

**DHHS / OSBM Review**  
**Permanent Rule Readoption with Changes, Amendment, Repeal**  
**and Adoption without Substantial Economic Impact**

**Agencies Proposing Rule Change**

North Carolina Medical Care Commission

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**Overview**

Quantified Impacts	Year 1	Year 2	Year 3	Year 4	Year 5
Total Benefits	\$231,500	\$151,500	\$151,500	\$151,500	\$151,500
<i>State Government</i>	\$20,000	\$20,000	\$20,000	\$20,000	\$20,000
<i>Local Government</i>	\$48,500	\$48,500	\$48,500	\$48,500	\$48,500
<i>Private Entities</i>	\$163,000	\$83,000	\$83,000	\$83,000	\$83,000
Total Costs	\$499,000	\$163,500	\$163,500	\$163,500	\$163,500
<i>State Government</i>	\$101,000	\$2,250	\$2,250	\$2,250	\$2,250
<i>Local Government</i>	\$106,000	\$2,250	\$2,250	\$2,250	\$2,250
<i>Private Entities</i>	\$292,000	\$159,000	\$159,000	\$159,000	\$159,000
Net Impact	-\$267,500	-\$12,000	-\$12,000	-\$12,000	-\$12,000
Aggregate Impact	\$730,500	\$315,000	\$315,000	\$315,000	\$315,000

<sup>1</sup> Private entities include small businesses as well as individuals affected by these rules.

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## **Titles of Rule Changes and Related Statutory Citations affected by amendments to the General Statutes of the State of North Carolina.**

To support revisions to the 10A NCAC 13P EMS and trauma rules, the Department of Health and Human Services (hereafter, “the Department”) and Office of Emergency Medical Services (OEMS) have collaborated with legislators to amend all statutes cited within these rules that grant authority to the Medical Care Commission to address EMS personnel credential nomenclature (i.e. Medical Responder, Emergency Medical Technician, Emergency Medical Technician – Intermediate and Emergency Medical Technician – Paramedic). This collaborative effort was necessary to be consistent with recent nomenclature changes by US Department of Transportation’s National Highway Traffic Safety Administration (NHTSA) regarding their educational and credentialing guidelines.<sup>1</sup>

Although these federal changes are not mandated for adoption by the individual states, all states have adopted the changes voluntarily to provide consistency in industry terminology supporting effective interaction between state governmental agencies and the individuals and organizations regulated under the individual authority of each governmental agency to move freely between states and attempt to standardize as many components of the EMS industry as practical without compromising the authority granted to each state.

Statutes amended by S.L 2015-290 (Appendix B) affecting the 10A NCAC 13P EMS and Trauma Rules are as follows:

G.S. 14-276.1	Impersonation of firemen or emergency medical services personnel
G.S. 131E-155	Definitions
G.S. 131E-158	Credentialed Personnel Required
G.S. 131E-159	Credentialing Requirements

Additionally, the rules that are being updated to reflect the new nomenclature necessary to mirror revised statutory language directly related to this change are as follows:

### **10A NCAC 13P**

#### **Section .0100 – Definitions**

- .0101 - Abbreviations
- .0102 - Definitions

#### **Section .0200 – EMS Systems**

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<sup>1</sup> US Department of Transportation: National Highway Traffic Safety Administration “National EMS Education Standards.”

- .0201 - EMS System Requirements
- .0219 - Staffing for Medical Ambulance/Evacuation Bus Vehicles
- .0221 - Patient Transportation Between Hospitals

Section .0300 – Specialty Care Transport Programs

- .0301 - Specialty Care Transport Program Criteria

Section .0400 – Medical Oversight

- .0403 - Responsibilities of the Medical Director for EMS Systems

Section .0500 – EMS Personnel

- .0501 - Educational Programs
- .0502 - Initial Credentialing Requirements for MR, EMT, EMT-I, EMT-P, and EMD
- .0504 - Renewal of Credentials for MR, EMT, EMT-I, EMT-P, and EMD
- .0507 - Credentialing Requirements for Level I EMS Instructors
- .0508 - Credentialing Requirements for Level II EMS Instructors
- .0510 - Renewal of Credentials for Level I and Level II EMS Instructors
- .0512 - Reinstatement of Lapsed EMS Credential (New Rule)
- .0513 - Refresher Courses (New Rule)

Section .0600 – EMS Educational Institutions

- .0601 - Continuing Education EMS Educational Institution Requirements
- .0602 - Basic EMS Educational Institution Requirements

The cost to mirror the national credentialing nomenclature is minimal, but should still be reflected as part of the overall fiscal impact associated with revising these rules. Because the current credentialing uniform patches worn by EMS personnel will no longer reflect NC credentialing levels, new patches have been developed and trademarked by OEMS (see Table 1). The method used to design the new uniform credentialing patches was by accepting patch designs from the EMS community for each new EMS credentialing level and having the EMS community vote electronically at the OEMS website for their top three choices for five designs selected by agency staff as best representing the criteria established by OEMS for consideration. The designs that received the most votes have been identified and trademarks for each patch have been obtained from the Trademark Section of the NC Department of the Secretary of State.

Before these patches can be manufactured and distributed to the EMS community, all statutory and rule revisions must be finalized as previously described. Although there is no requirement by OEMS that credentialed EMS personnel wear the state’s uniform patch, many EMS personnel are required by their employers or volunteer agencies to wear these as part of their official duty uniform. It is these persons that OEMS has attempted to estimate the individual and cumulative costs associated with implementing this change.

Currently, the wholesale costs of patches and the retail sale of the patches is handled through the NC Association of Rescue and EMS (NCAREMS). NCAREMS is a non-profit, tax-exempt organization that has agreed to handle the distribution of the patches statewide. Although OEMS holds the trademark on these patches, no State money is expended in the manufacture and distribution of the uniform patches; nor does the Department, the Division of Health Service Regulation (DHSR), or OEMS receive any funds

collected from the sale of the uniform patches. OEMS has agreed that the NCAREMS will be the sole authorized agent to manage the process of having uniform patches manufactured and distributed and is allowed to keep all proceeds from the sale of the patches to enhance the development of emergency medical services provided by volunteer agencies. The decision to utilize this approach was sanctioned by the Secretary of NC DHHS over 10 years ago and has continued to be the preferred method by each secretary since originally implemented and is expected to continue unchanged for the foreseeable future.

Impact – Federal Government

No impact associated with amending these rules.

Impact – State Government

The cost incurred by OEMS for the design, development, and trademarking of the new patches was minimal. OEMS utilized three agency staff and three uncompensated volunteer participants during the design phase. It took approximately two eight-hour days (16 hours) to complete this task. At \$32 per hour per staff this equates to an opportunity cost of staff time of roughly \$1,500 (i.e., \$32 x 16 hours x 3 staff). The \$32 per hour rate is consistent with the salary grade 72 OEMS staff utilized during this phase of development. The uncompensated volunteers incurred an unquantified opportunity cost since each were provided by their employers during duty hours to assist with the review and provided their input through exchange of emails and conference calls. No travel or per diem expenses were expended by either OEMS or the assisting agencies to complete this task.

The trademarking costs involved a total of five new credential-level patches (Emergency Medical Responder, Emergency Medical Technician, Advanced Emergency Medical Technician, Paramedic, and Emergency Medical Dispatch). The cost of trademarking these patches was \$75 per patch. For all five patch types, total state government costs was \$375 and was absorbed into the current operating budget.

Table 1

Task	Number Levels	Cost per Level	Total Costs
Patch Development	5	~\$300	~\$1,500
Patch Trademarking	5	\$75	\$375
TOTAL COSTS		~\$375	~\$1,875

<sup>1</sup> Patch development and trademarking represent a one-time cost to OEMS.

<sup>2</sup> The \$75 fee for trademarking is established pursuant to GS 80-3 and 80-5 by the Trademark Section, NC Department of Secretary of State.

Impact – Local Government

There are currently 95 county-operated EMS providers functioning in a primary 9-1-1 emergency response ambulance service capacity. Statewide, these providers utilize 16,000 paid EMS personnel. A significant number (nearly two-thirds) of these providers utilize uniforms (such as polo shirts) that do not require credentialing patches. The remaining third of providers utilize standard uniforms with credentialing patches on one sleeve. The number of credentialed personnel required to wear credentialing patches is approximately 3,500. OEMS expects these providers to issue four patches per employee at a cost of \$2 per patch. Under these assumptions, the total one-time cost to local governments would be roughly \$28,000 (i.e., ~3,500 personnel x 4 patches x \$2 per patch).

Number Agencies utilizing Patches	Number Personnel requiring new patches	Cost per Individual	Total Costs
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		(4 patches/employee at \$2/patch)	
~35	~3,500	\$8	~\$28,000
TOTAL COSTS			~\$28,000

<sup>1</sup> Assuming each agency decides to continue utilizing the state trademarked uniform patch, this is a one-time cost to change from the current uniform patch to the newly designed and adopted uniform patch. Patches purchased after initial release of the new design will remain consistent with the current cost of the uniform patches, barring any changes as the result of market adjustments to economic trends and costs of production and distribution.

Impact – Private Entities

There are currently 375 private and volunteer EMS providers that, together, utilize approximately 18,000 additional EMS personnel. If each provider issues two patches at a cost of \$2 per patch, the total cost to private service providers would be roughly \$72,000 (i.e., ~18,000 personnel x 2 patches x \$2 per patch). All private and volunteer EMS providers meet OEMS’s definition of a small business.

Number Agencies utilizing Patches	Number Personnel requiring new patches	Cost per Individual (2 patches/employee at \$2/patch)	Total Costs
375	~18,000	\$4	~\$72,000
TOTAL COSTS			~\$72,000

<sup>1</sup> Assuming each agency decides to continue utilizing the state trademarked uniform patch, this is a one-time cost to change from the current uniform patch to the newly designed and adopted uniform patch. Patches purchased after initial release of the new design will remain consistent with the current cost of the uniform patches, barring any changes as the result of market adjustments to economic trends and costs of production and distribution.

The NCAREMS has advised that it is researching other manufactures to lower their costs, but for the purpose of this fiscal note, has provided OEMS with their cost estimates utilizing their current manufacturer. In order to process the manufacture of the five new patch designs, the NCAREMS has indicated that using their current manufacturer, they will be required to pay a one-time set up charge of \$250 per design, with a total cost to NCAREMS of roughly \$1,250 (5 designs x \$250 per design).

One time Set-up Cost Per design	Number Designs	Total One-time Set-up Cost
~\$250	5	~\$1,250
TOTAL COSTS		~\$1,250

Once all statutory and rule changes have been completed, the NCAREMS will bulk order the patches at a cost of \$0.40 per patch. They will sell the patches at a price of \$2 per patch. The estimated number of patches needed for the initial change will be roughly 50,000 (i.e., 3,500 county personnel x 4 patches + 18,000 private and volunteer personnel x 2 patches). The initial output for bulk purchasing will be 50,000 patches x \$0.40 per patch, an expenditure of ~\$20,000. The anticipated revenue for resale of the patches will be roughly \$100,000 (i.e., 50,000 patches x \$2 per patch). The net gain to the NCAREMS is anticipated to be roughly \$80,000 (i.e., \$100,000 - \$20,000), which NCAREMS will use to augment the volunteer programs.

Bulk Cost (50,000 patches at \$.40 / Patch)	Sale Price per Patch	Number Sold	Total Net Revenue (Number sold – Bulk Cost)
~\$20,000	\$2	~50,000	~\$80,000

TOTAL REVENUES	~\$80,000
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**Impact Summary**

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	~\$1,875	\$0	one-time
Local Government	~\$28,000	\$0	one-time
Private Entities	~\$72,000	~\$80,000	one-time
<b>Total</b>	<b>~\$100,000</b>	<b>~\$80,000</b>	

**Sources of Salary Information Used to Support Employee Costs Associated with These Rule Changes**

All annual salaries used throughout this fiscal note are based on a work schedule of 2,080 hours per year and include salaries plus fringe benefit estimates. The hourly rates are estimated using salary grade ranges for state employees, and position titles for county government and non-governmental personnel. These hourly rates also include hourly wage plus fringe benefit estimates.

**State Government Employees**

Throughout this fiscal note any references to staff salaries are based on the figures in Table 2 below.

Table 2.

Salary Grade to Represent Comparable Position	Average Annual Compensation	Cost/Hr.
Management level positions (sg 76-78)	~\$102,000	~\$49
Technical level positions (sg 70-74)	~\$66,500	~\$32
Clerical level positions (sg 59- 61)	~\$47,850	~\$23

<sup>1</sup> References to OEMS staff hourly salaries are an average for each salary range grade based on the position levels including fringe currently budgeted for agency employees.

**County Government Employees**

References to county government staff hourly salaries are an average for each position considered by the OEMS to be comparable to agency staff, including fringe cost estimates at a rate of 55%, and considered appropriate to complete any change in rule requirements that require staff time.

Table 3

Position	Average Annual Compensation	Cost/Hr.
EMS Director	~\$108,500	~\$52
EMS Assistant Director/Operations Officer	~\$77,500	~\$37
EMS Training Officer/ Educator-Instructor	~\$62,000	~\$30
Office Assistant	~\$41,850	~\$20

<sup>1</sup> These positions are classified in the *University of North Carolina School of Government "County Salaries in North Carolina 2015"* <http://www.sog.unc.edu/node/32441>

**Non-Governmental Entities**

For private EMS agency employees, the OEMS chose to use some county government employee positions for administrative and support staff that were considered by OEMS staff in their professional judgment comparable to the positions identified for state government reflected in Table 3 using the same salary sources for each.

**Authorizing Statutes**

The following statutes are cited in the statutory authority of the rules under revision by the MCC.

G.S. 131E-155  
G.S. 131E-155.1  
G.S. 131E-157  
G.S. 131E-158  
G.S. 131E-159  
G.S. 131E-162  
G.S. 143-508  
G.S. 143-517  
G.S. 143-518  
G.S. 143B-952

As part of this fiscal note, the agency is complying with the periodic review and expiration of existing rules as set forth in:

G.S. 150B-21.3A

#### Federal Court Order of Permanent Injunction

On October 15, 2008, the Honorable Louise W. Flanagan, Chief United States District Judge, United States District Court for the Eastern District of North Carolina, Western Division issued an Order of Permanent Injunction; Case No. 5:07-cb-00222-FL, *Med-Trans Corporation, Plaintiff, v. Dempsy Benton, Secretary of the North Carolina Department of Health and Human Services, in his official capacity; Robert J. Fitzgerald, Director, Division of Health Service Regulation, North Carolina Department of Health and Human Services, in his official capacity; Lee B. Hoffman, Chief of the Certificate of Need Section, Division of Health Service Regulation, North Carolina Department of Health and Human Services, in her official capacity; Drexdal Pratt; Chief of the Office of Emergency Medical Services; Division of Health Service Regulation, North Carolina Department of Health and Human Services, in his official capacity, Defendants*, that directly affected language contained in the 10A NCAC 13P EMS and trauma rules.

This order of permanent injunction enjoined the Department and Office of Emergency Medical Services from enforcing regulatory authority on any rule conflicting the statutory and regulatory authority of the Federal Aviation Administration under the Airline Deregulation Act of 1973 for the regulation of air medical programs and aircraft equipment and permitting requirements.

The rules affected by this order of permanent injunction are as follows:

#### Section .0400 – Medical Oversight

- .0409 - EMS Peer Review Committee for Specialty Care Transport Programs

#### **Titles of Rule Changes Proposed for Re-adoption with Changes, Adoption, Amendment, or Repeal**

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. Additionally, in complying with G.S. 150B-21.3A, rules being readopted with substantive changes are included with rules being amended, repealed and adopted. The MCC, Rule Review Commission and the Joint Legislative Procedure Oversight Committee approved the subchapter report with classifications for the 10A NCAC 13P rules on May 15, 2015, January 21, 2016, and February 2, 2016 respectively.

These rules are identified as follows:

**10A NCAC 13P** (See proposed text of these rules as Appendix E.)

Section .0100 – Definitions

- .0101 - Abbreviations (Readopt with substantive changes)
- .0102 - Definitions (Readopt with substantive changes)

Section .0200 – EMS Systems

- .0201 - EMS System Requirements (Readopt with substantive changes)
- .0203 - Special Situations 10A NCAC 13P .0203 (readopt with substantive change as repeal)
- .0209 - Air Medical Ambulance: Vehicle and Equipment Requirements (Amend)
- .0214 - EMS Nontransporting Vehicle Permit Conditions (Amend)
- .0216 - Weapons and Explosives Forbidden (Readopt with substantive changes)
- .0219 - Staffing for Medical Ambulance/Evacuation Bus Vehicles (Readopt with substantive changes)
- .0221 - Patient Transportation Between Hospitals (Readopt with substantive changes)
- .0222 - Transport of Stretcher Bound Patients (Adopt)
- .0223 - Required Disclosure and Reporting Information (Adopt)

Section .0300 – Specialty Care Transport Programs

- .0301 - Specialty Care Transport Program Criteria (Readopt with substantive changes)
- .0302 - Air Medical Specialty Care Transport Program Criteria for Licensed EMS Providers Using Rotary-Wing Aircraft (Readopt with substantive changes)

Section .0400 – Medical Oversight

- .0403 - Responsibilities of the Medical Director for EMS Systems (Readopt with substantive changes)
- .0409 - EMS Peer Review Committee for Specialty Care Transport Programs (Amend)

Section .0500 – EMS Personnel

- .0501 - Educational Programs (Readopt with substantive changes)
- .0502 - Initial Credentialing Requirements for MR, EMT, EMT-I, EMT-P, and EMD (Readopt with substantive changes)
- .0503 - Term of Credentials for EMS Personnel (Amend)
- .0504 - Renewal of Credentials for MR, EMT, EMT-I, EMT-P, and EMD (Readopt with substantive changes)
- .0506 - Practice Settings for EMS Personnel (Amend)
- .0507 - Credentialing Requirements for Level I EMS Instructors (Readopt with substantive changes)
- .0508 - Credentialing Requirements for Level II EMS Instructors (Readopt with substantive changes)
- .0510 - Renewal of Credentials for Level I and Level II EMS Instructors (Readopt with substantive changes)
- .0511 - Criminal Histories (Amend)
- .0512 - Reinstatement of Lapsed EMS Credential (Adopt)
- .0513 - Refresher Courses (Adopt)



### Section .0600 – EMS Educational Institutions

- .0601 - Continuing Education EMS Educational Institution Requirements (Readopt with substantive changes)
- .0602 - Basic EMS Educational Institution Requirements (Readopt with substantive changes)
- .0603 - Advanced EMS Educational Institution Requirements (Readopt with substantive changes as repeal)
- .0605 - Accredited EMS Educational Institution Requirements (Adopt)

### Section .0900 – Trauma Center Standards and Approval

- .0901 - Level I Trauma Center Criteria (Readopt with substantive changes)
- .0902 - Level II Trauma Center Criteria (Readopt with substantive changes as repeal)
- .0903 - Level III Trauma Center Criteria (Readopt with substantive changes as repeal)
- .0904 - Initial Designation Process (Readopt with substantive changes)
- .0905 - Renewal Designation Process (Readopt with substantive changes)

### Section .1100 – Trauma System Design

- .1101 - State Trauma System (Amend)
- .1102 - Regional Trauma System Plan (Amend)

### Section .1400 – Recovery and Rehabilitation of Chemically Dependent EMS Personnel

- .1401 - Chemical Addiction or Abuse Treatment Program Requirements (Readopt with substantive changes)
- .1402 - Provisions for Participation in the Chemical Addiction or Abuse Treatment Program (Readopt with substantive changes)
- .1403 - Conditions for Restricted Practice with Limited Privileges (Readopt with substantive changes)
- .1405 - Failure to Complete the Chemical Addiction or Abuse Treatment Program (Amend)

### Section .1500 – Denial, Suspension, Amendment, or Revocation

- .1502 - Licensed EMS Providers (Amend)
- .1505 - EMS Educational Institutions (Amend)
- .1507 - EMS Personnel Credentials (Readopt with substantive changes)
- .1510 - Procedures for Voluntary Surrendering or Modifying the Level of an EMS Credential (Adopt)
- .1511 - Procedures for Qualifying for an EMS Credential Following Enforcement Action (Adopt)

## **Summary of Revisions and its Anticipated Impact**

**Rules .0101 – Abbreviations** and **.0102 – Definitions** are being readopted with substantive changes to address revisions throughout the rules.

### Impact

No impact associated with readopting these rules.

**Rule .0201 – EMS System Requirements** is being readopted with substantive changes and contains several revisions. Two changes are directed at the radio communications requirements. Language has been revised to use current terminology for public safety answering points. This change is technical and does not affect the communications centers. The other change is adding criteria for Emergency Medical Dispatch

Programs. Originally, these criteria were contained in Rule 21 NCAC 32H; however, when all EMS rules were consolidated into the current 10A NCAC 13P, this language was inadvertently omitted. All EMD centers use these criteria, and restoring the language is necessary to maintain standardization for these programs. No EMD centers are adversely impacted by restoring these criteria. The reference to the educational program requirements (13P .0201(a)(12)) used for EMS systems to provide continuing education is being updated to reflect the new national standards specifically addressed in rule .0501 of this Subchapter.<sup>2</sup>

Additional policies (13P .0201(a)(13)) have been added that require each EMS system to address a plan for mass casualty incidents, weapons on-board ambulances and non-transporting vehicles, a plan for how to comply with reporting suspected child abuse, and a plan for how to comply with reporting suspected abuse of the elderly or handicapped. The reporting of suspected child abuse and of abuse of the elderly and handicapped is required under G.S. 7B-302 and 108A-102 respectively. Currently these reporting policies are addressed in the “North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection.” However, the NCCEP policies are not consistent with statutory reporting language and require reporting elements not addressed in statute. Furthermore, NCCEP is addressing non-medical policies. The OEMS has instructed NCCEP to remove these policies from their standards. This change places the requirements directly in rule and requires each EMS system to abide by the statutory language. OEMS lacks sufficient information to estimate the cost to comply with this rule change. This is a one-time initial cost to each EMS system with no recurring costs.

A new requirement (13P .0201(c)) to obtain an EMS provider number for each responding agency providing EMS care within the system will necessitate submission of a one-page form for each agency. There is no cost for the form or issuance of the EMS provider number. There are an estimated 250 responding agencies not recognized by OEMS. The cost for completion of the forms by the EMS systems is four forms per hour at a cost of \$20 per hour. This will require an estimated 62.5 hours for completion of all forms for a total statewide EMS system opportunity cost of approximately \$1,250. The time to process the forms and issue the number by OEMS is estimated at four forms per hour at a cost of \$32 per hour for an OEMS opportunity cost of \$2,000. Under the time and cost assumptions noted above, the total local government and state government opportunity costs to comply with this requirement would be \$3,250.

#### Impact - Federal Government

No impact associated with readopting this rule.

#### Impact – State Government

EMS provider number application processing and issuance is estimated to be \$2,000.

#### Impact – Local Government

There are 98 approved EMS systems consisting of the 100 counties (several of which operate combined systems) and the Eastern Band of Cherokee Indians. The one-time cost to comply with this rule is estimated at \$1,250

#### Impact – Private Entities

No impact associated with readopting this rule.

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<sup>2</sup> US Department of Transportation: National Highway Traffic Safety Administration “National EMS Education Standards.”

### Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	~\$2,000	\$0	one-time
Local Government	~\$1,250	\$0	one-time
Private Entities	\$0	\$0	
Total	~\$3,250	\$0	

**Rule .0203 – Special Situations** rule is being readopted with substantive change as repeal.

### Impact

No impact associated with repealing this rule.

**Rule .0209 – Air Medical Ambulance: Vehicle and Equipment Requirements** is being amended to move the requirement for possession of a copy of the air medical program’s treatment program from rule .0302 to rule .0209 of this Subchapter for consistency in the vehicle-permitting criteria. The change does not create any costs to OEMS or air medical programs for compliance.

### Impact

No impact associated with amending this rule.

**Rule .0214 – EMS Nontransporting Vehicle Permit Conditions** is being amended to reflect the requirement to clarify that non-transporting EMS responding agencies functioning within an EMS System at the Advanced EMT or Paramedic level must be licensed in order to permit the non-transporting vehicles and to make technical changes in terminology.

### Impact

No impact associated with amending this rule. There is no fee associated with this requirement and, to date, all providers that will be affected by this requirement are already in compliance.

**Rule .0216 – Weapons and Explosives Forbidden** is being readopted with substantive changes to clarify the types of devices included in the rule’s definition of what qualifies as a weapon. The change expands the *weapons* definition to include a prohibition on the use of electrical devices (Tasers) and chemical irritants (mace, pepper spray, and tear gas).

Another revision is to have EMS Systems develop a policy that addresses securing a prohibited device (i.e. pepper spray, handgun, etc.) within an ambulance when found during assessment to be on the person of the patient. This policy will thereby enable EMS Systems utilizing EMS personnel as members of tactical law enforcement strike teams that require and authorize the possession of prohibited devices by these EMT and paramedic team members during a crisis event such as a SWAT team activation. This will affect 98 EMS Systems. OEMS staff estimates that it will take approximately 4 hours to complete the new weapons policy per system at ~\$37 per hour for a one-time cost of ~\$148 per system or ~\$14,500 statewide. The cost for OEMS staff to review the additional policy will be absorbed in EMS System renewals as addressed under Rule .0201.

### Impact – Federal Government

No impact associated with the amending this rule.

Impact – State Government

No impact associated with the amending this rule.

Impact – Local Government

There are a total of 100 EMS Systems.

	Number	One-time Cost per System	Total One-time Statewide Costs
EMS Systems	98	~\$148	~\$14,500
TOTAL COSTS			~\$14,500

Impact – Private Entities

No impact associated with the amending this rule.

The decision on where and how to secure these devices will be determined by each EMS system and may simply involve using a locked cabinet within the ambulance vehicle with restricted access to secure the devices and not involve the purchase of any specific storage container. Therefore, this revision does not mandate the expenditure of any funds to become compliant.

To clarify this revision, EMS personnel will still be prohibited from possessing or carrying any prohibited device during normal EMS operations without exception.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	~\$0	\$0	
Local Government	~\$14,500	\$0	one-time
Private Entities	~\$0	\$0	
<b>Total</b>	<b>~\$14,500</b>	<b>\$0</b>	

**Rule .0219 – Staffing for Medical Ambulance/Evacuation Bus Vehicles Situations** is being readopted with substantive changes and involves changing the names of the credentialing levels for EMS personnel to be consistent with national EMS standards terminology.

Impact

The costs associated with this readoption are addressed under rule .0502.

**Rule .0221 – Patient Transportation Between Hospitals** is being readopted with substantive changes and involves revising the names of the credentialing levels for EMS personnel to be consistent with national EMS standards terminology.

Impact

The costs associated with this readoption are addressed under rule .0502.

**Rule .0222 Transport of Stretcher Bound Patients** is being adopted to clarify when an EMS provider license and EMS vehicle permit will be required for the transport of mobility-impaired patients requiring transportation on a stretcher, but will not require a permit for transportation of mobility-impaired persons

capable of transport in a wheelchair. OEMS does not have the statutory authority to address transportation of persons who use wheelchairs but has concerns about use of ambulance stretchers in non-permitted vehicles. It is the position of the Department that any individual so impaired as to require transportation by stretcher meets the definition of a patient as defined in G.S. 131E-155(16) and is therefore is under the statutory authority of OEMS.

Currently, there are no organizations utilizing stretchers in non-permitted vehicles; however, the non-use of stretchers by non-permitted vehicles is likely due to OEMS working jointly with the local law enforcement agencies to cease use of these devices because of the risk of injury to the patient. Under the advice of the Office of Attorney General, OEMS has been advised that placing this requirement in rule will provide clarity on use of the stretchers. Since there are currently no organizations affected by this rule and because OEMS does not expect that organizations would begin using stretchers in non-permitted vehicles, OEMS expects no costs to be associated with its adoption.

Impact

No impact associated with the adoption of this rule.

**Rule .0223 – Required Disclosure and Reporting Information** is being adopted to ensure that any applicant for initial or renewal EMS provider licensing must disclose any criminal history associated with fiduciary responsibilities. This rule is being developed under the advice of the Centers for Medicare and Medicaid Services, Office of Inspector General, to identify those EMS agencies that have been adjudicated to be in violation of fraud or financial malfeasance. This will affect approximately 430 currently licensed agencies. Of the total, there are 91 county agencies and 60 municipal agencies. There are 32 hospital-owned agencies, 46 privately owned agencies, and 201 volunteer organizations.

OEMS staff estimate that it will take approximately 30 minutes to complete a disclosure statement per licensed EMS provider. OEMS estimates that it will review and process approximately 10 statements per hour at a cost of \$32 per hour for a total initial opportunity cost of ~\$1,400.

EMS Provider Licenses are valid for a period of six years. If one-sixth of the licensed providers renew each year, the annual cost to comply with this rule for the providers is estimated at ~\$1,800, and the annual cost to the OEMS will be ~\$230.

Although it is anticipated that there will be an increase in enforcement actions under rule .1502, OEMS lacks any information that would enable staff to estimate how many licensed providers will be subject to this rule nor the amount of time the provider’s staff and OEMS staff will have to expend should the Department have to initiate enforcement action. Furthermore, OEMS is unable to quantify any benefits that will occur if a licensed provider is subject to enforcement action.

Impact – Federal Government

No impact associated with the adoption of this rule.

Impact – State Government

Review and processing costs: ~\$1,400.

Impact – Local Government

There are a total of 151 Local Government licensed EMS Providers.

Provider Type	Number	Cost per Provider	Total Statewide Costs
Municipal Government	60	~\$25	~\$1,500

County Government	91	~\$25	~\$2,300
TOTAL COSTS			~\$3,800

Impact – Private Entities

There are a total of 279 private entities, all of which qualify as small businesses, licensed as EMS providers.

Provider Type	Number	Cost per Provider	Total Statewide Costs
Hospital Based	32	~\$25	~\$800
Privately Owned	46	~\$26	~\$1,200
Volunteer Organization	201	~\$26	~\$5,250
TOTAL COSTS			~\$7,250

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	~\$1,500	\$0	recurring
Local Government	~\$2,300	\$0	recurring
Private Entities	~\$7,250	\$0	recurring
Total	~\$11,050	\$0	

**Rule .0301 – Specialty Care Transport Program Criteria** is being readopted with substantive changes to address the educational program criteria and credentialing levels addressed in rules .0501 and .0502 of this Subchapter respectively.

Impact

The costs associated with this readoption are addressed under rules .0501 and .0502.

**Rule .0302 – Air Medical Specialty Care Transport Program Criteria for Licensed EMS Providers using Rotary-Wing Aircraft** is being readopted with substantive changes to include a requirement that rotary-wing programs address how they will obtain mutual aid assistance from both in-state and out-of-state air medical programs to this rule. This rule does not require any formalized mutual aid agreements but requires each program to address how mutual aid will be managed. Therefore, the only requirement is development of an internal policy to comply with this rule. There are currently eight rotary-wing air medical programs operating in the state. OEMS estimates that this policy will require approximately two hours to complete at a cost of ~\$49 per hour, for a total of ~\$98 per program. This will result in a one-time cost of approximately \$800 for all affected parties to comply.

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

No impact associated with readopting this rule.

Impact – Local Government

No impact associated with readopting this rule.

Impact – Private Entities

Each of the eight rotary-wing program will incur an opportunity cost of ~\$100, with total costs of ~\$800 to all affected parties. All affected programs meet OEMS definition of a small business.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	\$0	
Local Government	\$0	\$0	
Private Entities	~\$800	\$0	one-time
Total	~\$800	\$0	

**Rule .0403 – Responsibilities of the Medical Director for EMS Systems** is being readopted with substantive changes to clarify the authority of the medical director when an EMS professional has been suspended locally, pending due process review. The current rules are silent on what authority the medical director has if the EMS professional is deemed ineligible for continued practice following the due process review. This change is intended to clarify the authority of the medical director to continue to sanction the individual’s practice based on the severity of the circumstances confirmed following the medical director’s initial action.

Impact

No impact associated with readopting this rule.

**Rule .0409 – EMS Peer Review Committee for Specialty Care Transport Programs** is being amended to address the injunction issued by the federal court<sup>3</sup> prohibiting the state from requiring a county government official to serve on a peer review committee for air medical programs (both rotary- and fixed-wing programs). Since the injunction is specific to the air medical program component of specialty care programs and not the ground transportation component, and since all air medical programs currently approved are an extension of hospitals’ ground specialty care programs, this injunction does not have an effect on any existing program.

Impact

No impact associated with amending this rule.

**Rule .0501 – Education Programs** is being readopted with substantive changes and contains multiple significant revisions. Historically, North Carolina has adopted EMS educational curricula developed by the U.S. Department of Transportation’s (USDOT’s) National Highway Traffic and Safety Administration (NHTSA). In 2012, the NHTSA changed the structure of EMS education standards from a system of separate curricula for each credential level to a new comprehensive set of guidelines to replace the old standards. This change affected entry-level courses and continuing-education pathways and also eliminated refresher courses. In order to retain use of the national education standards, updating these programs becomes necessary.

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<sup>3</sup> *Order of Permanent Injunction; Case No. 5:07-cv-00222-FL, Med-Trans Corporation, Plaintiff, v. Dempsy Benton, Secretary of the North Carolina Department of Health and Human Services, in his official capacity; Robert J. Fitzgerald, Director, Division of Health Service Regulation, North Carolina Department of Health and Human Services, in his official capacity; Lee B. Hoffman, Chief of the Certificate of Need Section, Division of Health Service Regulation, North Carolina Department of Health and Human Services, in her official capacity; Drexdal Pratt; Chief of the Office of Emergency Medical Services; Division of Health Service Regulation, North Carolina Department of Health and Human Services, in his official capacity, Defendants.*

With the knowledge that the old curricula would become invalid and that OEMS would be moving to the new national guidelines in accordance with the existing rule provision to incorporate future amendments and additions to the NHTSA standards, all approved EMS education institutions in North Carolina adopted the new guidelines upon their release, a policy change supported by OEMS as addressed in a memorandum from the Agency Chief to all EMS Educational Institutions on October 1, 2012.<sup>4</sup>

There are several factors to consider when attempting to estimate any costs associated with this revision:

- All EMS educational institutions adjust their educational curricula to mirror changes in the scope of practice of all EMS credentialing levels as released by the NC Medical Board, pursuant to G.S. 143-514.
- The Department has required EMS educational institutions to adjust curricula to various changes as they occur, in order to reflect standards in healthcare delivery.
- The proposed EMS and Trauma rules merely codify existing requirements established by the NC Medical Board. Thus, the impacts associated with adoption of the revised national standards are not associated with the proposed rules.

Of the 102 institutions, 39 will need to modify their initial educational programs for the EMT-Basic level to include a clinical education module. The only direct cost to the educational institution to comply with the requirement will be to identify a clinical site and accommodate the clinical site's requirements to allow students access to their facility. OEMS lacks sufficient information to estimate the amount of time and resources institutions will spend to identify an appropriate clinical site that now must be reflected in this fiscal note. This specific change was a one-time cost to each EMS education institutions. However, based on OEMS staff's best professional judgment, the costs should be minimal.

There may be an additional costs to students if access to clinical sites requires insurance and criminal history background checks. OEMS has polled several of the EMS education programs that have already implemented clinical education into the EMT-Basic course. Based on their information it appears that on average, each student may incur additional expenses for insurance (\$15) and criminal history background checks (\$40). These 39 institutions average approximately 50 students per year for a total cost of approximately \$110,000. The advantage to having students insured and having their backgrounds checked is to safeguard both the student and clinical sites from potential liabilities. Failure to perform a background check and provide insurance could have an adverse effect through civil litigation due to errors in student performance or as a result of having students, who would be disqualified from credentialing due to a criminal history, access patients.

OEMS is unable to quantify the benefits to the student, educational institution, and of the public of requiring that students experience a hands-on interaction with patients in a controlled environment. Based on the professional judgment of OEMS staff, having a licensed healthcare provider observe the student applying the knowledge and skills attained during their educational experience, and then providing a critique back to the educational institution of the student's abilities, results in significant benefits.

In North Carolina, there are 85 emergency medical dispatch (EMD) centers. Of these, all centers but two utilize the International Academy of Emergency Medical Dispatch (IAEMD™) program for protocol development and performance-improvement standards. Of the two remaining centers, one utilizes the

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<sup>4</sup> Addendum C: EMS Educational Institution memorandum from Chief Regina Godette-Crawford to all NC EMS Educational Institutions, dated October 1, 2012.



Association of Public-Safety Communications Officials – International, Inc. (APCO™) standard and the other uses PowerPhone™. Each of these proprietary programs issue a credential verifying adherence to the proprietary program’s criteria for all tele-communicators utilizing their protocols and providing pre-arrival instructions to the public. Individuals who do not possess the proprietary program’s credential are not allowed to provide pre-arrival instructions using the proprietary materials. All three of these proprietary programs adhere to the American Society for Testing and Materials (ASTM™) F1258-95 (2006): “Standard Practice for Emergency Medical Dispatch” standard. Since these three programs use this common standard, and because each program requires attainment of their proprietary credential, OEMS will no longer develop its own educational program but will allow any individual holding a valid proprietary credential from any program meeting the ASTM™ standard to obtain a North Carolina EMD credential through the legal-recognition option defined in G.S. 131E-159(d).

Adoption of this new standard by OEMS will likely result in net benefits to OEMS and each EMD center. As discussed in rule .0503, the length of an EMS credential is being changed from “valid for a period of four years” to “valid for a period not to exceed four years.” The length of the credentials issued by the proprietary programs is two years for IAEMD™ and APCO™ and three years for PowerPhone™. Currently, all EMD programs have to complete duplicate credentialing documentation to maintain both the proprietary and OEMS credentials. Under this revised standard, the renewal process will be handled solely through the proprietary program documents and be completed online with OEMS. This will eliminate OEMS costs for ongoing renewal and allow these centers to handle state credentialing internally. The fiscal impact to the EMD and OEMS are covered in the impact included in rules .0503 and .0508 of this document.

Since the national guidelines no longer address refresher courses, OEMS is proposing to adopt rule .0513. The fiscal impact of the new refresher-course standards will be covered in the impact included in rule .0513 of this document.

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

The impact for this rule is contained under rules .0503 and .0508.

Impact – Local Government

The impact for this rule is contained under rules .0503 and .0508.

Impact – Private Entities

EMT-Basic personnel attending one of the 39 educational institutions that previously did not require insurance and criminal background checks for clinical education will be subject to additional course costs of \$55.

Number Institutions	Students/Institution	Total Students	Cost per student	Total cost
39	~50	~1,950	\$55	~\$110,000
<b>TOTAL COSTS</b>				~\$110,000

<sup>1</sup> These figures are based on OEMS staff polling EMS educational institutions that require insurance and criminal history checks and using their figures as the basis for this estimate.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	\$0	
Local Government	\$0	\$0	
Private Entities	~\$110,000	\$0	recurring
Total	~\$110,000	\$0	

**Rule .0502 – Initial Credentialing Requirements** is being readopted with substantive changes to 1) provide clarification on eligibility for initial credentialing, 2) provide a maximum number of attempts allowed to pass the written examination, 3) provide for a remediation protocol to continue eligibility, and 4) address changes in the names of the credentialing levels to be consistent with the new national standards as addressed in rule .0501 of this Subchapter.

Impact

No impact associated with readopting this rule.

**Rule .0503 – Term of Credentials for EMS Personnel** is amended to recognize the length of an EMS credential from four years to “not to exceed” four years. This change is to support the changes addressed in rule .0502 of this Subchapter where by OEMS will adopt the credential expiration associated with the nationally recognized Emergency Medical Dispatch proprietary program, which varies from two to three years depending on the program type used.

Impact

The impact of this change will be addressed in rule .0504 of this document.

**Rule .0504 – Renewal of Credentials for MR, EMT, EMT-I, EMT-P, and EMD** is being readopted with substantive changes to address the processing of renewal applications to include the provision of any documentation necessary for OEMS to verify eligibility for renewal. There is also a new option being provided that allows an individual to renew at a lower level upon his or her request and provides the criteria for returning to the original level should the individual choose to do so at a later date.

This change is to support the changes proposed in rules .0502 and .0503 of this Subchapter, whereby OEMS will adopt the credential expiration date associated with each nationally recognized Emergency Medical Dispatch proprietary program that vary from two to three years depending on the program type. By adopting the proprietary program’s renewal period, the administrative burden currently experienced by the Emergency Medical Dispatch Program and OEMS will be significantly reduced. OEMS estimates that the average program expends an average of 15 hours annually, and OEMS expends an average of 100 hours annually processing renewal applications for these personnel.

At an average opportunity cost of ~\$30 per hour for the program and ~\$32 per hour for OEMS staff, the proposed change will reduce opportunity costs by an estimated ~\$450 per year for each EMD program and ~\$3,200 per year for OEMS. There are currently 85 approved emergency medical dispatch programs operating statewide.

OEMS also proposes to include an additional paragraph that cites G.S. § 131E-159 disqualifying an applicant if the applicant is on the North Carolina Department of Justice’s Sex Offender and Public Protection Registry.

Since this has yet to be implemented, the OEMS is unable to estimate the number of instances whereby a court will notify the OEMS an individual is subject to the provision of these additional criteria. However, upon notification it is estimated by OEMS staff that the time to process this action order will be approximately 15 minutes by one OEMS staff at a of ~\$32 per hour to initiate the action, and approximately 30 minutes by one OEMS staff at a cost of ~\$32 per hour to reverse the action upon notification by the court, barring any circumstances that would prohibit the Department from restoring the individual’s credential because of the seriousness of the offense and precedent for such offenses in past administrative enforcement actions.

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

Unable to estimate a cost of action based upon court notification to suspend or revoke an individual’s credential, or restore the credential upon lifting of the court order. The annual EMD credential renewal processing savings are estimated at ~\$3,200.

Impact – Local Government

All 85 EMD programs are provided by the local government.

Provider Type	Number	Benefits per Provider	Total Statewide Benefits
EMD Program	85	~\$450	~\$38,250
TOTAL COSTS			~\$38,250

Impact – Private Entities

No impact associated with readopting this rule.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	~\$3,200	recurring
Local Government	\$0	~\$38,250	recurring
Private Entities	\$0	\$0	
Total	\$0	~\$41,450	

**Rule .0506 – Practice Settings for EMS Personnel** is being amended to address EMS personnel practicing in alternative practice settings. Currently, authorization to practice is dependent upon authorization of the county EMS System and System Medical Director. However, this is impractical if the individual is seeking employment in a clinical setting outside the authority of the EMS system (e.g., a hospital emergency department, an urgent care clinic, a physician’s office, etc.). The proposed change will allow the individual to function under a physician other than the system medical director and expand the career options for EMS personnel. There is also a change that enables EMR and EMT personnel not performing any invasive procedures to function within an industrial first aid team without physician oversight. These changes are not mandates but provide options currently unavailable under the existing rules.

OEMS staff lack sufficient information to estimate the number of alternative settings that may become available for EMS personnel to practice; thus, OEMS is unable to estimate the economic and fiscal impacts of the proposed change. However, any economic impacts should result in positive net benefits resulting from increased career opportunities for EMS staff and due to increased hiring flexibility on the part of clinics and industrial settings.

Impact

Unable to determine

**Rule .0507 – Credentialing Requirements for Level I EMS Instructors** is being readopted with substantive changes to 1) specify that the current requirement of 100 hours of teaching experience must be experience at the level of application (i.e., EMT, EMT-I or EMT-P), 2) reference a Level I instructor applicant’s ability to receive credential through legal recognition pursuant to G.S. 131E-159, and 3) remove all criteria specific to EMD instructors and EMD instructor applicants. There are currently 802 Level I EMS instructors subject to the provisions of this rule.

The benefit of requiring the teaching experience at the level of application is to assure the applicant has demonstrated the knowledge, skills, and abilities essential to the proper educational preparation of students enrolled in EMS educational programs. These students must be prepared to meet all credentialing requirements for their level of application, such as scope-of-practice evaluations and completion of a written examination administered by the OEMS to qualify for issuance of an EMS credential by the Department.

However, since there is no requirement that the instructor for each class session is credentialed as an EMS instructor, there is no way to estimate how this requirement will impact student success until the data representing first-time examination results for each student can be analyzed. OEMS staff believe there will be an increase in first-time examination pass rates if all sessions are led by credentialed instructors, but to what degree is unknown at this time.

The rule includes a new reference to Level I instructors’ ability to receive instructor credentials through legal recognition pursuant to G.S. 131E-159 to address an omission in current rule language that currently has been exercised daily under this statutory authority for years but should also be codified in rule.

There are approximately 85 EMD instructors that will no longer be subject to the provisions of this rule and will see a cost savings. In support of the new standard for emergency dispatch programs, as defined in rule .0501 of this Subchapter, the requirement that an instructor of EMD programs must be credentialed is removed, and OEMS will recognize the proprietary requirements necessary for the individual to qualify for the proprietary credential as the standard to be acceptable for credentialing in North Carolina in lieu of a specific North Carolina standard. This approach was viewed by OEMS, all EMD programs, and telecommunicators associations polled during the pre-vetting phase of rulemaking as the most practical approach since OEMS is not capable of keeping the quality of services to the level that the proprietary program can achieve, given the limited resources OEMS has available. OEMS estimates that EMD programs will experience reduced opportunity costs related to the maintenance of instructors’ EMS Instructor credential by an average of four hours per year at an estimated opportunity cost of \$30 per hour. This will reduce the cost to the EMS program for an average savings of ~\$120 per year.

OEMS expends an average of ~40 hours annually processing initial applications for EMD personnel. At an average cost of ~\$32 per hour for OEMS staff, the proposed change will reduce the cost by ~\$1,300 per year resulting in a savings for OEMS in program costs.

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

EMD credential renewal processing recurring savings of ~\$1,300

Impact – Local Government

All 85 EMD programs are provided by the local government.

Provider Type	Number	Savings per Provider	Total Statewide Savings
EMD Program	85	~\$120	~\$10,200
TOTAL SAVINGS			~\$10,200

Impact – Private Entities

No impact associated with readopting this rule.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	~\$1,300	recurring
Local Government	\$0	~\$10,200	recurring
Private Entities	\$0	\$0	
Total	\$0	~\$11,500	

**Rule .0508 – Credentialing Requirements for Level II EMS Instructors** is being readopted with substantive changes to 1) address the new EMS credentialing levels, delete reference to EMD instructors, 2) clarify that attendance at an OEMS instructor workshop must be completed within one year of application, and 3) authorize renewal under the legal recognition option defined in G.S. 131E-159. There are no anticipated costs associated with these changes.

Impact

No impact associated with readopting this rule.

**Rule .0510 – Renewal of Credentials for Level I and Level II Instructors** is being readopted with substantive changes to 1) address the new EMS credentialing levels, 2) delete references to EMD instructors, 3) add a renewal requirement to attend an OEMS instructor workshop within one year of application, 4) clarify the content for professional development and reduce the number of hours from 40 hours to 24 hours within the credentialing cycle, and 5) authorize renewal under the legal recognition option defined in G.S. 131E-159.

OEMS estimates that there are currently a combined total of 1,250 Level I and Level II EMS instructors subject to the provisions of this rule. The proposed rule change will result in additional opportunity costs for time spent traveling to and from the workshop and the time the instructor spends during the workshop session. Since these workshops are offered locally, 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 2015 of 57.5 cents per mile<sup>5</sup> and an OEMS assumption that individuals will drive an average of 50 miles to and from the workshops, instructors' travel costs will equal approximately \$30 per workshop. Over the course of a four-year renewal period, OEMS estimates that the total workshop travel costs for the 1,250 instructors would be ~\$36,000.

Since these workshops are conducted regionally throughout the state multiple times each year, the travel time necessary to for each instructor to attend varies. For the purpose of the fiscal analysis, the OEMS will use a round-trip travel time of 1.5 hours for each instructor. Each workshop lasts approximately 2 hours, depending on the number of individuals in attendance. At an estimated compensation rate of \$30 per hour, OEMS estimates that the total opportunity cost for each instructor would be \$105 per workshop. The aggregate workshop-related opportunity costs for all instructors would be approximately \$131,250 over the course of a four-year renewal period.

The length of the instructor credential is four years. If one quarter of EMS instructors renew each year, OEMS estimates that travel and opportunity costs would equal approximate \$42,000 per year.,

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

No impact associated with readopting this rule. All renewal applicants will be attending the workshops already held locally and not require any additional expenditure by OEMS staff.

Impact – Local Government

No impact associated with readopting this rule.

Impact – Private Entities

Renewing one quarter of these individuals annually, the total will be ~315 renewals annually, for a total cost of approximately \$42,000.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	\$0	
Local Government	\$0	\$0	
Private Entities	~\$42,000	\$0	recurring
<b>Total</b>	<b>\$42,000</b>	<b>~\$0</b>	

**Rule .0511 – Criminal Histories** is being amended to eliminate redundant criminal background checks for individuals residing in North Carolina less than five years who are applying to either renew their credentials or advance to a higher level while awaiting the five-year residency criteria. For example, if a person using the legal recognition option defined in G.S. 131E-159, and who complied with the initial background check for initial North Carolina credentialing, is seeking renewal of their North Carolina credential and has continuously resided in North Carolina since the initial credential was issued, a second criminal history background check will not be required. This occurs approximately 100 times annually and costs the

<sup>5</sup> Internal Revenue Service. "New Standard Mileage Rates Now Available; Business Rate to Rise in 2015." Dec. 10, 2014. <http://www.irs.gov/uac/Newsroom/New-Standard-Mileage-Rates-Now-Available;-Business-Rate-to-Rise-in-2015>.

individual an average of \$53 for the second background check (cost details noted below). Additionally, OEMS spends approximately one hour to process each application at a cost of ~\$32 per hour. Therefore, revising this rule will result in a savings of approximately \$5,300 annually for the qualifying individuals and reduced opportunity costs for OEMS staff equal to approximately \$3,200.

Impact – Federal Government

No impact associated with amending this rule.

Impact – State Government

The time needed by OEMS staff to process these applications is one hour per application at a cost of ~\$32 per hour for a total annual savings of approximately \$~3,200.

Impact – Local Government

No impact associated with amending this rule.

Impact – Private Entities

The cost of undergoing a criminal history background check is set by the State Bureau of Investigation pursuant to G.S. 143B-952 at a rate of \$38 per applicant, and fingerprinting costs, paid by the individual to the law enforcement agency, are an additional \$15. Thus, the total cost per individual for a criminal background check is \$53, plus additional opportunity costs for the time necessary to complete the background check. There are approximately 100 individuals subject to this requirement. Removing this requirement will result in an annual savings of approximately ~\$5,300, plus any benefits associated with reduced opportunity costs.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	~\$3,200	recurring
Local Government	\$0	\$0	
Private Entities	\$0	~\$5,300	recurring
<b>Total</b>	<b>\$0</b>	<b>~\$8,500</b>	

**Rule .0512 – Reinstatement of Lapsed EMS Credential** is proposed for adoption to provide guidance to individuals on restoring a lapsed EMS credential based upon the length of time since expiration.

Historically, the OEMS staff members have attempted to provide assistance to individuals seeking to reinstate a lapsed EMS credential on a case-by-case basis. However, this approach is better served by establishing a standardized set of criteria that clearly defines the processes necessary to reinstate the credential, that have been properly vetted and subject to rulemaking authority pursuant to G.S. 150B, and subsequently codified in rule rather than risking an arbitrary and capricious approach to assisting these individuals. Additionally, by utilizing this approach, individuals who are not eligible to regain their credentials because of the circumstances causing their credential to become lapsed will not expend unnecessary time and effort only to find themselves disqualified or ineligible when seeking resolution.

For OEMS staff attempting to assist these individuals, as well as the individuals who do qualify for restoring or regaining their credentials, the processes involved should be much more efficient and effective that the current method utilized by the agency. Not knowing the number of individuals or the circumstances related

to each specific situation, OEMS staff is unable to estimate the impacts associated with this rule. However, OEMS staff believes that the rule is likely to produce net benefits to the agency and to affected individuals.

**Impact**

Unable to determine – likely net benefits to OEMS and affected individuals

**Rule .0513 – Refresher Courses** is proposed for adoption to replace the old national USDOT NHTSA curricula. The set of criteria for course approval is consistent with new USDOT NHTSA EMS Educational Guidelines core content and are standardized in rule to allow the educational institutions more flexibility in how they construct and deliver the course. EMS Educational Institutions have been offering revised content refresher courses since October 1, 2012 (Addendum C). No fiscal impact is associated with adoption of this rule.

**Impact**

No impact associated with adopting this rule.

Section .0600 of the EMS and Trauma Rules address approval of institutions to teach initial, refresher, and continuing educational courses and programs. There are three types of institutions: Continuing Education (CE), Basic, and Advanced. CE institutions are only authorized to conduct courses and programs specifically for renewal of EMS credentials (e.g. refresher and CE). Basic and Advanced institutions offer initial and renewal courses and programs. There are currently 154 approved EMS institutions as follows:

	CE	Basic	Advanced	Totals
Privately owned	13	8	11	32
Local	23	6	21	50
State	1	3	68	72
<b>TOTALS</b>	<b>37</b>	<b>17</b>	<b>100</b>	<b>154</b>

**Rules .0601 – Continuing Education EMS Educational Institution Requirements and .0602 - Basic and Advanced EMS Educational Institution Requirements** are being readopted with substantive changes to reflect the new EMS educational program standards as previously described in the Section .0500 rules of this Subchapter. This will require new policies and procedures to be developed and implemented. It is estimated by OEMS staff that this will involve one institution employee an estimated 40 hours to develop and implement.

	Staff costs per hour	Total staff costs at 40 hours per institution	Total number institutions statewide	Total staff costs statewide
Privately owned	~\$30 <sup>1</sup>	~1,200	32	~\$60,000
Local	~\$30 <sup>1</sup>	~1,200	50	~\$60,000
State	~\$32 <sup>2</sup>	~1,280	72	~\$92,000
<b>TOTAL COSTS</b>				<b>~\$212,000</b>

<sup>1</sup>See Table 3

<sup>2</sup>See Table 2

It is estimated that it will take OEMS staff approximately 30 minutes to review each modification for total estimated staff time of 77 hours at a rate of ~\$32 per hour for a total one-time cost of ~\$2,500.



Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	one-time
State Government	~\$94,500	\$0	one-time
Local Government	\$60,000	\$0	one-time
Private Entities	\$60,000	\$0	one-time
<b>Total</b>	<b>~\$214,500</b>	<b>\$0</b>	

**Rule .0603 – Approved EMS Educational Institution Requirements** is being readopted with substantive change as a repeal and the criteria moved into rule .0602 of this Subchapter. The fiscal impact of this repeal is addressed under Rules .0601 and .0602.

**Rule .0605 – Accredited EMS Educational Institution Requirements** is proposed for adoption to support national standards that require paramedic education through an institution accredited by the Commission on Accreditation of Allied Health Education Programs to qualify for registration with the National Registry of Emergency Medical Technicians. OEMS has determined that these accreditation standards exceed state approval criteria, and the rule change may encourage additional educational institutions to pursue accreditation. The proposed rule does not mandate that programs become accredited. However, if the educational institution attains and continues to maintain this accreditation, renewal of the North Carolina approval will be granted without application. The current length of approval as a North Carolina EMS Educational Institution approval is four years, but institutions using accreditation will have approval for five years. This change is expected to eliminate the hours required by the institutions to complete the application and significantly reduce the number of hours needed by OEMS to review and issue the approval.

Currently there are ten accredited institutions that will meet this standard. The time necessary to complete the application is estimated to be roughly 16 hours at ~\$30 per hour. Utilizing this rule will enable these ten institutions to reduce the renewal cost by an estimated \$480 once every five years. The time needed by OEMS staff to review and issue the approval is estimated at four hours per application. At a staff cost of ~\$32 per hour for each renewal application, this will reduce the opportunity cost to OEMS by approximately \$130 per year.

Impact – Federal Government

No impact associated with adopting this rule.

Impact – State Government

There are currently ten accredited institutions. All are North Carolina community colleges. Impact estimates include an assumption that one-fifth of eligible institutions will renew each year (two per year).

Number Accredited Institutions Renewing Each Year	Reduced Opportunity Cost per Institution per Renewal	Total Annual Reduced Opportunity Costs Statewide
2	~\$130	~\$260
2	~\$480	~\$960
<b>TOTAL SAVINGS</b>	<b>~\$610</b>	<b>~\$1,200</b>

Impact – Local Government

No impact associated with adopting this rule.

Impact – Private Entities

No impact associated with adopting this rule.

## Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	~\$1,200	recurring
Local Government	\$0	\$0	
Private Entities	\$0	\$0	
Total	\$0	~\$1,200	

**Rule .0901 – Trauma Center Criteria** is being readopted with substantive changes to include incorporating Rules .0901, .0902, and .0903 of this Subchapter into a single comprehensive standard, removing North Carolina-specific trauma center criteria and adopting the American College of Surgeons (ACS) standard for Levels I, II and III Trauma Centers<sup>6</sup> as the baseline criteria for all trauma centers. Beginning with the initial trauma rules developed in the early 1990s, the Department used the ACS standard as a comparison reference but allowed for variances in individual standards to be codified in rule through collaboration with the North Carolina Chapter of the ACS Committee on Trauma (COT) and the State Trauma Advisory Committee (STAC). However, since the inception of the Statewide Trauma System, analysis of trauma registry data and trauma center renewal reviews have failed to show any evidence that North Carolina-specific criteria have improved patient outcomes. Therefore, it is to the benefit of all trauma centers for the Department to align designation criteria with the national ACS standard unchanged and allow hospitals to adjust to best practices for trauma care as the healthcare industry evolves without the added burden of meeting unsupported variations.

Currently there are 13 designated trauma centers in North Carolina. There are currently 6 Level I, 3 Level II, and 4 Level III trauma centers. With the repeal of the North Carolina specific criteria, only the currently non-ACS validated trauma centers that do not meet the ACS standard will be minimally impacted. This determination was reached following a thorough analysis of the ACS' Final Compendium of Changes<sup>7</sup> document by OEMS staff.

The most obvious change will be removing the North Carolina Chapter of the American College of Surgeons Committee on Trauma (NC COT) document "Performance Improvement Guidelines for North Carolina Trauma Centers" standard and adopting the ACS Performance Improvement and Patient Safety (PIPS) guidelines. This will not create a fiscal impact since the NC COT document was created using ACS guidelines but was enhanced with more specific detail on how the performance improvement programs are configured. This document will still be utilized by all NC-designated trauma centers since it exceeds the new ACS standard and is updated frequently by the NC COT in collaboration with the State Trauma Advisory Council and eight Regional Trauma Advisory Committees.

For comparison between these standards, the Performance improvement & Patient Safety Reference Manual available on line at: <http://www.socialtext.net/acs-demo-wiki/index.cgi> and the NC COT document is available on line at [https://www2.ncdhhs.gov/dhsr/EMS/trauma/pdf/pi\\_guidelines.pdf](https://www2.ncdhhs.gov/dhsr/EMS/trauma/pdf/pi_guidelines.pdf)

## Impact

<sup>6</sup> *"American College of Surgeons: Resources for Optimal Care of the Injured Patient."* This document can be downloaded at no cost online at [www.facs.org](http://www.facs.org)

<sup>7</sup>Appendix D: Final-Compendium 2014\_V1\_9\_26\_2014.xlsx.

No impact associated with amending this rule.

**Rule .0902 – Level II Trauma Center Criteria; and Rule .0903 – Level III Trauma Center Criteria**

These rules are being readopted with substantive change as a repeal. The criteria previously contained in these rules have been updated and incorporated into rule .0901 of this Subchapter. The rationale for this action is to make the rules less redundant and user friendly.

Impact

The impact associated with repealing these rules is addressed in rule .0901.

**Rule .0904 – Initial Designation Process** is being readopted with changes to address technical changes associated with amending rules .0101 and .0102, to remove the requirement of submitting a paper copy of the request for proposal, to revise the length of designation for hospitals using the combined OEMS and ACS process to align with the ACS verification standard, and to remove the requirement to utilize one in-state trauma program manager from the site-visit team. The only fiscal impact associated with these changes involves the removal of the requirement that site-visit teams include an in-state trauma program manager.

Prior to the site visit, the Department executes a contract with each site-team member. A contract is also executed between the Department and the applying hospital for reimbursement for all costs incurred during the site visit (excluding OEMS staff). The Department has established a rate of \$600 salary cost and \$1,000 for expenses for a total of \$1,600 per site team member. Only Level I and Level II applicants are subject to these costs. Level III applicants are not charged these costs since the complexity of the site visit and time to determine eligibility is managed within the OEMS annual budget.

Impact

The only time this will have a cost savings is if in the future a hospital seeks designation as a Level I or Level II trauma center. Should this occur the total savings will be \$1,600 for each hospital.

**Rule .0905 – Renewal Designation Process** is being readopted with substantive changes to clarify the composition of the site-visit team by referencing the removal of the in-state trauma program manager requirement addressed in the amendment to rule .0904. There are currently six Level I and three Level II trauma centers that will be subject to this change. Since the current renewal period is every four years, OEMS assumes that three centers will renew their designation each year, on average. At the \$1,600 reimbursement rate for in-state trauma program managers, noted in the analysis of rule .0904 above, centers will benefit by an average of approximately \$1,600 per year or an average of \$400 annually.

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

There is currently one state government owned Level I Trauma Center (University of North Carolina Hospital - Chapel Hill) subject to this change that will have a recurring cost savings of \$1,600 every four years (\$400 / year).

Impact – Local Government

There is currently one local government owned Level I Trauma Center (Carolinas Medical Center – Charlotte) subject to this change that will have a recurring cost savings of ~\$1,600 every four years (\$400 / year).

Impact – Private Entities

Total Number Level I and Level II Trauma Centers	Total Number Renewed every four years	Cost of In-state Trauma Program Manager	Total Annual Savings \$1,600 / 4 x 7
7	7	~\$1,600	~\$2,800
TOTAL SAVINGS			~\$2,800

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefit
Federal Government	\$0	\$0	
State Government	\$0	~\$400	recurring
Local Government	\$0	~\$400	recurring
Private Entities	\$0	~\$2,800	recurring
Total	\$0	~\$3,600	recurring

**Rule .1101 – State Trauma System** is being amended to provide clarification to hospitals regarding affiliation with a Regional Advisory Committee (RAC) based on the majority of patient referrals. Notification of patient referrals is already required, but OEMS routinely receives inquiries about what criteria qualifies to change RAC affiliation.

Impact

No impact associated with amending this rule.

**Rule .1102 – Regional Trauma System Plan** is being amended to provide clarification to RACs on what notification is required to OEMS regarding their membership and to make technical changes.

Impact

No impact associated with amending this rule.

**Rule .1401 – Chemical Addiction or Abuse Treatment Program Requirements** is being readopted with substantive changes to shift the monitoring of EMS professionals to an internal process rather than through a contractual agreement with the North Carolina Board of Nursing. This change will benefit the program participants by reducing the participation fees charged to the participants.

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, 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.

Under existing rule, individuals determined to be subject to enforcement action because of dependency to alcohol or drugs must be recommended by the North Carolina EMS Disciplinary Committee for eligibility to enter into the treatment program. G.S. 143-519 only authorizes the EMS Disciplinary Committee to make recommendations on individuals subject to enforcement action, however, and because the treatment

program is non-punitive and confidential, the rule change shifts responsibility for this program from the EMS Disciplinary Committee to OEMS staff.

Due to the costs associated with the Board of Nursing Program, no individuals have yet been able to afford entry to the program. The high costs have caused individuals to continue through the enforcement path and enter into a consent agreement with OEMS that contained all of the components of the Board of Nursing Program. However, although individuals were able to eventually complete the terms of the settlement agreement and return to unrestricted practice, their credential records reflected the enforcement action, and the enforcement actions were also reported to the National Practitioner Data Bank and Healthcare Integrity and Protection Integrity Data Bank as required by federal law.

A comparison of costs between the contractual agreement with the Board of Nursing and managing the monitoring of the participant’s progress in-house indicates a significant reduction in costs to the participant. Since no individuals were enrolled in the Board of Nursing program and OEMS staff had to manage all aspects of the treatment program through the settlement agreement process, the only affect moving the monitoring of the program in-house will have on OEMS staff costs will be dependent upon the number of individuals participating in the program. OEMS has already terminated the contract with the Board of Nursing and has enrolled an individual into the in-house program. There are also other individuals currently being monitored through the settlement agreement process. Because the current rules require involvement of the EMS Disciplinary Committee, even the participant in the in-house program was required to be reviewed and endorsed by the Committee. Upon amendment of the section .1400 rules, all future participants will remain confidential.

Under the contractual agreement, OEMS paid the Board of Nursing a one-time, non-refundable set-up fee of \$5,000. There is also an annual contract fee of \$1,500 paid by OEMS to the Board of Nursing. Moving the monitoring of the program in-house will eliminate the annual \$1,500 fee. Assuming that the fee to the Board of Nursing covers costs that will no longer be expended, the elimination of the fee will result in net benefits to the State.

A comparison between the costs paid by the participant for each program is as follows:

Program Requirement	Board of Nursing	OEMS	Difference (Savings)
Addictionologist Assessment	~\$150 to \$350	~\$150 to \$350	\$0
Program fee	~\$4,500	\$0	~\$4,500
Out-patient or In-patient care <sup>1</sup>	~\$1,200 to \$25,000	~\$1,200 to \$25,000	\$0
Annual random drug screens <sup>2</sup>	~\$4,158	~\$1,200	~\$2,958
<b>TOTALS</b>	<b>~\$10,008 to \$34,008</b>	<b>~\$2,550 to \$26,550</b>	<b>~\$7,458</b>

<sup>1</sup> The ranges associated with the program costs is dependent upon whether the individual’s treatment plan involves in-patient care or can be managed as an out-patient.

<sup>2</sup> The Board of Nursing program requires 18 witnessed drug screens annually at \$77 per screen. OEMS program requires 8 unwitnessed drug screens annually at \$50 per screen.

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

The annual savings in program costs is ~\$1,500.

Impact – Local Government

No impact associated with readopting this rule.

Impact – Small Business

No impact associated with readopting this rule.

Impact – Private Entities

The annual program savings to the individual is ~\$2,500 for a total three year program savings of ~\$7,500. OEMS anticipates that a maximum of 30 individuals will be participating in the program at any given time, resulting in an annual overall savings of ~\$75,000.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	\$0	~\$1,500	recurring
Local Government	\$0	\$0	
Private Entities	\$0	~\$75,000	recurring
<b>Total</b>	<b>\$0</b>	<b>~\$76,500</b>	<b>recurring</b>

**Rule .1402 – Provisions for Participation in the Chemical Addiction or Abuse Treatment Program** is being readopted with substantive changes to place the monitoring of the program in-house with OEMS and eliminate the contractual approach to program management with the North Carolina Board of Nursing.

Impact

The impact associated with this re adoption is addressed under rule .1401.

**Rule .1403 – Conditions for Restricted Practice with Limited Privileges** is being readopted with substantive changes to place the program in-house with OEMS and create a re-entry committee to review individuals for return to restricted practice. This task was previously managed by Board of Nursing staff. OEMS will provide per diem for the two individuals to travel to the Raleigh OEMS Office; however, each of the two will be providing their time pro-bono; however, each will receive the allowable \$15 per meeting service payment authorized under state budget guidelines. The number of meetings anticipated by OEMS to manage the program will be one meeting per quarter for a total of four meetings per year. The annual per diem cost is estimated not to exceed ~\$750. These funds will be provided under the existing OEMS operating budget and will not require any additional state funds to support the committee.

Impact – Federal Government

No impact associated with readopting this rule.

Impact – State Government

The annual program costs for support of the re-entry committee is estimated at ~\$750.

Impact – Local Government

No impact associated with readopting this rule.

Impact – Private Entities

No impact associated with readopting this rule. Note that there will be an unquantified opportunity cost of volunteers' time that would be roughly equal to the intrinsic benefits the volunteers receive for their service.

Impact Summary

	Costs	Benefits	Frequency of Costs/Benefits
Federal Government	\$0	\$0	
State Government	~\$750	\$0	recurring
Local Government	\$0	\$0	
Private Entities	\$0	\$0	
<b>Total</b>	<b>~\$750</b>	<b>\$0</b>	<b>recurring</b>

**Rule .1405 – Failure to Complete the Chemical Addiction or Abuse Treatment Program** is being amended by referencing the proposed rule re adoption for Rule .1401 of this Subchapter that places the program in-house with OEMS rather than have it be run through a contracted agreement with the North Carolina Board of Nursing

Impact

The impact associated with this amendment is addressed under rule .1401.

**Rule .1502 – Licensed EMS Providers** is being amended to expand revocation criteria, add failure to disclose information contained in the proposed rule adoption for rule .0223 of this Subchapter, and add convictions by any officer or agency for fiduciary misconduct or conviction of a felony as actionable offenses.

Impact

The impact of amending this rule was addressed under rule .0223. Changes not addressed in rule .0223 will have little or no impact.

**Rule .1505 – EMS Educational Institutions** is being amended to include failure to provide records as defined in rule .0601 of this Subchapter and loss of accreditation as defined in proposed rule adoption for rule .0605 of this Subchapter as actionable offenses.

Impact

The OEMS has never taken administrative action against an educational institution; however, there have been instances where the educational institution was reluctant to release the records until OEMS staff discussed the purpose of the record release and assured the institution the confidentiality of the students would not be compromised. Additionally, since rule .0605 is a new rule that has yet to be implemented, it is difficult to estimate if any accredited institution would lose accreditation and be subject to OEMS review. Therefore, until such time that these new additions to the rule have been implemented, the OEMS has determined in its professional judgment that there is unlikely to be any impact associated with this rule.

**Rule .1507 – EMS Personnel Credentials** is being re adopted with substantive changes to expand actionable offenses to include:

- continued practice in an EMS System in which the individual is not affiliated;
- willful delay or failure to respond when on-duty to a dispatched call for EMS assistance;
- positive drug screen criteria;

- harassing, abusing or intimidating a patient, student, by-stander, OEMS staff either physically, verbally, or in writing;
- unauthorized possession of weapons as defined in rule .0216;
- failure to provide patient care records to the licensed EMS provider; and
- continuing to provide EMS care after local suspension of practice privileges by the EMS System;

Also, this revision adds clarification that OEMS will take action pursuant to G.S. 50-13.12 upon notification by the court to suspend the individual's credential, and adds a requirement that OEMS notify an EMS professional that any action taken by OEMS will be entered into the National Practitioner Data Bank and Healthcare Integrity and Protection Integrity Data Bank.

#### Impact

Since the actionable offenses listed above are new additions to the rule, OEMS is unable to determine how often such actionable offenses will occur. However, OEMS has determined in its professional judgment that there will be little or no impact associated with this rule change.

**Rule .1510 – Procedures for Voluntary Surrendering or Modifying the Level of an EMS Credential** is being proposed for adoption to enable credentialed EMS personnel and OEMS to formalize the process of enabling personnel to voluntarily surrender or modify (lower) the level of his or her EMS credential. Historically, OEMS staff have attempted to provide assistance to individuals seeking this assistance on a case-by-case basis. However, this approach is better served by establishing a standardized set of criteria that 1) clearly define the processes necessary to restore or regain a credential, 2) have been properly vetted and subject to rulemaking authority pursuant to G.S. 150B, and 3) codified in rule rather than risking an arbitrary and capricious approach by staff to assisting these individuals.

Most often, the reason an individual seeks this action is because of their desire to maintain some form of credential but may be unable to expend the time and effort necessary to maintain the continuing education and renewal standards of a higher level. Their request may indicate the modification is only necessary for a specific time due to illness, pregnancy, family emergency, or other personal cause and may want to retain eligibility for restoring the credential to full status at a future date without having to utilize the steps for initial credentialing.

There are an additional subset of approximately five instances per year where individuals request the option to surrender credential(s) to avoid repercussions for failing to abide by local EMS practice standards or to avoid having OEMS initiate enforcement action for violating the EMS and trauma rules. These written requests are reviewed on a case-by-case basis and when granted, are based on the agency's determination the request will best serve the interest of the public and the individual and do so with the least expenditure of time and expense to resolve the situation.

However, the OEMS maintains an active database on each individual that contains the circumstances surrounding the individual's offense(s) and are prepared to reopen the investigation if the individual seeks to restore or regain his or her credential at the previous level.

OEMS staff estimates that the current time to review and process each request to lower or surrender a credential and the time to review and process requests in a standardized format as defined in the new rule language will remain unchanged. Therefore, there are no estimated opportunity costs or benefits to standardizing this criteria.



However, for those individuals willing to voluntarily surrender their credential(s) to avoid enforcement action by OEMS, it eliminates the staff time to conduct and complete the investigative and enforcement process and avoids having the credential-surrendering individual have her or his information submitted to the National Practitioner Data Bank and Healthcare Integrity and Protection Integrity Data Bank. Since the individual's file is still marked in the OEMS credentialing database as having been subject to an investigation with voluntary surrender, this information is available to any other state's EMS Office should this individual seek credentialing in that state.

An average investigation involves two OEMS investigators and one OEMS staff responsible for compliance management. The average number of hours to complete an investigation is 24 hours for the lead investigator and 8 hours for the assistant investigator. At an opportunity cost of \$32 per hour per investigator, the proposed rule would reduce the opportunity cost of investigators' time by roughly \$1,000 per investigation. The opportunity cost for the staff conducting compliance management is \$49 per hour for a total of 16 hours per investigation. Thus, the proposed change would reduce the management cost by roughly \$800 per investigation. The total reduction in opportunity cost per investigation would be, on average, \$1,800.

OEMS receives an average of five written requests each year to surrender a credential to avoid enforcement action. Additionally, entry of data into the National Practitioner Data Bank and Healthcare Integrity and Protection Integrity Data Bank takes approximately 30 minutes per action at an opportunity cost of \$23 per hour. The annual opportunity cost to enter the five individuals' actions into these data banks is roughly \$60. The total annual savings by adopting this rule is estimated at approximately \$9,300, assuming action was enacted and upheld through appeal.

Number Investigations Avoided	Cost per investigation	Total Savings
~5	~\$1,860	~\$9,300
<b>TOTAL SAVINGS</b>		~\$9,300

To date, the OEMS has not had any individual seek to restore or regain a credential using this option to avoid investigation and cannot estimate if this will occur in the future. However, should this occur, the cost of reopening the investigation will be absorbed into OEMS investigative staff's normal duties since the preliminary steps were initiated before the initial request was granted, and the investigation files remain open until archived or destroyed pursuant to the agency's record retention policy

Impact - Federal

No impact associated with adopting this rule.

Impact - State

The estimated recurring savings will ~\$9,300

Impact – Local Government

No impact associated with adopting this rule.

Impact – Private Entities

No impact associated with adopting this rule.

Impact Summary

Costs      Benefits      Frequency of  
Costs/Benefits

Federal Government	\$0	\$0	
State Government	~\$0	~\$9,300	recurring
Local Government	\$0	\$0	
Private Entities	\$0	~\$0	
<hr/> Total	<hr/> ~\$0	<hr/> ~\$9,300	<hr/> recurring

**Rule .1511 – Procedures for Qualifying for an EMS Credential Following Enforcement Action** is being proposed for adoption to assist individuals who have been subject to OEMS enforcement action with a means of undergoing a review process to qualify for restoration of a previous EMS credential. Currently, individuals seeking restoration of their credentials are required to meet all initial credentialing requirements defined in rule .0502 of this Subchapter. However, there is no guarantee that OEMS, after consultation with the North Carolina EMS Disciplinary Committee pursuant to G.S. 131E-159, will grant an individual’s request to restore her or his credential(s). This rule will provide standardized criteria otherwise unavailable to the individual and OEMS staff.

Historically, OEMS staff have attempted to provide assistance to individuals having been subject to enforcement action against a credential on a case-by-case basis. However, this approach is better served by establishing a standardized set of criteria that 1) clearly defines the processes necessary to restore or regain a credential, 2) has been properly vetted and subject to rulemaking authority pursuant to G.S. 150B, and 3) has been codified in rule rather than risking, no matter how well intentioned staff may be in desiring to assist these individuals, an arbitrary and capricious approach to assisting these individuals. Additionally, by utilizing this approach, individuals who are not eligible to restore or regain their credentials because of the seriousness of the circumstances surrounding the action will not expend unnecessary time and effort only to find themselves disqualified or ineligible when seeking resolution.

For OEMS staff attempting to assist these individuals, as well as the individuals themselves that do qualify for restoring or regaining his or her credential, the processes involved should be much more efficient and effective than the current method utilized by the agency. Not knowing the number of individuals or the circumstances surrounding their specific situations, OEMS staff are unable to estimate any impacts associated with this rule change.

Impact

Unable to determine

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 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 to the citizens of North Carolina, expand opportunities for growth for EMS personnel, and provide additional opportunities for entities regulated by these rules to provide services otherwise prohibited under the current standards.

## **Developmental Steps Taken in Creating the Final Draft of the 10A NCAC 13P Rules**

Prior to finalizing a preliminary draft of these rules for the Medical Care Commission (MCC), the Office of Emergency Medical Services (OEMS) approached the EMS Advisory Council (EMSAC) at the November 12, 2013,<sup>8</sup> meeting and asked that a task force be appointed that would assist in pre-vetting the preliminary draft rules to the public and stakeholders. This request was granted and a group of five council members and three at-large representatives were selected by the council chair to conduct a series of public meetings across the state to receive guidance and support for the proposed revisions. Also, following this meeting, OEMS published on its web site the draft of rules to be discussed during the pre-vetting during these public meetings.

At the May 13, 2014, EMSAC meeting, task force chair Bob Bailey provided the results of these meetings.<sup>9</sup> During the meeting, Mr. Bailey presented a final draft that would be used to ask the MCC to initiate rulemaking, and that OEMS staff would share with the legal counsel of the Rules Review Commission (RCC) to ensure any technical changes or potential objection could be addressed prior to formal rulemaking. After receiving the recommendations from RCC staff and making their recommended changes, the version of the rules used in preparation of this fiscal note that have been reviewed by the Department needed additional review by the EMSAC. As a means of vetting the last version before initiating rulemaking, this final draft was presented to the EMSAC at the November 10, 2015, meeting seeking comments and a final endorsement was provided at the February 9, 2016 meeting.

Additionally, in complying with G.S. 150B-21.3A, rules being readopted with substantive changes are included with rules being amended, repealed and adopted. These 29 rules were determined as “necessary with substantive public interest” and therefore are being readopted. The MCC, Rule Review Commission and the Joint Legislative Procedure Oversight Committee approved the subchapter report with classifications for the 10A NCAC 13P rules on May 15, 2015, January 21, 2016, and February 2, 2016 respectively. This final version of the rules represent a combination of the proposed rule changes as detailed above and rules progressing through the Periodic Review process.

This final version of the rules will be presented to the MCC on May 20, 2016, and are included as an attachment to this fiscal note. The minutes of the November 2015, February 2016, and May 2016 EMSAC meetings will be available online once posted at <https://www2.ncdhhs.gov/dhsr/EMS/advcouns.htm#minutes>.

Throughout this fiscal note, input received during the public meetings from the public, EMS stakeholders and agencies and professional organizations are reflected as the basis for stating that OEMS has attempted in good faith to make every effort to determine any cost that will be incurred by any regulated entity and every financial, operational, or programmatic benefit that will result from revising these rules. There are times that in the best professional judgment and with our best efforts, the ability to reflect the impact, either positive or negative, was found to be outside any reasonable method without delaying this project with no resolution to be found. In these instances, a note will be provided that states reflects these efforts and in no way is intended to withhold information that must be provided in order to proceed with rulemaking.

## **APPENDIX B**

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<sup>8</sup> North Carolina EMSAC, November, 13, 2013 Minutes, <http://www.ncdhhs.gov/dhsr/EMS/pdf/advc/advmin131112.pdf>

<sup>9</sup> North Carolina EMSAC, May 13, 2014 Minutes, <http://www.ncdhhs.gov/dhsr/EMS/pdf/advc/advmin140513.pdf>

**GENERAL ASSEMBLY OF NORTH CAROLINA  
SESSION 2015**

**SESSION LAW 2015-290  
HOUSE BILL 327**

AN ACT TO MAKE TECHNICAL AND CONFORMING CHANGES TO THE STATUTES GOVERNING THE REGULATION OF EMERGENCY MEDICAL SERVICES TO REFLECT NEW NATIONAL STANDARDS FOR EMERGENCY MEDICAL PERSONNEL.

The General Assembly of North Carolina enacts:

**SECTION 1.** G.S. 131E-155 reads as rewritten:

**"§ 131E-155. Definitions.**

As used in this Article, unless otherwise specified:

- (1) "Ambulance" means any privately or publicly owned motor vehicle, aircraft, or vessel that is specially designed, constructed, or modified and equipped and is intended to be used for and is maintained or operated for the transportation of patients on the streets or highways, waterways or airways of this State.
- (2) Repealed by Session Laws 1997-443, s. 11A.129C.
- (3) Redesignated as subdivision (13a).
- (4) "Commission" means the North Carolina Medical Care Commission.
- (5) "Emergency medical dispatcher" means an emergency telecommunicator who has completed an educational program approved by the Department and has been credentialed as an emergency medical dispatcher by the Department.
- (6) "Emergency medical services" means services rendered by emergency medical services personnel in responding to improve the health and wellness of the community and to address the individual's need for emergency medical care within the scope of practice as defined by the North Carolina Medical Board in accordance with G.S. 143-514 in order to prevent loss of life or further aggravation of physiological or psychological illness or injury.
- (6a) "Emergency medical services instructor" means an individual who has completed educational requirements approved by the Department and has been credentialed as an emergency medical services instructor by the Department.

- (6b) "Emergency Medical Services Peer Review Committee" means a panel composed of EMS program representatives to be responsible for analyzing patient care data and outcome measures to evaluate the ongoing quality of patient care, system performance, and medical direction within the EMS system. The committee membership shall include physicians, nurses, EMS personnel, medical facility personnel, and county government officials. Review of medical records by the EMS Peer Review Committee is confidential and protected under G.S. 143-518. An EMS Peer Review Committee, its members, proceedings, records and materials produced, and materials considered shall be afforded the same protections afforded Medical Review Committees, their members, proceedings, records, and materials under G.S. 131E-95.
- (7) "Emergency medical services personnel" means all the personnel defined in subdivisions (5), (6a), (8), (9), (10), (12), (13), (14), and (15) of this section.
- (8) "Emergency medical services-nurse practitioner" means a registered nurse who is licensed to practice nursing in North Carolina and approved to perform medical acts by the North Carolina Medical Board and the North Carolina Board of Nursing. Upon successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, emergency medical services-nurse practitioners shall be approved by the medical director to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.
- (9) "Emergency medical services-physician assistant" means a physician assistant who is licensed by the North Carolina Medical Board. Upon successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, emergency medical services-physician assistants shall be approved by the medical director to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.
- (10) "Emergency medical technician" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an emergency medical technician by the Department.
- (11) Repealed by Session Laws 2003-392, s. 2(a), effective August 7, 2003.
- (12) ~~"Emergency medical technician intermediate"~~ Advanced emergency medical technician means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as an ~~emergency medical technician intermediate~~ advanced emergency medical technician by the Department.

- (13) ~~"Emergency medical technician-paramedic"~~ "Paramedic" means an individual who has completed an educational program in emergency medical care approved by the Department and has been credentialed as ~~an emergency medical technician-paramedic~~ a paramedic by the Department.
- (13a) "EMS provider" means a firm, corporation or association which engages in or professes to provide emergency medical services.
- (14) ~~"Medical responder"~~ "Emergency medical responder" means an individual who has completed an educational program in emergency medical care and first aid approved by the Department and has been credentialed as ~~a~~ an emergency medical responder by the Department.
- (15) "Mobile intensive care nurse" means a registered nurse who is licensed to practice nursing in North Carolina and is approved by the medical director, following successful completion of an orientation program conducted under the authority of the medical director and approved by the Department, to issue instructions to EMS personnel. These instructions shall be in accordance with protocols approved by the EMS system and Office of Emergency Medical Services and under the direction of the medical director.
- (16) "Patient" means an individual who is sick, injured, wounded, or otherwise incapacitated or helpless such that the need for some medical assistance might be anticipated.
- (17) "Practical examination" means a test where an applicant for credentialing as an emergency medical technician, emergency medical responder, emergency medical technician-intermediate, or emergency medical technician-paramedic ~~advanced emergency medical technician, or paramedic~~ demonstrates the ability to perform specified emergency medical care skills."

**SECTION 2.** G.S. 131E-158 reads as rewritten:

**"§ 131E-158. Credentialed personnel required.**

(a) Every ambulance when transporting a patient shall be occupied at a minimum by all of the following:

- (1) At least one emergency medical technician who shall be responsible for the medical aspects of the mission prior to arrival at the medical facility, assuming no other individual with higher credentials is available.
- (2) One emergency medical responder who is responsible for the operation of the vehicle and rendering assistance to the emergency medical technician.

An ambulance owned and operated by a licensed health care facility that is used solely to transport sick or infirm patients with known nonemergency medical conditions between facilities or between a residence and a facility for scheduled medical appointments is exempt from the requirements of this subsection.

(b) The Commission shall adopt rules setting forth exemptions to the requirements stated in (a) of this section applicable to situations where exemptions are considered by the Commission to be in the public interest."

**SECTION 3.** G.S. 131E-159 reads as rewritten:

**"§ 131E-159. Credentialing requirements.**

(a) Individuals seeking credentials as an emergency medical technician, ~~emergency medical technician intermediate, emergency medical technician paramedic, advanced~~ emergency medical technician, paramedic, emergency medical responder, emergency medical dispatcher, or emergency medical services instructor shall apply to the Department using forms prescribed by that agency. The Department's representatives shall examine the applicant by either written, practical, or written and practical examination. The Department shall issue appropriate credentials to the applicant who meets all the requirements set forth in this Article and the rules adopted for this Article and who successfully completes the examinations required for credentialing. ~~Emergency medical technician, emergency medical responder, emergency medical dispatcher, emergency medical technician intermediate, emergency medical technician paramedic~~ advanced emergency medical technician, paramedic, and emergency medical services instructor credentials shall be valid for a period not to exceed four years and may be renewed if the holder meets the requirements set forth in the rules of the Commission. The Department is authorized to revoke or suspend these credentials at any time it determines that the holder no longer meets the qualifications prescribed.

(b) The Commission shall adopt rules setting forth the qualifications required for credentialing of emergency medical responders, emergency medical technicians, emergency medical technicians intermediates, emergency medical technician paramedics, advanced emergency medical technicians, paramedics, emergency medical dispatchers, and emergency medical services instructors.

(c) Individuals currently credentialed as an emergency medical technician, ~~emergency medical technician intermediate, emergency medical technician paramedic, advanced~~ emergency medical technician, paramedic, emergency medical responder, and emergency medical services instructor by the National Registry of Emergency Medical Technicians or by another state where the education/credentialing requirements have been approved for legal recognition by the Department of Health and Human Services, in accordance with rules promulgated by the Medical Care Commission, and who is either currently residing in North Carolina or affiliated with a permitted EMS provider offering service within North Carolina, may be eligible for credentialing as an emergency medical technician, ~~emergency medical technician intermediate, emergency medical technician paramedic,~~ advanced emergency medical technician, paramedic, emergency medical responder, and emergency medical services instructor without examination. This credentialing shall be valid for a period not to exceed the length of the applicant's original credentialing or four years, whichever is less.

...

(f) The Department may deny, suspend, amend, or revoke the credentials of ~~a~~ an ~~emergency medical responder, emergency medical technician, emergency medical technician intermediate, emergency medical technician paramedic, advanced emergency medical technician, paramedic, emergency medical dispatcher, or emergency medical services instructor~~ in any case in which the Department finds that there has been a substantial failure to comply with the provisions of this Article or the rules issued under this Article. Prior to implementation of any of the above disciplinary actions, the Department shall consider the recommendations of the EMS Disciplinary Committee pursuant to G.S. 143-519. The

Department's decision to deny, suspend, amend, or revoke credentials may be appealed by the applicant or credentialed personnel pursuant to the provisions of Article 3 of Chapter 150B of the General Statutes, the Administrative Procedure Act.

...."

**SECTION 4.** G.S. 14-276.1 reads as rewritten:

**"§ 14-276.1. Impersonation of firemen or emergency medical services personnel.**

It is a Class 3 misdemeanor, for any person, with intent to deceive, to impersonate a fireman or any emergency medical services personnel, whether paid or voluntary, by a false statement, display of insignia, emblem, or other identification on his person or property, or any other act, which indicates a false status of affiliation, membership, or level of training or proficiency, if:

- (1) The impersonation is made with intent to impede the performance of the duties of a fireman or any emergency medical services personnel, or
- (2) Any person reasonably relies on the impersonation and as a result suffers injury to person or property.

For purposes of this section, emergency medical services personnel means ~~a~~an emergency medical responder, emergency medical technician, ~~emergency medical technician intermediates, emergency medical technician paramedics, advanced emergency medical technician, paramedic,~~ or other member of a rescue squad or other emergency medical organization."

**SECTION 5.** The North Carolina Medical Care Commission shall amend its applicable rules consistent with this act no later than December 31, 2015.

**SECTION 6.** This act is effective when it becomes law.

In the General Assembly read three times and ratified this the 29<sup>th</sup> day of September, 2015.

s/ Philip E. Berger  
President of the Senate

s/ Tim Moore  
Speaker of the House of Representatives

s/ Pat McCrory  
Governor

Approved 9:30 a.m. this 29<sup>th</sup> day of October, 2015



*EMS Educational Institution Memorandum*

**MEMORANDUM**

TO: EMS Educational Institutions  
OEMS Staff

FROM: Regina Godette-Crawford, Chief  
NC Office of EMS

SUBJECT: Amending Educational Curricula to adopt the 2009 National EMS Education Standards

DATE: October 1, 2012

This notice is intended to clarify acceptable EMS education programs which qualify individuals for obtaining and renewing EMS credentials in North Carolina. As defined in the Rules of the North Carolina Medical Care Commission [10A NCAC 13P .0501], EMS educational programs intended to credential or renew an EMS credential must follow US Department of Transportation (USDOT), Highway Traffic Safety Administration (NHTSA) National Standard Curricula specific for the individual's level of application. This requirement specifies "these documents are incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions."

Based on the authority defined in this rule, the Office of Emergency Medical Services (OEMS) is accepting educational programs based on the most current USDOT/NHTSA "National Emergency Medical Services Education Standards," dated January 2009.

EMS Educational Programs will still be accepted to qualify individuals to obtain or renew their NC EMS credential using the previous standards during the process of revising the rules to reflect the new standards. All Approved EMS Educational Institutions must contact their respective Regional EMS Office for specific information on transitioning from the previous standards to the January 2009 edition.

As regards the names associated with each credentialing level, the January 2009 standards have modified the names of each credentialing level. North Carolina cannot adopt this terminology until the statutes and associated rules have been revised. Therefore, the OEMS will accept the educational programs as follows:

- National Emergency Medical Responder will qualify for NC Medical Responder
- National Emergency Medical Technician will qualify for NC Emergency Medical Technician
- National Advanced EMT will qualify for NC EMT Intermediate
- National Paramedic will qualify for NC EMT Paramedic

Once the statutes and associated rules have been revised, the NC credentialing names will align with the National levels. However, the scope of practice for each level will still be determined by the NC Medical Board in accordance with G.S. § 143-514, and may or may not align with the National Standards.

# ACS Compendium of Changes

# Appendix D

## Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III, IV		The individual trauma centers and their health care providers are essential system resources that must be active and engaged participants (CD 1-1).
I, II, III, IV		They must function in a way that pushes trauma center-based standardization, integration, and PIPS out to the region while engaging in inclusive trauma system planning and development (CD 1-2)
I, II, III, IV	1-1 All trauma centers must participate in the state and/or regional trauma system planning, development, or operation.	Meaningful involvement in state and regional trauma system planning, development, and operation is essential for all designated trauma centers and participating acute care facilities within a region (CD 1-3)
I, II, III, IV		This trauma center must have an integrated, concurrent performance improvement and patient safety (PIPS) program to ensure optimal care and continuous improvement in care (CD 2-1).
I, II, III	2-1 Surgical commitment is essential for a properly functioning trauma center.	Surgical commitment is essential for a properly functioning trauma center (CD 2-2).
I, II, III, IV	2-2 Trauma centers must be able to provide on their campus the necessary human and physical resources to properly administer acute care consistent with their level of verification.	Trauma centers must be able to provide the necessary human and physical resources (physical plant and equipment) to properly administer acute care consistent with their level of verification (CD 2-3).
I	2-3 A Level I trauma center must meet admission volume performance requirements (one of the following): a) Admit at least 1200 trauma patients yearly, b) 240 admissions with an Injury Severity Score (ISS) of more than 15, c) An average of 35 patients with an ISS of more than 15 for the trauma panel surgeons (general surgeons who take trauma all).	A Level I trauma center must admit at least 1,200 trauma patients yearly or have 240 admissions with an Injury Severity Score of more than 15. (CD 2-4).
I, II, III	2-4 The trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review.	[Level I] Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2-5).
		[Level II] Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2-5).
		[Level III] Through the trauma PIPS program and hospital policy, the trauma director must have responsibility and authority for determining each general surgeon's ability to participate on the trauma panel based on an annual review (CD 2-5).

## Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I	2-5 General surgeon or appropriate substitute (postgraduate-year 4 or 5 resident) must be in house 24 hours a day for major resuscitations (must be present and participate in major resuscitations, therapeutic decisions, and operations).	[Level I] A resident in postgraduate year 4 or 5 or an attending emergency physician who is part of the trauma team may be approved to begin resuscitation while awaiting the arrival of the attending surgeon but cannot independently fulfill the responsibilities of, or substitute for, the attending surgeon (CD 2-6).
I		[Level I] Qualified attending surgeons must participate in major therapeutic decisions, be present in the emergency department for major resuscitations, be present at operative procedures, and be actively involved in the critical care of all seriously injured patients (CD 2-6).

II		[Level II] A resident in postgraduate year 4 or 5 or an attending emergency physician who is part of the trauma team may be approved to begin resuscitation while awaiting the arrival of the attending surgeon but cannot independently fulfill the responsibilities of, or substitute for, the attending surgeon (CD 2–6).
II		[Level II] Qualified attending surgeons must participate in major therapeutic decisions, be present in the emergency department for major resuscitations, be present at operative procedures, and be actively involved in the critical care of all seriously injured patients (CD 2–6).
I, II	2-6 The PIPS program must define the conditions requiring the attending surgeon’s immediate hospital presence.	The presence of such a resident or attending emergency physician may allow the attending surgeon to take call from outside the hospital. In this case, local criteria and a PIPS program must be established to define conditions requiring the attending surgeon’s immediate hospital presence (CD 2–7).
I, II, III	2-7 It is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is <b>15 minutes for Level I and II</b> trauma centers and <b>30 minutes for Level III</b> trauma centers, tracked from patient arrival. The program must demonstrate that the surgeon’s presence is in compliance at least 80% of the time. Demonstration of the attending surgeon’s prompt arrival for patients with appropriate activation criteria must be monitored by the hospital’s trauma PIPS program.	For Level I trauma centers, it is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 15 minutes for the highest-level activation tracked from patient arrival. The minimum criteria for full trauma team activation are provided in Table 2 in Chapter 5. The program must demonstrate that the surgeon’s presence is in compliance at least 80 percent of the time (CD 2–8).
		For Level II trauma centers, it is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 15 minutes for the highest level of activation tracked from patient arrival. The minimum criteria for full trauma team activation are provided in Table 2 in Chapter 5. The program must demonstrate that the surgeon’s presence is in compliance at least 80 percent of the time (CD 2–8).

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
		For Level III trauma centers, it is expected that the surgeon will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation, tracked from patient arrival. The PIPS program must demonstrate that the surgeon’s presence is in compliance at least 80 percent of the time (CD 2–8).
IV		For Level IV trauma centers, it is expected that the physician or midlevel provider will be in the emergency department on patient arrival, with adequate notification from the field. The maximum acceptable response time is 30 minutes for the highest level of activation, tracked from patient arrival. The PIPS program must demonstrate that the physician’s presence is in compliance at least 80 percent of the time (CD 2–8).
I		[Level I] The attending surgeon’s immediate (within 15 minutes) arrival for patients with appropriate activation criteria must be monitored by the hospital’s trauma PIPS program (CD 2–9).
II		[Level II] Compliance with this requirement and applicable criteria must be monitored by the hospital’s PIPS program (CD 2–9).
I, II	2-8 The trauma surgeon on call must be dedicated to the trauma center while on duty.	[Level I] The trauma surgeon on call must be dedicated to a single trauma center while on duty (CD 2–10).

		[Level II] The trauma surgeon on call must be dedicated to a single trauma center while on duty (CD 2–10)
I, II	2-9 A published backup call schedule for trauma surgery must be available.	[Level I] In addition, a published backup call schedule for trauma surgery must be available (CD 2–11).
		[Level II] In addition, a published backup call schedule for trauma surgery must be available (CD 2–11).
III	2-10 A Level III trauma center must have continuous general surgical coverage.	A Level III trauma center must have continuous general surgical coverage (CD 2–12).
III	2-11 Trauma panel surgeons must respond promptly to activations, remain knowledgeable in trauma care principles, whether treating patients locally or transferring them to a center with more resources, and participate in performance review activities.	
III, IV	2-12 Well-defined transfer plans are essential (approved by the TMD and monitored by the PIPS program) that define appropriate patients for transfer and retention.	[Level III] Well-defined transfer plans are essential (CD 2–13).
		[Level IV] Well-defined transfer plans are essential (CD 2–13).

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
IV		Collaborative treatment and transfer guidelines reflecting the Level IV facilities' capabilities must be developed and regularly reviewed, with input from higher-level trauma centers in the region (CD 2–13).
IV	2-13 A Level III and IV facilities must have 24-hour emergency coverage by a physician.	A Level IV facility must have 24-hour emergency coverage by a physician or midlevel provider (CD 2–14).
IV		The emergency department at Level IV centers must be continuously available for resuscitation with coverage by a registered nurse and physician or midlevel provider, and it must have a physician director (CD 2–15).
IV		[Level IV] These providers must maintain current Advanced Trauma Life Support® certification as part of their competencies in trauma (CD 2–16).
I, II, III, IV		For Level I, II, III and IV trauma centers a trauma medical director and trauma program manager knowledgeable and involved in trauma care must work together with guidance from the trauma peer review committee to identify events, develop corrective action plans, and ensure methods of monitoring, reevaluation, and benchmarking. (CD 2-17).
I, II, III, IV		Level I, II, III and IV trauma centers the multidisciplinary trauma peer review committee must meet regularly, with required attendance of medical staff active in trauma resuscitation, to review systemic and care provider issues, as well as propose improvements to the care of the injured (CD 2–18).
I, II, III, IV		Level I, II, III and IV trauma centers a PIPS program must have audit filters to review and improve pediatric and adult patient care (CD 2–19).
IV		Because of the greater need for collaboration with receiving trauma centers, the Level IV trauma center must also actively participate in regional and statewide trauma system meetings and committees that provide oversight (CD 2–20).
IV		The Level IV trauma center must also be the local trauma authority and assume the responsibility for providing training for prehospital and hospital-based providers (CD 2–21).
I, II, III, IV		For Level I, II, III and IV trauma centers the facility must participate in regional disaster management plans and exercises (CD 2–22).

I, II, III	2-14 and 2-15 Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children: Trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body, there must be a pediatric emergency department area, pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program.	Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating their capability to care for injured children: Trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body (CD 2–23).
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#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III	2-15, See CD 2-14	There must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program (CD 2–24).
I, II, III	2-16 For adult trauma centers admitting fewer than 100 injured children younger than 15 years, these resources are desirable. These hospitals must, however, review the care of their injured children through their PIPS program.	For adult trauma centers annually admitting fewer than 100 injured children younger than 15 years, these resources are desirable. These hospitals, however, must review the care of their injured children through their PIPS program (CD 2–25).
I, II, III	3-1 The trauma director is involved in the development of the trauma center's bypass protocol.	The trauma director must be involved in the development of the trauma center's bypass (diversion) protocol (CD 3–4).
I, II, III	3-2 The trauma surgeon is involved in the decisions regarding bypass. The surgeons should be actively involved in prehospital personnel training, the PIPS process, and development of trauma components of EMS.	The trauma surgeon must be involved in the decision regarding bypass (diversion) each time the center goes on bypass (CD 3–5).
I, II, III, IV		The protocols that guide prehospital trauma care must be established by the trauma health care team, including surgeons, emergency physicians, medical directors for EMS agencies, and basic and advanced prehospital personnel (CD 3–2).
I, II, III		Rigorous multidisciplinary performance improvement is essential to evaluate overtriage and undertriage rates to attain the optimal goal of less than 5 percent undertriage (CD 3–3).
I, II, III, IV	3-3 The trauma program must participate in the development and improvement of pre-hospital care protocols and patient safety programs.	The trauma program must participate in the training of prehospital personnel, the development and improvement of prehospital care protocols, and performance improvement and patient safety programs (CD 3–1).
I, II, III	3-4 The facility can not exceed the maximum divert time of 5%	The trauma center must not be on bypass (diversion) more than 5 percent of the time (CD 3–6).
I, II, III, IV		When a trauma center is required to go on bypass or to divert, the center must have a system to notify dispatch and EMS agencies (CD 3–7). The center must do the following: <ul style="list-style-type: none"> <li>• Prearrange alternative destinations with transfer agreements in place</li> <li>• Notify other centers of divert or advisory status</li> <li>• Maintain a divert log</li> <li>• Subject all divers and advisories to performance improvement procedures</li> </ul>
I, II, III, IV	4-1 A mechanism for direct physician to physician contact is present for arranging patient transfers.	Direct physician-to-physician contact is essential (CD 4–1).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III	4-2 The decision to transfer an injured patient to a specialty care facility in an acute situation is based solely on the needs of the patient; for example, payment method is not considered.	The decision to transfer an injured patient to a specialty care facility in an acute situation must be based solely on the needs of the patient and not on the requirements of the patient's specific provider network (for example, a health maintenance organization or a preferred provider organization) or the patient's ability to pay (CD 4–2).

I, II, III, IV		A very important aspect of interhospital transfer is an effective PIPS program that includes evaluating transport activities (CD 4–3).
I, II, III, IV		Perform a PIPS review of all transfers (CD 4–3).
I, II, III, IV	5-1 The hospital has the commitment of the institutional governing body and the medical staff to become a trauma center.	A decision by a hospital to become a trauma center requires the commitment of the institutional governing body and the medical staff (CD 5–1).
I, II, III, IV		Documentation of administrative commitment is required from the governing body and the medical staff (CD 5–1)
I, II, III	5-2 [Administrative] There is a current resolution (reaffirmed every three years) supporting the trauma center from the hospital board.	This support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–2).
I, II, III	5-3 [Medical Staff] There is a current resolution (reaffirmed every three years) supporting the trauma center from the medical staff.	The support must be reaffirmed continually (every 3 years) and must be current at the time of verification (CD 5–3).
I, II, III		The trauma program must involve multiple disciplines and transcend normal departmental hierarchies (CD 5–4).
I, II, III	5-4 The multidisciplinary trauma program continuously evaluates its processes and outcomes to ensure optimal and timely care.	
I, II, III	5-5 The trauma medical director is either a board-certified surgeon or an ACS Fellow.	The TMD must be a current board-certified general surgeon (or a general surgeon eligible for certification by the American Board of Surgery according to current requirements) or a general surgeon who is an American College of Surgeons Fellow with a special interest in trauma care and must participate in trauma call (CD 5-5).
I, II, III	5-6 The trauma medical director participates in trauma call.	merged with CD 5-5
I, II, III	5-7 The trauma medical director is current in Advanced Trauma Life Support.	The TMD must be current in Advanced Trauma Life Support® (ATLS®) (CD 5–6).
		The TMD must maintain an appropriate level of trauma-related extramural continuing medical education (16 hours annually, or 48 hours in 3 years) (CD 5–7)
I, II	5-8 The trauma director is a member and an active participant in national or regional trauma organizations.	Membership and active participation in regional or national trauma organizations are essential for the trauma director in Level I and II trauma centers and are desirable for TMDs in Level III and IV facilities (CD 5–8).
I, II, III	5-9 The trauma director has the authority to correct deficiencies in trauma care or exclude from trauma call the trauma team members who do not meet specified criteria.	The TMD, in collaboration with the TPM, must have the authority to correct deficiencies in trauma care and exclude from trauma call the trauma team members who do not meet specified criteria(CD 5-11).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III		The TMD must have the authority to manage all aspects of trauma care (CD 5–9).
I, II, III		The TMD must chair and attend a minimum of 50% of the multidisciplinary trauma peer review committee meetings. (CD 5-10)
I, II, III		In addition, the TMD must perform an annual assessment of the trauma panel providers in the form of Ongoing Professional Practice Evaluation (OPPE) and Focused Professional Practice Evaluation (FPPE) when indicated by findings of the PIPS process (CD 5-11).
I, II, III		The TMD must have the responsibility and authority to ensure compliance with the above requirements and cannot direct more than one trauma center (CD 5-12).
I, II, III, IV	5-10 The criteria for a graded activation are clearly defined by the trauma center and continuously evaluated by the PIPS program. SEE FAQ	The criteria for a graded activation must be clearly defined by the trauma center, with the highest level of activation including the six required criteria listed in Table 2 (CD 5–13).

I, II, III, IV		Other potential criteria for trauma team activation that have been determined by the trauma program to be included in the various levels of trauma activation must be evaluated on an ongoing basis in the PIPS process (CD 5-16) to determine their positive predictive value in identifying patients who require the resources of the full trauma team.
I, II		In Level I and II trauma centers, the highest level of activation requires the response of the full trauma team within 15 minutes of arrival of the patient, and the criteria should include physiologic criteria and some or several of the anatomic criteria (CD 5-14)
III, IV		In Level III and IV trauma centers the team must be fully assembled within 30 minutes (CD 5-15).
I, II, III		The emergency physician may initially evaluate the limited-tier trauma patient, but the center must have a clearly defined response expectation for the trauma surgical evaluation of those patients requiring admission (CD 5-16).
I, II, III	5-11 Programs that admit more than 10% of injured patients to nonsurgical services have demonstrated the appropriateness of that practice through the PIPS process. <b>SEE FAQ</b>	Programs that admit more than 10% of injured patients to non-surgical services must review all non-surgical admissions through the trauma PIPS process (CD 5-18).
I, II	5-12 Seriously injured patients are admitted or evaluated by an identifiable surgical service staffed by credentialed providers.	In a Level I or II trauma center, seriously injured patients must be admitted to, or evaluated by, an identifiable surgical service staffed by credentialed trauma providers (CD 5-17).
I, II	5-13 There is sufficient infrastructure and support to the trauma service to ensure adequate provision of care.	[Level I and II] Sufficient infrastructure and support to ensure adequate provision of care must be provided for this service (CD 5-19).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II	5-14 In teaching facilities, the requirements of the Residency Review Committee are met.	[Level I and II] In teaching facilities, the requirements of the residency review committees also must be met (CD 5-20).
III	5-15 The structure of the trauma program allows the trauma director to have oversight authority for the care of injured patients who may be admitted to individual surgeons.	In Level III centers, injured patients may be admitted to individual surgeons, but the structure of the program must allow the trauma director to have oversight authority for the care of these patients. (CD 5-17)
III	5-16 There is a method to identify injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners.	[Level III] There must be a method to identify the injured patients, monitor the provision of health care services, make periodic rounds, and hold formal and informal discussions with individual practitioners (CD 5-21).
I, II, III		[Level I, II & III, TPM] In addition to administrative ability, the TPM must show evidence of educational preparation and clinical experience in the care of injured patients (CD 5-22).
I, II		In Level I and II trauma centers, the TPM must be full-time and dedicated to the trauma program (CD 5-23).
I, II	5-17 The trauma program manager shows evidence of educational preparation (a minimum of 16 hours of trauma-related continuing education per year) and clinical experience in the care of injured patients.	[Level I and II] The TPM must show evidence of educational preparation, with a minimum of 16 hours (internal or external) of trauma-related continuing education per year and clinical experience in the care of injured patients (CD 5-24).
I, II, III	5-18 There is a multidisciplinary peer review committee chaired by the trauma medical director or designee, with representatives from appropriate subspecialty services.	The trauma center's PIPS program must have a multidisciplinary trauma peer review committee chaired by the TMD (CD 5-25).
I, II, III	5-19 Adequate (>50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.	
I, II, III	5-20 The core group is adequately defined by the trauma medical director.	
I, II, III	5-21 The core group takes at least 60% of the total trauma call hours each month.	

I, II, III	5-22 The trauma medical director ensures and documents dissemination of information and findings from the peer review meetings to the non-core surgeons on the trauma call panel.	
I, II, III	5-23 There must be a Trauma Program Operational Process Performance Improvement Committee.	
I, II, III	6-1 The trauma medical director has responsibility and authority to ensure compliance with verification requirements.	
I, II, III		General surgeons caring for trauma patients must meet certain requirements, as described herein (CD-6-1). These requirements may be considered to be in four categories: current board certification, clinical involvement, performance improvement and patient safety, and education.

**Compendium of Changes**

<b>Key: Resources 2006 Green Book Criteria (no compatible CD in the Orange)</b>		<b>Resources 2014 Orange Book Criteria</b>
I, II, III	6-2 The general surgeon must be board-certified or meet the Alternate Pathway or is an ACS fellow.	Board certification or eligible for certification by the American Board of Surgery according to current requirements or the alternate pathway is essential for general surgeons who take trauma call in Level I, II, and III trauma centers (CD 6-2).
I, II, III		Alternate Criteria (CD 6-3) for non-Board-Certified Surgeons in a Level I, II, or III Trauma Centers.
I, II, III	6-3 The trauma surgeon must have privileges in general surgery.	Trauma surgeons must have privileges in general surgery (CD 6-4).
I, II	6-4 The trauma surgeon on call must be dedicated to the trauma service while on duty.	In Level I and II trauma centers, the trauma surgeon on call must be dedicated to a single trauma center while on duty (CD 6-5).
I, II	6-5 A published back-up call schedule for trauma surgery must be available.	[Level I and II] In addition, a published backup call schedule for trauma surgery must be available (CD 6-6).
I, II, III, IV	6-6 An attendance threshold of 80% must be met for trauma surgeon presence in the emergency department.	For Level I and II trauma centers, the maximum acceptable response time is 15 minutes; for Level III and IV trauma centers, the maximum acceptable response time is 30 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80 percent attendance threshold must be met for the highest-level activations (CD 2-8).
I, II, III	6-7 The criteria for the highest level of activations are clearly defined and evaluated by the PIPS program. <b>SEE FAQ</b>	
I, II, III	6-8 A mechanism for documenting trauma surgeon presence in the operating room for all trauma operations is in place.	For Level I, II, and III trauma centers, the attending surgeon is expected to be present in the operating room for all operations. A mechanism for documenting this presence is essential (CD 6-7).
I, II, III	6-9 There is a multidisciplinary peer review committee with participation from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia.	In Level I, II, and III trauma centers, there must be a multidisciplinary trauma peer review committee chaired by the trauma medical director (CD 5-25) and representatives from general surgery (CD 6-8), and liaisons from orthopaedic surgery (CD 9-16), emergency medicine (CD 7-11), ICU (CD 11-62), and anesthesia (CD 11-13) - and for Level I and II trauma centers, neurosurgery (CD 8-13) and radiology (CD 11-39).
I, II, III	6-10 Adequate (>50%) attendance by general surgery (core group) at the multidisciplinary peer review committee is documented.	Each member of the group of general surgeons must attend at least 50 percent of the multidisciplinary trauma peer review committee meetings (CD 6-8).
I, II, III	6-11 All general surgeons on the trauma team have successfully completed the ATLS® course at least once.	All general surgeons on the trauma team must have successfully completed the Advanced Trauma Life Support® (ATLS®) course at least once (CD 6-9).
I, II	6-12 The trauma medical director has documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.	The trauma medical director must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME (CD 5-7).

**Compendium of Changes**

<b>Key: Resources 2006 Green Book Criteria (no compatible CD in the Orange)</b>		<b>Resources 2014 Orange Book Criteria</b>
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I, II	6-13 Other trauma surgeons who take trauma call have documented 16 hours annually or 48 hours in the past 3 years of trauma-related CME or an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	In Level I and II trauma centers, this requirement must be met by the acquisition of 16 hours of CME per year on average or by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the performance improvement and patient safety program (CD 6–10).
I, II	6-14 The trauma medical director is a member of and participates in regional or national trauma organizations.	
I, II, III	7-1 The emergency department has a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients.	The emergency departments of Level I, II, and III trauma centers must have a designated emergency physician director supported by an appropriate number of additional physicians to ensure immediate care for injured patients (CD 7–1).
I, II	7-2 Emergency department physicians must be present in the emergency department at all times.	An emergency physician must be present in the department at all times in a Level I and Level II trauma centers (CD 7–2).
III	7-3 Emergency physicians cover in-house emergencies with a PIPS process demonstrating the efficacy of this practice.	Occasionally, in a Level III trauma center, it is necessary for the physician to leave the emergency department for short periods to address in-house emergencies. Such cases and their frequency must be reviewed by the performance improvement and patient safety (PIPS) program to ensure that this practice does not adversely affect the care of patients in the emergency department (CD 7–3).
I, II, III	7-4 In institutions in which there are emergency medicine residency training programs, supervision is provided by an in-house attending emergency physician 24 hours per day.	In institutions in which there are emergency medicine residency training programs, supervision must be provided by an in-house attending emergency physician 24 hours per day (CD 7–4).
I, II, III	7-5 The roles of emergency physicians and trauma surgeons are defined, agreed on, and approved by the director of trauma services.	These roles and responsibilities must be defined, agreed on, and approved by the director of the trauma service (CD 7–5).
I, II, III	7-6 An emergency physician is board-certified or meets the Alternate Pathway.	Board certification or eligibility for certification by the appropriate body according to current requirements or the alternate pathway is essential for physicians staffing the emergency department and caring for trauma patients in Level I, II, and III trauma centers (CD 7–6).
I, II, III		Alternate Criteria (CD 6-3) for Non–Board-Certified Emergency Medicine Physicians in Level I, II, and III Trauma Centers
I, II, III	7-7 Emergency physicians on the call panel are regularly involved in the care of injured patients.	Emergency physicians on the call panel must be regularly involved in the care of injured patients (CD 7–7).
I, II, III	7-8 A representative from the emergency department participates in the pre-hospital PIPS program.	A representative from the emergency department must participate in the prehospital PIPS program (CD 7–8).
I, II, III	7-9 A designated emergency physician is available to the trauma director for PIPS issues that occur in the emergency department.	A designated emergency physician liaison must be available to the trauma director for PIPS issues that occur in the emergency department (CD 7–9).

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III	7-10 There is emergency physician participation with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee (dealing with systems issues).	Emergency physicians must participate actively in the overall trauma PIPS program and the multidisciplinary trauma peer review committee (CD 7–10).
I, II, III	7-11 The emergency medicine representative or designee to the multi-disciplinary peer review committee attends a minimum of 50% of these meetings.	The emergency medicine liaison the multidisciplinary trauma peer review committee must attend a minimum of 50 percent of the committee meetings (CD 7–11).
I, II	7-12 The emergency physician liaison representative has the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME	In Level I and II trauma centers, the liaison representative from emergency medicine must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME (CD 7–12).

I, II	7-13 Other emergency physicians who take trauma call have the documented 16 hours annually or 48 hours in 3 years of trauma-related CME, or participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	Other emergency physicians who participate on the trauma team also must be knowledgeable and current in the care of injured patients. This requirement may be met by documenting the acquisition of 16 hours of trauma-related CME per year on average or by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program (CD 7–13).
I, II, III	7-14 There are emergency physicians who have successfully completed the ATLS® course.	In Level I, II, and III trauma centers, all board-certified emergency physicians or those eligible for certification by an appropriate body according to their current requirements must have successfully completed the ATLS course at least once (CD 7–14).
I, II, III	7-15 The physicians who are not board certified in emergency medicine who work in the emergency department are current in ATLS®.	Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status (CD 7–15).
I, II	8-1 A neurosurgical liaison is designated.	If this surgeon is not the director of the neurosurgery service, a neurologic surgeon liaison must be designated (CD 8–1).
I, II	8-2 Neurotrauma care is promptly and continuously available for severe traumatic brain injury and spinal cord injury and for less severe head and spine injuries when necessary. <b>SEE FAQ</b>	Neurotrauma care must be continuously available for all TBI and spinal cord injury patients and must be present and respond <b>within 30 minutes based on institutional- specific criteria</b> (CD 8–2).
I, II	8-3 The hospital provides an on-call neurosurgical backup schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed.	The trauma center must provide a reliable, published neurotrauma call schedule with formally arranged contingency plans in case the capability of the neurosurgeon, hospital, or system to care for neurotrauma patients is overwhelmed (CD 8–3).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II	8-4 There is a PIPS review of all neurotrauma patients who are diverted or transferred.	The center must have a predefined and thoroughly developed neurotrauma diversion plan that is implemented when the neurosurgeon on call becomes encumbered (CD 8–4). A predefined, thoroughly developed neurotrauma diversion plan must include the following: <ul style="list-style-type: none"> <li>• Emergency medical services notification of neurosurgery advisory status/diversion.</li> <li>• A thorough review of each instance by the performance improvement and patient safety (PIPS) program.</li> <li>• Monitoring of the efficacy of the process by the PIPS program.</li> </ul>
I, II, III		A formal, published contingency plan must be in place for times in which a neurosurgeon is encumbered upon the arrival of a neurotrauma case (CD 8–5). The contingency plan must include the following: <ul style="list-style-type: none"> <li>• A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the neurotrauma patient. <ul style="list-style-type: none"> <li>• Transfer agreements with a similar or higher-level verified trauma center.</li> </ul> </li> <li>• Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.</li> <li>• Monitoring of the efficacy of the process by the PIPS program.</li> </ul>
I, II	8-5 An attending neurosurgeon is promptly available to the hospital's trauma service when neurosurgical consultation is requested.	
I, II, III		If one neurosurgeon covers two centers within the same limited geographic area, there must be a published backup schedule (CD 8-6.)
I, II, III		In addition, the performance improvement process must demonstrate that appropriate and timely care is provided (CD 8–6).

III	8-6 There is a trauma-director approved plan that determines which types and severity of neurologic injury patients should remain at the facility when no neurosurgical coverage is present.	A Level III trauma center must have a plan approved by the trauma medical director that determines which types of neurosurgical injuries may remain and which should be transferred (CD 8–7).
III	8-7 There is a performance improvement program that convincingly demonstrates appropriate care in the facility that treats neurotrauma patients.	In all cases, whether patients are admitted or transferred, the care must be timely, appropriate, and monitored by the PIPS program (CD 8–9).
III	8-8 There are transfer agreements with appropriate Level I and Level II centers.	Transfer agreements must exist with appropriate Level I and Level II trauma centers (CD 8–8).
I, II, III	8-9 The neurosurgeons who care for trauma patients are board-certified or meet the Alternate Pathway.	Board certification or eligibility for certification by the current standard requirements or the alternate pathway is essential for neurosurgeons who take trauma call in Level I, II, or III trauma centers (CD 8–10).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III		Alternate Criteria (CD 6-3) for Non-Board-Certified Neurosurgeons in Level I, II, and III Trauma Centers
I, II	8-10 Qualified neurosurgeons are regularly involved in the care of head - and spinal cord- injured patients and are credentialed by the hospital with general neurosurgical privileges.	Qualified neurosurgeons should be regularly involved in the care of patients with head and spinal cord injuries and must be credentialed by the hospital with general neurosurgical privileges (CD 8–11).
I, II	8-11 The neurosurgery service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.	The neurosurgery service must participate actively in the overall trauma PIPS program (CD 8–12).
I, II	8-12 The neurosurgeon representative attends a minimum of 50% of the multidisciplinary peer review committee meetings.	The neurosurgery liaison on the multidisciplinary trauma peer review committee must attend a minimum of 50 percent of the committee’s meetings (CD 8–13).
III		Level III centers with any emergency neurosurgical cases must also have the participation of neurosurgery on the multidisciplinary trauma peer review committee (8-13)
I, II	8-13 The neurosurgeon liaison representative has documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME.	The liaison representative from neurosurgery must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related CME (CD 8–14)
I, II	8-14 Other neurosurgeons who take trauma call have the documented 16 hours annually or 48 hours in 3 years of verifiable, external trauma-related CME, and participate in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program.	This requirement may be documented by the acquisition of 16 hours of trauma CME per year on average or through an internal educational process (IEP) conducted by the trauma program and the neurosurgical liaison based on the principles of practice- based learning and the PIPS program (CD 8–15).
I, II	9-1 Physical and occupational therapists and rehabilitation specialists are present.	Because of their skills and training in the management of the acute and rehabilitation phases of musculoskeletal trauma, physical and occupational therapists and rehabilitation specialists are essential at Level I and II trauma centers (CD 9–1).
I, II, III	9-2 Operating rooms are promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization and compartment decompression.	Operating rooms must be promptly available to allow for emergency operations on musculoskeletal injuries, such as open fracture debridement and stabilization, external fixator placement, and compartment decompression (CD 9–2).
I, II	9-3 A mechanism to ensure operating room availability without undue delay for patients with semiurgent orthopaedic injuries is present.	In Level I and II trauma centers, a system must be organized so that musculoskeletal trauma cases can be scheduled without undue delay and not at inappropriate hours that might conflict with more urgent surgery or other elective procedures (CD 9–3).
I, II, III	9-4 There is an orthopaedic surgeon who is identified as the liaison to the trauma program.	Level I, II, and III trauma centers must have an orthopaedic surgeon who is identified as the liaison to the trauma program (CD 9–4).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
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I	9-5 Plastic surgery, hand surgery, and spinal injury care capabilities are present at Level I trauma centers.	
I		In a Level I trauma center the orthopaedic care must be overseen by an individual who has completed a fellowship in orthopaedic traumatology approved by the Orthopaedic Trauma Association (OTA) (CD 9-5).
PTC I		In Pediatric Level I trauma centers this requirement may be met by having formal transfer agreements that specify which cases will be transferred for high level orthopaedic oversight and assuring that all such transfers (or potential transfers) are reviewed as part of the performance improvement process (CD 9-5)
I, II	9-6 Orthopaedic team members have dedicated call at their institution and have a backup call system.	[Level I and II] Orthopaedic team members must have dedicated call at their institution or have an effective backup call system (CD 9-6).
I, II	9-7 An orthopaedic team member is promptly available in the trauma resuscitation area when consulted by the surgical trauma team leader for multiply injured patients.	[Level I and II] They must be available in the trauma resuscitation area within 30 minutes after consultation has been requested by the surgical trauma team leader for multiply injured patients (CD 9-7) based on institution-specific criteria.
I, II		[Level I and II] The performance improvement process must ensure that care is timely and appropriate (CD 9-8).
I, II	9-6 If the on-call orthopaedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available.	[Level I and II] If the on-call orthopaedic surgeon is unable to respond promptly, a backup consultant on-call surgeon must be available (CD 9-9).
I, II	9-8 The design of the backup call system, the responsibility of the orthopaedic trauma liaison, has been approved by the trauma program director.	[Level I and II] The design of this system is the responsibility of the orthopaedic trauma liaison but must be approved by the trauma program director (CD 9-10).
I, II	9-9 Level I and II centers provide sufficient resources, including instruments, equipment, and personnel, for modern musculoskeletal trauma care, with readily available operating rooms for musculoskeletal trauma procedures.	[Level I and II] The trauma center must provide all the necessary resources for modern musculoskeletal trauma care, including instruments, equipment, and personnel, along with readily available operating rooms for musculoskeletal trauma procedures (CD 2-3).
<del>II, III</del>	9-10 The PIPS process reviews the appropriateness of the decision to transfer or retain major orthopaedic trauma.	[Level III] The PIPS process must review the appropriateness of the decision to transfer or retain major orthopaedic trauma cases (CD 9-13).
III	9-11 The Level III facility has an orthopaedic surgeon on call and promptly available 24 hours a day.	Level III facilities vary significantly in the staff and resources that they can commit to musculoskeletal trauma care, but they must have an orthopaedic surgeon on call and promptly available 24 hours a day (CD 9-11).
III		[Level III] If the orthopaedic surgeon is not dedicated to a single facility while on call, then a published backup schedule is required (CD 9-12).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II		There must be protocols in Level I and II centers for the following orthopaedic emergencies: 1) the type and severity of pelvic and acetabular fractures that will be treated at the institutions as well as those that will be transferred out for care; 2) the timing and sequence for the treatment of long bone fractures in multiply injured patients; and 3) the wash out time for open fractures. These protocols must be included as part of the PIPS process (CD 9-14).
I, II, III	9-12 The orthopaedic service participates actively with the overall trauma PIPS program and the Trauma Program Operational Process Performance Committee.	The orthopaedic service must participate actively with the overall trauma PIPS program and the multidisciplinary trauma peer review committee (CD 9-15).
I, II, III	9-13 The orthopaedic trauma liaison or representative attends a minimum of 50% of the multidisciplinary peer review meetings.	The orthopaedic liaison to the trauma PIPS program must attend a minimum of 50 percent of the multidisciplinary trauma peer review committee meetings (CD 9-16).

I, II, III	9-14 Orthopaedic surgeons who care for injured patients are board certified or meet the Alternate Pathway.	Board certification or eligibility for certification by the appropriate body according to current standard requirements, or the alternate pathway is essential for orthopaedic surgeons who take trauma call in Level I, II, and III trauma centers (CD 9–17).
I, II, III		Alternate Criteria (CD 6-3) for Non–Board-Certified Orthopaedic Surgeons in a Level I, II, or III Trauma Center
I, II, III	<b>9-15 The orthopaedic surgeon has privileges in general orthopaedic surgery.</b>	
I, II	9-16 The orthopaedic surgical liaison to the trauma program at Level I and Level II centers has documented at least 16 hours annually or 48 hours in years of verifiable, external trauma-related CME.	The orthopaedic surgical liaison to the trauma program at Level I and II centers must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related continuing medical education (CME) (CD 9–18).
I, II	9-17 The orthopaedic trauma team member has documentation of the acquisition of 16 hours of CME per year on average and has participated in an internal educational process conducted by the trauma program and the orthopaedic liaison based on the principles of practice-based learning and the PIPS program.	This requirement may be documented by the acquisition of 16 hours of trauma CME per year on average or through an internal educational process conducted by the trauma program and the orthopaedic liaison based on the principles of practice-based learning and the PIPS program (CD 9–19).
PTC I, II	10-1 Hospitals that pursue verification as pediatric trauma centers must meet the same resource requirements as adult trauma centers, in addition to pediatric resource requirements (Table 1)	Hospitals that pursue verification as pediatric trauma centers must meet the same resource requirements as adult trauma centers, in addition to pediatric resource requirements (CD 2–3) (Table 1)
PTC I	10-2 A Level I pediatric trauma center must annually admit 200 or more injured children younger than 15 years.	A Level I pediatric trauma center must annually admit 200 or more injured children younger than 15 years (CD 10–1)
PTC II	10-3 A Level II pediatric trauma center must annually admit 100 or more injured children younger than 15 years.	A Level II pediatric trauma center must annually admit 100 or more injured children younger than 15 years (CD 10–2).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
PTC I, II	10-4 and 10-5 All pediatric trauma centers must have a pediatric trauma program manager or coordinator and a pediatric trauma registrar.	All Level I and II pediatric trauma centers must have a <b>dedicated</b> pediatric trauma program manager (CD 10–3)
PTC I, II	See CD10-4	All Level I and II pediatric trauma centers must have a pediatric trauma registrar (CD 10–4).
PTC I	10-6 In a Level I pediatric trauma center, the pediatric trauma program manager or coordinator must be dedicated to the pediatric trauma service.	In a Level I pediatric trauma center, the pediatric trauma program manager must be a <b>full-time position</b> dedicated to the pediatric trauma service (CD 10–5)
PTC I, II	10-7 All pediatric trauma centers must have a pediatric trauma PIPS program.	All pediatric trauma centers must have a pediatric trauma performance <b>improvement and patient safety (PIPS) program</b> (CD 10–6).
PTC I, II	10-8 All pediatric trauma centers must have the following programs: pediatric rehabilitation, child life and family support programs, pediatric social work, child protective services, pediatric injury prevention, community outreach, and education of health professionals and the general public in the care of pediatric trauma patients.	In addition, all pediatric trauma centers must have the following programs: pediatric rehabilitation, child life and family support programs, pediatric social work, child protective services, pediatric injury prevention, community outreach, and education of health professionals and the general public in the care of pediatric trauma patients (CD 10–7).
PTC I, II		<b>Level I and II pediatric trauma centers must have a mechanism in place to assess children for maltreatment (CD 10–8).</b>
PTC I	10-9 A pediatric trauma center must have identifiable pediatric trauma research.	Level I pediatric trauma centers must have identifiable pediatric trauma research (CD 10–9).
PTC I		<b>The pediatric Level I center’s research requirement is equivalent to that of adult Level I trauma centers (CD 10–10).</b>
PTC I		<b>In combined Level I adult and pediatric centers, half of the research requirement must be pediatric research (CD 10–11).</b>
PTC I	10-10 A Level I pediatric trauma center must have at least 2 surgeons who are board certified or board-eligible in pediatric surgery by the American Board of Surgery	A Level I pediatric trauma center must have at least two surgeons who are board certified or eligible for certification by the American Board of Surgery according to <b>current requirements in pediatric surgery (CD 10–12).</b>

PTC I	10-11 There must be 1 board-certified or board-eligible orthopaedic surgeon.	(Level I PTC) On staff, there must be one board-certified surgeon or one surgeon eligible for certification by an appropriate orthopaedic board (see Chapter 9, Clinical Functions: Orthopaedic Surgery) according to the current requirements of that board who also has had pediatric fellowship training (CD 10–13).
PTC I	10-12 There must be 1 board-certified or board-eligible neurosurgeon on staff who have had pediatric fellowship training.	(Level I PTC) Additionally, there must be on staff at least one board-certified surgeon or one surgeon eligible for certification by the American Board of Neurological Surgery (see Chapter 8, Clinical Functions: Neurosurgery) according to current requirements of that board who also has had pediatric fellowship training (CD 10–14).

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Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
PTC I	10-13 There must be 1 additional board-certified or board-eligible orthopaedic surgeon.	(Level I PTC) There must be one additional board-certified orthopaedic surgeon or surgeon eligible for certification by an appropriate orthopaedic board according to the current requirements of that board (CD 10–15), who is identified with demonstrated interests and skills in pediatric trauma care.
PTC I	10-14 There must be 1 additional board-certified or board-eligible neurosurgeon identified with demonstrated interests and skills in pediatric trauma care.	(Level I PTC) There must be one additional board-certified neurosurgeon or surgeon eligible for certification by the American Board of Neurological Surgery according to the current requirements of that board, who is identified with demonstrated interests and skills in pediatric trauma care (CD 10–16).
PTC I	10-15 There must be 2 physicians who are board-certified or board-eligible in pediatric critical care medicine or in pediatric surgery and surgical critical care by the American Board of Surgery.	(Level I PTC) There must be two physicians who are board certified or eligible for certification in pediatric critical care medicine, according to current requirements in in pediatric critical care medicine: or in pediatric surgery and surgical critical care by the American Board of Surgery (CD 10–17).
PTC I	10-16 There must be 2 physicians who are board-certified or board-eligible in pediatric emergency medicine.	(Level I PTC) There must be two physicians who are board certified or eligible for certification by an appropriate emergency medicine board according to current requirements in pediatric emergency medicine (CD 10–18).
PTC I, II	10-17 The pediatric intensive care unit must be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas.	The pediatric intensive care unit must be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas (CD 10–19).
PTC I, II	10-18 The pediatric section of the emergency department must be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas.	The pediatric section of the emergency department (CD 10–20) must be staffed by individuals credentialed by the hospital to provide pediatric trauma care in their respective areas.
PTC II	10-19 In a Level II pediatric trauma center, there must be at least 1 board-certified or board-eligible pediatric surgeon.	In a Level II pediatric trauma center, there must be at least one pediatric surgeon who is board-certified or eligible for certification by the American Board of Surgery according to current requirements in pediatric surgeon (CD 10–21).
PTC II	10-20 Level II pediatric trauma center must have 1 board-certified or board-eligible orthopaedic surgeon	There must be one surgeon who is board-certified or eligible for certification by the appropriate orthopaedic board (CD 10–22) identified with demonstrated interests and skills in pediatric trauma care.
PTC II	10-21 Level II pediatric trauma center must have 1 board-certified or board-eligible neurosurgeon identified with demonstrated interests and skills in pediatric trauma care.	There must be one surgeon who is board-certified or eligible for certification by the appropriate neurosurgical board (CD 10–23) identified with demonstrated interests and skills in pediatric trauma care.
PTC I, II	10-22 In a Level I pediatric trauma center, the pediatric trauma medical director must have successfully completed board examinations in general surgery.	In a Level I pediatric trauma center, the pediatric trauma medical director must be board certified or eligible for certification by the American Board of Surgery according to current requirements for pediatric surgery or alternatively, a pediatric surgeon who is a Fellow of the American College of Surgeons with a special interest in pediatric trauma care, and must participate in trauma call. (CD 10–24).

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Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
PTC I	10-23 In a Level I pediatric trauma center, the pediatric trauma medical director must be board-certified or board-eligible in pediatric surgery.	Merged with CD 10-22
PTC II		In a Level II pediatric trauma center, the pediatric trauma medical director should be a board-certified pediatric surgeon or a surgeon eligible for certification by the American Board of Surgery according to current requirements for pediatric surgery. This individual must be a board-certified general surgeon qualified to serve on the pediatric trauma team as defined in the following paragraph (CD 10–25).
PTC I, II	10-24 There are non-pediatric trained surgeons serving on the pediatric panel with proper qualifications: (1) credentialed by the hospital to provide pediatric trauma care, (2) members of the adult trauma panel, (3) the pediatric trauma medical director has agreed to their having sufficient training and experience in pediatric trauma care, and (4) their performance has been reviewed by the pediatric PIPS program.	When the number of pediatric surgeons on staff is too few to sustain the pediatric trauma panel, general surgeons who are board certified or eligible for certification by the American Board of Surgery according to current requirements may serve on the pediatric trauma team. In this circumstance, they must be credentialed by the hospital to provide pediatric trauma care, be members of the adult trauma panel, and be approved by the pediatric trauma medical director (CD 10–26).
PTC I		At a minimum, a Level I pediatric trauma center must have continuous rotations in trauma surgery for senior residents (Clinical PGY 3–5) who are part of an Accreditation Council for Graduate Medical Education–accredited program (CD 10–27).
PTC I		At a minimum, these rotations should include residency programs in all the following specialties: general surgery, orthopaedic surgery, emergency medicine, and neurosurgery. They may also include support of a pediatric surgical fellowship (CD 10–28).
PTC I, II	10-25 For Level I and II pediatric trauma centers, it is expected that the trauma surgeon be in the emergency department on patient arrival, with adequate advance notification from the field. The maximum acceptable response time is 15 minutes. Response time will be tracked from patient arrival rather than from notification or activation. An 80% attendance threshold must be met for the highest level of activation.	
PTC I, II	10-26 The trauma surgeon is expected to be present in the operating room for all trauma operations. A mechanism for documenting this presence is essential.	

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
PTC I, II	10-27 The program must make specialty-specific pediatric education available for other specialists (anesthesiology, neurosurgery, orthopaedic surgery, emergency medicine, radiology, and rehabilitation).	In Level I and II pediatric trauma centers, other specialists (in anesthesiology, neurosurgery, orthopaedic surgery, emergency medicine, radiology, and rehabilitation) providing care to injured children who are not pediatric-trained providers also should have sufficient training and experience in pediatric trauma care and be knowledgeable about current management of pediatric trauma in their specialty. The program must make specialty-specific pediatric education available for these specialists (CD 10–29).
PTC I, II	10-28 An organized pediatric trauma service led by a pediatric trauma medical director must be present.	An organized pediatric trauma service led by a pediatric trauma medical director must be present in Level I and II pediatric trauma centers (CD 10–30).
PTC I, II		The pediatric trauma service must maintain oversight of the patient’s management while the patient is in the intensive care unit (CD 10–31).
PTC I, II		The trauma service should work collaboratively with the pediatric critical care providers, although all significant therapeutic decisions must be approved by the trauma service, and the service must be made aware of all significant clinical changes (CD 10–32).

PTC I, II		The surgical director who is board certified in surgical critical care of the pediatric intensive care unit must participate actively in the administration of the unit, as evidenced by the development of pathways and protocols for care of surgical patients in the intensive care unit and in unit-based performance improvement (CD 10-33).
PTC I, II		Pediatric surgeons or trauma surgeons with pediatric privileges must be included in all aspects of the care of injured children admitted to an intensive care unit (CD 10-34).
A/PTC I, II	10-29 Full-service general hospitals providing comprehensive care for adults and children historically have provided the majority of adult and pediatric trauma care in urban and suburban areas. Hospitals that seek verification as an adult and pediatric trauma center must meet the criteria for the verification level sought in each type of center.	
ATCTIC I, II, III	10-30 and 10-31 Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating its capability to care for the injured child: the trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body, there must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program.	Any adult trauma center that annually admits 100 or more injured children younger than 15 years must fulfill the following additional criteria demonstrating its capability to care for the injured child (CD 2-23).
ATCTIC I, II		The trauma surgeons must be credentialed for pediatric trauma care by the hospital's credentialing body (CD 2-23).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
ATCTIC I, II, III	10-31, see 10-30	There must be a pediatric emergency department area, a pediatric intensive care area, appropriate resuscitation equipment, and a pediatric-specific trauma PIPS program (CD 2-24).
ATCTIC I, II, III	10-32 For adult trauma centers admitting fewer than 100 injured children younger than 15 years must review the care of injured children through their PIPS programs.	For adult trauma centers admitting fewer than 100 injured children younger than 15 years per year, these resources are desirable. These hospitals, however, must review the care of all injured children through their PIPS programs (CD 2-25).
PTC I, II		Level I and II pediatric trauma centers must submit data to the National Trauma Data Bank® (NTDB®) (CD 10-35).
PTC I, II	10-33 There must be a multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from pediatric/general surgery, orthopaedic surgery, neurosurgery, emergency medicine, critical care medicine, and anesthesia to improve trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses.	There must be a trauma peer review committee chaired by the pediatric trauma medical director with participation by the pediatric/general surgeons and liaisons from pediatric/general surgery, orthopaedic surgery, neurosurgery, emergency medicine, pediatric critical care medicine, anesthesia, and radiology to improve trauma care by reviewing selected deaths, complications, and sentinel events with the objectives of identification of issues and appropriate responses (CD 10-36).
PTC I, II		The aforementioned representatives must attend at least 50% of the trauma peer review meetings, and their attendance must be documented (CD 10-37)
PTC I, II	10-34 Attendance by the required representatives to at least 50% of the multidisciplinary peer review meetings must be documented, and all pediatric and general surgeons on the trauma panel treating children must attend at least 50% of the multidisciplinary peer review meetings.	All pediatric and general surgeons on the pediatric trauma panel treating children must attend at least 50% of the trauma peer review meetings (CD 10-38).



PTC I, II	10-35 In Level I and II pediatric trauma centers, the pediatric trauma medical director and the liaisons from neurosurgery, orthopaedic surgery, emergency medicine, and critical care medicine must each accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external CME, of which at least 12 hours (in 3 years) must be related to clinical pediatric trauma care.	In Level I and II pediatric trauma centers, the pediatric trauma medical director and the liaisons from neurosurgery, orthopaedic surgery, emergency medicine, and critical care medicine must each accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external CME, of which at least 12 hours (in 3 years) must be related to clinical pediatric trauma care (CD 10–39)
PTC I, II		The other general surgeons, orthopaedic surgeons, neurosurgeons, emergency medicine physicians, and critical care physicians who take trauma call in Level I and II pediatric trauma centers also must be knowledgeable and current in the care of injured patients. This requirement may be met by documenting the acquisition of 16 hours of CME per year on average or by demonstrating participation in an internal educational process conducted by the trauma program based on the principles of practice-based learning and the PIPS program (CD 10–41).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III	11-1 Anesthesiology services are promptly available for emergency operations.	Anesthesiology services are critical in the management of severely injured patients and must be available <b>within 30 minutes</b> for emergency operations (CD 11–1)
I, II, III	11-2 Anesthesiology services are promptly available for airway problems.	Anesthesiology services are critical in the management of severely injured patients and must be available <b>within 30 minutes</b> for managing airway problems (CD 11–2).
I, II	11-3 There is an anesthesiologist liaison designated to the trauma program.	The anesthetic care of injured patients in a Level I or II trauma center must be organized and supervised by an anesthesiologist who is highly experienced and committed to the care of injured patients and who serves as the designated liaison to the trauma program (CD 11–3).
I, II, III		In Level I, II, and III trauma centers, a qualified and dedicated physician anesthesiologist must be designated as the liaison to the trauma program (CD 11-3)
I, II	11-4 Anesthesia services in Level I trauma centers are available in-house 24 hours a day.	Anesthesia services in Level I and II trauma centers must be available in-house 24 hours a day (CD 11–4).
I, II	11-5 When anesthesiology chief residents or CRNAs are used to fulfill availability requirements, the staff anesthesiologist on call is (1) advised, (2) promptly available or all times, and (3) present for all operations.	When anesthesiology senior residents or CRNAs are used to fulfill availability requirements, the attending anesthesiologist on call must be advised, available <b>within 30 minutes</b> at all times, and present for all operations (CD 11–5).
I, II	11-6 The availability of the anesthesia services and the absence of delays in airway control or operations is documented by the hospital PIPS process.	The availability of anesthesia services and the absence of delays in airway control or operations must be documented by the hospital performance improvement and patient safety (PIPS) process (CD 11–6).
II, III	11-7 Anesthesia services are available 24 hours a day and present for all operations.	In Level III hospitals, in-house anesthesia services are not required, but anesthesiologists or CRNAs must be available <b>within 30 minutes</b> (CD 11–7).
II, III	11-8 In trauma centers without in-house anesthesia services, protocols are in place to ensure the timely arrival at the bedside of the anesthesia provider.	In Level III trauma centers without in-house anesthesia services, protocols must be in place to ensure the timely arrival at the bedside by the anesthesia provider <b>within 30 minutes of notification and request.</b> (CD 11–8).
II, III	11-9 In a center without anesthesia services, there is documentation of the presence of physicians skilled in emergency airway management.	Under these circumstances, the presence of a physician skilled in emergency airway management must be documented (CD 11–9).
III	11-10 Availability of anesthesia services and the absence of delays in airway control or operations are documented in the hospital PIPS process.	The availability of anesthesia services and delays in airway control or operations must be documented by the hospital PIPS process (CD 11–6).
I, II	11-11 All anesthesiologists taking call have successfully completed an anesthesiology residency.	All anesthesiologists taking call must have successfully completed an anesthesia residency program (CD 11–10).
I, II		Furthermore, in Level I and II trauma centers, anesthesiologists taking call must be <b>currently board certified in anesthesiology</b> (CD 11–11).

Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II		Board certification or eligibility for certification is essential for anesthesiologists who take trauma call in Level I and II trauma centers (CD 11–11).
I, II, III	11-12 The anesthesia liaison has been identified.	
I, II, III	11-13 The anesthesia resident participates in the trauma PIPS process.	In Level I, II, and III trauma centers participation in the trauma PIPS program by the anesthesia liaison is essential (CD 11–12).
I, II, III	11-14 The anesthesiology representative or designee to the trauma program attends at least 50% of the multidisciplinary peer review meetings.	The anesthesiology liaison to the trauma program must attend at least 50 percent of the multidisciplinary peer review meetings, with documentation by the trauma PIPS program (see Chapter 16, Performance Improvement and Patient Safety) (CD 11–13).
I, II	11-15 The operating room is adequately staffed and immediately available. In a Level 1 trauma center, this criterion is met by having a complete operating team in the hospital at all times, with individuals who are dedicated only to the operating room. <b>SEE FAQ</b>	An operating room must be adequately staffed and available within 15 minutes at Level I and II trauma centers (CD 11–14).
I, II	11-16 The operating room team is fully dedicated to the duties in the operating room and does not have functions requiring its presence outside the operating room.	In Level I and II trauma centers, if the first operating room is occupied, an adequately staffed additional room must be available (CD 11–15).
I, II	11-17 There is a mechanism for providing additional staff for a second operating room when the first operating room is occupied.	Availability of the operating room personnel and timeliness of starting operations must be continuously evaluated by the trauma PIPS process and measures must be implemented to ensure optimal care (CD 11–16).
II, III	11-18 The operating room is adequately staffed and immediately available. <b>SEE FAQ</b>	In Level III trauma centers, an operating room must be adequately staffed and available within 30 minutes (CD 11–17).
II, III	11-19 The PIPS program evaluates operating room availability and delays when an on-call team is used.	If an on-call team is used, the availability of operating room personnel and the timeliness of starting operations must be continuously evaluated by the trauma PIPS process, and measures must be implemented to ensure optimal care (CD 11–18).
I, II, III	11-20 The operating room has the essential equipment.	Level I, II, and III trauma centers should have the necessary operating room equipment for the patient populations they serve. All trauma centers must have rapid fluid infusers, thermal control equipment for patients and resuscitation fluids, intraoperative radiologic capabilities, equipment for fracture fixation, and equipment for bronchoscopy and gastrointestinal endoscopy (CD 11–19).
I, II	11-21 Trauma centers have the necessary equipment for a craniotomy.	Level I and II trauma centers must have the necessary equipment to perform a craniotomy (CD 11–20)

Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
III	11-22 There is craniotomy equipment in the Level III trauma center that offers neurosurgery services.	Level III trauma centers that provide neurosurgical services must have the necessary equipment to perform a craniotomy (CD 11–20). Only Level III trauma centers that do not offer neurosurgery services are not required to have craniotomy equipment.
I		Level I trauma centers must have cardiothoracic surgery capabilities available 24 hours per day and should have cardiopulmonary bypass equipment (CD 11–21).
I, II	11-23 The trauma center has cardiopulmonary bypass and an operating microscope available 24 hours per day.	In Level I and Level II trauma centers, if cardiopulmonary bypass equipment is not immediately available, a contingency plan, including immediate transfer to an appropriate center and 100 percent performance improvement review of all patients transferred, must be in place (CD 11–22).

I		Level I trauma centers must have an operating microscope available 24 hours per day (CD 11-23).
I, II, III	11-24 The PACU has qualified nurses available 24 hours per day as needed during the patient's post-anesthesia recovery phase.	At Level I, II, and III trauma centers, a PACU with qualified nurses must be available 24 hours per day to provide care for the patient if needed during the recovery phase (CD 11-24).
I, II, III	11-25 The PACU is covered by a call team from home with documentation by the PIPS program that PACU nurses are available and delays are not occurring.	If this availability requirement is met with a team on call from outside the hospital, the availability of the PACU nurses and compliance with this requirement must be documented by the PIPS program (CD 11-25).
I, II, III	11-26 (I, II, III) The PACU has the necessary equipment to monitor and resuscitate patients.	The PACU must have the necessary equipment to monitor and resuscitate patients, consistent with the process of care designated by the institution (CD 11-26).
I, II, III	11-27 The PIPS process ensures that the PACU has the necessary equipment to monitor and resuscitate patients.	The PIPS program, at a minimum, must address the need for pulse oximetry, end-tidal carbon dioxide detection, arterial pressure monitoring, pulmonary artery catheterization, patient rewarming, and intracranial pressure monitoring (CD 11-27).
I, II, III	11-28 Radiologists are promptly available, in person or by teleradiology, when requested, for the interpretation of radiographs, performance of complex imaging studies, or interventional procedures.	In Level I, II, and III trauma centers, qualified radiologists must be available within 30 minutes in person or by teleradiology for the interpretation of radiographs. (CD 11-32)
I, II		In Level I and II trauma centers qualified radiologists must be available within 30 minutes to perform complex imaging studies, or interventional procedures (CD 11-33).
I, II, III	11-29 Diagnostic information is communicated in a written form and in a timely manner.	In Level I, II, and III trauma centers diagnostic information must be communicated in a written or electronic form and in a timely manner (CD 11-34).
I, II, III	11-30 Critical information is verbally communicated to the trauma team.	Critical information deemed to immediately affect patient care must be verbally communicated to the trauma team in a timely manner (CD 11-35).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III	11-31 Final reports accurately reflect communications, including changes between preliminary and final interpretations.	The final report must accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretations (CD 11-36).
I, II, III	11-32 Changes in interpretation are monitored through the PIPS program.	Changes in interpretation between preliminary and final reports, as well as missed injuries, must be monitored through the PIPS program (CD 11-37).
I, II	11-33 There is at least 1 radiologist appointed as liaison to the trauma program.	In Level I and II facilities, a radiologist must be appointed as liaison to the trauma program (CD 11-38).
I, II		The radiologist liaison must attend at least 50 percent of peer review meetings and should educate and guide the entire trauma team in the appropriate use of radiologic services (CD 11-39).
I, II		In Level I and II trauma centers, participation in the trauma PIPS program process by radiologists is essential (CD 11-40).
I, II	11-34 Radiology participates in the trauma PIPS program by at least being involved in protocol development and trend analysis that relate to diagnostic imaging.	At a minimum, radiologists must be involved in protocol development and trend analysis that relate to diagnostic imaging (CD 11-41).
I, II		Level I and II facilities must have a mechanism in place to view radiographic imaging from referring hospitals within their catchment area (CD 11-42).
I, II		Board certification or eligibility for certification by the current standard requirements is essential for radiologists who take trauma call in Level I and II trauma centers (CD 11-43).

I, II, III	11-35 The trauma center has policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to and while in the radiology department.	The trauma center must have policies designed to ensure that trauma patients who may require resuscitation and monitoring are accompanied by appropriately trained providers during transportation to, and while in, the radiology department (CD 11-28).
I, II, III, IV	11-36 Conventional radiography and CT are available in all trauma centers 24 hours per day.	Conventional radiography must be available in all trauma centers 24 hours per day (CD 11-29).
I, II, III		Computed tomography (CT) must be available in Levels I, II, and III trauma centers 24 hours per day (CD 11-30)
I, II	11-37 There is an in-house radiographer at Level I and II trauma centers. <b>SEE FAQ</b>	An in-house radiology technologist and CT technologist are required at Level I and II trauma centers (CD 11-31).
I, II	11-38 In a Level I trauma center, there is an in-house CT technologist.	Merged with CD 11-31
II, III	11-39 When the CT technologist responds from outside the hospital, the PIPS program documents the response time. <b>SEE FAQ</b>	In Level III centers, if the CT technologist takes call from outside the hospital, the PIPS program must document the technologist's time of arrival at the hospital (CD 11-47).
I, II	11-40 Conventional catheter angiography and sonography are available 24 hours per day.	Interventional radiologic procedures and sonography must be available 24 hours per day at Level I and II trauma centers (CD 11-44).

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II	11-41 MRI capability is available 24 hours per day at Level I trauma centers.	Magnetic resonance imaging (MRI) capability must be available 24 hours per day at Level I and II trauma centers (CD 11-45).
I, II	11-42 The PIPS program documents the appropriate timeliness of the arrival of the MRI technologist.	The MRI technologist may respond from outside the hospital; however, the PIPS program must document and review arrival within 1 hour of being called. This time should meet current clinical guidelines (CD 11-46).
I	11-43 There is a surgically directed ICU physician team.	In a Level I trauma center, a surgically directed ICU physician team must be led by a surgeon boarded in surgical critical care, and critically ill trauma patients should be cared for in a designated ICU (CD 11-48).
I		The ICU must be staffed with a dedicated ICU physician team led by the ICU director (CD 11-50).
I		[Level I] If the trauma attending provides coverage, a backup ICU attending must be identified and readily available (CD 11-52).
I	11-44 The surgical director or coordinator of the ICU has the appropriate training and experience for the role.	
II, III	11-45 The trauma center has a surgical director or co-director for the ICU who is responsible for setting policies and administration related to trauma ICU patients.	In Level II and III trauma centers, a surgeon must serve as co-director or director of the ICU and be actively involved in, and responsible for, setting policies and administrative decisions related to trauma ICU patients (CD 11-53).
I, II, III	11-46 The trauma surgeon remains in charge of patients in the ICU.	
I, II	11-47 Physician coverage of critically ill trauma patients must be promptly available 24 hours per day.	Appropriately trained physicians must be available in-house within 15 minutes to provide care for the ICU patients 24 hours per day (CD 11-51).
II, III	11-48 Physicians must be capable of a rapid response to deal with urgent problems as they arise in critically ill trauma patients.	In Level II trauma centers, physician coverage of critically ill trauma patients must be available within 15 minutes 24 hours per day for interventions by a credentialed provider (CD 11-55).
III	11-49 When a critically ill trauma patient is treated locally, there must be a mechanism in place to provide prompt availability of ICU physician coverage 24 hours per day.	In Level III trauma centers, physician coverage of the ICU must be available within 30 minutes, with a formal plan in place for emergency coverage (CD 11-56).
I	11-50 The surgical director of the ICU must have obtained critical care training during residency or fellowship and must have expertise in perioperative and post-injury care of injured patients.	
I	11-51 The surgical director of the ICU must have added certification in surgical critical care from the American Board of Surgery or must have fulfilled the Alternate Pathway for critical care. <b>SEE FAQ</b>	A surgeon with current board certification in surgical critical care must be designated as the ICU director (CD 11-49).

I		The ICU team may be staffed by critical care physicians from different specialties but must remain surgically directed as noted above (CD 11-49).
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**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
II, III	11-52 The surgical director or the surgical co-director must be a surgeon, who is credentialed by the hospital to care for ICU patients, and who participates in the PIPS process.	In Level II and III facilities, the ICU director or co-director must be a surgeon who is currently board certified or eligible for certification by the current standard requirements (CD 11-54).
I, II, III	11-53 The trauma service retains responsibility for patients and coordinates all therapeutic decisions appropriate for its level.	In Level I, II, and III trauma centers, the trauma surgeon must retain responsibility for the patient and coordinate all therapeutic decisions (CD 11-58).
I, II, III	11-54 The trauma surgeon is kept informed of and concurs with major therapeutic and management decisions made by the ICU team.	Many of the daily care requirements can be collaboratively managed by a dedicated ICU team, but the trauma surgeon must be kept informed and concur with major therapeutic and management decisions made by the ICU team (CD 11-59).
I	11-55 The patients in Level I facilities have in-house physician coverage for ICU at all times. <b>SEE FAQ FOR 11.56</b>	
I, II, III, IV	11-56 Coverage of emergencies in the ICU does not leave the emergency department without appropriate physician coverage. <b>SEE FAQ</b>	For all levels of trauma centers, the PIPS program must document that timely and appropriate ICU care and coverage are being provided (CD 11-60).
I, II, III		In all Level I, II, and III trauma centers, the timely response of credentialed providers to the ICU must be continuously monitored as part of the PIPS program (CD-11-60).
I, II, III		[Level I, II and III] There must be a designated ICU liaison to the trauma service (CD 11-61).
I, II, III		This liaison must attend at least 50 percent of the multidisciplinary peer review meetings, with documentation by the trauma PIPS program (CD 11-62).
I, II		The ICU liaison to the trauma program at Level I and II centers must accrue an average of 16 hours annually or 48 hours in 3 years of verifiable external trauma-related continuing medical education (CME) (CD 11-63).
I, II		This requirement must be documented by the acquisition of 16 hours of trauma CME per year, on average, or through an internal educational process conducted by the trauma program and the ICU liaison based on the principles of practice-based learning and the PIPS program (CD 11-64).
III	11-57 The PIPS program reviews admissions and transfers to ensure appropriateness.	In Level III trauma centers, the PIPS program must review all ICU admissions and transfers of ICU patients to ensure that appropriate patients are being selected to remain at the Level III center vs. being transferred to a higher level of care (CD 11-57).
I, II, III	11-58 A qualified nurse is available 24 hours per day to provide care during the ICU phase.	At Level I, II, and III trauma centers, qualified critical care nurses must be available 24 hours per day to provide care for patients during the ICU phase (CD 11-65).
I, II, III	11-59 The patient/nurse ratio does not exceed 2:1 for critically ill patients in the ICU.	The patient-to-nurse ratio in the ICU must not exceed two to one (CD 11-66).

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III	11-60 The ICU has the necessary equipment to monitor and resuscitate patients.	The ICU must have the necessary equipment to monitor and resuscitate patients (CD 11-67).
I, II	11-61 Intracranial pressure monitoring equipment is available.	Intracranial pressure monitoring equipment must be available in Level I and II trauma centers for neurotrauma patients (CD 11-68).
III	11-62 There is intracranial pressure monitoring equipment in the Level III center that admits neurotrauma patients.	Intracranial pressure monitoring equipment must be available in Level III trauma centers with neurosurgical coverage that admit neurotrauma patients (CD 11-68).

III		Trauma patients must not be admitted or transferred by a primary care physician without the knowledge and consent of the trauma service, and the PIPS program should monitor adherence to this guideline (CD 11–69).
I	11-63 Level I facilities must have a full spectrum of surgical specialists available. (orthopaedic surgery, neurosurgery, cardiac surgery, thoracic surgery, hand surgery, microvascular surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology)	Level I facilities are prepared to manage the most complex trauma patients and must have available a full spectrum of surgical specialists, including specialists in orthopaedic surgery, neurosurgery, cardiac surgery, thoracic surgery, vascular surgery, hand surgery, microvascular surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology (CD 11–70).
II	11-64 Level II centers must have the following surgical specialists available. (orthopaedic surgery, neurosurgery, thoracic surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology)	Level II centers must have the surgical specialists described for Level I trauma centers and should provide cardiac surgery (CD 11–71). [Level I facilities must have specialists in orthopaedic surgery, neurosurgery, thoracic surgery, vascular surgery, hand surgery, microvascular surgery, plastic surgery, obstetric and gynecologic surgery, ophthalmology, otolaryngology, and urology.
III	11-65 Level III centers must have the availability of orthopaedic surgery.	Level III trauma centers must have the availability and commitment of orthopaedic surgeons (CD 11–72).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III		For all patients being transferred for specialty care, such as burn care, microvascular surgery, cardiopulmonary bypass capability, complex ophthalmologic surgery, or high-complexity pelvic fractures, agreements with a similar or higher-qualified verified trauma center should be in place. If this approach is used, a clear plan for expeditious critical care transport, follow-up, and performance monitoring is required (CD 8–5). If complex cases are being transferred out, a contingency plan should be in place and must include the following: <ul style="list-style-type: none"> <li>• A credentialing process to allow the trauma surgeon to provide initial evaluation and stabilization of the patient.</li> <li>• Transfer agreements with similar or higher-verified trauma centers.</li> <li>• Direct contact with the accepting facility to arrange for expeditious transfer or ongoing monitoring support.</li> <li>• Monitoring of the efficacy of the process by the PIPS programs. Ensure consistent wording through chapters.</li> </ul>
I, II	11-66 In a Level I trauma center, medical specialists on staff must include: cardiology, infectious disease, pulmonary medicine, and nephrology and their respective support teams (for example, respiratory therapy, dialysis team, and nutrition support).	In Level I and II trauma centers, medical specialists on staff must include specialists in cardiology, internal medicine, gastroenterology, infectious disease, pulmonary medicine, and nephrology and their respective support teams (for example, respiratory therapy, a dialysis team, and nutrition support) (CD 11–73).
III	11-69 In a Level III facility, internal medicine specialists must be available.	In a Level III facility, internal medicine specialists must be available on the medical staff (CD 11–74).
I, II	11-70 A respiratory therapist is available to care for trauma patients 24 hours per day.	Several support services are required to care for trauma patients. In Level I and II trauma centers, a respiratory therapist must be available in the hospital 24 hours per day (CD 11–75).
III	11-71 There is a respiratory therapist available and on call 24 hours per day.	In Level III centers, there must be a respiratory therapist on call 24 hours per day (CD 11–76).
I, II	11-72 Acute hemodialysis is available.	Acute hemodialysis must be available in Level I and II trauma centers (CD 11–77).
III	11-73 A Level II center has either dialysis capabilities or a transfer agreement.	Level III trauma centers that do not have dialysis capabilities must have a transfer agreement in place (CD 11–78).

I, II	11-74 Nutrition support services are available.	Nutrition support services must be available in Level I and II centers (CD 11–79).
I, II, III, IV	11-75 Laboratory services are available 24 hours per day for the standard analyses of blood, urine, and other body fluids, including microsampling when appropriate.	In trauma centers of all levels, laboratory services must be available 24 hours per day for the standard analyses of blood, urine, and other body fluids, including microsampling when appropriate (CD 11–80).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III, IV	11-76 The blood bank must be capable of blood typing and cross matching.	The blood bank must be capable of blood typing and cross-matching (CD 11–81).
I, II, III	11-77 The blood bank must have an adequate supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients.	For Level I and II centers, the blood bank must have an adequate in-house supply of red blood cells, fresh frozen plasma, platelets, cryoprecipitate, and appropriate coagulation factors to meet the needs of injured patients (CD 11–82).
III		In Level III centers, the blood bank must have an adequate supply of packed red blood cells and fresh frozen plasma available within 15 minutes (CD 11–83).
I, II, III, IV		Trauma centers of all levels must have a massive transfusion protocol developed collaboratively between the trauma service and the blood bank (CD 11–84).
I, II, III	11-78 The capability for coagulation studies, blood gases, and microbiology must be available 24 hours a day.	Coagulation studies, blood gas analysis, and microbiology studies must be available 24 hours per day (CD 11–85).
I, II, III, IV		Advanced practitioners who participate in the initial evaluation of trauma patients must demonstrate current verification as an Advanced Trauma Life Support® provider (CD 11–86).
I, II, III, IV		The trauma program must also demonstrate appropriate orientation, credentialing processes, and skill maintenance for advanced practitioners, as witnessed by an annual review by the trauma medical director (CD 11–87).
I, II	12-1 In Level I and II trauma centers, rehabilitation services must be available within its physical facilities or to a freestanding rehabilitation hospital, through a transfer agreement.	In Level I and II trauma centers, rehabilitation services must be available within the hospital's physical facilities or as a freestanding rehabilitation hospital, in which case the hospital must have transfer agreements (CD 12–1).
I, II		Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services are often needed in the critical care phase and must be available in Level I and II trauma centers (CD 12–2).
I, II, III	12-2 The hospital must provide physical therapy services.	Physical therapy (CD 12–3) must be provided in Level I, II, and III trauma centers.
I, II, III	12-3 The hospital must provide social services.	Social services (CD 12–4) must be provided in Level I, II, and III trauma centers.
I, II	12-4 The hospital must provide occupational therapy services.	Occupational therapy (CD 12–5) must be provided in Level I and II centers.
I, II	12-5 The hospital must provide speech therapy services.	Speech therapy (CD 12–6) must be provided in Level I and II centers.
I, II	12-6 Rehabilitation consultation services, occupational therapy, speech therapy, physical therapy, and social services are available during the acute phase of care.	In Level I and II trauma centers, these services must be available during the acute phase of care, including intensive care (CD 12–7).
II	13-1 A rural Level II center provides the same level of care as a nonrural Level II trauma center.	

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III, IV		Direct contact of the physician or midlevel provider with a physician at the receiving hospital is essential (CD 4–1).
III, IV		Transfer guidelines and agreements between facilities are crucial and must be developed after evaluating the capabilities of rural hospitals and medical transport agencies (CD 2–13).

I, II, III, IV		All transfers must be evaluated as part of the receiving trauma center's performance improvement and patient safety (PIPS) process (CD 4-3), and feedback should be provided to the transferring center.
I, II		Level I and II centers must be able to read images from referring centers (CD 11-41)
I, II, III, IV		The foundation for evaluation of a trauma system is the establishment and maintenance of a trauma registry (CD 15-1).
I, II, III, IV	13-2 The PIPS process demonstrates the appropriate care or response by providers.	Issues that must be reviewed will revolve predominately around (1) system and process issues such as documentation and communication; (2) clinical care, including identification and treatment of immediate life-threatening injuries (ATLS®); and (3) transfer decisions (CD 16-10).
I, II, III, IV		The best possible care for patients must be achieved with a cooperative and inclusive program that clearly defines the role of each facility within the system (CD 1-1).
I, II, III, IV		Trauma centers that refer burn patients to a designated burn center must have in place written transfer agreements with the referral burn center (CD 14-1)
I, II, III, IV	15-1 Trauma registry data are collected and analyzed.	Trauma registry data must be collected and analyzed by every trauma center (CD 15-1).
I, II, III	15-2 The data are submitted to the National Trauma Data Bank. <b>SEE FAQ</b>	Finally, these data must be collected in compliance with the National Trauma Data Standard (NTDS) and submitted to the National Trauma Data Bank® (NTDB®) every year in a timely fashion so that they can be aggregated and analyzed at the national level (CD 15-2).
I, II, III, IV	15-3 The trauma center uses the registry to support the PIPS process.	The trauma registry is essential to the performance improvement and patient safety (PIPS) program and must be used to support the PIPS process (CD 15-3).
I, II, III, IV		Furthermore, these findings must be used to identify injury prevention priorities that are appropriate for local implementation (CD 15-4).
I, II, III		All trauma centers must use a risk stratified benchmarking system to measure performance and outcomes (CD 15-5).
I, II, III, IV	15-4 The trauma registry has at least 80% of the trauma cases entered within 60 days of discharge	Trauma registries should be concurrent. At a minimum, 80 percent of cases must be entered within 60 days of discharge (CD 15-6)

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III		[Registrar] They must attend or have previously attended two courses within 12 months of being hired: (1) the American Trauma Society's Trauma Registrar Course or equivalent provided by a state trauma program; and (2) the Association of the Advancement of Automotive Medicine's Injury Scaling Course (CD 15-7).
I, II, III, IV	15-5 The trauma program ensures that trauma registry confidentiality measures are in place.	The trauma program must ensure that appropriate measures are in place to meet the confidentiality requirements of the data (CD 15-8).
I, II, III		One full-time equivalent employee dedicated to the registry must be available to process the data capturing the NTDS data set for each 500-750 admitted patients annually (CD 15-9).
I, II, III, IV	15-6 There are strategies for monitoring data validity for the trauma registry.	Strategies for monitoring data validity are essential (CD 15-10).
I, II, III	16-1 The trauma center demonstrates a clearly defined PIPS program for the trauma population.	
I, II, III		Trauma centers must have a PIPS program that includes a comprehensive written plan outlining the configuration and identifying both adequate personnel to implement that plan and an operational data management system (CD 16-1).



I, II, III, IV	16-2 The PIPS program is supported by a reliable method of data collection that consistently gathers valid and objective information necessary to identify opportunities for improvement.	The PIPS program must be supported by a reliable method of data collection that consistently obtains the information necessary to identify opportunities for improvement (CD 15–1).
I, II, III, IV		The processes of event identification and levels of review must result in the development of corrective action plans, and methods of monitoring, reevaluation, and benchmarking must be present (CD 2–17).
I, II, III		Problem resolution, outcome improvements, and assurance of safety (“loop closure”) must be readily identifiable through methods of monitoring, reevaluation, benchmarking, and documentation (CD 16–2).
I, II, III	16-3 The program is able to demonstrate that the trauma registry supports the PIPS process.	The trauma PIPS program must integrate with the hospital quality and patient safety effort and have a clearly defined reporting structure and method for provision of feedback (CD 16–3).
I, II, III	16-4 The process of analysis includes multidisciplinary review.	
I, II, III, IV	16-5 The process of analysis occurs at regular intervals to meet the needs of the program.	Peer review must occur at regular intervals to ensure that the volume of cases is reviewed in a timely fashion (CD 2–18).
I, II, III	16-6 The results of analysis define corrective strategies.	
I, II, III	16-7 The results of analysis and corrective strategies are documented.	
<b>Compendium of Changes</b>		
<b>Key:</b>	<b>Resources 2006 Green Book Criteria (no compatible CD in the Orange)</b>	<b>Resources 2014 Orange Book Criteria</b>
I, II, III, IV	16-8 The trauma program is empowered to address issues that involve multiple disciplines.	Because the trauma PIPS program crosses many specialty lines, it must be empowered to address events that involve multiple disciplines and be endorsed by the hospital governing body as part of its commitment to optimal care of injured patients (CD 5–1).
I, II, III, IV	16-9 The trauma program has adequate administrative support and defined lines of authority that ensure comprehensive evaluation of all aspects of trauma care.	There must be adequate administrative support to ensure evaluation of all aspects of trauma care (CD 5–1).
I, II, III, IV	16-10 The trauma program has a medical director with the authority and administrative support to lead the program.	The trauma medical director and trauma program manager must have the authority and be empowered by the hospital governing body to lead the program (CD 5–1).
I, II, III	16-11 The trauma medical director has sufficient authority to set the qualifications for the trauma service members.	The trauma medical director must have sufficient authority to set the qualifications for the trauma service members, including individuals in specialties that are routinely involved with the care of the trauma patient (CD 5–11).
I, II, III	16-14 The trauma center is able to separately identify the trauma patient population for review.	
I, II, III	16-12 The trauma medical director has sufficient authority to recommend changes for the trauma panel based upon performance reviews.	Moreover, the trauma medical director must have authority to recommend changes for the trauma panel based on performance review (CD 5–11).
I, II, III	16-13 Identified problem trends undergo multidisciplinary peer review by the Trauma Peer Review Committee.	Mortality data, adverse events and problem trends, and selected cases involving multiple specialties must undergo multidisciplinary trauma peer review (CD 16–14)
I, II, III, IV		Once an event is identified, the trauma PIPS program must be able to verify and validate that event (CD 16–11).
I, II, III	16-15 There is a process to address trauma program operational issues.	There must be a process to address trauma program operational events (CD 16–12).
I, II, III	16-16 There is documentation reflecting the review of operational issues and, when appropriate, the analysis and proposed corrective actions.	Documentation (minutes) reflects the review of operational events and, when appropriate, the analysis and proposed corrective actions (CD 16–13).
I, II, III, IV	16-17 The process identifies problems.	Sufficient mechanisms must be available to identify events for review by the trauma PIPS program (CD 16–10).

I, II, III	16-18 The process demonstrates problem resolution (loop closure).	An effective performance improvement program demonstrates through clear documentation that identified opportunities for improvement lead to specific interventions that result in an alteration in conditions such that similar adverse events are less likely to occur (CD 16–19).
I, II, III		The peer review committee must be chaired by the TMD (CD 5-25)

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III	16-19 There is a trauma multidisciplinary peer review committee with participation by the trauma medical director or designee and representatives from general surgery, orthopaedic surgery, neurosurgery, emergency medicine, and anesthesia.	In Level I, II, and III trauma centers, representation from general surgery (CD 6-8), and liaisons to the trauma program from emergency medicine (CD 7–11), orthopaedics (CD 9–16), and anesthesiology (CD 11–13), critical care (CD 11- 62)—and for Level I and II centers, neurosurgery (CD 8–13), and radiology (CD 11–39)—must be identified and participate actively in the trauma PIPS program with at least 50 percent attendance at multidisciplinary trauma peer review committee.
III		In Level III centers that do any amount of emergent neurosurgical cases must have also have participation of neurosurgery in the multidisciplinary trauma peer review committee (CD 8-13).
I, II, III		This effort may be accomplished in a variety of formats but must involve the participation and leadership of the trauma medical director (CD 5–10); the group of general surgeons on the call panel; and the liaisons from emergency medicine, orthopaedics, neurosurgery, anesthesia, critical care, and radiology (Level I, II and III, CD 6-8, CD 7-11, CD 9-16, CD 11-13, CD 11-62 - Level I and II centers, CD 8-13 CD 11-39).
I, II, III	16-20 The attendance by the trauma medical director and the specialty representatives is at least 50%.	Each member of the committee must attend at least 50 percent of all multidisciplinary trauma peer review committee meetings (CD 16–15).
I, II, III	16-21 The core general surgeon attendance at the trauma peer review committee is at least 50%.	
I, II, III	16-22 In circumstances when attendance is not mandated ( <del>non-core members</del> ), the trauma medical director ensures dissemination of information from the trauma peer review committee.	When these general surgeons cannot attend the multidisciplinary trauma peer review meeting, the trauma medical director must ensure that they receive and acknowledge the receipt of critical information generated at the multidisciplinary peer review meeting to close the loop (CD 16–16).
I, II, III	16-23 The trauma medical director documents the dissemination of information from the trauma peer review committee.	
I, II, III	16-24 Evidence of appropriate participation and acceptable attendance is documented in the PIPS process.	
I, II, III	16-25 Deaths are systematically categorized as preventable, non-preventable, or potentially preventable.	The multidisciplinary trauma peer review committee must systematically review mortalities, significant complications, and process variances associated with unanticipated outcomes and determine opportunities for improvement (CD 16–17).

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III		[A] Mortality Review (CD 16–6). All trauma-related mortalities must be systematically reviewed and those mortalities with opportunities for improvement identified for peer review. 1. Total trauma-related mortality rates. Outcome measures for total, pediatric (younger than 15 years), and geriatric (older than 64 years) trauma encounters should be categorized as follows: a. DOA (pronounced dead on arrival with no additional resuscitation efforts initiated in the emergency department), b. DIED (died in the emergency department despite resuscitation efforts), c. In-hospital (including operating room). 2. Mortality rates by Injury Severity Scale (ISS) subgroups using Table 1.

I, II, III, IV		[B] Trauma surgeon response to the emergency department (CD 2–9). See previous detail.
I, II, III, IV		[C] Trauma team activation (TTA) criteria (CD 5–13). See previous detail
I, II, III, IV		[D] All Trauma Team Activations must be categorized by the level of response and quantified by number and percentage, as shown in Table 2 (CD 5–14, CD 5–15).
I, II, III		[E] Trauma surgeon response time to other levels of TTA, and for back-up call response, should be determined and monitored. Variances should be documented and reviewed for reason for delay, opportunities for improvement, and corrective actions (CD 5–16)
I, II, III		[F] Response parameters for consultants addressing time-critical injuries (for example, epidural hematoma, open fractures, and hemodynamically unstable pelvic fractures) must be determined and monitored (CD 5–16).
I, II, III		[G] Rates of undertriage and overtriage can be calculated after the potential cases identified have been reviewed and validated. These rates must be monitored and reviewed quarterly (CD 16–7).
I, II, III		[H] Trauma patient admissions (NTDS definition) to a nonsurgical service is higher than 10 percent (Level I, II and III: CD 5–18).
I, II		Pediatric (14 years or younger) trauma care. 1. Trauma centers admitting at least 100 pediatric trauma patients annually require a pediatric-specific trauma PIPS program (CD 10–6). 2. Trauma centers admitting less than 100 pediatric trauma patients annually must review each case for timeliness and appropriateness of care (CD 10–6).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III, IV		[J] Acute transfers out (CD 9–14). All trauma patients who are diverted (CD 3–4) or transferred (CD 4–3) during the acute phase of hospitalization to another trauma center, acute care hospital, or specialty hospital (for example, burn center, reimplantation center, or pediatric trauma center) or patients requiring cardiopulmonary bypass or when specialty personnel are unavailable must be subjected to individual case review to determine the rationale for transfer, appropriateness of care, and opportunities for improvement. Follow-up from the center to which the patient was transferred should be obtained as part of the case review.
III		[K] Emergency physicians covering in-house emergencies at Level III trauma centers (CD 7–3). See previous detail
I, II, III		[L] Trauma center diversion-bypass hours must be routinely monitored, documented, and reported, including the reason for initiating the diversion policy (CD 3–6), and must not exceed 5 percent.
III		[M] Appropriate neurosurgical care at Level III trauma centers (CD 8–9).
I, II, III		[N] Availability of the anesthesia service (CD 11–4, CD 11-7, CD 11–16, CD 11-18). <ul style="list-style-type: none"> <li>o In-house anesthesia service (emergency department, intensive care unit, floor, and postanesthesia care unit) must be available for the care of trauma patients</li> <li>o Operating room delays involving trauma patients because of lack of anesthesia support services must be identified and reviewed to determine the reason for delay, adverse outcomes, and opportunities for improvement.</li> </ul>

I, II, III		[O] Delay in operating room availability (CD 11–16, CD 11–18) must be routinely monitored. Any case that is associated with a significant delay or adverse outcome must be reviewed for reasons for delay and opportunities for improvement
I, II, III		[P] Response times of operating room and postanesthesia care unit personnel when responding from outside the trauma center (CD 11–16, CD 11–18, CD 11–25) must be routinely monitored. Any case that exceeds the institutionally agreed upon response time and/or is associated with an adverse outcome must be reviewed for reasons for delay and opportunities for improvement.
I, II, III		[Q.] Rate of change in interpretation of radiologic studies (CD 11–32, CD 11–37) should be categorized by RADPEER or similar criteria (describe process/scoring metric used).

#### Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III		[R] Response times of computed tomography technologist(30 minutes)/magnetic resonance imaging (60 minutes) technologist/interventional radiology team (30 minutes) when responding from outside the trauma center (CD 11–29, CD 11–30, CD 11–31, CD 11–32, CD 11–33, CD 11–34, CD 11–35, CD 11–36, CD 11–37, and CD 11–46.) These times must be routinely monitored, and any case that exceeds the institutionally agreed upon response time or is associated with a significant delay or an adverse outcome must be reviewed for reasons for delay and opportunities for improvement.
I, II, III, IV		[S] Transfers to a higher level of care within the institution (CD 16–8).
I, II, III		[T] Solid Organ donation rate (CD 16–9).
I, II, III, IV		[U] Trauma registry (CD 15–6). See previous detail
I, II, III		[V] Multidisciplinary trauma peer review committee attendance (Level I, II, and III CD 5-10, CD 6–8, CD 7–11, CD 9–16, CD 11–13, CD 11-62 – and for Level I and II CD 8-13 and CD 11–39).
I, II, III	16-26 When a consistent problem or inappropriate variation is identified, corrective actions are taken and documented.	When an opportunity for improvement is identified, appropriate corrective actions to mitigate or prevent similar future adverse events must be developed, implemented, and clearly documented by the trauma PIPS program (CD 16–18).
I, II, III	16-27 The performance improvement program must be consistently functional, with structure and process.	
I, II		In Level I and II trauma centers, the TMD (CD 5-7), trauma program manager (CD 5-24) and the liaisons to the trauma program in emergency medicine (CD 7–12), orthopaedics (CD 9–18), critical care (CD 11–63), and neurosurgery (CD 8–14) must obtain 16 hours annually or 48 hours in 3 years of verifiable, external, trauma- related education (continuing medical education [CME] or CE as appropriate to the discipline).
I, II, III, IV		The trauma center must demonstrate that all trauma patients can be identified for review (CD 15–1).
I, II, III, IV		The trauma PIPS program must be supported by a registry and a reliable method of concurrent data collection that consistently obtains information necessary to identify opportunities for improvement (CD 15–3).
I, II, III		In Level I, II, and III trauma centers, the trauma registry must submit the required data elements to the NTDB (CD 15–2).
I, II, III		All trauma centers must use a risk-adjusted benchmarking system to measure performance and outcomes (CD 15-5).

Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III		To achieve this goal, a trauma program must use clinical practice guidelines, protocols, and algorithms derived from evidenced-based validated resources (new CD 16–4).
I, II, III, IV		All process and outcome measures must be documented within the trauma PIPS program’s written plan and reviewed and updated at least annually (CD 16–5).
I		[A] Trauma Center Volume (CD 2–4), See previous detail
I, II, III, IV	17-1 The trauma center is engaged in public and professional education.	All verified trauma centers, however, must engage in public and professional education (CD 17–1).
I, II	17-2 The trauma center provides some means of referral and access to trauma center resources.	Level I and II centers also must provide some means of referral and access to trauma center resources (CD 17–2).
I, II, III	17-3 The trauma center is involved in prevention activities, including public educational activities.	
I	17-4 The Level I trauma center provides and participates in an ATLS® course at least annually. <b>SEE FAQ</b>	
I	17-5 A Level I trauma center must provide a continuous rotation in trauma surgery for senior residents (PGY 4 or higher) that is part of an Accreditation Council for Graduate Medical Education-accredited program in any of the following disciplines: general surgery, orthopaedic surgery, or neurosurgery; or support an acute care surgery fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma. <b>See FAQ (for Pediatric Level I trauma centers – it is PGY 3 or higher)</b>	At a minimum, a Level I trauma center must have continuous rotations in trauma surgery for senior residents (Clinical PGY 4–5) that are part of an Accreditation Council for Graduate Medical Education-accredited program (CD 17–3). For pediatric Level I centers, the continuous rotation for surgical residents is extended to include clinical PGY 3.
I, II, III	17-6 The hospital provides a mechanism for trauma-related education for nurses involved in trauma care.	In Level I, II, and III trauma centers, the hospital must provide a mechanism to offer trauma-related education to nurses involved in trauma care (CD 17–4).
I, II, III, IV	17-7 All general surgeons and emergency medicine physicians on the trauma team have successfully completed the ATLS® course at least once.	The successful completion of the ATLS® course, at least once, is required in all levels of trauma centers for all general surgeons (CD 6-10), emergency medicine physicians (CD 7-14) and midlevel providers (CD 11-86) on the trauma team.
I, II	17-8 The trauma director and liaison representatives from neurosurgery, orthopaedic surgery, and emergency medicine have accrued an average of 16 hours annually or 48 hours in 3 years of trauma related CME. <b>SEE FAQ</b>	The trauma director (CD 5-7) and the liaison representatives from neurosurgery (CD 8-14), orthopaedic surgery (CD 9-18), emergency medicine (CD 7-12), and critical care (CD 11-63) must accrue an average of 16 hours annually, or 48 hours in 3 years, of external trauma-related CME.
I, II	17-9 Other general surgeons, neurosurgeons, orthopaedic surgeons, and emergency medicine specialists who take trauma call have acquired 16 hours of CME per year on average or participated in an internal educational process.	Other members of the general surgery (CD 6-11), neurosurgery (CD 8-15), orthopaedic surgery (CD 9-19), emergency medicine (CD 7-13), and critical care (CD 11-64) specialties who take trauma call also must be knowledgeable and current in the care of injured patients.
I, II, III	18-1 The trauma center participates in injury prevention.	

Compendium of Changes

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I, II, III, IV		Each trauma center must have someone in a leadership position that has injury prevention as part of his or her job description (CD 18-2)
I,II	18-2 The trauma center has a prevention coordinator with a demonstrated job description and salary support.	In Level I centers, this individual must be a prevention coordinator (separate from the trauma program manager) with a job description and salary support (CD 18–2).
I, II, III, IV	18-3 The trauma center demonstrates the presence of prevention activities that center on priorities based on local data.	Trauma centers must have an organized and effective approach to injury prevention and must prioritize those efforts based on local trauma registry and epidemiologic data (CD 18–1).
I, II	18-4 The trauma center demonstrates collaboration with or participation in national, regional, or state programs.	A trauma center’s prevention program must include and track partnerships with other community organizations (CD 18–6).

I, II	18-5 The trauma center has a mechanism to identify patients who are problem drinkers.	
I, II, III, IV		Universal screening for alcohol use must be performed for all injured patients and must be documented (CD 18-3)
I, II	18-6 The trauma center has the capability to provide intervention or referral for patients identified as problem drinkers. <b>SEE FAQ</b>	At Level I and II trauma centers, all patients who have screened positive must receive an intervention by appropriately trained staff, and this intervention must be documented (CD 18-4).
I, II		Level I and II trauma centers must implement at least two programs that address one of the major causes of injury in the community (CD 18-5).
I	19-1 The Level I trauma center meets either the minimum of 20 peer-reviewed articles published in Journals included in <i>Index Medicus</i> in 3 years or the criterion of 4 of 7 scholarly activities as listed in the chapter and 10 peer-reviewed articles published in journals included in <i>Index Medicus</i> in 3 years.	For a Level I trauma center, at a minimum, a program must have 20 peer-reviewed articles published in journals included in Index Medicus or PubMed in a 3-year period (CD 19-1).
I	19-2 The research resulted from work related to the trauma center.	These publications must result from work related to the trauma center or the trauma system in which the trauma center participates (19-2)
I	19-3 The articles include authorship or co-authorship by a member of the general surgery trauma team.	Of the 20 articles, at least one must be authored or co-authored by members of the general surgery trauma team (CD 19-3).
I	19-4 Of the 20 articles there is at least 1 that includes authorship or co-authorship by members of the general surgery trauma team and at least 1 each from 3 of 6 disciplines: neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, and rehabilitation. <b>SEE FAQ</b>	Additionally, at least one article each from three of the following disciplines is required: basic sciences, neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, and nursing (CD 19-4).
I, II, III, IV		CD 19-5 and CD 19-6, skipped
PTC I		Level I pediatric trauma centers must have identifiable pediatric trauma research. The pediatric Level I center's research requirement is equivalent to that of adult Level 1 trauma centers (CD 10-10).
PTC I		In combined Level I adult and pediatric centers, half of the research requirement must be pediatric research (CD 10-11).

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
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I	19-5 The trauma center meets the alternative criteria for research: *10 peer- reviewed articles published in journals included in <i>Index Medicus</i> resulting from work in the trauma center with at least 1 authored or coauthored by members of the general surgery trauma team and at least 1 each from 3 of 6 disciplines (neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, and rehabilitation). AND * 4 of 7 scholarly activities as stated in Chapter 19, Trauma Research & Scholarship. <b>SEE FAQ</b>	In the alternate method, a Level I program must have the following (CD 19–7) a. A program must have 10 peer-reviewed articles published in journals included in Index Medicus or PubMed in a 3-year period. These articles must result from work related to the trauma center or the trauma system in which the trauma center participates. Of the 10 articles, at least one must be authored or co-authored by members of the general surgery trauma team, and at least one article each from three of the following disciplines is required: basic sciences as related to injury, neurosurgery, emergency medicine, orthopaedics, radiology, anesthesia, vascular surgery, plastics/maxillofacial surgery, critical care, cardiothoracic surgery, rehabilitation, and nursing. Trauma-related articles authored by members of other disciplines or work done in collaboration with other trauma centers and participation in multicenter investigations may be included in the remainder. b. Of the following seven trauma- related scholarly activities, four must be demonstrated: • Evidence of leadership in major trauma organizations, which includes membership in trauma committees of any of the regional or national trauma organizations. • Demonstrated peer-reviewed funding for trauma research from a recognized government or private agency or organization. • Evidence of dissemination of knowledge that includes review articles, book chapters, technical documents, Web-based publications, videos, editorial comments, training manuals, and trauma-related educational materials or multicenter protocol development. • Display of scholarly application of knowledge as evidenced by case reports or reports of clinical series in journals included in MEDLINE. • Participation as a visiting professor or invited lecturer at national or regional trauma conferences.
I	19-5 (Continued)	----CD 19-7, Continued from above --- • Support of resident participation in mentoring scholarly activity, including laboratory experiences; clinical trials; resident trauma paper competitions at the state, regional, or national level; and other resident trauma presentations. • Mentorship of fellows, as evidenced by the development or maintenance of a recognized trauma, critical care, or acute care surgery fellowship.

**Compendium of Changes**

Key:	Resources 2006 Green Book Criteria (no compatible CD in the Orange)	Resources 2014 Orange Book Criteria
I	19-6 The administration of the trauma center demonstrates support of the research program.	Finally, the administration of a Level I trauma center must demonstrate support for the research program by, for example, providing basic laboratory space, sophisticated research equipment, advanced information systems, biostatistical support, salary support for basic and translational scientists, or seed grants for less experienced faculty (CD 19–8).
I, II, III, IV	20-1 The hospital meets the disaster-related requirements of JCAHO.	Trauma centers must meet the disaster-related requirements of the Joint Commission (CD 20–1).
I, II, III	20-2 A trauma panel surgeon is a member of the hospital's disaster committee.	A surgeon from the trauma panel must be a member of the hospital's disaster committee (CD 20–2).
I, II, III, IV	20-3 Hospital drills that test the individual hospital's disaster plan are conducted at least every 6 months.	Hospital drills that test the individual hospital's disaster plan must be conducted at least twice a year, including actual plan activations that can substitute for drills (CD 20–3)
I, II, III, IV	20-4 The trauma center has a hospital disaster plan described in the hospital disaster manual.	All trauma centers must have a hospital disaster plan described in the hospital's policy and procedure manual or equivalent (CD 20–4).

I, II, III	21-1 The trauma center has an established relationship with a recognized OPO.	The trauma center must have an established relationship with a recognized OPO (CD 21-1).
I, II, III	21-2 There are written policies for triggering notification of the OPO.	A written policy must be in place for triggering notification of the regional OPO (CD 21-2).
I, II, III	21-3 The PIPS process reviews the organ donation rate.	The trauma center must review its organ donation rate annually (CD 16.9).
I, II, III, IV	21-4 There are written protocols for declaration of brain death.	It is essential that each trauma center (Levels I, II, III, and IV) have written protocols defining the clinical criteria and confirmatory tests for the diagnosis of brain death (CD 21-3).



*Revised 10A NCAC 13P EMS and Trauma Rules*

10A NCAC 13P .0101 is proposed for reoption with substantive changes as follows:

**10A NCAC 13P .0101 ABBREVIATIONS**

As used in this Subchapter, the following abbreviations mean:

- (1) ACS: American College of Surgeons;
- ~~(2)~~ (2) AEMT: Advanced Emergency Medical Technician;
- ~~(2)~~ (3) AHA: American Heart Association;
- ~~(4)~~ (4) ASTM: American Society for Testing and Materials;
- ~~(3)~~ (5) ~~ATLS: Advanced Trauma Life Support~~;
- ~~(4)~~ (6) ~~CA3: Clinical Anesthesiology Year 3~~;
- ~~(5)~~ (7) ~~CAAHEP: Commission on Accreditation of Allied Health Education Programs~~;
- ~~(5)~~ (8) ~~CRNA: Certified Registered Nurse Anesthetist~~;
- (6) CPR: Cardiopulmonary Resuscitation;
- ~~(7)~~ (9) ~~DOA: Dead on Arrival~~;
- ~~(8)~~ (10) ED: Emergency Department;
- ~~(9)~~ (11) EMD: Emergency Medical Dispatcher;
- ~~(10)~~ (12) ~~EMDPRS: Emergency Medical Dispatch Priority Reference System~~;
- ~~(9)~~ (13) EMR: Emergency Medical Responder;
- ~~(14)~~ (14) EMS: Emergency Medical Services;
- ~~(12)~~ (15) EMS-NP: EMS Nurse Practitioner;
- ~~(13)~~ (16) EMS-PA: EMS Physician Assistant;
- ~~(14)~~ (17) EMT: Emergency Medical Technician;
- ~~(15)~~ (18) ~~EMT I: EMT Intermediate~~;
- ~~(16)~~ (19) ~~EMT P: EMT Paramedic~~;
- ~~(17)~~ (20) ~~ENT: Ear, Nose and Throat~~;
- ~~(18)~~ (21) FAA: Federal Aviation Administration;
- ~~(19)~~ (22) FAR: Federal Aviation Regulation;
- ~~(20)~~ (23) FCC: Federal Communications Commission;
- ~~(24)~~ (24) ~~GSC: GCS~~: Glasgow Coma Scale;
- ~~(22)~~ (25) ICD: International Classification of Diseases;
- ~~(23)~~ (26) ISS: Injury Severity Score;
- ~~(20)~~ (27) ICU: Intensive Care Unit;

- ~~(24)~~ (21) IV: Intravenous;
- ~~(25)~~ (22) LPN: Licensed Practical Nurse;
- ~~(26)~~ (23) MICN: Mobile Intensive Care Nurse;
- ~~(27)~~ —MR: ~~Medical Responder~~;
- ~~(28)~~ (24) NHTSA: National Highway Traffic Safety Administration;
- ~~(29)~~ (25) OEMS: Office of Emergency Medical Services;
- ~~(30)~~ —OMF: ~~Oral maxillofacial~~;
- ~~(31)~~ (26) OR: Operating Room;
- ~~(32)~~ —PGY2: ~~Post Graduate Year 2~~;
- ~~(33)~~ —PGY4: ~~Post Graduate Year 4~~;
- ~~(34)~~ (27) PSAP: Public Safety Answering Point;
- ~~(35)~~ (28) RAC: Regional Advisory Committee;
- ~~(36)~~ (29) RFP: Request For Proposal;
- ~~(37)~~ (30) RN: Registered Nurse;
- ~~(38)~~ (31) SCTP: Specialty Care Transport Program;
- ~~(39)~~ (32) SMARTT: State Medical Asset and Resource Tracking Tool;
- ~~(40)~~ (33) STEMI: ST Elevation Myocardial Infarction;
- ~~(41)~~ (34) TR: Trauma Registrar;
- ~~(42)~~ —TNC: ~~Trauma Nurse Coordinator~~;
- ~~(43)~~ (35) TPM: Trauma Program Manager; and
- ~~(44)~~ (36) 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~~. 2004;*  
*Readopted Eff. January 1, 2017;*

10A NCAC 13P .0102 is proposed for readoption with substantive changes as follows:

**10A NCAC 13P .0102 DEFINITIONS**

The following definitions apply throughout this Subchapter:

- ~~(1)~~ —"Advanced Trauma Life Support" means the course sponsored by the American College of Surgeons.
- ~~(2)~~ (1) "Affiliated EMS Provider" means the firm, corporation, agency, organization, or association identified to a specific county EMS system as a condition for EMS Provider Licensing as required by Rule ~~.0204(a)(1)~~ .0204(b)(1) of this Subchapter.

- (3) (2) "Affiliated Hospital" means a ~~non-Trauma Center~~ non-trauma center hospital that is owned by the Trauma Center or there ~~exists~~ 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~~ non-trauma center hospital.
- (4) (3) "Affiliate" or "Affiliation" means a reciprocal agreement and association that includes active participation, collaboration and involvement in a process or system between two or more parties.
- (4) "Alternative Practice Setting" means a clinical environment that may be not affiliated with or under the oversight of the EMS System or EMS System Medical Director.
- (5) "Air Medical Ambulance" means an aircraft configured and medically equipped to transport patients by air. The patient care compartment of air medical ambulances shall be staffed by medical crew members approved for the mission by the medical director.
- (6) "Air Medical Program" means a SCTP or EMS System utilizing rotary-wing or fixed-wing aircraft configured and operated to transport patients.
- (7) "Assistant Medical Director" means a physician, EMS-PA, or EMS-NP who assists the medical director with the medical aspects of the management of an EMS System or EMS SCTP.
- (8) ~~"Attending" means a physician who has completed medical or surgical residency and is either eligible to take boards in a specialty area or is boarded in a specialty.~~
- (9) ~~"Board Certified, Board Certification, Board Eligible, Board Prepared, or Boarded" means approval by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, or the Royal College of Physicians and Surgeons of Canada unless a further sub-specialty such as the American Board of Surgery or Emergency Medicine is specified.~~
- (10) (8) "Bypass" means the a decision made by the patient care technician to transport of an emergency medical services a patient from the scene of an accident or medical emergency past an emergency medical services 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.
- (11) (9) "Contingencies" mean conditions placed on a ~~trauma center's~~ designation that, if unmet, ~~can~~ may result in the loss or amendment of a ~~hospital's~~ designation.
- (12) (10) "Convalescent Ambulance" means an ambulance used on a scheduled basis solely to transport patients having a known non-emergency medical condition. Convalescent ambulances shall not be used in place of any other category of ambulance defined in this Subchapter.
- (13) ~~"Clinical Anesthesiology Year 3" means an anesthesiology resident having completed two clinical years of general anesthesiology training. A pure laboratory year shall not constitute a clinical year.~~
- (14) (11) "Deficiency" means the failure to meet essential criteria for a ~~trauma center's~~ designation as ~~specified in Section .0900 of this Subchapter~~, that can serve as the basis for a focused review or denial of a ~~trauma center~~ designation.
- (15) (12) "Department" means the North Carolina Department of Health and Human Services.
- (16) (13) "Diversion" means the hospital is unable to accept a ~~pediatric or adult~~ patient due to a lack of staffing or resources.
- (17) ~~"E Code" means a numeric identifier that defines the cause of injury, taken from the ICD.~~

- (14) "Educational Medical Advisor" means the physician responsible for overseeing the medical aspects of approved EMS educational ~~programs in continuing education, basic, and advanced EMS educational institutions;~~ programs.
- (15) "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 that would require the submission of System Data to the OEMS;~~ patient.
- (16) "EMS Educational Institution" means any agency credentialed by the OEMS to offer EMS educational programs.
- (17) "EMS ~~Nontransporting~~ 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 ~~EMT I or EMT P~~ an AEMT or Paramedic to the scene of a request for assistance. EMS nontransporting vehicles shall not be used for the transportation of patients on the streets, highways, waterways, or airways of the state.
- (18) "EMS Peer Review Committee" means a committee as defined in G.S. ~~131E-144(a)(6b);~~ 131E-155(6b).
- (19) "EMS Performance Improvement ~~Toolkits~~ STAT" ~~mean~~ 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 ~~toolkit~~ Performance Improvement STAT focuses on a topic of care such as trauma, cardiac arrest, EMS response times, stroke, STEMI (heart attack), and pediatric care.
- (20) "EMS Provider" means those entities defined in G.S. 131E-155(13a) that hold a current license issued by the Department pursuant to G.S. 131E-155.1.
- (21) "EMS System" means a coordinated arrangement of local resources under the authority of the county government (including all agencies, personnel, equipment, and facilities) organized to respond to medical emergencies and integrated with other health care providers and networks including public health, community health monitoring activities, and special needs populations.
- (26) "EMS System Peer Groups" are defined as:
- (a) ~~Urban EMS System means greater than 200,000 population;~~
  - (b) ~~Suburban EMS System means from 75,001 to 200,000 population;~~
  - (c) ~~Rural EMS System means from 25,001 to 75,000 population; and~~
  - (d) ~~Wilderness EMS System means 25,000 or less.~~
- (22) "Essential Criteria" means those items ~~listed in Rules .0901, .0902, and .0903 of this Subchapter~~ that are the ~~minimum~~ requirements for the respective level of trauma center designation (I, II, or III).
- (23) "Focused Review" means an evaluation by the OEMS of ~~a trauma center's~~ corrective actions to remove contingencies that are a result of deficiencies ~~placed upon it~~ following a ~~renewal~~ site visit.
- (24) "Ground Ambulance" means an ambulance used to transport patients with traumatic or medical conditions or patients for whom the need for specialty care or emergency or non-emergency medical care is anticipated either at the patient location or during transport.
- (25) "Hospital" means a licensed facility as defined in G.S. 131E-176.

- ~~(31)~~ (26) "Immediately Available" means the physical presence of the health professional or the hospital resource within the trauma center to evaluate and care for the trauma ~~patient without delay.~~ patient.
- ~~(32)~~ (27) "Inclusive Trauma System" means an organized, multi-disciplinary, evidence-based approach to provide quality care and to improve measurable outcomes for all defined injured patients. EMS, hospitals, other health systems and clinicians shall participate in a structured manner through leadership, advocacy, injury prevention, education, clinical care, performance ~~improvement~~ improvement, and research resulting in integrated trauma care.
- ~~(33)~~ (28) "Infectious Disease Control Policy" means a written policy describing how the EMS system will protect and prevent its patients and EMS professionals from exposure and illness associated with contagions and infectious disease.
- ~~(34)~~ (29) "Lead RAC Agency" means the agency (comprised of one or more Level I or II trauma centers) that provides staff support and serves as the coordinating entity for trauma ~~planning in a region.~~ planning.
- ~~(35)~~ (30) "Level I Trauma Center" means a hospital as defined by Item ~~(30)~~ (25) of this Rule that has the capability of providing leadership, guidance, research, and total care for every aspect of injury from prevention to rehabilitation.
- ~~(36)~~ (31) "Level II Trauma Center" means a hospital as defined by Item ~~(30)~~ (25) of this Rule that provides trauma care regardless of the severity of the injury but may lack the ~~not be able to provide the same~~ comprehensive care as a Level I trauma center and does not have trauma research as a primary objective.
- ~~(37)~~ (32) "Level III Trauma Center" means a hospital as defined by Item ~~(30)~~ (25) of this Rule that provides ~~prompt~~ assessment, resuscitation, emergency operations, and stabilization, and arranges for hospital transfer as needed to a Level I or II trauma center.
- ~~(38)~~ (33) "Licensed Health Care Facility" means any health care facility or hospital as defined by Item ~~(30)~~ (25) of this Rule licensed by the Department of Health and Human Services, Division of Health Service Regulation.
- ~~(39)~~ (34) "Medical Crew Member" means EMS personnel or other health care professionals who are licensed or registered in North Carolina and are affiliated with a SCTP.
- ~~(40)~~ (35) "Medical Director" means the physician responsible for the medical aspects of the management of an EMS System, Alternative Practice Setting, ~~or~~ SCTP, or Trauma Center.
- ~~(41)~~ (36) "Medical Oversight" means the responsibility for the management and accountability of the medical care aspects of an EMS System, Alternative Practice Setting, or SCTP. Medical Oversight includes physician direction of the initial education and continuing education of EMS personnel or medical crew members; development and monitoring of both operational and treatment protocols; evaluation of the medical care rendered by EMS personnel or medical crew members; participation in system or program evaluation; and directing, by two-way voice communications, the medical care rendered by the EMS personnel or medical crew members.
- ~~(42)~~ "Mid-level Practitioner" ~~means a nurse practitioner or physician assistant who routinely cares for trauma patients.~~
- ~~(43)~~ "Model EMS System" ~~means an EMS System that is recognized and designated by the OEMS for meeting and mastering quality and performance indicator criteria as defined by Rule .0202 of this Subchapter.~~

- (44) (37) "Off-line Medical Control" means medical supervision provided through the EMS System Medical Director or SCTP Medical Director who is responsible for the day to day medical care provided by EMS personnel. This includes EMS personnel education, protocol development, quality management, peer review activities, and EMS administrative responsibilities related to assurance of quality medical care.
- (45) (38) "Office of Emergency Medical Services" means a section of the Division of Health Service Regulation of the North Carolina Department of Health and Human Services located at ~~701 Barbour Drive,~~ 1201 Umstead Drive, Raleigh, North Carolina 27603.
- (46) (39) "On-line Medical Control" means the medical supervision or oversight provided to EMS personnel through direct communication in ~~person,~~ in-person, via radio, cellular phone, or other communication device during the time the patient is under the care of an EMS professional. ~~The source of on-line medical control is typically a designated hospital's emergency department physician, EMS nurse practitioner, or EMS physician assistant.~~
- (47) (40) "Operational Protocols" means the administrative policies and procedures of an EMS System or that provide guidance for the day-to-day operation of the system.
- (48) (41) "Participating Hospital" means a hospital that supplements care within a larger trauma system by the initial evaluation and assessment of injured patients for transfer to a designated trauma center if needed.
- (49) (42) "Physician" means a medical or osteopathic doctor licensed by the North Carolina Medical Board to practice medicine in the state of North Carolina.
- (50) ~~"Post Graduate Year Two" means any surgery resident having completed one clinical year of general surgical training. A pure laboratory year shall not constitute a clinical year.~~
- (51) ~~"Post Graduate Year Four" means any surgery resident having completed three clinical years of general surgical training. A pure laboratory year shall not constitute a clinical year.~~
- (52) ~~"Promptly Available" means the physical presence of health professionals in a location in the trauma center within a short period of time, that is defined by the trauma system (director) and continuously monitored by the performance improvement program.~~
- (53) (43) "Regional Advisory ~~Committee (RAC)"~~ Committee" means a committee comprised of a lead RAC agency and a group representing trauma care providers and the community, for the purpose of regional trauma planning, establishing, and maintaining a coordinated trauma system.
- (54) (44) "Request for ~~Proposal (RFP)"~~ Proposal" means a state document that must be completed by each hospital as defined by Item ~~(30)~~ (25) of this Rule seeking initial or renewal trauma center designation.
- (45) "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.
- (55) (46) "State Medical Asset and Resource Tracking Tool (~~SMARTT~~)" means the Internet web-based program used by the OEMS both daily in its operations and during times of disaster to identify, record and monitor EMS, hospital, health care and sheltering resources statewide, including facilities, personnel, vehicles, equipment, pharmaceutical and supply caches.
- (56) (47) "Specialty Care Transport Program" means a program designed and operated for the ~~provision of specialized medical care and transportation of critically ill or injured patients between health care facilities and for patients who are discharged from a licensed health care facility to their residence that require specialized medical care~~

~~during transport which exceeds the normal capability of the local EMS System.~~ transportation of a patient by ground or air requiring specialized interventions, monitoring and staffing by a paramedic who has received additional training as determined by the program medical director beyond the minimum training prescribed by the OEMS, or by one or more other healthcare professional(s) qualified for the provision of specialized care based on the patient's condition.

- (~~57~~) (48) "Specialty Care Transport Program Continuing Education Coordinator" means a Level I EMS Instructor within a SCTP who is responsible for the coordination of EMS continuing education programs for EMS personnel within the program.
- (49) "Stretcher" means any wheeled or portable device capable of transporting a person in a recumbent position and may only be used in an ambulance vehicle permitted by the Department.
- (~~58~~) (50) "Stroke" means an acute cerebrovascular hemorrhage or occlusion resulting in a neurologic deficit.
- (~~59~~) (51) "System Continuing Education Coordinator" means the Level I EMS Instructor designated by the local EMS System who is responsible for the coordination of EMS continuing education programs.
- (~~60~~) (52) "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 ~~in accordance with G.S. 150B-21.6~~; including subsequent amendments and ~~additions~~. editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost.
- (~~61~~) ~~"Transfer Agreement" means a written agreement between two agencies specifying the appropriate transfer of patient populations delineating the conditions and methods of transfer.~~
- (~~62~~) (53) "Trauma Center" means a hospital as defined by Item (~~30~~) (25) of this Rule designated by the State of North Carolina and distinguished by its ability to ~~immediately~~ manage, on a 24-hour basis, the severely injured patient or those at risk for severe injury.
- (~~63~~) (54) "Trauma Center Criteria" means essential criteria to define Level I, II, or III trauma centers.
- (~~64~~) (55) "Trauma Center Designation" means a process of approval in which a hospital as defined by Item (~~30~~) (25) of this Rule voluntarily seeks to have its trauma care capabilities and performance evaluated by experienced on-site reviewers.
- (~~65~~) (56) "Trauma Diversion" means a trauma center of its own volition declines to accept an acutely injured ~~pediatric or adult~~ patient due to a lack of staffing or resources.
- (~~66~~) (57) "Trauma Guidelines" mean standards for practice in a variety of situations within the trauma system.
- (~~67~~) (58) "Trauma Minimum Data Set" means the basic data required of all hospitals for submission to the trauma statewide database.
- (~~68~~) (59) "Trauma Patient" means any patient with an ~~ICD-9 CM discharge diagnosis 800.00-959.9 excluding 905-909 (late effects of injury), 910.0-924 (blisters, contusions, abrasions, and insect bites), and 930-939 (foreign bodies).~~ ICD-CM discharge diagnosis as defined in the "North Carolina Trauma Registry Data Dictionary," incorporated herein by reference in accordance with G.S.150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost

- (69) (60) "Trauma Program" means an administrative entity that includes the trauma service and coordinates other trauma related activities. It must also include the trauma medical director, trauma program manager/trauma coordinator, and trauma registrar. This program's reporting structure shall give it the ability to interact with at least equal authority with other departments providing patient care.
- (70) (61) "Trauma Registry" means a disease-specific data collection composed of a file of uniform data elements that describe the injury event, demographics, pre-hospital information, diagnosis, care, outcomes, and costs of treatment for injured patients collected and electronically submitted as defined by the OEMS.
- (71) ~~"Trauma Service" means a clinical service established by the medical staff that has oversight of and responsibility for the care of the trauma patient.~~
- (72) ~~"Trauma Team" means a group of health care professionals organized to provide coordinated and timely care to the trauma patient.~~
- (73) (62) "Treatment Protocols" means a document approved by the medical directors of ~~both~~ 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.
- (74) (63) "Triage" means the assessment and categorization of a patient to determine the level of EMS and healthcare facility based care required.
- (75) (64) "Water Ambulance" means a watercraft specifically configured and medically equipped to transport patients.

*History Note:* Authority ~~G.S. 131E-155(a)(6b);~~ G.S. 131E-155(6b); 131E-162; 143-508(b), ~~(d)(1), (d)(2), (d)(3), (d)(4), (d)(5), (d)(6), (d)(7), (d)(8), (d)(13);~~ 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~~. rule;*  
*Readopted Eff. January 1, 2017.*

10A NCAC 13P .0201 is proposed for readoption with substantive changes as follows:

#### **10A NCAC 13P .0201 EMS SYSTEM REQUIREMENTS**

- (a) County governments shall establish EMS Systems. Each EMS System shall have:
- (1) a defined geographical service area for the EMS System. The minimum service area for an EMS System shall be one county. There may be multiple EMS Provider service areas within ~~the service area of~~ an EMS System. The highest level of care offered within any EMS Provider service area must be available to the citizens within that service area 24 hours ~~per day;~~ a day, seven days a week;
  - (2) a defined scope of practice for all EMS ~~personnel,~~ personnel functioning in the EMS ~~System,~~ System within the parameters set forth by the North Carolina Medical Board pursuant to G.S. 143-514;



- (3) written policies and procedures describing the dispatch, ~~coordination~~ coordination, and oversight of all responders that provide EMS care, specialty patient care ~~skills~~ skills, and procedures as defined in Rule .0301(a)(4) of this Subchapter, and ambulance transport within the system;
- (4) at least one licensed EMS Provider;
- (5) a listing of permitted ambulances to provide coverage to the service area 24 hours ~~per day; a day, seven days~~ a week;
- (6) personnel credentialed to perform within the scope of practice of the system and to staff the ambulance vehicles as required by G.S. 131E-158. There shall be a written plan for the use of credentialed EMS personnel for all practice settings used within the system;
- (7) written policies and procedures specific to the utilization of the EMS System's EMS Care data for the daily and on-going management of all EMS System resources;
- (8) a written Infectious Disease Control Policy as defined in Rule ~~.0102(33)~~ .0102(28) of this Subchapter and written procedures ~~which~~ that are approved by the EMS System medical director that address the cleansing and disinfecting of vehicles and equipment that are used to treat or transport patients;
- (9) a listing of ~~facilities~~ resources that will provide online medical direction for all EMS Providers operating within the EMS System;
- (10) an EMS communication system that provides for:
  - (A) public access ~~using the emergency telephone number~~ to emergency services by dialing 9-1-1 within the public dial telephone network as the primary method for the public to request emergency assistance. This number shall be connected to the ~~emergency communications center or~~ PSAP with immediate assistance available such that no caller will be instructed to hang up the telephone and dial another telephone number. A person calling for emergency assistance shall not be required to speak with more than two persons to request emergency medical assistance;
  - (B) ~~an emergency communications system~~ a PSAP operated by public safety telecommunicators with training in the management of calls for medical assistance available 24 hours ~~per day; a day, seven~~ days a week;
  - (C) dispatch of the most appropriate emergency medical response unit or units to any caller's request for assistance. The dispatch of all response vehicles shall be in accordance with a written EMS System plan for the management and deployment of response vehicles including requests for mutual aid; and
  - (D) two-way radio voice communications from within the defined service area to the ~~emergency communications center or~~ PSAP and to facilities where patients are ~~routinely~~ transported. The ~~emergency communications system~~ PSAP shall maintain all required FCC radio licenses or authorizations;
- (11) written policies and procedures for addressing the use of SCTP and Air Medical ~~Programs~~ resources utilized within the system;
- (12) a written continuing education program for all credentialed EMS personnel, under the direction of a System Continuing Education Coordinator, developed and modified based on feedback from system EMS Care data, review, and evaluation of patient outcomes and quality management peer reviews, that follows the guidelines of the: criteria set forth in Rule .0501 of this Subchapter;

- ~~(A) "US DOT NHTSA First Responder Refresher: National Standard Curriculum" for MR personnel;~~
- ~~(B) "US DOT NHTSA EMT Basic Refresher: National Standard Curriculum" for EMT personnel;~~
- ~~(C) "EMT P and EMT I Continuing Education National Guidelines" for EMT I and EMT P personnel;~~  
and
- ~~(D) "US DOT NHTSA Emergency Medical Dispatcher: National Standard Curriculum" for EMD personnel;~~

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

- (13) written policies and procedures to address management of the EMS System that includes:
  - (A) triage and transport of all acutely ill and injured patients with time-dependent or other specialized care issues including trauma, stroke, STEMI, burn, and pediatric patients that may require the by-pass of other licensed health care facilities and ~~which that~~ are based upon the expanded clinical capabilities of the selected healthcare facilities;
  - (B) triage and transport of patients to facilities outside of the system;
  - (C) arrangements for transporting patients to appropriate facilities when diversion or bypass plans are activated;
  - (D) reporting, monitoring, and establishing standards for system response times using ~~data provided by the OEMS; data;~~ data;
  - (E) weekly updating of the SMARTT EMS Provider information;
  - (F) a disaster plan; ~~and~~
  - (G) a mass-gathering plan;
  - ~~(H) a mass-casualty plan;~~
  - ~~(I) a weapons plan for any weapon as set forth in Rule .0216 of this Section;~~
  - ~~(J) a plan on how EMS personnel shall report suspected child abuse pursuant to G.S. 7B-302;~~
  - ~~(K) a plan on how EMS personnel shall report suspected abuse of the elderly or disabled pursuant to G.S. 108A-102; and~~
  - ~~(L) a plan on how each responding agency is to maintain a current roster of its personnel providing EMS care within the county under the provider number issued pursuant to Paragraph (c) of this Rule, in the OEMS credentialing and information database;~~
- (14) affiliation as defined in Rule ~~.0102(4)~~ .0102(3) of this Subchapter with ~~the~~ a trauma RAC as required by Rule .1101(b) of this Subchapter; and
- (15) medical oversight as required by Section .0400 of this Subchapter.

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

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

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

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

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

*History Note: Authority G.S. ~~131E-155(1), (6), (8), (9), (15);~~ 131E-155(1); 131E-155(6); 131E-155(7); 131E-155(8); 131E-155(9); 131E-155(13a); 131E-155(15); ~~143-508(b), (d)(1), (d)(2), (d)(3), (d)(5), (d)(8), (d)(9), (d)(10), (d)(13);~~ 143-508(b); 143-508(d)(1); 143-508(d)(2); 143-508(d)(3); 143-508(d)(5); 143-508(d)(8); 143-508(d)(9); 143-508(d)(10); (d)(13); ~~143-509(1), (3), (4), (5);~~ 143-517; 143-518;  
Temporary Adoption Eff. January 1, 2002;  
Eff. August 1, 2004;  
Amended Eff. January 1, ~~2009~~; 2009;  
Readopted Eff. January 1, 2017.*

10A NCAC 13P .0203 is proposed for readoption as a repeal as follows:

#### **10A NCAC 13P .0203 SPECIAL SITUATIONS**

*History Note: Authority G.S. 143-508(b);  
Temporary Adoption Eff. January 1, 2002;  
Eff. April 1, 2003;  
Amended Eff. January 1, ~~2004~~; 2004;  
Repealed Eff. January 1, 2017.*

10A NCAC 13P .0209 is proposed for amendment as follows:

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

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

- (1) ~~Configuration~~ configuration of the aircraft patient care compartment does not compromise the ability to provide ~~appropriate care or prevent performing in-flight emergency patient care procedures as approved by the program medical director.~~ appropriate care or prevent performing in-flight emergency patient care procedures as approved by the program medical director.
- (2) ~~The~~ the aircraft has ~~on-board~~ on-board patient care equipment and supplies as defined in the treatment protocols for the ~~program.~~ program written by the medical director and approved by the OEMS. The equipment and supplies shall be clean, in working order, and secured in the ~~aircraft.~~ aircraft;

- (3) ~~There~~ there is installed in the rotary-wing aircraft an internal voice communication system to allow for communication between the medical ~~crew~~ and flight ~~crew~~; crew;
- (4) ~~The~~ the medical director designates the combination of medical equipment specified in Item (2) of this Rule that is carried on a mission based on anticipated patient care ~~needs~~; needs;
- (5) ~~The~~ the name of the EMS Provider is permanently displayed on each side of the ~~aircraft~~; aircraft;
- (6) ~~The~~ the rotary-wing aircraft is equipped with a two-way voice radio licensed by the FCC capable of operation on any frequency required to allow communications with public safety agencies such as fire departments, police departments, ambulance and rescue units, hospitals, and local government ~~agencies~~; agencies, within the service ~~area~~; area;
- (7) ~~In~~ in addition to equipment required by applicable air worthiness certificates and Federal Aviation Regulations (FAA Part 91 or 135), any rotary-wing aircraft permitted has the following functioning equipment to help ensure the safety of patients, crew ~~members~~; members, and ground personnel, patient comfort, and medical care:
  - (a) Global Positioning System;
  - (b) an external search light that can be operated from inside the aircraft;
  - (c) survival gear appropriate for the service area and the number, ~~age~~ age, and type of patients;
  - (d) permanently installed environmental control unit (ECU) capable of both heating and cooling the patient compartment of the aircraft; ~~and~~
  - (e) ~~capability to carry at least a 220 pound patient load and transport at least 60 nautical miles or nearest Trauma Center non-stop without refueling.~~
- (8) ~~The~~ the availability of one pediatric restraint device to safely transport pediatric patients and children under 40 pounds in the patient compartment of the air medical ~~ambulance~~; ambulance;
- (9) ~~The~~ the aircraft has no structural or functional defects that may adversely affect the patient, or the EMS ~~personnel~~; personnel; and
- (10) a copy of the patient care treatment protocols, either paper or electronic, carried aboard the aircraft.

*History Note: Authority G.S. 131E-157(a); 143-508(d)(8);  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. April 1, 2003;  
 Amended Eff. January 1, 2004;  
 Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;  
 Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this rule;  
 Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016~~; 2016;  
 Amended Eff. January 1, 2017.*

10A NCAC 13P .0214 is proposed for amendment as follows:

**10A NCAC 13P .0214 EMS ~~NONTRANSPORTING~~ NON-TRANSPORTING VEHICLE PERMIT CONDITIONS**

- (a) ~~An~~ A licensed EMS provider shall apply to the OEMS for an EMS ~~Nontransporting~~ non-transporting Vehicle Permit prior to placing such vehicle in service.
- (b) The ~~Department~~ OEMS shall issue a permit for a vehicle following verification of compliance with applicable laws and rules.
- (c) Only one EMS ~~Nontransporting~~ Non-transporting Vehicle Permit shall be issued for each vehicle.
- (d) EMS ~~Nontransporting~~ Non-transporting Vehicle Permits shall not be transferred.
- (e) The EMS ~~Nontransporting~~ Non-transporting Vehicle Permit shall be posted as designated by the OEMS inspector.
- (f) Vehicles that are not owned or leased by the licensed EMS Provider are ineligible for permitting.

*History Note: Authority G.S. 143-508(d)(8);  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. April 1, 2003;  
 Amended Eff. January 1, 2009; January 1, 2004;  
 Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016~~ 2016;  
 Amended Eff. January 1, 2017.*

10A NCAC 13P .0216 is proposed for readoption with substantive changes as follows:

**10A NCAC 13P .0216 WEAPONS AND EXPLOSIVES FORBIDDEN**

- (a) Weapons, ~~as defined by the local county district attorney's office, whether lethal or non-lethal,~~ and explosives shall not be worn or carried aboard an ambulance or EMS ~~nontransporting~~ non-transporting vehicle within the State of North Carolina when the vehicle is operating in any patient treatment or transport capacity or is available for such function.
- (b) Conducted electrical weapons and chemical irritants such as mace, pepper (oleoresin capsicum) spray, and tear gas are considered weapons for the purpose of this Rule.
- ~~(b)~~ (c) This Rule shall apply whether or not such weapons and explosives are concealed or visible.
- (d) If any weapon is found to be in the possession of a patient or person accompanying the patient during transportation, the weapon shall be safely secured in accordance with the weapons policy as set forth in Rule .0201(a)(13)(I) of this Subchapter.
- (e) Weapons authorized for use by EMS personnel attached to a law enforcement tactical team in accordance with the weapons policy as set forth in Rule .0201(a)(13)(I) of this Subchapter may be secured in a locked, dedicated compartment or gun safe mounted within the ambulance or non-transporting vehicle for use when dispatched in support of the law enforcement tactical team, but are not to be worn or carried open or concealed by any EMS personnel in the performance of normal EMS duties under any circumstances.
- ~~(e)~~ (f) This Rule shall not apply to duly appointed law enforcement officers.
- ~~(d)~~ (g) Safety flares are authorized for use on an ambulance with the following restrictions:
  - (1) ~~These~~ these devices are not stored inside the patient compartment of the ambulance; and
  - (2) ~~These~~ these devices shall be packaged and stored so as to prevent accidental discharge or ignition.

*History Note: Authority G.S. 131E-157(a); 143-508(d)(8);  
 Temporary Adoption Eff. January 1, 2002;*

*Eff. April 1, 2003- 2003;*

*Readopted Eff. January 1, 2017.*

10A NCAC 13P .0219 is proposed for readoption with substantive changes as follows:

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

Medical Ambulance/Evacuation Bus Vehicles are exempt from the requirements of G.S. 131E-158(a). The EMS System Medical ~~Director~~ Director, as set forth in Rule .0403 of this Subchapter, shall determine the combination and number of EMT, ~~EMT-Intermediate~~, AEMT, or ~~EMT-Paramedic~~ Paramedic personnel that are sufficient to manage the anticipated number and severity of injury or illness of the patients transported in the Medical Ambulance/Evacuation Bus ~~vehicle~~. Vehicle.

*History Note: Authority G.S. 131E-158(b);*

*Eff. July 1, 2011- 2011;*

*Readopted Eff. January 1, 2017.*

10A NCAC 13P .0221 is proposed for readoption with substantive changes as follows:

**10A NCAC 13P .0221 PATIENT TRANSPORTATION BETWEEN HOSPITALS**

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

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

- (1) one person who holds a credential issued by the OEMS as ~~a Medical Responder~~ an emergency medical responder or higher who is responsible for the operation of the vehicle and rendering assistance to the patient caregiver when needed; and
- (2) at least one of the following individuals as determined by the transferring physician to manage the anticipated severity of injury or illness of the patient who is responsible for the medical aspects of the mission:
  - (A) ~~Emergency Medical Technician~~; emergency medical technician;
  - (B) ~~EMT-Intermediate~~; advanced EMT;
  - (C) ~~EMT-Paramedic~~; paramedic;
  - (D) nurse practitioner;
  - (E) physician;
  - (F) physician assistant;
  - (G) registered nurse; or
  - (H) respiratory therapist.

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

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

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

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

*History Note: Authority G.S. 131E-155.1; 131E-158(b); ~~143-508(d)(1), (d)(8); 143-508(d)(1); 143-508(d)(8);~~  
Eff. July 1, ~~2012~~, 2012;  
Readopted Eff. January 1, 2017.*

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

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

(a) Any person transported on a stretcher as defined in Rule .0102(49) of this Subchapter meets the definition of patient as defined in G.S. 131E-155(16).

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

(c) The Medical Care Commission exempts wheeled chair devices used solely for the transportation of mobility impaired persons in non-permitted vehicles from the definition of stretcher as set forth in Rule .0102(49) of this Subchapter.

*History Note: Statutory Authority 143-508(d)(8); 131E-156; 131E-157;  
Eff. January 1, 2017.*

10A NCAC 13P .0223 is proposed for adoption as follows:

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

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

- (1) any prior name(s) used for providing emergency medical services in North Carolina or any other state;
- (2) any felony criminal charges and convictions, under Federal or State law, and any civil actions taken against the applicant or any of its owners or officers in North Carolina or any other state;
- (3) any misdemeanor or felony conviction, under Federal or State law, relating to the unlawful manufacture, distribution, prescription, or dispensing of a controlled substance;
- (4) any misdemeanor or felony conviction, under Federal or State law, related to theft, fraud, embezzlement, breach of fiduciary duty, or other financial misconduct in connection with the delivery of EMS care or service;
- (5) any current or prior investigations including outcomes for alleged Medicare, Medicaid, or other insurance fraud, tax evasion, and fraud;

(6) any revocation or suspension of accreditation; and

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

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

*History Note: Authority G.S. 131E-155.1(c); 143-508(d)(1); 143-508(d)(5);  
Eff. January 1, 2017.*

10A NCAC 13P .0301 is proposed for readoption with substantive changes as follows:

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

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

- (1) a defined service area that identifies the specific transferring and receiving facilities in which the program is intended to service;
- (2) written policies and procedures implemented for medical oversight meeting the requirements of Section ~~.0400;~~ .0400 of this Subchapter;
- (3) Service ~~continuously~~ available on a 24 hour ~~per day a day, seven days a week~~ per day a day, seven days a week basis;
- (4) the capability to provide the patient care skills and procedures as specified in "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection;" ~~Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost;~~
- (5) a written continuing education program for EMS personnel, under the direction of the Specialty Care Transport Program Continuing Education Coordinator, developed and modified based on feedback from program data, review and evaluation of patient outcomes, and quality management review that follows the guidelines of the criteria set forth in Rule .0501 of this Subchapter;
  - (A) ~~"US DOT NHTSA EMT Basic Refresher: National Standard Curriculum" for EMT personnel; and~~
  - (B) ~~"EMT P and EMT I Continuing Education National Guidelines" for EMT I and EMT P personnel. These documents are incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. These documents are available from NHTSA, 400 7<sup>th</sup> Street, SW, Washington, D.C. 20590, at no cost;~~
- (6) a communication system that ~~will provide~~ provides two-way voice communications for transmission of patient information to medical crew members anywhere in the service area of the program. The SCTP medical director shall verify that the communications system is satisfactory for on-line medical direction;
- (7) medical crew members that have ~~all~~ completed training conducted every six months regarding:
  - (A) operation of the EMS communications system used in the program; and
  - (B) the medical and patient safety equipment specific to the ~~program. This training shall be conducted every six months;~~ program;



- (8) written operational protocols for the management of equipment, supplies and medications. These protocols shall include:
- (A) a listing of all standard medical equipment, supplies, and ~~medications~~ medications, approved by the medical director sufficient to manage the anticipated number and severity of injury or illness of the patients, for all vehicles used in the program based on the treatment protocols and approved by ~~the medical director;~~ the OEMS; and
  - (B) a methodology to assure that each ground vehicle and aircraft contains the required equipment, ~~supplies~~ supplies, and medications on each response; and
- (9) written policies and procedures specifying how EMS Systems will dispatch and utilize the ground ambulances and aircraft operated by the program.

(b) When transporting patients, staffing for the ground ambulance and aircraft used in the SCTP shall be approved by the SCTP medical director as medical crew members, using any of the following ~~appropriate for the condition of the patient;~~ as determined by the transferring physician to manage the anticipated severity of injury or illness of the patient, who is responsible for the medical aspects of the mission:

- (1) ~~EMT Paramedic;~~ paramedic;
- (2) nurse practitioner;
- (3) physician;
- (4) physician assistant;
- (5) registered nurse; and
- (6) respiratory therapist.

(c) ~~Specialty Care Transport Programs~~ SCTP as defined in Rule ~~.0102(56)~~ .0102(47) of this Subchapter are exempt from the staffing requirements defined in G.S. 131E-158(a).

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

*History Note:* Authority G.S. 131E-158; 143-508; ~~143-508(d)(1), (d)(8), (d)(9); (d)(13); 143-508(d)(13);~~  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. January 1, 2004;  
 Amended Eff. January 1, 2004;  
 Amended Eff. March 3, 2009 pursuant to E.O. 9, Beverly Perdue, March 3, 2009;  
 Pursuant to G.S. 150B-21.3(c), a bill was not ratified by the General Assembly to disapprove this ~~rule~~ rule;  
 Readopted Eff. January 1, 2017.

10A NCAC 13P .0302 is proposed for readoption with substantive changes as follows:

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

(a) Air Medical Programs using rotary-wing aircraft shall document that the program has:

- (1) ~~Medical~~ medical crew members that have all completed training regarding:
  - (A) ~~Altitude~~ altitude physiology; and
  - (B) ~~The~~ the operation of the EMS communications system used in the program;
- (2) ~~Written~~ written policies and procedures for transporting patients to appropriate facilities when diversion or bypass plans are activated;
- (3) ~~Written~~ written policies and procedures specifying how EMS Systems will dispatch and utilize aircraft operated by the program;
- (4) ~~Written~~ written triage protocols for trauma, stroke, STEMI, burn, and pediatric patients reviewed and approved by the OEMS medical director;
- (5) ~~Written~~ written policies and procedures specifying how EMS Systems will receive the Specialty Care Transport Services offered under the program when the aircraft are unavailable for service; and
- (6) ~~A copy of the Specialty Care Transport Program patient care treatment protocols.~~ written policies and procedures specifying how mutual aid assistance will be obtained from both in-state and bordering out-of-state air medical programs.

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

*History Note: Authority G.S. 143-508; 143-508(d)(1), (d)(3); (d)(13);  
 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~~. rule;  
 Readopted Eff. January 1, 2017.*

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

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

- (a) The Medical Director for an EMS System is responsible for the following:
- (1) ensuring that medical control as set forth in Rule .0401 of this Section is available 24 hours a ~~day~~, day, seven days a week;
  - (2) the establishment, approval and annual updating of adult and pediatric treatment protocols;
  - (3) EMD programs, the establishment, approval, and annual updating of the EMDPRS;
  - (4) medical supervision of the selection, system orientation, continuing education and performance of all EMS personnel;
  - (5) medical supervision of a scope of practice performance evaluation for all EMS personnel in the system based on the treatment protocols for the system;
  - (6) the medical review of the care provided to patients;

- (7) providing guidance regarding decisions about the equipment, medical supplies, and medications that will be carried on all ambulances and EMS nontransporting vehicles operating within the system;
- (8) determining the combination and number of EMS personnel sufficient to manage the anticipated number and severity of injury or illness of the patients transported in Medical Ambulance/Evacuation Bus Vehicles defined in Rule .0219 of this Subchapter;
- ~~(8)~~ (9) keeping the care provided ~~up-to-date~~ up-to-date with current medical practice; and
- ~~(9)~~ (10) developing and implementing an orientation plan for all hospitals within the EMS system that use MICN, EMS-NP, or EMS-PA personnel to provide on-line medical direction to EMS ~~personnel, which includes~~ personnel. This plan shall include:
  - (A) a discussion of all EMS System treatment protocols and procedures;
  - (B) an explanation of the specific scope of practice for credentialed EMS personnel, as authorized by the approved EMS System treatment protocols as required by Rule .0405 of this Section;
  - (C) a discussion of all practice settings within the EMS System and how scope of practice may vary in each setting;
  - (D) a mechanism to assess the ability to ~~effectively~~ use EMS System communications equipment including hospital and prehospital devices, EMS communication protocols, and communications contingency plans as related to on-line medical direction; and
  - (E) the ~~successful~~ completion of a scope of practice performance evaluation ~~which that~~ which that verifies competency in Parts (A) through (D) of this Subparagraph and ~~which that~~ which that is administered under the direction of the ~~medical director.~~ Medical Director.

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

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

- (1) restrict the EMS personnel's scope of practice pending successful completion of remediation on the identified deficiencies;
- (2) continue the suspension pending successful completion of remediation on the identified deficiencies; or
- (3) permanently revoke the EMS personnel's participation in the EMS System.

*History Note: Authority G.S. 143-508(b); ~~143-508(d)(3),(d)(7); 143-508(d)(3); 143-508(d)(7); 143-509(12);~~  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. April 1, 2003;  
 Amended Eff. January 1, 2009; January 1, ~~2004.~~ 2004;  
 Readopted Eff. January 1, 2017.*

10A NCAC 13P .0409 is proposed for amendment as follows:

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

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

- (1) be composed of membership as defined in G.S. 131E-155(6b);
- (2) appoint a physician as chairperson;
- (3) meet at least quarterly;
- (4) analyze program data to evaluate the ongoing quality of patient care and medical direction within the program;
- (5) use information gained from program data analysis to make recommendations regarding the content of continuing education programs for medical crew members;
- (6) review adult and pediatric treatment protocols of the Specialty Care Transport Programs and make recommendations to the medical director for changes;
- (7) establish and implement a written procedure to guarantee due process reviews for medical crew members temporarily suspended by the medical director;
- (8) record and maintain minutes of committee meetings throughout the approval period of the Specialty Care Transport Program;
- (9) establish and implement EMS system performance improvement guidelines that meet or exceed the statewide standard as defined by the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," ~~incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina, 27699-2707, at no cost; Collection;~~ and
- (10) adopt written guidelines that address:
  - ~~(a)~~ (A) structure of committee membership;
  - ~~(b)~~ (B) appointment of committee officers;
  - ~~(c)~~ (C) appointment of committee members;
  - ~~(d)~~ (D) length of terms of committee members;
  - ~~(e)~~ (E) frequency of attendance of committee members;
  - ~~(f)~~ (F) establishment of a quorum for conducting business; and
  - ~~(g)~~ (G) confidentiality of medical records and personnel issues.

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

*History Note: Authority G.S. 143-508(b); ~~143-509(12)~~;  
Temporary Adoption Eff. January 1, 2002;  
Eff. April 1, 2003;  
Amended Eff. January 1, 2004;  
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;  
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016~~ 2016;  
Amended Eff. January 1, 2017.*

10A NCAC 13P .0501 is proposed for re Adoption with substantive changes as follows:

**10A NCAC 13P .0501 EDUCATIONAL PROGRAMS**

(a) ~~An educational program approved by the OEMS to~~ EMS educational programs that qualify credentialed EMS personnel to perform within their scope of practice shall be offered by an EMS educational ~~institution. Institution as set forth in Section .0600~~ 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 judgement 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 ~~objectives content of~~ the “US DOT NHTSA National EMS Education Standards” incorporated by reference including subsequent amendments and editions. This document is available online at [www.ems.gov/educationstandards.htm](http://www.ems.gov/educationstandards.htm).

- (1) ~~“US DOT NHTSA First Responder: National Standard Curriculum” for MR personnel;~~
- (2) ~~“US DOT NHTSA EMT Basic: National Standard Curriculum” for EMT personnel;~~
- (3) ~~“US DOT NHTSA EMT Paramedic: National Standard Curriculum” for EMT I and EMT P personnel. For EMT I personnel, the educational objectives shall be limited to the following:~~
  - (A) ~~Module 1: Preparatory~~

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

(B) ~~Module 2: Airway~~

SECTION	TITLE	LESSON OBJECTIVES
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2-1	Airway Management & Ventilation	2-1.1 — 2-1.10; 2-1.12 — 2-1.40; 2-1.42 — 2-1.64; 2-1.69; 2-1.73 — 2-1.89; 2-1.93 — 2-1.103; 2-1.104a-d; 2-1.105 — 2-1.106; 2-1.108
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(C) — Module 3: Patient Assessment

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

(D) — Module 4: Trauma

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

(E) — Module 5: Medical

SECTION	TITLE	LESSON OBJECTIVES
5-1	Pulmonary	5-1.2 — 5-1.7; 5-1.10bedefjk — 5-1.14
5-2	Cardiology	5-2.1 — 5-2.5; 5-2.8; 5-2.11 — 5-2.12; 5-2.14; 5-2.29 — 5-2.30; 5-2.53; 5-2.65 — 5-2.68;

		<del>5-2.70;</del> <del>5-2.72 5-2.73;</del> <del>5-2.75 5-2.77;</del> <del>5-2.79 5-2.81;</del> <del>5-2.84 5-2.89;</del> <del>5-2.91 5-2.95;</del> <del>5-2.121 5-2.125;</del> <del>5-2.128 5-2.133;</del> <del>5-2.150; 5-2.159;</del> <del>5-2.162; 5-2.165;</del> <del>5-2.168;</del> <del>5-2.179 5-2.180;</del> <del>5-2.184;</del> <del>5-2.193 5-2.194;</del> <del>5-2.201; 5-2.205ab;</del> <del>5-2.206 5-2.207</del>
5-3	Neurology	<del>5-3.11 5-3.17;</del> <del>5-3.82 5-3.83</del>
5-4	Endocrinology	<del>5-4.8 5-4.48</del>
5-5	Allergies and Anaphylaxis	<del>5-5.1 5-5.19</del>
5-8	Toxicology	<del>5-8.40 5-8.56;</del> <del>5-8.62</del>

(F) ~~Module 7: Assessment Based Management~~

SECTION	TITLE	LESSON OBJECTIVES
7-1	<del>Assessment Based Management</del>	<del>7-1.1 7-1.19</del> <del>(objectives 7-1.12</del> <del>and 7-1.19 include</del> <del>only abefhkl)</del>

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

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

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

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

- (1) ~~"US DOT NHTSA First Responder Refresher: National Standard Curriculum" for MR personnel;~~
- (2) ~~"US DOT NHTSA EMT Basic Refresher: National Standard Curriculum" for EMT personnel;~~
- (3) ~~"EMT P and EMT I Continuing Education National Guidelines" for EMT I and EMT P personnel;~~
- (4) ~~"US DOT NHTSA Emergency Medical Dispatcher: National Standard Curriculum" for EMD personnel;~~
- (5) ~~"US DOT NHTSA EMT Intermediate Refresher: National Standard Curriculum" for EMT I personnel; and~~
- (6) ~~"US DOT NHTSA EMT Paramedic Refresher: National Standard Curriculum" for EMT P personnel.~~

~~These documents are incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and additions. These documents are available from NHTSA, 400 7<sup>th</sup> Street, SW, Washington, D.C. 20590, at no cost. EMD personnel for credentialing shall conform with the "ASTM F1258 – 95(2006): Standard Practice for Emergency Medical 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 dollars (\$40.00) per copy.~~

~~(d) Instructional methodology courses approved to qualify Level I EMS instructors shall conform with the "US DOT NHTSA 2002 National Guidelines for Educating EMS Instructors" incorporated by reference including subsequent amendments and additions. This document is available online at [www.ems.gov/educationstandards.htm](http://www.ems.gov/educationstandards.htm).~~

~~(e) Continuing educational programs approved to qualify EMS personnel for renewal of credentials must 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) Refresher courses must comply with the requirements defined in Rule .0513 of this Section.~~

*History Note: Authority G.S. 143-508(d)(3), (d)(4); 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. 2009;  
 Readoption Eff. January 1, 2017.*

10A NCAC 13P .0502 is proposed for readoption with substantive changes as follows:

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

(a) In order to be credentialed as an ~~MR, EMR, EMT, EMT-I, EMT-P, AEMT, or EMD,~~ 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) ~~Successfully~~ complete an approved educational program as set forth in Rule .0501(b) of this Section for their level of application. ~~If the educational program was completed over one year prior to application, applicants shall submit evidence of completion of continuing education during the past year. This continuing education shall be based on the educational objectives in Rule .0501(e) of this Section consistent with their level of application and approved by the OEMS.~~



- (3) ~~Successfully~~ complete a scope of practice performance evaluation ~~which that~~ uses performance measures based on the cognitive, psychomotor, and affective educational objectives set forth in Rule .0501(b) of this Section and which are consistent with their level of ~~application~~ 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 ~~under the direction of the educational medical advisor or~~ by a Level I or Level II EMS Instructor credentialed at or above the level of application ~~and designated by the educational medical advisor, and may be included within the educational program or conducted separately.~~ If the evaluation was completed over one year prior to application, applicants must repeat the evaluation and submit evidence of successful completion during the previous year. or under the direction of the primary credentialed EMS instructor or educational medical advisor for the approved educational program.
- (4) ~~Successfully~~ within 90 days from their course graded date as reflected in the OEMS credentialing database, complete the first attempt to pass ~~complete~~ a written examination administered by the OEMS or a written examination ~~approved by OEMS as determined by OEMS staff in their professional judgement to be equivalent~~ to the examination administered by OEMS. If the applicant fails to register and complete a written examination within the 90 day period, the applicant shall obtain a letter of authorization to continue eligibility for testing from his or her EMS Educational Institution's program coordinator to qualify for an extension of the 90 day requirement set forth in this Paragraph. If the EMS Educational Institution's program coordinator declines to provide a letter of authorization, the applicant is 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 may qualify for EMS credentialing eligibility. The OEMS will notify the applicant in writing of the decision.
- (A) A maximum of three attempts within nine 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 has repeated a course specific scope of practice evaluation as set forth in Paragraph (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) If unable to complete the written examination requirement after six attempts within an 18 month period following course grading date as reflected in the OEMS credentialing database, the educational program becomes invalid and the individual may only become eligible for credentialing by repeating the requirements set forth in Rule .0501 of this Section.
- (5) submit to a criminal background history check pursuant to G.S. 131E-159(g) as set forth in Rule .0511 of this Section.
- (6) submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s).
- (b) ~~EMD applicants shall successfully complete, within one year prior to application, an AHA CPR course or a course determined by the OEMS to be equivalent to the AHA CPR course, including infant, child, and adult CPR. An individual seeking credentialing as an EMR, EMT, AEMT or Paramedic may qualify for initial credentialing under the legal recognition option set forth in G.S. 131E-159(c).~~
- (c) In order to be credentialed as an EMD, individuals shall:

- (1) be at least 18 years of age;
- (2) complete the educational requirements set forth in Rule .0501(c) 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 pursuant to G.S. 131E-159(g) as defined in Rule .0511 of this Section;
- (5) submit evidence of completion of all court conditions resulting from any misdemeanor or felony conviction(s);  
and
- (6) possess an EMD 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 Justice, 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)(b)~~; 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~~; 2009;  
 Readopted Eff. January 1, 2017.*

10A NCAC 13P .0503 is proposed for amendment as follows:

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

Credentials for EMS Personnel shall be valid for a period of ~~not to exceed four years~~; years, barring any delay in expiration as set forth in Rule .0504(f) of this Section.

*History Note: Authority G.S. 131E-159 (a);  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. April 1, 2003;  
 Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016~~; 2016;  
 Amended Eff. January 1, 2017.*

10A NCAC 13P .0504 is proposed for readoption with substantive changes as follows:

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

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

- (1) presenting documentation to the OEMS or an approved EMS educational institution as set forth in Rule .0601 or .0602 of this Subchapter that they have ~~successfully~~ completed an approved educational program as described in Rule ~~.0501(e)~~ .0501(e) or (f) of this ~~Section~~ Section;
- (2) submit to a criminal background history check pursuant to G.S. 131E-159(g) 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 judgement to be equivalent to the educations and credentialing requirements set forth in in Section .0500 of this Subchapter.

(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) 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 continuing education 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 does not expire until a decision on the credential is made by the Department. If the application is denied, the credential shall remain effective until the last day for applying for judicial review of the Department's order.

(g) Pursuant to G.S. 131E-159(h), the Department shall not renew the EMS credential for any person listed on the North Carolina Department of Justice, Sex Offender and Public Protection Registry, 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~~; 2009;  
Readopted Eff. January 1, 2017.*

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

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

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

- (1) at the location of a physiological or psychological illness or injury including transportation to ~~an appropriate a~~ treatment facility if required;
- (2) at public or community health facilities in conjunction with public and community health initiatives;
- (3) in hospitals and clinics;
- (4) in residences, facilities, or other locations as part of wellness or injury prevention initiatives within the community and the public health system; and
- (5) at mass gatherings or special events.

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

- (1) be under the medical oversight of a physician licensed by the North Carolina Medical Board that is associated with the practice setting where the individual will function; and
- (2) be restricted to performing within the scope of practice as defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the individual's level of EMS credential.

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

*History Note: Authority G.S. 143-508(d)(7);*

*Temporary Adoption Eff. January 1, 2002;*

*Eff. April 1, 2003;*

*Amended Eff. January 1, 2004;*

*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016; 2016;*

*Amended Eff. January 1, 2017.*

10A NCAC 13P .0507 is proposed for readoption with substantive changes as follows:

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

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

- (1) be currently credentialed by the OEMS as an EMT, ~~EMT-I, EMT-P, or EMD;~~ AEMT, or Paramedic;
- (2) have three years experience at the scope of practice for the level of application;
- (3) within one year prior to application, ~~successfully~~ complete an evaluation ~~which 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) of this Section consistent with their level of application and approved by the OEMS:
  - (A) ~~For~~ 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~~ for a credential to teach at the ~~EMT-I AEMT~~ or ~~EMT-P Paramedic~~ levels, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical ~~advisor;~~ and advisor;

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

(4) have 100 hours of teaching experience at the level of application in an approved EMS educational program or ~~an EMS educational program approved by OEMS as equivalent to an approved program; determined by OEMS staff in their professional judgement equivalent to an EMS education program;~~

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

(6) within one year prior to application, attend an OEMS Instructor workshop sponsored by the ~~OEMS;~~ OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at [www.ncems.org](http://www.ncems.org); and

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

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

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

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

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

(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 Justice, 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; 2009~~;  
Readopted Eff. January 1, 2017.*

10A NCAC 13P .0508 is proposed for readoption with substantive changes as follows:

#### **10A NCAC 13P .0508 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, ~~EMT-I, EMT-P, or EMD;~~ AEMT, or Paramedic;

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

- (3) within one year prior to application, ~~successfully~~ complete an evaluation ~~which 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) of this Section consistent with their level of application and approved by the OEMS:
- (A) ~~For~~ 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~~ for a credential to teach at the ~~EMT-I~~ AEMT or ~~EMT-P~~ Paramedic level, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical ~~advisor;~~ advisor.
  - ~~(C) For a credential to teach at the EMD level, this evaluation shall be conducted under the direction of the educational medical advisor or a Level I EMS Instructor credentialed at the EMD level designated by the educational medical advisor;~~
- (4) have two years teaching experience as a Level I EMS Instructor at the level of application in an approved EMS educational program or a teaching experience ~~approved as equivalent by the OEMS;~~ determined by OEMS staff in their professional judgement equivalent to an EMS education program;
- (5) ~~successfully~~ complete the "EMS Education Administration Course" conducted by a North Carolina Community College or the National Association of EMS Educators Level II Instructor Course; and
- (6) within one year of application, attend an OEMS Instructor workshop sponsored by the ~~OEMS;~~ OEMS. A listing of scheduled OEMS Instructor workshops is available from the OEMS at [www.ncems.org](http://www.ncems.org).

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

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

- (1) ~~The~~ the OEMS imposes an administrative action against the instructor credential; or
- (2) ~~The~~ the instructor fails to maintain a current EMT, ~~EMT-I, EMT-P, or EMD~~ AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

(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 Justice, 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;~~ 2009;  
 Readopted Eff. January 1, 2017.*

10A NCAC 13P .0510 is proposed for reoption with substantive changes 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, ~~EMT-I, AEMT or EMT-P, or EMD;~~ Paramedic;
- (2) ~~successfully completed,~~ within one year prior to application, complete a scope of practice performance an evaluation which use performance measures 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) of this ~~Subchapter~~ Section consistent with their level of application and approved by the OEMS:
  - (A) ~~To~~ 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~~ to renew a credential to teach at the ~~EMT-I~~ AEMT or ~~EMT-P~~ Paramedic level, this evaluation shall be conducted under the direction of the educational medical advisor, or a Level II EMS Instructor credentialed at or above the level of application and designated by the educational medical ~~advisor;~~ and advisor.
  - (C) ~~To~~ to renew a credential to teach at the EMD level, this evaluation shall be conducted under the direction of the educational medical advisor or a Level I EMS Instructor credentialed at the EMD level designated by the educational medical advisor.
- (3) completed 96 hours of EMS instruction at the level of application; and
- (4) completed ~~40~~ 24 hours of educational professional development as defined by the educational ~~institution.~~ institution that provides for:
  - (A) enrichment of knowledge;
  - (B) development or change of attitude; or
  - (C) acquisition or improvement of skills; and
- (5) within one year prior to renewal application, attend an OEMS Instructor workshop sponsored by the OEMS.

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

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

- (1) the OEMS imposes an administrative action against the instructor credential; or
- (2) the instructor fails to maintain a current EMT, ~~EMT-I, EMT-P, or EMD~~ AEMT, or Paramedic credential at the highest level that the instructor is approved to teach.

(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 Justice, 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)(b);~~ 131E-159(a); 131E-159(b); 143-508(d)(3);  
Eff. February 1, 2004;  
Amended Eff. February 1, ~~2009;~~ 2009;  
Readopted Eff. January 1, 2017.*

10A NCAC 13P .0511 is proposed for amendment as follows:

**10A NCAC 13P .0511 CRIMINAL HISTORIES**

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

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

- (1) obtain a signed consent form for a criminal history check;
- (2) obtain fingerprints on an SBI identification card or live scan electronic fingerprinting system at an agency approved by the North Carolina Department of ~~Justice, State Bureau of Investigation;~~ Public Safety;
- (3) obtain the criminal history from the Department of ~~Justice;~~ Public Safety and
- (4) collect any processing fees from the individual identified in Paragraph (a) or (b) of this Rule as required by the Department of ~~Justice~~ Public Safety pursuant to G.S. ~~114-19.21~~ 143B-952 prior to conducting the criminal history background check.

(c) An individual who makes application for renewal of a current EMS credential or advancement to a higher level EMS credential who has previously submitted a criminal background history required under the criteria contained in Paragraph (b) of this Rule for residing in North Carolina for 60 months or less, but has continuously resided in North Carolina since submission of the criminal background check may be exempt from the residency requirements of Paragraph (b) of this Rule if determined by OEMS staff in their professional judgement no other circumstances warrant another criminal history check as set forth in Paragraph (b) of this Rule.

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

*History Note: Authority G.S. ~~114-19.21;~~ 131E-159(g); ~~143-508(d)(3),(10);~~ 143-508(d)(3); 143-508(10); 143B-952;  
Eff. January 1, 2009;  
Amended Eff. January 1, 2013;  
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016~~ 2016;  
Amended Eff. January 1, 2017.*

10A NCAC 13P .0512 is proposed for adoption as follows:

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



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

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

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

- (1) be ineligible for legal recognition pursuant to Paragraph (b) of this Rule;
- (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) EMR and EMT 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 Paragraph (b) of this Rule; 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 Paragraph (b) of this Rule;
- (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) AEMT and Paramedic applicants for reinstatement of an EMS credential, lapsed more than 48 months, shall:

- (1) be ineligible for legal recognition pursuant to Paragraph (b) of this Rule; and
- (2) meet the provisions for initial credentialing set forth in Rule .0502 of this Section.

(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 Justice, 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. 143-508(d)(3); 143B-952;  
Eff. January 1, 2017.*

10A NCAC 13P .0513 is proposed for adoption as follows:

**10A NCAC 13P .0513 REFRESHER COURSES**

(a) Approved EMS educational institutions as set forth in Rule .0601 and .0602 of this Subchapter may develop refresher courses for the renewal or reinstatement of EMS credentials.

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

- (1) course objectives, content outline and time allocation;
- (2) teaching methodologies for measuring the student's abilities to perform at his or her level of application;
- (3) the method to be used to conduct a technical scope of practice evaluation for students seeking reinstatement of a lapsed EMS credential for their level of application.

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

- (1) an application for approval of a refresher course shall be completed at least 30 days prior to the expected date of enrollment and shall include evidence of complying with the rules for refresher courses.
  - (A) Refresher course approval shall be for a period not to exceed two years; and
  - (B) Any changes in curriculum shall be approved by the OEMS prior to implementation.
- (2) course curricula shall:
  - (A) meet the National Registry of Emergency Medical Technicians' recertification requirements including subsequent amendments and additions. This document is available from the National Registry of Emergency Medical Technicians, Rocco V. Morando Building, 6610 Busch Blvd., P.O. Box 29233, Columbus, Ohio 43229, at no cost; and
  - (B) demonstrate the ability to assess student knowledge and competency in the skills and medications as defined by the North Carolina Medical Board pursuant to G.S. 143-514 for the proposed level of EMS credential application.
- (3) The administrative responsibility for developing and implementing the refresher course shall be vested in the EMS educational institution's credentialed Level II EMS instructor.

*History Note: Authority G.S. 143-508(d)(3); 143B-952;  
Eff. January 1, 2017.*

10A NCAC 13P .0601 is proposed for readoption with substantive changes as follows:

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

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

(b) Continuing Education EMS Educational Institutions shall have:

- (1) at least a Level I EMS Instructor as program coordinator. The program coordinator shall hold a Level I EMS Instructor credential at a level equal to or greater than the highest level of continuing education program offered in the EMS System or Specialty Care Transport Program;
- (2) a continuing education program shall be consistent with the services offered by the EMS System or Specialty Care Transport Program ~~Program continuing education plan for EMS personnel: Program;~~

- (A) In an EMS System, the continuing education programs for ~~EMD, EMT I, and EMT P~~ shall be reviewed and approved by the system continuing education coordinator and medical director of the EMS System; director; and
- ~~(B) In a Model EMS System, the continuing education program shall be reviewed and approved by the system continuing education coordinator and medical director.~~
- ~~(C)~~ (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;
- ~~(3)~~ (4) written educational policies and procedures to include each of the following:
  - ~~(A)~~ (A) the delivery of educational programs in a manner as to which the content and material is delivered to the intended audience, with a limited potential for exploitation of such content and material;
  - ~~(B)~~ (B) the record-keeping system detailing student attendance and performance;
  - ~~(C)~~ (C) the selection and monitoring of EMS instructors;
  - ~~(D)~~ (D) the evaluation of faculty by their students, including the frequency of evaluations;
  - ~~(E)~~ (E) the evaluation of the program's courses or components by their students, including the frequency of evaluations.
- ~~(3)~~ (4) access to instructional supplies and equipment necessary for students to complete educational programs as defined in Rule .0501(c) of this Subchapter;
- ~~(4)~~ educational programs offered in accordance with Rule .0501(e) of this Subchapter;
- ~~(5)~~ an Educational Medical Advisor if offering educational programs that have not been reviewed and approved by a medical director of an EMS System or Specialty Care Transport Program. The Educational Medical Advisor shall meet the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost; and
- ~~(6)~~ written educational policies and procedures describing the delivery of educational programs, the record-keeping system detailing student attendance and performance, and the selection and monitoring of EMS instructors.
- ~~(5)~~ (5) meet at a minimum, the educational program requirements as defined in Rule .0501(e) of this Subchapter;
- ~~(6)~~ (6) Upon request, the approved EMS continuing education institution shall provide records in order to verify compliance and student eligibility for credentialing;
- ~~(7)~~ (7) an application for credentialing as an approved EMS continuing education institution shall be submitted to the OEMS for review; and
- ~~(8)~~ (8) unless accredited in accordance with Rule .0605 of this Section, approved education institution credentials are valid for a period not to exceed four years.

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

(c) Assisting physicians delegated by the EMS System medical director as authorized by Rule .0403(b) of this Subchapter or SCTP medical director as authorized by Rule .0404(b) 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.

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

*History Note: Authority G.S. 143-508(d)(4), (13); 143-508(d)(4); 143-508(13);  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. January 1, 2004;  
 Amended Eff. January 1, 2009; 2009;  
 Readopted Eff. January 1, 2017.*

10A NCAC 13P .0602 is proposed for readoption with substantive changes as follows:

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

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

(b) For initial courses, Basic EMS Educational Institutions shall ~~have~~ meet all requirements for continuing EMS educational institutions defined in Rule .0601 of this Section and shall have:

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

- ~~(2) at least a Level I EMS Instructor credentialed at the EMD level as lead course instructor for EMD courses;~~
- ~~(3) (2) a lead EMS educational program coordinator. This individual may be either a Level II EMS Instructor credentialed at or above the highest level of course offered by the institution, or a combination of staff who cumulatively meet the requirements of the Level II EMS Instructor referenced in this Subparagraph. These individuals may share the responsibilities of the lead EMS educational coordinator. The details of this option shall be defined in the educational plan required in Subparagraph (b)(5) of this Rule. Basic EMS Educational Institutions offering only EMD courses may meet this requirement with a Level I EMS Instructor credentialed at the EMD level; Rule;~~
- (3) written educational policies and procedures that includes:
- (A) the written educational policies and procedures set forth in Rule .0601(b)(4) 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) an Educational Medical Advisor that meets the criteria as defined in the "North Carolina College of Emergency Physicians: Standards for Medical Oversight and Data Collection" incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. ~~This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost; editions;~~
- (5) written educational policies and procedures describing the delivery of educational programs, the record-keeping system detailing student attendance and performance; and the selection and monitoring of EMS instructors; and
- (6) access to instructional supplies and equipment necessary for students to complete educational programs as defined in Rule .0501(b) of this Subchapter.
- (c) For ~~EMS continuing education programs, Basic EMS initial courses, Advanced~~ Educational Institutions shall meet ~~the all~~ requirements defined in ~~Paragraphs (a) and (b) of Rule .0601 of this Section. 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.~~
- ~~(d) An application for credentialing as a Basic EMS Educational Institution shall be submitted to the OEMS for review. The proposal shall demonstrate that the applicant meets the requirements in Paragraphs (b) and (c) of this Rule.~~
- ~~(e) (d) Basic and Advanced EMS Educational Institution credentials are valid for a period of not to exceed four years. years, unless the institution is accredited in accordance with Rule .0605 of this Section.~~

*History Note:* Authority ~~G.S. 143-508(d)(4), (13); 143-508(d)(4); 143-508(13);~~  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. January 1, 2004;  
 Amended Eff. January 1, 2009- 2009;  
 Readopted Eff. January 1, 2017.

10A NCAC 13P .0603 is proposed for readoption as a repeal as follows:

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

*History Note:* Authority ~~G.S. 143-508(d)(4), (13); 143-508(d)(4); 143-508(13);~~  
 Temporary Adoption Eff. January 1, 2002;  
 Eff. February 1, 2004;

*Amended Eff. January 1, 2009; 2009;*

*Repealed Eff. January 1, 2017.*

10A NCAC 13P .0605 is proposed for adoption as follows:

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

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

- (1) an application for credentialing;
- (2) evidence to the OEMS of current CAAHEP accreditation;
- (3) a copy of the self study;
- (4) a copy of the executive analysis; and
- (5) documentation reflecting compliance with Rule .0602(b) and (c) of this Section.

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

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

(d) EMS Educational Institutions that fail to maintain CAAHEP accreditation will be subject to the credentialing and renewal criteria set forth in Rule .0602 of this Section.

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

*History Note: Authority G.S. 143-508(d)(4); 143-508(d)(13);*

*Eff. January 1, 2017.*

10A NCAC 13P .0901 is proposed for readoption with substantive changes as follows:

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

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

- (1) ~~A~~ have a trauma program and a trauma service that have been operational for at least 12 months prior to application for designation;
- (2) ~~Membership~~ at least 12 months prior to submitting a RFP, have membership in and inclusion of all trauma patient records in the North Carolina Trauma Registry ~~for at least 12 months prior to submitting a Request for Proposal;~~ Registry, in accordance with the North Carolina Trauma Registry Data Dictionary incorporated by reference including subsequent amendments and editions. This document is available upon request by contacting the OEMS at 2707 Mail Service Center, Raleigh, NC 27699-2707, at no cost;
- (3) meet the verification criteria for designation as a Level I, Level II, or Level III Trauma Center, as defined in the “American College of Surgeons: Resources for Optimal Care of the Injured Patient” incorporated by

reference including subsequent amendments and editions. This document can be downloaded at no cost online at [www.facs.org](http://www.facs.org); and

- (4) meet all requirements of the designation Level applied for initial designation set forth in Rule .0904 of this Section or for renewal designation set forth in Rule .0905 of this Section.
- ~~(3) A trauma medical director who is a board-certified general surgeon. The trauma medical director must:~~
- ~~(a) Have a minimum of three years clinical experience on a trauma service or trauma fellowship training;~~
  - ~~(b) Serve on the center's trauma service;~~
  - ~~(c) Participate in providing care to patients with life-threatening or urgent injuries;~~
  - ~~(d) Participate in the North Carolina Chapter of the ACS Committee on Trauma as well as other regional and national trauma organizations;~~
  - ~~(e) Remain a provider in the ACS' ATLS Course and in the provision of trauma-related instruction to other health care personnel; and~~
  - ~~(f) Be involved with trauma research and the publication of results and presentations;~~
- ~~(4) A full-time TNC/TPM who is a registered nurse, licensed by the North Carolina Board of Nursing;~~
- ~~(5) A full-time TR who has a working knowledge of medical terminology, is able to operate a personal computer, and has the ability to extract data from the medical record;~~
- ~~(6) A hospital department/division/section for general surgery, neurological surgery, emergency medicine, anesthesiology, and orthopaedic surgery, with designated chair or physician liaison to the trauma program for each;~~
- ~~(7) Clinical capabilities in general surgery with separate posted call schedules. One shall be for trauma, one for general surgery and one back-up call schedule for trauma. In those instances where a physician may simultaneously be listed on more than one schedule, there must be a defined back-up surgeon listed on the schedule to allow the trauma surgeon to provide care for the trauma patient. If a trauma surgeon is simultaneously on call at more than one hospital, there shall be a defined, posted trauma surgery back-up call schedule composed of surgeons credentialed to serve on the trauma panel;~~
- ~~(8) A trauma team to provide evaluation and treatment of a trauma patient 24 hours per day that includes:~~
- ~~(a) An in-house trauma attending or PGY4 or senior general surgical resident. The trauma attending participates in therapeutic decisions and is present at all operative procedures.~~
  - ~~(b) An emergency physician who is present in the Emergency Department 24 hours per day who is either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine). Emergency physicians caring only for pediatric patients may, as an alternative, be boarded or prepared in pediatric emergency medicine. Emergency physicians must be board-certified within five years after successful completion of a residency in emergency medicine and serve as a designated member of the trauma team to ensure immediate care for the injured patient until the arrival of the trauma surgeon;~~
  - ~~(c) Neurosurgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, unless there is either an in-house attending neurosurgeon, a PGY2 or higher in-house neurosurgery resident or an in-house trauma surgeon or emergency physician as long as the institution can document management~~

- ~~guidelines and annual continuing medical education for neurosurgical emergencies. There must be a specified back up on the call schedule whenever the neurosurgeon is simultaneously on call at a hospital other than the trauma center;~~
- ~~(d) — Orthopaedic surgery specialists who are never simultaneously on call at another Level II or higher trauma center, who are promptly available, if requested by the trauma team leader, unless there is either an in-house attending orthopaedic surgeon, a PGY2 or higher in-house orthopaedic surgery resident or an in-house trauma surgeon or emergency physician as long as the institution can document management guidelines and annual continuing medical education for orthopaedic emergencies. There must be a specified written back up on the call schedule whenever the orthopaedist is simultaneously on-call at a hospital other than the trauma center;~~
  - ~~(e) — An in-house anesthesiologist or a CA3 resident as long as an anesthesiologist on call is advised and promptly available if requested by the trauma team leader; and~~
  - ~~(f) — Registered nursing personnel trained in the care of trauma patients;~~
- ~~(9) — A written credentialing process established by the Department of Surgery to approve mid-level practitioners and attending general surgeons covering the trauma service. The surgeons must have board certification in general surgery within five years of completing residency;~~
- ~~(10) — Neurosurgeons and orthopaedists serving the trauma service who are board certified or eligible. Those who are eligible must be board certified within five years after successful completion of the residency;~~
- ~~(11) — Written protocols relating to trauma management formulated and updated to remain current;~~
- ~~(12) — Criteria to ensure team activation prior to arrival, and trauma-attending arrival within 15 minutes of the arrival of trauma and burn patients that include the following conditions:~~
- ~~(a) — Shock;~~
  - ~~(b) — Respiratory distress;~~
  - ~~(c) — Airway compromise;~~
  - ~~(d) — Unresponsiveness (GSC less than nine) with potential for multiple injuries;~~
  - ~~(e) — Gunshot wound to neck, chest or abdomen;~~
  - ~~(f) — Patients receiving blood to maintain vital signs; and~~
  - ~~(g) — ED physician's decision to activate;~~
- ~~(13) — Surgical evaluation, based upon the following criteria, by the trauma-attending surgeon who is promptly available:~~
- ~~(a) — Proximal amputations;~~
  - ~~(b) — Burns meeting institutional transfer criteria;~~
  - ~~(c) — Vascular compromise;~~
  - ~~(d) — Crush to chest or pelvis;~~
  - ~~(e) — Two or more proximal long bone fractures; and~~
  - ~~(f) — Spinal cord injury.~~
- ~~A PGY4 or higher surgical resident, a PGY3 or higher emergency medicine resident, a nurse practitioner or physician's assistant, who is a member of the designated surgical response team, may initiate the evaluation;~~

- (14) ~~Surgical consults for patients with traumatic injuries, at the request of the ED physician, will be conducted by a member of the trauma surgical team. Criteria for the consults include:~~
- ~~(a) Falls greater than 20 feet;~~
  - ~~(b) Pedestrian struck by motor vehicle;~~
  - ~~(c) Motor vehicle crash with:
    - ~~(i) Ejection (includes motorcycle);~~
    - ~~(ii) Rollover;~~
    - ~~(iii) Speed greater than 40 mph; or~~
    - ~~(iv) Death of another individual in the same vehicle; and~~~~
  - ~~(d) Extremes of age, less than five or greater than 70 years.~~
- ~~A senior surgical resident may initiate the evaluation;~~
- (15) ~~Clinical capabilities (promptly available if requested by the trauma team leader, with a posted on-call schedule), that include individuals credentialed in the following:~~
- ~~(a) Cardiac surgery;~~
  - ~~(b) Critical care;~~
  - ~~(c) Hand surgery;~~
  - ~~(d) Microvascular/replant surgery, or if service is not available, a transfer agreement must exist;~~
  - ~~(e) Neurosurgery (The neurosurgeon must be dedicated to one hospital or a back-up call schedule must be available. If fewer than 25 emergency neurosurgical trauma operations are done in a year, and the neurosurgeon is dedicated only to that hospital, then a published back-up call list is not necessary);~~
  - ~~(f) Obstetrics/gynecologic surgery;~~
  - ~~(g) Ophthalmic surgery;~~
  - ~~(h) Oral maxillofacial surgery;~~
  - ~~(i) Orthopaedics (dedicated to one hospital or a back-up call schedule must be available);~~
  - ~~(j) Pediatric surgery;~~
  - ~~(k) Plastic surgery;~~
  - ~~(l) Radiology;~~
  - ~~(m) Thoracic surgery; and~~
  - ~~(n) Urologic surgery;~~
- (16) ~~An Emergency Department that has:~~
- ~~(a) A designated physician director who is board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);~~
  - ~~(b) 24-hour per day staffing by physicians physically present in the ED such that:
    - ~~(i) At least one physician on every shift in the ED is either board-certified or prepared in emergency medicine (by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine) to serve as the designated member of the trauma team to ensure immediate care until the arrival of the trauma surgeon. Emergency physicians caring only for pediatric patients may, as an alternative, be boarded in pediatric emergency~~~~



- ~~medicine. All emergency physicians must be board certified within five years after successful completion of the residency;~~
- ~~(ii) All remaining emergency physicians, if not board certified or prepared in emergency medicine as outlined in Subitem (16)(b)(i) of this Rule, are board certified, or eligible by the American Board of Surgery, American Board of Family Practice, or American Board of Internal Medicine, with each being board certified within five years after successful completion of a residency; and~~
  - ~~(iii) All emergency physicians practice emergency medicine as their primary specialty.~~
  - ~~(c) Nursing personnel with experience in trauma care who continually monitor the trauma patient from hospital arrival to disposition to an intensive care unit, operating room, or patient care unit;~~
  - ~~(d) Equipment for patients of all ages to include:
 
    - ~~(i) Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag-mask resuscitators, pocket masks, and oxygen);~~
    - ~~(ii) Pulse oximetry;~~
    - ~~(iii) End tidal carbon dioxide determination equipment;~~
    - ~~(iv) Suction devices;~~
    - ~~(v) Electrocardiograph oscilloscope defibrillator with internal paddles;~~
    - ~~(vi) Apparatus to establish central venous pressure monitoring;~~
    - ~~(vii) Intravenous fluids and administration devices that include large bore catheters and intraosseous infusion devices;~~
    - ~~(viii) Sterile surgical sets for airway control/cricothyrotomy, thoracotomy, vascular access, thoracostomy, peritoneal lavage, and central line insertion;~~
    - ~~(ix) Apparatus for gastric decompression;~~
    - ~~(x) 24-hour per-day x-ray capability;~~
    - ~~(xi) Two-way communication equipment for communication with the emergency transport system;~~
    - ~~(xii) Skeletal traction devices, including capability for cervical traction;~~
    - ~~(xiii) Arterial catheters;~~
    - ~~(xiv) Thermal control equipment for patients;~~
    - ~~(xv) Thermal control equipment for blood and fluids;~~
    - ~~(xvi) A rapid infuser system;~~
    - ~~(xvii) A dosing reference and measurement system to ensure appropriate age-related medical care;~~
    - ~~(xviii) Sonography; and~~
    - ~~(xix) A doppler;~~~~
  - ~~(17) An operating suite that is immediately available 24 hours per day and has:
 
    - ~~(a) 24-hour per-day immediate availability of in-house staffing;~~
    - ~~(b) Equipment for patients of all ages that includes:
 
      - ~~(i) Cardiopulmonary bypass capability;~~
      - ~~(ii) Thermal control equipment for patients;~~~~~~

- (iii) — Thermal control equipment for blood and fluids;
  - (iv) — 24 hour per day x ray capability including c arm image intensifier;
  - (v) — Endoscopes and bronchoscopes;
  - (vi) — Craniotomy instruments;
  - (vii) — The capability of fixation of long bone and pelvic fractures; and
  - (viii) — A rapid infuser system;
- (18) — A postanesthetic recovery room or surgical intensive care unit that has:
- (a) — 24 hour per day in house staffing by registered nurses;
  - (b) — Equipment for patients of all ages that includes:
    - (i) — The capability for resuscitation and continuous monitoring of temperature, hemodynamics, and gas exchange;
    - (ii) — The capability for continuous monitoring of intracranial pressure;
    - (iii) — Pulse oximetry;
    - (iv) — End tidal carbon dioxide determination capability;
    - (v) — Thermal control equipment for patients; and
    - (vi) — Thermal control equipment for blood and fluids;
- (19) — An intensive care unit for trauma patients that has:
- (a) — A designated surgical director for trauma patients;
  - (b) — A physician on duty in the intensive care unit 24 hours per day or immediately available from within the hospital as long as this physician is not the sole physician on call for the Emergency Department;
  - (c) — Ratio of one nurse per two patients on each shift;
  - (d) — Equipment for patients of all ages that includes:
    - (i) — Airway control and ventilation equipment (laryngoscopes, endotracheal tubes, bag mask resuscitators, and pocket masks);
    - (ii) — An oxygen source with concentration controls;
    - (iii) — A cardiac emergency cart;
    - (iv) — A temporary transvenous pacemaker;
    - (v) — Electrocardiograph oscilloscope defibrillator;
    - (vi) — Cardiac output monitoring capability;
    - (vii) — Electronic pressure monitoring capability;
    - (viii) — A mechanical ventilator;
    - (ix) — Patient weighing devices;
    - (x) — Pulmonary function measuring devices;
    - (xi) — Temperature control devices; and
    - (xii) — Intracranial pressure monitoring devices.
  - (e) — Within 30 minutes of request, the ability to perform blood gas measurements, hematocrit level, and chest x ray studies;
- (20) — Acute hemodialysis capability;

- (21) ~~Physician directed burn center staffed by nursing personnel trained in burn care or a transfer agreement with a burn center;~~
- (22) ~~Acute spinal cord management capability or transfer agreement with a hospital capable of caring for a spinal cord injured patient;~~
- (23) ~~Radiological capabilities that include:
  - (a) ~~24 hour per day in house radiology technologist;~~
  - (b) ~~24 hour per day in house computerized tomography technologist;~~
  - (c) ~~Sonography;~~
  - (d) ~~Computed tomography;~~
  - (e) ~~Angiography;~~
  - (f) ~~Magnetic resonance imaging; and~~
  - (g) ~~Resuscitation equipment that includes airway management and IV therapy;~~~~
- (24) ~~Respiratory therapy services available in house 24 hours per day;~~
- (25) ~~24 hour per day clinical laboratory service that must include:
  - (a) ~~Analysis of blood, urine, and other body fluids, including micro sampling when appropriate;~~
  - (b) ~~Blood typing and cross matching;~~
  - (c) ~~Coagulation studies;~~
  - (d) ~~Comprehensive blood bank or access to community central blood bank with storage facilities;~~
  - (e) ~~Blood gases and pH determination; and~~
  - (f) ~~Microbiology;~~~~
- (26) ~~A rehabilitation service that provides:
  - (a) ~~A staff trained in rehabilitation care of critically injured patients;~~
  - (b) ~~Functional assessment and recommendations regarding short and long term rehabilitation needs within one week of the patient's admission to the hospital or as soon as hemodynamically stable;~~
  - (c) ~~In house rehabilitation service or a transfer agreement with a rehabilitation facility accredited by the Commission on Accreditation of Rehabilitation Facilities;~~
  - (d) ~~Physical, occupational, speech therapies, and social services; and~~
  - (e) ~~Substance abuse evaluation and counseling capability;~~~~
- (27) ~~A performance improvement program, as outlined in the North Carolina Chapter of the American College of Surgeons Committee on Trauma document "Performance Improvement Guidelines for North Carolina Trauma Centers," incorporated by reference in accordance with G.S. 150B-21.6, including subsequent amendments and editions. This document is available from the OEMS, 2707 Mail Service Center, Raleigh, North Carolina 27699-2707, at no cost. This performance improvement program must include:
  - (a) ~~The state Trauma Registry whose data is submitted to the OEMS at least weekly and includes all the center's trauma patients as defined in Rule .0102(68) of this Subchapter who are either diverted to an affiliated hospital, admitted to the trauma center for greater than 24 hours from an ED or hospital, die in the ED, are DOA or are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital);~~
  - (b) ~~Morbidity and mortality reviews including all trauma deaths;~~~~

- ~~(c) — Trauma performance committee that meets at least quarterly and includes physicians, nurses, pre-hospital personnel, and a variety of other healthcare providers, and reviews policies, procedures, and system issues and whose members or designee attends at least 50 percent of the regular meetings;~~
- ~~(d) — Multidisciplinary peer review committee that meets at least quarterly and includes physicians from trauma, neurosurgery, orthopaedics, emergency medicine, anesthesiology, and other specialty physicians, as needed, specific to the case, and the trauma nurse coordinator/program manager and whose members or designee attends at least 50 percent of the regular meetings;~~
- ~~(e) — Identification of discretionary and non-discretionary audit filters;~~
- ~~(f) — Documentation and review of times and reasons for trauma-related diversion of patients from the scene or referring hospital;~~
- ~~(g) — Documentation and review of response times for trauma surgeons, neurosurgeons, anesthesiologists or airway managers, and orthopaedists. All must demonstrate 80 percent compliance.~~
- ~~(h) — Monitoring of trauma team notification times;~~
- ~~(i) — Review of pre-hospital trauma care that includes dead-on-arrivals; and~~
- ~~(j) — Review of times and reasons for transfer of injured patients;~~
- ~~(28) — An outreach program that includes:~~
  - ~~(a) — Transfer agreements to address the transfer and receipt of trauma patients;~~
  - ~~(b) — Programs for physicians within the community and within the referral area (that include telephone and on-site consultations) about how to access the trauma center resources and refer patients within the system;~~
  - ~~(c) — Development of a Regional Advisory Committee as specified in Rule .1102 of this Subchapter;~~
  - ~~(d) — Development of regional criteria for coordination of trauma care;~~
  - ~~(e) — Assessment of trauma system operations at the regional level; and~~
  - ~~(f) — ATLS;~~
- ~~(29) — A program of injury prevention and public education that includes:~~
  - ~~(a) — Epidemiology research that includes studies in injury control, collaboration with other institutions on research, monitoring progress of prevention programs, and consultation with researchers on evaluation measures;~~
  - ~~(b) — Surveillance methods that includes trauma registry data, special Emergency Department and field collection projects;~~
  - ~~(c) — Designation of an injury prevention coordinator; and~~
  - ~~(d) — Outreach activities, program development, information resources, and collaboration with existing national, regional, and state trauma programs.~~
- ~~(30) — A trauma research program designed to produce new knowledge applicable to the care of injured patients that includes:~~
  - ~~(a) — An identifiable institutional review board process;~~
  - ~~(b) — Educational presentations that must include 12 education/outreach presentations offered outside the trauma center over a three-year period; and~~

- (c) ~~10 peer reviewed publications over a three year period that could come from any aspect of the trauma program; and~~
- (31) ~~A written continuing education program for staff physicians, nurses, allied health personnel, and community physicians that includes:~~
  - (a) ~~A general surgery residency program;~~
  - (b) ~~20 hours of Category I or II trauma related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years for all attending general surgeons on the trauma service, orthopedists, and neurosurgeons, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center. Continuing education based on the reading of content such as journals or other continuing medical education documents is not considered education outside of the trauma center;~~
  - (c) ~~20 hours of Category I or II trauma related continuing medical education (as approved by the Accreditation Council for Continuing Medical Education) every two years for all emergency physicians, with at least 50 percent of this being external education including conferences and meetings outside of the trauma center or visiting lecturers or speakers from outside the trauma center. Continuing education based on the reading of content such as journals or other continuing medical education documents is not considered education outside of the trauma center;~~
  - (d) ~~ATLS completion for general surgeons on the trauma service and emergency physicians. Emergency physicians, if not boarded in emergency medicine, must be current in ATLS;~~
  - (e) ~~20 contact hours of trauma related continuing education (beyond in house in services) every two years for the TNC/TPM;~~
  - (f) ~~16 hours of trauma registry related or trauma related continuing education every two years, as deemed appropriate by the trauma nurse coordinator/program manager for the trauma registrar;~~
  - (g) ~~At least an 80 percent compliance rate for 16 hours of trauma related continuing education (as approved by the TNC/TPM) every two years related to trauma care for RN's and LPN's in transport programs, Emergency Departments, primary intensive care units, primary trauma floors, and other areas deemed appropriate by the TNC/TPM; and~~
  - (h) ~~16 hours of trauma related continuing education every two years for mid-level practitioners routinely caring for trauma patients.~~

*History Note: Authority G.S. 131E-162;*  
*Temporary Adoption Eff. January 1, 2002;*  
*Eff. April 1, 2003;*  
*Amended Eff. January 1, 2009; January 1, ~~2004~~. 2004;*  
*Readopted Eff. January 1, 2017.*

10A NCAC 13P .0902 - .0903 are proposed for readoption as a repeal as follows:

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

**10A NCAC 13P .0903 LEVEL III TRAUMA CENTER CRITERIA**

*History Note: Authority G.S. 131E-162;  
Temporary Adoption Eff. January 1, 2002;  
Eff. April 1, 2003;  
Amended Eff. January 1, 2009; January 1, 2004, 2004;  
Repealed Eff. January 1, 2017.*

10A NCAC 13P .0904 is proposed for readoption with substantive changes 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 have the consult 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~~ the population to be served and the extent to ~~which that~~ the population is underserved for trauma care with the methodology used to reach this conclusion;
- (2) ~~Geographic considerations~~ geographic considerations, to include trauma primary and secondary catchment area and distance from other Trauma Centers; and
- (3) ~~Evidence~~ evidence the Trauma Center will admit at least 1200 trauma patients yearly or show that its trauma service will be taking care of at least 240 trauma patients with an ~~Injury Severity Score (ISS)~~ ISS greater than or equal to 15 yearly. ~~This~~ These criteria shall be met without compromising the quality of care or cost effectiveness of any other designated Level I or II Trauma Center sharing all or part of its catchment area or by jeopardizing the existing Trauma Center's ability to meet this same 240-patient minimum.

(c) The hospital ~~must~~ shall be ~~actively~~ participating in the state Trauma Registry as defined in Rule .0102(61) of this Subchapter, and submit data to the OEMS ~~at least~~ weekly and include all the Trauma Center's trauma patients as defined in Rule ~~.0102(68)~~ .0102(59) of this Subchapter who are either diverted to an affiliated hospital, admitted to the Trauma Center for greater than 24 hours from an ED or hospital, die in the ED, are ~~DOA~~ DOA, or are transferred from the ED to the OR, ICU, or another hospital (including transfer to any affiliated hospital) a minimum of 12 months prior to application.

(d) OEMS shall review the regional Trauma Registry ~~data,~~ data from both the applicant and the existing trauma center(s), and ascertain the applicant's ability to satisfy the justification of need information required in Subparagraphs (b)(1) through (3) of this Rule. Simultaneously, the applicant's primary RAC shall be notified by the OEMS of the application and be provided the

regional data as required in Subparagraphs (b)(1) through (3) of this Rule submitted by the applicant for review and comment. The RAC shall be given a ~~minimum~~ of 30 days to submit ~~any concerns in writing for OEMS' consideration.~~ written comments to the OEMS. ~~If no comments are received, OEMS shall proceed.~~

~~(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.~~

~~(e) (f) OEMS shall notify the hospital in writing of its decision to allow submission of an RFP. The~~ If approved, the RAC and Board of County Commissioners in the applicant's primary catchment area shall also be notified by the OEMS so that any necessary changes in protocols can be considered.

~~(f) OEMS shall notify the respective Board of County Commissioners in the applicant's trauma primary catchment area of the request for initial designation to allow for comment.~~

~~(g) Hospitals~~ Once the hospital is notified that an RFP will be accepted, the hospital desiring to be considered for initial trauma center designation shall complete and submit ~~one paper copy with signatures and~~ an electronic copy of the completed RFP with signatures to the OEMS at least ~~90~~ 45 days prior to the proposed site visit date.

(h) For Level I, II, and III applicants, the RFP shall demonstrate that the hospital meets the standards for the designation level applied for as found in ~~Rules .0901, .0902, or .0903~~ Rule .0901 of this Section.

(i) If OEMS does not recommend a site visit based upon failure to comply with ~~Rules .0901, .0902, or .0903~~, Rule .0901 of this Section, the reasons shall be forwarded to the hospital in writing within 30 days of the decision. The hospital may reapply for designation within six months following the submission of an updated RFP. If the hospital fails to respond within six months, the hospital shall reapply following the process outlined in Paragraphs (a) through (h) of this Rule.

(j) If 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 site visit date shall be mutually agreeable to the hospital and the OEMS.

(k) ~~Any~~ Except for OEMS representatives, any in-state reviewer for a Level I or II visit (~~except the OEMS representatives~~) shall be from outside the ~~planning region~~ local or adjacent RAC, unless mutually agreed upon by the OEMS and the trauma center seeking designation, in which 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~~ one out-of-state trauma surgeon who is a Fellow of the ACS, experienced as a site surveyor, who shall be designated the primary reviewer;
- (2) ~~One one in-state~~ emergency physician who works in a designated trauma center, is a member of the American College of Emergency ~~Physicians, Physicians or American Academy of Emergency Medicine,~~ and is boarded in emergency medicine (~~by by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);~~ Medicine;
- (3) ~~One one~~ in-state trauma surgeon who is a member of the North Carolina Committee on Trauma;
- (4) ~~One for Level I designation, one~~ out-of-state trauma ~~nurse coordinator/program manager and one in-state trauma nurse coordinator/program manager;~~ and program manager with an equivalent license from another state;
- (5) ~~for Level II designation, one in-state program manager who is licensed to practice professional nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes; and~~

~~(5)~~ (6) OEMS Staff.

(l) All site team members for a Level III visit shall be from in-state, ~~and all (except for the OEMS representatives) and, except for the OEMS representatives,~~ shall be from outside the ~~planning region~~ local or adjacent RAC in which the hospital is located.

The composition of a Level III state site survey team shall be as follows:

- (1) ~~One~~ one Fellow of the ACS, who is a member of the North Carolina Committee on Trauma and shall be ~~designated~~ the primary reviewer;
- (2) ~~One~~ one emergency physician who currently works in a designated trauma center, is a member of the North Carolina College of Emergency ~~Physicians, Physicians or American Academy of Emergency Medicine,~~ and is boarded in emergency medicine ~~(by by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine);~~ Medicine;
- (3) ~~A one~~ one trauma ~~nurse coordinator/program manager; and~~ program manager who is licensed to practice professional nursing in North Carolina in accordance with the Nursing Practice Act, Article 9A, Chapter 90 of the North Carolina General Statutes; and
- (4) OEMS Staff.

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

(n) ~~The lead researcher~~ primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review ~~team at the summary conference. team. A written consensus report shall be completed, to include a peer review report, by the primary reviewer and submitted to OEMS within 30 days of the site visit. The primary reviewer shall complete and submit to the OEMS a written consensus report that includes a peer review report within 30 days of the site visit.~~

(o) The report of the site survey team and the staff recommendations shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting ~~which is more than 45 days~~ following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center designation be approved or denied.

(p) All criteria defined in Rule ~~.0901, .0902, or .0903~~ .0901 of this Section shall be met for initial designation at the level requested. Initial designation shall not be granted if deficiencies exist.

(q) Hospitals with a deficiency(ies) shall be given up to 12 months to demonstrate compliance. Satisfaction of deficiency(ies) may require an additional site visit. If compliance is not demonstrated within the time period, to be defined by OEMS, the hospital shall submit a new application and updated RFP and follow the process outlined in Paragraphs (a) through (h) of this Rule.

(r) The final decision regarding Trauma Center designation shall be rendered by the OEMS.

(s) The OEMS shall notify the hospital in ~~writing,~~ writing of the State Emergency Medical Services Advisory Council's and OEMS' final recommendation within 30 days of the Advisory Council meeting.

(t) If a trauma center changes its trauma program administrative structure ~~(such such~~ such that the trauma service, trauma medical director, trauma ~~nurse coordinator/program~~ program manager or trauma registrar are relocated on the hospital's organizational ~~chart~~ chart at any time, it shall notify OEMS of this change in writing within 30 days of the occurrence.

(u) Initial designation as a trauma center is valid for a period of three years.

*History Note: Authority G.S. 131E-162; 143-508; 143-509(3);  
Temporary Adoption Eff. January 1, 2002;  
Eff. April 1, 2003;*



*Amended Eff. January 1, 2009; 2009;*

*Readopted Eff. January 1, 2017.*

10A NCAC 13P .0905 is proposed for readoption with substantive changes as follows:

**10A NCAC 13P .0905 RENEWAL DESIGNATION PROCESS**

(a) Hospitals may utilize one of two options to achieve Trauma Center renewal:

- (1) ~~Undergo~~ undergo a site visit conducted by OEMS to obtain a four-year renewal designation; or
- (2) ~~Undergo~~ undergo a verification visit ~~arranged~~ by the ACS, in conjunction with the OEMS, to obtain a ~~four-year~~ three-year renewal designation.

(b) For hospitals choosing Subparagraph (a)(1) of this Rule:

- (1) ~~Prior~~ 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~~ hospitals shall complete and submit one paper copy and an electronic copy of the RFP to the OEMS and the specified site surveyors at least 30 days prior to the site visit. The RFP shall include information that supports compliance with the criteria contained in Rule ~~.0901, .0902, or .0903~~ .0901 of this Section as it relates to the Trauma Center's level of designation.
- (3) ~~All~~ all criteria defined in Rule ~~.0901, .0902, or .0903~~ .0901 of this Section, as relates to the Trauma Center's level of designation, shall be met for renewal designation.
- (4) ~~A~~ a site visit shall be conducted within 120 days prior to the end of the designation period. The site visit shall be scheduled on a date mutually agreeable to the hospital and the OEMS.
- (5) ~~The~~ 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~~ 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~~ on the day of the site visit the hospital shall make available all requested patient medical charts.
- (8) ~~The~~ the primary reviewer of the site review team shall give a verbal post-conference report representing a consensus of the site review ~~team at the summary conference. A written consensus report shall be completed, to include a peer review report, by the primary reviewer and submitted to OEMS within 30 days of the site visit.~~ team. The primary reviewer shall complete and submit to the OEMS a written consensus report that includes a peer review report within 30 days of the site visit.
- (9) ~~The~~ the report of the site survey team and a staff recommendation shall be reviewed by the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting ~~which is more than 30 days~~ following the site visit. Based upon the site visit report and the staff recommendation, the State Emergency Medical Services Advisory Council shall recommend to the OEMS that the request for Trauma Center renewal

be approved; approved with a contingency(ies) due to a deficiency(ies) requiring a focused review; approved with a contingency(ies) not due to a deficiency(ies) requiring a consultative visit; or denied.

- (10) ~~Hospitals~~ hospitals with a deficiency(ies) have up to 10 ~~working business~~ days prior to the State EMS Advisory Council meeting to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this period prior to the State EMS Advisory Council meeting, the hospital, instead of a four-year renewal, shall be given 12 months by the OEMS to demonstrate compliance and undergo a focused ~~review,~~ review that may require an additional site visit. The hospital shall retain its Trauma Center designation during the focused review period. If compliance is demonstrated within the prescribed time period, the hospital shall be granted its designation for the four-year period from the previous designation's expiration date. If compliance is not demonstrated within the time period, as specified by OEMS, the Trauma Center designation shall not be renewed. To become redesignated, the hospital shall submit an updated RFP and follow the initial applicant process outlined in Rule .0904 of this Section.
- (11) ~~The~~ the final decision regarding trauma center renewal shall be rendered by the OEMS.
- (12) ~~The~~ 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.
- (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.~~
- ~~(14)~~ (14) ~~The~~ the four-year renewal date that may be eventually granted shall not be extended due to the focused review period.

(c) For hospitals choosing Subparagraph (a)(2) of this Rule:

- (1) ~~At~~ at least six months prior to the end of the Trauma Center's designation period, the trauma center ~~must shall~~ notify the OEMS of its intent to undergo an ACS verification visit. It ~~must shall~~ simultaneously define in writing to the OEMS its trauma primary catchment area. Trauma Centers choosing this option ~~must shall~~ then comply with all the ACS' verification procedures, as well as any additional state criteria as outlined in ~~Rule .0901, .0902, or .0903,~~ Rule .0901 of this Section, as apply to their level of designation.
- (2) ~~When~~ when completing the ACS' documentation for verification, the Trauma Center ~~must shall~~ ensure access to the ACS on-line PRQ (pre-review questionnaire) to OEMS. The Trauma Center ~~must shall~~ simultaneously complete any documents supplied by OEMS ~~to verify compliance with additional North Carolina criteria (i.e., criteria that exceed the ACS criteria)~~ and forward these to the OEMS and the ACS.
- (3) ~~The~~ 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) ~~The~~ the Trauma Center ~~must 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 State Emergency Medical Services Advisory Council meeting to ensure that the Trauma Center's state designation period does not terminate without consideration by the State Emergency Medical Services Advisory Council.
- (5) ~~The composition of the Level I or Level II site team must be as specified in Rule .0904(k) of this Section, except that both the required trauma surgeons and the emergency physician may be from out of state. Neither North Carolina Committee on Trauma nor North Carolina College of Emergency Physician membership is~~

- ~~required of the surgeons or emergency physician, respectively, if from out of state. The date, time, and all proposed site team members of the site visit team must be submitted to the OEMS for review at least 45 days prior to the site visit. The OEMS shall approve the site visit schedule if the schedule does not conflict with the ability of attendance by required OEMS staff. The OEMS shall approve the proposed site team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site team member associated with the site visit. any in-state review for a hospital choosing Subparagraph (a)(2) of this Rule, except for the OEMS staff, shall be from outside the local or adjacent RAC in which the hospital is located.~~
- (6) ~~The composition of the Level III site team must be as specified in Rule .0904(l) of this Section, except that the trauma surgeon, emergency physician, and trauma nurse coordinator/program manager may be from out of state. Neither North Carolina Committee on Trauma nor North Carolina College of Emergency Physician membership is required of the surgeon or emergency physician, respectively, if from out of state. The date, time, and all proposed site team members of the site visit team must be submitted to the OEMS for review at least 45 days prior to the site visit. The OEMS shall approve the site visit schedule if the schedule does not conflict with the ability of attendance by required OEMS staff. The OEMS shall approve the proposed site team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site team member associated with the site visit. 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) ~~the date, time, and all proposed site team 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 team members if the OEMS determines there is no conflict of interest, such as previous employment, by any site team member associated with the site visit.~~
- (7) (8) ~~All~~ all state Trauma Center criteria ~~must~~ shall be met as defined in ~~Rules .0901, .0902, and .0903~~ Rule .0901 of this Section, for renewal of state designation. An ACS' verification is not required for state designation. An ACS' verification does not ensure a state designation.
- (8) (9) ACS reviewers shall complete the state designation preliminary reporting form ~~immediately~~ prior to the post conference meeting. This document and the ACS final written report and supporting documentation described in Subparagraph (c)(4) of this Rule shall be used to generate a staff summary of findings report following the post conference meeting for presentation to the NC EMS Advisory Council for redesignation.

- (9) ~~(10)~~ The the final written report issued by the ACS' verification review committee, the accompanying medical record reviews ~~(from from~~ which all identifiers may be ~~removed)~~; removed and cover letter ~~must shall~~ be forwarded to OEMS within 10 ~~working business~~ days of its receipt by the Trauma Center seeking renewal.
- (40) ~~(11)~~ The the OEMS shall present its summary of findings report to the State Emergency Medical Services Advisory Council at its next regularly scheduled meeting. The State EMS Advisory Council shall recommend to the Chief of the OEMS that the request for Trauma Center renewal be approved; approved with a contingency(ies) due to a deficiency(ies) requiring a focused review; approved with a contingency(ies) not due to a deficiency(ies); or denied.
- (44) ~~(12)~~ The 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.
- (13) the final decision regarding trauma center designation shall be rendered by the OEMS.
- (42) ~~(14)~~ Hospitals hospitals with contingencies, as the result of a deficiency(ies), as determined by OEMS, have up to 10 ~~working business~~ days prior to the State EMS Advisory Council meeting to provide documentation to demonstrate compliance. If the hospital has a deficiency that cannot be corrected in this time period prior to the State EMS Advisory Council meeting, the hospital, instead of a ~~four-year~~ three-year renewal, may undergo a focused review ~~(to to~~ be conducted by the ~~OEMS)~~ OEMS whereby the Trauma Center is given 12 months by the OEMS to demonstrate compliance. Satisfaction of contingency(ies) may require an additional site visit. The hospital shall retain its Trauma Center designation during the focused review period. If compliance is demonstrated within the prescribed time period, the hospital shall be granted its designation for the ~~four-year~~ three-year period from the previous designation's expiration date. If compliance is not demonstrated within the time period, as specified by OEMS, the Trauma Center designation shall not be renewed. To become redesignated, the hospital shall submit a new RFP and follow the initial applicant process outlined in Rule .0904 of this Section.
- (15) 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.
- (16) the three-year renewal date that may be eventually granted shall not be extended due to the focused review period.

(d) If a Trauma Center currently using the ACS' verification process chooses not to renew using this process, it must notify the OEMS at least six months prior to the end of its state trauma center designation period of its intention to exercise the option in Subparagraph (a)(1) of this Rule. Upon notification, the OEMS shall extend the designation for one additional year to ensure consistency with hospitals using Subparagraph (a)(1) of this Rule.

(e) Renewal shall be for a period not to exceed four years. If the hospital chooses the option in Subparagraph (a)(2) of this Rule, the renewal shall coincide with the three-year designation period of the ACS verification.

*History Note: Authority G.S. 131E-162; 143-508; 143-509(3);  
Temporary Adoption Eff. January 1, 2002;  
Eff. April 1, 2003;  
Amended Eff. April 1, 2009; January 1, 2009; January 1, 2004; 2004;  
Readoption Eff. January 1, 2017.*

10A NCAC 13P .1101 is proposed for amendment as follows:

**10A NCAC 13P .1101 STATE TRAUMA SYSTEM**

- (a) The state trauma system ~~consists~~ 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(4) of this Subchapter and participate with the RAC that includes the Level I or II Trauma Center in which the majority of trauma patient referrals and transports occur. Each hospital and EMS System shall submit to the OEMS upon request patient transfer patterns from data sources that support the choice of their primary RAC affiliation. Each RAC shall include at least one Level I or II Trauma Center.
- (c) The OEMS shall notify each RAC of its hospital and EMS System ~~membership.~~ membership annually.
- (d) Each hospital and each EMS System ~~must~~ shall update and submit its RAC affiliation information to the OEMS no later than July 1 of each year. RAC affiliation may only be changed during this annual update and only if supported by a change in the majority of transfer patterns. patterns to a Level I or Level II Trauma Center. Documentation detailing these new transfer patterns must be included in the request to change affiliation. If no change is made in RAC affiliation, notification of continued affiliation shall be provided to the OEMS in writing.

*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.~~ 2016;  
Amended Eff. January 1, 2017.*

10A NCAC 13P .1102 is proposed for amendment as follows:

**10A NCAC 13P .1102 REGIONAL TRAUMA SYSTEM PLAN**

- (a) ~~A~~ After consultation with all Level I and II Trauma Centers within their catchment areas, a Level I or II Trauma Center shall be selected as the lead RAC agency by the OEMS to facilitate development of and provide RAC staff support that includes the following:
  - (1) ~~The~~ the trauma medical director(s) from the lead RAC agency;
  - (2) ~~Trauma~~ a trauma nurse coordinator(s) or program manager(s) from the lead RAC agency; and
  - (3) ~~An~~ an individual to coordinate RAC activities.
- (b) The RAC membership shall include the ~~following:~~ following from the lead agency:
  - (1) ~~The~~ the trauma medical director(s) and the trauma nurse coordinator(s) or program manager(s) from the lead RAC agency;

- (2) ~~If if on staff, an the outreach coordinator(s), or designee(s); injury prevention coordinator(s) or designee(s), as well as a RAC registrar or designee(s) designee(s) from the lead RAC agency;~~
- (3) if on staff, an injury prevention coordinator(s), or designees(s) from the lead RAC agency;
- (4) the RAC registrar or designee(s) from the lead RAC agency;
- ~~(3) (5) A a senior level hospital administrator; administrator from the lead RAC agency;~~
- ~~(4) (6) An an emergency physician; physician from the lead RAC agency;~~
- ~~(5) (7) A a representative from each EMS system participating in the RAC;~~
- ~~(6) (8) A a representative from each hospital participating in the RAC;~~
- ~~(7) (9) Community representatives; community representatives from the lead RAC agency's catchment area; and~~
- ~~(8) (10) An EMS System physician involved in medical oversight. Medical Director or Assistant Medical Director from the lead RAC agency's catchment area.~~

(c) The lead RAC agency shall develop and submit a plan within one year of notification of the RAC membership, ~~or for existing RACs within six months of the implementation date of this rule, to the OEMS~~ membership a regional trauma system plan containing:

- (1) ~~Organizational~~ organizational structure to include the roles of the members of the system;
- (2) ~~Goals~~ goals and objectives to include the orientation of the providers to the regional system;
- (3) RAC membership list, rules of order, terms of office, and meeting schedule ~~(held held~~ at a minimum of two times per year); year;
- (4) ~~Copies of documents and~~ information required by the OEMS as defined in Rule .1103 of this Section;
- (5) ~~System~~ the regional trauma system evaluation tools to be utilized;
- (6) ~~Written documentation~~ written verification indicating ~~of regional support~~ from members of the RAC for the regional trauma system plan; and
- (7) ~~Performance~~ performance improvement activities to include utilization of regional trauma system patient care data.

(d) The RAC shall ~~submit to the OEMS~~ prepare an annual progress report no later than July 1 of each year that assesses compliance with the regional trauma system plan and specifies any updates to the plan. This report shall be made available to the OEMS for review upon request.

(e) Upon OEMS' receipt of a letter of intent for initial Level I or II Trauma Center designation ~~pursuant to~~ by a hospital in the lead RAC agency's catchment area as set forth in Rule .0904(b) of this Subchapter, the applicant's lead RAC agency shall be provided the applicant's data from the OEMS ~~to~~ for distribution to all RAC members for review and comment.

(f) The RAC membership has 30 days to comment on the request for initial designation. All comments should be sent from each RAC member directly to the OEMS, with the lead RAC agency provided a copy of their response, within this 30 day comment period.

(g) The OEMS shall notify the RAC of the OEMS approval to submit an RFP so that necessary changes in protocols can be considered.

*History Note: Authority G.S. 131E-162; 143-508;  
Temporary Adoption Eff. January 1, 2002;  
Eff. April 1, 2003;*

*Amended Eff. January 1, 2009;*

*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, ~~2016~~, 2016;*

*Amended Eff. January 1, 2017.*

10A NCAC 13P .1401 is proposed for re Adoption with substantive changes as follows:

**10A NCAC 13P .1401 CHEMICAL ADDICTION OR ABUSE TREATMENT PROGRAM REQUIREMENTS**

(a) The OEMS shall provide a treatment program for aiding in the recovery and rehabilitation of EMS personnel subject to disciplinary action for being unable to perform as credentialed EMS personnel with reasonable skill and safety to patients and the public by reason of use of alcohol, drugs, chemicals, or any other type of material and who are recommended by the EMS Disciplinary Committee pursuant to G.S. 143-519. material as set forth in Rule .1507 of this Subchapter.

(b) This program requires:

- (1) an initial assessment by a healthcare professional specialized in chemical dependency ~~affiliated with~~ approved by the treatment program;
- (2) a treatment plan developed by the healthcare professional described in Subparagraph (b)(1) of this Rule for the individual using the findings of the initial assessment;
- (3) random body fluid ~~screenings;~~ 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) monitoring by OEMS program staff of the individual for compliance with the treatment program; and
- (6) written progress ~~reports~~ reports, including detailed information on the individual's progress and compliance with program criteria as set forth in this Rule, shall be made available for review by the EMS Disciplinary Committee; upon request of OEMS program staff:
  - (A) upon completion of the initial assessment by the treatment program;
  - (B) upon request by the ~~EMS Disciplinary Committee~~ OEMS program staff throughout the individual's participation in the treatment program;
  - (C) upon completion of the treatment program;
  - (D) of all body fluid screenings showing chain of custody;
  - (E) by the therapist or counselor assigned to the individual during the course of the treatment program; and
  - (F) listing attendance at self-help recovery meetings.

*History Note: Authority G.S. 131E-159(f); 143-508(d)(10); ~~143-509(13); 143-519;~~  
Eff. October 1, ~~2010~~, 2010;  
Readopted Eff. January 1, 2017.*

10A NCAC 13P .1402 is proposed for re Adoption with changes as follows:

**10A NCAC 13P .1402 PROVISIONS FOR PARTICIPATION IN THE CHEMICAL ADDICTION OR ABUSE TREATMENT PROGRAM**

Individuals ~~recommended by the EMS Disciplinary Committee~~ authorized by the OEMS, using screening criteria set forth in Section .1400 of this Subchapter, to enter the Treatment Program ~~defined established~~ in Rule .1401 of this Section may participate ~~if~~ if the individual meets all the following requirements:

- (1) ~~the individual~~ acknowledges, in writing, the actions ~~which that~~ violated the performance requirements found in this Subchapter;
- (2) ~~the individual~~ has not been ~~charged~~ charged, awaiting adjudication, or convicted at any time in his or her past, of diverting chemicals for the purpose of sale or distribution or dealing or selling illicit drugs; sale, or distribution, or dealing, or selling illicit drugs;
- (3) ~~the individual~~ is not under criminal investigation or subject to pending criminal charges by law enforcement;
- (4) ~~the individual~~ ceases in the direct delivery of any patient care and surrenders all EMS credentials until either the individual is eligible for issuance of an encumbered EMS credential pursuant to Rule .1403 of this Section, or has ~~successfully~~ completed the treatment program established in Rule .1401 of this Section; and
- (5) ~~the individual~~ agrees to accept responsibility for all costs including assessment, treatment, monitoring, and body fluid screening.

*History Note: Authority G.S. 131E-159(f); 143-508(d)(10); ~~143-509(13); 143-519;~~  
Eff. October 1, ~~2010~~. 2010;  
Readopted Eff. January 1, 2017.*

**10A NCAC 13P .1403 CONDITIONS FOR RESTRICTED PRACTICE WITH LIMITED PRIVILEGES**

(a) In order to assist in determining eligibility for an individual to return to restricted practice with an encumbered credential containing limited privileges pursuant to G.S. 143-509(13), the OEMS shall create a standing Reinstatement Committee that shall consist of at least the following members:

- (1) one physician licensed by the North Carolina Medical Board, representing EMS Systems who 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 Chemical Addiction or Abuse Treatment Program.

~~(a)~~ (b) Individuals who have surrendered ~~their~~ his or her EMS ~~credential~~ credential(s) as a condition of entry into the treatment ~~program~~ program, as established in Rule .1402(4) of this Section, may be reviewed by the ~~EMS Disciplinary~~ OEMS Reinstatement Committee to determine if a recommendation to the OEMS for issuance of an encumbered EMS credential is ~~warranted~~. warranted by the Department.

~~(b)~~ (c) In order to obtain an encumbered credential with limited privileges, an individual ~~must~~ shall:

- (1) be compliant for a minimum of 90 consecutive days with the treatment program described in Paragraph (b) of Rule ~~.1402~~ .1401 of this Section;
- (2) be recommended in writing for review by the individual's treatment counselor;



- (3) be interviewed by the ~~EMS Disciplinary~~ OEMS Reinstatement Committee; and
- (4) be recommended in writing by the ~~EMS Disciplinary~~ OEMS Reinstatement Committee for issuance of an encumbered EMS credential. The ~~EMS Disciplinary~~ OEMS Reinstatement Committee shall detail in their recommendation ~~to the OEMS~~ all restrictions and limitations to the individual's practice privileges.

~~(e)~~ (d) The individual ~~must~~ shall agree to sign a consent agreement with the OEMS ~~which that~~ which that details the practice restrictions and privilege limitations of the encumbered EMS credential, and ~~which that~~ which that contains the consequences of failure to abide by the terms of this agreement.

~~(d)~~ (e) The individual shall be issued the encumbered credential within 10 business days following execution of the consent agreement described in Paragraph ~~(e)~~ (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(d)(10); ~~143-509(13); 143-519;~~*

*Eff. October 1, ~~2010~~ 2010;*

*Readopted Eff. January 1, 2017.*

10A NCAC 13P .1405 is proposed for amendment as follows:

#### **10A NCAC 13P .1405 FAILURE TO COMPLETE THE CHEMICAL ADDICTION OR ABUSE TREATMENT PROGRAM**

Individuals who fail to complete the treatment ~~program~~, program established in Rule .1401 of this Section, upon review ~~and recommendation~~ by the ~~North Carolina EMS Disciplinary Committee to the OEMS~~, are subject to revocation of their EMS credential.

*History Note: Authority G.S. 131E-159(f); 143-508(d)(10); ~~143-519;~~*

*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. January 1, 2017.*

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

#### **10A NCAC 13P .1502 LICENSED EMS PROVIDERS**

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

- (1) failure to comply, as defined in Rule .0102(45) of this Subchapter, with the applicable licensing requirements as found in Rule .0204 of this Subchapter;
- (2) making false statements or representations to the OEMS or willfully concealing information in connection with an application for licensing;
- (3) tampering with or falsifying any record used in the process of obtaining an initial license or in the renewal of a license; or

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

~~(a)~~ (b) The Department shall amend any EMS Provider license by reducing it from a full license to a provisional license whenever the Department finds that:

- (1) the licensee failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article; and
- (2) there is a ~~reasonable~~ probability that the licensee can ~~remedy the licensure deficiencies~~ take corrective measures to resolve the issue of non-compliance with Rule .0204 of this Subchapter, and be able thereafter to remain in compliance within a reasonable length of time; and time determined by OEMS staff.
- (3) there is a ~~reasonable probability~~ probability, determined by OEMS staff using their professional judgement based upon analysis of the licensee's ability to take corrective measures to resolve the issue of non-compliance with the licensure rules, that the licensee will be able thereafter to remain in compliance with the licensure ~~rules for the foreseeable future.~~ rules.

~~(b)~~ (c) The Department shall give the licensee written notice of the amendment of the EMS Provider license. This notice shall be given personally or by certified mail and shall set forth:

- (1) the length of the provisional EMS Provider license;
- (2) the factual allegations;
- (3) the statutes or rules alleged to be violated; and
- (4) notice of the EMS provider's right to a contested case ~~hearing~~ hearing, as set forth in Rule .1509 of this Subchapter, on the amendment of the EMS Provider license.

~~(e)~~ (d) The provisional EMS Provider license is effective ~~immediately~~ upon its receipt by the licensee and shall be posted in a location at the primary business location of the EMS Provider, accessible to public view, in lieu of the full license. ~~The~~ Pursuant to G.S. 131E-155.1(d), the provisional license remains in effect until the Department:

- (1) restores the licensee to full licensure status; or
- (2) revokes the licensee's license.

~~(d)~~ (e) The Department shall revoke or suspend an EMS Provider license whenever the Department finds that the licensee:

- (1) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that article and it is not ~~reasonably~~ probable that the licensee can remedy the licensure deficiencies within 12 months or less;
- (2) failed to comply with the provisions of G.S. 131E, Article 7, and the rules adopted under that Article and, although the licensee may be able to remedy the deficiencies, it is not ~~reasonably~~ probable that the licensee will be able to remain in compliance with licensure rules for the foreseeable future;
- (3) failed to comply with the provision of G.S. 131E, Article 7, and the rules adopted under that article that endanger the health, safety or welfare of the patients cared for or transported by the licensee;
- (4) obtained or attempted to obtain an ambulance permit, EMS nontransporting vehicle permit, or EMS Provider license through fraud or misrepresentation;
- (5) ~~repeated~~ continues to repeat the same deficiencies placed on the EMS Provider License in previous compliance site visits;
- (6) ~~failed~~ has recurring failure to provide emergency medical care within the defined EMS service area in a ~~timely~~ manner as determined by the EMS ~~System;~~ System pursuant to G.S. 153A-250;

- (7) failed to disclose or report information in accordance with Rule .0223 of this Subchapter;
- (8) is deemed by OEMS to place the public at risk because the owner or any officer or agent is convicted in any court of a crime involving fiduciary misconduct or a conviction of a felony;
- ~~(7)~~ (9) altered, destroyed, attempted to destroy, ~~withheld~~ withheld, or delayed release of evidence, records, or documents needed for a complaint investigation; investigation being conducted by the OEMS; or
- ~~(8)~~ (10) continues to operate within an EMS System after a Board of County Commissioners has terminated its affiliation with the ~~licensee~~. licensee, resulting in a violation of the licensing requirement set forth in Rule 0204 (b)(1) of this Subchapter.

(f) The Department shall give the EMS Provider written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:

- (1) the factual allegations;
- (2) the statutes or rules alleged to be violated; and
- (3) notice of the EMS Provider's right to a contested case hearing, as set forth in Rule .1509 of this Section, on the revocation of the EMS Provider's license.

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

*History Note: Authority G.S. 131E-155.1(d); 143-508(d)(10);*

*Eff. January 1, 2013;*

*Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. February 2, 2016- 2016;*

*Amended Eff. 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.

~~(a)~~ (b) The Department shall deny the initial or renewal ~~credential~~, designation, without first allowing a focused review, of an EMS Educational Institution for any of the following reasons:

- (1) failure to comply with the provisions of Section .0600 of this Subchapter;
- (2) attempting to obtain an EMS Educational Institution designation through fraud or misrepresentation; or
- ~~(3) —endangerment to the health, safety, or welfare of patients cared by students of the EMS Educational Institution;~~
- ~~or~~
- ~~(4)~~ (3) ~~repetition of~~ repetitive deficiencies placed on the EMS Educational Institution in previous compliance site visits.

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

~~(e)~~ (d) The Department ~~will~~ shall revoke an EMS Educational Institution ~~credential~~ designation at any time or deny a request for renewal of ~~credential~~ designation whenever the Department finds that the EMS Educational Institution has failed to ~~comply~~ comply, as defined in Rule .0102(45) of this Subchapter, with the provisions of Section .0600 of this Subchapter; and:

- (1) it is not probable that the EMS Educational Institution can remedy the deficiencies within 12 months or ~~less~~; 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 for the foreseeable future;~~ rules;
- (3) failure to produce records upon request as defined in Rule .0601(b)(6) of this Subchapter;
- ~~(3)~~ (4) the EMS Educational Institution failed to meet the requirements of a focused review;
- ~~(4)~~ (5) the failure to comply endangered the health, safety, or welfare of patients cared for as part of an EMS educational ~~program;~~ program is determined by OEMS staff in their professional judgement based upon a complaint investigation, using a standardized methodology designed by OEMS program staff through consultation with the Department and Office of the Attorney General legal counsel, to verify the results of the investigations are sufficient to initiate enforcement action pursuant to G.S. 150B; or
- ~~(5)~~ (6) the EMS Educational Institution altered, ~~destroyed~~ destroyed, or attempted to destroy evidence needed for a complaint investigation.

~~(d)~~ (e) The Department shall give the EMS Educational Institution written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:

- (1) the factual allegations;
- (2) the statutes or rules alleged to be violated; and
- (3) notice of the EMS Educational Institution's right to a contested case ~~hearing~~ hearing, set forth in Rule .1509 of this Subchapter, on the revocation of the ~~credential~~ designation.

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

~~(f)~~ (g) ~~An~~ If determined by the educational institution that suspending its approval to offer EMS educational programs is necessary, the EMS Educational Institution may voluntarily ~~withdraw~~ surrender its credential ~~without explanation for a maximum of one year~~ by submitting a written ~~request.~~ request to the OEMS stating its intention. To voluntarily surrender shall not affect the original expiration date of the EMS Educational Institution's designation. This request shall include the reasons for withdrawal and a plan for resolution of the deficiencies. To reactivate the credential, the institution shall provide to the Department written documentation of compliance. Voluntary withdrawal does not affect the original expiration date of the EMS Educational Institution's credential. 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.

~~(g)~~ (h) If the institution fails to resolve the issues which resulted in a voluntary ~~withdrawal within one year,~~ surrender, the Department shall revoke the EMS Educational Institution ~~credential~~ designation.

(i) The OEMS shall give the EMS Educational Institution written notice of revocation. This notice shall be given personally or by certified mail and shall set forth:

- (1) the factual allegations;
- (2) the statutes or rules alleged to be violated; and
- (3) notice of the EMS Educational Institution 's right to a contested case hearing, set forth in Rule .1509 of this Section, on the revocation of the designation.

~~(h)~~ (j) In the event of a revocation or voluntary withdrawal, 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 if, and when, when the voluntary withdrawal surrender reactivates to full credential.

(k) When an accredited EMS Educational Institution as defined in Rule .0605 of this Subchapter has administrative action taken against its accreditation, the OEMS shall determine if the cause for action is sufficient for revocation of the EMS Educational Institution designation or imposing a focused review pursuant to Paragraph (b) and (c) of this Rule is warranted.

*History Note: Authority G.S. ~~143-508(d)(4), (d)(10);~~ 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;~~ 2016;*

*Amended Eff. January 1, 2017.*

10A NCAC 13P .1507 is proposed for reoption with substantive changes as follows:

#### **10A NCAC 13P .1507 EMS PERSONNEL CREDENTIALS**

(a) An EMS credential ~~which that~~ has been forfeited under G.S.15A-1331A may not be reinstated until the person has ~~successfully~~ complied with the court's requirements, has petitioned the Department for reinstatement, ~~has appeared before the EMS Disciplinary Committee, and has had reinstatement approved.~~ has completed the disciplinary process, and has established Department reinstatement approval.

(b) The Department shall amend, deny, suspend, or revoke the credentials of EMS personnel for significant failure to comply with, as defined in Rule .0102(45), any of the following reasons: ~~following:~~

- (1) failure to comply with the applicable performance and credentialing requirements as found in this Subchapter;
- (2) making false statements or representations to the ~~Department~~ Department, or ~~willfully~~ concealing information in connection with an application for credentials;
- (3) making false statements or representations, ~~willfully~~ concealing information, or failing to respond ~~within a reasonable period of time and in a reasonable manner~~ to inquiries from the Department during a complaint investigation;
- (4) tampering ~~with~~ with, or falsifying any record used in the process of obtaining an initial EMS ~~credential~~ credential, or in the renewal of an EMS credential;
- (5) in any manner or using any medium, engaging in the stealing, manipulating, copying, ~~reproducing-reproducing,~~ or reconstructing of any written EMS credentialing examination ~~questions~~ questions, or scenarios;

- (6) ~~cheating~~ cheating, or assisting others to cheat while preparing to ~~take~~ take, or when taking a written EMS credentialing examination;
- (7) altering an EMS credential, using an EMS credential that has been ~~altered~~ altered, ~~or permitting~~ permitting, or allowing another person to use his or her EMS credential for the purpose of alteration. Altering includes changing the name, expiration ~~date~~ date, or any other information appearing on the EMS credential;
- (8) unprofessional conduct, including a failure to comply with the rules relating to the proper function of credentialed EMS personnel contained in this ~~Subchapter~~ Subchapter, or the performance ~~of~~ of, or attempt to perform a procedure that is detrimental to the health and safety of any ~~person~~ person, or that is beyond the scope of practice of credentialed EMS ~~personnel~~ 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~~ illness, use of alcohol, drugs, chemicals, or any other type of ~~material~~ material, or by reason of any ~~physical~~ physical, or mental abnormality;
- (10) conviction in any court of a crime involving moral turpitude, a conviction of a felony, a conviction requiring registering on a sex offender registry, or conviction of a crime involving the scope of practice of credentialed EMS personnel;
- (11) by false representations ~~obtaining~~ obtaining, or attempting to obtain ~~money~~ money, or anything of value from a patient;
- (12) adjudication of mental incompetence;
- (13) lack of competence to practice with a reasonable degree of skill and safety for patients including a failure to perform a prescribed procedure, failure to perform a prescribed procedure ~~competently~~ competently, or performance of a procedure that is not within the scope of practice of credentialed EMS ~~personnel~~ personnel, or EMS instructors;
- (14) performing as ~~an EMT I, EMT P, or EMD~~ 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~~ positive, whether for-cause or at random, through urine, blood, or breath sampling, for any substance, legal or illegal, that ~~has impaired~~ is likely to impair the physical or psychological ability of the credentialed EMS personnel to perform all required or expected functions while on duty;
- (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 ~~reasonable~~ 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~~ patient, student, bystander, or OEMS staff, either ~~physically or verbally~~ physically, verbally, or in writing;

- ~~(21)~~ (23) engaging in any activities of a sexual nature with a patient including kissing, ~~fondling~~ fondling, or touching while responsible for the care of that individual;
- ~~(22)~~ (24) any criminal arrests that involve charges ~~which~~ 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;
- ~~(23)~~ (25) altering, ~~destroying~~ destroying, or attempting to destroy evidence needed for a complaint ~~investigation~~; being conducted by the OEMS;
- ~~(24)~~ (26) ~~as~~ a condition to the issuance of an encumbered EMS credential with limited and restricted practices for persons in the chemical addiction or abuse treatment program; ~~or~~
- (27) unauthorized possession of lethal or non-lethal weapons, chemical irritants to include mace, pepper (oleoresin capsicum) spray and tear gas, or explosives while in the performance of providing emergency medical services;
- (28) failure to provide EMS care records to the licensed EMS provider for submission to the OEMS as required by Rule .0204 of this Subchapter;
- (29) continuing to provide EMS care after local suspension of practice privileges by the local EMS System, Medical Director, or Alternative Practice Setting; or
- ~~(25)~~ (30) representing or allowing others to represent that the credentialed EMS personnel has a credential that the credentialed EMS personnel does not in fact have.

(c) Pursuant to the provisions of ~~S.L. 2011-37~~, G.S. 131-E-159(h), the OEMS shall not issue an EMS credential for any person listed on the North Carolina Department of Justice Sex Offender and Public Protection ~~Registry shall be denied initial or renewal EMS credentials~~. 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 immediately revoke an individual's EMS credential until the Department has been notified by the court evidence has been obtained of compliance with a child support order.

~~(d)~~ (e) When a person who is credentialed to practice as an EMS professional is also credentialed in another jurisdiction and that other jurisdiction takes disciplinary action against the person, the Department shall summarily impose the same or lesser disciplinary action upon receipt of the other jurisdiction's action. The EMS professional may request a hearing before the EMS Disciplinary Committee. At the hearing the issues shall be limited to:

- (1) whether the person against whom action was taken by the other jurisdiction and the Department are the same person;
- (2) whether the conduct found by the other jurisdiction also violates the rules of the 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
- (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.

*History Note: Authority G.S. 131-E-159; ~~G.S. 131E-159(f),(g)~~; 143-508(d)(10); S.L. 2011-37;*  
*Eff. January 1, 2013, 2013;*  
*Readopted Eff. January 1, 2017.*

10A NCAC 13P .1510 is proposed for adoption as follows:

**10A NCAC 13P .1510 PROCEDURES FOR VOLUNTARY SURRENDERING OR MODIFYING THE LEVEL OF AN EMS CREDENTIAL**

(a) An individual who holds a valid North Carolina EMS credential may request to voluntarily surrender the credential to the OEMS by completing the following:

- (1) provide, in writing, a letter expressing the individual's desire to surrender the credential and explaining in detail the circumstances surrounding the request; and
- (2) return the pocket credential and wall certificate to the OEMS upon notification the request has been approved.

(b) An individual who holds a valid North Carolina EMS credential may request to voluntarily modify the current credentialing level from a higher level to a lower level by the OEMS by completing the following:

- (1) provide, in writing, a letter expressing the individual's desire to lower their current level and explaining in detail the circumstances surrounding the request;
- (2) state the desired level of credentialing; and
- (3) return the pocket credential and wall certificate to the OEMS upon notification the request has been approved.

(c) The OEMS shall provide a written response to the individual within 10 working days following receipt of the request either approving or denying the request. This response shall detail the reason(s) for approval or denial.

(d) If, at a future date, the individual seeks to restore the credential to the previous status, the individual must:

- (1) wait a minimum of six months from the date the action was taken;
- (2) provide, in writing, a letter expressing the individual's desire to restore the previous credential;
- (3) provide evidence of continuing education at a minimum of 2 hours per month at the level of the EMS credential being sought; and
- (4) undergo a National Criminal History background check.

(e) If the OEMS denies the individual's request for restoration of the previous EMS credential, the OEMS shall provide in writing the reason(s) for denial and inform the individual of the procedures for contested case hearing as defined 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.*

10A NCAC 13P .1511 is proposed for adoption 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 must submit in writing to the OEMS a request for review to determine eligibility for credentialing.

(b) Factors to be considered by the Department when determining eligibility shall include:

(1) the reason for administrative action, that includes:

(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 must:

(1) wait a minimum of 36 months following administrative action before seeking review; and

(2) undergo a national criminal history background check. If the individual has been charged or convicted of a misdemeanor or felony in this or any other state or country within the previous 36 months, the 36 month waiting period will begin from the date of the latest charge or conviction.

(d) If determined to be eligible, the Department shall grant authorization for the individual to begin the process for EMS credentialing as defined in Rule .0502 of this Subchapter.

(e) Prior to enrollment in an EMS educational program, the individual must disclose the prior administrative action taken against the individual's credential in writing to the EMS educational institution.

(f) 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. 131E-159(e).

(g) For a period of 10 years following restoration of the EMS credential, the individual must disclose the prior administrative action taken against his or her credential to every EMS System, Medical Director, EMS Provider, and EMS Educational Institution in which the 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, the Department shall provide in writing the reason(s) for denial and inform him or her of the procedures for contested case hearing as defined 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.*

