. General Assembly passed the Coronavirus Relief Act 3.0, providing $20,000,000 to licensed facilities with residents receiving Special Assistance funds to offset the increased cost of caring for residents during the pandemic. Personal Care Service rates increased for facilities with Medicaid recipients by approximately 83% from $4.10 per unit to $7.50 per unit to assist ACHs with the cost associated with providing personal care to residents.[15] Additionally, another $9,667,539 was appropriated to the N.C. Assisted Living Association and N.C. Senior Living Association to purchase COVID-19 tests for residents, staff and visitors in adult care homes.

Also, Session Law 2020-4, the 2020 COVID-19 Recovery Act, allocated $7,500,000.00 to the N.C. Senior Living Association for "(i.) the purchase of supplies and equipment necessary for life safety, health, and sanitation, such as ventilators, touch-free thermometers, gowns, disinfectant, and sanitizing wipes, and (ii) the purchase of personal protective equipment that meets the federal standards and guidelines from the Centers for Disease Control and Prevention, such as surgical and respiratory masks and gloves."

Due to the advancement of vaccines, it is likely that the cost for providers to comply with coronavirus specific precautions will be decreasing and will not extend into perpetuity.

Benefits Related to Reduction of Infectious Disease Transmission & Avoidance of Disease
Non-compliance cited due to failure or refusal of a facility to implement CDC, NCDHHS and/or local public health recommendations to prevent the spread of COVID-19, has many other associated costs as well. Some of these are: increased cost for additional PPE to the facility as the virus spreads and impacts more residents and staff; cost of staff who call out sick; cost of treatment and hospitalizations of residents and staff who contracted the virus; and the cost of resident and staff lives lost from COVID-19.

There are numerous benefits that would result from decreasing the transmission of infectious diseases to both residents and healthcare workers. As the COVID-19 pandemic represents somewhat of a worst-case scenario, the discussion of benefits also runs the gamut depending on

[15] (NC Division of Health Benefits, 2020) https://medicaid.ncdhhs.gov/blog/2020/05/06/special-bulletin-covid-19-82-expedited-hardship-advances-and-retroactive-targeted

the scale of outbreak and type of infectious disease. Decreased incidence of disease could potentially have the following benefits:

- Decrease in emergency room visits and hospitalizations for both residents and healthcare workers: According to Healthcare Finance, the average cost of a COVID-19 hospitalization for insured patients over the age of 60 was $40,208. For an uninsured patient over 60, the cost spiked to $77,323.[16] The average cost of an influenza-related inpatient hospital stay between 2006-2016 was $16,000.[17]
- Decreased occurrence of long-term impacts/reduction of risk for long-term impacts: Long-term impacts of COVID-19 infections are more likely in older people and those with many serious medical conditions. They include fatigue, shortness of breath, cough, joint pain, chest pain, muscle pain/headache, tachycardia, loss of smell or taste, memory, concentration, or sleep problems, rash, and hair loss. Heart, lung, and brain damage is also possible as are blood clots and blood vessel problems that lead to liver and kidney problems.[18] .
- Reduction of risk of death: While we cannot necessarily say that a death would be avoided, but using CDC recommended infection practices would reduce the risk of death. The central VSL estimate for 2021 according to HHS is $10.3M in 2014 dollars. This amount is not the value of saving an individual's life with certainty, but rather represents the amount that an individual would be willing to pay for a defined change in his or her own risk.
- Decrease in PPE costs: Reduced risk of transmission can lead to fewer residents with infections where staff need to use transmission precautions to determine appropriate PPE. This can decrease the overall cost of PPE if an outbreak is confined instead of spreading through the entire home.
- Decrease in sick call outs for employees: Reduced risk of transmission could lead to fewer sick day call outs from employees. This benefits the administration by leading to less time spent dealing with making sure there are enough staff to cover all of the residents. Absences may equate to approximately 5.7% of a provider's payroll in overtime for staff coverage.[19]
- A study of 161 hospitals in Pennsylvania involving 7,076 nurses who treated patients with urinary tract infections (UTIs) and surgical site infections (SSIs) focused on the impact of increasing the number of patients and patient care. The study revealed by "increasing [the] nurse workload by one patient resulted in an increase of UTIs and SSIs, resulting in 1,351 additional infections in the study population. Similarly, decreasing nurse burnout from an average of 30% to 10% 33 could result in preventing 4,160 infections, leading to cost savings of $41 million in the Pennsylvania hospitals (Cimiotti et al., 2012)".[11] "Hall, Johnson, Watt, Tsipa, and O'Connor (2016) included 46 research studies in their review and found that poor patient safety associated with moderate to high burnout and poor wellbeing of healthcare professionals. Of those 30 studies on burnout, 83.3% had a direct connection between healthcare professional burnout and poor patient safety; similarly, 88.9% of the studies on wellbeing had a direct correlation between poor wellbeing and

[16] https://www.healthcarefinancenews.com/news/average-cost-hospital-care-covid-19-ranges-51000-78000-based-age

[17] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb253-Influenza-Hospitalizations-ED-Visits-2006-2016.jsp

[18] https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351

[19] https://www.shrm.org/hr-today/news/hr-magazine/documents/kronos_us_executive_summary_final.pdf

poor patient safety (Hall et al., 2016).[11] Although the study takes place at a hospital setting, the impact of staff shortage or staff call outs can have similar impacts when providing care to multiple residents.

- Better quality of care for residents due to less staffing issues: A study shows that the number of care hours per resident per day delivered by NAs is an important contributor to residents' qualify of care in LTC homes.[20] If there are too many call-outs among staff due to infections or the need to quarantine after exposure, staff to resident ratios rise and quality of care may suffer.

Benefits of implementing effective infection prevention and control are reduction of staff call-outs, staff burnout and better care provided to residents. Practicing good infection prevention may reduce the number of staff getting from infected residents and co-workers. Staff infected with COVID-19 may be absent from work for several days and based on medical advice.[21] Practicing infection prevention and control reduces violations cited by ACLS for non-compliance with rules.

Alternatives Considered

The proposed permanent rules were preceded by emergency and temporary rules. The emergency and temporary infection prevention and control rules for adult care homes and family care homes included language and requirements that addressed specific COVID-19 related issues that have been prevalent in facilities during the time of the pandemic. An alternative to the current proposed permanent rules would be to keep the rules the same as the emergency and temporary rules, making no changes. However, because it is expected that the impacts of COVID-19 will continue to lessen and no longer be as great a threat to resident and staff health and safety, this language would become overly burdensome to providers and may eventually become outdated. The current proposed permanent rules are a better alternative as they lay the foundation for a basic infection prevention and control program with ACHs and help to ensure facilities are prepared for and can respond to any type of illness or transmittable disease that may impact the facility. The rules ensure that policies and procedures are based on evidence and standard practice, that staff are adequately trained, and that there is good communication between the facility and others who need to be involved.

A second alternative that could be considered in lieu of the proposed rules would be to adopt the infection prevention and control regulations for nursing homes, which are established by the federal Centers for Medicare & Medicaid Services (CMS). The CMS State Operations Manual, which governs the implementation of nursing home regulations, sets for the requirements for §483.80(a),(e),(f) and states, "*The facility must establish and maintain an IPCP (Infection Prevention and Control Program)designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This program must include, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors. The IPCP must follow national standards and guidelines.*" Since nursing home

[20] Boscart, V. M., Sidani, S., Poss, J., Davey, M., d'Avernas, J., Brown, P., Heckman, G., Ploeg, J., & Costa, A. P. (2018). The associations between staffing hours and quality of care indicators in long-term care. *BMC health services research*, *18*(1), 750. https://doi.org/10.1186/s12913-018-3552-5

[21] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

residents are typically more medically complex and susceptible to illness and rapid changes in condition, nursing homes are required to employ a myriad of clinical staff to oversee their care, including a Medical Director, Director of Nursing, and Registered Nurses. To comply with CMS regulation §483.80(b), nursing homes must also employ an "Infection Preventionist" at least part-time. The Infection Preventionist must, "*have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; and have completed specialized training in infection prevention and control*." This staff person must also serve on the facility's quality assurance team and report out on any infection control related issues identified in the facility. Again, this alternative was not considered because ACHs do not generally care for residents with as high acuity as nursing homes, and they do not employ clinical staff that could oversee an IPCP such as Medical Director or Registered Nurses. Adopting CMS regulation for ACHs would be unduly burdensome and costly.

Lastly, another alternative would be to require the administrator of an adult care home to complete the "Infection Control in Long Term Care Facilities" course offered by the University of Chapel Hill's SPICE (Statewide Program for Infection Control and Epidemiology) program. The cost of this program is $465.00 per person. This three-day program held every spring and fall is designed to provide participants with current and practical information for the recognition and management of common infection prevention issues in non-acute care facilities, with an emphasis on long term care. Basic statistics for surveillance and antibiotic stewardship are new additions to the course. This alternative is not the most effective at this time as the course is very clinical in nature and geared toward nursing home managers and infection control nurses in those settings. The training would not be appropriate for direct care staff and ancillary staff in ACHs. SPICE does, however, offer a number of free infection prevention and control web-based trainings for all types of long-term care facilities, including adult care homes.

Conclusion

Rule Impacts	Known Costs/Benefits
Time Required to Update Policies and Procedures	$214,771 (initial cost, changes to CDC and other public health guidance would require additional time in the future)
Time Required to Provide Staff Training	$365,380 annually (based on average of 30 adult care home employees and 5 family care home employees)
Time for ACLS Staff to Spend on Enforcement of these Rules	$265.56 per survey (2 ACLS staff; three hours spent conducting the survey process)
Time Required to Notify Resident or Representatives	$9.52 for each weekly notification ($2,380 based on 2018 Aggregate Outbreak data)
Average Cost of PPE/Day for an Average ACH During an Outbreak	$207.86 (based on average requests from adult care homes that requested PPE in Dec 2020)
Cost of Provider Violations	Estimated $25,500

Benefits	$25,500 reduction in violations; unquantifiable benefits discussed above

Because of the high transmission and death rate, COVID-19 has highlighted a greater need for providers to have systems in place to mitigate the spread of communicable diseases within congregate living settings, such as adult care and family care homes. The proposed permanent rules establish minimum requirements for an infection prevention and control (IPC) plan based on sound public health practices, require on-going training of unlicensed staff, set forth reporting requirements to the local health department, and identifies for facilities when to implement more specific guidance for communicable disease control outbreaks or emerging infectious disease threats. The rules also ensure that residents, families and staff are kept informed of outbreak conditions in a facility so that they can act as necessary to protect the health and safety of themselves or their loved ones. When these IPC policies and procedures are implemented, ACHs will be able to mitigate and reduce the spread of communicable diseases, whether during a pandemic or the seasonal flu and prevent further harm and loss of life to residents and staff.

APPENDIX

10A NCAC 13F .1801 is proposed for adoption as follows:

SECTION .1800 - INFECTION PREVENTION AND CONTROL

10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

(b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following:

(1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including:

(A) respiratory hygiene and cough etiquette;

(B) environmental cleaning and disinfection;

(C) reprocessing and disinfection of reusable resident medical equipment;

(D) hand hygiene;

(E) accessibility and proper use of personal protective equipment (PPE); and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions:

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section:

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the residents.

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or

emerging infectious disease threat have been issued in writing by the North Carolina Department of Health and Human Services or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020;~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13F .1802 is proposed for adoption as follows:

10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall inform the residents and their representative(s) and staff within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change;

(3) provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and

(4) provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

History Note: *Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13G .1701 is proposed for adoption as follows:

SECTION .1700 - INFECTION PREVENTION AND CONTROL

10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

(b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following:

(1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including:

(A) respiratory hygiene and cough etiquette;

(B) environmental cleaning and disinfection;

(C) reprocessing and disinfection of reusable resident medical equipment;

(D) hand hygiene;

(E) accessibility and proper use of personal protective equipment (PPE); and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions:

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1702 of this Section:

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the residents.

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the North Carolina Department of Health and Human Services or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020;~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13G .1702 is proposed for adoption as follows:

10A NCAC 13G .1702 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall inform the residents and their representative(s) and staff within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change;

(3) provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and

(4) provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

History Note: *Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. October 1, 2021.

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 3rd Quarter FYE 2021)

	FYE 2020	FYE 2021
Program Measures	Ending: 6/30/2020	Ending: 3/31/2021
Outstanding Debt	**$5,694,191,427**	**$5,459,262,954**
Outstanding Series	**125**[1]	**129**[1]

Detail of Program Measures	Ending: 6/30/2020	Ending: 3/31/2021
Outstanding Debt per Hospitals and Healthcare Systems	$4,496,197,271	$4,051,102,543
Outstanding Debt per CCRCs	$1,141,594,156	$1,353,790,411
Outstanding Debt per Other Healthcare Service Providers	$56,400,000	$54,370,000
Outstanding Debt Total	**$5,694,191,427**	**$5,459,262,954**
Outstanding Series per Hospitals and Healthcare Systems	73	70
Outstanding Series per CCRCs	50	57
Outstanding Series per Other Healthcare Service Providers	2	2
Series Total	**125**	**129**
Number of Hospitals and Healthcare Systems with Outstanding Debt	17	15
Number of CCRCs with Outstanding Debt	17	17
Number of Other Healthcare Service Providers with Outstanding Debt	1	1
Facility Total	35	33

Exhibit B (Outstanding Balance)

Note 1: For FYE 2021, NCMCC has closed 16 **Bond Series**. Out of the 16 closed Bond Series: 2 were conversions, 11 were new money projects, 3 were refundings. The Bond Series outstanding from FYE 2020 to current represents all new money projects, refundings, conversions, and redemptions.

GENERAL NOTES: Facility Totals represent a parent entity total and do not represent each individual facility owned/managed by the parent entity. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities. The following parent entities represent the current "other healthcare service providers" with outstanding NC MCC debt: DePaul (Assisted Living)

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 3rd Quarter FYE 2021)

Program Measures	FYE 2020 Ending: 6/30/2020	FYE 2021 Ending: 3/31/2021
Total PAR Amount of Debt Issued	**$26,550,874,158**	**$27,332,332,159**
Total Project Debt Issued (excludes refunding/conversion proceeds)[1]	**$12,940,409,253**	**$13,358,022,254**
Total Series Issued	**643**	**659**

Detail of Program Measures	Ending: 6/30/2020	Ending: 3/31/2021
PAR Amount of Debt per Hospitals and Healthcare Systems	$21,575,249,855	$22,044,354,855
PAR Amount of Debt per CCRCs	$4,601,329,073	$4,913,682,074
PAR Amount of Debt per Other Healthcare Service Providers	$374,295,230	$374,295,230
Par Amount Total	**$26,550,874,158**	**$27,332,332,159**
Project Debt per Hospitals and Healthcare Systems	$10,167,759,674	$10,273,019,674
Project Debt per CCRCs	$2,525,635,665	$2,837,988,666
Project Debt per Other Healthcare Service Providers	$247,013,915	$247,013,915
Project Debt Total	**$12,940,409,253**	**$13,358,022,254**
Series per Hospitals and Healthcare Systems	404	411
Series per CCRCs	200	209
Series per Other Healthcare Service Providers	39	39
Series Total	**643**	**659**
Number of Hospitals and Healthcare Systems issuing debt	99	99
Number of CCRCs issuing debt	40	40
Number of Other Healthcare Service Providers issuing debt	46	46
Facility Total	185	185

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

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

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

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

Via Microsoft Teams: Click here to join the meeting
OR
Dial-IN: 1-984-204-1487 / Passcode: 313-708-106#

February 22, 2021
11:30 A.M.

Members of the Executive Committee Present:

John J. Meier, IV, M.D., Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Linwood B. Hollowell, III
Eileen C. Kugler, RN, MSN, MPH, FNP
Jeffrey S. Wilson

Members of the Executive Committee Absent:

Albert F. Lockamy, Jr., RPh

Members of Staff Present:

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

Others Present:

Carlos Manzano, Parker Poe Adams & Bernstein, LLP
Jeff Poley, Parker Poe Adams & Bernstein, LLP
Charles Stafford, Ponder & Co.
Matt Thomas, Appalachian Regional Healthcare
Joe Richardson, Appalachian Regional Healthcare

1. Purpose of Meeting

To approve an Amended and Restated Master Trust Indenture for the Appalachian Regional Hospital System Obligated Group

2. Resolution of the North Carolina Medical Care Commission to Approve an Amended and Restated Master Trust Indenture for the Appalachian Regional Hospital System Obligated Group

Executive Committee Action: **Motion was made approve the Amended and Restated Master Trust Indenture by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.**

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

WHEREAS, **Watauga Medical Center, Inc.**, **Appalachian Regional Healthcare System, Inc., Appalachian Regional Medical Associates, Inc., Charles A. Cannon, Jr. Memorial Hospital, Incorporated, Appalachian Regional Healthcare Foundation, and Appalachian Regional Behavioral Healthcare, Inc.** (collectively, the "*ARHS Obligated Group*") are each a nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina and is a "non-profit agency" within the meaning of the Act; and

WHEREAS, the Commission has entered into a Loan Agreement, dated as of November 1, 2018 (the "*2018 Loan Agreement*"), with **Watauga Medical Center, Inc.** and **Appalachian Regional Healthcare System, Inc., in connection with the** North Carolina Medical Care Commission Health Care Facilities Revenue Refunding Bonds (Appalachian Regional Healthcare System Obligated Group), Series 2018 (Taxable) and Series 2021B (Tax-Exempt) (collectively, the "*ARHS Commission Bonds*"); and

WHEREAS, Section 5.12 of the 2018 Loan Agreement requires that, so long as the ARHS Commission Bonds are Outstanding (as defined in the 2018 Loan Agreement), Article III of the Master Indenture (as defined in the 2018 Loan Agreement) may not be amended without the prior written consent of the Commission; and

WHEREAS, the ARHS Obligated Group has requested the Commission approve an Amended and Restated Master Trust Indenture, to be dated as of March 1, 2021 (the "*Amended and Restated MTI*"), by and between the ARHS Obligated Group and U.S. Bank National Association, as master trustee. Such Amended and Restated MTI would replace in its entirety the existing Master Indenture; and

Whereas, the Assistant Secretary of the Commission has reviewed such Amended and Restated MTI to ensure it conforms in all material respects with other master trust indentures used by the Commission's bond program participants, and

Whereas, Exhibit A hereto describes the purpose for certain of the amendments (such related sections being highlighted in the Amended and Restated MTI); and

WHEREAS, there has been presented at this meeting a draft copy of the Amended and Restated MTI and a comparison thereof to the original Master Indenture.

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

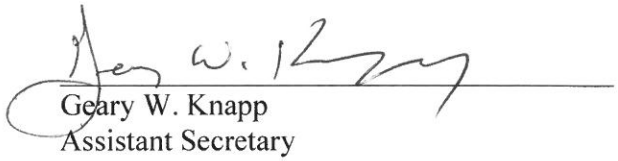
Section 1. The Amended and Restated MTI is hereby approved in all respects in substantially the form presented at this meeting, together with such changes, modifications and deletions as the Assistant Secretary of the Commission, with the advice of counsel, may deem necessary and appropriate.

Section 2. This resolution shall take effect immediately upon its passage.

3. Adjournment

There being no further business, the meeting was adjourned at 11:40 a.m.

Respectfully submitted,



Geary W. Knapp
Assistant Secretary

Exhibit A

Description of Certain Changes to the Amended and Restated MTI

1. The change to the definition of "Income Available for Debt Service" protects against changes to Generally Accepted Accounting Principles (GAAP) that alter the way in which financial covenants are calculated, which could adversely impact the Obligated Group. This same definition was approved in previous transactions. By way of background, GAAP recently changed its treatment of "operating leases", requiring these leases to be treated as Indebtedness rather than an expense, which adversely impacts debt service coverage. Most of the GAAP related changes in the Amended and Restated MTI address this issue.

2. The change to the definition of Indebtedness references the definition of Income Available for Debt Service, which enables leases that would have been considered operating leases prior to the GAAP change to be treated as an expense rather than Indebtedness. This same definition was approved in previous transactions.

3. The change in the definition of "Long-Term Debt Service Requirement" allows "Balloon Long-Term Indebtedness" to be "smoothed" over 30 years rather than 25 years. The 30-year provision is common in most Commission approved Master Trust Indentures.

4. The change to the definition of "Long-Term Indebtedness" clarifies that leases that would have been considered operating leases prior to the GAAP change will not be treated as Long-Term Indebtedness. This same definition was approved in previous transactions.

5. The change to the definition of "Short-Term Indebtedness" prevents leases which will be considered Indebtedness following the GAAP change referenced in 1. above, and have a term of one year or less, from being considered Short-Term Indebtedness. This same definition was approved in previous transactions.

6. The change to Section 3.05(b)(viii) increases the permitted Lien amount on Property, Plant and Equipment securing Indebtedness and not part of a Deed of Trust from 10% to 20% of the Net Book Value of the Obligated Group, to give the Obligated Group more borrowing flexibility. This change is consistent with most Commission approved Master Trust Indentures.

7. The change to Section 3.06(b) increases the potential issuance limit in this particular provision for additional indebtedness (Long-Term Indebtedness plus Short-Term Indebtedness plus Indebtedness secured by Accounts) from 10% to 25% of Total Operating Revenues to give the Obligated Group more flexibility. The change is consistent with most Commission approved Master Trust Indentures.

8. The change to Section 3.06(c) increases the Obligated Group's flexibility in issuing refunding indebtedness by permitting up to a 15% increase in maximum annual debt service from the refunding, instead of the current 10%. This change is consistent with most Commission approved Master Trust Indentures.

9. The changes to 3.07(d) and (e) are related to "Force Majeure" events (like a pandemic) and clarify that a "hard" event of default can occur if the Long-Term Debt Service

Coverage Ratio is less than 1.00x for two consecutive fiscal years. This change is consistent with recent Commission approved Master Trust Indentures.

10. The addition of 6.01(h) is consistent with recent Commission approved Master Trust Indentures and allows for the adjustments of terms/definitions due to changes in GAAP.

STATE OF NORTH CAROLINA
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE OF THE COMMISSION
CONFERENCE TELEPHONE MEETING ORIGINATING
FROM THE OFFICES OF THE COMMISSION
March 4, 2021
11:30 A.M.

Via Microsoft Teams: Click here to join the meeting
OR
Dial-In: 1-984-204-1487 / Passcode: 620902475#

Members of the Commission Present:
Dr. John J. Meier, IV, Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Eileen C. Kugler, RN, MSN, MPH, FNP
Albert F. Lockamy, RPh
Jeffrey S. Wilson

Members of the Commission Absent:
Linwood B. Hollowell, III

Members of Staff Present:
Geary W. Knapp, JD, CPA, Assistant Secretary
Kathy C. Larrison, MCC Auditor
Alice S. Creech, Executive Assistant

Others Present:
Paul Billow, Womble Bond Dickinson (US) LLP
Jon Mize, Womble Bond Dickinson (US) LLP
Charles Stafford, Ponder & Co.
Bradley Dills, Ponder & Co.
David Hughes, Vidant Health
Allen Robertson, Robinson Bradshaw & Hinson, PA
Charles, Bowyer, Robinson Bradshaw & Hinson, PA
Matt Callaghan, Echo Financial Products
Kent Thompson, Hugh Chatham Memorial Hospital

1. Purpose of Meeting

To authorize (1) the execution and delivery of a First Supplemental Trust Agreement for the 2015 Bonds issued for the benefit of Hugh Chatham Memorial Hospital, Inc., and (2) a series resolution authorizing the sale and issuance of revenue refunding bonds for Vidant Health, Series 2021A.

2. Resolution of the North Carolina Medical Care Commission Approving and Authorizing Execution and Delivery of a First Supplemental Trust Agreement Relating to the North Carolina Medical Care Commission Health Care Facilities Refunding Revenue Bonds (Hugh Chatham Memorial Hospital) Series 2015.

Executive Committee Action: Motion was made to approve the resolution by Mr. Joe Crocker, seconded by Mr. Al Lockamy, and unanimously approved with the recusal of Dr. John Meier.

WHEREAS, the North Carolina Medical Care Commission (the "Commission"), a commission of the Department of Health and Human Services of the State of North Carolina, issued $25,495,000 aggregate principal amount of its Health Care Facilities Refunding Revenue Bonds (Hugh Chatham Memorial Hospital) Series 2015, of which $17,245,000 aggregate principal amount is currently outstanding (the "Bonds"); and

WHEREAS, the Bonds have been issued and are outstanding under the terms of a Trust Agreement dated as of December 1, 2015 (the "Trust Agreement") between the Commission and U.S. Bank National Association, as bond trustee (the "Bond Trustee"), and the Commission loaned the proceeds from the sale of the Bonds to Hugh Chatham Memorial Hospital, Inc. d/b/a Hugh Chatham Memorial Hospital (the "Corporation") pursuant to a Loan Agreement dated as of December 1, 2015 between the Commission and the Corporation; and

WHEREAS, the Bonds were purchased upon their initial issuance by Siemens Public, Inc.; and

WHEREAS, the Corporation intends to deliver a Conversion Notice changing the Interest Rate Determination Method for the Bonds from the existing Medium-Term Rate (as such terms are defined in the Trust Agreement) to a new Medium-Term Rate effective April 1, 2021 (the "Conversion Date"); and

WHEREAS, on the Conversion Date, the Bonds will be subject to mandatory tender for purchase and will be purchased by JPMorgan Chase Bank, National Association (the "Purchaser"); and

WHEREAS, the Trust Agreement provides for the establishment and maintenance of a Debt Service Reserve Fund (as defined in the Trust Agreement); and

WHEREAS, the Purchaser is not requiring that the Debt Service Reserve Fund continue to be maintained; and

WHEREAS, Corporation and the Purchaser have agreed to modify and supplement certain provisions of the Trust Agreement simultaneously with the conversion to the new Medium-Term Rate Period (as defined in the Trust Agreement) on the Conversion Date; and

WHEREAS, Sections 11.02 and 11.08 of the Trust Agreement permit the Commission and the Bond Trustee, with the consent of the Purchaser as the Holder (as defined in the Trust Agreement) of 100% of the Bonds, to enter into agreements supplemental to the Trust Agreement to make any change to the Trust Agreement; and

WHEREAS, there has been presented to the staff of the Commission a draft copy of a First Supplemental Trust Agreement to be dated the date of delivery thereof (the "Supplement") between the Commission and the Bond Trustee that would amend the Trust Agreement to make the changes agreed upon by the Corporation and the Purchaser; and

WHEREAS, the Corporation has requested that the Commission approve the Supplement and authorize its execution and delivery;

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

Section 1. The form, terms and provisions of the Supplement are hereby approved in all respects, and the Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are hereby authorized and directed to execute and deliver the Supplement in substantially the form presented at this meeting, together with such changes, modifications and deletions as they, with the advice of bond counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 2. The Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) or any duly authorized Commission Representative under the Trust Agreement are authorized and directed to take such other action and to execute and deliver any such other documents, certificates, undertakings, agreements or other instruments as they, with the advice of bond counsel, may deem necessary or appropriate to effect the changes made in the Supplement.

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

3. Series Resolution Authorizing the Sale and Issuance of North Carolina Medical Care Commission Taxable Health Care Facilities Revenue Refunding Bonds (Vidant Health), Series 2021A (the "2021A Bonds") and a subsequent series of tax-exempt bonds to refund the 2021A Bonds (the "Tax-Exempt Bonds" and together with the 2021A Bonds, the "Bonds").

Executive Committee Action: Motion was made to approve the sale and issuance of bonds by Mrs. Eileen Kugler, seconded by Mr. Joe Crocker, and unanimously approved with the recusal of Dr. John Meier.

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

WHEREAS, University Health Systems of Eastern Carolina, Inc. d/b/a Vidant Health (the "Parent Corporation") and Pitt County Memorial Hospital, Incorporated d/b/a Vidant Medical Center (the "Corporation") are each a North Carolina nonprofit corporation and a "non-profit agency" within the meaning and intent of the Act, which operate, by themselves and through controlled affiliates, various health care facilities; and

WHEREAS, the Parent Corporation and the Corporation have made application to the Commission for issuance of the 2021A Bonds and the lending of the proceeds thereof to the Parent Corporation and the Corporation for the purpose of providing funds, together with any other available funds, to (a) advance refund the North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (Vidant Health), Series 2015 maturing on June 1, 2028 to 2033, inclusive (the "Refunded Bonds"), and (b) pay the fees and expenses incurred in connection with the sale and issuance of the 2021A Bonds; and

WHEREAS, pursuant to the plan of finance set forth in such application, the Parent Corporation and the Corporation also desire for the Commission to provide for the future sale and issuance by the Commission of a subsequent issue of tax-exempt bonds (the "Tax-Exempt Bonds") in an aggregate principal amount equal to the outstanding principal amount of the 2021A Bonds at the time of issuance of the Tax-Exempt Bonds for the purpose of refunding and redeeming the 2021A Bonds; and

WHEREAS, the Commission has, by resolution duly adopted on February 12, 2021 (the "Commission Resolution"), approved the issuance of the Bonds, subject to compliance with the conditions set forth in such resolution, and the Parent Corporation and the Corporation have complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented at this meeting draft forms or executed copies, as applicable, of the following documents relating to the Bonds:

(a) Trust Agreement, to be dated as of March 1, 2021 (the "Trust Agreement"), between the Commission and U.S. Bank National Association, as bond trustee (the

"Bond Trustee"), together with the form of the 2021A Bonds and the Tax-Exempt Bonds attached thereto, relating to the 2021A Bonds and the Tax-Exempt Bonds;

(b) Loan Agreement, to be dated as of March 1, 2021 (the "Loan Agreement"), between the Parent Corporation, the Corporation and the Commission, relating to the 2021A Bonds and the Tax-Exempt Bonds;

(c) Contract of Purchase, to be dated the date of delivery thereof (the "Contract of Purchase"), between the Local Government Commission of North Carolina (the "LGC") and BB&T Community Holdings Co. (the "Purchaser"), and approved by the Commission and the Parent Corporation, relating to the sale of the 2021A Bonds;

(d) Forward Purchase Agreement, to be dated as of March 1, 2021 (the "Forward Agreement"), among the LGC, the Purchaser, the Commission and the Parent Corporation, relating to the sale of the Tax-Exempt Bonds;

(e) Master Trust Indenture (Amended and Restated), dated as of February 1, 2006 (as supplemented and amended, the "Master Indenture"), between the Parent Corporation, the Corporation and First-Citizens Bank & Trust Company (succeeded by U.S. Bank National Association), as master trustee (the "Master Trustee");

(f) Supplemental Master Trust Indenture No. 32, to be dated as of March 1, 2021 ("Supplemental Indenture No. 32"), between the Parent Corporation, the Corporation and the Master Trustee, supplementing the Master Indenture, including the form of Master Obligation, Series 2021A, to be dated the date of delivery thereof (the "2021A Master Obligation"), executed and delivered by the Parent Corporation to the Commission;

(g) Supplemental Master Trust Indenture No. 33, to be dated as of March 1, 2021 ("Supplemental Indenture No. 33" and, together with Supplemental Indenture No. 32, the "Supplemental Indentures"), between the Parent Corporation, the Corporation and the Master Trustee, supplementing the Master Indenture, including the form of Master Obligation, Series 2021A-1, to be dated the date of delivery thereof (the "2021A-1 Master Obligation" and, together with the 2021A Master Obligation, the "Obligations"), executed and delivered by the Parent Corporation to the Purchaser;

(h) Continuing Covenants Agreement, to be dated as of March 1, 2021 (the "Continuing Covenants Agreement"), among the Parent Corporation, the Corporation and the Purchaser, relating to the 2021A Bonds and, if and when issued, the Tax-Exempt Bonds; and

(i) Escrow Deposit Agreement, to be dated as of March 1, 2021 (the "Escrow Agreement"), among the Commission, the Parent Corporation, the Corporation and U.S. Bank National Association, as escrow agent (the "Escrow Agent"), relating to the advance refunding of the 2015 Bonds to be refunded with the proceeds of the 2021A Bonds; and

(j) Rate Lock Letter, to be dated the date of delivery thereof (the "Rate Lock Letter"), from the Purchaser and accepted by the Parent Corporation and the Corporation.

WHEREAS, the Commission has determined that the Parent Corporation and the Corporation are financially responsible and capable of fulfilling their obligations under each of the documents described above to which the Parent Corporation and/or the Corporation are a party; and

WHEREAS, the Commission has determined that the public interest will be served by the proposed refinancing and that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

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

Section 1. Capitalized terms used in this Series Resolution and not defined herein shall have the meanings given such terms in the Trust Agreement, the Loan Agreement and the Master Indenture, as applicable.

Section 2. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes the issuance of (a) the 2021A Bonds in an aggregate principal amount not-to-exceed $125,000,000 and (b) the Tax-Exempt Bonds in an aggregate principal amount equal to the outstanding principal amount of the 2021A Bonds at the time of issuance of the Tax-Exempt Bonds for the purposes set forth above. Each series of the Bonds shall be dated as of their respective dates of delivery. The 2021A Bonds shall initially bear interest at a rate not-to-exceed 2.60% per annum, and the Tax-Exempt Bonds, if and when issued, shall initially bear interest at a rate not-to-exceed 2.08% per annum, all subject to adjustment in the manner provided in the Trust Agreement. The final maturity date of the 2021A Bonds and the Tax-Exempt Bonds shall be June 1, 2033. The preliminary mandatory sinking fund redemption schedule for the 2021A Bonds is set forth in Exhibit A hereto and is subject to adjustment once the final interest rates are determined, subject to the conditions set forth in this resolution.

The Bonds shall be initially issued as fully registered bonds in denominations of $100,000 or any integral multiple of $5,000 in excess of $100,000 as described in the Trust Agreement. While the Bonds bear interest at the Fixed Bank Rate (as defined in the Trust Agreements), interest on the Bonds shall be payable on the first Business Day of each calendar month. Payments of principal of and interest on the Bonds shall be forwarded by the Bond Trustee to the registered owners of the Bonds in such manner as is set forth in the Trust Agreement.

Section 3. The Bonds shall be subject to optional, extraordinary optional and mandatory sinking fund redemption and optional and mandatory tender for purchase and shall be subject to conversion to different interest rate modes, at the times, upon the terms and conditions and, with respect to redemptions and tenders, at the prices set forth in the Trust Agreement.

Section 4. The proceeds of the 2021A Bonds shall be applied as provided in Section 2.08 of the Trust Agreement, and the proceeds of the Tax-Exempt Bonds, if and when issued, shall be applied on the date of issuance thereof to the redemption of the 2021A Bonds.

Section 5. The forms, terms and provisions of the Loan Agreement, the Trust Agreement and the Escrow Agreement are hereby approved in all respects, and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such

purpose and the Secretary or any Assistant Secretary of the Commission are each hereby authorized and directed to execute and deliver the Loan Agreement, the Trust Agreement and the Escrow Agreement in substantially the forms presented at this meeting, together with such modifications as such persons, with the advice of counsel, may deem necessary or appropriate, including, but not limited to, modifications necessary to incorporate the final terms of the Bonds, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 6. The form, terms and provisions of the Contract of Purchase and the Forward Agreement are hereby approved in all respects and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such purpose and the Secretary or any Assistant Secretary of the Commission are each hereby authorized and directed to execute and deliver the Contract of Purchase and the Forward Agreement in substantially the forms presented at this meeting, together with such modifications as such persons, with the advice of counsel, may deem necessary or appropriate, including, but not limited to, modifications necessary to incorporate the final terms of the Bonds, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The forms of the Bonds as set forth in the Trust Agreement are hereby approved in all respects and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such purpose and the Secretary or any Assistant Secretary of the Commission are each hereby authorized and directed to execute, by manual or facsimile signature as provided in such forms of the respective Bonds, and to deliver to the Bond Trustee for authentication on behalf of the Commission, the Bonds in definitive form, which shall be in substantially the form presented at this meeting, together with such modifications as such persons, with the advice of counsel, may deem necessary or appropriate and consistent with the provisions of the Trust Agreement, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. The forms, terms and provisions of the Supplemental Indentures, the Obligations, Rate Lock Letter and the Continuing Covenants Agreement are hereby approved in substantially the forms presented at this meeting, and the execution and delivery of the Trust Agreement by the Commission shall be conclusive evidence of the approval of such documents by the Commission.

Section 9. The Commission hereby approves the action of the LGC in authorizing (a) the private sale of the 2021A Bonds to the Purchaser in accordance with the Contract of Purchase and (b) the private sale of the Tax-Exempt Bonds (if and when issued) to the Purchaser in accordance with the Forward Agreement and the Trust Agreement, in each case at a purchase price equal to 100% of the principal amount thereof.

Section 10. Upon execution of the Bonds in the form and manner set forth in the Trust Agreement, the Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Bonds and, upon compliance with the provisions of Section 2.08 of the Trust Agreement with respect to the 2021A Bonds, and compliance with the provisions of Section 2.16 of the Trust Agreement with respect to the Tax-

Exempt Bonds, the Bond Trustee shall deliver the Bonds to the Purchaser against payment (or deemed payment) therefor.

Section 11. U.S. Bank National Association is hereby appointed as the Bond Trustee for the Bonds and as the Escrow Agent for the Refunded Bonds under the Escrow Agreement.

Section 13. The redemption of the Refunded Bonds in accordance with the provisions of the Refunded Bonds, the trust agreement relating thereto and the Escrow Agreement, is hereby authorized, ratified and approved, and all prior actions taken by the Commission and its officers in connection with such redemption are hereby authorized, ratified and approved.

Section 13. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary, Kathy C. Larrison, Auditor, and Crystal Watson-Abbott, Auditor, for the Commission, are each hereby appointed a Commission Representative (as that term is defined in the Loan Agreement) of the Commission with full power to carry out the duties set forth therein.

Section 14. The Chairman, the Vice Chairman, any member of the Commission designated in writing by the Chairman, the Secretary or Secretary and the Assistant Secretary of the Commission are each hereby authorized and directed (without limitation, except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the Loan Agreement, the Trust Agreement, the Contract of Purchase, the Escrow Agreement and the Forward Agreement.

The members, officers and employees of the Commission are each hereby authorized and directed to do all acts and things required of them by the provisions of this Series Resolution, the Bonds, the Trust Agreement, the Loan Agreement, the Escrow Agreement, the Contract of Purchase and the Forward Agreement for the full, punctual and complete performance of the terms, covenants, provisions and agreements of the same.

Section 15. A comparison of the professional fees as set forth in the Commission Resolution granting preliminary approval of this financing with the actual professional fees incurred in connection with the financing is set forth as Exhibit B hereto.

Section 16. This Series Resolution shall take effect immediately upon its adoption.

EXHIBIT A

MANDATORY SINKING FUND REDEMPTION SCHEDULE*

2021A Bonds

June 1	Amount	June 1	Amount
2021	$ 890,000	2028	$ 8,785,000
2022	1,510,000	2029	9,015,000
2023	1,545,000	2030	22,475,000
2024	1,570,000	2031	22,835,000
2025	1,865,000	2032	23,225,000
2026	2,160,000	2033	23,580,000
2027	2,195,000		

* Preliminary; subject to change upon final pricing.

EXHIBIT B

PROFESSIONAL FEES

Professional	Preliminary Approval	Actual*
Financial Advisor	$165,000	$162,000
Bond Counsel	90,000	75,000
Purchaser's Counsel	60,000	50,000
Combined Group Counsel	62,500	45,000
Trustee (including counsel)	14,000	12,650

* Not-to-exceed fees. Includes fees relating to issuance of the 2021A Bonds. Fees and expenses relating to subsequent issuance of Tax-Exempt Bonds to be paid directly by the Parent Corporation and the Corporation.

4. Adjournment

There being no further business, the meeting was adjourned at 11:45 a.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

NC MCC Bond Sale Approval Form							
Facility Name: Vidant Health							
	Time of Preliminary Approval		**Time of Final Approval**		**Total Variance**		**Explanation of Variance**
SERIES: 2021A							
PAR Amount	$123,780,000.00		$121,155,000.00		($2,625,000)		Escrow investment interest rates increased, reducing the size of borrowing needed; Vidant also elected to make an accured interest contribution to the escrow fund
Estimated Interest Rate [1]	1.89%		2.32%		0.43%		Market interest rates increased from preliminary approval, increased the interest rate on the bank bonds
All-in True Interest Cost	1.73%		2.11%		0.38%		Market interest rates increased from preliminary approval, increased the interest rate on the bank bonds
Maturity Schedule (Interest) - Date	Monthly, 4/1/2021 - 6/1/2033		Monthly, 4/1/2021 - 6/1/2033		None		
Maturity Schedule (Principal) - Date	Annually, 6/1/2021 - 6/1/2033		Annually, 6/1/2021 - 6/1/2033		None		
Bank Holding Period (if applicable) - Date	6/1/2033 (to maturity)		6/1/2033 (to maturity)		None		
Estimated NPV Savings ($) (if refunded bonds)	$10,746,689		$9,431,584		($1,315,105)		Market interest rates increased from preliminary approval, decreasing the savings achieved from refunding
Estimated NPV Savings (%) (if refunded bonds)	10.50%		9.25%		-1.25%		Market interest rates increased from preliminary approval, decreasing the savings achieved from refunding
NOTES:							
1. Estimated interest rate is represented by taxable rate on the Cinderella Bonds							
	Time of Preliminary Approval		**Time of Final Approval**		**Total Variance**		**Explanantion of Variance**
SERIES: 2025A							
PAR Amount	$117,520,000.00		$116,055,000.00		($1,465,000)		Escrow investment interest rates increased, reducing the size of borrowing needed; Vidant also elected to make an accured interest contribution to the escrow fund
Estimated Interest Rate [1]	1.49%		1.83%		0.34%		Market interest rates increased from preliminary approval, increased the interest rate on the bank bonds
All-in True Interest Cost	1.73%		2.11%		0.38%		Market interest rates increased from preliminary approval, increased the interest rate on the bank bonds
Maturity Schedule (Interest) - Date	Monthly, 4/1/2025 - 6/1/2033		Monthly, 4/1/2025 - 6/1/2033		None		
Maturity Schedule (Principal) - Date	Annually, 6/1/2025 - 6/1/2033		Annually, 6/1/2025 - 6/1/2033		None		
Bank Holding Period (if applicable) - Date	6/1/2033 (to maturity)		6/1/2033 (to maturity)		None		
Estimated NPV Savings ($) (if refunded bonds)	$10,746,689		$9,431,584		($1,315,105)		Market interest rates increased from preliminary approval, decreasing the savings achieved from refunding
Estimated NPV Savings (%) (if refunded bonds)	10.50%		9.25%		-1.25%		Market interest rates increased from preliminary approval, decreasing the savings achieved from refunding
NOTES:							
1. Estimated interest rate is represented by tax-exempt rate on the Cinderella Bonds							

STATE OF NORTH CAROLINA

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
North Carolina Medical Care
Commission 809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE OF THE COMMISSION CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE OFFICES OF THE COMMISSION
April 12, 2021
11:30 A.M.
Via Microsoft Teams: Click here to join the meeting
OR
Dial-In: 1-984-204-1487 / Passcode: 408 980 501#

Members of the Commission Present:
Dr. John J. Meier, IV, Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Linwood B. Hollowell, III
Eileen C. Kugler, RN, MSN, MPH, FNP
Jeffrey S. Wilson

MEMBERS OF THE COMMISSION ABSENT:
Albert F. Lockamy, Jr., RPh

MEMBERS OF STAFF PRESENT:
Geary W. Knapp, JD, CPA, Assistant Secretary
Kathy C. Larrison, MCC Auditor
Crystal Watson-Abbott, MCC Auditor
Alice S. Creech, Executive Assistant

OTHERS PRESENT:
Allen Robertson, Robinson Bradshaw & Hinson, PA
Chris McCann, JP Morgan
Ted Goins, Lutheran Services
Kirby Nickerson, Lutheran Services
JK Griffin, Novant Health
Seth Wagner, Truist Bank

STATE OF NORTH CAROLINA

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES
North Carolina Medical Care
Commission 809 Ruggles Drive
Raleigh, North Carolina

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Ted Goins, Lutheran Services
Kirby Nickerson, Lutheran Services
JK Griffin, Novant Health
Seth Wagner, Truist Bank

1. **Purpose of Meeting**

To consider a (1) resolution granting preliminary approval for the sale and issuance of bonds, the proceeds of which will be loaned to Lutheran Services for the Aging, Inc.. and to (2) grant approval for amendments to the Master Trust Indenture for Novant Health. Inc.

2. **The Commission grants preliminary approval to a transaction for Lutheran Services for the Aging, Inc. (LSA) to (1) provide funds, to be used, together with other available funds, to refund the North Carolina Medical Care Commission $44,790,000 Health Care Facilities First Mortgage Revenue Refunding Bonds, Series 2012A, outstanding as of the date of the refunding in the amount of $40,150,000, (2) provide funds, to be used, together with other available funds, to refund the North Carolina Medical Care Commission $33,795,000 Health Care Facilities First Mortgage Revenue Refunding Bonds, Series 2017, outstanding as of the date of refunding in the amount of $27,919,989, (3) provide funds, to be used, together with other available funds, to refund the North Carolina Medical Care Commission $115,338,000 Health Care Facilities First Mortgage Revenue Bonds, Series 2020A, outstanding and not fully drawn as of the date of the refunding in the amount of $53,586,894, (4) and provide funds, to be used, together with other available funds, to refund a private bank loan. The intent of the proposed 2021 Bond Issue is to take advantage of the low interest rate environment, eliminate put bond risk, and allow for bank debt capacity for future needs. The estimated net present value of this transaction is $1,736,335. The proposed transaction is in accordance with an application received as follows:**

ESTIMATED SOURCES OF FUNDS

Principal Amount of Bonds to be Issued	$204,459,691
Series 2012 Debt Service Reserve Fund	3,030,887
Series 2012 Principal Account	847,500
Series 2012 Interest Account	474,084
Total Sources	**$208,812,162**

ESTIMATED USES OF FUNDS

Escrow Amount to Refund Series 2012A & Series 2017 & Bank Loan	$ 77,811,727
Amount to Refund Series 2020A Bonds (Draw-Down)	53,586,894
Remaining Construction Costs from Series 2020A (Draw-Down)	56,263,396
Bond Interest During Construction	7,157,747
Underwriter Discount	1,880,112
Debt Service Reserve Fund	11,473,786
Feasibility Study Fee	120,000
Financial Advisor Fee	45,000
Accountant's Fee	5,000
Title Insurance	100,000
Local Government Commission's Fee	10,000
Corporation's Counsel	110,000
Bond Counsel	165,000
Underwriter's Counsel	60,000
Printing Costs	10,000
Trustee's Fees	13,500
Total Uses	**$208,812,162**

Tentative approval is given with the understanding that the governing board of Lutheran Services for the Aging, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Final financial feasibility must be determined prior to the issuance of bonds.

3. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

4. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

5. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

6. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

7. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

8. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is -

1. Financially feasible	✓ Yes	____ No	____ N/A
2. Construction and related costs are reasonable	____ Yes	____ No	✓ N/A

Executive Committee Action: Motion was made to approve the refunding by Mrs. Eileen Kugler, seconded by Mr. Joe Crocker, and unanimously approved.

EXHIBIT A

Lutheran Services for the Aging

Compliance Summary:

- **No Violation of MCC Compliance policy**

1) Does Organization have a formal post tax issuance compliance policy?

   No

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?

   Chief Financial Officer (Kirby Nickerson)

3) What is the Organization's compliance monitoring plan?

   LSA utilizes a compliance checklist (submitted to the NCMCC) which is reviewed by a financial analyst and approved the CFO annually. The compliance monitoring plan encompasses monthly, quarterly, and annual procedures.

4) How will the Organization report compliance deficiencies to leadership and the Board?

   Any noted deficiencies will be communicated to the CEO and Board via a written report.

Selected Application Information:

1) Information from FYE 2020 (9/30 Year End) Audit of Lutheran Services for the Aging:

Net Income	$ 11,277,947
Operating Revenue	$131,334,149
Operating Expenses	$126,995,282
Net Cash provided by Operating Activities	$ 13,301,122
Unrestricted cash	$ 15,522,989
Change in cash	$ 5,940,047

2) Ratings:

NONE

3) Community Benefits (FYE 2020):

Per N.C.G.S § 105 – 12.69% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $13,605,336

4) Long-Term Debt Service Coverage Ratios:

Actual	FYE	2020	2.75
Forecasted	FYE	2021	2.13
Forecasted	FYE	2022	1.61
Forecasted	FYE	2023	1.62
Forecasted	FYE	2024	2.29
Forecasted	FYE	2025	1.55

5) Transaction Participants:

Underwriter	Truist Securities
Feasibility Consultant	CliftonLarsonAllen LLP
Bond Counsel	McGuireWoods LLP
Corporation Counsel	Young, Morphis, Bach, & Taylor, LLP
Underwriter Counsel	Robinson, Bradshaw, & Hinson, P.A.
Trustee	Bank of New York Mellon Trust Company, N.A.
Trustee Counsel	*TBD*

6) Other Information:

(a) Board diversity

Male:	8
Female:	12
Total:	20

Caucasian:	14
African American:	6
	20

(b) Diversity of residents

Male:	25%
Female:	75%
Total:	100%

Caucasian:	91%
African American/Asian/American Indian:	9%
	100%

(c) Fee Schedule – Attached (Pages 5 – 10)
(d) MCC Bond Sale Approval Policy Form – Attached (Page 11)

3. Resolution of the North Carolina Medical Care Commission Approving Amendments to Novant Health, Inc.'s Master Trust Indenture.

WHEREAS, Novant Health, Inc. ("Novant") has entered into a Master Trust Indenture (Amended and Restated) dated as of June 1, 2003 (as amended and supplemented, the "Master Indenture"), among Novant, Forsyth Memorial Hospital, Inc. ("Forsyth"), The Presbyterian Hospital ("Presbyterian") and Wachovia Bank, National Association, succeeded by Regions Bank, as master trustee (the "Master Trustee"); and

WHEREAS, the North Carolina Medical Care Commission (the "Commission"), a commission of the Department of Health and Human Services of the State of North Carolina, has previously issued and has outstanding multiple series of tax-exempt bonds set forth on Exhibit A hereto (which are referred to herein as the "Commission Bonds") and has loaned the proceeds thereof to Novant pursuant to various loan agreements relating to one or more series of the Commission Bonds (each a "Loan Agreement"); and

WHEREAS, in connection with the issuance of its taxable bonds in 2021 (the "2021 Bonds"), Novant is entering into a Supplemental Master Trust Indenture No. 31, dated as of April 1, 2021 (the "2021 Supplemental Indenture"), among Novant, Forsyth, Presbyterian and the Master Trustee; and

WHEREAS, Section 5.02 of the 2021 Supplemental Indenture contains amendments to the Master Indenture (the "2021 Amendments") that will be approved by the holders of the 2021 Bonds when purchased by such holders on the issue date of the 2021 Bonds; and

WHEREAS, pursuant to Section 5.07 of the Loan Agreements relating to the Series 2008A Bonds, Series 2008B Bonds, Series 2008C Bonds, Series 2013A Bonds and Series 2019A Bonds (each as described on Exhibit A), the Commission must consent to the 2021 Amendments before the 2021 Amendments can become effective; and

WHEREAS, a copy of the 2021 Amendments and excerpts from the Official Statement for the 2021 Bonds reflecting the 2021 Amendments have been presented to the staff of the Commission; and

WHEREAS, Novant has requested the Commission to consent to the 2021 Amendments; and

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

Section 1. The 2021 Amendments are hereby approved and consented to.

Section 2. This Resolution shall take effect immediately upon its passage.

Executive Committee Action: Motion was made to approve the Master Trust Indenture amendments by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.

Exhibit A

Outstanding North Carolina Medical Care Commission Bonds
Issued for the Benefit of Novant Health, Inc.

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Bonds, Series 2004A

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Bonds, Series 2004B

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Refunding Bonds, Series 2008A (the "Series 2008A Bonds")

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Refunding Bonds, Series 2008B (the "Series 2008B Bonds")

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Refunding Bonds, Series 2008C (the "Series 2008C Bonds")

North Carolina Medical Care Commission Health Care Facilities Revenue and Revenue Refunding Bonds, Series 2013A (the "Series 2013A Bonds")

North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (Novant Health Obligated Group) Series 2019A (the "Series 2019A Bonds")

4. Adjournment

There being no further business, the meeting was adjourned at 12:05 p.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

1. Purpose of Meeting

To consider a (1) resolution granting preliminary approval for the sale and issuance of bonds, the proceeds of which will be loaned to Lutheran Services for the Aging, Inc.. and to (2) grant approval for amendments to the Master Trust Indenture for Novant Health. Inc.

2. The Commission grants preliminary approval to a transaction for Lutheran Services for the Aging, Inc. (LSA) to (1) provide funds, to be used, together with other available funds, to refund the North Carolina Medical Care Commission $44,790,000 Health Care Facilities First Mortgage Revenue Refunding Bonds, Series 2012A, outstanding as of the date of the refunding in the amount of $40,150,000, (2) provide funds, to be used, together with other available funds, to refund the North Carolina Medical Care Commission $33,795,000 Health Care Facilities First Mortgage Revenue Refunding Bonds, Series 2017, outstanding as of the date of refunding in the amount of $27,919,989, (3) provide funds, to be used, together with other available funds, to refund the North Carolina Medical Care Commission $115,338,000 Health Care Facilities First Mortgage Revenue Bonds, Series 2020A, outstanding and not fully drawn as of the date of the refunding in the amount of $53,586,894, (4) and provide funds, to be used, together with other available funds, to refund a private bank loan. The intent of the proposed 2021 Bond Issue is to take advantage of the low interest rate environment, eliminate put bond risk, and allow for bank debt capacity for future needs. The estimated net present value of this transaction is $1,736,335. The proposed transaction is in accordance with an application received as follows:

ESTIMATED SOURCES OF FUNDS	
Principal Amount of Bonds to be Issued	$204,459,691
Series 2012 Debt Service Reserve Fund	3,030,887
Series 2012 Principal Account	847,500
Series 2012 Interest Account	474,084
Total Sources	**$208,812,162**

ESTIMATED USES OF FUNDS	
Escrow Amount to Refund Series 2012A & Series 2017 & Bank Loan	$ 77,811,727
Amount to Refund Series 2020A Bonds (Draw-Down)	53,586,894
Remaining Construction Costs from Series 2020A (Draw-Down)	56,263,396
Bond Interest During Construction	7,157,747
Underwriter Discount	1,880,112
Debt Service Reserve Fund	11,473,786
Feasibility Study Fee	120,000
Financial Advisor Fee	45,000
Accountant's Fee	5,000
Title Insurance	100,000
Local Government Commission's Fee	10,000
Corporation's Counsel	110,000
Bond Counsel	165,000
Underwriter's Counsel	60,000
Printing Costs	10,000
Trustee's Fees	13,500
Total Uses	**$208,812,162**

Tentative approval is given with the understanding that the governing board of Lutheran Services for the Aging, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Final financial feasibility must be determined prior to the issuance of bonds.

3. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

4. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

5. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

6. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

7. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

8. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is -

1.	Financially feasible	✓	Yes	_____	No	_____ N/A
2.	Construction and related costs are reasonable	_____	Yes	_____	No	✓ N/A

Executive Committee Action: Motion was made to approve the refunding by Mrs. Eileen Kugler, seconded by Mr. Joe Crocker, and unanimously approved.

EXHIBIT A

Lutheran Services for the Aging

Compliance Summary:

- **No Violation of MCC Compliance policy**

1) Does Organization have a formal post tax issuance compliance policy?

   No

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?

   Chief Financial Officer (Kirby Nickerson)

3) What is the Organization's compliance monitoring plan?

   LSA utilizes a compliance checklist (submitted to the NCMCC) which is reviewed by a financial analyst and approved the CFO annually. The compliance monitoring plan encompasses monthly, quarterly, and annual procedures.

4) How will the Organization report compliance deficiencies to leadership and the Board?

   Any noted deficiencies will be communicated to the CEO and Board via a written report.

Selected Application Information:

1) Information from FYE 2020 (9/30 Year End) Audit of Lutheran Services for the Aging:

Net Income	$ 11,277,947
Operating Revenue	$131,334,149
Operating Expenses	$126,995,282
Net Cash provided by Operating Activities	$ 13,301,122
Unrestricted cash	$ 15,522,989
Change in cash	$ 5,940,047

2) Ratings:

NONE

3) Community Benefits (FYE 2020):

Per N.C.G.S § 105 – 12.69% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $13,605,336

4) Long-Term Debt Service Coverage Ratios:

Actual	FYE	2020	2.75
Forecasted	FYE	2021	2.13
Forecasted	FYE	2022	1.61
Forecasted	FYE	2023	1.62
Forecasted	FYE	2024	2.29
Forecasted	FYE	2025	1.55

5) Transaction Participants:

Underwriter	Truist Securities
Feasibility Consultant	CliftonLarsonAllen LLP
Bond Counsel	McGuireWoods LLP
Corporation Counsel	Young, Morphis, Bach, & Taylor, LLP
Underwriter Counsel	Robinson, Bradshaw, & Hinson, P.A.
Trustee	Bank of New York Mellon Trust Company, N.A.
Trustee Counsel	*TBD*

6) Other Information:

(a) Board diversity

Male:	8
Female:	12
Total:	20

Caucasian:	14
African American:	6
	20

(b) Diversity of residents

Male:	25%
Female:	75%
Total:	100%

Caucasian:	91%
African American/Asian/American Indian:	9%
	100%

(c) Fee Schedule – Attached (Pages 5 – 10)
(d) MCC Bond Sale Approval Policy Form – Attached (Page 11)

3. Resolution of the North Carolina Medical Care Commission Approving Amendments to Novant Health, Inc.'s Master Trust Indenture.

WHEREAS, Novant Health, Inc. ("Novant") has entered into a Master Trust Indenture (Amended and Restated) dated as of June 1, 2003 (as amended and supplemented, the "Master Indenture"), among Novant, Forsyth Memorial Hospital, Inc. ("Forsyth"), The Presbyterian Hospital ("Presbyterian") and Wachovia Bank, National Association, succeeded by Regions Bank, as master trustee (the "Master Trustee"); and

WHEREAS, the North Carolina Medical Care Commission (the "Commission"), a commission of the Department of Health and Human Services of the State of North Carolina, has previously issued and has outstanding multiple series of tax-exempt bonds set forth on Exhibit A hereto (which are referred to herein as the "Commission Bonds") and has loaned the proceeds thereof to Novant pursuant to various loan agreements relating to one or more series of the Commission Bonds (each a "Loan Agreement"); and

WHEREAS, in connection with the issuance of its taxable bonds in 2021 (the "2021 Bonds"), Novant is entering into a Supplemental Master Trust Indenture No. 31, dated as of April 1, 2021 (the "2021 Supplemental Indenture"), among Novant, Forsyth, Presbyterian and the Master Trustee; and

WHEREAS, Section 5.02 of the 2021 Supplemental Indenture contains amendments to the Master Indenture (the "2021 Amendments") that will be approved by the holders of the 2021 Bonds when purchased by such holders on the issue date of the 2021 Bonds; and

WHEREAS, pursuant to Section 5.07 of the Loan Agreements relating to the Series 2008A Bonds, Series 2008B Bonds, Series 2008C Bonds, Series 2013A Bonds and Series 2019A Bonds (each as described on Exhibit A), the Commission must consent to the 2021 Amendments before the 2021 Amendments can become effective; and

WHEREAS, a copy of the 2021 Amendments and excerpts from the Official Statement for the 2021 Bonds reflecting the 2021 Amendments have been presented to the staff of the Commission; and

WHEREAS, Novant has requested the Commission to consent to the 2021 Amendments; and

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

Section 1. The 2021 Amendments are hereby approved and consented to.

Section 2. This Resolution shall take effect immediately upon its passage.

Executive Committee Action: Motion was made to approve the Master Trust Indenture amendments by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.

Exhibit A

Outstanding North Carolina Medical Care Commission Bonds
Issued for the Benefit of Novant Health, Inc.

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Bonds, Series 2004A

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Bonds, Series 2004B

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Refunding Bonds, Series 2008A (the "Series 2008A Bonds")

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Refunding Bonds, Series 2008B (the "Series 2008B Bonds")

North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Refunding Bonds, Series 2008C (the "Series 2008C Bonds")

North Carolina Medical Care Commission Health Care Facilities Revenue and Revenue Refunding Bonds, Series 2013A (the "Series 2013A Bonds")

North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (Novant Health Obligated Group) Series 2019A (the "Series 2019A Bonds")

4. Adjournment

There being no further business, the meeting was adjourned at 12:05 p.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE
CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE
April 29, 2021
11:30 A.M.

Via Microsoft Teams: Click here to join the meeting
OR
Dial-In: 1-984-204-1487 / Passcode: 566 508 803#

Members of the Executive Committee Present:

John J. Meier, IV, M.D., Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Linwood B. Hollowell, III
Eileen C. Kugler, RN, BSN, MPH, FNP
Jeffrey S. Wilson

Members of the Executive Committee Absent:

Albert F. Lockamy, RPh

Members of Staff Present:

Geary W. Knapp, JD, CPA, Assistant secretary
Kathy C. Larrison, MCC Auditor
Crystal Watson-Abbott, MCC Auditor
Alice S. Creech, Executive Assistant

Others Present:

Allen Robertson, Robinson Bradshaw & Hinson, PA
Charles Bowyer, Robinson Bradshaw & Hinson, PA
Brandon Lofton, Robinson Bradshaw & Hinson, PA
Kent Thompson, Hugh Chatham Memorial Hospital
Matt Callahan, Echo Financial Products

1. Purpose of Meeting

To authorize the execution and delivery of a Second Supplemental Trust Agreement for the 2008 Bonds issued for the benefit of Hugh Chatham Memorial Hospital, Inc.

2. Resolution of the North Carolina Medical Care Commission Approving and Authorizing Execution and Delivery of a Second Supplemental Trust Agreement Relating to the North Carolina Medical Care Commission Variable Rate Demand Health Care Facilities Revenue Bonds (Hugh Chatham Memorial Hospital Project) Series 2008.

Executive Committee Action: Motion was made to approve Second Supplemental Trust Agreement by Mr. Joe Crocker, seconded by Mr. Jeff Wilson, and unanimously approved.

WHEREAS, the North Carolina Medical Care Commission (the "Commission"), a commission of the Department of Health and Human Services of the State of North Carolina, issued $45,455,000 aggregate principal amount of its Variable Rate Demand Health Care Facilities Revenue Bonds (Hugh Chatham Memorial Hospital Project) Series 2008, of which $37,435,000 aggregate principal amount is currently outstanding (the "Bonds"); and

WHEREAS, the Bonds have been issued and are outstanding under the terms of an Amended and Restated Trust Agreement dated as of July 25, 2013, as supplemented and amended by the First Supplemental Trust Agreement dated as of July 25, 2018 (together, the "Trust Agreement"), between the Commission and U.S. Bank National Association as bond trustee (the "Bond Trustee"), and the Commission loaned the proceeds from the sale of the Bonds to Hugh Chatham Memorial Hospital, Inc. d/b/a Hugh Chatham Memorial Hospital (the "Corporation") pursuant to an Amended and Restated Loan Agreement dated as of July 25, 2013 between the Commission and the Corporation; and

WHEREAS, the Bonds were purchased upon their initial issuance by Wells Fargo Municipal Capital Strategies, LLC; and

WHEREAS, the Corporation intends to deliver a Conversion Notice changing the Interest Rate Determination Method for the Bonds from an Index Interest Rate Period (as such terms are defined in the Trust Agreement) to a new Index Interest Rate Period effective May 3, 2021 (the "Conversion Date"); and

WHEREAS, on the Conversion Date, the Bonds will be subject to mandatory tender for purchase and will be purchased by First National Bank of Pennsylvania (the "Purchaser"); and

WHEREAS, in connection with such purchase, it is necessary to provide for a new Default Rate (as defined in the Trust Agreement) and certain additional terms related to the potential unavailability of the LIBOR Index Rate (as defined in the Trust Agreement); and

WHEREAS, Corporation and the Purchaser have agreed to modify and supplement certain provisions of the Trust Agreement simultaneously with the conversion to the new Index Interest Rate Period (as defined in the Trust Agreement) on the Conversion Date; and

WHEREAS, Sections 11.02 and 11.08 of the Trust Agreement permit the Commission and the Bond Trustee, with the consent of the Purchaser as the Holder (as defined in the Trust Agreement) of 100% of the Bonds, to enter into agreements supplemental to the Trust Agreement to make any change to the Trust Agreement; and

WHEREAS, there has been presented to the staff of the Commission a draft copy of a Second Supplemental Trust Agreement (EXHIBIT A) to be dated the date of delivery thereof (the "Second Supplement") between the Commission and the Bond Trustee that would amend the Trust Agreement to make the changes agreed upon by the Corporation and the Purchaser; and

WHEREAS, the Corporation has requested that the Commission approve the Second Supplement and authorize its execution and delivery;

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

Section 1. The form, terms and provisions of the Second Supplement are hereby approved in all respects, and the Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are hereby authorized and directed to execute and deliver the Second Supplement in substantially the form presented at this meeting, together with such changes, modifications and deletions as they, with the advice of bond counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 2. The Chairman, Vice Chairman, Secretary or Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) or any duly authorized Commission Representative under the Trust Agreement are authorized and directed to take such other action and to execute and deliver any such other documents, certificates, undertakings, agreements or other instruments as they, with the advice of bond counsel, may deem necessary or appropriate to effect the changes made in the Second Supplement.

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

3. <u>Adjournment</u>

There being no further business, the meeting was adjourned at 11:45 a.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

EXHIBIT A

SECOND SUPPLEMENTAL TRUST AGREEMENT

By and Between

NORTH CAROLINA MEDICAL CARE COMMISSION

And

U.S. BANK NATIONAL ASSOCIATION, as Bond Trustee

Dated as of May 3, 2021

Supplementing the
Amended and Restated Trust Agreement
Dated as of July 25, 2013

SECOND SUPPLEMENTAL TRUST AGREEMENT

THIS SECOND SUPPLEMENTAL TRUST AGREEMENT (this "Supplement"), dated as of May 3, 2021, is made and entered into by and between the **NORTH CAROLINA MEDICAL CARE COMMISSION**, a commission of the Department of Health and Human Services of the State of North Carolina (the "Commission"), and **U.S. BANK NATIONAL ASSOCIATION**, a national banking association organized under and by virtue of the laws of the United States of America, and having its designated corporate trust office in Charlotte, North Carolina, which is authorized to exercise trust powers and is subject to examination by federal authority and duly qualified to accept and administer the trusts created hereby (together with any successor trustee under the Trust Agreement (as hereinafter defined), the "Bond Trustee").

W I T N E S S E T H:

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

WHEREAS, Hugh Chatham Memorial Hospital, Inc. d/b/a Hugh Chatham Memorial Hospital (the "Corporation") is a North Carolina nonprofit corporation and a "non-profit agency" within the meaning and intent of the Act, which owns and operates health care facilities located in Elkin, North Carolina; and

WHEREAS, on September 24, 2008, the Commission issued $45,455,000 aggregate principal amount of its Variable Rate Demand Health Care Facilities Revenue Bonds (Hugh Chatham Memorial Hospital Project), Series 2008, of which $37,435,000 aggregate principal amount is currently outstanding (the "Bonds"), pursuant to the terms of a Trust Agreement dated as of September 1, 2008 (the "Original Trust Agreement"), between the Commission and the Bond Trustee; and

WHEREAS, on July 25, 2013 (the "Initial Conversion Date"), the Commission and the Bond Trustee entered into an Amended and Restated Trust Agreement dated as of July 25, 2013 (the "A&R Trust Agreement"), for the purpose of amending and restating in its entirety the Original Trust Agreement to add an "Index Interest Rate" mode and converting to that mode; and

WHEREAS, the Commission has loaned the proceeds of the Bonds to the Corporation pursuant to an Amended and Restated Loan Agreement dated as of July 25, 2013 (the "Agreement") between the Commission and the Corporation; and

WHEREAS, the Bonds were purchased on the Initial Conversion Date by Wells Fargo Municipal Capital Strategies, LLC (the "Initial Purchaser"); and

WHEREAS, the Corporation previously delivered a Conversion Direction to elect that the Bonds bear interest at a new Index Interest Rate beginning on July 25, 2018, and in connection with that conversion to a new Index Interest Rate, the Bond Trustee and the Commission, upon the request of the Initial Purchaser as Holder of 100% of the Bonds, entered

into the First Supplemental Trust Agreement dated as of July 25, 2018 (the "First Supplement," and together with the A&R Trust Agreement, the "Trust Agreement").

WHEREAS, on May 3, 2021 (the "Conversion Date"), pursuant to a Conversion Notice sent by the Corporation on April 26, 2021, the Bonds will be converted from an Index Interest Rate Period to a new Index Interest Rate Period and will be subject to a mandatory tender for purchase (the "Conversion"); and

WHEREAS, on the Conversion Date, the Bonds will be purchased by First National Bank of Pennsylvania (the "Purchaser"); and

WHEREAS, the Corporation and the Purchaser have agreed to modify and supplement certain provisions of the Trust Agreement simultaneously with the Conversion; and

WHEREAS, Sections 11.02 and 11.08 of the Trust Agreement permit the Commission and the Bond Trustee, with the consent of the Purchaser as the Holder of 100% of the Bonds, to enter into agreements supplemental to the Trust Agreement to make any change to the Trust Agreement;

WHEREAS, the Corporation has requested that the Commission and the Bond Trustee enter into this Supplement; and

WHEREAS, under the Constitution and laws of the State of North Carolina, including the Act, the Commission is authorized to enter into this Supplement and to do or cause to be done all the acts and things herein provided or required to be done as hereinafter covenanted; and

WHEREAS, all acts and things necessary to constitute this Supplement a valid indenture and agreement according to its terms have been done and performed;

NOW, THEREFORE, in consideration of the premises, the Commission covenants and agrees with the Bond Trustee, for the benefit of the Holders from time to time of the Bonds, as follows:

Section 1. Definitions. For the purposes hereof, unless the context otherwise indicates, all capitalized terms used herein which are defined in the Trust Agreement shall have the meanings assigned to them therein.

Section 2. Amendment to Trust Agreement Requiring Holder Consent.

(a) The following definitions in Section 1.01 of the Trust Agreement are hereby deleted in their entirety and the following are substituted therefor:

> "Applicable Factor" means (a) during the Direct Purchase Period beginning on July 25, 2013, 70% and (b) during any other LIBOR Index Rate Period, 82%, or, with an approval Opinion of Bond counsel, such other percentage as may be designated in writing by the Corporation as the Applicable Factor for such LIBOR Index Rate Period pursuant to **Section 2.10(a)** or **Section 2.10(b)**.

"Applicable Spread" means, with respect to each Index Interest Rate Period, the following: (a) during the Direct Purchase Period beginning on July 25, 2013, 165 basis points (1.65%); and (b) during any Index Interest Rate Period other than the initial Direct Purchase Period beginning on July 25, 2013, the number of basis points determined by the Market Agent on or before the first day of such Index Rate Period and designated by the Corporation in accordance with **Section 2.10(a)** or **Section 2.10(b)**. As of the date of the Second Supplement, the Applicable Spread is 77 basis points (0.77%).

"Calculation Agent" means, as of the Second Supplement (as appointed by the Corporation), First National Bank of Pennsylvania, and any successor appointed by the Corporation, with the consent of the Purchaser, to serve as calculation agent for the Bonds pursuant to **Section 9.19**.

"Default Rate" means (i) during the Direct Purchase Rate Period beginning on the date hereof, "Default Rate" as defined in Exhibit I hereto and (ii) during any Direct Purchase Rate Period other than the Direct Purchase Rate Period beginning on the date hereof, "Default Rate" as defined in the Conversion Notice for such Direct Purchase Rate Period.

"LIBOR Index" means, for any date of determination, (1) the per annum rate of interest determined on the basis of the rate on deposits in United States dollars of amounts equal to or comparable to the Principal Amount, offered for a term of one month, which rate appears on the display designated as Reuters Screen LIBOR01 Page (or any successor page), determined as of approximately 11:00 a.m., London time, on each Computation Date for effect on the immediately succeeding LIBOR Index Reset Date, divided by 1.00 minus the Eurodollar Reserve Percentage, or (2) or upon the occurrence of a Benchmark Transition Event or an Early Opt-in Election, as applicable, a Benchmark Replacement determined by the Calculation Agent as set forth in Exhibit I hereto. Notwithstanding the foregoing provisions of this paragraph, during any Benchmark Unavailability Period, the LIBOR Index shall be replaced with the rate determined by the Calculation Agent as set forth in Exhibit I hereto. Notwithstanding anything herein to the contrary, during any period of time while the LIBOR Index, determined as provided above, would be less than zero percent (0.0%), the LIBOR Index shall be deemed to be zero percent (0.0%).

"Margin Rate Factor" means the product of (a) one minus the prevailing Maximum Federal Corporate Tax Rate multiplied by (b) the quotient of (A) one divided by (B) (1) one minus (2) the Maximum Federal Corporate Tax Rate on the Margin Rate Factor Pricing Date. The effective date of any change in the Margin Rate Factor shall be the effective date of the decrease or increase (as applicable) in the Maximum Federal Corporate Tax Rate resulting in such change.

(b) Section 1.01 of the Trust Agreement is hereby amended by inserting the following new definitions of "Benchmark Replacement," "Benchmark Transition Event," "Benchmark Unavailability Period," "Early Opt-In Election," "Eurodollar Reserve Percentage" and "Second Supplement" in appropriate alphabetical order:

"Benchmark Replacement" has the meaning given such term in Exhibit I hereto.

"Benchmark Transition Event" has the meaning given such term in Exhibit I hereto.

"Benchmark Unavailability Period" has the meaning given such term in Exhibit I hereto.

"Early Opt-In Election" has the meaning given such term in Exhibit I hereto.

"Eurodollar Reserve Percentage" has the meaning given such term in Exhibit I hereto.

"Second Supplement" means, the Second Supplemental Trust Agreement, dated as of May 3, 2021.

(c) The Trust Agreement is hereby amended by adding the attached Exhibit I as Exhibit I to the Trust Agreement.

(d) Section 1.01 of the Trust Agreement is hereby amended by deleting the definitions of "Base Rate," "Fed Funds Rate" and "Prime Rate" in their entirety.

(e) Section 2.10(a) of the Trust Agreement is hereby amended by deleting the second paragraph thereof in its entirety and substituting the following therefor:

> Each Conversion Notice shall state (i) that the Corporation elects to change the Interest Rate Determination Method to a new Interest Rate Determination Method, or from the interest rate applicable during a Medium-Term Rate Period to a new interest rate during a new Medium-Term Rate Period, or from an Index Interest Rate Period to a new Index Interest Rate Period, (ii) the proposed Conversion Date, (iii) the Interest Rate Determination Method to be in effect from and after such Conversion Date, (iv) whether a Credit Facility is to be in effect from and after such Conversion Date, and, if so, the terms of such Credit Facility, (v) the Default Rate and (vi) if a Medium-Term Rate or Fixed Rate is to be in effect from and after such Conversion Date, and if redemption premiums different from those set forth in Section 3.01, are to be applicable as described in Section 2.09(d) and Section 2.09(e), the redemption premiums to be applicable during such Medium-Term Rate Period or Fixed Rate Period. In addition, if an Index Interest Rate is to be in effect immediately following such Conversion Date, such Conversion Notice shall state (1) whether such Index Interest Rate shall be a SIFMA Index Rate or a LIBOR Index Rate, (2) the new Direct Purchase Period Purchase Date, (3) the new Applicable Spread and (4) if such Index Interest Rate shall be a LIBOR Index Rate, the new Applicable Factor. If the Bonds are converted to an Index Interest Rate Period, the new Applicable Spread shall be the Applicable Spread which when used to calculate the new Index Interest Rate shall be, in the judgment of the Market Agent, having due regard for prevailing market conditions for bonds or other securities similar to the Bonds, the interest rate necessary, but shall not exceed the interest rate necessary, to enable the Bonds to be placed at a price of par on the Conversion Date. In the event that the Bonds are converted to any other Direct Purchase Period, the new interest rate shall be, in the

judgment of the Market Agent, having due regard for prevailing market conditions for bonds or other securities similar to the Bonds, the interest rate necessary, but not to exceed the interest rate necessary to enable the Bonds to be placed at a price of par on the Conversion Date. In the case of a conversion to a Weekly Rate Period or a Flexible Rate Period, each Conversion Notice shall be accompanied by evidence that a Remarketing Agent shall have been appointed and accepted such appointment

(f) Section 9.03 of the Trust Agreement is hereby amended by adding the following paragraphs at the end thereof:

The Bond trustee shall not be under any obligation (i) to monitor, determine or verify the unavailability or cessation of the LIBOR Index (or other applicable Index Interest Rate), or whether or when there has occurred, or to give notice to any other transaction party of the occurrence of, any Benchmark Unavailability Period, Benchmark Transition Event, Early Opt-in Election, Benchmark Replacement Date or Benchmark Transition Start Date, (ii) to select, determine or designate any Benchmark Replacement, FNB Base Rate, or other successor or replacement benchmark index, or to determine or confirm whether any standards or conditions to the selection, determination or designation of such Benchmark Replacement, FNB Base Rate or other rate have been satisfied, (iii) to select, determine or designate any Benchmark Replacement Date or Benchmark Transition Start Date (iv) to select, determine or designate any Benchmark Replacement Adjustment, or other modifier to any replacement or successor index, or determine or confirm whether any standards or conditions to the selection, determination or designation of Benchmark Replacement Adjustment or other modify have been satisfied, or (v) to determine whether or what Benchmark Replacement Conforming Changes are necessary or advisable, if any, in connection with any of the foregoing.

The Bond Trustee shall not be liable for any inability, failure or delay on its part to perform any of its duties set forth in this Trust Agreement as a result of the unavailability of the LIBOR Index (or other applicable Index Interest Rate) and absence of a designated Benchmark Replacement, including as a result of any inability, delay, error or inaccuracy on the part of any other transaction party, including without limitation the Calculation Agent, in providing any direction, instruction, notice or information required or contemplated by the terms of this Trust Agreement and reasonably required for the performance of such duties.

The Bond Trustee shall not be under any duty to succeed to, assume or otherwise perform any of the duties of the Calculation Agent, or to appoint a successor or replacement Calculation Agent in the event of its resignation or removal, or to remove and replace the Calculation Agent in the event of a default, breach or failure of performance on the part of the Calculation Agent with respect to its duties and obligations under the terms of this Trust Agreement.

Section 3. Ratification of Trust Agreement; Consents. As supplemented hereby, the Trust Agreement is in all respects ratified and confirmed and the Trust Agreement as so supplemented hereby shall be read, taken and construed as one and the same instrument. By

their signatures below, the Purchaser and the Corporation consent to the terms of this Supplement.

Section 4. Severability. If any provision of this Supplement shall be held or deemed to be or shall, in fact, be inoperative or unenforceable as applied in any particular case and any jurisdiction or jurisdictions or in all jurisdictions, or in all cases, because it conflicts with any other provision or provisions hereof or any constitution, statute, rule or public policy, or for any other reason, such circumstances shall not have the effect of rendering the provision in question inoperative or unenforceable in any other case or circumstance, or of rendering any other provision or provisions herein contained invalid, inoperative or unenforceable to any extent whatever. The invalidity of any one or more phrases, sentences, clauses, sections or subsections contained in this Supplement shall not affect the remaining portions of this Supplement or any part thereto.

Section 5. Counterparts. This Supplement (and the consents of the Purchaser and the Corporation) may be executed in several counterparts, each of which shall be an original and all of which shall constitute one instrument.

Section 6. Governing Law. This Supplement shall be governed by and construed in accordance with the laws of the State of North Carolina.

[The remainder of this page is left blank intentionally]

IN WITNESS WHEREOF, the Commission has caused this Supplement to be signed in its name and on its behalf by its Assistant Secretary, and the Bond Trustee has caused these presents to be signed in its name and on its behalf by one of its duly authorized officers, all as of the date first written above.

NORTH CAROLINA MEDICAL CARE COMMISSION

By: _____
Assistant Secretary

U.S. BANK NATIONAL ASSOCIATION, as Bond Trustee

By: _____
Vice President

WE CONSENT:

FIRST NATIONAL BANK OF PENNSYLVANIA,
as Purchaser

By: _____
Vice President

HUGH CHATHAM MEMORIAL HOSPITAL, INC.,
d/b/a HUGH CHATHAM MEMORIAL HOSPITAL

By: _____
Chief Financial Officer

EXHIBIT I

SUCCESSOR LIBOR INTEREST RATE PROVISIONS

1. Benchmark Replacement. Notwithstanding anything to the contrary herein or in the Trust Agreement, upon the occurrence of a Benchmark Transition Event or an Early Opt-in Election, as applicable, the Calculation Agent may replace the LIBOR Index with a Benchmark Replacement. No replacement of the LIBOR Index with a Benchmark Replacement pursuant to this Exhibit will occur prior to the applicable Benchmark Transition Start Date.

2. Benchmark Replacement Conforming Changes. In connection with the implementation of a Benchmark Replacement, the Calculation Agent will have the right to make Benchmark Replacement Conforming Changes from time to time and, notwithstanding anything to the contrary herein or in the Trust Agreement, any amendments implementing such Benchmark Replacement Conforming Changes will become effective without any further action or consent of the Corporation.

3. Notices; Standards for Decisions and Determinations. The Calculation Agent will promptly notify the Corporation of (i) any occurrence of a Benchmark Transition Event or an Early Opt-in Election, as applicable, and its related Benchmark Replacement Date and Benchmark Transition Start Date, (ii) the implementation of any Benchmark Replacement, (iii) the effectiveness of any Benchmark Replacement Conforming Changes and (iv) the commencement or conclusion of any Benchmark Unavailability Period. Any determination, decision or election that may be made by the Calculation Agent pursuant to this Exhibit, including any determination with respect to a tenor, rate or adjustment or of the occurrence or non-occurrence of an event, circumstance or date and any decision to take or refrain from taking any action, will be conclusive and binding absent manifest error and may be made in the Calculation Agent's sole discretion and without consent from the Corporation, except, in each case, as expressly required pursuant to this Exhibit.

4. Benchmark Unavailability Period. Upon the commencement and during the continuance of a Benchmark Unavailability Period, the LIBOR Index shall be replaced with the FNB Base Rate.

5. Definitions.

"Benchmark Replacement" means the sum of: (a) the alternate benchmark rate that has been selected by the Calculation Agent giving due consideration to (i) any selection or recommendation of a replacement rate or the mechanism for determining such a rate by the Relevant Governmental Body or (ii) any evolving or then-prevailing market convention for determining a rate of interest as a replacement to the LIBOR Index for U.S. dollar-denominated syndicated or bilateral credit facilities and (b) the Benchmark Replacement Adjustment;

provided that, if the Benchmark Replacement as so determined would be less than zero percent (0.0%), the Benchmark Replacement will be deemed to be zero percent (0.0%); provided further, however, notwithstanding the foregoing, in the event that the Bonds or any portion thereof become subject to an Interest Rate Swap Agreement, such 0.00% floor will not apply to the Bonds or portion thereof, and the Benchmark Replacement will comply with the "ISDA 2020 IBOR Fallbacks Protocol" (as such protocol has been provided, and as the same may be updated, supplemented or otherwise amended from time to time by the International Swaps and Derivatives Association) while such Interest Rate Swap Agreement is in effect. For the purposes of this Trust Agreement, Interest Rate Swap Agreement shall mean any interest rate protection agreement, interest rate future agreement, interest rate swap agreement, interest rate cap agreement, interest rate collar agreement, option agreement or any other similar hedging agreement or arrangement (whether cancellable or otherwise).

"Benchmark Replacement Adjustment" means, with respect to any replacement of the LIBOR Index with an Unadjusted Benchmark Replacement for each applicable LIBOR Index Rate Period, the spread adjustment, or method for calculating or determining such spread adjustment that has been selected by the Calculation Agent giving due consideration to (i) any selection or recommendation of a spread adjustment, or method for calculating or determining such spread adjustment, for the replacement of LIBOR Index with the applicable Unadjusted Benchmark Replacement by the Relevant Governmental Body or (ii) any evolving or then-prevailing market convention for determining a spread adjustment, or method for calculating or determining such spread adjustment, for the replacement of the LIBOR Index with the applicable Unadjusted Benchmark Replacement for U.S. dollar-denominated syndicated or bilateral credit facilities at such time.

"Benchmark Replacement Conforming Changes" means, with respect to any Benchmark Replacement, any technical, administrative or operational changes (including changes to the definition of "LIBOR Index Rate Period," timing and frequency of determining rates and making payments of interest and other administrative matters) that the Calculation Agent decides may be appropriate to reflect the adoption and implementation of such Benchmark Replacement and to permit the administration thereof by the Calculation Agent in a manner substantially consistent with market practice (or, if the Calculation Agent decides that adoption of any portion of such market practice is not administratively feasible or if the Calculation Agent determines that no market practice for the administration of the Benchmark Replacement exists, in such other manner of administration as the Calculation Agent decides is reasonably necessary in connection with the Trust Agreement).

"Benchmark Replacement Date" means the earlier to occur of the following events with respect to the LIBOR Index: (a) in the case of clause (a) or (b) of the definition of "Benchmark Transition Event," the later of (i) the date of the public statement or publication of information referenced therein and (ii) the date on which the administrator of the LIBOR Index permanently or indefinitely ceases to provide the LIBOR Index or (b) in the case of clause (c) of the definition

of “Benchmark Transition Event,” the date of the public statement or publication of information referenced therein.

"Benchmark Transition Event" means the occurrence of one or more of the following events with respect to the LIBOR Index: (a) a public statement or publication of information by or on behalf of the administrator of the LIBOR Index announcing that such administrator has ceased or will cease to provide the LIBOR Index, permanently or indefinitely, provided that, at the time of such statement or publication, there is no successor administrator that will continue to provide the LIBOR Index; (b) a public statement or publication of information by the regulatory supervisor for the administrator of the LIBOR Index, the U.S. Federal Reserve System, an insolvency official with jurisdiction over the administrator for the LIBOR Index, a resolution authority with jurisdiction over the administrator for the LIBOR Index or a court or an entity with similar insolvency or resolution authority over the administrator for the LIBOR Index, which states that the administrator of the LIBOR Index has ceased or will cease to provide the LIBOR Index permanently or indefinitely, provided that, at the time of such statement or publication, there is no successor administrator that will continue to provide the LIBOR Index; or (c) a public statement or publication of information by the regulatory supervisor for the administrator of the LIBOR Index announcing that the LIBOR Index is no longer representative.

“Benchmark Transition Start Date” means (a) in the case of a Benchmark Transition Event, the earlier of (i) the applicable Benchmark Replacement Date and (ii) if such Benchmark Transition Event is a public statement or publication of information of a prospective event, the 90th day prior to the expected date of such event as of such public statement or publication of information (or if the expected date of such prospective event is fewer than 90 days after such statement or publication, the date of such statement or publication) and (b) in the case of an Early Opt-in Election, the date specified by the Calculation Agent by notice to the Corporation, so long as the Calculation Agent has not received, by such date, written notice of objection to such Early Opt-In Election from the Corporation.

“Benchmark Unavailability Period” means, if a Benchmark Transition Event and its related Benchmark Replacement Date have occurred with respect to the LIBOR Index and solely to the extent that the LIBOR Index has not been replaced with a Benchmark Replacement, the period (x) beginning at the time that such Benchmark Replacement Date has occurred if, at such time, no Benchmark Replacement has replaced the LIBOR Index for all purposes hereunder in accordance with the terms hereof and (y) ending at the time that a Benchmark Replacement has replaced the LIBOR Index for all purposes hereunder.

“Default Rate” means the fluctuating rate of interest which is equal to the rate that would otherwise be applicable to the Bonds plus 5.00%.

“Early Opt-in Election” means the occurrence of: (a) a determination by the Calculation Agent that at least three (3) currently outstanding U.S. dollar-denominated syndicated or bilateral

credit facilities at such time contain (as a result of amendment or as originally executed) as a benchmark interest rate, in lieu of the LIBOR Index, a new benchmark interest rate to replace the LIBOR Index, and (b) the election by the Calculation Agent to declare that an Early Opt-in Election has occurred and the provision by the Calculation Agent of written notice of such election to the Corporation.

"Eurodollar Reserve Percentage" means, for any day, the percentage which is in effect for such day as prescribed by the Board of Governors of the Federal Reserve System of the United States for determining the maximum reserve requirement (including any basic, supplemental or emergency reserves) in respect of eurocurrency liabilities or any similar category of liabilities for a member bank of the Federal Reserve System in New York City.

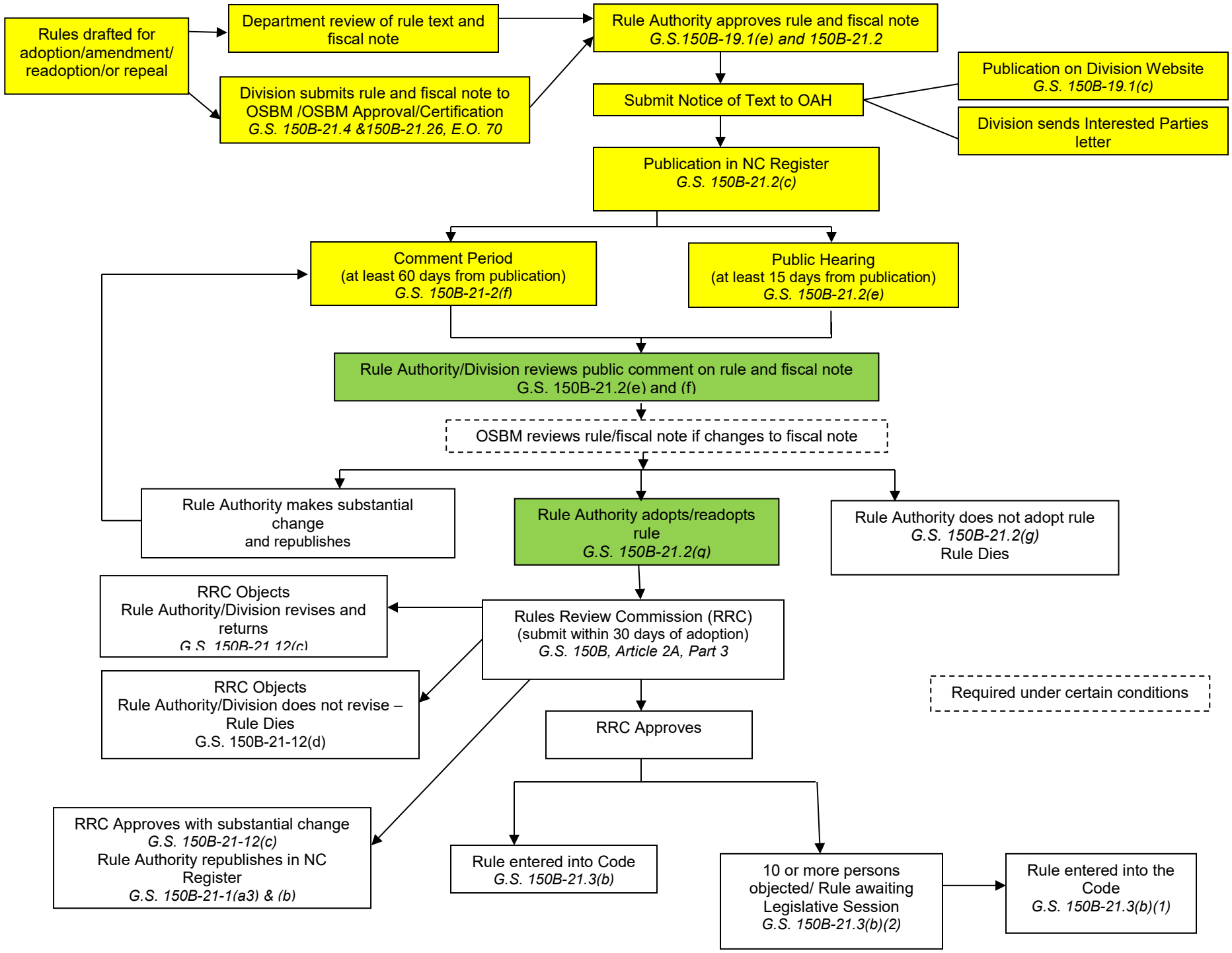
"FNB Base Rate" means a fluctuating rate of interest as determined by the Calculation Agent as its prime rate of interest ("Prime Rate"). The Prime Rate is determined from time to time by the Lender as a means of pricing some loans to its borrowers. The Prime Rate is not necessarily tied to any external rate of interest or index, and may not reflect the lowest rate of interest actually charged by the Lender to any particular class or category of customers. The Prime Rate will be adjusted, as needed, such that the applicable rate will be economically equivalent, and adjusted at least monthly to account for changes in the interest rate environment. To the extent the Prime Rate shall, at any time, be less than zero basis points (0.00%), the Prime Rate shall be deemed to be zero basis points (0.00%) for purposes hereof.

"Relevant Governmental Body" means the Federal Reserve Board and/or the Federal Reserve Bank of New York, or a committee officially endorsed or convened by the Federal Reserve Board and/or the Federal Reserve Bank of New York or any successor thereto.

"Unadjusted Benchmark Replacement" means the Benchmark Replacement excluding the Benchmark Replacement Adjustment.

Process for Medical Care Commission to Adopt/Readopt Rule

Exhibit C



10A NCAC 13F .0403 is readopted as published in 35:12 NCR 1348-1349 as follows:

10A NCAC 13F .0403 QUALIFICATIONS OF MEDICATION STAFF

(a) Adult care home staff who administer medications, hereafter referred to as medication aides, and ~~staff who directly supervise the administration of medications~~ their direct supervisors shall ~~have documentation of successfully completing the clinical skills validation portion of the competency evaluation according to Paragraphs (d) and (e) of Rule 10A NCAC 13F .0503 prior to the administration or supervision of the administration of medications.~~ complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B.

~~(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall successfully pass the written examination within 90 days after successful completion of the clinical skills validation portion of a competency evaluation according to Rule .0503 of this Section.~~

~~(c)~~(b) Medication aides and ~~staff who directly supervise the administration of medications,~~ their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.5B; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. July 1, 2021.

10A NCAC 13F .0406 is amended as published in 35:12 NCR 1348-1349 as follows:

10A NCAC 13F .0406 TEST FOR TUBERCULOSIS

(a) Upon employment or living in an adult care home, the ~~administrator and~~ administrator, all other ~~staff~~ staff, and any ~~live-in non-residents~~ persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A ~~.0205~~ .0205, including subsequent amendments and editions. Copies of the rule ~~are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.~~ may be accessed at http://reports.oah.state.nc.us/ncac.asp at no charge.

(b) There shall be documentation on file in the adult care home that the administrator, all other ~~staff~~ staff, and any ~~live-in non-residents~~ persons living in the adult care home are free of tuberculosis ~~disease that poses a direct threat to the health or safety of others.~~ disease.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. July 1, 2021.

10A NCAC 13G .0402 is readopted as published in 35:12 NCR 1348-1349 as follows:

10A NCAC 13G .0402 QUALIFICATIONS OF SUPERVISOR-IN-CHARGE

The ~~supervisor in charge~~ supervisor-in-charge, who is responsible to the administrator for carrying out the program in ~~the~~ a family care home in the absence of the ~~administrator. All of~~ administrator, shall meet the following ~~requirements must be met:~~ requirements:

~~(1) The applicant must complete the Application for Supervisor in Charge (DSS-1862);~~

(1) be 21 years or older, employed on or after the effective date of this Rule;

(2) ~~The qualifications of the administrator and co-administrator referenced in Paragraphs (2), (5), (6), and (7) of Rule .0401 of this Subchapter shall apply to the supervisor in charge. The supervisor in charge~~ the supervisor-in-charge, ~~(employed~~ employed on or after August 1, ~~1991) must meet a minimum educational requirement by being at least~~ 1991, shall be a high school graduate or certified under the GED ~~Program or by passing an alternative examination established by the Department of Health and Human Services. Documentation that these qualifications have been met must be on file in the home prior to employing the supervisor in charge;~~ Program or passed the alternative examination established by the Department of Health and Human Services prior to the effective date of this Rule; and

~~(3) The supervisor in charge must be willing to work with bonafide inspectors and the monitoring and licensing agencies toward meeting and maintaining the rules of this Subchapter and other legal requirements;~~

~~(4)~~(3) ~~The supervisor in charge must verify that he earns~~ earn 12 hours a year of continuing education credits related to the management of ~~domiciliary~~ adult care homes and care of aged and disabled ~~persons in accordance with procedures established by the Department of Health and Human Services;~~ persons.

~~(5) When there is a break in employment as a supervisor in charge of one year or less, the educational qualification under which the person was last employed will apply.~~

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
ARRC Objection June 16, 1988;
Amended Eff. July 1, 1990; December 1, 1988; April 1, 1987; January 1, 1985;
ARRC Objection Lodged January 18, 1991;
Amended Eff. August 1, ~~1991.~~ 1991;
Readopted Eff. July 1, 2021.

10A NCAC 13G .0403 is readopted as published in 35:12 NCR 1348-1349 as follows:

10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF

(a) Family care home staff who administer medications, hereafter referred to as medication aides, and ~~staff who directly supervise the administration of medications~~ their direct supervisors shall ~~have documentation of successfully completing the clinical skills validation portion of the competency evaluation according to Paragraphs (d) and (e) of Rule .0503 of this Subchapter prior to the administration or supervision of the administration of medications.~~ complete training, clinical skills validation, and pass the written examination as set forth in, G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.

~~(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall successfully pass the written examination within 90 days after successful completion of the clinical skills validation portion of a competency evaluation according to Rule .0503 of this Subchapter.~~

~~(c)~~(b) Medication aides and ~~staff who directly supervise the administration of medications,~~ their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 131D-4.5B; 143B- 165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. July 1, 2021.

10A NCAC 13G .0405 is readopted as published in 35:12 NCR 1348-1349 as follows:

10A NCAC 13G .0405 TEST FOR TUBERCULOSIS

(a) Upon employment or living in a family care home, the administrator, all other ~~staff~~ staff, and any ~~live in non residents~~ persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A ~~.0205~~ .0205, including subsequent amendments and editions. Copies of the rule ~~are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.~~ may be accessed at http://reports.oah.state.nc.us/ncac.asp at no charge.

(b) There shall be documentation on file in the family care home that the administrator, all other ~~staff~~ staff, and any ~~live in non residents~~ persons living in the family care home are free of tuberculosis ~~disease that poses a direct threat to the health or safety of others.~~ disease.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Amended Eff. October 1, 1977; April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. July 1, 2021.

Exhibit C/3
Fiscal Note
Phase 2

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

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Tichina Hamer, Director of Programs, (919) 855-3782
Ibtisam Zatari, Program Manager, (919) 855-3791

Impact:

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

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

Rule Readoptions (*See proposed text of these rules in Appendix)*
10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge
10A NCAC 13G .0403 Qualifications of Medication Staff
10A NCAC 13G .0405 Test for Tuberculosis
10A NCAC 13F .0403 Qualifications of Medication Staff
10A NCAC 13F .0406 Test for Tuberculosis

Authorizing Statutes: G.S. 131D-2.16; 131D-4.5; 131D-4.5B, 143B-165

Introduction and Background

The Adult Care Licensure Section is proposing to increase the minimum age of a Supervisor-In-Charge of a family care home from 18 years to 21 years old in an effort to improve the quality of care and services and improve the overall management of the family care homes. A proposed change in education will end the use of the alternative exam to better reflect current industry standards. Additional technical changes are proposed for clarity and consistency but do not affect current operations. The proposed changes will have limited fiscal impact on family care homes as they are privately owned and are mostly in current practice based on recent surveys. The proposed changes will have no fiscal impact on the Adult Care Licensure Section.

Under the authority of G.S. 150B-21.3A, Periodic review of existing rules. The North Carolina Medical Care Commission and Rule Review Commission approved the Subchapter reports with classifications for the rules under 10A NCAC 13F Licensing of Adult Care Homes of Seven or More Beds and 10 NCAC 13G Licensing of Family Care Homes. The rules were classified in the reports as necessary with substantive public interest. Rules 10A NCAC 13F .0403, 13G .0402 and .0403 are being

presented for readoption with substantive changes. Rule 13G .0405 is being presented for readoption without substantive changes and therefore not discussed in this analysis per statute. The following rule was not identified for readoption with substantive changes based on public comment but is being proposed for amendment to correlate with the 13G rule of the same title and similar content being proposed for readoption: 10A NCAC 13F .0406. Most of the rules for both types of assisted living residences, adult care homes of seven beds or more and family care homes, are the same with the primary exception of staffing and physical plant requirements since they serve the same population based on need for care and services. Therefore, the 13F rules corresponding to the 13G rules being proposed for readoption with substantive changes are being amended concurrently to assure this traditional consistency. The rule proposed for amendment, while not receiving comment for substantive change, is being amended for clarification and updating purposes.

Rules Summary and Anticipated Fiscal Impact

10A NCAC 13F .0406 Test for Tuberculosis: This rule specifies who is required to obtain a test for tuberculosis prior to employment or living in an adult care home. The rule addresses the testing of staff of licensed assisted living facilities for tuberculosis disease and documentation of that testing.

1. In Paragraph (a) and Paragraph (b), the rule as currently written requires any live in non-residents to obtain a tuberculosis test. The proposed language clarifies the rule as any person living in the home is required to obtain a test for tuberculosis.

Rationale: According to the North Carolina Tuberculosis Control Program, tuberculosis is a "communicable, potentially deadly disease that usually affects the lungs but can attack other parts of the body as well. It is spread when a person with an active case of TB breathes out the disease-causing bacteria, which are then inhaled by another person". The proposed language does not change the current requirement to test for tuberculosis for people living in the home. The proposed rule language simplifies the language of "live in non-resident" to "persons" living in the home must obtain a test for tuberculosis. The proposed change will avoid any ambiguity while it does not signify additional persons to be tested from what the rule currently requires. Testing for tuberculosis will help to protect everyone living in adult care home. The rule has no impact. Only technical changes were made.

Fiscal Impact: None

2. The rule as written provides a mailing address for copies of the rule 10A NCAC 41A .0205 and subsequent amendments. The proposed language is an update to remove the mailing address and provide the website address where the rule and subsequent amendments are available free of charge.

Rationale: The proposed language updates the access to copies of 10A NCAC 41A .0205 and subsequent amendments.

Fiscal Impact: None

10A NCAC 13F .0403 and 10A NCAC 13G .0403 Qualifications of Medication Staff: This rule specifies the qualifications of staff responsible for administering medications and their direct supervisors.

1. In Paragraph (a), the reference to Subchapter Rule .0503 is proposed for deletion since the implementation of NC Gen. Stat. § 131D-4.5B regarding medication aides training and competency

evaluation requirements. Paragraph (a) will reference NC Gen. Stat. § 131D-4.5B since the statute supersedes the rule. The rule has no impact. Changes to the rule are proposed to bring the rule in alignment with the statute and make technical changes.

Fiscal Impact: None

2. In Paragraph (a) and Paragraph (c), the current rule lists qualification requires for staff who directly supervise medication administration. The proposed language changes the reference from staff who directly supervise medication administration to direct supervisors.

Rationale: The change reorganizes the language in the previous rule and provides clarify by referring to staff who directly supervise medication administration as direct supervisors. The proposed language does not change any current requirements.

Fiscal Impact: None

10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge: This rule addresses the qualifications of supervisors working in licensed adult care homes categorized as family care.

1. Changes to the rule are proposed to bring the rule in alignment with the repeal of 10A NCAC 13G .0401 and make technical changes. Technical changes are proposed to simplify the rule text. The proposed changes in Item (1) removes the requirement for family care home providers to utilize a specific employment application for potential supervisory employees. The change proposes a deletion of Item (1) as written. An objection was raised to this rule on January 18, 1991. This objection has been resolved as a result of NC Gen. Stat. § 131D-4.5(3) Rules adopted by Medical Care Commission. The changes proposed have no impact.

Rationale: The proposed change allows family care home providers to utilize applications that align with their policies and hiring practices and does not limit them to a utilizing the DSS-1862 which was developed in the year of 1987.

Fiscal Impact: None

2. A new Item (1) is proposed to this rule to require the age of family care home employees working as a Supervisor-In-Charge change from 18 years old to 21 years of age of older when hired.

Rationale:
The Adult Care Licensure Section is proposing to increase the staff qualifications of the Supervisor-in-Charge from a minimum age of 18 years to 21 years old. The Supervisor-in-Charge is often the only staff member in the facility to provide care to two to six residents with varied cognitive, medical and physical needs. The amount of care needed for residents of adult care homes has increased over time and at least 54 instances of management-related violations resulting in serious risk or harm occurred in the last three years. The Adult Care Licensure Section is proposing the change in staff qualification in an effort to improve the quality of care and services and improve the overall management of the family care homes.

The increase in age from 18 years old to at least 21 years old is a trend occurring in hiring practices of family care home providers. Based on a recent survey of family care homes, 96% of employees hired within the past 3 years as Supervisors-in-Charge were at least 21 years or older. Family care homes are often staffed with one staff member who provides care and supervision to two to six residents. The staff is

responsible for performing multiple tasks for residents which include administering medications, meal preparation, assistance with activities of daily living and ensuring safety. The proposed change increases opportunities for potential Supervisors-in-Charge to gain work experiences prior to caring for a vulnerable population.

Fiscal Impact:
Currently, approximately 4% of new hires for a supervisor in charge (SIC) are under age 21. Increasing the minimum age of a SIC would disqualify these applicants, a lost employment opportunity. The change could also increase hiring costs for care facilities.

There are currently 577 licensed family care home, and hourly rates for hiring SICs vary. According to respondents of the survey, the average hourly rate when hiring a SIC ranges from $10.10 for age 18 to an average of $11.88 for age 21. Based on the age at hire, the difference in hourly rate is $1.78 or $3,702.40 annually at 40 hours per week for 52 weeks.

Twenty-one (21) years and older	$11.88 average hourly rate
Eighteen (18) years old	$10.10 average hourly rate

Assuming the individual was hired at 18, the cumulative cost increase over the three year period could average $11,107.20 per hire. Roughly 4% of new hires in the recent past were under age 21. This analysis assumes this proportion of hires under age 21 would remain constant in absence of the proposed rule change. Respondents to the survey reported 100% of Supervisors-in-Charge are currently over 18 years old. Therefore, the proposed rule change affects only future hires.

3. The change to Paragraph 2 proposes an update to the educational qualification for a Supervisor-in-Charge by ending the use of an alternative exam.

Rationale: As the rule is currently written, the educational qualification for hiring a Supervisor-in-Charge are be a high school graduate, be certified under the GED Program or pass an alternative exam established by the Department. Review of the data provided by the NC Division of Health Service Regulation, Health Care Personnel Education and Credentialing Section, reveals a 97% decrease in test takers over the past 3 years.

Year 2017 - Total Test Takers for Alternative Exam	296
Year 2018 - Total Test Takers for Alternative Exam	34
Year 2019 - Total Test Takers for Alternative Exam	9

Based on a recent survey, 100% of Supervisors-in-Charge hired in the past three years have at least a GED. The survey also revealed 93% of Supervisors-in-Charge currently employed have at least a GED. This is based on family care home policies and preferences for Supervisor-in-Charge to have a GED or higher level of education. The educational changes are proposed to better reflect current industry standards. Requiring a GED or high school diploma will have minimum impact because the industry is already requiring at least a GED as part of general hiring practices.

Appendix 1: Proposed Rule Text

10A NCAC 13F .0403 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0403 QUALIFICATIONS OF MEDICATION STAFF

(a) Adult care home staff who administer medications, hereafter referred to as medication aides, and ~~staff who directly supervise the administration of medications~~ their direct supervisors shall ~~have documentation of successfully completing the clinical skills validation portion of the competency evaluation according to Paragraphs (d) and (e) of Rule 10A NCAC 13F .0503 prior to the administration or supervision of the administration of medications.~~ complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B.

~~(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall successfully pass the written examination within 90 days after successful completion of the clinical skills validation portion of a competency evaluation according to Rule .0503 of this Section.~~

(c) Medication aides and ~~staff who directly supervise the administration of medications,~~ their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; G.S. 131D-4.5B; 143B-165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. July 1, 2021.

10A NCAC 13F .0406 is proposed for amendment as follows:

10A NCAC 13F .0406 TEST FOR TUBERCULOSIS

(a) Upon employment or living in an adult care home, the ~~administrator and~~ administrator, all other ~~staff~~ staff, and any ~~live-in non-residents~~ persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A ~~.0205~~ .0205, including subsequent amendments and editions. Copies of the rule ~~are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.~~ may be accessed at http://reports.oah.state.nc.us/ncac.asp at no charge.

(b) There shall be documentation on file in the adult care home that the administrator, all other ~~staff~~ staff, and any ~~live-in non-residents~~ persons living in the adult care home are free of tuberculosis ~~disease that poses a direct threat to the health or safety of others.~~ disease.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. June 1, 2004;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. July 1, 2021.

10A NCAC 13G .0402 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0402 QUALIFICATIONS OF SUPERVISOR-IN-CHARGE

The ~~supervisor-in-charge~~ supervisor-in-charge, who is responsible to the administrator for carrying out the program in ~~the~~ a family care home in the absence of the ~~administrator. All of~~ administrator, shall meet the following ~~requirements must be met:~~ requirements:

~~(1) The applicant must complete the Application for Supervisor-in-Charge (DSS-1862);~~

(1) be 21 years or older, employed on or after the effective date of this Rule;

(2) ~~The qualifications of the administrator and co-administrator referenced in Paragraphs (2), (5), (6), and (7) of Rule .0401 of this Subchapter shall apply to the supervisor-in-charge. The supervisor-in-charge~~ the supervisor-in-charge, ~~(employed~~ employed on or after August 1, ~~1991) must meet a minimum educational requirement by being at least~~ 1991, shall be a high school graduate or certified under the GED ~~Program or by passing an alternative examination established by the Department of Health and Human Services. Documentation that these qualifications have been met must be on file in the home prior to employing the supervisor-in-charge;~~ Program or passed the alternative examination established by the Department of Health and Human Services prior to the effective date of this Rule; and

~~(3) The supervisor-in-charge must be willing to work with bonafide inspectors and the monitoring and licensing agencies toward meeting and maintaining the rules of this Subchapter and other legal requirements;~~

~~(4)~~ (3) ~~The supervisor-in-charge must verify that he earns~~ earn 12 hours a year of continuing education credits related to the management of ~~domiciliary~~ adult care homes and care of aged and disabled ~~persons in accordance with procedures established by the Department of Health and Human Services;~~ persons.

~~(5) When there is a break in employment as a supervisor-in-charge of one year or less, the educational qualification under which the person was last employed will apply.~~

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
ARRC Objection June 16, 1988;
Amended Eff. July 1, 1990; December 1, 1988; April 1, 1987; January 1, 1985;
ARRC Objection Lodged January 18, 1991;

Amended Eff. August 1, ~~1991.~~ 1991;
Readopted Eff. July 1, 2021.

10A NCAC 13G .0403 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF

(a) Family care home staff who administer medications, hereafter referred to as medication aides, and ~~staff who directly supervise the administration of medications~~ their direct supervisors shall ~~have documentation of successfully completing the clinical skills validation portion of the competency evaluation according to Paragraphs (d) and (e) of Rule .0503 of this Subchapter prior to the administration or supervision of the administration of medications.~~ complete training, clinical skills validation, and pass the written examination as set forth in, G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.

~~(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall successfully pass the written examination within 90 days after successful completion of the clinical skills validation portion of a competency evaluation according to Rule .0503 of this Subchapter.~~

~~(c)~~(b) Medication aides and ~~staff who directly supervise the administration of medications,~~ their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; G.S. 131D-4.5B; 143B- 165;*
Temporary Adoption Eff. January 1, 2000; December 1, 1999;
Eff. July 1, 2000;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. July 1, 2021.

10A NCAC 13G .0405 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .0405 TEST FOR TUBERCULOSIS

(a) Upon employment or living in a family care home, the administrator, all other ~~staff~~ staff, and any ~~live-in non-residents~~ persons living in the family care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A ~~.0205~~ .0205, including subsequent amendments and editions. Copies of the rule ~~are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.~~ may be accessed at http://reports.oah.state.nc.us/ncac.asp at no charge.

(b) There shall be documentation on file in the family care home that the administrator, all other ~~staff~~ staff, and any ~~live-in non-residents~~ persons living in the family care home are free of tuberculosis ~~disease that poses a direct threat to the health or safety of others.~~ disease.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Amended Eff. October 1, 1977; April 22, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. December 1, 1993; April 1, 1984;
Temporary Amendment Eff. September 1, 2003;
Amended Eff. June 1, ~~2004.~~ 2004;
Readopted Eff. July 1, 2021.

10A NCAC 13P .0101 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .0101 ABBREVIATIONS

As used in this Subchapter, the following abbreviations mean:

(1) ACS: American College of Surgeons;

(2) AEMT: Advanced Emergency Medical Technician;

(3) AHA: American Heart Association;

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

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

(6) CPR: Cardiopulmonary Resuscitation;

(7) ED: Emergency Department;

(8) EMD: Emergency Medical Dispatcher;

(9) EMR: Emergency Medical Responder;

(10) EMS: Emergency Medical Services;

(11) EMS-NP: EMS Nurse Practitioner;

(12) EMS-PA: EMS Physician Assistant;

(13) EMT: Emergency Medical Technician;

(14) FAA: Federal Aviation Administration;

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

~~(16)~~(15) FCC: Federal Communications Commission;

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

~~(18)~~(16) ICD: International Classification of Diseases;

~~(19)~~(17) ISS: Injury Severity Score;

~~(20) ICU: Intensive Care Unit;~~

~~(21) IV: Intravenous;~~

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

~~(23)~~(18) MICN: Mobile Intensive Care Nurse;

~~(24)~~(19) NHTSA: National Highway Traffic Safety Administration;

~~(25)~~(20) OEMS: Office of Emergency Medical Services;

~~(26)~~(21) OR: Operating Room;

~~(27)~~(22) PSAP: Public Safety Answering Point;

~~(28)~~(23) RAC: Regional Advisory Committee;

~~(29)~~(24) RFP: Request For Proposal;

~~(30) RN: Registered Nurse;~~

~~(31)~~(25) SCTP: Specialty Care Transport Program;

~~(32)~~(26) SMARTT: State Medical Asset and Resource Tracking Tool;

~~(33)~~(27) STEMI: ST Elevation Myocardial Infarction; and

~~(34)~~ ~~TR: Trauma Registrar;~~

~~(35)~~ ~~TPM: Trauma Program Manager; and~~

~~(36)~~(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.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0102 is amended as published in 35:12 NCR 1350-1369 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 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 a hospital of its own volition reroutes a patient from the scene of an accident or medical emergency or referring hospital to a facility with a higher level of care.

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

(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) "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) "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) "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) "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) "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) "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) "Immediately Available" means the physical presence of the health professional or the hospital resource within the trauma center to evaluate and care for the trauma patient.~~

~~(28)~~(27) "Inclusive Trauma System" means an organized, multi-disciplinary, evidence-based approach to provide quality care and to improve measurable outcomes for all defined injured patients. EMS, hospitals, other health systems, and clinicians shall participate in a structured manner through leadership, advocacy, injury prevention, education, clinical care, performance improvement, and research resulting in integrated trauma care.

~~(29)~~(28) "Infectious Disease Control Policy" means a written policy describing how the EMS system will protect and prevent its patients and EMS professionals from exposure and illness associated with contagions and infectious disease.

~~(30)~~(29) "Lead RAC Agency" means the agency (comprised of one or more Level I or II trauma centers) that provides staff support and serves as the coordinating entity for trauma planning.

~~(31)~~(30) "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.

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

~~(33)~~(32) "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.

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

~~(35)~~(33) "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.

~~(36)~~(34) "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.

~~(37)~~(35) "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.

~~(38)~~(36) "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.

~~(39) "Off-line Medical Control" means medical supervision provided through the EMS System Medical Director or SCTP Medical Director who is responsible for the day-to-day medical care provided by EMS personnel. This includes EMS personnel education, protocol development, quality management, peer review activities, and EMS administrative responsibilities related to assurance of quality medical care.~~

~~(40)~~(37) "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.

~~(41)~~(38) "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.

~~(42)~~(39) "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.

~~(43) "Participating Hospital" means a hospital that supplements care within a larger trauma system by the initial evaluation and assessment of injured patients for transfer to a designated trauma center if needed.~~

~~(44)~~(40) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.

~~(45)~~(41) "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.

~~(46)~~(42) "Request for Proposal" means a State document that must be completed by each hospital seeking initial or renewal trauma center designation.

~~(47)~~(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.

~~(48)~~(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.

~~(49)~~(45) "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.

~~(50)~~(46) "Specialty Care Transport Program Continuing Education Coordinator" means a ~~Level I~~ Level II EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.

~~(51)~~(47) "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.

~~(52)~~(48) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

~~(53)~~(49) "System Continuing Education Coordinator" means the ~~Level I~~ Level II EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.

~~(54)~~(50) “System Data" means all information required for daily electronic submission to the OEMS by all EMS Systems using the EMS data set, data dictionary, and file format as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated herein by reference including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699- 2707, at no cost and online at www.ncems.org at no cost.

~~(55)~~(51) "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.

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

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

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

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

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

~~(61)~~(52) "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 online at https://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html at no cost.

~~(62)~~(53) "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.

~~(63)~~(54) "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 at no cost.

~~(64)~~(55) "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.

~~(65)~~(56) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.

~~(66)~~(57) "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. July 1, 2021; September 1, 2019; July 1, 2018.

10A NCAC 13P .0222 is amended as published in 35:12 NCR 1350-1369 as follows:

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

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

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

(c) The Medical Care Commission exempts wheeled chair devices used solely for the transportation of mobility impaired persons seated in an upright position in non-permitted vehicles from the definition of stretcher.

History Note: *Authority G.S. 131E-156; 131E-157; 143-508(d)(8);*
Eff. January 1, 2017;
Amended Eff. July 1, 2021; July 1, 2018.

10A NCAC 13P .0501 is amended with changes as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .0501 EDUCATIONAL PROGRAMS

(a) EMS educational programs that qualify credentialed EMS personnel to perform within their scope of practice shall be offered by an EMS educational institution as set forth in Section .0600 of this Subchapter, or by an EMS educational institution in another state where the education and credentialing requirements have been approved for legal recognition by the Department pursuant to G.S. 131E-159 as determined using the professional judgment of OEMS staff following comparison of out-of-state standards with the program standards set forth in this Rule.

(b) Educational programs approved to qualify EMS personnel for credentialing shall meet the educational content of the "US DOT NHTSA National EMS Education Standards," which is hereby incorporated by reference, including subsequent amendments and editions. This document is available online at no cost at www.ems.gov/education.html.

(c) Educational programs approved to qualify EMS personnel for initial AEMT and Paramedic credentialing shall meet the requirements of Paragraph (b) of this Rule and possess verification of accreditation or a valid letter of review from the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or other accrediting agency determined using the professional judgment of OEMS staff following a comparison of standards. The Department shall not approve initial AEMT or Paramedic courses for educational programs that fail to meet accreditation requirements by January 1, 2023.

~~(c)~~ (d) Educational programs approved to qualify EMD personnel for credentialing shall conform with the "ASTM ~~F1258 – 95(2006):~~ F1258 – 95(2014): Standard Practice for Emergency Medical ~~"Dispatch"~~ Dispatch" incorporated by reference including subsequent amendments and editions. This document is available from ASTM International, 100 Barr Harbor Drive, PO Box C700, West Conshohocken, PA, 19428-2959 USA, at a cost of forty eight dollars ~~($40.00)~~ ($48.00) per copy.

~~(d)~~ (e) Instructional methodology courses approved to qualify Level I EMS instructors shall conform with the "US DOT NHTSA 2002 National Guidelines for Educating EMS Instructors" incorporated by reference including subsequent amendments and additions. This document is available online at no cost at www.ems.gov/education.html.

~~(e)~~ (f) Continuing educational programs approved by the OEMS to qualify EMS personnel for renewal of credentials shall be approved by demonstrating the ability to assess cognitive competency in the skills and medications for the level of application as defined by the North Carolina Medical Board pursuant to G.S. 143-514.

~~(f)~~ (g) Refresher courses shall comply with the requirements defined in Rule .0513 of this Section.

History Note: *Authority G.S. 143-508(d)(3); 143-508(d)(4); 143-514;*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readoption Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0502 is amended with changes as published in 35:12 NCR 1350-1369 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~~ 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~~ Complete an approved educational program as set forth in Rule ~~.0501(b)~~ .0501 of this Section for their level of application.

(3) ~~complete~~ 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(b)~~ .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~~ 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~~ 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~~ 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 ~~nine~~ six months shall be allowed.

~~(B) if the individual fails to pass a written examination, the individual may continue eligibility for examination for an additional three attempts within the following nine months by submitting to the OEMS evidence the individual repeated a course specific scope of practice evaluation as set forth in Subparagraph (a)(3) of this Rule, and evidence of completion of a refresher course as set forth in Rule .0513 of this Section for the level of application; or~~

~~(C)~~(B) if unable to pass the written examination requirement after ~~six attempts~~ three attempts, ~~within an 18 period following course grading date as reflected in the OEMS credentialing database,~~ 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) ~~submit~~ Submit to a criminal background history check as set forth in Rule .0511 of this Section.

(6) ~~submit~~ 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~~ AEMT, or Paramedic may qualify for initial credentialing under the legal recognition option set forth in G.S. 131E-159(c).

[~~(1) Individuals possessing a credential for less than two years being used for the level of application shall complete a written examination administered by the OEMS as set forth in this Rule.~~]

[~~(2)~~]

Individuals seeking credentialing as an AEMT or Paramedic shall submit documentation that the credential being used for application is from [~~a CAAHEP Accredited program.~~] 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(c)~~ .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;

(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.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0504 is amended as published in 35:12 NCR 1350-1369 as follows:

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

(a) EMR, EMT, AEMT, and Paramedic applicants shall renew credentials by meeting the following criteria:

(1) presenting documentation to the OEMS or an approved EMS educational institution or program as set forth in Rule .0601 or .0602 of this Subchapter that they have completed an approved educational program as described in Rule ~~.0501(e) or (f)~~ .0501 of this Section;

(2) submit to a criminal background history check as set forth in Rule .0511 of this Section;

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

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

(b) An individual may renew credentials by presenting documentation to the OEMS that he or she holds a valid EMS credential for his or her level of application issued by the National Registry of Emergency Medical Technicians or by another state where the education and credentialing requirements have been determined by OEMS staff in their professional judgment to be equivalent to the educations and credentialing requirements set forth in this Section.

(c) EMD applicants shall renew credentials by presenting documentation to the OEMS that he or she holds a valid EMD credential issued by a national credentialing agency using the education criteria set forth in Rule ~~.0501(c)~~ .0501 of this Section.

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

(e) EMS credentials may not be renewed through a local credentialed institution or program more than 90 days prior to the date of expiration.

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

(g) Pursuant to G.S. 131E-159(h), the Department shall not renew the EMS credential for any person listed on the North Carolina Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159(a); 131E-159(g); 131E-159(h); 143-508(d)(3); 143B-952; 150B-3(a);*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0507 is amended as published in 35:12 NCR 1350-1369 as follows:

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

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

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

(2) have completed post-secondary level education equal to or exceeding a minimum of an Associate Degree from an institution accredited by an approved agency listed on the U.S. Department of Education website, www.ed.gov:

(A) The Department shall accept degrees from programs accredited by the Accreditation Commission for Education in Nursing (ACEN) and the Commission on Accreditation of Allied Health Education Programs.

(B) Additional degrees may be accepted based on the professional judgment of OEMS staff following a comparison of standards;

~~(2)~~(3) have three years experience at the scope of practice for the level of application;

~~(3)~~(4) within one year prior to application, complete an in-person evaluation that demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule ~~.0501(b)~~ .0501 of this Section consistent with their level of application and approved by the OEMS:

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

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

~~(4)~~(5) have 100 hours of teaching experience at or above the level of application in an approved EMS educational program or a program determined by OEMS staff in their professional judgment equivalent to an EMS education program;

~~(5)~~(6) complete an educational program as described in Rule ~~.0501(d)~~ .0501 of this Section; and

~~(6)~~(7) within one year prior to application, attend an OEMS Instructor workshop sponsored by the OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at ~~www.ncems.org; and~~ https://info.ncdhhs.gov/dhsr/ems.

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

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

(c) The credential of a Level I EMS Instructor shall be valid for four years, or less pursuant to G.S. ~~131E-159(c)~~ 131E-159(c), unless any of the following occurs:

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

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

(d) Pursuant to the provisions of 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; 143-508(d)(3);*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. January 1, 2022; September 1, 2019.

10A NCAC 13P .0508 is amended with changes as published in 35:12 NCR 1350-1369 as follows:

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

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

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

(2) be currently credentialed by the OEMS as a Level I Instructor at the EMT, AEMT, or Paramedic level;

~~(2)~~(3) have completed post-secondary level education equal to or exceeding ~~an Associate Degree;~~ a Bachelor's Degree from an institution accredited by an approved agency listed on the U.S. Department of Education website, www.ed.gov:

(A) The Department shall accept degrees from programs accredited by the Accreditation Commission for Education in Nursing (ACEN) and the Commission on Accreditation of Allied Health Education Programs.

(B) Additional degrees may be accepted based on the professional judgment of OEMS staff following a comparison of standards;

~~(3)~~(4) within one year prior to application, complete an in-person evaluation that demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule ~~.0501(b)~~ .0501 of this Section consistent with their level of application and approved by the OEMS:

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

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

~~(4)~~(5) ~~have two~~ a minimum two concurrent years teaching experience as a Level I EMS Instructor at or above the level of ~~application~~ application, or as a Level II EMS Instructor at a lesser credential level applying for a higher level in an approved EMS educational ~~program~~ program, or teaching experience determined by OEMS staff in their professional judgment to be equivalent to an EMS Level I education program;

~~(5)~~(6) complete the "EMS Education Administration Course conducted by a North Carolina Community College or the National Association of EMS Educators Level II Instructor ~~Course;~~ Course that is valid for the duration of the active Level II Instructor credential; and

~~(6)~~(7) within one year prior to application, attend an OEMS Instructor workshop sponsored by the OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at ~~www.ncems.org.~~ https://info.ncdhhs.gov/dhsr/ems.

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

(c) The credential of a Level II EMS Instructor is valid for four years, or less pursuant to G.S. ~~131E-159(c)~~ 131E-159(c), unless any of the following occurs:

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

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

(d) Pursuant to the provisions of 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; 143-508(d)(3);*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. January 1, 2022; September 1, 2019.

10A NCAC 13P .0510 is amended as published in 35:12 NCR 1350-1369 as follows:

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

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

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

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

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

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

(3) completed 96 hours of EMS instruction at the level of ~~application; and~~ application. Individuals identified as EMS program coordinators or positions determined by OEMS staff in the professional judgment to the equivalent to an EMS program coordinator may provide up to 72 hours related to the institution's needs, with the remaining 24 hours in EMS instruction;

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

(A) enrichment of knowledge;

(B) development or change of attitude in students; or

(C) acquisition or improvement of skills; and

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

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

(c) The credential of a Level I or Level II EMS Instructor is valid for four years, or less pursuant to G.S. 131E-159(c) unless any of the following occurs:

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

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

(d) Pursuant to the provisions of 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); 143-508(d)(3);*
Eff. February 1, 2004;
Amended Eff. February 1, 2009;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0512 is amended with changes as published in 35:12 NCR 1350-1369 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 ~~that~~ who was 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 ~~24~~ [~~12~~] 36 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;

(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) ~~EMRs and EMTs shall~~ 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

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

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

~~(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c); and~~

~~(2) meet the provisions for initial credentialing set forth in Rule .0502 of this Section~~

~~(e) AEMT and Paramedic applicants for reinstatement of an EMS credential, lapsed between 24 and 48 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;~~

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

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

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

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

~~(f)~~(d) ~~AEMT~~ EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed more than ~~48~~ [~~12~~] 36 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.

(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.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0601 is amended as published in 35:12 NCR 1350-1369 as follows:

SECTION .0600 – EMS EDUCATIONAL INSTITUTIONS AND PROGRAMS

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

(a) Continuing Education EMS Educational ~~Institutions~~ Programs shall be credentialed by the OEMS to provide only EMS continuing ~~education programs.~~ education. An application for credentialing as an approved EMS continuing education ~~institution~~ program shall be submitted to the OEMS for review.

(b) Continuing Education EMS Educational ~~Institutions~~ 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 or~~ System, Specialty Care Transport ~~Program;~~ Program, or Agency;

(2) a continuing education program shall be consistent with the services offered by the EMS ~~System or~~ System, Specialty Care Transport ~~Program;~~ 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; ~~and~~

(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(b)~~ .0501 of this Subchapter;

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

(6) Upon request, the approved EMS continuing education ~~institution~~ program shall provide records to the OEMS in order to verify compliance and student eligibility for credentialing; and

(7) ~~unless accredited in accordance with Rule .0605 of this Section,~~ approved education ~~institution~~ 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.

~~(c)~~(d) Assisting physicians delegated by the EMS System Medical Director as authorized by Rule ~~.0403(b)~~ .0403 of this Subchapter or SCTP Medical Director as authorized by Rule ~~.0404(b)~~ .0404 of this Subchapter for provision of medical oversight of continuing education programs must 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.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0602 is amended with changes as published in 35:12 NCR 1350-1369 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 [~~for each~~] 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 in Rule .1505 of this Subchapter.

(b) For initial courses, Basic EMS Educational Institutions shall meet all of the requirements for continuing EMS educational ~~institutions~~ programs defined in Rule .0601 of this Section and shall have:

(1) at least a Level I EMS Instructor as each lead course instructor for ~~EMR and EMT~~ all courses. The lead course instructor must be credentialed at a level equal to or higher than the course ~~offered;~~ 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. 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 ~~may be either~~ shall be a Level II EMS Instructor credentialed at or above the highest level of course offered by the ~~institution, or a combination of staff who cumulatively meet the requirements of the Level II EMS Instructor set forth in this Subparagraph. These individuals may share the responsibilities of the lead EMS educational coordinator. The details of this option shall be defined in the educational plan required in Subparagraph (b)(5) of this Rule;~~ institution, 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, evidenced-informed clinical practice, and incorporated by Rule .0501 of this Section;

(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;

~~(3)~~(4) written educational policies and procedures that include:

(A) the written educational policies and procedures set forth in Rule ~~.0601(b)(4)~~ .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;

~~(4)~~(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;" and~~ 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

~~(5)~~(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 ~~defined~~ set forth in Paragraph (b) of this ~~Rule, and have a Level II EMS Instructor as lead instructor for AEMT and Paramedic initial courses. The~~

~~lead instructor shall be credentialed at a level equal to or higher than the course offered.~~ 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) 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.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0905 is amended with changes as published in 35:12 NCR 1350-1369 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. ~~Upon this notification, OEMS shall notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for renewal to allow 30 days for comment.~~

(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) of this Section.

(6) the composition of a Level III site survey team shall be the same as that specified in Rule .0904(l) of this Section.

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

(8) the primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team. 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,~~ 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 OEMS shall notify the Board of County Commissioners within the trauma center's trauma primary catchment area of the Trauma Center's request for renewal to allow 30 days for comments.~~

~~(4)~~(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.

~~(5)~~(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.

~~(6)~~(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; and

(D) OEMS staff.

~~(7)~~(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.

~~(8)~~(7) all state Trauma Center criteria shall be met as defined in Rule .0901of this Section for renewal of state designation. ACS' verification is not required for state designation. ACS' verification does not ensure a state designation.

~~(9)~~(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.

~~(10)~~(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.

~~(11)~~(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.

~~(12)~~(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.

~~(13)~~(12) the final decision regarding trauma center designation shall be rendered by the OEMS.

~~(14)~~(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.

~~(15)~~(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.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1101 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1101 STATE TRAUMA SYSTEM

(a) The state trauma system shall consist of regional plans, policies, guidelines, and performance improvement initiatives by the RACs to create an Inclusive Trauma System monitored by the OEMS.

(b) Each hospital and EMS System shall affiliate as defined in Rule ~~.0102(3)~~ .0102 of this Subchapter and participate with the RAC that includes the Level I or II Trauma Center where the majority of trauma patient referrals and transports occur. Each hospital and EMS System shall submit to the OEMS upon request patient transfer patterns from data sources that support the choice of their primary RAC affiliation. Each RAC shall include at least one Level I or II Trauma Center.

~~(c) The OEMS shall notify each RAC of its hospital and EMS System membership annually.~~

~~(d)~~(c) Each ~~hospital and each EMS System~~ Lead RAC Coordinator shall update and submit ~~its~~ RAC affiliation ~~information~~ membership for hospitals and EMS Systems to the OEMS no later than July 1 of each year. Each hospital or EMS System shall submit written notification to the OEMS for any RAC affiliation change. RAC affiliation may ~~only~~ be changed ~~during this annual update and~~ only if supported by a change in the majority of transfer patterns to a Level I or Level II Trauma Center. Documentation of these new transfer patterns shall be included in the request to change affiliation. ~~If no change is made in RAC affiliation, written notification shall be required annually to the OEMS to maintain current RAC affiliation.~~

History Note: *Authority G.S. 131E-162;*
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;
Amended Eff. July 1, 2021; January 1, 2017.

10A NCAC 13P .1401 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1401 CHEMICAL ADDICTION OR ABUSE ~~TREATMENT~~ RECOVERY PROGRAM REQUIREMENTS

(a) The OEMS shall provide a ~~treatment~~ monitoring program for aiding in the recovery ~~and rehabilitation~~ of EMS personnel subject to disciplinary action for being unable to perform as credentialed EMS personnel with reasonable skill and safety to patients and the public by reason of use of alcohol, drugs, chemicals, or any other type of material as set forth in Rule ~~.1507(b)(9)~~ .1507 of this Subchapter.

(b) This program requires:

(1) an initial assessment by a healthcare professional ~~specialized~~ specializing in chemical dependency approved by the ~~treatment~~ program;

(2) a treatment plan developed ~~by the healthcare professional described in Subparagraph (b)(1) of this Rule~~ by a healthcare professional specializing in chemical dependency for the individual using the findings of the initial ~~assessment;~~ assessment. The Department and individual will enter into a consent agreement based up on the treatment plan; and

~~(3) random body fluid screenings using a standardized methodology designed by OEMS program staff to ensure reliability in verifying compliance with program standards;~~

~~(4) the individual attend three self-help recovery meetings each week for the first year of participation, and two each week for the remainder of participation in the treatment program;~~

~~(5)~~(3) monitoring by OEMS program staff of the individual for compliance with the ~~treatment program;~~ consent agreement entered into by the Department and the individual entering the program.

~~(6) written progress reports, shall be made available for review by OEMS upon completion of the initial assessment of the treatment program, upon request by OEMS throughout the individual's participation in the treatment program, and upon completion of the treatment program. Written progress reports shall include:~~

~~(A) progress or response to treatment and when the individual is safe to return to practice;~~

~~(B) compliance with program criteria;~~

~~(C) a summary of established long-term program goals; and~~

~~(D) contain pertinent medical, laboratory, and psychiatric records with a focus on chemical dependency.~~

History Note: *Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);*
Eff. October 1, 2010;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1403 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1403 CONDITIONS FOR RESTRICTED PRACTICE WITH LIMITED PRIVILEGES

(a) In order to assist in determining eligibility for an individual to return to restricted practice, ~~the OEMS shall create a standing Reinstatement Committee that shall consist of at least the following members:~~ completion of all requirements outlined in the individual's consent agreement with the Department as described in Rule .1401 of this Section shall be presented to the Chief of the OEMS.

~~(1) one physician licensed by the North Carolina Medical Board, representing EMS Systems, who shall serve as Chair of this committee;~~

~~(2) one counselor trained in chemical addiction or abuse therapy; and~~

~~(3) the OEMS staff member responsible for managing the treatment program as set forth in Rule.1401 of this Section.~~

(b) Individuals who have surrendered his or her EMS credential(s) as a condition of entry into the ~~treatment~~ recovery program, as required in Rule ~~.1402(4)~~ .1402 of this Section, shall be reviewed by the OEMS ~~Reinstatement Committee~~ Chief to determine if ~~a recommendation to the OEMS for~~ issuance of an encumbered EMS credential is warranted by the Department.

(c) In order to obtain an encumbered credential with limited privileges, an individual shall:

(1) be compliant for a minimum of 90 consecutive days with the treatment program described in Rule ~~.1401(b)~~ .1401 of this Section; and

(2) be recommended in writing for review by the individual's ~~treatment counselor;~~ recovery healthcare professional overseeing the treatment plan developed as described in Rule .1401 of this Section.

~~(3) be interviewed by the OEMS Reinstatement Committee; and~~

~~(4) be recommended in writing by the OEMS Reinstatement Committee for issuance of an encumbered EMS credential. The OEMS Reinstatement Committee shall detail in their recommendation all restrictions and limitations to the individual's practice privileges.~~

(d) The individual shall agree to sign a consent agreement with the OEMS that details the practice restrictions and privilege limitations of the encumbered EMS credential, and that contains the consequences of failure to abide by the terms of this agreement.

(e) The individual shall be issued the encumbered credential by the OEMS within 10 business days following execution of the consent agreement described in Paragraph (d) of this Rule.

(f) The encumbered EMS credential shall be valid for a period not to exceed four years.

History Note: *Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);*
Eff. October 1, 2010;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1404 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1404 REINSTATEMENT OF AN UNENCUMBERED EMS CREDENTIAL

Reinstatement of an unencumbered EMS credential is ~~dependant~~ dependent upon the individual successfully completing all requirements of the ~~treatment program~~ consent agreement as ~~defined in~~ set forth in Rule .1401 of this Section.

History Note: *Authority G.S. 131E-159(f); 143-508(d)(10); 143-509(13);*
Eff. October 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. July 1, 2021.

10A NCAC 13P .1405 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1405 FAILURE TO COMPLETE THE CHEMICAL ADDICTION OR ABUSE ~~TREATMENT~~ RECOVERY PROGRAM

Individuals who fail to complete the ~~treatment program~~ consent agreement established in Rule .1401 of this Section, upon review by the OEMS, are subject to revocation of their EMS credential.

History Note: *Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);*
Eff. October 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2021; January 1, 2017.

10A NCAC 13P .1505 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1505 EMS EDUCATIONAL INSTITUTIONS

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

(b) The Department shall deny the initial or renewal designation, without first allowing a focused review, of an EMS Educational Institution for any of the following reasons:

(1) significant failure to comply with the provisions of ~~Section .0600~~ 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 ~~Section .0600~~ Sections .0500 and .0600 of this Subchapter within ~~12~~ 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 ~~12~~ 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(b)(6)~~ .0601 of this Subchapter;

(4) the EMS Educational Institution failed to meet the requirements of a focused review within ~~12~~ 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 ~~revocation and denial.~~ 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. July 1, 2021; July 1, 2018; January 1, 2017.

10A NCAC 13P .1507 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1507 EMS PERSONNEL CREDENTIALS

(a) ~~An~~ 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;~~ 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, 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; ~~or~~

(30) representing or allowing others to represent that the credentialed EMS personnel has a credential that the credentialed EMS personnel does not in fact ~~have.~~ 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.

(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.

History Note: *Authority G.S. 131E-159; 143-508(d)(10); 143-519;*
Eff. January 1, 2013;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1511 is amended as published in 35:12 NCR 1350-1369 as follows:

10A NCAC 13P .1511 PROCEDURES FOR QUALIFYING FOR AN EMS CREDENTIAL FOLLOWING ENFORCEMENT ACTION

(a) Any individual who has been subject to ~~denial,~~ suspension, revocation, or amendment of an EMS credential shall submit in writing to the OEMS a request for review to determine eligibility for credentialing.

(b) Factors the Department shall consider when determining eligibility shall include:

(1) the reason for administrative action, including:

(A) criminal history;

(B) patient care;

(C) substance abuse; and

(D) failure to meet credentialing requirements;

(2) the length of time since the administrative action was taken; and

(3) any mitigating or aggravating factors relevant to obtaining a valid EMS credential.

(c) In order to be considered for eligibility, the individual shall:

(1) wait a minimum of 36 months following administrative action before seeking review; and

(2) undergo a criminal history background check. If the individual has been charged or convicted of a misdemeanor or felony in this or any other state or country within the previous 36 months, the 36 month waiting period shall begin from the date of the latest charge or conviction.

(d) If determined to be eligible, the Department shall grant authorization for the individual to begin the process for EMS credentialing as set forth in Rule .0502 of this Subchapter.

(e) Prior to enrollment in an EMS educational program, the individual shall disclose the prior administrative action taken against the individual's credential in writing to the EMS Educational Institution.

(f) An individual who has undergone administrative action against his or her EMS credential is not eligible for legal recognition as defined in G.S. 131E-159(d) or issuance of a temporary EMS credential as defined in G.S. 131E159(e).

(g) For a period of 10 years following restoration of the EMS credential, the individual shall disclose the prior administrative action taken against his or her credential to every EMS System, Medical Director, EMS Provider, and EMS Educational Institution where he or she is affiliated and provide a letter to the OEMS from each verifying disclosure.

(h) If the Department determines the individual is ineligible for EMS credentialing pursuant to this Rule, the Department shall provide in writing the reason(s) for denial and inform him or her of the procedures for contested case hearing as set forth in Rule .1509 of this Section.

History Note: *Authority G.S. 131E-159(g); 143-508(d)(3); 143-508(d)(10);*
Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

DHHS Fiscal Note
Permanent Rule Amendment without Substantial Economic Impact

Agencies Proposing Rule Change
North Carolina Medical Care Commission

Contact Persons
Nadine Pfeiffer, DHSR Rule Making Manager – (919) 855-3811
Tom Mitchell, OEMS Chief – (919) 855-3935
Chuck Lewis, OEMS Assistant Chief – (919) 855-3935
Wally Ainsworth, OEMS Central Regional Manager – (919) 855-4680

Table of Contents

Lists of Appendices
Appendix A: The EMS and Trauma Rules under revision 10A NCAC 13P.

Authorizing Statutes
The following statutes are cited in the statutory authority of the rules under revision by the MCC.

G.S. 131E-151	Definitions
G.S. 131E-155.1	EMS Provider License Required
G.S. 131E-158	Credentialed Personnel Required
G.S. 131E-159	Credentialing Requirements
G.S. 131E-160	Exemptions
G.S. 143-508	Department of HHS to establish program; rules and regulations of Medical Care Commission
G.S. 143-509	Powers and Duties of Secretary
G.S. 143-510	North Carolina Emergency Medical Services Advisory Council
G.S. 143-511	Powers and Duties of the Council
G.S. 143-519	Emergency Medical Services Disciplinary Committee.

Titles of Rule Changes and Related Statutory Citations affected by amendment to the General Statues of the State of North Carolina.

To support proposed revisions to the 10A NCAC 13P EMS and Trauma rules, the OEMS is recommending §131E-159 be changed to remove "without testing" for individuals seeking legal recognition. The rule being updated to reflect the proposed change to the statutory language directly related to this change is as follows:

10A NCAC 13P

Section .0500 – EMS Personnel

- .0502 - Initial Credentialing Requirements for EMR, EMT, AEMT, Paramedic, and EMD

Titles of Rule Changes Proposed for Amendment

The following rules reflect the changes needed to update obsolete or unnecessary standards, clarify ambiguous language, incorporate changes in healthcare delivery models, recognize new technologies, and to provide all regulated entities and the public the most efficient and effective structure for services regulated for emergency medical and trauma systems. The Medical Care Commission meeting for initial approval of the proposed rules is scheduled for November 13, 2020.

These rules are identified as follows:

10A NCAC 13P (*See proposed text of these rules as Appendix A)*

Section .0100 – Definitions

- .0101 – Abbreviations (Amend)
- .0102 – Definitions (Amend)

Section .0200 – EMS Systems

- .0222 – Transport of Stretcher Bound Patients (Amend)

Section .0500 – EMS Personnel

- .0501 – Educational Programs (Amend)
- .0502 – Initial Credentialing Requirements for EMR, EMT, AEMT, Paramedic, and EMD (Amend)
- .0504 – Renewal of Credentials for EMR, EMT, AEMT, Paramedic, and EMD (Amend)
- .0507 – Credentialing Requirements for Level I EMS Instructors (Amend)
- .0508 – Initial credentialing Requirements for Level II EMS Instructors (Amend)
- .0510 – Renewal of Credentials for Level I and II EMS Instructors (Amend)
- .0512 – Reinstatement of Lapsed EMS Credential (Amend)

Section .0600 – EMS Educational Institutions

- .0601 Continuing Education EMS Educational Institution Requirements (Amend)
- .0602 – Basic and Advanced EMS Educational Institution Requirements (Amend)

Section .0900 – Trauma Center Standards and Approval

- .0904 – Initial Designation Process (Amend)

- .0905 – Renewal Designation Process (Amend)

Section .1100 – Truama System Design
- .1101 – State Trauma System (Amend)

.1400 – Recovery and Rehabilitation of Chemically Dependent EMS Personnel
- .1401 – Chemical Addiction or Abuse Treatment Program Requirements (Amend)
- .1403 – Conditions for Restricted Practice with Limited Privileges (Amend)
- .1404 – Reinstatement of an Unencumbered EMS Credential (Ament)
- .1405 – Failure to Complete the Chemical Addiction or Abuse Treatment Program (Amend)

.1500 – Denial, Suspension, Amendment, or Revocation
- .1505 – EMS Educational Institutions (Amend)
- .1507 – EMS Personnel Credentials (Amend)
- .1511 – Procedures for Qualifying for an EMS Credential Following Enforcement Action (Amend)

Overview

Overall, these rule changes do not present substantial economic impact to the regulated community. The primary costs related to these rules are the upfront costs of accreditation and the recurring ongoing fee for accreditation, as well as staff time and mileage for the annual conference for continuing education workshop. While OEMS cannot quantify the benefits of the increase in the educational quality offered by requiring accreditation for these programs, we believe that there are several important benefits to the accreditation process. These include but are not limited to: reduced barriers to professional mobility for EMT/AEMT professionals, increased quality of educational programs resulting in better prepared EMT professionals, and the potential for expansion of paramedicine programs that lead to lower costs and increased diversion from emergency departments.

Titles of Rule Changes Proposed for Amendment

The following rules reflect the changes needed to update obsolete or unnecessary standards, clarify ambiguous language, incorporate changes in healthcare delivery models, recognize new technologies, and to provide all regulated entities and the public the most efficient and effective structure for services regulated for emergency medical and trauma systems.

Summary of Revisions and its Anticipated Impact

Rules .0101 – Abbreviations and **.0102 – Definitions** are being amended to address revisions throughout the rules.

Impact

No impact associated with these rules.

Rule .0222 - Transport of Stretcher Bound Patients is being amended to clarify the permitted vehicle exemption of persons transported in wheeled chair devices. Rule 10A NCAC 13P .0102 defines a "stretcher" as "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."

Advancement in the design of "wheeled" chair mobility devices has changed significantly in recent years. Newer mobility chairs designed for transport may recline, up to 90 degrees or completely flat, and some allow reclining even further into Trendelenburg Position (feet are higher than the head by 15-30 degrees). A Position Statement shared by the OEMS stated "any mobility impaired person incapable of being transported seated in a wheelchair is considered "incapacitated or helpless such the need for some medical assistance might be needed," [G.S. 131E-155(16)]. Mobility impaired persons transported unattended in a position other than "upright" in a wheeled chair device poses a significant safety concern for the individual. The OEMS has received complaints from licensed ambulance providers questioning the compliance and safety of these transports by unlicensed wheel chair transportation services. Although such complaints are rare, the safety concerns are serious and investigated by OEMS staff promptly. Complaint resolution may include the agency ceasing such transports when notified, a formal "cease and desist" issued, or OEMS staff provides technical assistance to the transport service in order to obtain an EMS Provider License.

Impact

No cost impact associated with amending this rule.

Rule .0501 - Educational Programs is being amended to require educational programs for the AEMT and paramedic credentials to be accredited through either CAAHEP or another accrediting agency that OEMS deems comparable. The intent of this change is to strengthen academic EMS programs for Advanced Emergency Medical Technician and Paramedic credentialing. Community Colleges are intimately familiar with the importance of not only institutional accreditation but also program accreditation. The Commission on Accreditation of Allied Health Education Programs (CAAHEP) is the only nationally recognized accrediting agency for EMS education programs. Many other Community College healthcare programs are accredited, including but not limited to Cardiovascular Technology, Dental Hygiene, Medical Laboratory Technology, Pharmacy Technology, Radiography, Respiratory Therapy, and Surgical Technology.

Strengthening the academic programs for AEMT and Paramedic programs is important because EMS as a profession continues to evolve. Paramedics are not only functioning as prehospital technicians, but also expanding their role as part of a healthcare team. Community Paramedicine and Mobile Integrated Healthcare Programs are growing nationally. Paramedics are transitioning from a technician who transports patients and performs certain medical care to a clinician who can treat patients within their scope of practice while also providing transport services. Paramedics are interacting more in the community and health system, and do not just transport

patients to the emergency department but to the most appropriate facility for the patient. The Centers for Medicare and Medicaid Services (CMS) is allowing limited participation in a program for EMS agencies to be reimbursed for not just transport of a patient to the emergency department, but also transport to an alternate facility (such as a primary care provider or mental health facility), or to even treat in place as defined by local EMS protocols. The 2017 Community Paramedicine Pilot Programs Report to the Joint Legislative Oversight Committee on Health and Human Services provided opportunity for significant savings in preventative cost (readmissions), high utilizers of Emergency Departments, and mental health patients being transported directly to an appropriate mental health facility rather than an Emergency Department. Patients received appropriate care, follow up, improved outcomes, and improved long-term health stability. The report stated Community Paramedicine programs implemented statewide could avoid potential EMS and Emergency Department charges of $1,355,681 - $1,885, 326 to NC Medicaid.[1] Telehealth can provide better assessments and more appropriate clinical decisions in conjunction with a medical provider. EMS personnel may also have access to patient's comprehensive medical records. These are all concepts discussed in the National Highway Transportation and Safety Administration's (NHTSA) EMS Agenda 2050.

Accredited EMS Programs are vital to the institutions providing eligibility for National Registry credentialing especially for military personnel (and spouses). National Registry creates more mobility and employment opportunities by reducing barriers to achieve other state credentialing. Currently, 47 states require a National Registry credential for state certification or licensure. Failure for North Carolina to require accreditation for Paramedic Programs would constrain mobility of military personnel, spouses, and others from employment opportunities outside of North Carolina.

High-quality, accredited education programs are instrumental to expanding the role of EMS in the future. Accredited EMS Programs better prepare students by ensuring they meet uniform, nationally accepted standards. Effective January 1, 2018, the National Registry of Emergency Medical Technicians ceased eligibility for examination as a Paramedic for applicants in states that graduated from a non-CAAHEP accredited program[2]. The National Registry of Emergency Medical Technicians as well as the National Association of State EMS Officials (NASEMSO) have endorsed CAAHEP.[3] "The accreditation process promotes continual self-analysis and is in place to make the program, its graduates, and ultimately, the care they deliver to the public BETTER."[4] Additionally, when students choose an accredited program, they can have more confidence in the quality of the education they are receiving and investing their money in.

[1] "Community Paramedicine Pilot Programs, Report to the Joint Legislative Oversight Committee on Health and Human Services and Fiscal Research Division," March 1, 2017. https://files.nc.gov/ncosbm/documents/files/DHHS_2017-10-19_AppendixB.pdf

[2] "Paramedic Program Accreditation Policy." https://nremt.org/rwd/public/document/policy-paramedic.

[3] "Resolution 2010-04 National EMS Certification and Program Accreditation." https://nasemso.org/wp-content/uploads/Resolution2010-04NationalCertificationandProgramAccreditation20101013.pdf

[4] "What do I need to know to become accredited?" https://coaemsp.org/why-become-accredited-benefits-caahep-accreditation

The OEMS Administration and Education staff have been actively communicating and promoting the accreditation process to teaching institutions for several years. Rule 10A NCAC 13P .0605, Accredited EMS Educational Institution Requirements, was adopted January 1, 2017. This rule permits OEMS to credential teaching institutions that possess CAAHEP accreditation without a formal OEMS institution review. The groundwork has been in place to prepare teaching institutions for accreditation requirement. The initial draft of this set of proposed rules was presented to the North Carolina EMS Advisory Council on February 12, 2019 for approval for the OEMS to enter the rule making process. The EMS Advisory Council recommended a task form be created from members of the EMS Advisory Council. The task force attended public hearings and made recommendations to the OEMS based on the responses received. Feedback from the public hearings strongly agreed that strengthening EMS programs would sustain a more reliable workforce for the future.

The public hearings were conducted at five community colleges across the state. Meetings were held at 1:00 pm and 7:00 pm at Bladen Community College (March 20, 2019), Pitt Community College (March 28, 2019), Durham Technical Community College (April 1, 2019), Mitchell Community College (April 4, 2019), and Haywood Community College (April 9, 2019). Written comments were also received during this period. Proposed draft education rules were posted on the OEMS website and hard copies were provided at each site. Public support voiced at the meetings strongly supported efforts to strengthen EMS programs through accreditation.

There are presently 62 educational institutions approved the OEMS for initial Paramedic education programs that are impacted by this proposed rule change. Currently, 32 educational institution EMS Programs are already CAAHEP accredited (1 University, 31Community Colleges and 1 military institution). Approximately 13 institutions are in the accreditation process, either scheduled for a site visit or in the process of completing a Letter of Review. Several institutions that are unable to comply with accreditation requirements have partnered to establish articulation agreements with accredited institutions. There are currently 17 OEMS credentialed educational institutions with Paramedic or AEMT courses that have taken no action toward accreditation. The institutions that have not taken steps to gain accreditation are spread throughout the state but are primarily smaller institutions.

Educational institutions already accredited have absorbed the costs associated with the initial accreditation. The OEMS staff cannot predict whether the 17 educational institutions will seek accreditation, enter into articulation agreements with other accredited institutions, or cease initial Paramedic program courses. Costs may be estimated for the 11 educational institutions in the process of accreditation.

The Committee on Accreditation for the EMS Professions (CoAEMSP) is the branch of CAAHEP used to grant accreditation specifically to EMS programs for preparing students for initial credentialing. The cost for the accreditation process of CoAEMSP is detailed on the website in Appendix E.

Utilizing the program fees provided by CoAEMSP, the initial accreditation cost for each of the 17 educational institutions would be approximately $6,350, for a total opportunity cost of

~$107,950. The accreditation is valid for five years. The annual ongoing fee for each institution is $1,700, for an annual recurring total cost of ~$28,900.

Impact – Federal Government
No impact associated with the amendment of this rule.

Impact – State Government
Community Colleges (15) costs: ~$95,250 during initial year, ongoing cost of $28,900

Impact – Local Government
Local Government licensed EMS Providers (two): ~$12,700 during initial year, ongoing cost of $3,400

Impact – Private Entities
No impact associated with the amendment of this rule.

Educational Institution Type	Number	Cost per Provider	Total Statewide Costs
State Government	15	~$6,350	~$95,250
County Government	2	~$6,350	~$12,700
TOTAL COSTS			~$107,950

Impact from Accreditation Requirements						
Year	0	1	2	3	4	5
Benefits						
State Government	Possible opportunity for significant savings in preventing readmissions, appropriate redirection of mental health patients, and other high utilizers of Emergency Departments; potential savings of $1.3M to $1.8M to NC Medicaid annually					
Local Government						
Private Entities	Reduction of barriers to mobility and licensure transfer; potential increased quality of education for AEMT and paramedic students; potential of increased quality of care and cost savings for patients					
Costs						
Federal Government						
State Government	(95,250)	(25,500)	(25,500)	(25,500)	(25,500)	(25,500)
Local Government	(12,700)	(3,400)	(3,400)	(3,400)	(3,400)	(3,400)
Private Entities						
Total Costs	(107,950)	(28,900)	(28,900)	(28,900)	(28,900)	(28,900)
Discount Rate	7%					
NPV of accreditation costs	(211,632)					

Rule .0502 - Initial Credentialing Requirements for EMR, EMT, AEMT, Paramedic, and EMD is being amended to strengthen the EMS workforce and enhance safety of the public. Candidates for examination who do not pass the credentialing examination after three attempts within six months will be required to repeat initial educational requirements set forth in Rule 10A NCAC 13P .0501. Shortening the time frame for examination from 9 months to 6 months is intended to urge the candidate to test earlier while the course content remains fresh.

EMS Educational Institutions may allow credit for courses completed previously. Examination results identify specific topics in which the individual may have tested poorly. The individual may only be required to complete specific courses in that area to again become eligible for examination. Currently, a "refresher course" is required after a candidate fails 3 attempts. The refresher course encompasses all topics and skills. The institution may use the examination results to "target" specific areas that require review or additional education. The OEMS cannot quantify or estimate the potential failures or specific areas of need of future individuals.

The proposed change also requires individuals with less than two years of experience who are seeking reciprocity, to complete a written examination administered by the OEMS. This amendment will strengthen the EMS workforce for North Carolina agencies through verification of competence and thereby enhance the safe care provided to the public. New paramedics applying for reciprocity will be required to confirm the education credentials used in the

application were issued through a CAAHEP accredited program referenced in Rule 10A NCAC 13P .0501.

Application information will be updated to include initial credential date and verification of EMS program completion (institution) to insure CAAHEP requirement.

Cost Impact

Unable to determine – it is unknown how many of previous number of reciprocity applicants had less than 2 years of experience, the information is not currently tracked. There were 343 paramedic applications received in calendar year 2019 and of those, 265 were approved. There will be a cost associated with the examination but unable to quantify the number that may be required to take the exam.

Rule .0504 - Renewal of Credentials for EMR, EMT, AEMT, Paramedic, and EMD is being amended for technical change only.

Impact

No impact associated with amending this rule.

Rule .0507 & .0508 - Credentialing Requirements for Level I EMS Instructors and Credentialing Requirements for Level II EMS instructors are both recommended for amendment to comply with requirements for CAAHEP accreditation as discussed under Rule 10A NCAC 13P .0501. The associate degree requirement will only pertain to new Level I applicants effective July1, 2021 and the required bachelor's degree will only apply to new Level II Instructor applicants effective July 1, 2021; therefore, the recommendation is to amend the title for "initial" credentialing.

The NCOEMS EMS Instructor Application currently requires the applicant to submit verification of a high school or GED diploma for Level I and associate degree for Level II respectively. The application will be updated to require verification of the applicable degree. Most teaching institutions have been meeting the requirement already. Potential cost impact is difficult to quantify since only new applicants will be required to have a degree. OEMS currently tracks Instructor applications for both Level I and Level II together, so we are unable to determine the amount of Level I instructor applications that were received in 2019. A total of 212 initial instructor applications were received in calendar year 2019.

Impact -Rules .0507 and .0508

There may be potential opportunity cost for instructors due to the proposed educational degree requirements. The OEMS staff are unable to estimate potential salary increases for the community college system, local government agencies, or private entities. OEMS is unable to quantify.

Rule .0510 - Renewal of Credentials for Level I and Level II EMS Instructors is being amended to more clearly define the breakdown of the 96 hours of EMS instruction for renewal. Allowing up to 72 hours to be focused on the institution's specific needs will strengthen the performance improvement process of the initial and ongoing accreditation requirement. The total 96 hours for renewal remain the same.

Impact

No cost impact associated with amending this rule.

Rule .0512 - Reinstatement of Lapsed EMS Credential is recommended for amendment to ensure the safety of the public by requiring individuals to maintain appropriate knowledge and skills in order to reinstate their credential. The current rule uses the credential level to determine the length of time of expiration and the reinstatement requirements. Prehospital medical care is constantly changing - EMS protocols, policies, procedures, medications, and skills are reviewed annually and frequently updated. In order to protect the public, EMS personnel should be up to date with best practices. Ensuring EMS personnel are knowledgeable and maintain the appropriate skills strengthens safe patient care to the public.

The current rule contains multiple processes, based on level of certification, for reinstatement of a lapsed credential. The recommended changes for reinstatement requirements affect all credential levels equally. The proposed amendment should not have a financial impact on the individual. The new rule requires individuals expired more than 12 months to complete educational requirements for initial credentialing in Rule 10A NCAC 13P .0502, as opposed to the current rule, where individuals must complete a refresher course and a course specific scope of practice. The institution may only require the individual to complete specific courses to qualify for the written examination. The OEMS cannot quantify or estimate the potential failures or specific areas of need of future individuals. The OEMS staff does anticipate the cost may closely align with current cost involving the hours associated with the current refresher courses.

Reinstatement of lapsed instructor credentials greater than 12 months would now require meeting the proposed degree requirements for initial instructor applicants as stated in Rules 10A NCAC 13P .0507 and .0508 respectively.

Impact

OEMS estimates no cost impact associated with amending this rule.

Rule .0601 - Continuing Education EMS Educational Institution Requirements is being amended from designation categorized as Institutions to Programs.

Currently, North Carolina OEMS has approved both community colleges and EMS agencies to provide continuing education that allows local credential renewal of system or agency EMS

personnel. Approving EMS systems and agencies to offer in-house continuing education to their employees allows the agencies or systems to ensure that their employees have appropriate continuing education opportunities based on needs identified through performance improvement data of the respective EMS System. Continuing education "program" more accurately reflects the goal of the rule which is to ensure adequate continuing education to properly recredentialed EMS personnel. The Continuing Education Programs do not, nor are they intended to offer "initial" EMS courses.

After thorough review and feedback from the OEMS Public Meetings held in 2019 , the proposed changes were refined. Continuing education is required for renewing EMS credentials (Rule 10A NCAC 13P .0504(a)(1)). According to Rule 10A NCAC 13P .0403(a)(4), the local EMS system Medical Director is responsible for providing the medical supervision of the continuing education for EMS personnel in that respective system. The EMS Peer Review Committee for the EMS system analyzes patient care data to make recommendations regarding the content of continuing education (Rule 10A NCAC 13P .0408(5)).

The new requirement of the Program Coordinator workshop provides direct interaction with OEMS education staff to strengthen program compliance with the educational requirements. Basic and Advanced teaching institutions (Rule 10A NCAC 13P .0602) must also meet this rule's requirements, therefore all designated program coordinators will be required to attend a workshop annually. The benefits of attending a workshop include but are not limited to, increased educational opportunities, networking opportunities, and best practices. OEMS staff conducted the pilot Program Coordinator workshop March 11, 2020 in Wilmington. The workshop was approximately 8 hours in length.

There are 165 active education programs and institution approved by OEMS. The average cost per hour for an agency program coordinator (EMS Training Officer) is approximately $35.77. The Community College Program Coordinator average costs is approximately $41.42. Under these time and cost assumptions, the annual total opportunity cost would be $61,487.

Job Titles	**Average Salary**	**Benefits[5]**	**Total Employee Compensation Est.**	**Average Hourly Cost Estimate**
Training Officer (EMS)[6]	$50,332	$22,649	$72,981	$35.77
Community College Program Coordinator[7]	$56,795 - $59,757	$25,558 - $26,891	$82,354 - $86,647	$40.37 - $42.47

[5] Benefits calculated using a 45% benefit rate

[6] Calculated using the UNC SOG County Salary Survey - https://www.sog.unc.edu/publications/reports/county-salaries-north-carolina-2019

[7] NC Community Colleges Website Job Listings, https://jobs.nccommunitycolleges.edu.

The OEMS staff assumption that there is one program coordinator for each of the 165 educational institutions/programs subject to the provisions of this rule. The proposed rule change will result in additional costs for time spent in traveling to and from the workshop, and the time the program coordinator spent during the workshop session. Since these workshops are offered regionally, any direct travel cost to the individual will be minimal, involving only fuel costs, vehicle depreciation, and related costs to travel to the workshop site. Based on the standard IRS mileage rates for 2020 of 57.5 cents per mile and an OEMS assumption that individuals will drive an average of 100 miles to and from the workshops, program coordinators' travel costs will equal approximately ~$58 per workshop. OEMS estimates that the total workshop travel costs annually for the 165 instructors would be ~$9,570.

Impact – Federal Government
No impact associated with amending this rule.

Impact – State Government
Hourly rate for class and mileage

Impact – Local Government
Hourly rate for class and mileage

Impact – Private Entities
Hourly rate for class time

Impact Summary: Class Time & Travel Costs

Provider Type	Number	Cost per Provider	Total Statewide Costs
State Government Educational Institutions	79	~$331.36	~$26,177
Local Government Educational Institutions	61	~$286.16	~$17,456
Private Entities	25	~$331.36[8]	~$8,284
TOTAL CLASS TIME COSTS			~$51,917

Total Travel Costs

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	$0	$0	
State Government	~$4,582	Unquantifiable	recurring
Local Government	~$3,538	Unquantifiable	recurring
Private Entities	~$1,450	Unquantifiable	recurring
Total	~$9,570	Unquantifiable	

[8] OEMS does not have data regarding the salaries for private entities, so choosing to use the higher cost related to community college staff results in a more conservative cost estimate for the private entities.

Rule .0602 - Basic and Advanced EMS Educational Institution Requirements has been amended to strengthen educational programs as well as roles and responsibilities of the educational institution oversight staff.

Language has been added to confirm educational institutions provide at least two initial courses for each program level offered (EMR, EMT, AEMT, or Paramedic). The OEMS education staff strongly recommend these educational institution changes to be more effective and proficient.

Specific roles and responsibilities have been more clearly defined and emphasize CAAHEP standards that are required for accreditation.

Cost Impact

Costs associated with the accreditation requirements in this amendment are addressed under rule 10A NCAC 13P .0501.

Rule .0904 - Initial Designation Process rules are being amended to more accurately reflect comprehensive criteria defined by the American College of Surgeons (ASC) for trauma center designation.

The admission criteria language is being updated to align with national standards. The ASC standards only require Level I Trauma Centers to comply with trauma patient admission requirements listed in Paragraph (b)(3) of this rule. The admission requirement as currently written in this rule presents a challenge for some Level III Trauma Centers that otherwise may meet all other criteria to obtain Level II designation. As part of a national federal initiative, this proposed change also provides better opportunity for military hospitals to build more community influence as state designated Trauma Centers. Additionally, the OEMS also does not evaluate the "cost effectiveness" of a designated Trauma Center.

Specific defined trauma data elements, Paragraphs (c)(1) – (5), are being deleted. The hospitals submit data established by national standards to the National Trauma Database. The data submitted is defined by the ASC and is recommended to be removed in this rule. Paragraph (d) is being amended since the OEMS does not "justify" the need for designated trauma centers. Notification of the "respective Board of County Commissioners" in the applicant's primary catchment area is recommended for removal, Paragraph (e). The notification does not impact the process for approval. Comments may still be received during the 30-day comment period through the applicant's Primary RAC. The Requests for Proposal (RFP) no longer require a written "signature" for electronic submission. These recommended changes will further streamline the application process.

The timeline criteria for a site visit after approval as described in Paragraph (j) is recommended to be deleted. The specified timeframe does not allow for flexibility if needed due to unforeseen

circumstances that may adversely impact the process. Coordinating with hospitals and out of state ASC survey team members pose scheduling challenges. The scheduling should be an internal process policy rather than defined in Rule. OEMS staff will continue to coordinate with the survey team members and appropriate hospital staff to schedule a date agreeable to all parties for the required visit.

Impact

Unable to determine – OEMS primarily expects new applications for Level II Trauma Centers for military hospitals. Overall, OEMS expects positive impacts from the military hospitals being able to achieve Level II Trauma Center designations, but does not expect substantial economic impacts.

.0905 - Renewal Designation Process is recommended for amendment to remove Paragraph (c)(3), requiring notification of the "Board of County Commissioners." This change coincides the amendments to 10A NCAC 13P .0904.

Impact

No impact associated with amending this rule.

Rule .1101 - State Trauma System is being amended to reflect a more accurate and efficient process for annual membership and updates. Each of the eight Trauma Regional Advisory Committees (RAC) are familiar with and communicate routinely with their respective hospital and EMS System members. Annual notification of membership rosters from the OEMS to the RAC for confirmation is inefficient. Having the RAC coordinator send the OEMS membership information streamlines the notification process. The proposed change also removes the unnecessary restriction of only changing RAC affiliation during the annual update. The amendment simply reverses the notification process, therefore there is no projected cost impact.

Impact

No impact associated with amending this rule.

Rule .1401 - Chemical Addiction or Abuse Treatment Program Requirements is being amended to more accurately define the "Recovery" Program. The "Chemical Addiction or Abuse Treatment Program" is authorized by G.S. 143-509(13) to monitor participants for safe practice. This program is intended to provide an individual, who would otherwise be subject to loss of their EMS credential for a confirmed addiction problem, with a mechanism to remain eligible for retention of their credential, provided they successfully complete all aspects of a structured treatment program. This program is comprehensive and extremely structured, consisting of required random drug screenings, active participation in an approved treatment program, attendance at support meetings, and authorization to return to limited practice with an

encumbered credential until the individual is restored to full practice. This program is a minimum of three years in length. An individual's participation in the program is confidential and non-punitive. However, failure to complete the program subjects the individual to enforcement action by OEMS.

Existing rule is cumbersome and inefficient for the OEMS and the EMS credentialed personnel enrolled in the program. Healthcare professionals specialized in chemical dependency develop treatment plans based on the initial assessment. The recommendation is to utilize the specific treatment plan for that individual to establish a consent agreement between the Department and the individual entering the program. The consent agreement will be used by the OEMS staff to "monitor" compliance of the individual. The change removes specific required criteria that could potentially be outside the treatment plan developed by the healthcare professionals specialize in chemical dependency.

Removing the numerous OEMS mandated body fluid screenings and OEMS mandated self-help recovery meetings may produce an opportunity cost savings. Due to the extremely low rate of participation in the program and the unknown of the individual specific treatment plans, potential savings are not quantifiable. Due to employer "zero tolerance" policies, most of these individuals are terminated. The OEMS administration has partnered with the North Carolina Association of EMS Administrators in efforts to present program information and open dialogue for potential employment options to the North Carolina Association of County Commissioners and other related groups.

Impact
Unable to determine – likely net benefit to affected individual

Rule 1403. - Conditions for Restricted Practice with Limited Privileges is proposed for amendment to enhance efficiency of the process. Removing the Reinstatement Committee will streamline the process, eliminate the Committee "interviewing" the individual, and forwarding recommendations for restrictions or limitations. Under current rule the Chief of the OEMS has the final decision for such actions. The proposed language places the final accountability on the Chief to ensure all requirements of the consent agreement to determine if an encumbered credential is warranted.

Removing the Reinstatement Committee requirement would reduce the cost of members' time and travel for potential meetings, avoid scheduling conflicts or delays, as well as creating an opportunity cost for the individual to return to work more quickly. Due to the very low rate of participation in the program and the unknown of the individual treatment plans, potential savings are not quantifiable.

Impact
Unable to determine – likely net benefit to affected individual and state government

.1404 - Reinstatement of an Unencumbered EMS Credential and

.1405 - Failure to Complete the Chemical Addiction or Abuse Program are recommended for amendment with technical changes in response to the proposed change to "consent agreement" in Rule 10A NCAC 13P .1401. In addition, the title of Rule 10A NCAC 13P .1405 is proposed for a change to accurately reflect the program.

Impact

No cost impact associated with amending this rule.

.1505 EMS - Educational Institutions is being amended to allow more appropriate action against an institution as necessary. Current rule only allows denial of the initial or renewal designation, and revocation of designation for significant failure to comply with education rules. Language has been revised to add amend and suspends as alternate actions versus only revocation. These actions allow the Department to take action on the designation, but also work with the institution to develop a corrective action plan to achieve full compliance with applicable rules. The OEMS provides technical assistance to educational institutions and routinely audits institutions to ensure the programs maintain documentation of pre-requisites, didactic hours, clinical hours, exams, and skills verification. As a result of complaints received by the OEMS and audits, several institutions were found to have significant compliance concerns that warranted investigations and corrective action plans to continue the approved programs. Adding the options to amend or suspend provides more efficient authority to the OEMS to take action on the institution designation without shutting the program down completely. The change would not increase cost as OEMS staff presently work with educational institution staff currently conducting audits, investigating complaints, and developing or monitoring corrective action plans as necessary.

Impact

No cost impact associated with amending this rule.

.1507 - EMS Personnel Credentials is being amended to more accurately focus on specific actions of EMS personnel formally investigated by the OEMS and may be required to appear before the Emergency Medical Services Disciplinary Committee defined in G.S. 143-519. A growing number of specific concerns leading to action against EMS personnel credentials are not adequately addressed in the current rule. These include theft from a patient, agency, or institution; medication diversion; and filing false complaints against individuals, EMS agencies, or educational institutions. OEMS compliance staff, the Disciplinary Committee, and the Chief are faced with relying on "unprofessional conduct" since such egregious actions such as these are not defined in the rule. Defining these behaviors potentially strengthens the "authority" if formal action against the EMS personnel is warranted. The Disciplinary Committee, the Chief of OEMS, and the Department seek action when the safety and welfare of the individual, agency, or public is jeopardized as a result of these actions by the individual. Relying on "unprofessional conduct" because these acts are not defined in rule trivialize the threat to the public. There is no

impact with this change as these complaints continue to be investigated and presented for potential action.

An additional challenge to the complaint/investigation/disciplinary process has been the absence of any requirement to report any of the violations as listed in this rule, Paragraph (h). EMS administrators and medical directors have expressed concern that county, agency, hospital or other human resources or administrative decisions have discouraged or halted reporting violations to the OEMS. During an EMS Medical Directors meeting at the 2019 EMSEXPO conference (sponsored by the NCOEMS), numerous Medical Directors complained they felt their "hands were tied" by administrative and legal channels since there was no state requirement for reporting these violations.

Failure to approve the recommended amendment for reporting violations will only allow the current concerns to continue and potentially decrease safety to the general public. Credentialed EMS personnel may have privileges revoked by the Medical Director locally or be subject to termination by the employer for violations listed in rule. The individual may move from one EMS System or employer to another without divulging details that led to the actions from the previous employer and or Medical Director. Certain violations create serious concerns for the safety of the general public and greater potential liability to the future Medical Director or employer.

The OEMS cannot appropriately estimate any potential increase of investigations, Disciplinary Committee hearings, or actions based on the recommended change.

Impact

Unable to determine.

.1511 - Procedures for Qualifying for an EMS Credential Following Enforcement Action is being amended for technical correction. "Denial" is not applicable in Paragraph (a) as this rule addresses enforcement action. Rule 10A NCAC 13P .1507 EMS Personnel Credentials establishes criteria to "amend, deny, suspend, or revoke" credentials and provides information for the "individual's right to a consent hearing." Enforcement action on a credential, as the rule is written, implies a credential was previously issued. It is the opinion of the OEMS this rule sets forth the criteria for qualifying to be recredentialed after action was taken for violations listed in Rule 10A NCAC 13P .1507.

Impact

No cost impact associated with amending this rule.

Conclusion

The revisions to the EMS and trauma rules have been drafted to address all areas required for supporting the growth in the EMS industry and changes that have occurred with national EMS and

trauma standards. Additionally, every effort has been made to minimize any financial burden that may be associated with compliance with these revised rules. Although there will be an increase in state government, local government, and private expenditures and opportunity costs associated with many of the changes, there are also many benefits associated with the proposed rules, many of which OEMS was unable to quantify. Overall, OEMS believes that the effect of incorporating these changes will benefit the quality of care provided and enhance safety for the citizens of North Carolina.

APPENDIX A

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

10A NCAC 13P .0101 ABBREVIATIONS

As used in this Subchapter, the following abbreviations mean:

(1) ACS: American College of Surgeons;

(2) AEMT: Advanced Emergency Medical Technician;

(3) AHA: American Heart Association;

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

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

(6) CPR: Cardiopulmonary Resuscitation;

(7) ED: Emergency Department;

(8) EMD: Emergency Medical Dispatcher;

(9) EMR: Emergency Medical Responder;

(10) EMS: Emergency Medical Services;

(11) EMS-NP: EMS Nurse Practitioner;

(12) EMS-PA: EMS Physician Assistant;

(13) EMT: Emergency Medical Technician;

(14) FAA: Federal Aviation Administration;

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

~~(16)~~(15) FCC: Federal Communications Commission;

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

~~(18)~~(16) ICD: International Classification of Diseases;

~~(19)~~(17) ISS: Injury Severity Score;

~~(20) ICU: Intensive Care Unit;~~

~~(21) IV: Intravenous;~~

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

~~(23)~~(18) MICN: Mobile Intensive Care Nurse;

~~(24)~~(19) NHTSA: National Highway Traffic Safety Administration;

~~(25)~~(20) OEMS: Office of Emergency Medical Services;

~~(26)~~(21) OR: Operating Room;

~~(27)~~(22) PSAP: Public Safety Answering Point;

~~(28)~~(23) RAC: Regional Advisory Committee;

~~(29)~~(24) RFP: Request For Proposal;

~~(30) RN: Registered Nurse;~~

~~(31)~~(25) SCTP: Specialty Care Transport Program;

~~(32)~~(26) SMARTT: State Medical Asset and Resource Tracking Tool;

~~(33)~~(27) STEMI: ST Elevation Myocardial Infarction; and

~~(34) TR: Trauma Registrar;~~

~~(35) TPM: Trauma Program Manager; and~~

~~(36)~~(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.~~ 2017;
Amended Eff. 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 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 a hospital of its own volition reroutes a patient from the scene of an accident or medical emergency or referring hospital to a facility with a higher level of care.

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

(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) "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) "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) "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) "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) "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) "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) "Immediately Available" means the physical presence of the health professional or the hospital resource within the trauma center to evaluate and care for the trauma patient.~~

~~(28)~~(27) "Inclusive Trauma System" means an organized, multi-disciplinary, evidence-based approach to provide quality care and to improve measurable outcomes for all defined injured patients. EMS, hospitals, other health systems, and clinicians shall participate in a structured manner through leadership, advocacy, injury prevention, education, clinical care, performance improvement, and research resulting in integrated trauma care.

~~(29)~~(28) "Infectious Disease Control Policy" means a written policy describing how the EMS system will protect and prevent its patients and EMS professionals from exposure and illness associated with contagions and infectious disease.

~~(30)~~(29) "Lead RAC Agency" means the agency (comprised of one or more Level I or II trauma centers) that provides staff support and serves as the coordinating entity for trauma planning.

~~(31)~~(30) "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.

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

~~(33)~~(32) "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.

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

~~(35)~~(33) "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.

~~(36)~~(34) "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.

~~(37)~~(35) "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.

~~(38)~~(36) "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.

~~(39) "Off-line Medical Control" means medical supervision provided through the EMS System Medical Director or SCTP Medical Director who is responsible for the day-to-day medical care provided by EMS personnel. This includes EMS personnel education, protocol development, quality management, peer review activities, and EMS administrative responsibilities related to assurance of quality medical care.~~

~~(40)~~(37) "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.

~~(41)~~(38) "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.

~~(42)~~(39) "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.

~~(43) "Participating Hospital" means a hospital that supplements care within a larger trauma system by the initial evaluation and assessment of injured patients for transfer to a designated trauma center if needed.~~

~~(44)~~(40) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.

~~(45)~~(41) "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.

~~(46)~~(42) "Request for Proposal" means a State document that must be completed by each hospital seeking initial or renewal trauma center designation.

~~(47)~~(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.

~~(48)~~(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.

~~(49)~~(45) "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.

~~(50)~~(46) "Specialty Care Transport Program Continuing Education Coordinator" means a ~~Level I~~ Level II EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.

~~(51)~~(47) "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.

~~(52)~~(48) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.

~~(53)~~(49) "System Continuing Education Coordinator" means the ~~Level I~~ Level II EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.

~~(54)~~(50) “System Data" means all information required for daily electronic submission to the OEMS by all EMS Systems using the EMS data set, data dictionary, and file format as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated herein by reference including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699- 2707, at no cost and online at www.ncems.org at no cost.

~~(55)~~(51) "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.

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

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

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

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

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

~~(61)~~(52) "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 online at https://info.ncdhhs.gov/dhsr/EMS/trauma/traumaregistry.html at no cost.

~~(62)~~(53) "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.

~~(63)~~(54) "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 at no cost.

~~(64)~~(55) "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.

~~(65)~~(56) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.

~~(66)~~(57) "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. July 1, 2021; September 1, 2019; July 1, 2018.

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

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

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

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

(c) The Medical Care Commission exempts wheeled chair devices used solely for the transportation of mobility impaired persons seated in an upright position in non-permitted vehicles from the definition of stretcher.

History Note: *Authority G.S. 131E-156; 131E-157; 143-508(d)(8);*
Eff. January 1, 2017;
Amended Eff. July 1, 2021; July 1, 2018.

10A NCAC 13P .0501 is proposed for amendment as follows:

10A NCAC 13P .0501 EDUCATIONAL PROGRAMS

(a) EMS educational programs that qualify credentialed EMS personnel to perform within their scope of practice shall be offered by an EMS educational institution as set forth in Section .0600 of this Subchapter, or by an EMS educational institution in another state where the education and credentialing requirements have been approved for legal recognition by the Department pursuant to G.S. 131E-159 as determined using the professional judgment of OEMS staff following comparison of out-of-state standards with the program standards set forth in this Rule.

(b) Educational programs approved to qualify EMS personnel for credentialing shall meet the educational content of the "US DOT NHTSA National EMS Education Standards," which is hereby incorporated by reference, including subsequent amendments and editions. This document is available online at no cost at www.ems.gov/education.html.

(c) Educational programs approved to qualify EMS personnel for AEMT and Paramedic credentialing shall meet the requirements of Paragraph (b) of this Rule and possess verification of accreditation or a valid letter of review from the Commission on Accreditation of Allied Health Education Programs (CAAHEP) or other accrediting agency determined using the professional judgment of OEMS staff following a comparison of standards.

~~(c)~~ (d) Educational programs approved to qualify EMD personnel for credentialing shall conform with the "ASTM ~~F1258 – 95(2006).~~ F1258 – 95(2014): Standard Practice for Emergency Medical ~~"Dispatch"~~ Dispatch" incorporated by reference including subsequent amendments and editions. This document is available from ASTM International, 100 Barr Harbor Drive, PO Box C700, West Conshohocken, PA, 19428-2959 USA, at a cost of forty eight dollars ~~($40.00)~~ ($48.00) per copy.

~~(d)~~ (e) Instructional methodology courses approved to qualify Level I EMS instructors shall conform with the "US DOT NHTSA 2002 National Guidelines for Educating EMS Instructors" incorporated by reference including subsequent amendments and additions. This document is available online at no cost at www.ems.gov/education.html.
~~(e)~~ (f) Continuing educational programs approved by the OEMS to qualify EMS personnel for renewal of credentials shall be approved by demonstrating the ability to assess cognitive competency in the skills and medications for the level of application as defined by the North Carolina Medical Board pursuant to G.S. 143-514.
~~(f)~~ (g) Refresher courses shall comply with the requirements defined in Rule .0513 of this Section.

History Note: *Authority G.S. 143-508(d)(3); 143-508(d)(4); 143-514;*
Temporary Adoption Eff. January 1, 2002;
Eff. January 1, 2004;
Amended Eff. January 1, 2009;
Readoption Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

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~~ 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~~ Complete an approved educational program as set forth in Rule ~~.0501(b)~~ .0501 of this Section for their level of application.

(3) ~~complete~~ 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(b)~~ .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~~ 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~~ 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~~ 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 ~~nine~~ six months shall be allowed.

~~(B) if the individual fails to pass a written examination, the individual may continue eligibility for examination for an additional three attempts within the following nine months by submitting to the OEMS evidence the individual repeated a course specific scope of practice evaluation as set forth in Subparagraph (a)(3) of this Rule, and evidence of completion of a refresher course as set forth in Rule .0513 of this Section for the level of application; or~~

~~(C)~~(B) if unable to pass the written examination requirement after ~~six attempts~~ three attempts, ~~within an 18 period following course grading date as reflected in the OEMS credentialing database,~~ 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) ~~submit~~ Submit to a criminal background history check as set forth in Rule .0511 of this Section.

(6) ~~submit~~ 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~~ AEMT, or Paramedic may qualify for initial credentialing under the legal recognition option set forth in G.S. 131E-159(c).

(1) Individuals possessing a credential for less than two years being used for the level of application shall complete a written examination administered by the OEMS as set forth in this Rule.

(2) Individuals seeking credentialing as an AEMT or Paramedic shall submit documentation that the credential being used for application is from a CAAHEP Accredited program.

(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(c)~~ .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;

(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.~~ 2017;
Amended Eff. July 1, 2021.

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

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

(a) EMR, EMT, AEMT, and Paramedic applicants shall renew credentials by meeting the following criteria:

(1) presenting documentation to the OEMS or an approved EMS educational institution or program as set forth in Rule .0601 or .0602 of this Subchapter that they have completed an approved educational program as described in Rule ~~.0501(e) or (f)~~ .0501 of this Section;

(2) submit to a criminal background history check as set forth in Rule .0511 of this Section;

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

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

(b) An individual may renew credentials by presenting documentation to the OEMS that he or she holds a valid EMS credential for his or her level of application issued by the National Registry of Emergency Medical Technicians or by another state where the education and credentialing requirements have been determined by OEMS staff in their professional judgment to be equivalent to the educations and credentialing requirements set forth in this Section.

(c) EMD applicants shall renew credentials by presenting documentation to the OEMS that he or she holds a valid EMD credential issued by a national credentialing agency using the education criteria set forth in Rule ~~.0501(c)~~ .0501 of this Section.

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

(e) EMS credentials may not be renewed through a local credentialed institution or program more than 90 days prior to the date of expiration.

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

(g) Pursuant to G.S. 131E-159(h), the Department shall not renew the EMS credential for any person listed on the North Carolina Department of Public Safety, Sex Offender and Public Protection Registry, or who was convicted of an offense that would have required registration at a time when registration would have been required by law.

History Note: *Authority G.S. 131E-159(a); 131E-159(g); 131E-159(h); 143-508(d)(3); 143B-952; 150B-3(a);*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .0507 is proposed for amendment as follows:

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

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

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

(2) have completed post-secondary level education equal to or exceeding a minimum of an Associate Degree from an institution accredited by an approved agency listed on the U.S. Department of Education website, www.ed.gov:

(A) The Department shall accept degrees from programs accredited by the Accreditation Commission for Education in Nursing (ACEN) and the Commission on Accreditation of Allied Health Education Programs.

(B) Additional degrees may be accepted based on the professional judgment of OEMS staff following a comparison of standards;

~~(2)~~(3) have three years experience at the scope of practice for the level of application;

~~(3)~~(4) within one year prior to application, complete an in-person evaluation that demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule ~~.0501(b)~~ .0501 of this Section consistent with their level of application and approved by the OEMS:

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

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

~~(4)~~(5) have 100 hours of teaching experience at or above the level of application in an approved EMS educational program or a program determined by OEMS staff in their professional judgment equivalent to an EMS education program;

~~(5)~~(6) complete an educational program as described in Rule ~~.0501(d)~~ .0501 of this Section; and

~~(6)~~(7) within one year prior to application, attend an OEMS Instructor workshop sponsored by the OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at ~~www.ncems.org; and~~ https://info.ncdhhs.gov/dhsr/ems.

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

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

(c) The credential of a Level I EMS Instructor shall be valid for four years, or less pursuant to G.S. ~~131E-159(c)~~ 131E-159(c), unless any of the following occurs:

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

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

(d) Pursuant to the provisions of 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; 143-508(d)(3);*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. July 1, 2021; September 1, 2019.

10A NCAC 13P .0508 is proposed for amendment as follows:

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

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

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

(2) be currently credentialed by the OEMS as a Level I Instructor at the EMT, AEMT, or Paramedic level;

~~(2)~~(3) have completed post-secondary level education equal to or exceeding ~~an Associate Degree;~~ a Bachelor's Degree from an institution accredited by an approved agency listed on the U.S. Department of Education website, www.ed.gov:

(A) The Department shall accept degrees from programs accredited by the Accreditation Commission for Education in Nursing (ACEN) and the Commission on Accreditation of Allied Health Education Programs.

(B) Additional degrees may be accepted based on the professional judgment of OEMS staff following a comparison of standards;

~~(3)~~(4) within one year prior to application, complete an in-person evaluation that demonstrates the applicant's ability to provide didactic and clinical instruction based on the cognitive, psychomotor, and affective educational objectives in Rule ~~.0501(b)~~ .0501 of this Section consistent with their level of application and approved by the OEMS:

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

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

~~(4)~~(5) ~~have two~~ a minimum two concurrent years teaching experience as a Level I EMS Instructor at or above the level of ~~application~~ application, or as a Level II EMS Instructor at a lesser credential level applying for a higher level in an approved EMS educational ~~program~~ program, or teaching experience determined by OEMS staff in their professional judgment to be equivalent to an EMS Level I education program;

~~(5)~~(6) complete the "EMS Education Administration Course conducted by a North Carolina Community College or the National Association of EMS Educators Level II Instructor ~~Course;~~ Course that is valid for the duration of the active Level II Instructor credential; and

~~(6)~~(7) within one year prior to application, attend an OEMS Instructor workshop sponsored by the OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at ~~www.ncems.org.~~ https://info.ncdhhs.gov/dhsr/ems.

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

(c) The credential of a Level II EMS Instructor is valid for four years, or less pursuant to ~~G.S. 131E-159(c)~~ 131E-159(c), unless any of the following occurs:

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

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

(d) Pursuant to the provisions of 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; 143-508(d)(3);*
Temporary Adoption Eff. January 1, 2002;
Eff. February 1, 2004;
Amended Eff. January 1, 2009;
Readopted Eff. January 1, 2017;
Amended Eff. July 1, 2021; September 1, 2019.

10A NCAC 13P .0510 is proposed for amendment as follows:

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

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

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

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

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

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

(3) completed 96 hours of EMS instruction at the level of ~~application; and~~ application. Individuals identified as EMS program coordinators or positions determined by OEMS staff in the professional judgment to the equivalent to an EMS program coordinator may provide up to 72 hours related to the institution's needs, with the remaining 24 hours in EMS instruction;

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

(A) enrichment of knowledge;

(B) development or change of attitude in students; or

(C) acquisition or improvement of skills; and

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

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

(c) The credential of a Level I or Level II EMS Instructor is valid for four years, or less pursuant to G.S. 131E-159(c) unless any of the following occurs:

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

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

(d) Pursuant to the provisions of 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); 143-508(d)(3);*
Eff. February 1, 2004;
Amended Eff. February 1, 2009;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

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 ~~that~~ who was 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 ~~24~~ 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;

(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) ~~EMRs and EMTs shall~~ 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

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

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

~~(1) be ineligible for legal recognition pursuant to G.S. 131E-159(c); and~~

~~(2) meet the provisions for initial credentialing set forth in Rule .0502 of this Section~~

~~(e) AEMT and Paramedic applicants for reinstatement of an EMS credential, lapsed between 24 and 48 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;~~

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

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

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

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

~~(f)~~(d) ~~AEMT~~ EMR, EMT, AEMT, and Paramedic applicants for reinstatement of an EMS credential, lapsed more than ~~48~~ 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.

(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 April 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.~~ 2017;
Amended Eff. 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 ~~INSTITUTION~~ PROGRAM REQUIREMENTS

(a) Continuing Education EMS Educational ~~Institutions~~ Programs shall be credentialed by the OEMS to provide only EMS continuing ~~education programs.~~ education. An application for credentialing as an approved EMS continuing education ~~institution~~ program shall be submitted to the OEMS for review.

(b) Continuing Education EMS Educational ~~Institutions~~ 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 or~~ System, Specialty Care Transport ~~Program;~~ Program, or Agency;

(2) a continuing education program shall be consistent with the services offered by the EMS ~~System or~~ System, Specialty Care Transport ~~Program;~~ 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; ~~and~~

(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(b)~~ .0501 of this Subchapter;

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

(6) Upon request, the approved EMS continuing education ~~institution~~ program shall provide records to the OEMS in order to verify compliance and student eligibility for credentialing; and

(7) ~~unless accredited in accordance with Rule .0605 of this Section,~~ approved education ~~institution~~ 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.

~~(c)~~(d) Assisting physicians delegated by the EMS System Medical Director as authorized by Rule ~~.0403(b)~~ .0403 of this Subchapter or SCTP Medical Director as authorized by Rule ~~.0404(b)~~ .0404 of this Subchapter for provision of medical oversight of continuing education programs must 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.~~ 2017;
Amended Eff. 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 for each 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 in Rule .1505 of this Subchapter.

(b) For initial courses, Basic EMS Educational Institutions shall meet all of the requirements for continuing EMS educational ~~institutions~~ programs defined in Rule .0601 of this Section and shall have:

(1) at least a Level I EMS Instructor as each lead course instructor for ~~EMR and EMT~~ all courses. The lead course instructor must be credentialed at a level equal to or higher than the course ~~offered;~~ 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. 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 ~~may be either~~ shall be a Level II EMS Instructor credentialed at or above the highest level of course offered by the ~~institution, or a combination of staff who cumulatively meet the requirements of the Level II EMS Instructor set forth in this Subparagraph. These individuals may share the responsibilities of the lead EMS educational coordinator. The details of this option shall be defined in the educational plan required in Subparagraph (b)(5) of this Rule;~~ institution, 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, evidenced-informed clinical practice, and incorporated by Rule .0501 of this Section;

(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;

~~(3)~~(4) written educational policies and procedures that include:

(A) the written educational policies and procedures set forth in Rule ~~.0601(b)(4)~~ .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;

~~(4)~~(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;" and~~ 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

~~(5)~~(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 ~~defined~~ set forth in Paragraph (b) of this ~~Rule, and have a Level II EMS Instructor as lead instructor for AEMT and Paramedic initial courses. The lead instructor shall be credentialed at a level equal to or higher than the course offered.~~ 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) 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.~~ 2017;
Amended Eff. 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, 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~~ for Level 1 applicants, evidence the Trauma Center will admit at least 1200 trauma patients annually or show that its trauma service will be taking care of at least 240 trauma patients yearly with an ISS greater than or equal to ~~15 yearly.~~ 15. ~~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 to the OEMS weekly a minimum of 12 months prior to application that includes all the Trauma Center's trauma patients as defined in Rule .0102 of this ~~Subchapter who are:~~ Subchapter.

~~(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.~~ application. ~~The~~ The applicant's primary 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)~~(e) 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)~~(f) Once the hospital is notified that an RFP will be accepted, the hospital shall complete and submit an electronic copy of the completed RFP ~~with signatures~~ to the OEMS at least 45 days prior to the proposed site visit date.

~~(h)~~(g) 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)~~(h) 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)~~ (g) of this Rule.

~~(j) If after review of the RFP, the OEMS recommends the hospital for a site visit, the OEMS shall notify the hospital within 30 days and the site visit shall be conducted within six months of the recommendation. The hospital and the OEMS shall agree on the date of the site visit.~~

~~(k)~~(i) Except for OEMS representatives, any in-state reviewer for a Level I or II visit shall be from outside the local or adjacent RAC, unless mutually agreed upon by the OEMS and the trauma center seeking designation where the hospital is located. The composition of a Level I or II state site survey team shall be as follows:

(1) one out-of-state trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be the primary reviewer;

(2) one in-state emergency physician who currently works in a designated trauma center, is a member of the American College of Emergency Physicians or American Academy of Emergency Medicine, and is boarded in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;

(3) one in-state trauma surgeon who is a member of the North Carolina Committee on Trauma;

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

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

(6) OEMS Staff.

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

(1) one trauma surgeon who is a Fellow of the ACS, who is a member of the North Carolina Committee on Trauma and shall be the primary reviewer;

(2) one emergency physician who currently works in a designated trauma center, is a member of the North Carolina College of Emergency Physicians or American Academy of Emergency Medicine, and is boarded in emergency medicine by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine;

(3) one trauma program manager who is licensed to practice nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes; and

(4) OEMS Staff.

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

~~(n)~~(l) 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)~~(m) 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)~~(n) All criteria defined in Rule .0901 of this Section shall be met for initial designation at the level requested.

~~(q)~~(o) 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)~~ (g) of this Rule.

~~(r)~~(p) The final decision regarding Trauma Center designation shall be rendered by the OEMS.

~~(s)~~(q) 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)~~(r) 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)~~(s) 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. July 1,2021; July 1, 2018.

10 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. Upon this notification, OEMS shall notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for renewal to allow 30 days for comment.

(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) of this Section.

(6) the composition of a Level III site survey team shall be the same as that specified in Rule .0904(l) of this Section.

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

(8) the primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review team. 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,~~ 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 OEMS shall notify the Board of County Commissioners within the trauma center's trauma primary catchment area of the Trauma Center's request for renewal to allow 30 days for comments.~~

~~(4)~~(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.

~~(5)~~(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.

~~(6)~~(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; and

(D) OEMS staff.

~~(7)~~(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.

~~(8)~~(7) all state Trauma Center criteria shall be met as defined in Rule .0901of this Section for renewal of state designation. ACS' verification is not required for state designation. ACS' verification does not ensure a state designation.

~~(9)~~(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.

~~(10)~~(11) 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.

~~(11)~~(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.

~~(12)~~(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.

~~(13)~~(12) the final decision regarding trauma center designation shall be rendered by the OEMS.

~~(14)~~(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.

~~(15)~~(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.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1101 is proposed for amendment as follows:

10A NCAC 13P .1101 STATE TRAUMA SYSTEM

(a) The state trauma system shall consist of regional plans, policies, guidelines, and performance improvement initiatives by the RACs to create an Inclusive Trauma System monitored by the OEMS.

(b) Each hospital and EMS System shall affiliate as defined in Rule ~~.0102(3)~~ .0102 of this Subchapter and participate with the RAC that includes the Level I or II Trauma Center where the majority of trauma patient referrals and transports occur. Each hospital and EMS System shall submit to the OEMS upon request patient transfer patterns from data sources that support the choice of their primary RAC affiliation. Each RAC shall include at least one Level I or II Trauma Center.

~~(c) The OEMS shall notify each RAC of its hospital and EMS System membership annually.~~

~~(d)~~(c) Each ~~hospital and each EMS System~~ Lead RAC Coordinator shall update and submit ~~its~~ RAC affiliation ~~information~~ membership for hospitals and EMS Systems to the OEMS no later than July 1 of each year. Each hospital or EMS System shall submit written notification to the OEMS for any RAC affiliation change. RAC affiliation may ~~only~~ be changed ~~during this annual update and~~ only if supported by a change in the majority of transfer patterns to a Level I or Level II Trauma Center. Documentation of these new transfer patterns shall be included in the request to change affiliation. ~~If no change is made in RAC affiliation, written notification shall be required annually to the OEMS to maintain current RAC affiliation.~~

History Note: *Authority G.S. 131E-162;*
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;
Amended Eff. July 1, 2021; January 1, 2017.

10A NCAC13P .1401 is proposed for amendment as follows:

10A NCAC 13P .1401 CHEMICAL ADDICTION OR ABUSE ~~TREATMENT~~ RECOVERY PROGRAM REQUIREMENTS

(a) The OEMS shall provide a ~~treatment~~ monitoring program for aiding in the recovery ~~and rehabilitation~~ of EMS personnel subject to disciplinary action for being unable to perform as credentialed EMS personnel with reasonable skill and safety to patients and the public by reason of use of alcohol, drugs, chemicals, or any other type of material as set forth in Rule ~~.1507(b)(9)~~ .1507 of this Subchapter.

(b) This program requires:

(1) an initial assessment by a healthcare professional ~~specialized~~ specializing in chemical dependency approved by the ~~treatment~~ program;

(2) a treatment plan developed ~~by the healthcare professional described in Subparagraph (b)(1) of this Rule~~ by a healthcare professional specializing in chemical dependency for the individual using the findings of the initial ~~assessment;~~ assessment. The Department and individual will enter into a consent agreement based up on the treatment plan; and

~~(3) random body fluid screenings using a standardized methodology designed by OEMS program staff to ensure reliability in verifying compliance with program standards;~~

~~(4) the individual attend three self-help recovery meetings each week for the first year of participation, and two each week for the remainder of participation in the treatment program;~~

~~(5)~~(3) monitoring by OEMS program staff of the individual for compliance with the ~~treatment program;~~ consent agreement entered into by the Department and the individual entering the program.

~~(6) written progress reports, shall be made available for review by OEMS upon completion of the initial assessment of the treatment program, upon request by OEMS throughout the individual's participation in the treatment program, and upon completion of the treatment program. Written progress reports shall include:~~

~~(A) progress or response to treatment and when the individual is safe to return to practice;~~

~~(B) compliance with program criteria;~~

~~(C) a summary of established long-term program goals; and~~

~~(D) contain pertinent medical, laboratory, and psychiatric records with a focus on chemical dependency.~~

History Note: *Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);*
Eff. October 1, 2010;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1403 is proposed for amendment as follows:

10A NCAC 13P .1403 CONDITIONS FOR RESTRICTED PRACTICE WITH LIMITED PRIVILEGES

(a) In order to assist in determining eligibility for an individual to return to restricted practice, ~~the OEMS shall create a standing Reinstatement Committee that shall consist of at least the following members:~~ completion of all requirements outlined in the individual's consent agreement with the Department as described in Rule .1401 of this Section shall be presented to the Chief of the OEMS.

~~(1) one physician licensed by the North Carolina Medical Board, representing EMS Systems, who shall serve as Chair of this committee;~~

~~(2) one counselor trained in chemical addiction or abuse therapy; and~~

~~(3) the OEMS staff member responsible for managing the treatment program as set forth in Rule.1401 of this Section.~~

(b) Individuals who have surrendered his or her EMS credential(s) as a condition of entry into the ~~treatment~~ recovery program, as required in Rule ~~.1402(4)~~ .1402 of this Section, shall be reviewed by the OEMS ~~Reinstatement Committee~~ Chief to determine if ~~a recommendation to the OEMS for~~ issuance of an encumbered EMS credential is warranted by the Department.

(c) In order to obtain an encumbered credential with limited privileges, an individual shall:

(1) be compliant for a minimum of 90 consecutive days with the treatment program described in Rule ~~.1401(b)~~ .1401 of this Section; and

(2) be recommended in writing for review by the individual's ~~treatment counselor;~~ recovery healthcare professional overseeing the treatment plan developed as described in Rule .1401 of this Section.

~~(3) be interviewed by the OEMS Reinstatement Committee; and~~

~~(4) be recommended in writing by the OEMS Reinstatement Committee for issuance of an encumbered EMS credential. The OEMS Reinstatement Committee shall detail in their recommendation all restrictions and limitations to the individual's practice privileges.~~

(d) The individual shall agree to sign a consent agreement with the OEMS that details the practice restrictions and privilege limitations of the encumbered EMS credential, and that contains the consequences of failure to abide by the terms of this agreement.

(e) The individual shall be issued the encumbered credential by the OEMS within 10 business days following execution of the consent agreement described in Paragraph (d) of this Rule.

(f) The encumbered EMS credential shall be valid for a period not to exceed four years.

History Note: *Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);*
Eff. October 1, 2010;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10A NCAC 13P .1404 is proposed for amendment as follows:

10A NCAC 13P .1404 REINSTATEMENT OF AN UNENCUMBERED EMS CREDENTIAL

Reinstatement of an unencumbered EMS credential is ~~dependant~~ dependent upon the individual successfully completing all requirements of the ~~treatment program~~ consent agreement as ~~defined in~~ set forth in Rule .1401 of this Section.

History Note: *Authority G.S. 131E-159(f); 143-508(d)(10); 143-509(13);*
Eff. October 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016.~~ 2016;
Amended Eff. July 1, 2021.

10A NCAC 13P .1405 is proposed for amendment as follows:

10A NCAC 13P .1405 FAILURE TO COMPLETE THE CHEMICAL ADDICTION OR ABUSE ~~TREATMENT~~ RECOVERY PROGRAM

Individuals who fail to complete the ~~treatment program~~ consent agreement established in Rule .1401 of this Section, upon review by the OEMS, are subject to revocation of their EMS credential.

History Note: *Authority G.S. 131E-159(f); 143-508(b); 143-508(d)(10);*
Eff. October 1, 2010;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016;
Amended Eff. July 1, 2021; January 1, 2017.

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

10A NCAC 13P .1505 EMS EDUCATIONAL INSTITUTIONS

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

(b) The Department shall deny the initial or renewal designation, without first allowing a focused review, of an EMS Educational Institution for any of the following reasons:

(1) significant failure to comply with the provisions of ~~Section .0600~~ 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 ~~Section .0600~~ Sections .0500 and .0600 of this Subchapter within ~~12~~ 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 ~~12~~ 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(b)(6)~~ .0601 of this Subchapter;

(4) the EMS Educational Institution failed to meet the requirements of a focused review within ~~12~~ 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 ~~revocation and denial.~~ 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. July 1, 2021; July 1, 2018; January 1, 2017.

10A NCAC 13P .1507 EMS PERSONNEL CREDENTIALS

(a) ~~An~~ 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;~~ 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, 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; ~~or~~

(30) representing or allowing others to represent that the credentialed EMS personnel has a credential that the credentialed EMS personnel does not in fact ~~have.~~ 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.

(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.

History Note: *Authority G.S. 131E-159; 143-508(d)(10); 143-519;*
Eff. January 1, 2013;
Readopted Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2021.

10 NCAC 13P .1511 is proposed for amendment as follows:

10A NCAC 13P .1511 PROCEDURES FOR QUALIFYING FOR AN EMS CREDENTIAL FOLLOWING ENFORCEMENT ACTION

(a) Any individual who has been subject to ~~denial,~~ suspension, revocation, or amendment of an EMS credential shall submit in writing to the OEMS a request for review to determine eligibility for credentialing.

(b) Factors the Department shall consider when determining eligibility shall include:

(1) the reason for administrative action, including:

(A) criminal history;

(B) patient care;

(C) substance abuse; and

(D) failure to meet credentialing requirements;

(2) the length of time since the administrative action was taken; and

(3) any mitigating or aggravating factors relevant to obtaining a valid EMS credential.

(c) In order to be considered for eligibility, the individual shall:

(1) wait a minimum of 36 months following administrative action before seeking review; and

(2) undergo a criminal history background check. If the individual has been charged or convicted of a misdemeanor or felony in this or any other state or country within the previous 36 months, the 36 month waiting period shall begin from the date of the latest charge or conviction.

(d) If determined to be eligible, the Department shall grant authorization for the individual to begin the process for EMS credentialing as set forth in Rule .0502 of this Subchapter.

(e) Prior to enrollment in an EMS educational program, the individual shall disclose the prior administrative action taken against the individual's credential in writing to the EMS Educational Institution.

(f) An individual who has undergone administrative action against his or her EMS credential is not eligible for legal recognition as defined in G.S. 131E-159(d) or issuance of a temporary EMS credential as defined in G.S. 131E159(e).

(g) For a period of 10 years following restoration of the EMS credential, the individual shall disclose the prior administrative action taken against his or her credential to every EMS System, Medical Director, EMS Provider, and EMS Educational Institution where he or she is affiliated and provide a letter to the OEMS from each verifying disclosure.

(h) If the Department determines the individual is ineligible for EMS credentialing pursuant to this Rule, the Department shall provide in writing the reason(s) for denial and inform him or her of the procedures for contested case hearing as set forth in Rule .1509 of this Section.

History Note: *Authority G.S. 131E-159(g); 143-508(d)(3); 143-508(d)(10);*
Eff. January 1, ~~2017.~~ 2017;
Amended Eff. July 1, 2020

Emergency Services and Trauma Rules Amendments Public Comments
10A NCAC 13P .0101, .0102, .0222, .0501, .0502, .0504, .0507, .0508, .0510, .0512, .0601, .0602, .0905, .1101, .1401-.1405, .1505, .1507, and .1511
Comment Period 12/15/20 – 02/15/21

Introduction:
There were 12 individual comments received, two being duplicates, during the public comment period on the amendment of Rules 10A NCAC 13P .0101, .0102, .0222, .0501, .0502, .0504, .0507, .0508, .0510, .0512, .0601, .0602, .0905, .1101, .1401-.1405, .1505, .1507, and .1511. Of these comments, eight people made statements during the public hearing conducted on February 8, 2021. These comments were submitted by representatives from the NC Community College System, City of Raleigh Fire Department, Skyland Fire and Rescue, Wake County EMS, Mission Healthcare Trauma Program Manager, N.C. Committee on Trauma Chairman x2, Atrium Health Metrolina Trauma Regional Advisory Committee, Atrium Health Cleveland, HCA Healthcare, and Southeastern Trauma Regional Advisory Committee. One individual also commented: Joshua Barnett. All the comments received on these rules are summarized below:

1) Listing of Comments Received and Agency's Consideration of Comments for Amendment Rule 13P .0501 – Educational Programs:

Commenter	Comment Summary
Tim Hinman, Skyland Fire and Rescue *(public hearing)*	Looks like that we're going to have to be become an accredited institution in looking at line 12 of the rule and it concerns us. It's something we're going to have to expend time on, as well as encumber a cost for that either annually or during that accreditation period. This came out fairly quickly to us, but we are concerned about that for the future. We renew in March, so hopefully this won't incur for us until four years down the road. As a small institution, we're concerned about encumbering more costs and time to keep our personnel educated.
NC Community College System	Request clarification about the implementation period for this rule. NC OEMS typically provides for transition periods and grandfathering when issuing new or amended rules. The NC Register specifies an anticipated effective date of July 1, 2021, but no other details. This rule change is not unexpected and is consistent with EMS's educational vision at national and state levels. The lack of a specified implementation period and grandfathering is concerning. OEMS discussed proposals at since 2019; but the process's details weren't available to educational institutions until December 15, 2020. They will be official on the effective date this year, not providing educational institutions a reasonable time for compliance. Most college EMS Educational Institutions are already in compliance with most or all of this rule or are in the middle of a strategic transition toward compliance. However, there are programs compliant under the current rule but not yet nationally accredited. They rely on instructors and key program managers with Level I and Level II EMS credentials, who are again qualified under current rules but will not meet the new rule requirements for higher degrees as of July 1, 2021. A transition period and grandfathering provision will minimize disruption to the current EMS education and workforce by allowing colleges and communities to identify financial and staffing resources needed to support compliance while continuing current programming. Paragraph (c):

Commenter	Comment Summary
	Propose a minimum 18-month implementation period for educational institutions to comply with Paragraph (c) in the rule for national accreditation of Educational Institutions offering AEMT and Paramedic programs. • **The accreditation process is lengthy**: it is not reasonable for institutions to work through the national accreditation process in the time between rule adoption and the anticipated effective date of July 1, 2021. (National accreditation takes at least 6 to 18 months to progress to the necessary Letter of Review (LoR) stage). • **Additional resources will be needed in already strained times:** COVID-19 has negatively impacted financial resources at colleges, put strains on students, instructors, administrators, and the communities they partner with to support EMS education. EMS educational institutions are implementing new EMS education and credentialing guidelines with 2021 compliance deadlines requiring additional resources and program and personnel alignment. Sufficient time is needed to identify financial resources to support these additional rules changes. • **The absence of an 18-month implementation period will disproportionately impact rural and Tier 1 and 2 distressed counties**: as of February 12, 2021, 39 of the state's 58 community colleges have programs that are fully accredited or are under a Letter of Review. The remaining serve rural or distressed counties that are resource-constrained. An 18-month implementation period would allow resource allocation to span two fiscal years, ensuring fewer workforce pipeline disruptions as programs align to the new standards.

Agency Response to Comments Above:

In response to Mr. Hinman's comments, the agency was able to provide Skyland Rescue with further clarification of the proposed rule. The proposed changes would not impact this agencies operation.

In response to the comments received from the NC Community College System, we have reviewed their comments and made the suggested changes to the proposed rule allowing for an 18-month implementation period.

2) Listing of Comments Received and Agency's Consideration of Comments for Amendment Rule 13P .0507 – Initial Credentialing Requirements for Level I EMS Instructors:

Commenter	Comment Summary
City of Raleigh Fire Department	Currently OSFM requires a HS diploma or GED for Level I instructor. Understands changing to an Associate Degree for EMS Instructor I much like with Paramedic, but this change would limit the number of eligible people on their end because there is no policy for an Associate Degree, rather credits equal to, until rank of Captain. Their biggest hurdle is getting people to get the EMS Instructor Methodology in addition to Fire Ed Methodology. Strides are being made towards this; however, it seems like an additional hurdle.

Commenter	Comment Summary
NC Community College System	Request clarification about the grandfathering provisions for this rule. NC OEMS typically provides transition periods and grandfathering when issuing new or amended rules. The NC Register specifies an anticipated effective date of July 1, 2021, but no other details. This rule change is not unexpected and is consistent with EMS's educational vision at national and state levels. The lack of a specified implementation period and grandfathering is concerning. OEMS discussed proposals at since 2019; but the process's details weren't available to educational institutions until December 15, 2020. They will be official on the effective date this year, not providing educational institutions a reasonable time for compliance. Most college EMS Educational Institutions are already in compliance with most or all of this rule or are in the middle of a strategic transition toward compliance. However, there are programs compliant under the current rule but not yet nationally accredited. They rely on instructors and key program managers with Level I and Level II EMS credentials, who are again qualified under current rules but will not meet the new rule requirements for higher degrees as of July 1, 2021. A transition period and grandfathering provision will minimize disruption to the current EMS education and workforce by allowing colleges and communities to identify financial and staffing resources needed to support compliance while continuing current programming. <u>13P .0507(a)(2)</u> Propose grandfathering provisions related to Level I EMS Instructors. • **Programs need time to recruit newly qualified Level I instructors.** There are currently qualified instructors who do not have the associate or bachelor's degrees required under this new rule. Without a grandfathering clause, some currently viable EMS education programs would be required to identify different instructors while also doing the work required of national accreditation amid the strains of COVID-19. This will disrupt programs' stability and continuity across the State and in our most vulnerable communities.

<u>Agency Response to Comments Above:</u>

In response to the comments received from the NC Community College System, we have reviewed their comments and made the suggested changes to the proposed rule allowing for an additional 6-month implementation period.

<u>3) Listing of Comments Received and Agency's Consideration of Comments for Amendment Rule 13P .0508 – Initial Credentialing Requirements for Level II EMS Instructors:</u>

Commenter	Comment Summary
Tim Hinman, Skyland Fire and Rescue *(public hearing)*	We have some Level I instructors, and that was the requirements right now for the continuing education institutions, but see the future requirements are for a Level II educational instructor. We have one person who has

Commenter	Comment Summary
	met all the requirements as of 1/1/20, except for an OEMS Instructor workshop, but OEMS has not had an Instructor workshop this year so she is still waiting on that to get her Level II. If that person has a Associates Degree and does not have a Bachelor's Degree as of July 1, requirement will be for that person to have the Bachelor's Degree. If that person does not get their bachelor's degree by July 1, will they be grandfathered since they've been trying to get that since 2020 and the only thing they lack is an instructor workshop? Why hasn't an instructor workshop been offered to since the nation has been going to some virtual method for these things?
NC Community College System	Request clarification about the grandfathering provisions for this rule. NC OEMS typically provides transition periods and grandfathering when issuing new or amended rules. The NC Register specifies an anticipated effective date of July 1, 2021, but no other details. This rule change is not unexpected and is consistent with EMS's educational vision at national and state levels. The lack of a specified implementation period and grandfathering is concerning. OEMS discussed proposals at since 2019; but the process's details weren't available to educational institutions until December 15, 2020. They will be official on the effective date this year, not providing educational institutions a reasonable time for compliance. Most college EMS Educational Institutions are already in compliance with most or all of this rule or are in the middle of a strategic transition toward compliance. However, there are programs compliant under the current rule but not yet nationally accredited. They rely on instructors and key program managers with Level I and Level II EMS credentials, who are again qualified under current rules but will not meet the new rule requirements for higher degrees as of July 1, 2021. A transition period and grandfathering provision will minimize disruption to the current EMS education and workforce by allowing colleges and communities to identify financial and staffing resources needed to support compliance while continuing current programming. <u>13P .0508(a)(3)</u> Request grandfathering provisions related to Level II EMS Instructors. • **Programs need time to recruit newly qualified Level II instructors.** There are currently qualified instructors who do not have the associate or bachelor's degrees required under this new rule. Without a grandfathering clause, some currently viable EMS education programs would be required to identify different instructors while also doing the work required of national accreditation amid the strains of COVID-19. This will disrupt programs' stability and continuity across the State and in our most vulnerable communities.

<u>Agency Response to Comments Above:</u>

In response to Mr. Hinman's comments, the agency was able to provide Skyland Rescue with further clarification of the proposed rule. The proposed changes would not impact this agencies operation.

In response to the comments received from the NC Community College System, we have reviewed their comments and made the suggested changes to the proposed rule allowing for an additional 6-month implementation period. In reference to the comment regarding a need for a "grandfather" clause, this proposed rule in only applicable to initial Level I and II Instructor credentials. All existing credentials would not be affected by this proposed language.

4) Listing of Comments Received and Agency's Consideration of Comments for Amendment Rule 13P .0601 – Continuing Education EMS Educational Program Requirements:

Commenter	Comment Summary
NC Community College System	NC OEMS typically provides transition periods and grandfathering when issuing new or amended rules. The NC Register specifies an anticipated effective date of July 1, 2021, but no other details. This rule change is not unexpected and is consistent with EMS's educational vision at national and state levels. The lack of a specified implementation period and grandfathering is concerning. OEMS discussed proposals at since 2019; but the process's details weren't available to educational institutions until December 15, 2020. They will be official on the effective date this year, not providing educational institutions a reasonable time for compliance. Most college EMS Educational Institutions are already in compliance with most or all of this rule or are in the middle of a strategic transition toward compliance. However, there are programs compliant under the current rule but not yet nationally accredited. They rely on instructors and key program managers with Level I and Level II EMS credentials, who are again qualified under current rules but will not meet the new rule requirements for higher degrees as of July 1, 2021. A transition period and grandfathering provision will minimize disruption to the current EMS education and workforce by allowing colleges and communities to identify financial and staffing resources needed to support compliance while continuing current programming. Propose grandfathering provisions related to Educational Program Coordinators. • **Programs need time to recruit newly qualified Educational Program Coordinators.** There are currently qualified educational program coordinators who do not have the associate or bachelor's degrees required under this new rule. Without a grandfathering clause, some currently viable EMS education programs would be required to identify different instructors while also doing the work required of national accreditation amid the strains of COVID-19. This will disrupt programs' stability and continuity across the State and in our most vulnerable communities.

Agency Response to Comments Above:

In response to the comment received from the NC Community College System, it appeared they made a valid comment making it applicable to all Education-related proposed rules. These proposed changes to .0601 were to lessen the restrictions for continuing education programs, not make them more restrictive, which is the emphasis in the comment. Therefore, no changes were made to the proposed language based on the comment.

5) Listing of Comments Received and Agency's Consideration of Comments for Amendment Rule 13P .0602 – Basic and Advanced EMS Educational Institution Requirements:

Commenter	Comment Summary
Wake County EMS	13P .0602 (a)(1): The goal of OEMS ensuring that Educational Institutions are meeting the needs of their respective communities is supported. Concerned this may be too prescriptive and doesn't offer needed flexibility to Educational Institutions. Suggests modifying to allow the Education Institution to demonstrate their course offerings are meeting the EMS System's need. This would be done through their CoAEMSP Advisory Committee and/or the EMS System's Peer Review Committee. The Educational Institution could elect to offer two courses at each level or provide documentation showing the EMS System's needs are being meet without two offerings at each credential level. Advanced Educational Institutions have EMS agencies represented on their CoAEMSP Advisory Committees. The Educational Institution could demonstrate to the OEMS how their offerings are meeting the needs of the EMS System. Basic Educational Institutions could use EMS System's Peer Review Committees to discuss and approve course offerings. As an example, Wake County EMS doesn't primarily need or want AEMTs. We would rather Wake Tech offer an additional paramedic program than conduct an AEMT course. Forcing Wake Tech to teach two AEMT classes doesn't necessarily do either party any good. This revision to the proposed rule would strengthen the rule, and also foster the relationships between the Educational Institutions and their communities of interest.

Agency Response to Comments Above:

In response to the comment received from Wake County EMS, we have reviewed their comments and made changes to the proposed rule allowing a "minimum of two initial courses at the highest level" rather than a "minimum of two initial courses for each level".

6) Listing of Comments Received and Agency's Consideration of Comments for Amendment of Trauma Rules: 13P .0905 – Renewal Designation Process; and Rule 13P .1101 – State Trauma System:

Commenter	Comment Summary
Jackie Gosnell, MSN, RN, TCRN, CEN, Mission Healthcare Trauma Program Manager (*Duplicate submitted: one via written comments and one via public hearing*)	Committee suggests delaying proposed changes until release and review of new ACS standards are released in March 2021. Request NCOEMS develop a subcommittee with RAC and trauma center representatives from all NC areas to complete a needs assessment suggested by the 2004 ACS NC site review. Quality of care and cost to patients should not be jeopardized through amendments. Request pediatric trauma and burn become a NC state designation.

Commenter	Comment Summary
	If rule changes are not delayed pending new ACS standards release, suggest the following: • 13P .1101: If rule changes are not delayed pending new ACS standards release, suggest no change to the current process with the proposed rules. This process works well. Changes to the process would jeopardize RAC relationships and unnecessary politics in our state and the pre-hospital agencies.
Dr. David G. Jacobs, NC Committee on Trauma, Chair (*public hearing*)	The rule changes' purpose was to provide greater alignment with guidelines of the American College of Surgeons Committee on Trauma (COT). The COT believes trauma center (TC) designation is the responsibility of the governmental lead agency. This agency should be guided by the local needs of the region it provides oversight rather than the needs of individual health care organizations or hospital groups. The NC-COT believes that the net effect of the proposed rules is to diminish the role of the OEMS. We do not endorse these proposed rules. Propose: a thorough review of all existing Trauma Rules, with the goal of better defining NC's state trauma system's purpose and function, and OEMS's role to ensure timely access to state-of-the-art trauma care for all in NC while avoiding unnecessary duplication of trauma resources. There are inconsistencies in the proposed rules between the rules document itself, and between the document and the current practice of trauma designation in NC. This provides further justification for taking a thorough review and update of all the trauma rules. The proposed rules would do the following: 1. For renewal designation processes, remove OEMS' obligation to notify the respective Board of County Commissioners in the applicant's primary catchment area of the designation request to allow for comment during the same 30-day comment period, prior to the decision by OEMS on allowing submission of an RFP. 2. Impair the RAC's ability to have input in the re-designation processes and would similarly deny the Board of County Commissioners their opportunity for input. The changes proposed for Rule .0905 (c) (3) would contradict the process outlined in Rule .0905 (b)(1). NC-COT would like to partner with OEMS to develop guidelines and standards to ensure an inclusive and collaborative state trauma system, with appropriate oversight and monitoring provided by OEMS. This might involve conducting another statewide trauma systems evaluation, or assembling a task force to address the recommendations made in the 2004 survey. The 2004 NC Trauma Systems Consultation identified strong and consistent state OEMS leadership. This leadership over long spans of time has permitted continued progress towards goals resulting in NC becoming a leader in the nation's trauma care. OEMS' strengths is its ability to identify and collaborate with a multitude of stakeholders for trauma and EMS. Adopting the proposed changes to our current rules would be short-sighted.
Scott Wilson, Metrolina Trauma Regional Advisory Committee (*Duplicate submitted: one via written comments and one via public hearing*)	13P .0905(c)(3) Concern with the proposed removal of the notification of local government representatives. This decreases the oversight and opportunity for input from those who are impacted the most by any changes, the community these hospitals serve.

Commenter	Comment Summary
	13P .1101(c) and (d) Why remove a working method of OEMS reporting of RAC alliances, when OEMS is an integral part of the trauma network? This should remain in the rule. Paragraph (d) reverses the process and requires RAC Coordinators to reach out to each regional EMS Agency and Hospital to confirm their RAC affiliation. The rule also asks those same agencies and hospitals to do the reverse and report to the state if they intend to change RACs. This process is conflicting and adds confusion, especially when the requirement to provide written notification to the state is also proposed for removal. Additionally, this allows for one RAC to potentially encroach on another by recruiting hospitals and EMS systems. Having OEMS remain the primary contact makes the most sense.
Dr. David Jacobs, N.C. Committee on Trauma, Chair	**10A NCAC 13P .0905 Renewal Designation Process** 13P .0905(c) This rule change removes OEMS' obligation to notify the renewal designation applicant's primary catchment area's Board of County Commissioners to allow a 30-day comment period. The Board of County Commissioners in the applicant's primary catchment area, should be notified of the applicant's TC renewal designation intent, and provided an opportunity to submit comment on the necessity of the re-designation. The proposed change contradicts the OEMS conducted site visit renewal designation process outlined in 13P .0905 (b)(1) for a four-year renewal. That renewal process says "OEMS shall notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for renewal to allow 30 days for comment." **Other identified concerns with trauma rules:** Section .0900 - Trauma Center Standards and Approval The rules are unclear on which rule process should be used for currently designated TC seeking to "upgrade" their designation level (to Level II or Level I), either 13P .0904 (initial designation) or 13P .0905 (renewal designation). Rules 13P .0905(c)(6) The composition of a Level I, II, or III site survey team for the initial & renewal designation processes is not consistently followed. The composition of these teams is frequently determined by the ACS-COT itself, and not by OEMS. Teams are typically comprised of 2 out-of-state trauma surgeons, as opposed to 1, as the rules state. The rules should be revised to acknowledge the prerogative of the ACS-COT to determine the composition of the site survey team. 13P .0905(b)(10) and (c)(14) The process for correction of cited deficiencies outlined in the rule for the renewal designation process does not consider the ACS-COT's decision process and should be clarified. If a trauma center fails their ACS-COT site

Commenter	Comment Summary
	visit, the rules allow the OEMS to conduct a focused review to re-verify that center, without the input or consent from the ACS-COT. 13P .1101 The design and function of NC's Trauma System, as defined in this state trauma system rule falls short of ACS-COT's vision that a trauma system recognize "the importance of controlling the allocation of trauma centers, as well as the need for a process to designate trauma centers based upon regional population need". Our current rules read "the state trauma system shall consist of regional plans, policies, guidelines, and performance improvement initiatives by the RACs to create an Inclusive Trauma System monitored by the OEMS." There is no reference to OEMS' responsibility to "ensure that the optimum number and type of trauma centers exist in a given geographic region", instead, this is relegated to the RAC's. Indeed, 2 of the "challenges" identified during our ACS-COT NC Trauma Systems Consultation in 2004 were: a. Lack of a comprehensive statewide trauma plan, and b. Divergent expectations for trauma system regulation between centralized (state) versus de-centralized governance (RAC/county, etc.) A comprehensive state Trauma Plan should be developed, and reflected in the NC' Trauma Rules. Updating and strengthening our trauma system might involve conducting another statewide trauma systems evaluation, or assembling a task force to address the recommendations made in the 2004 survey. Adopting the proposed changes to these rules would be short-sighted, and not move NC closer to achieving the goal of providing optimal trauma care to all the citizens of NC.
Joshua Barnett	Concern about the proposed rules 13P .0905, and .1101. These changes did not appear well thought out and should not be approved. 13P .0905 The rule proposes to take away the notification of the County Commissioners. Against this because the Commissioners need to be aware of any possible changes to their community. 13P .1101 The proposed rule changes do not appear justified. The burden of figuring out who is in the RAC membership should not be on the Coordinator but on the hospitals. This is confusing in that for some things the hospital and EMS agencies report but on others the RAC reports.
Atrium Health Cleveland, Trauma Director, present and past (& members of NC COT)	Agree with the statement presented by the NC-COT. Do not endorse the proposed Trauma Rules changes. Cleveland has experience with the trauma system since 1994, being the 1st Level III TC in NC. Restructuring of trauma system development by NC-COT and OEMS partnering could progress trauma care for all NC in a systematic and comprehensive way. Our TC are outstanding and well-recognized in the US, but the system lags as other states advance due to appropriated resources.

Commenter	Comment Summary
	*Duplicate of comments submitted as the NC COT's. See above comments from Dr. David G. Jacobs, NC Committee on Trauma, Chair (*public hearing*).
HCA Healthcare	Strongly suggests holding on proposed changes until release and review of new ACS criterion standards, which will be released in March 2021. In the interim, requests: OEMS develop a subcommittee (RAC and TC reps) from all areas of NC, to complete a needs-based assessment (NBAT or geospatial) as suggested by the 2004 ACS NC site review. Requests: pediatric trauma and burn become a NC state designation. 13P .1101: no change to the current NCOEMS process for obtaining RAC affiliations.
Brian Simonson, Southeastern Regional Advisory Committee, RAC Sub-Committee *(public hearing)*	Support what was stated by the Trauma Program Manager Subcommittee, there should be a delay in the rules due to lack of information. There's been a burden placed on what is now the orange book as guidance for a trauma designation in NC. Unclear what the rules will look like with that material being referenced so often. The RAC is defined by geography in the state of North Carolina, it does not sub-define the entire system. Agree it needs a space assessment and the decisions based on that for top quality care and safety for NC patients.

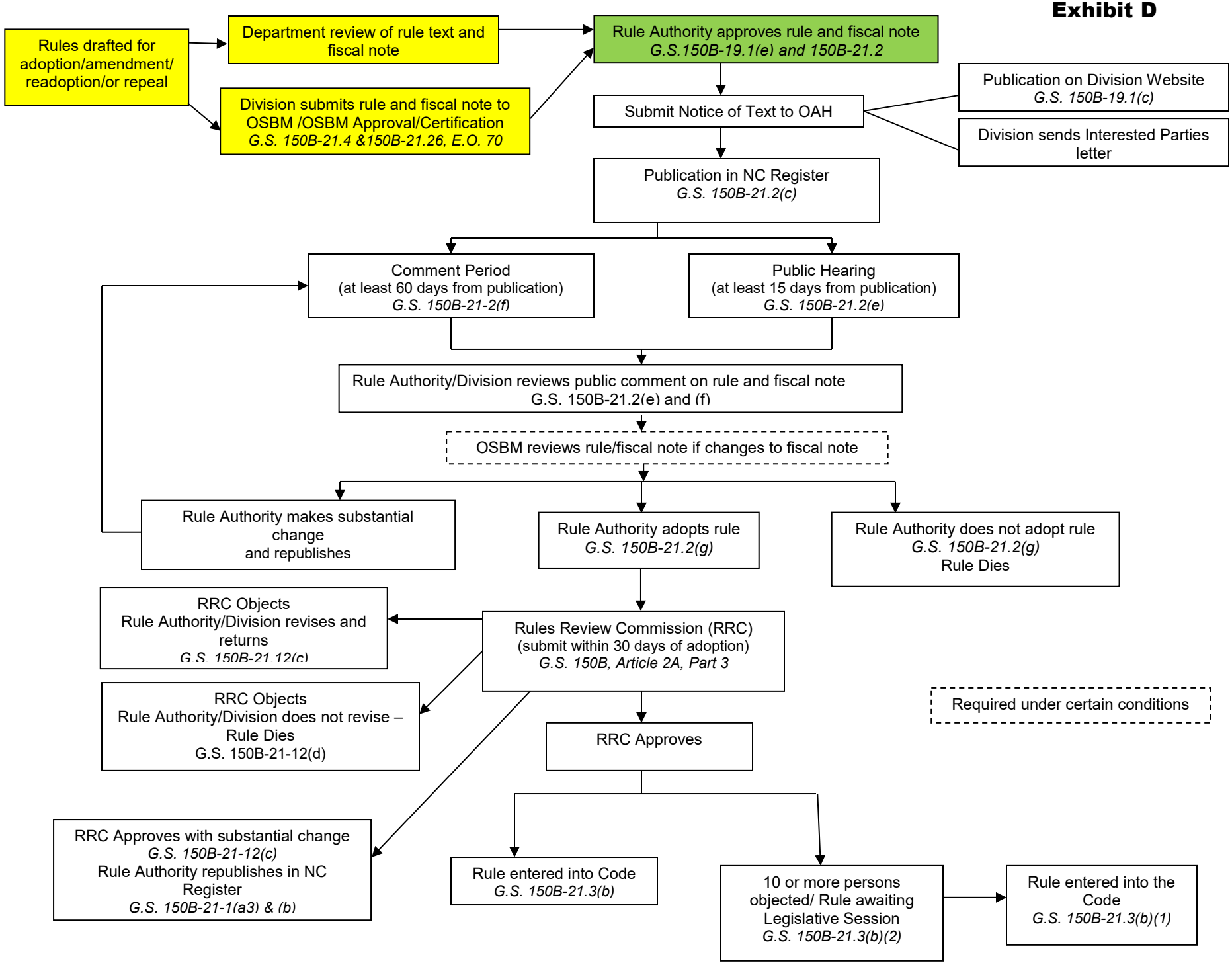
Agency Response to Comments Above:

In response to the comments above related to the proposed changes in .0905, we have reviewed those comments and have made the decision to keep the proposed language and proceed to Medical Care Commission for approval. This proposed change only affects renewal of trauma center designations, and the notification provided to the County Board of Commissioners. Looking at historical data, the agency has never received a response from a county Board of Commissioners regarding an initial or renewal designation.

In response to the comments above related to the proposed changes in .1101, we have reviewed those comments and have made the decision to keep the proposed language and proceed to Medical Care Commission for approval. This proposed change will only change the process for determining the membership of each of the eight Regional Advisory Councils (RAC). Currently, the agency annually sends out a minimum of 214 emails to determine which RAC each stakeholder is affiliated and monitors responses to ensure the membership of the RAC's is determined. In the proposed language, we would annually communicate with the eight RAC's to determine who is participating with their program to confirm the membership. This proposed change is based solely on trying to become more efficient in our processes.

Process for Medical Care Commission to Initiate Rulemaking

Exhibit D



10A NCAC 13F .0405 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0405 QUALIFICATIONS OF FOOD SERVICE SUPERVISOR

~~(a) The~~ Each facility shall have a food service supervisor ~~shall be~~ experienced in food service in commercial or institutional settings ~~and willing to accept consultation from~~ who shall consult with a registered ~~dietitian.~~ dietitian as necessary, to meet the dietary needs of the residents in accordance with Rule .0904 of this Subchapter.

~~(b) Rule 10A NCAC 13G .0405 (c) and (d) shall control for this Subchapter.~~

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, ~~1984.~~ 1984;
Readopted Eff. January 1, 2022.

10A NCAC 13F .0509 is proposed for amendment as follows:

10A NCAC 13F .0509 FOOD SERVICE ORIENTATION

The food service supervisor and adult care home dietary staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. Registered dietitians are exempt from this orientation. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. January 1, 2022.

10A NCAC 13F .1213 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .1213 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

An adult care home shall make available to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and ~~within the facility, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months.~~ in a publicly viewable place in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;

(2) any other reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and

(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority G.S. 131D-2.16; 143-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .0509 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .0509 FOOD SERVICE ORIENTATION

~~The family~~ Family care home staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .1214 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .1214 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

A family care home shall make available ~~within the facility, upon request, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months to residents and their families or responsible persons and to prospective residents and their families or responsible persons.~~ to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and in a publicly viewable place in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;

(2) any other survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and

(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority 131D-2.16; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

Exhibit D/3
Fiscal Note
Phase 2.5

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

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Tichina Hamer, Director of Programs, (919) 855-3782

Impact:

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

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

Rule Readoptions (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0405 Qualifications of Food Service Supervisor
10A NCAC 13F .1213 Availability of Corrective Action and Survey Reports
10A NCAC 13G .0509 Food Service Orientation
10A NCAC 13G .1214 Availability of Corrective Action and Survey Reports

Rule Amendment (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0509 Food Service Orientation

Authorizing Statutes: G.S. 131D-2.16; 131D-4.5; 143B-165

Introduction and Background

The Adult Care Licensure Section is proposing changes to clarify the experience needed for Food Service Supervisors in adult care homes and further clarify when a food service supervisor should consult with a dietitian. Additional technical changes clarify staff who are required to complete the food service manual. Technical changes to the rules update them to current standards according to statute and provide clarity to the types of reports providers should make available to residents, residents' families and other responsible persons. The technical changes are proposed for clarity and consistency but do not affect current operations. The proposed changes will have limited fiscal impact on adult care homes and family care homes as they are privately owned and are mostly in line with current practice based on recent surveys. The proposed changes will have no fiscal impact on the Adult Care Licensure Section.

Under the authority of G.S. 150B-21.3A, Periodic review of existing rules, the North Carolina Medical Care Commission and Rule Review Commission approved the Subchapter reports with classifications for the rules under 10A NCAC 13F Licensing of Adult Care Homes of Seven or More

Beds and 10 NCAC 13G Licensing of Family Care Homes. The rules were classified in the reports as necessary with substantive public interest. Rules 10A NCAC 13G .0509, 13G .1214 and 13F .0405 and 13F .1213 are being presented for readoption with substantive changes. The following rule was not identified for readoption with substantive changes based on public comment but is being proposed for amendment to correlate with the 13G rule of the same title and similar content being proposed for readoption: 10A NCAC 13F .0509. Most of the rules for both types of assisted living residences, adult care homes of seven beds or more and family care homes, are the same with the primary exception of staffing and physical plant requirements since they serve the same population based on need for care and services. Therefore, the 13F rules corresponding to the 13G rules being proposed for readoption with substantive changes are being amended concurrently to assure this traditional consistency. The rule proposed for amendment, while not receiving comment for substantive change, is being amended for clarification and updating purposes.

Rules Summary and Anticipated Fiscal Impact

10A NCAC 13F .0405 Qualifications of Food Service Supervisor: Technical changes were made to this rule to provide clarification on the experience of a food service supervisor and when to consult with a dietitian. Revisions to this rule also includes the deletion 13F .0405 (b) due to the reference to rules 10A NCAC 13G .0405 (c) and (d) no longer exist.

1. The rule as written requires food service supervisors to have experience in food service. The proposed rule language allows providers the opportunity to implement their hiring practices and employ food service supervisors based on the experience the provider determines will best meets the dietary needs of the residents and duties assigned as an employee of the facility.

Rationale: In a recent survey conducted by ACLS in January 2021 of adult care providers, 67% percent of providers reported hiring food service supervisors with at least one year of experience in food service and experience as a food service supervisor. The survey revealed while 26% of providers sought restaurant experience, 41% of experiences include working at other adult care and long-term care facilities, cafeterias, hospitals, resorts, culinary school, and as a certified dietary manager. This experience is consistent with the proposed language to reflect experience in commercial or institutional settings. The survey revealed providers promote dietary staff into the role of food service supervisor. Although food service supervisors have experience from varied food service roles, they are required to complete the additional training of the food service orientation manual in accordance with 13F .0509.

Fiscal Impact: There is no fiscal impact since the rule language was updated to reflect providers' current standards for hiring food service supervisors.

2. The current rule as written directs food service supervisors be willing to accept consultation from a dietitian. The proposed rule modifies the language to reflect the intent of the rule which directs food service supervisors to consult with a dietitian when there is an identified need for assistance related to rule 13F .0904.

Rationale: Adult Care providers establish the types of therapeutic diets they are able to prepare and serve to residents based on dietitian-approved therapeutic menus. The menus serve as guides to the unlicensed dietary staff on what to prepare and how to prepare food items for individuals with therapeutic diets.
The need for consultation is primarily associated with therapeutic diets. Therapeutic diets provide limitations or modifies "the intake of certain foods or nutrients. It is part of the treatment of a medical

condition and are normally prescribed by a physician and planned by a dietician. A therapeutic diet is usually a modification of a regular diet. In therapeutics diets, modifications are done in nutrients, texture and food allergies or food intolerances" (Journal of Clinical Nutrition & Dietetics, 2021). Food Service Supervisors are required to have experience in settings where food is prepared for a variety of individuals and where foods prepared are based on therapeutic menus approved by dietitians. Adult Care facilities are not required to employ registered dietitians as part of their daily operations. In accordance with rule 10A NCAC 13F .0904(c)(6), therapeutic menus are to be planned or reviewed by registered dietitian.

Facilities are required to provide nutrition to residents based on daily food requirements as outlined in 10A NCAC 13F .0904(d). Residents without nutritional restrictions are considered on a regular diet. Any physician-ordered modification to residents' nutritional intake, such as diet type, requires a therapeutic menu approved by a dietitian to provide guidance to the facility's dietary staff as what foods to prepare and how to prepare food modification. Examples of therapeutic diets ordered by physicians include "No Concentrated Sweets" to reduce sugar intake for residents diagnosed with diabetes or "No Added Salt" to reduce sodium for hypertension. As a resident's medical or nutritional needs change, a physician may order a therapeutic diet to address the resident's need. A consultation with the dietitian may be needed when there is not an approved therapeutic diet to match the order. Providers may notify the physician of the types of therapeutic menus already approved by the dietitian and request the physician clarify the order by ordering the use of an existing therapeutic menu. A consultation with a dietitian may be needed to provide guidance to food service supervisors when ordered to change the texture of food or liquids or managing food preferences of newly admitted residents.

Fiscal Impact: There is no fiscal impact since consultation with a dietitian is required based on current rules. There is limited data on the frequency of dietary consultations required; however, dietitian hourly rate is approximately $30/hour in North Carolina[1].

10A NCAC 13F .0509 & 13G .0509 Food Service Orientation: Technical changes were made to this rule to clarify the type of food service orientation training, who is required to complete the training and how to obtain copies of the training.

1. Both 13F .0509 and 13G .0509 requires food service staff to complete the orientation manual. Technical changes to the rule clarifies the staff required to complete the food service orientation manual.

Rationale: In family care homes, due to the size of the facility with a maximum capacity of 6 residents, there is primarily one staff preparing each meal. Unlike adult care facilities, due to the resident capacity, multiple food service staff are required to prepare and serve food to ensure the food service standards are met. In a December 2020 survey, adult care facilities reported, 55% employ between 1-5 food service staff.

Table 1: December 2020 ACLS Survey, Number of Food Service Staff at Adult Care Facilities

Number of Food Service Staff	Percentage of Adult Care Facilities
1-5 employees	55%
6-10 employees	35%
11-15 employees	6%
16-20 employees	2%
21 or more employees	2%

[1] (U.S. Bureau of Labor Statistics, 2019)

In the December 2020 survey, 61% of adult care facilities reported that all of their food service staff completed the food service orientation manual, while an additional 31% of facilities reported all food service staff, personal care aides and medication aides that are involved in serving food.

2. Technical changes were made to the rule to clarify the wording the required training for food service staff. The language as currently written refers to the required training as a food service "orientation program". The proposed language was modified to reflect the name of the training which is food service "orientation manual". The orientation manual includes a quiz for food service staff based on the information presented in the manual.

3. The rule as written provides a mailing address for copies of the Food Service Orientation manual. The proposed language removes the mailing address and provides an updated internet address where the orientation manual is available at no cost.

Fiscal Impact: There are no fiscal impacts to providers for the technical changes made to these rules.

10A NCAC 13F .1213 & 13G .1214 Availability of Corrective Action and Survey Reports: Technical changes were made to this rule to clarify the length of time survey reports and corrective action reports are to remain available at the facility for review by residents, residents' family members and responsible persons.

Rationale: The Adult Care Licensure Section and local County Department of Social Services (DSS) are mandated to by N.C. Gen. Stat. §131D-2.11 to inspect and monitor facilities for regulatory compliance. Types of inspections conducted by ACLS at facilities include annual or biennial surveys and follow up or subsequent surveys related to identified deficient practice and complaint investigations. Local County DSS conduct quarterly routine monitoring and complaint investigations. Providers receive written reports for all ACLS inspections and Corrective Action Reports issued by local County DSS that result in noncompliance with rules.

N.C. Gen. Stat. §131D-2.11 outlines the frequency of inspections by ACLS based on facility's rating effective in the year 2007. The facility's rating determines if ACLS inspections of the facility will be annual or biennial. The rule as currently written does account for the statute including biennial inspections. The proposed rule language clarifies the type of survey reports required to be available to residents, residents' family members and responsible persons. The proposed rule clarifies available to include within public view. The proposed rule updates the survey frequency to be consistent with the statute.

Fiscal Impact: There is no fiscal impact as providers were previously required to make these reports available. There is limited to no cost to provide the reports as these reports are mailed or hand-delivered to the facility.

10A NCAC 13F .0405 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0405 QUALIFICATIONS OF FOOD SERVICE SUPERVISOR

~~(a) The~~ Each facility shall have a food service supervisor ~~shall be~~ experienced in food service in commercial or institutional settings ~~and willing to accept consultation from~~ who shall consult with a registered ~~dietitian.~~ dietitian as necessary, to meet the dietary needs of the residents in accordance with Rule .0904 of this Subchapter.

~~(b) Rule 10A NCAC 13G .0405 (c) and (d) shall control for this Subchapter.~~

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, ~~1984.~~ 1984;
Readopted Eff. January 1, 2022.

10A NCAC 13F .0509 is proposed for amendment as follows:

10A NCAC 13F .0509 FOOD SERVICE ORIENTATION

The food service supervisor and adult care home dietary staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. Registered dietitians are exempt from this orientation. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gepage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. January 1, 2022.

10A NCAC 13F .1213 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .1213 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

An adult care home shall make available to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and ~~within the facility, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months.~~ in a publicly viewable place in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;

(2) any other reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and

(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority G.S. 131D-2.16; 143-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .0509 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .0509 FOOD SERVICE ORIENTATION

~~The family~~ Family care home staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .1214 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .1214 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

A family care home shall make available ~~within the facility, upon request, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months to residents and their families or responsible persons and to prospective residents and their families or responsible persons.~~ to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and in a publicly viewable place in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;

(2) any other survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and

(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority 131D-2.16; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

EXHIBIT E

Arbor Acres
Unit Mix and Pricing Schedule

EXISTING

	Number of Units	Square Footage	Entrance Fee	Monthly Fee
Independent Living Apartments				
Studio	17	315	$43,000	$1,889
1 BR w/ Kitchenette	39	630	$110,250	$2,755
1 BR Corpening w/ Kitchen	20	630	$113,400	$2,808
A (1 BR, 1 BA)	2	991	$183,335	$2,747
B (1 BR, 1.5 BA w/ Den)	6	1,160	$214,600	$3,040
C1 (2 BR, 2 BA)	6	1,217	$225,145	$3,229
C2 (2 BR, 2 BA)	6	1,397	$258,445	$3,425
C3 (2 BR, 2 BA)	6	1,500	$277,500	$3,621
D1 (2 BR, 2 BA w/ Den)	6	1,592	$294,520	$3,913
D2 (2 BR, 2 BA w/ Den)	8	1,602	$296,370	$3,958
D3 (2 BR, 2 BA w/ Den)	3	1,728	$319,680	$4,211
E1 (2 BR, 2 BA w/ Den	1	1,982	$366,670	$4,371
Independent Living Homes				
1 BR, 1 BA	4	1,150	$241,000	$2,594
2 BR, 2 BA	20	1,300	$261,300	$3,187
2 BR, 2 BA	30	1,500	$301,500	$3,412
2 BR, 2 BA	12	1,700	$341,700	$3,822
2 BR, 2 BA	19	1,900	$381,900	$4,267
2 BR, 2 BA	8	2,100	$432,600	$4,512
2 BR, 2 BA	18	2,300	$473,800	$4,905
Patio Home (2 BR, BA)	12	1,326	$266,526	$3,100
Courtyard Home (1 BR, 1 BA)	6	1,060	$213,060	$2,986
Courtyard Home (2 BR, 2 BA)	6	1,187	$238,590	$3,172
Second Person Fee			*$10,000*	*$1,013*
Total ILUs/Weighted Average	**255**	**1,276**	**$248,911**	**$3,354**
				Daily Rate
Assisted Living Units				
Studio	24	453	$2,800	$213
1 BR Apt.	42	541	$2,800	$248
2 BR Apt.	1	904	$2,800	$294
Memory Care	30	450	$2,800	$318
Second Person Fee				*$172*
Total Assisted Living Units	**97**	**495**	**$2,800**	**$261**
Skilled Nursing Care	**83**	**314**	**$2,800**	**$351**

Note: Number of ILUs pulled from the DHG Compilation Table 1 in the Disclosure Statement.

PROJECT

	Number of Units	Square Footage	Entrance Fee	Monthly Fee
Project ILU's				
Duo (2 BR, 2 BA)	2	1,546	$376,500	$3,896
Standard (2 BR, 2 BA)	14	1,615	$382,500	$4,070
Alcove (2 BR, 2 BA)	14	1,800	$431,500	$4,536
Deluxe (2 BR, 2 BA)	12	1,767	$427,000	$4,453
Den Deluxe (2 BR, 2 BA)	14	2,005	$510,000	$5,053
Total Project ILUs	**56**	**1,789**	**$435,946**	**$4,508**

Note: Unit count from DHG compilation, Sq Ft from Arbor Acres website.

NC MCC Bond Sale Approval Form		
Facility Name: Arbor Acres		
	Time of Preliminary Approval	
SERIES: 2021A (Publicly Offered)		
PAR Amount	$44,000,000.00	
Estimated Interest Rate	2.50%	
All-in True Interest Cost	3.50%	
Maturity Schedule (Interest) - Date	12/1/2021 - 12/1/2037	
Maturity Schedule (Principal) - Date	12/1/2021 - 12/1/2037	
Bank Holding Period (if applicable) - Date	N/A	
Estimated NPV Savings ($) (if refunded bonds)	($208,311.00)	
Estimated NPV Savings (%) (if refunded bonds)	0.51%	
NOTES:		
- Interest rate assumption assumes The Forest at Duke is rated BBB for the proposed financing.		
	Time of Preliminary Approval	
SERIES: Series 2021B (Bank Held)		
PAR Amount	$55,000,000.00	
Estimated Interest Rate	2.75%	
All-in True Interest Cost	3.15%	
Maturity Schedule (Interest) - Date	9/1/2021 - 12/1/2051	
Maturity Schedule (Principal) - Date	12/1/2023 - 12/1/2051	
Bank Holding Period (if applicable) - Date	12 years	
Estimated NPV Savings ($) (if refunded bonds)	N/A	
Estimated NPV Savings (%) (if refunded bonds)	N/A	
NOTES:		

EXHIBIT F

		2021 Rounded Entrance Fees			
Unit	**Feature**	**50%**	**90%**	**Traditional**	**Monthly Fee**
1BC	One Bedroom Convertible	105,450	159,400	83,150	2,810
1BD	One Bedroom Deluxe	156,350	236,350	123,750	3,406
1BT	One Bedroom Traditional	133,300	201,900	105,050	3,113
2BC	Two Bedroom Classic Apartment	206,350	310,600	162,300	4,415
2BCMBO	Two Bedroom Combo	201,900	304,000	159,250	3,900
2BCV	Two Bedroom Custom Villa	245,900	371,300	192,000	4,707
2BD	Two Bedroom Deluxe Apt	204,100	307,350	159,500	4,006
2BDV	Two Bedroom Deluxe Villa	218,200	333,200	170,250	4,110
2BL	Two Bedroom Lakeside	193,050	290,600	150,700	3,812
2BT	Two Bedroom Traditional	180,800	272,900	142,500	3,711
Ashland	Ashland	235,050	299,650	-	3,482
Ashland (Accessible)	Ashland (Acessible)	235,050	299,650	-	3,482
Carlisle	Carlisle	373,650	477,300	-	4,575
COTA	Cottage A	349,450	482,000	-	5,546
COTB	Cottage B	337,350	470,000	-	5,417
Covington	Covington	366,500	467,550	-	4,605
DG	Duplex Grande	294,150	443,600	229,550	5,088
DGII	Duplex Grande II	314,650	473,700	245,900	5,343
DR	Duplex Regency	263,950	398,950	205,950	4,795
DRII	Duplex Regency II	279,600	420,700	218,600	4,984
DROY	Duplex Royale	288,150	436,300	225,700	5,024
DROYII	Duplex Royale II	308,600	465,350	241,100	5,248
DUPLEX A	Duplex A	343,400	476,050	-	5,546
DUPLEX B	Duplex B	331,300	464,000	-	5,417
DV	Duplex Vista	251,950	380,000	196,650	4,784
DVII	Duplex Vista II	268,750	406,250	210,200	4,953
Elmwood	Elmwood	228,500	291,600	-	3,413
Ingleside	Ingleside	272,450	348,100	-	3,719
Ingleside (Accessible)	Ingleside (Accessible)	272,450	348,100	-	3,719
Oatland	Oatland	279,050	356,200	-	3,838
Orton	Orton	348,350	444,950	-	4,369
VILSP	Villa Special	272,450	412,250	213,250	4,806
VILTR	Villa Traditional	245,900	370,050	192,000	4,281
Waverly	Waverly	353,150	451,400	-	4,546
Woodlawn	Woodlawn	336,250	428,800	-	4,339

LCS DEVELOPMENT

PLANTATION VILLAGE PHASE 1
SALES PRICING AND SCHEDULE
March 2021

INDEPENDENT LIVING UNIT MIX AND PRICING - PRIORITY SALES

Unit Description	Square Footage	No. Units	Entrance Fee 90% ROC	Entrance Fee TRAD	Entrance Fee 50% ROC	Monthly Fee
2BR - Deluxe	1,370	4	$ 444,900		$ 346,900	$ 4,350
2BR - Deluxe	1,425	4	$ 454,900		$ 354,900	$ 4,550
2BR - Deluxe	1,550	18	$ 529,900		$ 413,500	$ 4,750
2BR - Deluxe	1,650	12	$ 559,900		$ 436,900	$ 5,225
2BR - Deluxe	1,930	6	$ 654,900		$ 509,900	$ 5,700
TOTAL UNITS / WTD. AVG. FEE	**1,585**	**44**	**$ 540,582**	**$ -**	**$ 421,645**	**$ 4,955**
DOUBLE OCC. % / 2ND PERSON FEE		**50%**	**$ 20,000**	**$ 20,000**	**$ 20,000**	**$ 1,409**

INDEPENDENT LIVING UNIT MIX AND PRICING - POST PRIORITY SALES

Unit Description	Square Footage	No. Units	Entrance Fee 90% ROC	Entrance Fee TRAD	Entrance Fee 50% ROC	Monthly Fee
2BR - Deluxe	1,370	4	$ 458,247		$ 357,307	$ 4,481
2BR - Deluxe	1,425	4	$ 468,547		$ 365,547	$ 4,687
2BR - Deluxe	1,550	18	$ 545,797		$ 425,905	$ 4,893
2BR - Deluxe	1,650	12	$ 576,697		$ 450,007	$ 5,382
2BR - Deluxe	1,930	6	$ 674,547		$ 525,197	$ 5,871
TOTAL UNITS / WTD. AVG. FEE	**1,585**	**44**	**$ 556,799**	**$ -**	**$ 434,295**	**$ 4,955**
DOUBLE OCC. % / 2ND PERSON FEE		**50%**	**$ 20,000**	**$ 20,000**	**$ 20,000**	**$ 1,409**

INDEPENDENT LIVING UNIT MIX AND PRICING - AFTER SEP 2022

Unit Description	Square Footage	No. Units	Entrance Fee 90% ROC	Entrance Fee TRAD	Entrance Fee 50% ROC	Monthly Fee
2BR - Deluxe	1,370	4	$ 471,994		$ 368,026	$ 4,615
2BR - Deluxe	1,425	4	$ 482,603		$ 376,513	$ 4,827
2BR - Deluxe	1,550	18	$ 562,171		$ 438,682	$ 5,039
2BR - Deluxe	1,650	12	$ 593,998		$ 463,507	$ 5,543
2BR - Deluxe	1,930	6	$ 694,783		$ 540,953	$ 6,047
TOTAL UNITS / WTD. AVG. FEE	**1,585**	**44**	**$ 573,503**	**$ -**	**$ 447,324**	**$ 4,955**
DOUBLE OCC. % / 2ND PERSON FEE		**50%**	**$ 20,000**	**$ 20,000**	**$ 20,000**	**$ 1,409**

Initial Sales Pace - Gross	Cancels	Net Sales	Cumulative Net Sales	% Sold - Net	Net Entrance Fees - 1st Person	Net Entrance Fees - 2nd Person	Total Entrance Fees
53	**9**	**44**			**21,886,868**	**445,679**	**22,332,546**

NC MCC Bond Sale Approval Form		
Facility Name: Plantation Village		
	Time of Preliminary Approval	
SERIES:		
PAR Amount	$87,618,535.00	
Estimated Interest Rate	4.50%	
All-in True Interest Cost	4.44%	
Maturity Schedule (Interest) - Date	Semi-annual; 4/1 and 10/1	
Maturity Schedule (Principal) - Date	Annual 4/1; max 4/1/2051	
Bank Holding Period (if applicable) - Date	N/A	
Estimated NPV Savings ($) (if refunded bonds)	N/A	
Estimated NPV Savings (%) (if refunded bonds)	N/A	
NOTES:	For the application, we assumed	
	all fixed rate bonds. We are soliciting	
	bank interest for a portion of the par	
	to be repaid with entrance fees with	
	a maximum term of 7 years. The balance	
	would be fixed rate bonds.	