Title 15: Mississippi Department of Health

Part 12: Bureau of Emergency Medical Services

Subpart 31: Emergency Medical Services

Chapter 1 AMBULANCE SERVICE LICENSURE

Subchapter 1 Ambulance Service Licensure

Rule 1.1.1 The Bureau of Emergency Medical Services (BEMS) licenses ambulance services by location and issues permits for each vehicle operated at the location licensed. Individual problems regarding licensure that arise are dealt with by the BEMS. If locations are used to intermittently station ambulance employees and vehicles, and do not serve as points of contact for public business or for deployment control/dispatch centers, licenses for those locations are not required. Ambulance service areas that extend through multiple and/or adjacent counties require an ambulance service license for each county within that area. In these instances, licensure is required though there may not be a fixed identifiable location in each county. BEMS may, at its discretion, allow for exceptions, i.e. when an ambulance service from a single control point provides coverage for only portions of counties that are adjacent, only one license is required.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.2 A provider of ambulance service can be licensed by the Bureau of Emergency Medical Services as an ambulance service by request and by signing a completed application for service license (EMS Form 1). An inspection of premises must be made. A member of the BEMS staff will complete the EMS Form 1 due to the coding requirements of the form.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.3 If it is determined that the provider meets all requirements, the BEMS staff member has the authority to grant a license at the time of inspection. The owner copy of EMS Form 1 shall serve as proof of service license until permanent document is received by owner. The license is valid for one (1) year from date of issuance. Any change of service ownership constitutes issuance of a new license and permit(s).

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.4 Applicants for ambulance service license must provide a roster of all employees including Medical First Responders, EMTs, EMS-Ds, dispatchers, RNs, and others if appropriate. This list must include state-issued certification and/or license numbers where applicable.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.5 Applicant must submit one copy of the plan of medical control at least 30 days prior to service start date for approval by the BEMS staff and the State EMS Medical Director. The plan must include the patient destination criteria and treatment protocols for the trauma patient as delineated by the State Trauma Plan. All Medical Control Plans shall comply with the Mississippi State Trauma Plan as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.6 Plan must include the names of all off-line and on-line medical directors accompanied by credentials, proof of Mississippi physician licensure and controlled substances registration number. The Ambulance Service Medical Director must be approved by the State EMS Medical Director. In addition, controlled substances registration number and DEA required controlled substances registration certificate for non-hospital based paramedic services for the off-line medical director. Only the lead on-line medical director or each medical control hospital need be listed. Additionally the primary resource hospital and associate receiving hospital(s); description of methods of medical control; quality assurance and skill maintenance process must be included (See Appendix 1). *NOTE: Revisions in the medical control plan must be submitted prior to implementation. At a minimum, medical control plans shall be resubmitted to BEMS every three (3) years for approval by the BEMS staff and the State EMS Medical Director.*

1. Applicant must provide a letter signed by the off-line medical director stating he/she approves the ambulance provider's protocols and understands his/her responsibilities as stated in Appendix 1 of this document. This statement may be on forms provided by BEMS.

2. Applicant must provide evidence of 24-hour continuous service capabilities including back-up. Should also include staffing pattern and affiliations with non-transporting ALS services where applicable.

3. Applicant must provide a description of its communications capabilities, however - minimally - the system must be capable of communicating with the primary resource hospital throughout its immediate area of response.*

4. 911 is the universal emergency phone number for public access of Emergency Medical Services in the State. Ambulance service providers shall only advertise 911 as their emergency number. Exception: If a municipality or county has not implemented 911, then for that area, a seven-digit phone number may be used. This exception must have prior approval in writing by the BEMS. It is the intent of this regulation that 911, the universal access number for EMS, be the only emergency number advertised to the public. Any advertisement of a non-

emergency phone number must include a prominent display of 911 or other BEMS approved emergency phone number.*(Bio-medical telemetry is not required if so documented in the communications plan by the medical director). *NOTE: Ambulance services shall submit Mississippi Uniform Accident Reports involving EMS permitted vehicles with license renewals*

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 Periodic inspections.

Rule 1.2.1 Inspections to insure compliance with the law will be made not less than two (2) times each year licensed and in most cases four (4) times.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.2 No employer shall employ or permit any employee to perform any services for which a license/certificate or other authorization (as required by this act or by the rules and regulations promulgated pursuant to this act) unless and until the person possesses all the licenses, certificates or authorization that are so required.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.3 No owner of a publicly or privately owned ambulance service shall permit the operation of the ambulance in emergency service unless the attendant on duty therein possesses evidence of that specialized training as is necessary to insure that the attendant or operator is competent to care for the sick or injured persons, according to their degree of illness or injury, who may be transported by the ambulance, as set forth in the emergency medical training and education standards for emergency medical service personnel established by the State Department of Health, Bureau of EMS.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.4 The owner/manager or medical director of each publicly or privately owned ambulance service shall immediately inform the State Department of Health, Bureau of EMS of the termination or other disciplinary action taken against an employee because of the misuse of alcohol, narcotics, other controlled substances, or any failure to comply with an employer's request for testing.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.5 A Mississippi licensed ambulance service shall comply with the Mississippi State Trauma Plan as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services. Licensed service must follow the respective region's patient destination criteria and treatment protocols for the trauma patient as delineated by the State Trauma Plan.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.6 Other common grounds for suspension or revocation are for example, but not limited to:

1. Lack of State certified EMT attending patient.

2. Lack of driver with valid driver's license and state EMS driver certification.

3. Lack of proper equipment required by law.

4. Not adhering to sanitation of vehicle and equipment requirements.

5. Failure to adhere to record keeping or reporting requirements required by BEMS.

6. Failure to maintain proper insurance required by law.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.7 A license can be temporarily suspended or revoked by any staff member of the BEMS at time of violation, and will be followed up by a letter of temporary suspension or revocation. This letter will be certified, return receipt requested. This action may be taken with just cause in an effort to protect the public. Within five days from the time of temporary suspension or revocation, BEMS may extend the suspension, reinstate or revoke the license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.8 The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.9 The right to appeal process is discussed in section 41-59-49.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Ownership Changes

Rule 1.3.1 Any change of ownership or location voids original license and permit(s). Such changes constitute issuance of new service license and permit(s). (Application process must be initiated and completed by the new owner).

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Permits, All Vehicles

Rule 1.4.1 Permits are issued by the BEMS to a licensed ambulance service after an inspection of the vehicles and equipment has been completed and a determination made by BEMS that all requirements have been met.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.2 Permits issued shall expire concurrently with the service license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.3 An EMS Form 2 must be filled out by BEMS and signed by the owner or his designated representative.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.4 BEMS may give permission for vehicle operation at the time of inspection if judgment is made that the vehicle meets all requirements. The owner copy of EMS Form 2 shall serve as proof of permit until permanent document is received by owner.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.5 All permits for vehicles are issued by licensed location. If, at any time, a vehicle is permanently moved to a new location a new inspection must be made and a new permit issued in accordance with the service license for the new location.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.6 Common grounds for suspension or revocation of vehicle permit are, for example:

1. Improper or lack of essential required equipment, design and construction standards

2. Sanitary requirements not maintained

3. Lack of properly certified personnel in rear of vehicle when patient is present or lack of properly qualified driver

4. Failure to maintain insurance as required

5. Change in location of vehicle

6. Failure to carry BEMS issued permit card on vehicle

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.7 Common grounds for issuance of temporary permit (limited to 90 days) are for example:

1. Minor equipment items missing, but to be replaced within a reasonable time period.

2. Permitted vehicle is under repair and a replacement vehicle, meeting standards, is needed on a temporary basis.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 Vehicle Standards

Rule 1.5.1 Standards for the design, construction and equipment of ambulance vehicles.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.2 All new ambulance vehicles, before being issued an original ambulance permit as authorized by Mississippi Code 41-59-23, shall conform to current Federal Specification `Star-of-Life Ambulance' as published by the General Services Administration, Specification Section. Ambulances that were constructed prior to the implementation of the current Federal Specifications shall conform to the applicable Federal Specifications that were in effect at the time of original construction. The following are exceptions and additions:

1. Height: Overall height of the ambulance at curb weight shall not exceed 110 inches, excluding roof-mounted light bars and communications accessories.

2. Color Paint and Finish: The exterior color of the ambulance shall be basically white in combination with a solid uninterrupted orange stripe and blue lettering and emblems. The band (stripe) of orange not less than 6 inches wide, nor more than 14 inches wide shall encircle the entire ambulance body configuration at the belt line below the lowest edge of cab windows but may exclude the front of the hood panel. (The orange stripe may be edged/pin striped in black or blue.) This solid (single) band, when viewed horizontally, shall appear as a stripe near parallel to the road. When vinyl orange stripes are used rather than paint, it is acceptable to interrupt the strip at the corners of the vehicle to allow the vinyl to mold appropriately.

3. Additional lettering and markings are allowed in, above and below the stripe, however, these markings shall not completely traverse or interrupt the stripe at any point.

4. The name of the ambulance company shall be printed in minimum 4 inch high letters of highly visible contrasting color on each side of the ambulance or on the doors.

5. Letters, words, phrases, or designs suggesting special services, i.e., advanced life support, etc., shall be allowed provided such specialty services are in fact available in the vehicle at all times when in operation.

6. If the construction and design of an ambulance prohibits the placement of the ambulance (reverse) decal on the front hood, it shall be an acceptable exemption. BEMS shall have the authority to grant exceptions to requirements for color, paint, finish and essential equipment for certain transport capable vehicles that are used exclusively for special situations, i.e. neonatal transport.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.3 The BEMS shall have the authority to grant exceptions to requirements for color, paint, finish, and essential equipment for certain transport capable vehicles that are used exclusively for special situations, i.e. neonatal transport, etc. If the special needs of the patient-types for these special use vehicles are not met by the standards required in these regulations, the vehicles shall be exempt from said regulations and instead should be equipped with essential equipment needed to manage the individual patient types.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.4 Suction aspirator system: Shall be electrically powered. Shall provide a free airflow of at least 30 lpm at the distal end of the connected patient hose. It shall achieve a vacuum of at least 300 mmHG (11.8 inches) within 4 seconds after the suction tube is clamped closed.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.5 Portable suction aspirator: The unit will be self-contained, portable, battery operated, suction apparatus with wide-bore tubing. Gas powered or manual, portable suction aspirators may be substituted for battery operated suction units provided that they meet same operational standards.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.6 Two-way (mobile) radio equipment: One two-way radio (155.340 MHZ) or acceptable alternative that is compatible or interoperable for communication on radio frequency 155.340.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.7 Standard mandatory miscellaneous equipment: Unless otherwise precluded elsewhere in this specification, each ambulance shall be equipped with, but not limited to, the following:

1. Fire extinguisher: one, ABC dry chemical, multi-purpose (Halon, C02) minimum 5 pound unit in a quick-release bracket mounted in the patient compartment.

2. Hazardous Material Reference Guide.

3. Reflective Safety wear for each crewmember (must meet or exceed ANSI/ISEA performance class II or III).

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.8 Medical, surgical, and bio-medical equipment: When specified, the ambulance shall be equipped with, but not limited to, the following:

1. One stretcher for primary patient as specified in current Federal Specifications for ambulances, dimensions as per KKK-A-1822.

2. 3 strap type restraining devices (chest, hip, knee, and shoulder) attached to stretcher. Straps shall not be less than two inches wide, nylon, and consist of quick release buckles.

3. Portable and fixed oxygen equipment with variable flow regulator capable of delivering 15 lpm in calibrated increments. Cylinder must contain 300 psi of medical grade 02 at a minimum.

4. Three oxygen masks, adult. (Non-rebreathing face mask)

5. One oxygen mask, child. (Non-rebreathing face mask)

6. One oxygen mask, infant.

7. Three oxygen bi-pronged nasal cannulas.

8. One oxygen bi-pronged nasal cannula - pediatric.

9. One mouth-to-mask artificial ventilation device with supplemental oxygen inlet port with one-way valve, i.e., "pocket mask", etc.

10. Bag Valve Mask (manual resuscitator) hand operated, self reexpanding bag, adult (>1000 ml), without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

11. Bag Valve Mask (manual resuscitator) hand operated, self reexpanding bag, pediatric (450-750 ml), without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

12. Bag Valve Mask (manual resuscitator) hand operated, self reexpanding bag, infant, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

13. Bag Valve Mask (manual resuscitator) hand operated, self reexpanding bag, neonate, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen. May substitute infant bag and utilize neonate specific mask.

14. Two adult oropharyngeal airways, one each sizes 4-5.

15. Two child oropharyngeal airways, one each sizes 2-3.

16. Two infant oropharyngeal airways, one each sizes 0-1.

17. One adult nasopharyngeal airway 28-36 fr. or 7.0-9.0 mm.

18. One child nasopharyngeal airway 20-26 fr. or 5.0-6.0 mm.

19. Lubricating jelly (water soluable).

20. One bite stick.

21. Six large, sterile, individually wrapped, trauma dressings (minimal six 8" x 10"). Must include one ABD pad, 10”x12” or larger.

22. Twelve sterile, individually wrapped (or in two's), dressings 4" x 4".

23. Three soft roller bandages, 4" or larger.

24. Three triangular bandages or commercial arm slings.

25. Adhesive tape

26. Various sizes (including 1” and 2”) hypoallergenic

27. Various sizes (including 1” and 2”) adhesive

28. Arterial Tourniquet

29. One pair heavy bandage or EMT shears for cutting clothing, belts and boots.

30. Cold Packs

31. One sterile, occlusive dressing or equivalent, 3" x 8" or larger.

32. Cervical Collars; minimum one rigid for children ages 2 years or older; one each child and adult sizes (small, medium, large). Other available sizes are recommended. *NOTE: Two adjustable, rigid collars may be substituted*.

33. One lower extremity traction splint, limb-support slings, padded ankle hitch, padded pelvic support, traction strap.

34. Assorted sized extremity immobilization devices which will provide for immobilization of joint above and joint below fracture and rigid support and be appropriate material (cardboard, metal, pneumatic, wood, plastic, etc.). Sizes shall be appropriate for adult and pediatric patients.

35. One short spine board with accessories or commercial equivalent (KED, Kansas Board, etc.).

36. Two long spine boards multi-use impervious to blood and body fluid or single use disposable - with accessories. (Radiolucent preferred.)

37. One folding stretcher as specified in current Federal Specifications for Ambulances, style 3 (folding legs optional) or a combination stretcher chair designed to permit a patient to be carried on stairways and/or through narrow areas.

38. Head Immobilization Device multi-use impervious to blood and body fluid or single use disposable .

39. Two sterile or clean burn sheets (packaged and stored separately from other linens).

40. Six clean sheets (2 on cot and 4 spare).

41. Three pillow cases (1 on pillow and 2 spare).

42. Two blankets.

43. Towels.

44. Triage tags. Color code must be (from top to bottom) black (deceased), red (immediate), yellow (delayed), and green (minor). White for worried well, etc. is optional.

45. One sterile OB kit.

46. One Sphygmomanometer (adult with regular and large size cuffs).

47. One Sphygmomanometer (pediatric).

48. One length based tape or appropriate reference material for pediatric equipment sizing and drug dosing based on estimated or known weight.

49. One stethoscope.

50. One roll aluminum foil or silver swaddler (enough to cover newborn).

51. Infant blood pressure cuff with aneroid gauge.

52. Flashlights (2).

53. Two liters sterile water for irrigation. One liter shall be sterile saline solution for irrigation. May be packaged in bottles or bags. Unbroken seal required.

54. One container of water for purging fixed suction device.

55. One container of water for purging portable suction devices.

56. One 15g. glucose or other commercial derivative for oral administration.

57. 50g. activated charcoal.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.9 Infectious disease precaution materials: *NOTE: Latex-free equipment should be available.*

1. Disposable latex gloves (6 pair). Gloves shall meet NFPA 1999 requirements.

2. Disposable goggles and masks (2 pair) or face shields (4)

3. Impervious gown or apron (2) and 2 pair shoe covers.

4. Respiratory protection (i.e. N95 or N100 mask) (2)

5. Disinfectant for hands (waterless hand cleanser, commercial antimicrobial. May be towelette, spray or liquid.) and equipment.

6. Sharps container (see OSHA regulations in Appendix 8) one each fixed and portable.

7. Two leakproof plastic bags for contaminated or biohazard waste.

8. Two disposable rigid non-metallic suction tips with wide-bore inside diameter of at least 18 fr.

9. Two of each size sterile disposable suction catheters: (2 each - 5-6 fr.); (2 each - 8-10 fr.); (2 each - 14-18 fr.)

10. One bedpan, one urinal, and at least two emesis basins or bags or commercial equivalent.

11. Automated external defibrillator (AED) (Basic Level Ambulance Only). AED should have pediatric capabilities, including child sized pads and cables. *NOTE: In addition to the previously listed BLS regulations, the following additional ALS requirements must be met:*

    a. Only vehicles meeting current state regulations for emergency ambulance classifications may be approved and permitted as ALS vehicles.

    b. All ALS vehicles shall conform to the advanced equipment guidelines established by the American College of Surgeons, Committee on Trauma, and as may be modified by the State Board of Health.

c. If not stored on the ambulance, the equipment and supplies required for advanced life support at the EMT-Intermediate or EMT-Paramedic level, must be stored and packaged in such a manner that they can be delivered to the scene on or before the response of the ALS personnel. This may be accomplished by rapid response units or other non-ambulance emergency vehicle. *NOTE: ALS services are required to have ALS equipment commensurate with the ALS staffing plan submitted as part of the application for service licensure*.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 EMT- Intermediate

Rule 1.6.1 For the EMT-I all the equipment for the EMT-B as previously listed plus the following equipment and supplies:

1. Intravenous administration equipment (fluid should be in bags, not bottles): Ringer's Lactate and/or normal saline solution (4,000 ml minimum)

2. Antiseptic Solution (i.e. alcohol wipes)

3. IV Pole or Roof Hook

4. Intravenous catheter with needle (1"-3" in length) minimum 6 each sizes 14G-24G .

5. Venous tourniquet.

6. Syringes various sizes, including tuberculin (Paramedic Level Only).

7. Needles, various sizes (one at least 1 ½ " for IM injection-Paramedic Level Only)

8. Three (3) Intravenous administration sets (microdrip and macrodrip)

9. Intravenous arm boards (adult and pediatric)

10. Airway

    a. Esophageal obturator airway or esophageal gastric tube airway with mask, 35cc syringe, stethoscope. (NOTE: May utilize-combitube – single or dual lumen airway.)

    b. End-tidal CO2 Detectors (may be made onto bag valve mask assemblies or separate)

    c. Pulse Oximeter with pediatric and adult probes. (Pulse ox may be independent or integrated with a monitor/defibrillator or other device).

11. Cardiac: Portable, battery operated Manual monitor defibrillator (with tape write-out), defibrillation pads or jell, quick-look paddles (adult and pediatric) or electrodes (adult and pediatric) or hands free patches (adult and pediatric), EKG leads, chest attachment pads (adult and pediatric) (telemetry radio capability optional). Automated or semi-automated defibrillator (AED) which: a) is capable of cardiac rhythm analysis; b) will charge and deliver a shock after electrically detecting the presence of a cardiac dysrhythmia or is a rhythm and display a message advising the operator to press a "shock" control to deliver the shock; c) must be capable or retaining and reproducing a post event summary (at a minimum the post event summary should include time, joules delivered and ECG). (Intermediate Level Ambulance Only)

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 EMT-Paramedic

Rule 1.7.1 Airway All the equipment and supplies listed above plus the following additional equipment and supplies:

1. Laryngoscope handle with extra batteries and bulbs. May be substituted with disposable handles and/or blades.

2. One each Laryngoscope blades, sizes 0-4, straight (Miller); sizes 2-4, curved (McIntosh).

3. Endotracheal tubes, 2 each sizes 2.5-5.5 mm uncuffed and 2 each sizes 6-8 mm cuffed. Other sizes optional.

4. 10 cc non-Luerlock syringes.

5. Stylettes for endotracheal tubes (adult and pediatric).

6. One pair each Magill forceps (adult and pediatric).

7. End-tidal CO2 detection capability.

8. Portable, battery operated Manual monitor defibrillator (with tape write-out), defibrillation pads or jell, quick-look paddles (adult and pediatric) or electrodes (adult and pediatric) or hands free patches (adult and pediatric), EKG leads, chest attachment pads (adult and pediatric) (telemetry transmission capability optional). Transcutaneous cardiac pacemaker, including adult and pediatric capabilities and supplies. (Either stand alone or integrated into monitor/defibrillator)

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.7.2 Other Medical Supplies – Paramedic Level

1. Nebulizer

2. Glucometer or blood glucose measuring device

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.7.3 Drugs: The Bureau of EMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA) will approve pharmaceuticals available for use by EMS providers. A list of 'Required', 'Optional', and 'Transport only' drugs for EMS providers in the State is compiled and maintained by the BEMS and the MDTQA. All pharmaceuticals carried and administered by EMS providers in the state must be in the 41 classifications of drugs as defined by the 1998 EMT-Paramedic National Standard Curriculum. A current list of fluids and medications approved for initiation and transport by Mississippi EMS providers is available from the BEMS office or the BEMS website (www.msems.org). *NOTE: A System Medical Director may make requests for changes to the list. These requests should be submitted in writing to the BEMS. All requests must detail the rationale for the additions, modifications, or deletions.*

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 Sanitation regulations

Rule 1.8.1 The following shall apply regarding sanitation standards for all types of ambulance vehicles:

1. The interior of the ambulance and the equipment within the ambulance shall be sanitary and maintained in good working order at all times.

2. Equipment shall be made of smooth and easily cleanable construction.

3. Freshly laundered linen or disposable linen shall be used on cots and pillows and linens shall be changed after each patient is transported.

4. Clean linen storage shall be provided on each ambulance.

5. Closed compartments shall be provided within the ambulance for medical supplies.

6. Pillows and mattresses shall be kept clean and in good repair.

7. Closed containers shall be provided for soiled supplies.

8. Exterior and interior surfaces of ambulance shall be cleaned routinely.

9. Blankets and hand towels used in any ambulance shall be clean.

10. Implements inserted into the patient's nose or mouth shall be single service, wrapped and properly stored and handled. When multi-use items are used, the

local health care facilities should be consulted for instructions in sanitation and handling of such items.

11. When an ambulance has been utilized to transport a patient known to the operator to have a communicable disease, the vehicle shall be placed "out of service" until a thorough cleansing is conducted.

12. All storage spaces used for storage of linens, equipment, medical supplies and other supplies at base stations shall be kept clean and free from unnecessary articles. The contents shall be arranged so as to permit thorough cleaning.

13. In addition, current CDC and OSHA requirements apply.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.8.2 Narcotics: Certified ALS personnel (paramedics and RNs) functioning under approved medical control jurisdiction may be issued approved controlled substances for pre-hospital use upon the discretion of the off-line medical director. For ALS services that are not hospital-based, the Drug Enforcement Administration (DEA) requires the off-line medical director to secure a separate CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE to store, issue and prescribe controlled substances to ALS personnel. This CERTIFICATE should list the medical director as a "practitioner" at the physical address of the ambulance service where the drugs are stored. The off-line medical director will determine who may issue and administer the controlled substances and who will have access to storage of these narcotics.

1. Controlled substances must be secured in accordance with applicable state and federal regulations. The paramedic's narcotics should be secured in a designated location when he is not on duty and actively functioning under the service's medical control. When on duty, each paramedic should keep his controlled drugs in his immediate possession or securely locked in the vehicle at all times.

2. Whenever an order is received from medical control for administration of a narcotic, the paramedic must keep track of the vial/ampule being utilized. If the full amount of the narcotic was not administered, the remainder must be wasted in the presence of a witness and the witness must sign the patient report documenting same. The witness should preferably be a licensed health care provider who is authorized to administer narcotics themselves.

3. Narcotics should be replaced and logged within 24 hours of administration. Narcotics logs should be maintained by the ALS service. Paramedics should individually document the following minimum information in the narcotics log: Date of administration; Time of administration; Amount administered; Amount wasted; Witness to wasted amount; Patient's name; Call number; Ordering physician

4. Any paramedic/RN that is separated from the ALS service's medical control authority shall surrender his narcotics upon demand or be subject to prosecution under applicable statutes.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.8.3 Prescription Items: All ambulance services licensed by the BEMS are required to have approved medical directors. BLS ambulance services are required to have designated an off-line medical director only. These physician directors are necessary to allow the services to store and administer certain prescription items as required in the Rules and Regulations of the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 Storage of Prescription Items:

Rule 1.9.1 Ambulance services and personnel should not store or carry prescription drugs or items which they are prohibited from using. Personnel who are allowed to administer prescription drugs or use prescription items should carry these drugs and/or items only when they are on duty and actively functioning under their ambulance service's medical control authority.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.9.2 Prescription items and drugs should always be stored and carried in secure locations accessible only to authorized personnel. These items and drugs should be stored within temperature ranges as recommended by the manufacturer.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.9.3 High Visibility Safety Apparel for Staff: Each ambulance must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Special Use EMS Vehicles

Rule 1.10.1 Special Use Emergency Medical Services Vehicles (SUEMSV) used on roadways shall be equipped with the following minimum emergency warning devices:

1. A combination electronic siren with integral public address system.

2. Strobe, light emitting diode (LED) or quartz halogen incandescent red or combination red/clear emergency lights providing the vehicle with a conspicuous appearance for safety during emergency response. The emergency lights must display highly perceptible and attention-getting signals designed to convey the message "clear the right-of-way."

3. Use of emergency warning devices by SUEMSV is restricted to actual EMS responses as authorized and requested by the licensed ambulance service or BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.2 Permits for special use EMS vehicles are issued by BEMS to a licensed ambulance service after an inspection of the vehicles has been completed and a determination made by BEMS that all requirements have been met.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.3 Permits issued shall expire concurrently with the service license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.4 All permits for vehicles are issued by licensed location. If, at any time, a vehicle is moved to a new location, a new inspection must be made and a new permit issued in accordance with the service license for the new location.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.5 Payment of a renewal fee to be fixed by the Board, which shall be paid to the Board.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.6 Personnel operating ground SUEMSV must be certified as EMS-D.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.7 Each SUEMSV must be insured as per Section 41-59-27, Mississippi Code of 1972, Annotated.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.8 All Special Use EMS Vehicles must be marked with flashing red lights front and back and may be marked with white and amber lights in addition to red lights.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.9 High Visibility Safety Apparel for Staff: Each Special Use EMS Vehicle must be equipped with high visibility safety apparel for each person staffing or

participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Required Personnel

Rule 1.11.1 Every ALS ambulance, when responding to and transporting patients requiring care beyond the basic life support level, must be occupied by a driver with a valid driver's license and one (1) person who possesses a valid EMT-I or EMT-P state certificate (if service is licensed as Intermediate level), or one (1) person who possesses a valid EMT-P state certificate (if service is licensed as a Paramedic level), or one (1) person who possesses a valid medical/nursing license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.11.2 In addition, any ambulance service that wishes to provide ALS and employ ALS personnel to function in an ALS role, intermittently or consistently, must be licensed at the ALS level by the State Department of Health, Bureau of Emergency Medical Services.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.11.3 Anyone driving an ambulance or (invalid) vehicle must possess a valid emergency medical service driver (EMS-D) state certificate in addition to a valid driver's license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.11.4 Certification of training for personnel functioning in an out-of-hospital Advanced Life Support (ALS) role may be as follows:

1. Current registration as an EMT-I/EMT-P by the National Registry of EMTs.

2. Letter/statement signed by the ambulance service owner/manager which attests to equivalency of training (National Standard Training Curriculum for EMT I/P) for each employee possessing a medical/nursing license.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 12 Record Keeping

Rule 1.12.1 All licensed ambulance services operating in the State of Mississippi must submit electronically, the State of Mississippi Patient Encounter Form and/or information

contained on the form via network, or direct computer link, for each ambulance run made and/or for each patient transported.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.2 A completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form shall be left with hospital staff for all patients delivered to licensed Hospitals. If in the best interest of the public good, an immediate response to a patient is required of an ambulance delivering a patient to a licensed Hospital, a complete oral report on the patient being delivered will be given to the receiving facility and a completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form for that patient shall be delivered in person or by fax to the hospital staff of the licensed Hospital within 24 hours.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.3 All Mississippi Patient Encounter Forms are due in the BEMS office by the seventh day after the close of the preceding month.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.4 All Mississippi Patient Encounter Forms or computer disk information returned to an ambulance service for correction must be corrected and returned to the BEMS office within two weeks calculated from the date of their return.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.5 Returns to a licensed ambulance service provider greater than 3 times may result in a penalty as outlined under Section 41-59-45, paragraph 3.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 Invalid Vehicles

Rule 1.13.1 Standards for invalid vehicles:

1. No vehicle used exclusively for invalid transfer is to have any markings, flashing lights, sirens, or other equipment that might indicate it is an Emergency Vehicle. The word "Ambulance" is not to appear on the vehicle.

2. The vehicle will have at least two doors leading into the patient compartment; one at the rear for patient loading and one on the curbside so that the patient may be easily removed should the rear door become jammed. All doors should be constructed so that they may be opened from inside or outside.

3. Stretcher holders and litter straps will be required for patient safety. Seat belts will be required for occupants of the driver compartment.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.2 Required equipment:

1. First aid kit: Commercially available kit containing gauze pads, roller bandages, and adhesive tape acceptable

2. 5 pound dry chemical fire extinguisher

3. 1 box disposable tissues

4. 1 bed pan (fracture type acceptable)

5. 1 emesis basin

6. 2 towels

7. 1 blanket

8. 4 sheets

9. 2 pillow cases

10. wheeled cot meeting or exceeding requirements in Federal Specifications for Ambulances

11. wheeled cot retention system as determined by BEMS

12. detachable safety retaining strap for wheeled cot

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.3 Vehicle Standards:

1. Patient Compartment:

   a. 42" high, floor to ceiling

   b. 48" wide, measured 15" above floor from side to side

   c. 92" long, measured 15" above floor from divider to rear door

2. Emblems and markings: The name of the company shall be printed on each side of the vehicle or the cab doors of the vehicle.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.4 High Visibility Safety Apparel for Staff: Each invalid vehicle must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 14 Appeal Process

Rule 1.14.1 The State Board of Health and the Bureau of EMS shall provide an opportunity for a fair hearing for every licensee of ambulance service who is dissatisfied with administrative decisions made in the denial and/or suspension/revocation of a license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.14.2 BEMS shall notify the licensee by registered mail, the particular reason for denial or revocation/suspension of the license. Upon written request of the licensee within ten days of the notification, BEMS shall fix a date not less than thirty days from the date of such service at which time the licensee shall be given an opportunity for a prompt and fair hearing before officials of the Mississippi State Department of Health.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.14.3 On the basis of such hearing or upon the fault of the applicant or licensee, the Mississippi State Department of Health shall make a determination specifying the findings of fact in conclusion of the law. A copy of such determination shall be sent by registered mail to the last known address of the licensee or served personally upon the licensee.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.14.4 The decision to suspend, revoke or deny a license shall become final thirty days after it is mailed or served unless the applicant or licensee within such thirty days, appeals the decision to the Chancery Court of the county where the applicant or licensee is domiciled.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 15 Subscription Services

Rule 1.15.1 All subscription permits issued are valid for a maximum period of one (1) year. This period is from January 1 through December 31. Regardless of date of issuance, all subscription permits expire on December 31 of each calendar year.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.15.2 The Five Hundred Dollars ($500.00) permit fee is in addition to the fee for BLS or ALS licensure.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 16 Program Requirements

Rule 1.16.1 Each membership subscription ambulance service provided must forward a copy (copies) of all surety bonds purchased along with an official statement of total subscribers covered. Such information is made part of the application for subscription permit. During the permit period, should bonds be cancelled, voided, or changed in any way, BEMS must be notified by the service provider.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.16.2 Proof of the establishment of a reserve fund must be provided to BEMS as a prerequisite to BEMS issuance of a subscription permit. Monthly reserve statements of cash balances must be forwarded to BEMS by either the EMS provider and/or the bank in which the reserve account is established.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 17 Annual Reports

Rule 1.17.1 Each subscription ambulance service must submit its annual report with all information as required in Section 41-59-69 within 45 days after the expiration of the subscription permit period (February 14).

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.17.2 The annual report may be submitted in letter form to BEMS with supporting documentation as is necessary.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.17.3 BEMS will suspend all subscription permits of ambulance services failing to file annual reports within the prescribed period.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 2 TRANSFERS

Subchapter 1 General Information

Rule 2.1.1 EMS personnel are restricted to performance of those skills as authorized by the State Department of Health, Bureau of Emergency Medical Services. EMS personnel cannot transport patients with needs or reasonably perceived needs for care which exceed the scope of practice for the ambulance attendant.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.2 The only exception to the above is as follows:

1. EMT's may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

2. There is no need, or reasonably perceived need, for the device or procedure during transport; and

3. An individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.3 Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.4 Ambulance personnel aiding in the transfer should confirm that the facility to which the patient is to be transferred has been notified and has agreed to accept the patient. They should also inquire whether the patient's condition is stable (no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from the facility) and whether a nurse, physician or other medical personnel should accompany the patient during transfer.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.5 If a patient at a hospital has an emergency medical condition which has not been stabilized (as defined herein), the hospital should not request the transfer and the ambulance service should not transfer the patient unless:

1. the patient (or legally responsible person acting on the patient's behalf) request that the transfer be effected;

2. a physician or other qualified medical personnel when a physician is not readily available, has verified that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at

another medical facility outweigh the increased risk to the individual's medical condition from effecting the transfer; or,

3. the transfer is an appropriate transfer to that facility.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 3 AERO MEDICAL SERVICES

Subchapter 1 Definitions Relative to Aero Medical EMS:

Rule 3.1.1 Advanced Life Support Care (ALSC) - Means a sophisticated level of pre-hospital and inter-hospital emergency care which includes basic life support functions including cardiopulmonary resuscitation (CPR), plus cardiac defibrillation, telemetered electrocardiography, administration of anti-arrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures. This level of care (quantity and type of staff member(s), equipment and procedures) is consistent with a patient in a pre-hospital emergency or non-emergency incident. In addition, this level of care (quantity and type of staff member(s), equipment and procedures) is consistent with a patient in a inter-hospital incident who is in a non-acute situation and is being cared for in an environment where monitoring of cardiac rhythm, neurological status, and/or continuous infusions of anti-arrhythmic and/or vasopressors, are part of the patient's care needs.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.2 Aeromedical Physiology - (Ualtitude physiology, flight physiology)U Means the physiological changes imposed on humans when exposed to changes in altitude and atmospheric pressure and the physical forces of aircraft in flight. Persons whose physiologic state is already compromised may be more susceptible to these changes and the potential physiologic responses they may experience while in flight in an aircraft. It is directly related to physical gas laws and the physics of flight. See also Stressor of Flight.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.3 Air Ambulance Aircraft - (aircraft, airplane) Means a fixed-wing or rotor-wing aircraft specially constructed or modified that is equipped and designated for transportation of sick or injured persons. It does not include transport of organ transplant teams or organs.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.4 Air Ambulance Service - (service, provider) Means an entity or a division of an entity (sole proprietorship, partnership or corporation) that is authorized by the Federal Aviation Administration (FAA) and BEMS to provide patient transport

and/or transfer by air ambulance aircraft. The patient(s) may be ambulatory or non-ambulatory and may or may not require medical intervention of basic or advanced nature. It uses aircraft, equipped and staffed to provide a medical care environment on board appropriate to patient's needs. The term air ambulance service is not synonymous with and does not refer to the FAA air carrier certificate holder unless they also maintain and control the medical aspects that make up a complete service.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.5 Air Medical Personnel - Means a licensed physician, registered nurse, respiratory therapist, State of Mississippi current certified EMT-Paramedic, EMT-Intermediate or EMT-Basic who has successfully completed a course in aeromedical physiology and flight safety training and orientation.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.6 Air Ambulance Transport System Activation - Formerly referred to as Dispatch, the term was changed to avoid conflict with the meaning in the FAR's - Means the process of receiving a request for transport or information and the act of allocating, sending and controlling an air ambulance and air medical personnel in response to such request as well as monitoring the progress of the transport.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.7 Authorized Representative - Means any person delegated by a licensee to represent the provider to county, municipal or federal regulatory officials.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.8 Basic Life Support Care (BLSC) - (UBLS, basic care) Means the level of care (quantity and type of staff members(s), equipment and procedures) which is consistent with a stable patient in a non-acute situation who prior to transport may be in a skilled care setting or non-health care facility. The patient's condition will be such that he requires only minimal care such as monitoring of vital signs or administration of oxygen. It does not include patients with continuous IV infusions with or without additives or artificial airways. This level of care will be rendered by at least a basic level emergency medical technician. This level of care requires minimal equipment such as basic monitoring and diagnostic equipment - stethoscope, blood pressure cuff, flashlight, etc.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.9 Cockpit Crew Member - (pilot, co-pilot, and flight crew) Means a pilot, co-pilot, flight engineer, or flight navigator assigned to duty in an aircraft cockpit.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.10 Critical Care Life Support (CCLS) - Means the level of care (quantity and type of staff member(s), equipment and procedures) that is consistent with a patient who may or may not be stable and who is in an acute situation or at high risk of decompensating prior to transport. The following patient categories are included: cardiovascular, pulmonary, neurologic, traumatic injury including spinal or head injury, burns, poisonings and toxicology. These patients are being cared for in an acute care facility such as the emergency department, intensive, critical, coronary or cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilatory functions by artificial means is being performed. This level of care must be rendered by at least two air medical personnel, one of which is a registered nurse or physician. This level of care requires specific monitoring and diagnostic equipment above the advanced level.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.11 FAA - Means the Federal Aviation Administration.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.12 FAR - Means the Federal Aviation Regulation.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.13 FCC - Means the Federal Communications Commission.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.14 Fixed-wing Air Ambulance - (fixed-wing) Means a fixed-wing type aircraft that is constructed or modified to transport at least one sick or injured patient in the supine or prone position on a medically appropriate, FAA approved stretcher. It also includes an array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.15 Inter-facility Transfer - (transfer) Means the transportation of a patient, by an air ambulance service provider, initiating at a health care facility whose destination is another health care facility.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.16 Medical Director - Means a licensed physician (MD or DO) who is specifically designated by an air ambulance provider and has accepted the responsibility for providing medical direction to the air ambulance service. He or she must be a Mississippi licensed physician, M.D. or D.O., and show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have a System medical director whose primary practice is in Mississippi or at a Mississippi

trauma center. (Air Ambulance provided from and based out-of-state must have a system medical director that is board certified in emergency medicine or board eligible in emergency medicine.) The medical director is ultimately responsible for all aspects of a service's operation which effect patient care. The medical director is responsible for assuring that appropriately trained medical personnel and equipment are provided for each patient transported and that individual aircraft can provide appropriate care environments for patients. The Air Ambulance Service Medical Director must be approved by the State EMS Medical Director.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.17 Patient - Means an individual who is sick, injured, or otherwise incapacitated or whose condition requires or may require skilled medical care for intervention.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.18 Permit - Means a document issued by BEMS indicating that the aircraft has been approved for use as an air ambulance vehicle by BEMS in the state of Mississippi.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.19 Physician - (doctor) Means a person licensed to practice medicine as a physician (MD or DO) by the state where the air ambulance service is located.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.20 Pilot - Means a person who holds a valid certificate issued by the FAA to operate an aircraft.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.21 Public Aircraft - Means an aircraft used only in the service of a government agency. It does not include government-owned aircraft engaged in carrying persons or property for commercial purposes.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.22 Reciprocal Licensing - (reciprocity) means mutual acceptance of an air ambulance service provider's valid license to operate an air ambulance service in a state other than the one in which it is licensed.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.23 Registered Nurse - (RN) Means an individual who holds a valid license issued by the state licensing agency to practice professional nursing as a registered nurse.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.24 Rotor-wing Air Ambulance - (rotor-wing) Means a rotor-wing type aircraft that is constructed or modified to transport at least one sick or injured patient in the supine or prone position on a medically appropriate, FAA approved stretcher/litter (as per FAR Section 23.785 and 23.561). It also includes an array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.25 Specialty Care Transport (SCS) - Means the level of care (quantity and type of staff member(s), equipment and procedures) that is consistent with a patient whose condition requires special care specific to their age and/or diagnosis. The patient may or may not be stable or in an acute situation prior to transport. The following patient categories are included: pediatric intensive care, maternal care, neonatal intensive care and burn care. These patients are being cared for in an acute care facility environment such as the emergency department, coronary care unit, intensive care unit, pediatric or neonatal unit, burn care or other similar unit where continuous monitoring of vial signs, cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilatory functions by artificial means are being performed. This level of care must be rendered by medical personnel of appropriate training. This level of care requires monitoring and diagnostic equipment specific to the patients special care needs. Patients requiring this level of care should be identified during medical screening so that special staffing and equipment requirements can meet the patients potential needs. These patients are considered at risk for de-compensation during transport which may require close attention or intervention.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.26 Stressors of Flight - Means the factors which humans may be exposed to during flight which can have an effect on the individual's physiologic state and ability to perform. The stressors include - hypoxia, barometric changes (expanding and contracting gas), fatigue (sometimes self induced), thermal variations (extremes of temperature), dehydration, noise, vibration, motion and G-forces.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 Air Ambulance Licensure

Rule 3.2.1 Licensure as an air ambulance service shall only be granted to a person or entity that directs and controls the integrated activities of both the medical and aviation components. *Note: Air ambulance requires the teaming of medical and aviation functions. In many instances, the entity that is providing the medical staffing, equipment and control is not the certificate aircraft operator but has an arrangement with another entity to provide the aircraft. Although the aircraft operator is directly responsible to the FAA for the operation of the aircraft, one organization, typically the one in charge of the medical functions directs the*

combined efforts of the aviation and medical components during patient transport operations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.2 No person or organization may operate an air ambulance service unless such person or organization has a valid license issued by BEMS. Any person desiring to provide air ambulance services shall, prior to operation, obtain a license from BEMS. To obtain such license, each applicant for an air ambulance license shall pay the required fee and submit an application on the prescribed air ambulance licensure application forms. Applicant must submit one copy of the plan of medical control at least 30 days prior to service start date for approval by BEMS and State EMS Medical Director. The license shall automatically expire at the end of the licensing period.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.3 Prior to operation as an air ambulance, the applicant shall obtain a permit for each aircraft it uses to provide its service.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.4 Each licensee shall be able to provide air ambulance service within 90 days after receipt of its license to operate as an air ambulance from the licensing authority.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.5 Each aircraft configured for patient transport shall meet the structural, equipment and supply requirements set forth in these regulations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.6 An air ambulance license is dependent on, and concurrent with, proper FAA certification of the aircraft operator(s) to concurrent with proper FAA certification of the aircraft operator(s) to conduct operations under the applicable parts of the Federal Aviation Regulations (included are Parts 1, 43, 61, 67, 91, 135).

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.7 Current, full accreditation by the Commission on Accreditation of Air Medical Services (CAAMS) or equivalent program will be accepted by BEMS as compliance with the requirements set forth.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.8 A provider's license will be suspended or revoked for failure to comply with the requirements of these regulations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.9 No licensee shall operate a service if their license has been suspended or revoked.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.10 Any provider that maintains bases of operation in more than one state jurisdiction shall be licensed at each base by BEMS having jurisdiction.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.11 The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 RECIPROCITY

Rule 3.3.1 Any provider who is licensed in another jurisdiction whose regulations are at least as stringent as these, and provides proof of such license, and who meets all other regulatory requirements shall be regarded as meeting the specifications of these regulations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.2 Access - Inspection of records; equipment/supply categories, and air ambulance aircraft.

1. BEMS, after presenting proper identification, shall be allowed to inspect any aircraft, equipment, supplies or records of any licensee to determine compliance with these regulations. BEMS shall inspect the licensee at least twice every licensing period.

2. The finding of any inspection shall be recorded on a form provided for this purpose. BEMS shall furnish a copy of the inspection report form to the licensee or the licensee's authorized representative. Upon completion of an inspection, any violations shall be noted on the form.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.3 Issuance of Notices.

1. Whenever BEMS makes an inspection of an air ambulance aircraft and discovers that any of the requirements of these regulations have been violated or have not been complied with in any manner, BEMS shall notify the licensee of the infraction(s) by means of an inspection report or other written notice.

2. The report shall: Set forth the specific violations found; Establish a specific period of time for the correction of the violation(s) found, in accordance with the provisions in Violations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.4 Reports

1. Notification

   a. Each holder of a license shall notify BEMS of the disposition of any criminal or civil litigation or arbitration based on their actions as a licensee within 5 days after a verdict has been rendered.

   b. The licensee will notify BEMS when it removes a permitted aircraft from service or replaces it with a substitute aircraft meeting the same transport capabilities and equipment specifications as the out-of-service aircraft for a period of time greater than 7 days but not to exceed 90 calendar days. Upon receipt of notification, BEMS shall issue a temporary permit for the operation of said aircraft.

2. Patient Reports

   a. Each licensee shall maintain accurate records upon such forms as may be provided, and contain such information as may be required by BEMS concerning the transportation of each patient within this state and beyond its limits. Such records shall be available for inspection by BEMS at any reasonable time, and copies thereof shall be furnished to BEMS upon request.

   b. All licensed ambulance services operating in the State of Mississippi must electronically submit the State of Mississippi Patient Encounter Form and/or information contained on the form for each ambulance run made and/or for each patient transported.

   c. A completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data elements of the Mississippi Patient Encounter Form shall be left with hospital staff for all patients delivered to license Hospitals. If in the best interest of the public good, an immediate response to a patient is required of an ambulance delivering a patient to a licensed Hospital, a complete oral report on the patient being delivered will be given to the receiving facility and a completed copy of a Mississippi Patient Encounter Form or Patient Care Report containing the data

elements of the Mississippi Patient Encounter Form for that patient shall be delivered in person or by fax to the hospital staff of the licensed Hospital within 24 hours.

d. Mississippi Patient Encounter Forms are due in the BEMS office by the seventh day after the close of the preceding month.

e. All encounter forms or computer disk information returned to a licensee for correction must be corrected and returned to the BEMS office within two weeks calculated from the date of their return.

f. Returns to a licensee greater than 3 times may result in a penalty as outlined under Section 41-59-45, paragraph 3.

g. The licensee shall maintain a copy of all the run records according to statutory requirements, accessible for inspection upon request by BEMS.

h. A copy of the patient encounter form shall be given to the person accepting care of the patient.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.5 Location identification: The Licensee shall identify on the prescribed form any and all physical locations where a function of their operations are conducted. These locations include: permanent business office, aircraft storage, repair, communications/activation facilities, training and sleeping areas.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.6 Aero Medical Advertisement

1. No person, entity or organization shall advertise via printed or electronic media as an air ambulance service provider in the state of Mississippi unless they hold a valid license in the state of Mississippi or has licensure in another state which is reciprocally honored by BEMS.

2. The licensee's advertising shall be done only under the name stated on their license.

3. The licensee's advertising and marketing shall demonstrate consistency with the licensee's actual licensed level of medical care capabilities and aircraft resources. The name of the Air Carrier Operating Certificate holder shall be listed if the licensee leases or otherwise does not operate the aircraft under their own Air Carrier certificate.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.7 Property & Casualty Liability

1. Every licensee or applicant shall ensure that the Part 135 Air Carrier Operating certificate holder operating the aircraft carries bodily injury and property damage insurance with solvent insurers licensed to do business in the state of Mississippi, to secure payment for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any of the certificate holders aircraft. Each aircraft shall be insured for the minimum amount of $1,000,000 for injuries to, or death of, any one person arising out of any one incident or accident; the minimum amount of $3,000,000 for injuries to, or death of, more than one person in any one accident; and, for the minimum amount of $500,000 for damage to property from any one accident.

2. Government-operated service aircraft shall be insured for the sum of at least $500,000 for any claim or judgment and the sum of $1,000,000 total for all claims or judgments arising out of the same occurrence. Every insurance policy or contract for such insurance shall provide for the payment and satisfaction of any financial judgment entered against the licensee or any aircraft owner or pilot(s) operating the insured aircraft. All such insurance policies shall provide for a certificate of insurance to be issued to BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.8 Professional Medical Liability (Malpractice)

1. Every air ambulance licensee or applicant shall carry professional liability coverage with solvent insurers licensed to do business in the state of Mississippi, to secure payment for any loss or damage resulting from any occurrence arising out of or caused by the care or lack of care of a patient. The licensee or applicant shall maintain professional liability coverage in the minimum amount of $500,000 per occurrence.

2. In lieu of such insurance, the licensee or applicant may furnish a certificate of self-insurance establishing that the licensee or applicant has a self-insurance plan to cover such risks and that the plan has been approved by the State of Mississippi Insurance Commissioner.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Aircraft Permits Required

Rule 3.4.1 BEMS shall issue a permit to the licensee when the licensee initially places the aircraft into service or when the licensee changes the level of service relative to that aircraft. The permit shall remain valid as long as the aircraft is operated or leased by the licensee subject to the following conditions:

1. The licensee submits an aircraft permit application for the aircraft and pays the required fees.

2. Permits issued by BEMS for an aircraft pursuant to this rule shall be carried inboard the aircraft and readily available for inspection.

3. If ownership of any permitted aircraft is transferred to any other person or entity, the permit is void and the licensee shall remove the permit from the aircraft at the time the aircraft is transferred and return the permit to the licensing authority within 10 days of the transfer.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.4.2 If a substitute aircraft is in service for longer than 90 days, this aircraft shall be required to be permitted. An un-permitted aircraft cannot be placed into service, nor can an aircraft be used unless it is replacing aircraft that has been temporarily taken out of service. When such a substitution is made, the following information shall be maintained by the licensee and shall be accessible to BEMS: Registration number of permitted aircraft taken out of service; Registration number of substitute aircraft; The date on which the substitute aircraft was placed into service and the date on which it was removed from service and the date on which the permitted aircraft was returned to service.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.4.3 Aircraft permits are not transferable.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.4.4 Duplicate aircraft permits can be obtained by submitting a written request to BEMS. The request shall include a letter signed by the licensee certifying that the original permit has been lost, destroyed or rendered unusable.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.4.5 Each licensee shall obtain a new aircraft permit from BEMS prior to returning an aircraft to service following a modification, change or any renovation that results in a change to the stretcher placement or seating in the aircraft's interior configuration.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.4.6 The holder of a permit to operate an air ambulance service, shall file an amended list of its permitted aircraft with BEMS within 10 days after an air ambulance is removed permanently from service.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 Off-Line Medical Direction

Rule 3.5.1 Qualifications: Each air ambulance service shall designate or employ an off-line medical director. The off-line medical director shall meet the following qualifications:

1. The off-line medical director shall be a physician (MD or DO) currently licensed and in practice.

2. The physician shall be licensed to practice medicine in the state(s) where the service is domiciled.

3. Services having multiple bases of operation shall have an off-line medical director for each base. If the off-line medical director for the service's primary location is licensed in the state where the base(s) is/are located, they may function as the off-line medical director for that base in place of a separate individual.

4. Must be a Mississippi licensed physician, M.D. or D.O., and show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have a System medical director whose primary practice is in Mississippi or at a Mississippi trauma center. (Air Ambulance provided from and based out-of-state must have a system medical director that is board certified in emergency medicine or board eligible in emergency medicine.) The medical director is ultimately responsible for all aspects of a service's operation which effect patient care. The medical director is responsible for assuring that appropriately trained medical personnel and equipment are provided for each patient transported and that individual aircraft can provide appropriate care environments for patients. The Air Ambulance Service Medical Director must be approved by the State EMS Medical Director.

5. The off-line medical director shall have knowledge and experience consistent with the transport of patient's by air.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.2 Responsibilities: The physician shall be knowledgeable in aeromedical physiology, stresses of flight, aircraft safety, patient care, and resource limitations of the aircraft, medical staff and equipment.

1. The off-line medical director shall have access to consult with medical specialists for patient(s) whose illness and care needs are outside his/her area of practice.

2. The off-line medical director shall ensure that there is a comprehensive plan/policy to address selection of appropriate aircraft, staffing and equipment.

3. The off-line medical director shall be involved in the selection, hiring, training and continuing education of all medical personnel.

4. The off-line medical director shall be responsible for overseeing the development and maintenance of a quality assurance or a continuous quality improvement program.

5. The off-line medical director shall ensure that there is a plan to provide direction of patient care to the air medical personnel during transport. The system shall include on-line (radio/telephone) medical control, and/or an appropriate system for off-line medical control such as written guidelines, protocols, procedures patient specific written orders or standing orders.

6. The off-line medical director shall participate in any administrative decision making processes that affects patient care.

7. The off-line medical director will ensure that there is an adequate method for on-line medical control, and that there is a well defined plan or procedure and resources in place to allow off-line medical control.

8. In the case where written policies are instituted for medical control, the off-line medical director will oversee the review, revision and validation of them annually.

9. The plan for medical control must be submitted to BEMS at least 30 days prior to the service start date for approval by BEMS and the State EMS Medical Director.

10. Revisions in the medical control plan must be submitted prior to implementation. At a minimum, medical control plans shall be resubmitted to BEMS every three (3) years.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.3 On-line Medical Control: The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to air medical personnel on board any of its air ambulance aircraft at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.4 CQI process

1. The licensee shall have an ongoing collaborative process within the organization that identifies issues affecting patient care.

2. These issues should address the effectiveness and efficiency of the organization, its support systems, as well as that of individuals within the organization.

3. When an issue is identified, a method of information gathering shall be developed. This shall include outcome studies, chart review, case discussion, or other methodology.

4. Findings, conclusions, recommendations and actions shall be made and recorded. Follow-up, if necessary, shall be determined, recorded, and performed.

5. Training and education needs, individual performance evaluations, equipment or resource acquisition, safety and risk management issues all shall be integrated with the CQI process.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.5 Licensing of Air Medical Personnel: There shall be at least one licensed air medical person on board an air ambulance to perform patient care duties on that air ambulance. The requirements for air medical personnel shall consist of not less than the following:

1. A valid license or certificate to practice their level of care (MD, DO, RN, EMT-B, EMT-I, EMT-P, RT) in the state; and possess as applicable to their scope of practice current Basic Life Support (BLS), Advanced Cardiac Life Support (ACLS), Pediatric Advanced Life Support (PALS) and Pre-hospital Trauma Life Support (PHTLS) or Basic Trauma Life Support (BTLS) certifications.

2. *Note: The requirements of this section are established in regard to scope of practice for air medical personnel and the mission of the air ambulance service. The medical director of the service will outline requirements in the medical control plan of the service and upon approval of BEMS, verification of these requirements will be the documentation required.*

3. Documentation of successful completion of training as outlined in Training-Medical Attendants.

4. The licensee shall maintain documentation of each attendant's training and qualifications and shall insure that the attendant meets the continuing education requirements for their licensed specialty.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.6 Required Staffing: When an aircraft is in service as an air ambulance, it will be staffed according to the level of care being provided:

1. Basic level care (BLS) requires at least one state of Mississippi current certified basic level EMT.

2. Advanced level care (ALS) – Intermediate:

a. Fixed-wing aircraft requires at least two personnel, one of which must be at least a state of Mississippi current certified Intermediate.

b. Rotor-wing aircraft requires at least a state of Mississippi current certified Intermediate.

3. Advanced level care (ALS) – Paramedic:

a. Fixed-wing aircraft requires at least two personnel, one of which must be at least a state of Mississippi current certified Paramedic.

b. Rotor-wing aircraft requires at least a state of Mississippi current certified Paramedic.

4. Critical care (CCLS) requires at least two personnel, one of which must be at least a registered nurse, or physician.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.7 Additional medical staff not licensed as air medical personnel can be added to or in place of licensed air medical personnel as long as at least one licensed air medical personnel with the highest level of certification (EMT-B, EMT-I, EMT-P, RN) required to care for the patient is also on board.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.8 Air medical personnel will not assume cockpit duties when it may interfere with patient care responsibilities.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.9 The aircraft shall be operated by a pilot or pilots certified in accordance with applicable FAR's. The captain or pilot in command will meet the following requirements:

1. Fixed-wing air ambulance: Has accumulated at least 2000 hours total time as a pilot; Has accumulated at least 1000 hours as pilot in command of an airplane; Must have accumulated at least 500 hours as pilot of a multi-engine aircraft; Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance; Possess an Airline Transport certificate.

2. Rotor-wing air ambulance: Has accumulated at least 2000 rotor craft flight hours total time as a pilot; At least 1000 of those hours must be as pilot in command; At least 100 of those hours must be night-flight time; Factory school or equivalent in aircraft type (ground and flight); Has accumulated 5 hours in aircraft type as pilot in command or at the controls prior to EMS missions if transitioning from a single engine to a single engine; from a twin engine to a single engine; or from a twin

engine to a twin engine; Has accumulated 10 hours as pilot in command or at the controls prior to EMS missions if transitioning from a single engine to a twin engine aircraft; Must possess at least a commercial rotor craft-helicopter rating; ATP certificate is encouraged.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.10 A First Officer or co-pilot, if used, will meet the following requirements:

1. Fixed-wing air ambulance; Has accumulated at least 500 hours total time as a pilot; Must have accumulated at least 100 hours as pilot of a multi-engine aircraft; Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance; Possess a Commercial Pilot certificate;

2. Rotor-wing air ambulance: Has accumulated at least 500 rotor craft flight hours total time as a pilot; Factory school or equivalent in aircraft type (ground and flight); Must possess at least a commercial rotor craft-helicopter rating.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 Training

Rule 3.6.1 Air Medical Personnel: The licensee shall ensure that all medical personnel receive orientation and training specific to their respective aircraft (fixed-wing or rotor-wing) transport environment in general and the licensee's operation specifically. The curriculum shall be consistent with the Department of Transportation (DOT) Air Medical Crew - National Standard Curriculum, or equivalent program.

1. Initial - The licensee shall ensure that all air medical personnel successfully complete initial training and orientation to their position including adequate instruction, practice and drills. This training will include the following topics: Aeromedical physiology, gas laws and stressors of flight; Aircraft familiarization and flight safety; aircraft and cabin systems familiarization; operation of emergency exits, evacuation procedures and use of emergency equipment; location of medical equipment and supplies; enplaning, deplaning and securing of patients for flight; In flight procedures for normal conditions and emergencies such as cabin depressurization, smoke or fire in the cabin, fire suppression, electrical failures; Medical equipment familiarization; Patient care policies, procedures and protocols, standards of care, and patient assessment; Documentation; Local EMS system communication and medical conventions; Survival; Infection control including OSHA blood borne pathogens; Pharmacology; Hazardous materials; Legal and ethical issues.

2. Recurrent - The licensee shall ensure that all air medical personnel shall successfully complete training consistent with the requirements set forth in the previous section annually.

3. Drills - The licensee shall make provisions for actual practice of those procedures that require complicated physical work or those that are technically complex such as enplaning and deplaning of patients, emergency evacuation, medical equipment identification, mock situational problem annually.

4. Documentation - The licensee will document the completed training for each air medical staff member.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.6.2 Flight Crew Member: The licensee shall have a structured program of initial and recurrent training for the aviation personnel specific to their function in the medical transport environment. The aviation specific requirements of FAR (section 135.345) are controlling, however, BEMS recommended guidelines are listed below:

1. Initial - The licensee shall ensure that all cockpit crew members successfully complete initial training and orientation to the skills and knowledge necessary to perform their functions in air medical transport operations. Training shall include the following topics:

   a. Pre-flight planning to accommodate special patient needs including weather considerations, altitude selection, fuel requirements, weight and balance, effective range and performance and selection of alternate airports appropriate for a medial or aviation diversion.

   b. Flight release - effective communication between communications specialist, air medical personnel and pilot(s). Aviation considerations for release (approval to proceed) based on the latest weather and aircraft status.

   c. Ground ambulance handling in direct vicinity of aircraft; Baggage and equipment handling (pressurized and non-pressurized compartments)(fixed-wing pilots); Patient enplaning - passenger briefing. (fixed-wing pilots); Coordination of aircraft movement with air medical personnel activities prior to taxi to ensure their safety; Smooth and coordinated control of the aircraft when maneuvering, transition of control surface configurations and ground operations for patient, air medical personnel and passenger comfort; Intermediate stop procedures - (fueling, fire equipment standby, customs); Medical emergencies during flight; Aircraft emergency procedures - evacuations including patient; Cabin temperature control to maintain comfortable cabin temperature for the occupants.

2. Recurrent - The licensee shall ensure that all aviation personnel receive recurrent training - at least annually - on the topics included in their initial indoctrination as well as any changes or updates made to policies or procedures.

3. Drills - The licensee shall make provisions for actual practice of those procedures that require complicated physical work or that is technically complex such as enplaning and deplaning of patients, emergency evacuation, medical equipment identification, and mock situational problem solving.

4. Documentation - The licensee will document the completed training for each air medical staff member.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 Communications

Rule 3.7.1 Activation Capability: The licensee shall have facilities and plans in place to provide the telephonic and radio systems necessary to carry verbal communication. The system should be consistent with the services scope of care and includes three elements: receipt of incoming inquiries and transport requests; activation and communications with aircraft flight crews and air medical personnel during transport operations; and medical control communications.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.2 Initial contact/coordination point - The licensee shall have a plan to receive requests for service and assign resources to handle the transport requests.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.3 Contact data resources - The licensee shall maintain an information file available to the person handling communications that contains the necessary contact person's phone numbers and other pertinent data to manage routine and emergency communication needs.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.4 Documentation - The licensee shall record the chronological events of each transport. The following data elements shall be included: Time of initial request; Time of aircraft liftoff; Time of aircraft arrival at pickup point; Time of aircraft liftoff; Time of any intermediate aircraft stops; Time of aircraft arrival at destination; and Time aircraft and crew are returned to service and available.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.5 Communications Continuity and Flight Following Capability: There shall be a well defined process to track transport activities and provide the necessary support to efficiently follow aircraft, flight crews and air medical personnel movement. The licensee shall have a written emergency plan which addresses the actions to be taken in the event of an aircraft incident or accident, breakdown or patient deterioration during transport operations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.6 Medical Control Communications: The licensee shall have a means of providing communications between the aircraft, the coordination point, medical control personnel and other agencies by telephonic or radio as appropriate. This shall be accomplished by local or regional EMS radio systems; and/or radio or flight phone as available inboard the aircraft. All aircraft shall have 155.340 statewide hospital net available for air crew member(s) in the patient area.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 Requirements For Aircraft

Rule 3.8.1 When being used as an air ambulance, in addition to meeting other requirements set forth in these rules, and aircraft shall:

1. Be multi-engine. (Fixed-wing);

2. Be pressurized. (Fixed-wing);

3. Be equipped for IFR flight.

4. *Note: Fixed-wing aircraft should be equipped and rated for IFR operations in accordance with FAR's. Rotor-wing aircraft should be equipped for inadvertent IFR if operating as a VFR operator.*

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.2 Have a door large enough to allow a patient on a stretcher to be enplaned without excessive maneuvering or tipping of the patient which compromises the function of monitoring devices, IV lines or ventilation equipment.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.3 Be designed or modified to accommodate at least 1 stretcher patient.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.4 Have a lighting system which can provide adequate intensity to illuminate the patient care area and an adequate method (curtain, distance) to limit the cabin light from entering the cockpit and impeding cockpit crew vision during night operations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.5 Have an environmental system (heating and cooling) capable of maintaining a comfortable temperature at all times. (Fixed-wing)

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.6 Have an interior cabin configuration large enough to accommodate the number of air medical personnel needed to provide care to the patient in accordance with Required Staffing, as well as an adult stretcher in the cabin area with access to the patient. The configuration shall not impede the normal or emergency evacuation routes.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.7 Have an electrical system capable of servicing the power needs of electrically powered on-board patient care equipment.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.8 Have all installed and carry on equipment secured using FAA approved devices and methods.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.9 Have sufficient space in the cabin area where the patient stretcher is installed so that equipment can be stored and secured with FAA approved devices in such a manner that it is accessible to the air medical personnel.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.10 Have two fire extinguishers approved for aircraft use. Each shall be fully charged with valid inspection certification and capable of extinguishing type A, B or C fires. One extinguisher shall be accessible to the cockpit crew and one shall be in the cabin area accessible to the medical crew members. (fixed-wing)

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.11 One fire extinguisher type A, B or C, fully charged with valid inspection, shall be accessible to the cockpit crew and cabin area medical crew members. If not accessible, two fire extinguishers are required. (rotor-wing)

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 Medical Equipment and Supplies

Rule 3.9.1 Each air ambulance aircraft shall carry the following minimum equipment set forth in the following section unless a substitution is approved by BEMS and an off-line medical director.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.2 Medical Equipment for All Levels of Care Shall Include:

1. STRETCHER - There shall be 1 or more stretcher(s) installed in the aircraft cabin which meets the following criteria:

a. Can accommodate a patient who is in the 95 percentile for an adult male - 6 feet tall, 212 lbs. or 96.2 kg. There shall be restraining devices or additional appliances available to provide adequate restraint of patients under 60 lbs or 36" in height.

b. Shall have at least two cross-body patient restraining straps, one of which secures the chest area and the other about the area of the knee and thigh area. If the patient(s) is/are secured in the aircraft with his/their head toward the nose of the aircraft, there shall be a harness which goes over the shoulders to secure him/them from forward movement.

c. The stretcher shall be installed in the aircraft cabin so that it is sufficiently isolated by distance or physical barrier from the cockpit so that the patient cannot reach the cockpit crew from a supine or prone position on the stretcher.

d. Attachment points of the stretcher to the aircraft, the stretcher itself, and the straps securing the patient to the stretcher, shall meet FAR Part 23 restraint requirements.

e. The head of each stretcher shall be capable of being elevated up to 45 degrees. The elevating section must hinge at or near the patent's hips and shall not interfere with or require that the patient or stretcher securing straps and hardware be removed or loosened. (fixed-wing)

f. The stretcher shall be positioned in the cabin to allow the air medical personnel clear view of the patient's body.

g. Air medical personnel shall always have access to the patient's head and upper body for airway control procedures as well as sufficient space over the area where the patient's chest is to adequately perform closed chest compression or abdominal thrusts on the patient. *Note: The licensee may be required to demonstrate to the licensing authority that airway control procedures and cardiac compressions/abdominal thrusts can be adequately performed on a training manikin in any of its aircraft.*

h. The stretcher pad or mattress shall be impervious to moisture and easily cleaned and disinfected according to OSHA blood borne pathogens requirements.

i. If the surface of the stretcher under the patient’s torso is not firm enough to support adequate chest compressions, a device to make the surface rigid enough will be provided.

j. A supply of linen for each patient.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.3 Respiratory Care

1. OXYGEN - An adequate and manually controlled supply of gaseous or liquid medical oxygen, attachments for humidification, and a variable flow regulator for each patient. A humidifier, if used, shall be a sterile, disposable, one-time usage item. The licensee shall have and demonstrate the method used to calculate the volume of oxygen required to provide sufficient oxygen for the patients needs for the duration of the transport. The licensee will have a plan to provide the calculated volume of oxygen plus a reserve equal 1000 liters or the volume required to reach an appropriate airport whichever is longer. All necessary regulators, gauges and accessories shall be present and in good working order. The system shall be securely fastened to the airframe using FAA approved restraining devices.

    a. A separate emergency backup supply of oxygen of not less than one E cylinder with regulator and flow meter. *Note: "D" cylinder with regulator and flow meter is permissible for rotor-wing aircraft in place of the "E" cylinder requirement.*

    b. 1 adult and 1 pediatric size non-rebreathing oxygen mask; 1 adult size nasal cannula and necessary connective tubing and appliances.

2. SUCTION - As the primary source, an electrically powered suction apparatus with wide bore tubing, a large reservoir and various sizes suction catheters. The suction system can be built into the aircraft or provided with a portable unit. Backup suction is required and can be a manually operated device.

3. BAG-VALVE-MASK - Hand operated bag-valve-mask ventilators of adult, pediatric and infant size with clear masks in adult, pediatric and infant sizes. It shall be capable of use with a supplemental oxygen supply and have an oxygen reservoir.

4. AIRWAY ADJUNCTS

    a. Oropharyngeal airways in at least 5 assorted sizes, including adult, child, and infant.

    b. Nasopharyngeal airways in at least 3 sizes with water soluble lubricant.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.4 Patient Assessment Equipment: Equipment suitable to determine blood pressure of the adult, pediatric and infant patient(s) during flight.

1. Stethoscope.

2. Penlight/Flashlight.

3. Bandage scissors, heavy duty.

4. Pulse Oximeter

5. Bandages & Dressings

6. Sterile Dressings such as 4x4's, ABD pads.

7. Bandages such as Kerlix, Kling.

8. Tape - various sizes.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.5 Miscellaneous Equipment and Supplies

1. Potable or sterile water.

2. Container(s) and methods to collect, contain and dispose of body fluids such as emesis, oral secretions and blood consistent with OSHA blood borne pathogens requirements.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.6 Infection control equipment. The licensee shall have a sufficient quantity of the following supplies for all air medical personnel, each flight crew member and all ground personnel with incidental exposure risks according to OSHA requirements:

1. Latex gloves.

2. Protective gowns.

3. Protective goggles.

4. Protective face masks.

5. There shall be an approved bio-hazardous waste plastic bag or impervious container to receive and dispose of used supplies.

6. Hand washing capabilities or antiviral towellets.

7. An adequate trash disposal system exclusive of bio-hazardous waste control provisions.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.7 Survival Kit: The licensee shall maintain supplies to be used in a survival situation. It shall include, but not be limited to, the following items which are appropriate to the terrain and environments the licensee operates over: Instruction manual; Water; Shelter - space blanket; Knife; Signaling device - mirror, whistle, flares, dye marker; Compass; Fire starting items - matches, candle, flint, battery.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.8 ALS level equipment: To function at the ALS level, the following additional equipment is required:

1. Endotracheal Intubation Equipment: Laryngoscope handle; One each adult, pediatric and infant blades; Two of each size of assorted disposable endotracheal tubes according to the scope of the licensee's service and patient mixture with assorted stylets, syringes; End-tidal CO2 detectors (may be made onto bag valve mask assemblies or separate); Alternate airway management equipment.

2. IV Equipment and Supplies: Sterile crystalloid solutions in plastic containers, IV catheters, and administration tubing sets; Hanger for IV solutions; A device for applying external pressure to flexible IV fluid containers; Tourniquets, tape, dressings; Suitable equipment and supplies to allow for collection and temporary storage of two blood samples; A container appropriate to contain used sharp devices - needles, scalpels which meets OSHA requirements.

3. Medications: Security of medications, fluids and controlled substances shall be maintained by each air ambulance licensee. Security procedures shall be approved by the service's medical director and be in compliance with the licensee's policies and procedures. Medication inventory techniques and schedules shall be maintained in compliance with all applicable local, state and federal drug laws.

4. The following table indicates the minimum medications required:

Quantity	**Medication**	**Concentration**
2	Atropine	1 mg/10 ml
2	Benadryl	5 mg/ml
2	Calcium Cholride	1 mg/10 ml
2	Dextrose	50%5gm/50ml
2	Dramamine(fixed-wing only	50mg/ml

25	Dramamine (fixed-wing only)	50mg/tab
1	Dopamine	400mg/5ml or 400mg/50ml D5W
4	Epinephrine	1:10,0001mg/10ml
2	Epinephrine	1:1,0001mg/1ml
8 or 4	Lasix	20mg/2ml or10mg/4ml
2	Lidocaine	100mg/5ml or 10 ml
2 or 1	Lidocaine	1gm/5ml or 10ml or2gm/500ml D5W
2	Narcan	1mg/2ml
1	Nitroglycerin	1/150gr tabs or 0.4mg/metered dose spray
4	Sodium Bicarbonate	50mg/50ml

a. The medical director can modify the medication inventory as required to meet the care needs of their patient mix and in compliance with section (111.06-3C) below.

b. The licensee shall have a sufficient quantity of needles, syringes and accessories necessary to administer the medications in the inventory supply.

c. The medical director of the licensee may authorize the licensee with justification to substitute medication(s) listed provided that he first obtains approval from BEMS, and provided further that he signs such authorization.

5. Cardiac Monitor-Defibrillator - D.C. battery powered portable monitor/defibrillator with paper printout and spare batteries, accessories and supplies.

6. External Cardiac Pacing Device

7. Non-Invasive Automatic Blood Pressure Monitor

8. IV Infustion Pump capable of strict mechanical control of an IV infusion drip rate. Passive devices such as dial-a-flows are not acceptable.

9. Electronic Monitoring Devices - Any electronic or electrically powered medical equipment to be used on board an aircraft should be tested prior to actual patient use to insure that it does not produce Radio Frequency Interference (RFI) or

Electro Magnetic Interference (EMI) which would interfere with aircraft radio communications or radio navigation systems. This may be accomplished by reference to test data from organizations such as the military or by actual tests performed by the licensee while airborne.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.9 To function at the CCLS or SPECIALTY level of care the following additional equipment shall be available as required:

1. Mechanical Ventilator - A mechanical ventilator that can deliver up to 100% oxygen concentration at pressures, rates and volumes appropriate for the size of patient being cared for.

2. Isolette - for services performing transport of neonatal patients.

3. Intraaortic Balloon Pump (IABP)

4. Invasive Line (ARTERIAL AND SWAN-GANZ CATHETERS) monitoring capability.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Equipment Maintenance and Inspection Program:

Rule 3.10.1 The licensee shall have a program to inspect and maintain the effective operation of its medical equipment. The program should include daily or periodic function checks and routine preventive inspection and maintenance. There should be a plan for securing replacement or backup equipment when individual items are in for repair. There should be manufacturer's manuals as well as brief checklist available for reference. The equipment maintenance and inspection program shall include:

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.10.2 Daily or periodic checks - shall include a checklist based on the manufacturer's recommendations which verifies proper equipment function and sterile package integrity.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.10.3 Routine preventive maintenance - shall include a program of cleaning and validating proper performance, supply packaging integrity.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.10.4 A documentation system which tracks the history of each equipment item.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.10.5 A procedure for reporting defective or malfunctioning equipment when patient care has been affected.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.10.6 High Visibility Safety Apparel for Staff: Each air ambulance must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Violations

Rule 3.11.1 Violations should be corrected at the time of the inspection, if possible.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.11.2 Violations of the requirements set forth in this section will require appropriate corrective action by the licensee.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.11.3 Category "A" Violations: Category “A” violations require the air ambulance aircraft be immediately removed from service until it has been reinspected and found to be in compliance with these regulations. Category "A" violations include: Missing equipment or disposable supply items; Insufficient number of trained air medical personnel to fill the services staffing requirements; The provider has no medical director; Violation or non-compliance of FAR or OSHA mandates.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.11.4 Category "B" Violations: Category “B” violations must be corrected within 72 hours of receiving notice and a written report shall be sent to BEMS verifying the correction. Category "B" violations include: Unclean or unsanitary equipment or aircraft environment; Non-functional or improperly functioning equipment; Expired shelf life of supplies such as medications, IV fluids and items having limited shelf life; Package integrity of sealed or sterile items is compromised; Failure to produce requested documentation of patient records, attendant training or other reports required by BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 12 Suspension; Revocation of License

Rule 3.12.1 May occur as outlined in 41-59-17 and 41-59-45. Appeals from decision of the board can also be referred to in 41-59-49.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.12.2 A Mississippi licensed ambulance service shall comply with the Mississippi State Trauma Plan as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services. Licensed service must follow the respective region's patient destination criteria and treatment protocols for the trauma patient as delineated by the State Trauma Plan.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 Medical Control: See Appendix 1.

Chapter 4 MEDICAL FIRST RESPONDER

Subchapter 1 Training Authority Medical First Responder

Rule 4.1.1 The guidelines and minimum standards are set forth in order to establish a minimum level of training for the Medical First Responder in the State of Mississippi. These guidelines and minimum standards shall be met by all Medical First Responder courses in the state. BEMS may approve Medical First Responder programs if it is determined after review by the BEMS staff, State EMS Medical Director, and the Medical Direction, Training and Quality Assurance Committee that the objectives of the training program equal or exceed those of the State of Mississippi. Additionally, organized EMS districts as recognized by BEMS, Mississippi State Department of Health, are authorized to provide this training. All Medical First Responder training programs must have BEMS approval prior to the start of class.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 2 Medical First Responder Curriculum

Rule 4.2.1 Medical First Responder training curriculums must conform, at minimum, to the National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions as approved for use by BEMS. Minimum hours required for Medical First Responder are: 40 didactic/lab. In addition, a Healthcare Provider CPR course that meets current AHA Standards and Guidelines for CPR and AED must be completed. BEMS and the State EMS Medical Director must approve all training curriculums. Written permission from BEMS must be obtained prior to the start of a Medical First Responder course.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 3 Request for approval of Medical First Responder training programs

Rule 4.3.1 A list of BEMS approved Medical First Responder training programs will be available at the BEMS office and on the BEMS website. Request for approval of Medical First Responder training programs not contained on the approved list shall be sent to BEMS with evidence and verification that:

1. The Medical First Responder training program meets, at minimum, the requirements of the Medical First Responder curriculum as given in this Section.

2. There are Medical First Responder instructor certification and re-certification requirements, including an evaluation of instructor terminal competencies, provided in the requested training program. *Note: Credentialed EMS instructors of BEMS as trained through the Mississippi EMS Instructor training program and in good standing, are considered as meeting the above requirement*.

3. Approval must be given by the Medical Direction, Training and Quality Assurance Committee (MDTQA), State EMS Medical Director, and BEMS, prior to the start of any classes utilizing the proposed Medical First Responder training program.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 4 Medical First Responder Training Programs:

Rule 4.4.1 Mississippi Medical First Responder training should include at least forty hours of instruction on the objectives of the First Responder National Standard Curriculum. The participants must receive training at the Healthcare Provider level in CPR and AED prior to completion of the program. This portion of the training should be a minimum of eight additional hours if incorporated into the Medical First Responder training program.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.2 The length of the Healthcare Provider CPR and AED course shall not be less than 8 hours (didactic and practical). This training should meet the current AHA Standards and Guidelines for CPR and AED.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.3 The complete Mississippi Medical First Responder educational program should be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the Medical First Responder.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.4 The program should consist of at minimum two components: didactic instruction and clinical instruction, with optional supervised field experience in a system which functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.5 The program should maintain on file for each component of the curriculum a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives should delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.6 The student should be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.7 Evidence of student competence in achieving the educational objectives of the program should be kept on file. Documentation should be in the form of both written and practical examinations.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.8 Classroom, clinical, and optional field faculty should also prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.9 Faculty should be presented with the program's educational objectives for uses in preparation of lectures and clinical and field practice. The course coordinator should ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

1. Didactic instruction: Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

2. Clinical and other settings: Instruction and supervised practice of emergency medical skills. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation should be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

3. Field Experience (optional): The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The initial position of the student on the EMS care team should be that of observer and should progress to participation in actual patient care. The student should not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.10 General courses and topics of study must be achievement oriented and shall provide students with The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Job Description" and "Functional Job Analysis" found in the DOT, NSTC Course Guide.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.11 Comprehensive instruction which encompasses:

1. Development of knowledge and clinical skills appropriate for this level of care in the areas of: Introduction to EMS Systems; The well-being of the First Responder; Legal and Ethical Issues; The Human Body; Lifting and Moving Patients; Airway management procedures; Patient assessment including both initial and ongoing assessment; Managing patient circulation; Identify and manage illness and injury; Childbirth; Assessment and management of common medical and trauma situations of infants/children

2. EMS operations: Operational Policies: Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex, or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number accepted, as well as a placement history of those who complete the program. Announcements and advertising about the program shall reflect accurately the training being offered.

The program shall be educational and students shall use their scheduled time for educational experiences. Health and safety of students, faculty, and patients shall be adequately safeguarded. Costs to the student shall be reasonable and accurately stated and published. Policies and process for student withdrawal and refunds on tuition and fees shall be fair, and made known to all applicants.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.12 Curriculum Description: Instructional content of the educational program should include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum should be organized to provide the student with knowledge required to understand fully the skills that are taught in this program. It is important not to lose sight of the original purpose of the Medical First Responder level. Students should have an opportunity to acquire clinical experience and practice skills related to the emergency medical care of these patients. Students should also understand the ethical and legal responsibilities they assume as students and are being prepared to assume as graduates.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 5 Medical First Responder classes, class approval

Rule 4.5.1 The BEMS may approve Medical First Responder training classes if it is determined, after review of Medical First Responder class request forms that the objectives of the class equal or exceed those of the State of Mississippi.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.5.2 Medical First Responder class approval forms can be requested from BEMS or be completed on the BEMS website. Credentialed Medical First Responder instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class. BEMS will assign a class number to all approved requests and return to the credentialed Medical First Responder instructor. Incomplete paperwork will be returned without action.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 6 Medical First Responder classes, initial roster

Rule 4.6.1 Initial rosters shall be completed by the credentialed Medical First Responder instructor immediately following the second meeting of the class. Initial roster forms can be obtained from BEMS or be completed on the BEMS website. A final roster for a full or refresher Medical First Responder class will not be accepted without an initial roster on file with BEMS.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 7 Medical First Responder classes, final roster

Rule 4.7.1 Final rosters shall be completed by the credentialed Medical First Responder instructor immediately following the end of a full Medical First Responder or Medical First Responder refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the Medical First Responder class. The final roster form can be obtained from BEMS or be completed on the BEMS website. Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with BEMS. Credentialed Medical First Responder instructors must complete the final roster affidavit regarding Medical First Responder DOT practical skills completion

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 8 Medical First Responder Training Programs, Minimum Admittance Criteria

Rule 4.8.1 Must be eighteen (18) years of age prior to class completion.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.8.2 Students currently enrolled in a Mississippi Community or Junior College dual enrollment program may also be considered eligible to enter First Responder training program in exception to other stated admission requirements.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 9 Medical First Responder Refresher Training

Rule 4.9.1 The Mississippi Medical First Responder Refresher curriculum must conform, at minimum, to the National Standard Training Curriculum (NSTC) developed by the United States Department of Transportation and all current revisions as approved for use by BEMS. Minimum hours required for Medical First Responder refresher training are: 12 hours didactic/lab. Written permission from BEMS must be obtained prior to the start of a Medical First Responder refresher course. Instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class. Medical First Responder refresher training must be accomplished by all certified Mississippi Medical First Responders during their National Registry certification period.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.9.2 *NOTE: Medical First Responder Refresher Course Instructors should refer to: for request for approval of Medical First Responder training programs; for Medical First Responder classes, class approval; for Medical First Responder classes, initial roster; for Medical First Responder classes, final roster.*

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.9.3 Prerequisites to certification as a Medical First Responder (training obtained in Mississippi):

1. Age of at least 18 years.

2. Completion of the Board's approved Medical First Responder Training Program *(Note: This includes passage of the National Registry examination).*

3. National Registry certification at minimum level of First Responder

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.9.4 Prerequisites to certification as a Medical First Responder (training obtained in another state):

1. Age of at least 18 years.

2. Completion of a Medical First Responder program which meets the minimum guidelines of the First Responder National Standard Curriculum. Provide written verification from the State of training and of current status.

3. Completion of a State-approved Medical First Responder skills course.

4. Applicant must be registered at a minimum level of First Responder by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card.

5. *NOTE: The Mississippi BEMS maintains the right to refuse reciprocity to any Nationally Registered Medical First Responder applicant if the submitted curriculum does not meet the guidelines of the national standard curriculum and those required by the State of Mississippi.*

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 10 Medical First Responder Certification

Rule 4.10.1 Any person desiring certification as a Medical First Responder shall apply to the BEMS using forms provided (Application for State Certification).

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.10.2 All certification applications must be accompanied by a ten dollar ($10.00) money order or business check payable to the Mississippi State Department of Health - BEMS, a copy of the applicant's current National Registry card. BEMS may withhold or deny the application for certification for a like period of time equal to the like period of time under which a person failed to comply. Mississippi requires that all Medical First Responder’s maintain current registration with the National Registry of Emergency Medical Technicians.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 11 Grounds for Suspension or Revocation

Rule 4.11.1 Grounds for Suspension or Revocation include:

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty.

6. Recklessly disregarding the speed regulations prescribed by law while on duty.

7. Failure to carry the Mississippi State Department of Health issued certification card while on duty or failure to wear appropriate identification as approved by State Department of Health, Bureau of EMS.

8. Failure to maintain current registration by the National Registry of EMTs.

9. Failure to maintain all current training standards as required by the State Department of Health.

10. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the State Department of Health, BEMS, pertaining to pre-hospital personnel.

13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

15. Functioning outside the Medical First Responder scope of practice.

16. Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

17. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

18. Failure to comply with an employer's request for drug and alcohol testing.

19. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 12 Recertification of Medical First Responders

Rule 4.12.1 Any person desiring re-certification as a Medical First Responder shall apply to BEMS using forms provided (Application for state certification).

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.12.2 All re-certification applications must be accompanied by ten dollar ($10.00) money order or business check payable to the Mississippi State Department of Health – BEMS. Also, include a copy of the applicant's current National Registry card.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.12.3 All Medical First Responders failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.12.4 BEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.12.5 A Medical First Responder certificate issued shall be valid for a period not exceeding two and one-half (2 ½) years from date of issuance and may be renewed upon payment of a renewal fee of ten dollars ($10.00), which shall be paid to the Board, provided that the holder meets the qualifications set forth in regulations promulgated by the Board.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.12.6 The Board may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 13 Job Summary

Rule 4.13.1 A Mississippi Medical First Responder activates the EMS system, surveys the scene for hazards, contains those hazards, gains access to the injured or sick, gathers relevant patient data, provides immediate emergency medical care using a limited amount of equipment, controls the scene, and prepares for the arrival of the ambulance. Ongoing evaluation of the functioning Medical First Responder is essential to the maintenance of medical care quality. As with all professionals in the medical community, it must be realized that continuing education is an integral part of the Medical First Responder's ability to maintain a high degree of competency.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 14 Functional Job Analysis

Rule 4.14.1 Mississippi Medical First Responder Characteristics

1. The Mississippi Medical First Responder must be a person who can remain calm while working in difficult and stressful circumstances, as well as one who is capable of combining technical skills, theoretical knowledge, and good judgment to insure optimal level of fundamental emergency care to sick or injured patients while adhering to specific guidelines within the given scope of practice.

2. The Mississippi Medical First Responder is expected to be able to work alone, but must also be a team player. Personal qualities such as the ability to "take charge" and control the situation are essential, as are the maintaining of a caring and professional attitude, controlling one's own fears, presenting a professional appearance, staying physically fit, and keeping one's skills and abilities up to date. The Mississippi Medical First Responder must be receptive to the evaluation required for the maintenance of quality medical care.

3. Self-confidence, a desire to work with people, emotional stability, tolerance for high stress, honesty, a pleasant demeanor, and the ability to meet the physical and intellectual requirements demanded by this position are characteristics of the competent First Responders. The Mississippi Medical First Responder also must be able to deal with adverse social situations which include responding to calls in districts known to have high crime rates. The Mississippi Medical First Responder ideally possesses an interest in working for the good of society and has a commitment to doing so.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.14.2 Physical Demands: Aptitudes required for work of this nature are good physical stamina, endurance, and body condition that would not be adversely affected by having to walk, stand, lift, carry, and balance at times, in excess of 125 pounds. Motor coordination is necessary because over uneven terrain, the patient's and the First Responder's well being, as well as other workers' well-being must not be jeopardized.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.14.3 Other

1. Use of telephone or radio dispatch for coordination of prompt emergency services is essential. Accurately discerning street names through map reading, and correctly distinguishing house numbers or business addresses are essential to task completion in the most expedient manner. Concisely and accurately describing orally, to dispatchers and other concerned staff, one's impression of a patient's condition, is critical as the First Responder works in emergency conditions where there may not be time for deliberation. The Mississippi Medical First Responder must also be able to accurately report all relevant patient data, which is generally, but not always, outlined on a prescribed form. Verbal and reasoning skills are used extensively. The ability to perform mathematical tasks is minimal, however, it does play a part in activities such as taking vital signs, making estimates of time, calculating the number of persons at a scene, and counting the number of persons requiring specific care.

2. *Note: A more detailed Functional Job Analysis can be found in Appendix A of the First Responder National Standard Curriculum*

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 15 Performance Standards for Medical First Responder

Rule 4.15.1 The Mississippi Medical First Responder who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the certifying agency. Training programs must be approved by the Mississippi State Department of Health, BEMS, and/or the Department of Education.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.15.2 The Medical First Responder's primary responsibility is to the patient and should include both an oral exam and an appropriate physical exam. Scene size-up including: scene safety, mechanism of injury, number of patients, additional help, and consideration of cervical stabilization.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.15.3 The skills listed herein will enable the Medical First Responder to carry out all First Responder level patient assessment and emergency care procedures.

1. Given a possible infectious exposure, the First Responder will use appropriate personal protective equipment. At the completion of care, the First Responder will properly remove and discard the protective garments.

2. Given a possible infectious exposure, the First Responder will complete disinfection/cleaning and all reporting documentation.

3. Demonstrate an emergency move.

4. Demonstrate a non-emergency move.

5. Demonstrate the use of equipment utilized to move patient's in the pre-hospital arena.

6. Demonstrate competence in psychomotor objectives for: EMS Systems; Well-Being of the First Responder; Legal and Ethical Issues; The Human Body; and Lifting and Moving Patients.

7. Demonstrate the steps in the head-tilt chin lift.

8. Demonstrate the steps in the jaw thrust.

9. Demonstrate the techniques of suctioning.

10. Demonstrate the steps in mouth-to-mouth ventilation with body substance isolation.

11. Demonstrate how to use a resuscitation mask to ventilate a patient.

12. Demonstrate how to ventilate a patient with a stoma.

13. Demonstrate how to measure and insert an oropharyngeal and nasopharyngeal airway.

14. Demonstrate how to ventilate infant and child patients.

15. Demonstrate how to clear a foreign body airway obstruction in a responsive child and adult.

16. Demonstrate how to clear a foreign body airway obstruction in a responsive and unresponsive in Infant; Child; and Adult.

17. Demonstrate the ability to differentiate various scenarios and identify potential hazards.

18. Demonstrate the techniques for assessing:

    a. Mental status

    b. The airway

    c. If the patient is breathing

    d. If the patient has a pulse

    e. External bleeding

    f. Patient skin color, temperature, condition, and capillary refill (infants and children only)

19. Demonstrate questioning a patient to obtain SAMPLE history.

20. Demonstrate the skills involved in performing the physical exam.

21. Demonstrate the on-going assessment.

22. Demonstrate the proper technique of chest compression on Adult, Child and Infant

23. Demonstrate the steps of CPR: One rescuer adult CPR; Two rescuer adult CPR; Child CPR; Infant CPR

24. Demonstrate the steps in providing emergency medical care to patient with A general medical complaint; Altered mental status; Seizures; Exposure to cold; Exposure to heat; A behavioral change; A psychological crisis.

25. Demonstrate the following methods of emergency medical care for external bleeding: Direct pressure; Diffuse pressure; Pressure points.

26. Demonstrate the care of the patient exhibiting signs and symptoms of internal bleeding.

27. Demonstrate the steps in the emergency medical care of:

    a. Open soft tissue injuries

    b. A patient with an open chest wound

    c. A patient with open abdominal wounds

    d. A patient with an impaled object

    e. A patient with an amputation

f. An amputated part

28. Demonstrate the emergency medical care of a patient with a painful, swollen, deformed extremity.

29. Demonstrate opening the airway in a patient with suspected spinal cord injury.

30. Demonstrate evaluating a responsive patient with a suspected spinal cord injury.

31. Demonstrate stabilizing of the cervical spine.

32. Demonstrate the steps to assist in the normal cephalic delivery.

33. Demonstrate necessary care procedures of the fetus as the head appears.

34. Attend to the steps in the delivery of the placenta.

35. Demonstrate the post-delivery care of the mother.

36. Demonstrate the care of the newborn.

37. Demonstrate assessment of the infant and child.

38. Perform triage of a mass casualty incident.

39. Other knowledge and competencies may be added as revisions occur within the National Standard EMT Basic Curriculum.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.15.4 *Note: Skills not listed in these regulations may not be performed by a Mississippi Medical First Responder.*

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 16 Area and Scope of Practice of the Medical First Responder

Rule 4.16.1 The Mississippi Medical First Responder represents the first component of the emergency medical care system. Through proper training, the Medical First Responder will be able to provide basic life support to victims during emergencies, minimize discomfort and possible further injuries. The Medical First Responder may provide non-invasive emergency procedures and services to the level described in the First Responder National Standard Training Curriculum. Those procedures include recognition, assessment, management, transportation, and liaison.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.16.2 A Mississippi Medical First Responder is a person who has successfully completed an approved training program and is certified. The Medical First Responder training program must equal or exceed the educational goals and objectives of the National Standard Training curriculum for the First Responder.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.16.3 Description of Tasks

1. The Mississippi Medical First Responder answers verbally to telephone or radio emergency calls from dispatcher to provide efficient and immediate care to critically ill and injured persons using a limited amount of equipment. Responds safely to the address or location as directed by radio dispatcher. Visually inspects and assesses or "sizes up" the scene upon arrival to determine if scene is safe, to determine the mechanism of illness or injury, and the total number of patients involved. Directly reports verbally to the responding EMS unit or communications center as to the nature and extent of injuries, the number of patients, and the condition of each patient, and identifies assessment findings which may require communication with medical direction for advice.

2. Assesses patient constantly while awaiting additional EMS resources, administers care as indicated. Requests additional help if necessary. Creates a safe traffic environment in the absence of law enforcement. Renders emergency care to adults, children, and infants based on assessment findings, using a limited amount of equipment. Opens and maintains patient airway, ventilates patient, performs CPR, utilizes automated and semi-automated external defibrillators. Provides pre-hospital emergency care of simple and multiple system trauma such as controlling hemorrhage, bandaging wounds, manually stabilizing painful, swollen, and deformed extremities. Provides emergency medical care to include assisting in childbirth, management of respiratory problems, altered mental status, and environmental emergencies.

3. Searches for medical identification as clues in providing emergency care. Reassures patients and bystanders while working in a confident and efficient manner, avoids misunderstandings and undue haste while working expeditiously to accomplish the task. Extricates patients from entrapment, assesses extent of injury, assists other EMS providers in rendering emergency care and protection to the entrapped patient. Performs emergency moves, assists other EMS providers in the use of prescribed techniques and appliances for safe removal of the patient.

4. Assists other EMS providers in lifting patient onto stretcher, placing patient in ambulance, and insuring that patient and stretcher are secured. Radios dispatcher for additional help or special rescue and/or utility services. Reports verbally all observations and medical care of the patient to the transporting EMS unit, provides assistance to transporting staff. Performs basic triage where multiple patients needs exist. Restocks and replaces used supplies, uses appropriate disinfecting procedures to clean equipment, checks all equipment to insure

adequate working condition for next response. Attends continuing education and refresher courses as required.

SOURCE: Miss. Code Ann. §41-59-81

Chapter 5 EMERGENCY MEDICAL SERVICES (EMS) DRIVER

Subchapter 1 Training Authority

Rule 5.1.1 These guidelines and minimum standards are set forth in order to establish a minimum level of training for the EMS Driver in the state of Mississippi. These guidelines and minimum standards shall be met by all EMS Driver courses in the state. Additionally, organized EMS districts as recognized by the BEMS, are authorized to provide this training. The BEMS may approve EMS Driver programs if it is determined after review by the BEMS staff, State EMS Medical Director, and the Medical Direction, Training and Quality Assurance Committee that the objectives of the training program equal or exceed those of the state of Mississippi. All EMS Driver training programs must have the BEMS approval prior to the start of class.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 EMS Driver Curriculum

Rule 5.2.1 EMS Driver Curriculum must conform, at minimum, to the National Standard Emergency Vehicle Operator Curriculum developed by the United States Department of Transportation and all current revisions as approved for use by the BEMS. Minimum hours required for EMS Driver are: 4 didactic, and lab instruction sufficient to ensure operator competency, minimum 4 hours. BEMS and the State EMS Medical Director must approve all training curriculums. Written permission from the BEMS must be obtained prior to the start of an EMS Driver course.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Request for Approval of EMS Driver training programs

Rule 5.3.1 *Note: A list of BEMS approved EMS Driver training programs will be available at the BEMS office and BEMS web site. (www.msems.org)*

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.3.2 Request for approval of EMS Driver training programs not contained on the approved list shall be sent to BEMS with evidence and verification that:

1. the EMS Driver training program meets, at minimum, the requirements of the EMS Driver curriculum as given in this section.

2. there are EMS Driver Instructor certification and re-certification requirements, including an evaluation of instructor terminal competencies, provided in the requested training program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.3.3 *Note: Credentialed EMS Instructors of BEMS as trained through the MS EMS Instructor Training Program, and in good standing, are considered as meeting the above requirement.*

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.3.4 Approval of any EMS Driver training program curriculum must be given by the Medical Direction, Training and Quality Assurance Committee (MDTQA), State EMS Medical Director, and the BEMS staff, prior to the start of any classes.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 EMS Driving Training Programs

Rule 5.4.1 The length of the EMS Driver course shall not be less than eight (8) hours (didactic and practical).

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.2 The complete EMS Driver educational program shall be designed to provide the knowledge that will allow the student to safely operate emergency vehicles.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.3 The program shall consist of, at minimum, two components: didactic instruction and practical evaluation. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.4 The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives shall delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.5 The student shall be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from

the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.6 Evidence of student competence in achieving the educational objectives of the program shall be kept on file. Documentation must be in the form of both written and practical examinations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.7 Classroom and field practical faculty must prepare written evaluations on each student. Documentation should be maintained identifying the counseling given to individual students regarding their performance and the recommendations given to students must be maintained. Instruction must be supported by performance assessments.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.8 Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer. The field practical is a period of supervised experience.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.9 Policy for Administration - Operational Policies: Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex, or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 EMS Driver classes, class approved

Rule 5.5.1 BEMS may approve EMS Driver training classes if it is determined, after review of EMS Driver class request forms that the objectives of the class equal or exceed those of the State of Mississippi.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.5.2 *Note: EMS Driver class approval forms can be requested from the BEMS or be completed on the BEMS website. (www.msems.org)*

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.5.3 Credentialed EMS Driver instructors must complete the class approval form and submit to the BEMS, at minimum, fourteen (14), preferably thirty (30) calendar days prior to the first day of class. The BEMS will assign a class number to all approved requests and return to the credentialed EMS Driver instructor. Incomplete paperwork will be returned without action.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 EMS Driver classes, final roster

Rule 5.6.1 Final rosters shall be completed by the credentialed EMS Driver instructor immediately following the end of training. The final roster shall be inclusive of all students successfully completing the course. The final roster will note students who withdrew, failed, and completed the EMS Driver class.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.6.2 *Note: The final roster form can be obtained from the BEMS or be completed on the BEMS web site. (www.msems.org)*

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.6.3 Students successfully completing an EMS Driver course will not be eligible for state certification until a final roster is on file with the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 EMS Driver Training Programs, minimum admittance criteria:

Rule 5.7.1 Possession of a valid driver's license

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.7.2 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 EMS Driver Refresher Training

Rule 5.8.1 EMS Drivers are required to complete an initial EMS Driver course. There is currently no BEMS approved refresher training course for EMS Driver re-certification with the exception of BEMS approved vehicle operation monitoring system.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.8.2 *Note: Licensed ambulance services operating approved vehicle operation monitoring systems are required to repeat the didactic section of their training program and submit a copy of the latest employer approved performance driver monitor strip/record.*

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 Prerequisites to certification as an EMS Driver (training obtained in Mississippi):

Rule 5.9.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.9.2 Completion of the Board's approved EMS Driver Training Program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.9.3 Possession of valid driver's license.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Prerequisites to certification as an EMS Driver (training obtained in another state:

Rule 5.10.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.10.2 Completion of the Board's approved EMS Driver Training Program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.10.3 Possession of valid driver's license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.10.4 Written verification that training obtained out of state meets the guidelines of the Mississippi EMS Driver Training Program(s).

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.10.5 Verification of training within the past two years, or written verification of training from sending state and of current status.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.10.6 Submission of official driver's license history concurrent with date of application

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.10.7 *Note: The BEMS maintains the right to refuse reciprocity to any EMS Driver if the submitted curriculum does not meet the requirements of this section.*

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Temporary EMS Driver Certification.

Rule 5.11.1 The BEMS may issue temporary EMS driver certification not to exceed 90 days. Temporary certification will be issued only upon receipt of a written request from an owner/manager of a licensed ambulance provider. Licensed ambulance providers may utilize personnel awaiting temporary EMS driver certification provided that such providers notify the BEMS prior to employment.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.11.2 A temporary EMS Driver certification will not be granted to an individual who has previously been issued a Mississippi BEMS EMS Driver certification.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 12 EMS Driver Certification

Rule 5.12.1 Any person desiring certification as an EMS Driver shall apply to the BEMS using forms provided (application for state certification). All certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include a copy of EMS Driver course certificate of completion, a copy of a current state driver’s license and complete a successful review by the BEMS of the driver's license history from the Mississippi Highway Patrol.

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.12.2 An EMS Driver certificate shall be valid for a period not exceeding four years from the date of issuance and may be renewed provided that the holder meets qualifications as required by the Board. The expiration date of each EMS Driver certificates shall be the same as the holder's driver's license.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 EMS Driver Re-certification

Rule 5.13.1 Any person desiring re-certification as an EMS Driver shall apply to the BEMS using forms provided (Application for state certification). All re-certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include a copy of EMS Driver course certificate of completion and a copy of current state driver's license. The BEMS will conduct a

review of the applicant's driver license history from the Mississippi Highway Patrol.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 14 EMS Driver, Grounds for Suspension or Revocation.

Rule 5.14.1 Grounds for suspension or revocation include:

1. Fraud or any mis-statement of fact in the procurement of any certification or in any other statement of representation to the BEMS or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disregarding the speed regulations prescribed by law while on duty.

6. Revocation or any other loss of Mississippi driver's license.

7. Failure to carry the BEMS issued certification card while on duty or failure to wear appropriate identification as approved by BEMS.

8. Failure to maintain all current EMS Driver training standards as required by the BEMS.

9. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

10. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel, or the conviction of any felony. The record of conviction or a certified copy thereof will be conclusive evidence of such conviction.

11. Violating or attempting to violate directly or indirectly or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

12. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

13. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

14. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

15. Failure to comply with an employer's request for drug and alcohol testing.

16. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 6 EMERGENCY MEDIAL TECHNICIAN BASIC (EMT-B)

Subchapter 1 Training Authority EMT

Rule 6.1.1 The Mississippi Vocational-Technical Education Division of the Department of Education, with the cooperation of the Governor's Highway Safety Program, the Mississippi State Department of Health, and the American College of Surgeons-Mississippi Committee on Trauma, and the Mississippi Chapter of the American College of Emergency Physicians, offered the EMT training course through the Mississippi Community College System. Additionally, organized EMS districts as recognized by the BEMS, are authorized to provide this training. The Guidelines and minimum standards are set forth in order to establish a minimum level of training for the Emergency Medical Technician. These guidelines and minimum standards shall be met by all Emergency Medical Technician Courses in the state.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 EMT Curriculum

Rule 6.2.1 EMT Curriculum must conform, at minimum, to the National EMS Education Standards developed by the United States Department of Transportation and current revisions as approved for use by the BEMS. Minimum hours required for EMT Basic are: 135 clock hours of didactic instruction and laboratory; 48 clock hours of clinical and field of which at least ten hours will be hospital clinical and at least five EMS runs shall be completed and documented. BEMS and the State EMS Medical Director must approve all training curriculums. Written permission from the BEMS must be obtained prior to the start of an EMT Training course.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.2.2 Beginning August 2011, EMT curriculum must conform, at minimum, to the National EMS Core Content, National EMS Scope of Practice, National EMS Education Standards and all current revisions as approved for use by the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.2.3 The current approved curriculum is the 2011 Mississippi Curriculum Framework – Basic as approved by the Mississippi Department of Education, Office of Career and Technical Education and the State Board for Community and Junior Colleges (SBCJC), the Mississippi Emergency Medical Services Advisory Board and the Medical Direction, Training and Quality Assurance Committee.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Request for Approval of EMT training programs

Rule 6.3.1 *Note: A list of BEMS approved EMT training programs will be available at the BEMS office and BEMS web site. (www.health.ms.gov)*

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.3.2 Request for approval of EMT training programs not contained on the approved list shall be sent to BEMS with evidence and verification that:

1. The Community College has been approved by the Mississippi State Department of Education, Mississippi Vocational-Technical Education Division.

2. EMT training program meets, at minimum, the requirements of the National EMS Education Standards

3. EMT Instructors meet the requirements of the Mississippi State Department of Education and the BEMS. There must be certification and re-certification requirements that must be met, including an evaluation of instructor terminal competencies, provided in the requested training program.

4. *Note: Credentialed EMS Instructors of BEMS as trained through the MS EMS Instructor Training Program, and in good standing, are considered as meeting the above requirement*

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 EMT Training Programs

Rule 6.4.1 The length of the EMT course shall not be less than 135 clock hours of didactic instruction and laboratory; 48 clock hours of clinical and field of which at least ten hours will be hospital clinical and at least five EMS runs shall be completed and documented.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.2 The complete EMT educational program shall be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the EMT.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.3 The program shall consist of, at minimum, three components: didactic and lab instruction, hospital clinical and practical evaluation on emergency runs under a medical command authority. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.4 The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives must delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.5 The student must be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program must be clearly defined in writing and distributed to the student at the beginning of the training program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.6 Evidence of student competence in achieving the educational objectives of the program must be kept on file. Documentation must be in the form of both written and practical examinations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.7 Classroom, clinical and optional field faculty must prepare written evaluations on each student. Documentation must be maintained identifying the counseling given to individual students regarding their performance and the recommendations maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.8 Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

1. Didactic Instruction: Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

2. Clinical and Other Settings:

   a. Instruction and supervised practice of emergency medical skills.

   b. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation must be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

3. A Field Experience: The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There should be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The EMT ~~Basic~~ must have telecommunication with medical command authority. The initial position of the student on the EMS care team should be that of observer only utilizing limited learned skills. After progression through record keeping and participation in actual patient care, the student should eventually function as the patient care leader. However, the student should not be placed in the position of being a necessary part of the patient care team. The team must be able to function without the necessary use of a student who may be present.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.9 General courses and topics of study must be achievement oriented and shall provide students with:

1. The ability to recognize the nature and seriousness of the patient's condition or extent of injuries to access requirements for emergency medical care;

2. The ability to administer appropriate emergency medical care based on assessment findings of the patients condition;

3. Lift, move, position and otherwise handle the patient to minimize discomfort and prevent further injury; and,

4. Perform safely and effectively the expectations of the job description.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.4.10 Policy for Administration: Operational Policies: Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex, or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

1. Announcements and advertising about the program shall reflect accurately the training being offered.

2. The program shall be educational and students shall use their schedule time for educational experiences.

3. Health and safety for students, faculty, and patients shall be adequately safeguarded.

4. Cost to the student shall be reasonable and accurately stated and published.

5. Policies and process for student withdrawal and refunds on tuition on fees shall be fair, and made known to all applicants.

6. Curriculum Description: Instructional content of the EMT training program shall include the minimal terminal objectives for entry-level EMS personnel to achieve the parameters outlined in the National EMS Scope of Practice as defined in the National EMS Education Standards.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 EMT classes, class approved

Rule 6.5.1 EMT class approval forms can be requested from the BEMS or be completed on the BEMS website. (*www.health.ms.gov*) Credentialed EMT ~~Basic~~ instructors should complete the class approval form and submit to the BEMS, at minimum, thirty (30) calendar days prior to the first day of class. The BEMS will assign a class number to all approved requests and return to the credentialed EMT instructor. Incomplete paperwork will be returned without action.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 EMT classes, initial roster

Rule 6.6.1 Initial rosters shall be completed by the credentialed EMT instructor immediately following the second meeting of the class. Initial roster forms can be obtained from the BEMS or be completed on the BEMS website (*www.health.ms.gov*). A

final roster for full or refresher EMT class will not be accepted without an initial roster on file with the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 EMT classes, final roster

Rule 6.7.1 Final rosters shall be completed by the credentialed EMT instructor immediately following the end of a full EMT or EMT Refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the EMT class. The final roster form can be obtained from the BEMS or be completed on the BEMS web site. (*www.health.ms.gov*) Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 EMT Training Programs, minimum admittance criteria

Rule 6.8.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.8.2 Students currently enrolled in a Mississippi Community or Junior College dual enrollment program may also be considered eligible to enter an EMT training program in exception to other stated admission requirements.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 EMT Refresher Training

Rule 6.9.1 EMT refresher training shall consist of: the current National Standard Basic EMT Refresher Curriculum (24 hour minimum), and shall include successful completion of a local written and practical examination. Written permission from BEMS must be obtained prior to the start of an EMT refresher course. Instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.9.2 *Note: All EMT's trained prior to August 2011 must complete a MSDH, BEMS approved transitional course by March 31, 2014.*

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Prerequisites to certification as an EMT (training obtained in Mississippi).

Rule 6.10.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.10.2 Completion of the Board's approved Emergency Technician Training Program *(Note: This includes passage of the National Registry examination).*

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.10.3 Verification of medical control (Jurisdictional Medical Control Agreement)

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Prerequisites to certification as an EMT (training obtained in another state)

Rule 6.11.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.11.2 An applicant must demonstrate a need for reciprocity by submitting a Jurisdictional Medical Control Agreement from a licensed ambulance service or a facility providing basic life support service indicating the applicant is presently employed or will be employed upon moving to the state.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.11.3 Completion of an EMT program which meets the guidelines as approved by BEMS. A copy of the program curriculum and educational objectives must be submitted to an approved by the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.11.4 Applicant must be registered as an EMT by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 12 EMT Certification

Rule 6.12.1 Any person desiring certification as an EMT shall apply to BEMS using forms provided (Application for state certification)

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.12.2 All certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.12.3 The BEMS may withhold or deny an application for certification for a like period of time equal to the period of time under which a person failed to comply. Mississippi requires that all EMT maintain current registration with the National Registry of Emergency Medical Technicians.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 EMT Re-certification

Rule 6.13.1 Any person desiring re-certification as an EMT shall apply to BEMS using forms provided (Application for state certification)

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.13.2 All re-certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.13.3 All EMTs failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.13.4 BEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

Subchapter 14 EMT, Grounds for Suspension or Revocation.

Rule 6.14.1 Grounds for suspension or revocation include:

1. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty

6. Disregarding the speed regulations prescribed by law while on duty.

7. Failure to carry the Mississippi State Department of Health issued certification card while on duty or failure to wear appropriate identification as approved by the BEMS.

8. Failure to maintain current registration by the National Registry of EMTs.

9. Failure to maintain all current EMT training standards as required by the BEMS.

10. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

11. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

12. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

13. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

14. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

15. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the BLS provider.

16. Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

17. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

18. Failure to comply with the requirements of a Mississippi EMS Scholarship program.

19. Failure to comply with an employer's request for drug and alcohol testing.

20. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 15 Description of the Occupation and Competency of the EMT

Rule 6.15.1 The EMT's Primary responsibility is to bring expert emergency medical care to the victims of emergencies and to transport them safely and expeditiously to the proper facility." The EMT-must accomplish these duties unsupervised, in a great variety of circumstances and often under considerable physical and emotional stress. The concept of an emergency medical technician, therefore, is of a person capable of exercising technical skills with authority and good judgment under difficult and stressful conditions. Personal qualities of stability, leadership, and judgment are primary. It must also be stressed that ongoing medical control and evaluation of the functioning EMT is essential to the maintenance of medical care quality. As with all professionals in the medical community, it must be realized that continuing education is an integral part of the EMT's ability to maintain a high degree of competence.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 16 Job Summary

Rule 6.16.1 Emergency Medical Technicians (EMTs) function as the first responders to medical emergencies. They are trained to care for patients in the field and while transporting the patient to the hospital. EMTs are trained to assess patients' conditions and assist in the management of medical and trauma emergencies.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.2 After receiving the call from the dispatcher, drives the ambulance to address or location given, using the most expeditious route, depending on the traffic and weather conditions. Observes traffic ordinances and regulations concerning emergency vehicle operations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.3 Upon arrival at the scene of the crash or illness, parks the ambulance in a safe location to avoid additional injury. Prior to initiating patient care, the EMT-Basic will also "size-up" the scene to determine that the scene is safe, the mechanism of injury or nature of illness, total number of patients, and to request additional help if necessary. In the absence of law enforcement, creates a safe traffic environment, such as the placement of road warning devices, removal of debris and re-direction of traffic for the protection of the injured and those assisting in the care of injured patients.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.4 Determines the nature and extent of illness or injury and establishes priority for required emergency care. Based on assessment findings, renders emergency medical care to adult, infant and child, medical and trauma patients. Duties include, but are not limited to, opening and maintaining an airway, ventilating

patients and cardiopulmonary resuscitation, including use of Automated External Defibrillators. Provide pre-hospital emergency medical care of simple and multiple system trauma such as controlling hemorrhage, treatment of shock (hypoperfusion), bandaging wounds, and immobilization of painful, swollen, deformed extremities. Medical patients include: Assisting in childbirth, management of respiratory, cardiac, diabetic, allergic, behavioral, and environmental emergencies, and suspected poisonings. Searches for medical identification emblem as a clue in providing emergency care. Additional care is provided based upon assessment of the patient and obtaining historical information. These interventions, include assisting patients with prescribed medications, including sublingual nitroglycerine, epinephrine auto-injectors and hand-held aerosol inhalers. The EMT-Basic will also be responsible for administration of Oxygen, oral glucose, and activated charcoal.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.5 Reassures patients and bystanders by working in a confident, efficient manner. Avoids mishandling and undue haste while working expeditiously to accomplish the task.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.6 Where a patient is extricated from entrapment, assesses the extent of injury and gives all possible emergency care and protection to the entrapped patient and uses the prescribed techniques and appliances for safely removing the patient. If needed, radios the dispatcher for additional help or special rescue and/or utility services. Provides simple rescue service if the ambulance has not been accompanied by a specialized unit. After extrication, provides additional care in triaging the injured in accordance with standard emergency procedures.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.7 Complies with regulations on the handling of the deceased, notifies authorities, and arranges for protection of property and evidence at scene.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.8 Lifts stretcher, placing in ambulance and seeing that the patient and the stretcher are secure, continues emergency medical care.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.9 From the knowledge of the condition of the patient and the extent of injuries and the relative locations and staffing of emergency hospital facilities, determines the most appropriate facility to which the patient will be transported, unless otherwise directed by medical control plan or director. Reports directly to the emergency department or communications center the nature and extent of injuries, the number being transported, and the destination to assure prompt medical care on

arrival. Identifies assessment findings which may require communications with medical direction for advice and for notification that special professional services and assistance be immediately available upon arrival at the medical facility.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.10 Constantly assesses patient en route to emergency facility, administers additional care as indicated or directed by medical direction.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.11 Assists in lifting and carrying the patient out of the ambulance and into the receiving facility.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.12 Reports verbally and in writing their observation and emergency medical care of the patient at the emergency scene and in transit to the receiving facility staff for purposes of records and diagnostics. Upon request, provides assistance to the receiving facility's staff.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.13 After each call, restocks and replaces used linens, blankets and other supplies, cleans all equipment following appropriate disinfecting procedures, makes careful check of all equipment so that the ambulance is ready for the next run. Maintains ambulance in efficient operating condition. Ensures that the ambulance is cleaned and washed and kept in a neat orderly condition. In accordance with local, state, or federal regulations, decontaminates the interior of the vehicle after transport of patient with contagious infection or hazardous materials exposure.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.14 Determines that vehicle is in proper mechanical condition by checking items required by service management. Maintains familiarity with specialized equipment used by the service.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.15 Attends continuing education and refresher training programs as required by employers, medical direction, licensing, or certifying agencies.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.16.16 Meets qualifications within the functional job analysis.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 17 Functional Job Analysis

Rule 6.17.1 EMT work as part of a team. Thorough knowledge of theoretical procedures and ability to integrate knowledge and performance into practical situations are critical. Self-confidence, emotional stability, good judgment, tolerance for high stress, and a pleasant personality are also essential characteristics of a successful EMT at any level. EMT also must be able to deal with adverse social situations, which include responding to calls in areas having high crime rates.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 18 Physical demands

Rule 6.18.1 Aptitudes required for work of this nature are good physical stamina, endurance, and body condition which would not be adversely affected by lifting, carrying, and balancing at times, patients in excess of 125 lbs. (250, with assistance). EMT must be able to work twenty-four-hour shifts. Motor coordination is necessary for the well-being of the patients, the EMT, and co-worker over uneven terrain.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 19 Performance Standards for EMT.

Rule 6.19.1 The EMT who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the BEMS Training programs must be approved by the BEMS. The skills listed herein will enable the basic level EMT to carry out all EMT level patient assessment and emergency care procedures.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.19.2 Skills included in the Scope of Practice for a Mississippi EMT includes the following:

1. Oropharengeal and Nasopharengeal Airway
2. Bag-Valve Mask
3. Sellick's Maneuver
4. Demand Valve – manually triggered ventilation
5. Head Tilt Chin Lift
6. Jaw Thrust
7. Modified Jaw Thrust

8. Mouth to Barrier; Mouth to Mask; Mouth to Mouth; Mouth to Nose; Mouth to Stoma

9. Obstruction – Manual

10. Oxygen Therapy – humidifiers; Oxygen Therapy –Nasal Cannula; Oxygen Therapy –Non-rebreather mask; Oxygen Therapy –Partial rebreathr mask; Oxygen Therapy –simple face mask; Oxygen Therapy –Venturi mask

11. Pulse oximetry (beginning April 1, 2014);

12. Suctioning – Upper airway;

13. Ventilator – Automated transport (ATV) *(prehospital, nonintubated patient)* - (beginning April 1, 2014);

14. Cardiopulmonary Resuscitation (CPR)

15. Defibrillation – automated/semi-automated

16. Hemorrhage control – Direct pressure; Hemorrhage control – tourniquet

17. MAST/PASG

18. Mechanical CPR Device (beginning April 1, 2014);

19. Spinal immobilization – cervical collar; Spinal immobilization – long board; Spinal immobilization – manual; Spinal immobilization – seated patient; Spinal immobilization – rapid manual extrication;

20. Extremity stabilization – manual;

21. Extremity splinting; Splint – traction

22. Mechanical patient restraint;

23. Emergency moves for endangered patients;

24. Assisting patient with his/her own prescribed medications (aerosolized/nebulized); Oral Glucose; Oral Aspirin; sublingual nitroglycerine; Auto-injector (self or peer care); Auto-injector (patient's own prescribed medication;

25. Assisted delivery (childbirth); Assisted complicated delivery (childbirth)

26. Blood pressure – automated (beginning April 1, 2014); Blood pressure – manual;

27. Eye irrigation

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.19.3 *Note: Skills and medications not listed in these regulations may not be performed by any BLS provider until each skill and/or medication has been individually and specifically approved by BEMS in writing.*

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 20 Area and Scope of Practice of the EMT-Basic

Rule 6.20.1 The EMT-Basic represents the first component of the emergency medical care system. Through proper training the EMT-Basic will be able to provide basic life support to victims during emergencies, minimize discomfort and possible further injuries. The EMT-Basic may provide non-invasive emergency procedures and services to the level described in the EMT-Basic National Standard Training Curriculum. Those procedures include recognition, assessment, management, transportation and liaison.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.20.2 An EMT-Basic is a person who has successfully completed an approved training program and is certified. The EMT-Basic training program must equal or exceed the educational goals and objectives of the National Standard Training curriculum for the EMT-Basic.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.20.3 It is appropriate to transport patients whose urgent needs or reasonably perceived needs for care exceed the scope of practice for the ambulance attendant, if the following conditions are present:

1. The patient has existing advanced therapeutics or treatment modalities for a preexisting condition, and

2. The patient is located in a non-hospital setting, and

3. The patient's condition is considered to be so urgent that the benefits of prompt transport by available personnel to an appropriate hospital outweigh the increased risk to the patient from affecting a delay waiting for qualified medical personnel to arrive.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.20.4 The person possessing the highest level of certification/license must attend the patient unless otherwise authorized by medical control or as otherwise specified by approved protocols.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.20.5 EMTs of all levels, may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

1. there is no need, or reasonably perceived need, for the device or procedure during transport; and

2. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

3. *Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.*

SOURCE: Miss. Code Ann. §41-59-5

Chapter 7 EMERGENCY MEDICAL TECHNICIAN ADVANCED LEVEL SUPPORT

Subchapter 1 Training Authority for Paramedic

Rule 7.1.1 The Mississippi Department of Education, Office of Career and technical Education,-with the cooperation of the Governor's Highway Safety Program, the Mississippi State Department of Health, and the American College of Surgeons-Mississippi Committee on Trauma, and the Mississippi Chapter of the American College of Emergency Physicians, offered the advanced life support training course through the Mississippi Community College System. The guidelines and minimum standards are set forth in order to establish a minimum level of training for the Paramedic-level. These guidelines and minimum standards shall be met by all Paramedic Courses in the state. The University of Mississippi Medical Center, Department of Emergency Medical Technology, is authorized by the BEMS to conduct ALS training programs statewide. All advanced life support programs must have the BEMS approval.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 2 Paramedic Curriculum

Rule 7.2.1 Paramedic curriculum must conform, at minimum, to the National EMS Scope of Practice developed by the United States Department of Transportation and the 2011 Mississippi Curriculum Framework – Post Secondary Paramedic and all current revisions as approved for use by the BEMS. Minimum hours required for Paramedic are: 810 didactic/lab and 585 clinical/field. BEMS, the State EMS Medical Director, and the Medical Direction, Training, and Quality Assurance Committee must approve all training curriculums.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 3 Request for Approval of Paramedic Training Programs

Rule 7.3.1 *Note: A list of BEMS approved Paramedic training programs will be available at the BEMS office and BEMS web site.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.3.2 All BEMS approved Paramedic training programs must be accredited by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP). BEMS shall be present for any site visit conducted by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP).

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.3.3 Pre-requisites for beginning a new Paramedic program without the existence of an accredited paramedic program.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.3.4 The following requirements are to be met and approved by the BEMS before the approval will be issued to begin the programs instructional component:

1. Full time program director that's position is delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.a.1. This must be verified by a copy of a contractual agreement to the BEMS.

2. A Medical Director who's position is delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.a.2. This must be verified by a copy of a contractual agreement to the BEMS.

3. Instructional Faculty who's qualifications will be delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.1.b. This must be verified by a copy of a contractual agreement to the BEMS.

4. Financial Resources will be adequate as described by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.2. This must be verified by a letter from administration.

5. Physical Resources as delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.3.a. and b. This will be verified by a site visit by a staff member of BEMS.

6. Clinical Resources as delineated by the Standards and Guidelines for an Accredited Educational Program For the Emergency Medical Technician-Paramedic, B.4.and B.5. This must be verified by a copy of a contractual agreement from each site to the BEMS.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.3.5 Before a consecutive class will be authorized to commence, the Self Study, as specified by Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP) formerly known as the Joint Review Committee on Educational Programs for the EMT Paramedic (JRCEMT-P), is to be completed and submitted to the CoAEMSP's administrative office with the appropriate fees. To maintain training authority, the programs must submit:

1. Reports of training activities as specified by BEMS; copies of any and all written communications to and from the school and the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP) and/or CAAHEP, will be submitted within (10) ten working days from submitting or receiving to BEMS.

2. Program updates and revisions as specified by BEMS. All reports and updates must be submitted to the BEMS no later than June 30 of each year.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.3.6 *NOTE: The University of Mississippi Medical Center, Department of Emergency Medical Technology, is authorized by the BEMS to conduct ALS training programs statewide.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 4 Paramedic Training Programs

Rule 7.4.1 The complete Paramedic educational programs must be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit professional growth.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.2 The program shall consist of, at minimum, three components: didactic instruction, hospital clinical lab and practical evaluation in pre-hospital field clinicals under a medical command authority. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.3 The program shall maintain on file, for each component of the curriculum, a reasonable comprehensive list of the terminal performance objectives to be achieved by the student. These objectives must delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.4 The student must be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.5 Evidence of student competence in achieving the educational objectives of the program must be kept on file. Documentation must be in the form of both written and practical examinations.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.6 Classroom, clinical and field faculty must also prepare written evaluations on each student. Documentation must be maintained identifying the counseling given to individual students regarding their performance and the recommendations maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation on whether or not the student followed through on faculty recommendations should also be maintained. Instruction should be supported by performance assessments.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.7 Faculty must be presented with the program's educational objectives for uses in preparation of lectures and field practicals. The course coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

1. Didactic instruction: Lectures, discussions, and demonstrations presented by physicians and others who are competent in the field.

2. Clinical and Other Settings: Instruction and supervised practice of emergency medical skills. Practice should not be limited to the development of practical skills alone, but should include knowledge and techniques regarding patient evaluations, development of patient rapport, and care for and understanding of the patient's illness. Documentation must be maintained for each student’s performance in all of the various areas. A frequent performance evaluation is recommended.

3. A Field Experience: The field internship is a period of supervised experience in a structured overall EMS system. It provides the student with a progression of increasing patient care responsibilities which proceed from observation to working as a member of a team. There must be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience. The Paramedic ~~EMT-Advanced Level~~ student must have telecommunication with medical command authority. The initial position of the student on the EMS care team should be that of observer only utilizing limited learned skills. After progression through record keeping and participation in actual patient care, the student must eventually function as the patient care leader. However, the student must not be placed in the position of being a necessary part of the patient care team. The team must be able to function without the necessary use of a student who may be present.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.8 General courses and topics of study must be achievement oriented and shall provide students with:

1. The ability to recognize the nature and seriousness of the patients condition or extent of injuries to access requirements for emergency medical care;

2. The ability to administer appropriate emergency medical care based on assessment findings of the patients condition;

3. Lift, move, position and otherwise handle the patient to minimize discomfort and prevent further injury; and,

4. Perform safely and effectively the expectations of the job description.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.4.9 Operational Policies

1. Student matriculation practices and student and faculty recruitment should be non-discriminatory with respect to race, color, creed, sex or national origin. Student matriculation and student and faculty recruitment practices are to be consistent with all laws regarding non-discrimination. It is recommended that records be kept for a reasonable period of time on the number of students who apply and the number who successfully complete training.

2. Announcements and advertising about the program shall reflect accurately the training being offered.

3. The program shall be educational and students shall use their schedule time for educational experiences.

4. Health and safety for students, faculty, and patients shall be adequately safeguarded.

5. Cost to the student shall be reasonable and accurately stated and published.

6. Policies and process for student withdrawal and refunds on tuition on fees shall be fair, and made known to all applicants.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 5 Curriculum Description - Paramedic

Rule 7.5.1 Instructional content of the educational program shall include the successful completion of stated educational objectives that fulfill local and regional needs and that satisfy the requirements of this curriculum section. The curriculum shall be organized to provide the student with knowledge of the acute, critical changes in physiology, and in psychological, and clinical symptoms as they pertain to the pre-hospital emergency medical care of the infant, child, adolescent, adult, and geriatric patient. Students shall have an opportunity to acquire clinical experience and practice skills related to the emergency medical care of these patients. Students shall also understand the ethical and legal responsibilities which they assume as students and which they are being prepared to assume as graduates.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.2 The educational program shall be designed to provide the knowledge that will allow the student to arrive at decisions based on accepted medical knowledge and that will permit the professional growth of the Paramedic.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.3 The program shall consist of three components: didactic instruction, clinical instruction, and supervised field internship in an advanced life support unit that functions under a medical command authority. The time required to complete each component may vary, in part being dependent upon the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.4 The program shall maintain on file for each component of the curriculum a reasonably comprehensive list of the terminal performance objectives to be achieved by the student. These objectives shall delineate mastery in all competencies identified, including curriculum documentation, measurement techniques used, and the records maintained on each student's work.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.5 The student shall be informed about the methods and data used in determining grades, about pass/fail criteria, and about the mechanism for appeal. Conditions governing dismissal from the program shall be clearly defined in writing and distributed to the student at the beginning of the training program.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.6 Evidence of student competence in achieving the educational objectives of the program shall be kept on file. Documentation shall be in the form of both written and practical examinations.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.7 Classroom, clinical, and field faculty shall also prepare written evaluations on each student. Documentation shall be maintained identifying the counseling given to individual students regarding their performance and the recommendations made to correct inadequate performance. Documentation identifying whether or not the student followed through on faculty recommendations shall also be maintained.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.8 Instruction shall be supported by performance assessments. Faculty shall be presented with the program's educational objectives for use in preparation of lectures and clinical and field practice. The course coordinator shall insure that stated educational objectives are covered and shall answer any questions from students or clarify information presented by a lecturer.

1. Didactic instruction: Lectures, discussion, and demonstrations presented by physicians and others who are competent in the field.

2. Clinical (in-hospital) and other settings:

   a. Instruction and supervised practice of emergency medical skills in critical care units, emergency departments, OB units, operating rooms, psychological crisis intervention centers, and other settings as appropriate.

   b. Supervision in the hospital can be provided either by qualified hospital personnel, such as supervisory nurses, department supervisors and physicians, or by paramedic or nurse program instructors. The hospital practice shall not be limited to the development of practical skills alone, but shall include knowledge and techniques regarding patient evaluations, pathophysiology of medical and surgical conditions, development of patient rapport, and care for and understanding of the patient's illness.

   c. Documentation shall be maintained for each student's performance in all of the various areas. A frequent performance evaluation is recommended.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.9 Field Internship:

1. "The field internship is a period of supervised experience on an intensive care vehicle which provides the student with a progression of increasing patient care responsibilities which proceeds from observation to working as a team member. There shall be a provision for physician evaluation of student progress in acquiring the desired skills to be developed through this experience."

2. The intensive care vehicle shall have communication with medical command authority and equipment and drugs necessary for advanced life support. The student must be under the direct supervision and observation of a physician or nurse with experience in the pre-hospital ALS setting, or a Paramedic approved by the medical command authority.

3. The experience shall occur within an emergency medical care system that involves Paramedics in the provision of advanced emergency medical services and that maintains a defined program of continuing education for its personnel.

4. "The initial position of the student on the pre-hospital care team shall be that of observer. After progressing through record keeping and participation in actual patient care, the student shall ultimately function as the patient care leader. However, the student shall not be placed in the position of being a necessary part of the patient care team. The team should be able to function without the necessary use of a student who may be present."

5. The ALS Provider being used shall have established a continuing education program for its field personnel that adequately maintain an acceptable level of required skills and knowledge.

6. The ALS Provider shall function under direct communications with a medical control authority that provides pre-hospital direction of the patient care.

7. The ALS Provider shall also have a program to provide prompt review of pre-hospital care provided by the EMT-Paramedic.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.10 General courses and topics of study must be achievement oriented and shall provide students with: The necessary knowledge, skills, and attitudes to perform accurately and reliably the functions and tasks stated and implied in the "Description of the Occupation" found in the DOT, NSTC Course Guide.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.11 Comprehensive instruction which encompasses:

1. Orientation to the occupation

    a. Responsibilities of the occupation

    b. Professional responsibilities

    c. Career pathways in emergency medical services

    d. Legal responsibilities

2. Development of interpersonal skills

    a. Awareness of one's abilities and limitations

    b. Ability to accept direction

    c. Awareness of impact on others

    d. Willingness and ability to communicate with others

    e. Ability to build a working relationship with patients and peers

    f. Ability to function as a team member and/or team leader

    g. Ability to accept patients as they present themselves, without passing judgment

    h. Ability to involve others significant to the patient

    i. Ability to respond to a patient's sense of crisis

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.12 Development of clinical assessment skills

1. Ability to obtain information rapidly by talking with the patient and by physical examination; by interviewing others; and from observation of the environment

2. Ability to organize and interpret data rapidly

3. Ability to communicate concisely and accurately

4. Ability to understand pertinent anatomy, physiology, pharmacology, microbiology, and psychology

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.13 Development of clinical management and technical skills (from American Medical Association Joint Review Committee Essential Guidelines for EMT-Paramedic Training Programs) relating to the assessment and emergency treatment of:

1. Medical Emergencies including: Respiratory System (as addressed in didactic objectives), Cardiovascular system (as addressed in didactic objectives), Endocrine system (as addressed in didactic objectives), Nervous system (as addressed in didactic objectives), Gastrointestinal system (as addressed in didactic objectives), Toxicology (as addressed in didactic objectives), Infectious diseases (as addressed in didactic objectives), Environmental problems (as addressed in didactic objectives), Problems by age extremes i.e., pediatrics, neonatal, geriatrics (as addressed in didactic objectives), Shock (as addressed in didactic objectives), Central nervous system (as addressed in didactic objectives).

2. Traumatic Emergencies including: Central nervous system (as addressed in didactic objectives), Neck (as addressed in didactic objectives), Thorax (as addressed in didactic objectives), Abdomen (as addressed in didactic objectives), Extremities (as addressed in didactic objectives), Skin (as addressed in didactic objectives), Environmental (as addressed in didactic objectives), Shock (as addressed in didactic objectives)

3. Obstetrical/Gynecological Emergencies (as addressed in didactic objectives),

4. Behavioral Emergencies (as addressed in didactic objectives)

5. Stress (as addressed in didactic objectives)

6. Psychiatric disease (as addressed in didactic objectives)

7. Emotional dysfunction (as addressed in didactic objectives)

8. Medical personnel communications (as addressed in didactic objectives)

9. Clinical/Medical equipment (as addressed in didactic objectives and by institution or service policy)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.14 Development of technical skills: associated with biomedical communications, including telemetry, record keeping, use of equipment, emergency and defensive driving, and principles and techniques of extrication.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.5.15 Optional skills shall be included in all Paramedic training programs.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 6 Paramedic classes, class approved

Rule 7.6.1 Paramedic class approval forms can be requested from the BEMS or be completed on the BEMS website. (www.msems.org) Credentialed Paramedic instructors should complete the class approval form and submit to the BEMS, at minimum, thirty (30) calendar days prior to the first day of class. The BEMS will assign a class number to all approved requests and return to the credentialed Paramedic instructor. Incomplete paperwork will be returned without action.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 7 Paramedic classes, initial roster

Rule 7.7.1 Initial rosters shall be completed by the credentialed Paramedic instructor immediately following the second meeting of the class. Initial roster forms can be obtained from the BEMS or be completed on the BEMS website. (*www.health.ms.gov*) A final roster for full or refresher Paramedic class will not be accepted without an initial roster on file with the BEMS.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 8 Paramedic classes, final roster

Rule 7.8.1 Final rosters shall be completed by the credentialed Paramedic instructor immediately following the end of a full Paramedic Refresher class. The final roster shall be inclusive of all students on the initial roster. The final roster will note students who withdrew, failed, and completed the Paramedic class. The final roster form can be obtained from the BEMS or be completed on the BEMS web site. (*www.health.ms.gov*) Students successfully completing the class will not be allowed to test National Registry until a final roster is on file with the BEMS.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 9 Paramedic Training Programs, minimum admittance criteria

Rule 7.9.1 Must be a Mississippi certified EMT-Basic (EMT)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.9.2 Must successfully pass a re-test of EMT-Basic (EMT) skills and knowledge.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.9.3 Must provide past academic records for review by an admissions committee (may or may not be faculty members).

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.9.4 Completion of 8 semester hours of human anatomy and physiology (A&P 1 and II with labs) from an accredited post-secondary school. Minimum average of C or higher must be obtained. Human anatomy and physiology may be taken as prerequisite or co-requisite courses.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 10 Intermediate and Paramedic Refresher Training

Rule 7.10.1 EMT Intermediate Refresher training shall consist of: Successful competition of the EMT-Basic refresher course as outlined previously and successful competition of a formal 14 hour DOT EMT Intermediate refresher training program (must include 2 hours of defibrillation refresher training). Successful competition of Division 1 and 2 of the EMT Paramedic Curriculum will satisfy this requirement.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.10.2 Written permission from BEMS must be obtained prior to the start of an Paramedic refresher course. Instructors should complete the class approval form and submit to BEMS, at minimum, thirty (30) calendar days prior to the first day of class.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.10.3 *Note: All Paramedics trained prior to August 2011 must complete a MSDH, BEMS approved transitional course no later than March 31, 2014.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 11 Prerequisites to certification as an EMT Intermediate (training obtained in Mississippi).

Rule 7.11.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.11.2 Completion of the Board's approved Emergency Medical Technician Intermediate Training Program *(Note: This includes passage of the National Registry EMT-I examination).*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.11.3 Competition of a BEMS approved EMT-I defibrillation course and passage of the state defibrillation exam (applicable to EMT-Intermediate only), or equivalent with MSDH, BEMS approved terminal competencies (ACLS may be substituted for the EMT-I defibrillation course, but applicant must still pass the state defibrillation exam.)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.11.4 Must meet all Mississippi EMT criteria for certification.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.11.5 Verification of medical control (Jurisdictional Medical Control Agreement)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 12 Prerequisites to certification as a Paramedic (training obtained in Mississippi).

Rule 7.12.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.12.2 Completion of the Board's approved Paramedic Training Program *(Note: This includes passage of the National Registry Paramedic examination).*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.12.3 Must meet all Mississippi EMT criteria for certification.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.12.4 Verification of medical control (Jurisdictional Medical Control Agreement)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.12.5 *Note: All Paramedics trained prior to august 2011 must complete a MSDH, BEMS approved transitional course no later than March 31, 2014.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 13 Prerequisites to certification EMT-Intermediate (training obtained in another state)

Rule 7.13.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.13.2 An applicant must demonstrate a need for reciprocity by submitting a Jurisdictional Medical Control Agreement.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.13.3 Completion of an EMT-Intermediate program (Advanced level), which meets the guidelines of the national standard curriculum for EMT-I. A copy of the program

curriculum and educational objectives must be submitted to and approved by the BEMS.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.13.4 Applicant must be registered as an EMT-Intermediate by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card to the BEMS. Must meet all Mississippi criteria for certification.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.13.5 *Note: The Mississippi BEMS maintains the right to refuse reciprocity to any EMT-Intermediate and EMT-Paramedic if the submitted curriculum does not meet the guidelines of the national standard curriculum and those required by the state of Mississippi.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 14 Prerequisites to certification Paramedic (training obtained in another state)

Rule 7.14.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.14.2 An applicant must demonstrate a need for reciprocity by submitting a Jurisdictional Medical Control Agreement.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.14.3 Completion of a Paramedic program which meets the guidelines as approved by BEMS. A copy of the program curriculum and educational objectives must be submitted to and approved by the BEMS.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.14.4 Applicant must be registered as a Paramedic by the National Registry of EMTs. This is documented by submitting a copy of the National Registry wallet card to the BEMS. Must meet all Mississippi criteria for certification.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.14.5 *Note: All Paramedics trained prior to August 2011 must complete a MSDH. BEMS approved transitional course no later than March 31, 2014.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.14.6 *Note: The Mississippi BEMS maintains the right to refuse reciprocity to any EMT-Intermediate and EMT-Paramedic if the submitted curriculum does not*

meet the guidelines of the national standard curriculum or those required by the state of Mississippi.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 15 EMT Intermediate Certification

Rule 7.15.1 Any person desiring certification as an EMT-Intermediate shall apply to BEMS using forms provided (Application for state certification)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.15.2 All certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card and a Jurisdictional Medical Control Agreement.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.15.3 The BEMS may withhold or deny an application for certification for a like period of time equal to the period of time under which a person failed to comply. Mississippi requires that all EMT-I maintain current registration with the National Registry of Emergency Medical Technicians.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 16 Intermediate Level Re-certification

Rule 7.16.1 Any person desiring re-certification as an EMT- I/P shall apply to BEMS using forms provided (Application for state certification)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.16.2 All re-certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card equivalent to or exceeds the level of re-certification requested and is reflected in a Jurisdictional Medical Control Agreement (JMCA). (Jurisdictional Medical Control Agreements are valid only for the certification period in which they are submitted. Therefore, all EMT-Intermediates recertifying must complete and resubmit a JMCA for each licensed provider for which they function.)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.16.3 All EMT-Intermediates failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.16.4 BEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 17 Paramedic Level Re-certification

Rule 7.17.1 Any person desiring re-certification as an EMT- I/P shall apply to BEMS using forms provided (Application for state certification)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.17.2 All re-certification applications must be accompanied by a fee fixed by the Board, which shall be payable to the Board. Also include copy of current National Registry card equivalent to the level of re-certification requested and a Jurisdictional Medical Control Agreement (JMCA). (Jurisdictional Medical Control Agreements are valid only for the certification period in which they are submitted. Therefore, all EMT-Intermediates and EMT-Paramedics recertifying must complete and resubmit a JMCA for each licensed provider for which they function.)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.17.3 All Paramedics failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.17.4 BEMS may withhold or deny an application for re-certification for a like period of time equal to the like period of time under which a person fails to comply.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.17.5 *Note: All Paramedics trained prior to August 2011 must complete a MSDH BEMS approved transitional course no later than march 31, 2014.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 18 EMT Intermediate, Grounds for Suspension or Revocation.

Rule 7.18.1 Grounds for suspension or revocation include:

1. The BEMS may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

2. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

3. Gross negligence.

4. Repeated negligent acts.

5. Incompetence.

6. Disturbing the peace while on duty

7. Disregarding the speed regulations prescribed by law while on duty.

8. Failure to carry the BEMS issued certification card while on duty or failure to wear appropriate identification as approved by the BEMS.

9. Failure to maintain current registration by the National Registry of EMTs.

10. Failure to maintain all current EMT-Advanced training standards as required by the BEMS.

11. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

12. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

13. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

14. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

15. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

16. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.

17. Permitting, aiding or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

18. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

19. Failure to comply with the requirements of a Mississippi EMS scholarship program.

20. Failure to comply with an employer’s request for drug and alcohol testing.

21. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006

Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 19 Paramedic, Grounds for Suspension or Revocation.

Rule 7.19.1 Grounds for suspension or revocation include:

1. The BEMS may suspend or revoke a certificate so issued at any time it is determined that the holder no longer meets the prescribed qualifications.

2. Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

3. Gross negligence.

4. Repeated negligent acts.

5. Incompetence.

6. Disturbing the peace while on duty

7. Disregarding the speed regulations prescribed by law while on duty.

8. Failure to carry the BEMS issued certification card while on duty or failure to wear appropriate identification as approved by the BEMS.

9. Failure to maintain current registration by the National Registry of EMTs.

10. Failure to maintain all current EMT-Advanced training standards as required by the BEMS.

11. The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

12. Conviction of any crime which is substantially related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

13. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

14. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

15. Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

16. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.

17. Permitting, aiding or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

18. Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

19. Failure to comply with the requirements of a Mississippi EMS scholarship program.

20. Failure to comply with an employer's request for drug and alcohol testing.

21. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard**.**

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 20 Description and Competency of the EMT-Intermediate

Rule 7.20.1 "An EMT-Intermediate is a person who has successfully completed both an EMT-B and an EMT-I training program curriculum that shall consist of modules numbers I, II, and III as developed for the US Department of Transportation as well as the MSDH BEMS EMT-Intermediate defibrillation curriculum and is certified and licensed."

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.20.2 Given the knowledge, skills, and field experience, the EMT-I is competent in:

1. Recognizing a medical emergency; assessing the situation managing emergency care and, if needed, extrication; coordinating his efforts with those of other agencies involved in the care and transportation of the patient; and establishing rapport with the patient and significant others to decrease their state of crisis.

2. Assigning priorities of the emergency treatment and recording and communicating data to the designated medical command authority.

3. Initiating and continuing emergency medical care under medical control including the recognition of presenting conditions and initiation of appropriate invasive and non-invasive therapy.

4. Exercising personal judgment in case of interruption in medical direction caused by communication failure or in case of immediate life-threatening conditions. (Under these circumstances, provides such emergency care as has been specifically authorized in advance.)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 21 Description and Competency of the Paramedic

Rule 7.21.1 A Paramedic is a person who has successfully completed a BEMS approved EMT and Paramedic training curriculums, holds certification with the National Registry of Emergency Medical Technicians, and state certified.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.21.2 Given the knowledge, skills, and field experience, the EMT-P is competent in:

1. Recognizing a medical emergency; assessing the situation; managing emergency care and, if needed, extrication; coordinating his efforts with those of other agencies involved in the care and transportation of the patient; and establishing rapport with the patient and significant others to decrease their state of crisis.

2. Assigning priorities of emergency treatment and recording and communicating data to the designated medical command authority.

3. Initiating and continuing emergency medical care under medical control, including the recognition of presenting conditions and initiation of appropriate invasive and noninvasive therapies (e.g., surgical and medical emergencies, airway and respiratory problems, cardiac dysrhythmias, cardiac pulmonary arrest, and psychological crises), and assessing the response of the patient to that therapy.

4. Exercising personal judgment in case of interruption in medical direction caused by communications failure or in cases of immediate life-threatening conditions. (Under these circumstances, the Paramedic provides such emergency care as has been specifically authorized in advance.)

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 22 Performance Standards for Emergency Medical Technician-Intermediate.

Rule 7.22.1 The EMT-Intermediate who functions within the State of Mississippi, must be able to demonstrate the following skills to the satisfaction of the EMS medical director and the BEMS, State Department of Health, to meet criterion established for advanced life support personnel.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.2 The skills listed herein are in addition to those performed by the EMT-Basic.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.3 It should be noted that utilization of some of the more specialized advanced skills requires special approval by the medical director each time they are attempted.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.4 Perform an appropriate patient assessment, including: history taking a chief complaint, pertinent history of the present illness and past medical history). Physical examination, including: assessment of vital signs, including pulse, blood pressure, and respirations. Trauma-oriented and medically oriented head-to-toe surveys, including, but not limited to:

1. Inspection and palpation of the head and neck;

2. inspection of the chest and auscultation of heart and lung sounds

3. inspection of the abdomen and auscultation of abdominal sounds;

4. inspection and palpation of extremities;

5. evaluation of neurological status and neuromuscular function.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.5 Demonstrate aseptic technique of extremity peripheral venipuncture and drawing blood samples for hospital use only and Blood Glucose Determination by capillary sample (Limited to Unconscious Patients only for EMT-Intermediate).

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.6 Demonstrates the techniques for aseptic assembly of intravenous equipment and for calculation of flow rates.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.7 Demonstrate the techniques of establishing an IV infusion using a catheter-over-the-needle device.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.8 Recall and demonstrate use of the type of IV fluid appropriate in:

1. a "keep open" lifeline in cardiac patients

2. hypovolemic shock

3. specific medical emergencies

4. *Note: (EMT-Intermediates do not routinely start IV's on patients in categories 1 and 3. Their training concentrates on trauma and hypovolemic patients. They may, however, be requested to establish IV's in other situations such as when they are awaiting the arrival of higher qualified ALS personnel).*

5. *The BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA) will compile a list of intravenous fluids and medications that may be initiated and transported by EMS providers in the State. The current list of fluids and medications approved for initiation and transport by Mississippi EMS providers is available from the BEMS office or the BEMS website(www.health.ms.gov).*

6. *Requests for additions or deletions from the list should be made in writing by the System Medical Director to the BEMS. Requests should detail the rationale for the additions, modifications, or deletions.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.9 Demonstrate the application, inflation, and correct sequence of deflation of the pneumatic anti-shock garment (PASG).

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.10 Demonstrate the technique of aseptic and atraumatic endotracheal and tracheotomy suctioning.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.11 Recall the indications for and demonstrate the insertion of an esophageal obturator and esophageal gastric tube airway.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.12 Demonstrate the application of electrodes and monitoring of a patient's electrocardiographic activity.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.13 Identify on Lead II or modified chest lead - 1 (MCLl) and provide appropriate therapy (according to American Heart Association) for the following cardiac rhythms:

1. normal sinus rhythm
2. ventricular tachycardia
3. ventricular fibrillation
4. electromechanical dissociation
5. asystole
6. PVC recognition
7. Artifact

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.14 Demonstrate the proper use of the defibrillator paddle electrodes to obtain a sample Lead II rhythm strip

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.15 Demonstrate how to properly assess the cause of poor ECG tracing.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.16 Demonstrate correct operation of a monitor-defibrillator to perform defibrillation on an adult and infant.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.17 Demonstrate proficiency in:

1. biomedical communications, VHF and UHF (RTSS)
2. ECG telemetry
3. medicolegal responsibilities
4. record keeping
5. emergency and defensive driving
6. principles and techniques of light extrication
7. management of mass casualties and triage

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.22.18 In addition to the above skills, the EMT-Intermediate should be well versed in pertinent anatomy, pathophysiology, history taking, physical examination, assessment and emergency treatment relating to:

1. the cardiovascular system including recognition of selected dysrhythmias associated with potential acute cardiac compromises;

2. the respiratory system, including pneumothorax, chronic obstructive pulmonary disease, acute asthma, trauma to the chest and airways, respiratory distress syndrome, and acute airway obstruction;

3. chest and abdominal trauma;

4. soft tissue injuries including: burns, avulsions, impaled objects, eviscerations, amputations, and bleeding control;

5. the central nervous system (medical) in regard to cerebrovascular accidents, seizures, drug overdose, drug incompatibilities, and alterations in levels of consciousness;

6. musculoskeletal trauma including management of fractures, strains, sprains and dislocations;

7. medical emergencies, including: endocrine disorders, anaphylactic reactions, environmental emergencies, poisonings, overdose and acute abdomen;

8. obstetrical and gynecological emergencies including: breech birth, premature birth, abortion, multiple-infant birth, arm or leg presentation, prolonged delivery, prolapsed umbilical cord, pre- and postpartum hemorrhage, ruptured uterus, birth of an apenic infant, preeclampsia or eclampsia, rape, and supine hypotensive syndrome;

9. pediatric emergencies, including: asthma, bronchiolitis, croup, epiglottis, sudden infant death syndrome, seizures, child abuse;

10. behavioral emergencies, including: negotiations, recognition and intervention techniques with suicidal assaultive, destructive, resistant, anxious, bizarre, confused, alcoholic, drug-addicted, toxic, amnesic, paranoid, drugged, raped and assaulted patients.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 23 Optional skills for EMT-Intermediates

Rule 7.23.1 These optional skills and optional medications must be included in the BEMS approved medical control plan of each ALS provider utilizing them. Currently there are no optional skills or optional medications approved by the BEMS.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 24 Other skills

Rule 7.24.1 Other skills and medications not listed in these regulations may not be performed by any ALS provider through ALS trained employees until each skill and/or medication has been approved by BEMS in writing.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.24.2 EMTs of all levels, may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

1. there is no need, or reasonably perceived need, for the device or procedure during transport; or

2. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.24.3 *Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.24.4 The EMT-Intermediate who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the BEMS. Training programs must be approved by the BEMS and the Department of Education. The skills listed herein will enable the EMT- Intermediate to carry out all EMT- Intermediate level patient assessment and emergency care procedures.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.24.5 The EMT's – Intermediate's primary responsibility is to the patient and should include both an oral exam and an appropriate physical exam. Scene size-up including: scene safety, mechanism of injury, number of patients, additional help and consideration of cervical stabilization.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 25 Performance Standards for Paramedic Levels

Rule 7.25.1 Performance Standards for Paramedic Level.

1. The Paramedic who functions within the State of Mississippi, must be able to demonstrate the following skills to the satisfaction of the EMS medical director and the BEMS, State Department of Health, to meet criterion established for advanced life support personnel.

2. The skills listed herein are in addition to those performed by the EMT-Basic.

3. It should be noted that utilization of some of the more specialized advanced skills requires special approval by the medical director each time they are attempted.

    a. Perform an appropriate patient assessment, including: history taking a chief complaint, pertinent history of the present illness and past medical history). Physical examination, including: assessment of vital signs, including pulse, blood pressure, and respirations. Trauma-oriented and medically oriented head-to-toe surveys, including, but not limited to:

        i. Inspection and palpation of the head and neck;

        ii. inspection of the chest and auscultation of heart and lung sounds

        iii. inspection of the abdomen and auscultation of abdominal sounds;

        iv. inspection and palpation of extremities;

        v. evaluation of neurological status and neuromuscular function.

2. Demonstrate aseptic technique of extremity peripheral venipuncture and drawing blood samples for hospital use only and Blood Glucose Determination by capillary sample (Limited to Unconscious Patients only for EMT-Intermediate).

3. Demonstrates aseptic technique of external jugular intravenous insertion in life threatening situations when alternate sites are impractical. Demonstrate techniques of maintenance of central intravenous therapy (internal jugular, subclavian, femoral) EMT-P's are limited to only monitoring central line IV's; they shall not initiate central lines. The central line IV's may be used for approved fluid and drug administration only. Hemodynamic monitoring shall not be performed by EMT-P's

4. *NOTE: EMT-Intermediates and EMT-Paramedics are permitted to monitor and administer only those IV fluids and/or medications which are approved by the BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA). A current "Required and Approved EMS Fluids and Drugs List" is available from the BEMS office and on the BEMS website (www.ems.doh.ms.gov). Requests for additions or deletions from the list should be made in writing by the*

System Medical Director to the BEMS. Requests should detail the rational for the additions, modifications, or deletions

5. In addition, EMT - Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.

6. Demonstrates the techniques for aseptic assembly of intravenous equipment and for calculation of flow rates.

7. Demonstrate the techniques of establishing an IV infusion using a catheter-over-the-needle device.

8. Recall and demonstrate use of the type of IV fluid appropriate in:

    a. a "keep open" lifeline in cardiac patients

    b. hypovolemic shock

    c. specific medical emergencies

9. *Note: (EMT-Intermediates do not routinely start IV's on patients in categories 1 and 3. Their training concentrates on trauma and hypovolemic patients. They may, however, be requested to establish IV's in other situations such as when they are awaiting the arrival of higher qualified ALS personnel).*

10. The BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA) will compile a list of intravenous fluids and medications that may be initiated and transported by EMS providers in the State. The current list of fluids and medications approved for initiation and transport by Mississippi EMS providers is available from the BEMS office or the BEMS website(www.ems.doh.ms.gov).

11. Requests for additions or deletions from the list should be made in writing by the System Medical Director to the BEMS. Requests should detail the rationale for the additions, modifications, or deletions.

12. Demonstrate the application, inflation, and correct sequence of deflation of the pneumatic anti-shock garment (PASG).

13. Demonstrate the technique for calculating dosage and drawing up a designated volume of medication in a syringe from an ampule or vial.

14. Demonstrate the technique for administering drugs using a prepackaged disposable syringe.

15. Demonstrate technique of subcutaneous, intradermal, intramuscular, intravenous, and intra tracheal administration of drugs.

16. *Note: In addition, EMT - Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route-that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.*

17. EMT-Paramedics should be familiar with all of the 41 classifications of medications as defined by the 1998 EMT-Paramedic National Standard Curriculum. Paramedics must be able to list indications, contraindications, actions, dosage, and route of administration of each of the fluids and medications on the "Approved and Required EMS Fluids and Drugs List" as compiled by the BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA).

18. Demonstrate the technique of aseptic and atraumatic endotracheal and tracheotomy suctioning.

19. Recall the indications for and demonstrate the insertion of an esophageal obturator and esophageal gastric tube airway.

20. Demonstrate the technique for direct laryngoscopy and insertion of an endotracheal tube and end-tidal CO2 detection in an adult and infant.

21. Demonstrate the technique for insertion of a nasotracheal tube using the blind technique and by direct laryngoscopy with use of Magill forceps.

22. Demonstrate the application of electrodes and monitoring of a patient's electrocardiographic activity.

23. Identify on Lead II or modified chest lead - 1 (MCLl) and provide appropriate therapy (according to American Heart Association) for the following cardiac rhythms:

    a. normal sinus rhythm

    b. sinus arrhythmia

    c. sinus arrest

    d. sinus bradycardia

    e. premature atrial contractions

    f. premature junctional contractions

    g. supraventricular tachycardia

h. atrial fibrillation

i. atrial flutter

j. first degree heart block

k. second degree heart block

l. third degree heart block

m. premature ventricular contractions

n. ventricular tachycardia

o. ventricular fibrillation

p. electromechanical dissociation

q. asystole

r. pacemaker rhythms

s. PVC recognition

t. Artifact

24. Demonstrate the proper use of the defibrillator paddle electrodes to obtain a sample Lead II rhythm strip

25. Demonstrate how to properly assess the cause of poor ECG tracing.

26. Demonstrate correct operation of a monitor-defibrillator to perform defibrillation on an adult and infant.

27. Demonstrate correct operation and indications for an external non-invasive pacemaker (optional).

28. Apply rotating tourniquets in cases of acute heart failure.

29. Demonstrate proficiency in:

a. biomedical communications, VHF and UHF (RTSS)

b. ECG telemetry

c. medicolegal responsibilities

d. record keeping

e. emergency and defensive driving

f. principles and techniques of light extrication

g. management of mass casualties and triage

30. In addition to the above skills, the EMT-Paramedic and the EMT-Intermediate should be well versed in pertinent anatomy, pathophysiology, history taking, physical examination, assessment and emergency treatment relating to:

a. the cardiovascular system including recognition of selected dysrhythmias associated with potential acute cardiac compromises;

b. the respiratory system, including pneumothorax, chronic obstructive pulmonary disease, acute asthma, trauma to the chest and airways, respiratory distress syndrome, and acute airway obstruction;

c. chest and abdominal trauma;

d. soft tissue injuries including: burns, avulsions, impaled objects, eviscerations, amputations, and bleeding control;

e. the central nervous system (medical) in regard to cerebrovascular accidents, seizures, drug overdose, drug incompatibilities, and alterations in levels of consciousness;

f. musculoskeletal trauma including management of fractures, strains, sprains and dislocations;

g. medical emergencies, including: endocrine disorders, anaphylactic reactions, environmental emergencies, poisonings, overdose and acute abdomen;

h. obstetrical and gynecological emergencies including: breech birth, premature birth, abortion, multiple-infant birth, arm or leg presentation, prolonged delivery, prolapsed umbilical cord, pre- and postpartum hemorrhage, ruptured uterus, birth of an apenic infant, preeclampsia or eclampsia, rape, and supine hypotensive syndrome;

i. pediatric emergencies, including: asthma, bronchiolitis, croup, epiglottis, sudden infant death syndrome, seizures, child abuse;

j. behavioral emergencies, including: negotiations, recognition and intervention techniques with suicidal assaultive, destructive, resistant, anxious, bizarre, confused, alcoholic, drug-addicted, toxic, amnesic, paranoid, drugged, raped and assaulted patients.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.25.2 Optional skills: Performances of these skills are optional however, they must be taught in all training programs.

1. Administration of transfusions of blood and its components.

2. Automatic Transport Ventilators (as specified in UJAMA, Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiac CareU).

3. CPap and BiPap Initiation and Management

4. Chest decompression

5. External cardiac pacing

6. INT Placement

7. Pediatric and Adult Intraosseous infusion

8. *Note: EMT - Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.*

9. MSDH approved Nitroglycerin and Thrombolytic Transport Course

10. Nasogastric Tube Insertion

11. Orogastric Tube Insertion

12. Percutaneous transtracheal catheter ventilation

13. Twelve Lead Electrocardiography

14. Umbilical Vein Cannulation

15. Vascular Access Devices

16. Drug Assisted Intubation, using benzodiazepine class drugs, in strict adherence with the following measures:

    a. A specific verbal order from online medical direction must be obtained to institute DAI;

    b. Initiate and continue, before, during and after each DAI, continuous monitoring and recording of heart rate and rhythm, oxygen saturation, and end-tidal carbon dioxide using a capnography or capnometric device (to exclude colormetric only devices);

c. Appropriate resources for drug storage and delivery must be present and used;

d. DAI protocols must contain continuing quality assurance, quality control and performance review measures, and when indicated, supplemental training;

e. DAI protocols must include requirements for initial training and continuing education in:

i. Proper patient selection for DAI;

ii. Demonstrating initial and continuing competency in the DAI procedure;

iii. Confirming initial and verifying ongoing tube placement, including training in the utilization of appropriate instrumentation;

iv. Airway management of patients who cannot be intubated;

v. The use of backup rescue airway methods in the event of failed DAI.

vi. Every instance of the initiation or attempted initiation of an airway by DAI shall be reported to BEMS by the local EMS on forms or in a format approved by BEMS. Every instance of the institution or attempted institutionof an airway by DAI shall be reviewed by the State Medical Director, who shall submit a quarterly report to MDTQA and the EMS Advisory Council.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.25.3 Other skills

1. Other skills and medications not listed in these regulations may not be performed by any ALS provider through ALS trained employees until each skill and/or medication has been approved by BEMS in writing.

2. EMTs of all levels may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

a. there is no need, or reasonably perceived need, for the device or procedure during transport; or

b. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

c. *Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.*

d. The Paramedic who functions within the State of Mississippi must be able to demonstrate the following skills and understand the elements of total emergency care to the satisfaction of the local training coordinator and the BEMS. Training programs must be approved by the BEMS and the Department of Education. The skills listed herein will enable the Paramedic to carry out all Paramedic level patient assessment and emergency care procedures.

e. The Paramedic's primary responsibility is to the patient and should include both an oral exam and an appropriate physical exam. Scene size-up including: scene safety, mechanism of injury, number of patients, additional help and consideration of cervical stabilization.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 26 Performance Standards for Paramedic (After March 31, 2014)

Rule 7.26.1 The Paramedic who functions within the State of Mississippi, must be able to demonstrate the skills as listed in the National EMS Education Standards – Paramedic Instruction Guidelines and the 2011 Mississippi Curriculum Framework – Postsecondary Paramedic to the satisfaction of the EMS medical director and the BEMS, Mississippi State Department of Health, to meet criterion established for advanced life support personnel.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.26.2 Skills within the Scope of Practice for a Mississippi Paramedic include the following:

1. All skills listed in Performance Standards for EMT
2. Airway – esophageal; Airway – supraglottic
3. BiPAP/CPAP initiation and monitoring
4. Chest Decompression
5. Chest Tube Monitoring and management
6. Cricothyrotomy - needle; Cricothyrotomy - percutaneous
7. End Tidal CO2 monitoring/capnography
8. Gastric Decompression – NG Tube; Gastric Decompression – OG Tube
9. Intubation – nasotracheal; Intubation – orotracheal

10. Obstruction – direct laryngoscopy

11. PEEP – therapeutic;

12. Suctioning – tracheobronchial

13. Cardiac Monitoring – multi-lead (interpretive); Cardiac Monitoring – single lead (interpretive);

14. Cardioversion – electrical

15. Carotid massage;

16. Internal; cardiac pacing – monitoring only

17. Transcutaneous Pacing – manual;

18. Medication Administration Routes: Aerosolized/nebulized (beta agonist); Buccal; Endotracheal tube; Inhaled- self-administered (nitrous oxide); Intramuscular (epinephrine or glucagons); intranasal (naloxone); intravenous push (naloxone, dextrose 50%); intravenous piggyback; Nasogastric; Rectal; Subcutaneous (epinephrine);

    a. *NOTE: The BEMS and the Committee on Medical Direction, Training, and Quality Assurance (MDTQA) will compile a list of intravenous fluids and medications that may be initiated and transported by EMS providers in the State. The current list of fluids and medications approved for initiation and transport by Mississippi EMS providers is available from the BEMS office or the BEMS website(www.health.ms.gov).*

    b. Requests for additions or deletions from the list should be made in writing by the System Medical Director to the BEMS. Requests should detail the rationale for the additions, modifications, or deletions.

19. Access indwelling catheters and implanted central IV ports;

20. Central Line – monitoring;

21. Intraosseous – initiation;

22. Intravenous access;

23. Intravenous initiation – peripheral;

24. Intravenous – maintenance of non-medicated IV fluids; Intravenous – maintenance of medicated IV fluids;

25. Blood Glucose monitoring;

26. Eye irrigation – Morgan Lens;

27. Thrombolytic therapy – initiation; Thrombolytic therapy – monitoring;

28. Venous blood sampling;

29. Blood chemistry analysis.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.26.3 Optional skills: Performances of these skills are optional however, they must be taught in all training programs.

1. Administration of transfusions of blood and its components.

2. Percutaneous transtracheal catheter ventilation

3. Umbilical Vein Cannulation

4. Drug Assisted Intubation, using benzodiazepine class drugs, in strict adherence with the following measures:

    a. A specific verbal order from online medical direction must be obtained to institute DAI;

    b. Initiate and continue, before, during and after each DAI, continuous monitoring and recording of heart rate and rhythm, oxygen saturation, and end-tidal carbon dioxide using a capnography or capnometric device (to exclude colormetric only devices);

    c. Appropriate resources for drug storage and delivery must be present and used;

    d. DAI protocols must contain continuing quality assurance, quality control and performance review measures, and when indicated, supplemental training;

    e. DAI protocols must include requirements for initial training and continuing education in:

        i. Proper patient selection for DAI;

        ii. Demonstrating initial and continuing competency in the DAI procedure;

        iii. Confirming initial and verifying ongoing tube placement, including training in the utilization of appropriate instrumentation;

        iv. Airway management of patients who cannot be intubated;

v. The use of backup rescue airway methods in the event of failed DAI;.

vi. Every instance of the initiation or attempted initiation of an airway by DAI shall be reported to BEMS by the local EMS on forms or in a format approved by BEMS. Every instance of the institution or attempted institution of an airway by DAI shall be reviewed by the State Medical Director, who shall submit a quarterly report to MDTQA and the EMS Advisory Council.

5. Other skills: Other skills and medications not listed in these regulations may not be performed by any ALS provider through ALS trained employees until each skill and/or medication has been approved by BEMS in writing.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.26.4 EMT and Paramedics, may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

1. there is no need, or reasonably perceived need, for the device or procedure during transport; or

2. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

3. *Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Subchapter 27 Area and Scope of Practice of the Paramedic

Rule 7.27.1 ALS personnel are restricted to functioning within the geographic boundaries of their licensed ALS service employer. They primarily provide out-of-hospital emergency care to acutely ill or injured patients while on duty for a licensed ALS provider under medical command authority approved by the BEMS. This does not apply to extended transports which may require EMS personnel to function outside of said boundaries.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.27.2 Paramedics may routinely or periodically participate in patient care in the emergency department of a licensed hospital. Their presence may be in the form of:

1. student clinical rotations

2. graduates participating in a clinical rotation for skill retention.

3. field units stationed out of the emergency department under direct physician supervision (i.e., hospital based ALS services). BEMS Certified Paramedics will be able to function in the emergency service area of the hospital. They would also be permitted to function in life-threatening emergency situations in other areas of the hospital if directed to do so by the medical command authority.

4. providing assistance to the emergency department staff after delivering a patient.

5. **NOTE: In accordance with letter B,* Paramedics *must, when functioning in the hospital, only do so under the direct supervision of a physician. This is necessary because the scope of practice of an* Paramedics *does not coincide with that of any other licensed personnel. Paramedics of a hospital owned and based ambulance service may function in the Emergency Department under the direct supervision of a Mississippi licensed physician, physically located in Mississippi, via telemedicine. Paramedics may not function in other areas of hospitals which do not have on-site 24 hour physician availability.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.27.3 Paramedics students may function in all areas of a hospital, under direct supervision of licensed or certified personnel, in a continuing education program or in a training program approved by the licensed ALS service.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.27.4 Paramedics P may perform only those skills authorized by the BEMS regulations relating to their certification.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.27.5 Because the Paramedic's primary responsibility is to respond to emergency situations outside the hospital, they cannot be utilized to replace any members of the hospital emergency service area staff, but may be utilized to support and assist the staff in the care of patients in accordance with their performance standards. Since their scope of practice is limited to a number of specific procedures, which can only be performed under the direction of a physician, all emergency patients clearly require nursing intervention in order to insure that all the patients' needs are met.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.27.6 It is appropriate to transport patients whose urgent needs or reasonably perceived needs for care exceed the scope of practice for the ambulance attendant, if the following conditions are present:

1. The patient has existing advanced therapeutics or treatment modalities for a preexisting condition and

2. The patient is located in a non-hospital setting, and

3. The patient's condition is considered to be so urgent that the benefits of prompt transport by available personnel to an appropriate hospital outweigh the increased risk to the patient from affecting a delay waiting for qualified medical personnel to arrive.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.27.7 The person possessing the highest level of certification/license must attend the patient unless otherwise authorized by medical control.

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Rule 7.27.8 EMTs of all levels, may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:

1. there is no need, or reasonably perceived need, for the device or procedure during transport; or

2. an individual (including the patient himself) that has received training and management of the procedure or device accompanies the patient to the destination.

3. *Note: Should doubt exist in regards to the transport of any device or procedure, medical control should be contacted for medical direction.*

SOURCE: Miss. Code Ann. §41-59-5; Miss. Code Ann. §41-60-13

Chapter 8 Emergency Medical Services Operating Fund (EMSOF)

Subchapter 1 Eligibility

Rule 8.1.1 Applicants are restricted to counties, municipalities and emergency medical service districts formed and recognized pursuant to §41-59-53 through §41-59-59. Political subdivisions are not eligible to receive Emergency Medical Services Operating Funds (EMSOF).

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.1.2 To be eligible for EMSOF, in part, governmental units must have expended from local funds directly to the ambulance service, at minimum, an amount equal to or greater than $0.15 per capita, with population computed from the most current federal census, in the year the EMSOF was collected. For governmental units that own and operate governmental ambulance service, to be eligible, in part, the

governmental unit must show equal to or greater than $0.15 per capita, with population computed from the most current federal census, in the year the EMSOF fund was collected.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 Process

Rule 8.2.1 Applications for EMSOF will be forwarded to applicants receiving EMSOF funds for the prior year. Other counties, municipalities and legal EMS districts wishing to receive applications shall submit, in writing, a request for application on or before October 1 of the year in which they plan to request EMSOF. Original applications, as provided by BEMS, for EMSOF must be received at the Bureau of Emergency Medical Services office by 5:00 PM on the second Friday of November each year. Applications received after this date will not be processed.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.2.2 Applications for EMSOF must have satisfactory proof of the maintenance of the funding effort by the governmental unit in the form of a line item local fund expense for ambulance in the fiscal year in which EMSOF funds were collected. Satisfactory proof must also be provided in the form of a line item budget of local funds for ambulance in the fiscal year that EMSOF is being requested.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.2.3 It is important that applicants create their EMSOF applications with input from their licensed ambulance service provider and/or county EMS regulatory programs. Evidence of this collaboration will be a memorandum or letter of support for the application from the licensed ambulance service provider(s) and/or county EMS regulatory programs and must be attached to the EMSOF application. Applications received by BEMS without these memorandum or letters of support will be returned without action.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.2.4 Applications must be signed by:

1. Counties: Chancery Clerk, County Administrator or President Board of Supervisors

2. Municipalities: Mayor

3. EMS Districts: District Administer or President of the Board.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.2.5 Applicants are required to attend an "EMSOF grantee meeting" to be held in their public health region before grant approval.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.2.6 All EMSOF funds must be deposited into the governmental units' treasury. Items purchased with EMSOF funds must be purchased in the name of the governmental unit. The Governmental unit must follow its existing rules for the purchasing, inventory and disposal of these items. A sticker which states "This equipment purchased by the citizens of the State of Mississippi" shall identify equipment purchased with EMSOF funds.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Eligible Uses of EMSOF Funds

Rule 8.3.1 EMSOF must be used for improvements in the Bureau of Emergency Medical Services regulated Emergency Medical Services and may not be used for operating expenses. All EMSOF funds must be expended or escrowed by the end of the local fiscal year in which the EMSOF funds were disbursed to the governmental unit. "Escrow" is defined as depositing the funds in an interest-bearing account in accordance with Miss. Code Ann. §27-105-1, et seq. and applicable state fiscal and financial control regulations, said funds to be used only in accordance with the provisions of the EMSOF grant. No funds granted hereunder may be escrowed for more than three (3) years. All expenditures of funds from an EMSOF grant must be done in accordance with Mississippi purchasing and property accounting laws, rules and regulations. A detailed justification for all EMSOF expenditures or funds escrowed, indicating their compliance with purchasing laws and regulations, as well as how they will improve local emergency medical services, must be provided.

1. EMSOF must be expended to the direct benefit of a Mississippi Licensed Ambulance Service (as described in Chapter 59 of the Mississippi Code Ann.). These funds may not be used in support of "EMS Support Services" including, but not limited to, the following

2. local or county fire service rescue operations, and

3. local or county first responders other than training, medical supplies, or medical equipment to be used for direct patient care.

4. Additionally, EMSOF may not be used for hospital equipment or supplies. If a licensed ambulance service is hospital-based, EMSOF funds can only be used for items that are to the direct benefit of the hospital-based licensed ambulance service. The director of the hospital-based licensed ambulance service must indicate by memorandum or letter of support that the request will provide direct benefit to the hospital-based licensed ambulance service.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.3.2 Personnel Expenses. EMSOF may be used to pay payroll and benefit differential pay for governmental units for the first year that a governmental unit applies to the BEMS to improve~~s~~ its' level of ambulance service licensure. No other personnel expenses are allowed under EMSOF.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.3.3 Regionalization. EMSOF may be used to pay dues to an EMS district formed and recognized pursuant to §41-59-53 through §41-59-59, for regional medical control, training, or improvements in Bureau of Emergency Medical Services. Based on support of the licensed ambulance service, EMSOF may also be used for governmental support of trauma care systems.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.3.4 Training. EMSOF may be used for initial training or continuing education of EMS Drivers, EMT-Basic, EMT-Intermediate, or EMT-Paramedic. EMSOF may not be used for the initial training of first responders. These funds may be used for re-certification of Medical First Responders (as regulated by the Bureau of EMS).

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.3.5 Commodities. EMSOF may be used for the purchase of commodities that improve local Emergency Medical Services. EMSOF may not be used to purchase any commodities that will be billed to a patient. Applicant must show that the requested commodity is a direct benefit to the licensed ambulance service. This must be acknowledged by the county recognized lead licensed ambulance service director by letter or memorandum of support.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.3.6 Equipment. EMSOF may be used to purchase equipment or capital outlay items that improve local Emergency Medical Services. Equipment purchased with EMSOF by a governmental unit must appear on the governmental units equipment inventory and be accounted for in accordance with State of Mississippi property inventory laws, rules and regulations. This is not intended to limit the temporary use of equipment in adjacent counties or jurisdictions within Mississippi or during patient transport either inside or outside the state. Applicant must show that the requested equipment is a direct benefit to the licensed ambulance service. This must be acknowledged by the county recognized lead licensed ambulance service director by letter or memorandum of support.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.3.7 Escrow. EMSOF may be escrowed (up to a maximum of three years) for local improvements in Emergency Medical Services regulated by the Bureau of Emergency Medical Services. (Example: Purchasing a new ambulance or radio system that cost more than grant amount.) Grant awards may be escrowed up to three years from the disbursement. All escrow amounts and interest must be fully expended by the end of the fourth grant year. (Example: ABC County received $10,000 in EMSOF for FY2008, $10,000 for FY2009 and $10,000 for FY2010 and wishes to replace a high mileage ambulance that will cost $40,400. ABC County received $10,000 in EMSOF for FY 2011 and must fully expend the $40,000 plus interest accrued on escrowed amounts prior to the end of the governmental fiscal year for FY2011.) Escrow funds not fully expended by the end of the fourth grant year must be returned to the State. All interest posted must be reported and expended consistent with these regulations.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Reports

Rule 8.4.1 Prior to EMSOF proceeds being distributed to any governmental unit, proof or proper expenditure of EMSOF in the previous year, if applicable, must be submitted to include the signature of the signing authority of the governmental unit indicating all expenditures were made properly.

SOURCE: Miss. Code Ann. §41-59-5

Rule 8.4.2 The director of the Bureau of Emergency Medical Services or his designee will perform random program reviews of governmental units to assure that EMSOF law, rules, regulations and policies are followed.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 Appeal Process

Rule 8.5.1 Any county, municipality or organized medical service districts whose application for EMSOF has been rejected shall have the right to appeal such decision, within thirty (30) days after receipt of the Bureau of Emergency Medical Services' written decision, to a hearing officer who will make a final recommendation to the State Health Officer.

SOURCE: Miss. Code Ann. §41-59-5

Title 15: Mississippi Department of Health

Part 12: Bureau of Emergency Medical Services

Subpart 32: Trauma System

Chapter 1 Mississippi Trauma Care System

Subchapter 1 General

Rule 1.1.1. Legal Authority: The Mississippi State Department of Health (the Department) is assigned the responsibility for creating, implementing and managing the statewide trauma care system. The Department shall be designated as the lead agency for trauma care system development. The Department shall develop and administer trauma regulations that include, but are not limited to, the Mississippi Trauma Care System Plan, trauma system standards, trauma center designations, field triage, inter-facility trauma transfer, pediatric trauma care, burn care, trauma data collection, trauma care system evaluation and management of state trauma system funding. The Department shall promulgate regulations specifying the methods and procedures by which Mississippi-licensed acute care facilities shall participate in the statewide trauma system. Those regulations shall include mechanisms for determining the appropriate level of participation for each facility or class of facilities. The Department shall also adopt a schedule of fees to be assessed for facilities that choose not to participate in the statewide trauma care system, or which participate at a level lower than the level at which they are capable of participating. The Department shall take the necessary steps to develop, adopt and implement the Mississippi Trauma Care System Plan and all associated trauma care system regulations necessary to implement the Mississippi trauma care system. The Department shall cause the implementation of both professional and lay trauma education programs. These trauma educational programs shall include both clinical trauma education and injury prevention. As it is recognized that rehabilitation services are essential for traumatized individuals to be returned to active, productive lives, the Department shall coordinate the development of the inclusive trauma system with the Mississippi Department of Rehabilitation Services and all other appropriate rehabilitation systems.

Source: Miss. Code Ann. § 41-59-5

Rule 1.1.2. Mississippi Trauma Advisory Committee: The Mississippi Trauma Advisory Committee (MTAC) is created as a committee of the Emergency Medical Services Advisory Council. The membership of the MTAC is comprised of the members of the Emergency Medical Services Advisory Council (EMSAC); the members of which are appointed by the Governor. The Chairman of EMSAC, the State Health Officer, shall appoint EMSAC members to the MTAC. This committee shall act as the advisory body for trauma care system development, and provide technical support to the department in all areas of trauma care system design, trauma standards, data collection and evaluation, continuous quality

improvement, trauma care system funding, and evaluation of the trauma care system and trauma care programs.

Source: Miss. Code Ann. § 41-59-7

Rule 1.1.3. Mississippi Trauma Advisory Committee Meetings: The Mississippi Trauma Advisory Committee (MTAC) shall meet at least quarterly and report to the State Board of Health at its regularly scheduled meetings on the performance of Trauma System. For attendance at such meetings, the members of the MTAC shall be reimbursed for their actual and necessary expenses including food, lodging and mileage as authorized by law, and they shall be paid per diem compensation. Source: Miss. Code Ann. § 41-59-7; Miss. Code Ann. § 25-3-41; and Miss. Code Ann. § 25-3-69.

Source: Miss. Code Ann. § 41-59-5

Rule 1.1.4. **Definitions:** For the purposes of the Mississippi Trauma Care System, the following abbreviations, acronyms, and terms shall be defined as listed.

1. ACEP - American College of Emergency Physicians

2. ACLS - Advanced Cardiac Life Support.

3. ACSCOT - American College of Surgeons Committee on Trauma.

4. AIS - Abbreviated Injury Scale.

5. ALS - Advanced life support, including techniques of resuscitation, such as, intravenous access, and cardiac monitoring.

6. APLS - Advanced Pediatric Life Support.

7. ATCN – Advanced Trauma Care for Nurses. A course designed for the registered nurse interested in increasing his/her knowledge in management of the multiple trauma patient.

8. ATLS - Advanced Trauma Life Support.

9. Alpha Patient – A trauma patient meeting the criteria for an Alpha (major trauma or critically injured) Alert/Activation (refer to Appendix B).

10. BEMS – Bureau of Emergency Medical Services, Mississippi State Department of Health.

11. BLS - Basic life support techniques of resuscitation, including simple airway maneuvers, administration of oxygen, and intravenous access.

12. Board Certified - Physicians and oral/maxillofacial surgeons certified by appropriate specialty boards recognized by the American Board of Medical Specialties and the Advisory Board of Osteopathic Specialties and the American Dental Association.

13. Burn Fund – Mississippi Burn Care Fund established under Miss. Code Ann. § 7-9-70.

14. BTLS - Basic Trauma Life Support.

15. Bravo Patient – A trauma patient not meeting the criteria for an Alpha Alert/ Activation, however, has received injuries requiring immediate attention (refer to Appendix B).

16. Bypass (diversion) - A medical protocol or medical order for the transport of a trauma patient past a normally used EMS receiving facility to a designated medical facility for the purpose for accessing more readily available or appropriate medical care.

17. CAP – Corrective Action Plan.

18. CCRN - Critical Care Registered Nurse.

19. CEN - Certified Emergency Nurse.

20. Catchment Area - Geographic area served by a designated Trauma Center for the purpose of regional trauma care system planning, development and operations.

21. Department - Mississippi State Department of Health, Bureau of Emergency Medical Services, Division of Trauma.

22. Designation - Formal recognition of hospitals by the Department as providers of specialized trauma services to meet the needs of the severely injured patient.

23. E&D – Essential and Desirables chart for each Trauma Center designation level.

24. Emergency Department (or Emergency Room) - The area of an acute care hospital that customarily receives patients in need of emergency medical evaluation and/or care.

25. EMS - Emergency Medical Services.

26. EMSAC – Emergency Medical Services Advisory Council.

27. ENA - Emergency Nurses Association.

28. Field Triage - Classification of patients according to medical need at the scene of an injury or onset of an illness.

29. GCS - Glasgow Coma Scale.

30. Immediately (or immediately available) - (a) unencumbered by conflicting duties or responsibilities; (b) responding without delay when notified; and (c) being within the specified resuscitation area of the Trauma Center when the patient is delivered or when notified by EMS that a patient is enroute, whichever is shorter. Specific times for each physician specialty are in the applicable Trauma Center level chapter.

31. Inclusive Trauma Care System - a trauma care system that incorporates every health care facility within a community in a system in order to provide a continuum of services for all injured persons who require care in an acute care facility; in such a system, the injured patient's needs are matched to the appropriate hospital resources.

32. Injury - the result of an act that damages, harms, or hurts; unintentional or intentional damage to the body resulting from acute exposure to thermal, mechanical, electrical or chemical energy or from the absence of such essential as heat or oxygen.

33. Injury Prevention - efforts to forestall or prevent incidents that might result in injuries.

34. ISS - Injury Severity Score.

35. Level I Trauma Centers - Hospitals that have met the requirements for Level I as stated in Chapter 2 and are designated by the Department.

36. Level II Trauma Centers - Hospitals that have met the requirements for Level II as stated in Chapter 3 and are designated by the Department.

37. Level III Trauma Centers - Hospitals that have met the requirements for Level III as stated in Chapter 4 and are designated by the Department.

38. Level IV Trauma Centers - Hospitals that have met the requirements for Level IV as stated in Chapter 5 and are designated by the Department.

39. Medical Control - Physician direction over pre-hospital activities to ensure efficient trauma triage, transportation, and care, as well as ongoing quality management.

40. Mid-level Providers/Practitioners – Physician Assistant (PA) and/or Nurse Practitioners (NP)

41. Mississippi Trauma Care System Plan - A formally organized plan developed by the Department which sets out a comprehensive system of prevention and management of major traumatic injuries.

42. Multidisciplinary Trauma Committee - committee composed of the trauma service Director, other physician members and other members appointed by the Trauma Medical Director that reviews trauma deaths in a system or hospital.

43. MTAC - Mississippi Trauma Advisory Committee.

44. Non-Designated Hospital - A licensed acute care hospital that has applied for designation as a Trauma Center, but has not been designated by the Department.

45. Non-Participating Hospital – A licensed acute care hospital that has informed the Department that they do not desire to participate in the Trauma Care System, or a hospital that does not have a current designation or application for designation on file with the Department.

46. On-Call - Available to respond to the Trauma Center in order to provide a defined service.

47. PALS - Pediatric Advanced Life Support.

48. Pediatric Trauma Center - Hospitals that have met the requirements for Primary, Secondary, or Tertiary Pediatric Trauma Center as stated in Chapter 6 and has been designated by the Department.

49. PHTLS – Pre-Hospital Trauma Life Support.

50. Promptly (or promptly available) – Arrival of on-call physician specialists within the trauma receiving resuscitation area, emergency department, operating room, or other specified area of the Trauma Center within a maximum of 60 minutes from the time of notification to respond.

51. Performance Improvement (PI or Quality Improvement) - A method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome.

52. Regional Trauma Plan - A document developed by the various Trauma Care Regions, and approved by the Department, which describes the policies, procedures and protocols for a comprehensive system of prevention and management of major traumatic injuries in a specific geographic region.

53. Rehabilitation - Services that seek to return a trauma patient to the fullest physical, psychological, social, vocational, and educational level of functioning of which he or she is capable, consistent with physiological or anatomical impairments and environmental limitations.

54. Research - Clinical or laboratory studies designed to produce new knowledge applicable to the care of injured patients.

55. Residency Program - A residency program of the Trauma Center or a residency program formally affiliated with the Trauma Center where senior residents can participate in educational rotations.

56. RTC – Rural Trauma Course.

57. RTS - Revised Trauma Score, a pre-hospital/trauma center scoring system in which numerical values are assigned to differing levels of Glasgow Coma Scale, systolic blood pressure, and respiratory rate.

58. Senior Resident (or "senior level resident") - A physician licensed in the State of Mississippi who has completed at least two years of the residency under consideration and has the capability of initiating treatment, when the clinical situation demands, and who is in training as a member of the residency program, as defined in regulation, at a designated Trauma Center. Residents in general surgery shall have completed three clinical years of general surgery residency in order to be considered a senior resident.

59. Service Area (or "catchment area") - Geographic area defined by the local EMS agency in its Regional Trauma Plan as the area served by a designated Trauma Center.

60. SHO – State Health Officer.

61. TCR - Trauma Care Region; a geographic area of the state formally organized, in accordance with standards promulgated by the department and has received designation from the department, for purposes of developing and inclusive care system.

62. TCTF – Trauma Care Trust Fund.

63. TMD - Trauma Medical Director; a physician designated by the Trauma Center to coordinate trauma care.

64. TNCC – Trauma Nursing Core Course.

65. TPM - Trauma Program Manager; a designated RN with responsibility for coordination of all activities on the trauma service and works in collaboration with the TMD.

66. Trauma Registry - a database program managed by the Department that hospitals use to track treatment of trauma victims.

67. Trauma Team - A group of health care professionals organized to provide care to the trauma patient in a coordinated and timely fashion. The composition of a trauma team is delineated by hospital policy.

68. Triage - the process of sorting injured patients on the basis of the actual or perceived degree of injury and assigning them to the most effective and efficient trauma care resources, in order to insure optimal care and the best chance of survival (refer to Appendix C).

69. TSA – Trauma System Administrator.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Designation of Trauma Centers

Rule 1.2.1. **Application for Trauma Center Designation:** All Mississippi licensed hospitals with a functioning emergency department must apply for trauma center designation. Hospitals that potentially may be Level IV Trauma Centers may elect not to participate in the system, however, state funding for trauma care is available only to designated hospitals which are actively participating in the Trauma Care System. To receive designation as a Trauma Center, an applicant hospital shall forward a letter of intent to the Department, accompanied by a complete original and two copies of the Department's "Application for Trauma Center Designation". Within 30 days of receipt of the application, the Department shall provide written notification to the applicant hospital that the application has been received by the Department; whether the Department accepts or rejects the application; if accepted, the date scheduled for a consultative visit or a hospital inspection; if rejected, the reasons for rejection and a deadline for submission of the corrected "Application for Trauma Center Designation" to the Department.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.2. Trauma Center Consultative Visit:

1. An applicant hospital may request a Consultative Visit of its facilities. This visit is used to assist the applicant hospital in preparation for a Trauma Center inspection. Results of Trauma Center Consultative Visits will be provided by the Department in writing to the applicant hospital. These results will be held in confidence by the Department. The Department will work with, and provide

assistance to, the applicant hospital to correct any deficiencies noted during the Consultative Review.

2. If an applicant hospital requests a Trauma Center inspection without having first received a Consultative Visit and the hospital fails to meet designation criteria, the inspection shall be deemed a Consultative Visit. Any subsequent inspection for designation as a Trauma Center will be at the hospital's expense.

3. A Consultative Visit, regardless of outcome, confers no designation status upon the applicant hospital. A hospital, having completed a Consultative Visit, may apply for a Trauma Center inspection at any time after receiving the report from the Consultative Review.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.3. Trauma Center Inspections

1. The Department shall provide for the inspection of the applicant hospital, provided that its application has been formally approved by the Department, on the date scheduled and indicated in the Department's acceptance letter to the applicant hospital, unless the Department provides written notification with justification of change to the applicant hospital no later than 14 days prior to the inspection date; or the applicant hospital provides written request with justification for a change in the inspection date to the Department no later than 30 days prior to the inspection date.

2. Results of Trauma Center inspections will be provided by the Department in writing to each applicant hospital. Details related to hospital's inspection will be considered confidential and will not be released.

3. No inspection or designation process provided by any other agency, organization, or group maybe substituted for a Department inspection.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.4. Level I, II, and III Trauma Center Inspections

1. The Department shall provide multidisciplinary teams for all on-site Trauma Center inspections.

2. Trauma Center Inspection Teams shall consist of disciplines as follows:

   a. Level I and II Trauma Centers: As a minimum, teams shall consist of the following representative disciplines: trauma surgeon, emergency physician, and trauma nurse. The Department may add additional team members as necessary. All members of teams for Level I and II Trauma

Center inspections shall reside and practice outside the State of Mississippi.

b. Level III Trauma Centers: As a minimum, teams shall consist of the following representative disciplines: trauma surgeon and trauma nurse. One member of each Level III team must reside and practice out of the State of Mississippi. The remaining member(s) may reside and practice in Mississippi; however, they may not practice in any hospital or reside in any area of the trauma care region in which the applicant hospital is located.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.5. Level IV Trauma Center Inspections: The Level IV trauma center inspection process shall consist of a review of the completed trauma center application, compliance with all of the "Essential" elements listed in the Mississippi Trauma Care Regulations Essential and Desirables Chart, and satisfactory review of specific trauma registry data reports as identified in the trauma center application. These documents shall be reviewed off-site by the Department's Division of Trauma staff. If the information contained in the completed application and the trauma registry data reports do not demonstrate compliance with the Mississippi Trauma Care Regulations, there will be a request for additional information and an opportunity to supply supplementary data/information for review. If this additional information does not demonstrate compliance with the Mississippi Trauma Care Regulations, an on-site survey inspection may be scheduled. At a minimum, the on-site team shall consist of one member of the Division of Trauma and one of the following representative disciplines: a physician specializing in trauma/emergency medicine or a trauma nurse. The member of the inspection team that is not a Division of Trauma staff member may reside and practice in Mississippi, however; they may not practice in any hospital or reside in any area of the trauma care region in which the applicant hospital is located.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.6. Categories of Trauma Center Designations

1. Complete Designation: The hospital has completed all of the requirements for designation at their application level.

2. Complete Designation with Conditions: The hospital has completed all of the requirements for Complete Designation at their application level with the exception of minor (no patient or operational impact) condition(s). This designation category may be used for initial designations or an interim change in status from Complete Designation due to a temporary loss of a capacity or capability.

3. Any hospital receiving written notification of Complete Designation with Conditions must immediately notify the Trauma Care Region and submit to the Department within thirty (30) days from the receipt of notification a written Corrective Action Plan (CAP) including time lines for completion. The Department, upon receipt, shall either approve or disapprove the plan within thirty (30) days. The Department may require a "Focused Survey" with an inspection team to review the hospitals' CAP for complete implementation. If the Focused Survey team deems the CAP fully implemented, the hospital will receive Complete Designation.

4. No Designation: The hospital has failed to meet the requirements for Complete Designation with Conditions at their application level. Any hospital receiving notice of failure of their Trauma Center inspection shall immediately notify the Trauma Care Region and all pre-hospital providers who routinely transport trauma patients to the hospital of the lack of a Trauma Center designation. Any hospital receiving a No Designation notice shall no longer be permitted to act as, nor be permitted to advertise itself as, a Trauma Center.

5. The hospital shall, within ten (10) working days of notification of No Designation, submit a written CAP, including correction time lines to the Department. Upon receipt of the plan, the Department shall either approve or disapprove the plan within ten (10) working days.

6. Upon completion of the CAP, the hospital shall notify the Department and request a verification visit. The Department shall conduct a focused survey of the hospital to verify completion of the CAP and compliance with regulations. The Department may, subsequently, reinstate the hospital to its original Trauma Center status (if any) or designate the hospital as a Trauma Center (Complete or Complete with Conditions). In addition, the appropriate fee associated with the unmet capability commensurate with the facilities annual assessment shall be made to the Trauma Care Trust Fund (TCTF).

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.7. Appeal Process for Failing a Trauma Center Inspection: If a hospital fails a trauma center inspection, the hospital shall have 30 days from the date of notification of the failure to appeal the decision in writing to the Department. The Department shall make a determination within three months of receipt of the appeal. The Department will provide the hospital with a written report of its decision. If the decision of the Department is unfavorable to the hospital, the hospital may request to be inspected for trauma center designation at another level, but must pay all costs associated with the inspection. In addition, the appropriate fee associated with the unmet capability commensurate with the facilities annual assessment shall be made to the Trauma Care Trust Fund (TCTF).

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.8. Term of Trauma Center Designations: The department shall designate Trauma Centers for a period not to exceed three (3) years. Designations shall remain active for three years provided no substantive changes or variances have occurred. The Department (and Trauma Care Regions for Level IV Trauma Centers only) may perform periodic trauma center audit/reviews at each designated Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.9. Trauma Center Designation Renewal: Trauma Centers desiring renewal of their designation must submit a new application (downloaded from the Department's Trauma website) no later than 90 days prior to expiration of designation. The original signed application and two copies must be submitted to the appropriate Trauma Care Region. The region will review the application and forward the original application and one copy to the Department, along with any comments the region may have regarding the application. The application must be received at the Department no later than 60 days prior to expiration of designation. The Department will acknowledge receipt of the application within 30 days to the applicant hospital and begin the designation process as provided by this regulation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.10. Loss of Required Trauma Care Capability: Any Trauma Center that loses, either permanently or temporarily, physician, nursing, or other patient care specialties required by this regulation, shall report that loss to the Department utilizing the State Medical Asset Resource Tracking Tool (SMARTT) or other designated automated reported system. If the loss will result in diminished capability for a period longer than 30 days, the facility must also submit a Corrective Action Plan (CAP) that addresses how the facility will become compliant.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.11. Suspension of Trauma Center Designation: The State Health Officer may suspend the Trauma Center designation of any hospital for:

1. Documented conditions of serious threat or jeopardy to patients' health or welfare;

2. Failure to comply with laws or regulations;

3. Failure to satisfactorily complete the reinstatement process for hospitals failing a Trauma Center designation inspection or losing Trauma Care capabilities.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.12. Hospitals having their Trauma Center Designation status suspended may reapply for Trauma Center designation after resolution of all issues related to the suspension, and completion of a new Trauma Center application and designation inspection. Should a trauma center's status be suspended, the hospital is responsible for paying the pro-rata fees as set forth in the "Play or Pay" section of these regulations.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.13. Non-Designated Trauma Centers: Any hospital that has not previously been designated as a Trauma Center or whose designation has expired, has submitted a Trauma Center application, and is actively pursuing a Trauma Center designation, including participation in Trauma Region activities and submission of Trauma Registry data, is considered a Non-designated Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.14. Non-Participant Hospitals: Any hospital that has not completed the Trauma Center designation, or has had its Trauma Center designation suspended by the Department, will be considered a Non-Participant hospital. Such facilities shall not advertise itself as a Trauma Center and are not eligible for any funding from the Trauma Care Trust Fund or Burn Fund, as appropriate.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.15. Change of Trauma Center Designation: Trauma Centers will be permitted to change their designation if the following conditions are met in their entirety:

1. The Trauma Center has been inspected and designated by the Department, the designation is current, and the Trauma Center is in full compliance with Department and Region rules, regulations, policies, procedures, and protocols;

2. The request to change designation has been approved by the applicable Trauma Care Region;

3. The Department's Trauma Consultant has reviewed the request and determines that there is no adverse impact to the Region or Trauma Care System;

4. The Mississippi Trauma Advisory Council (MTAC) has recommended approval of the request.

5. The Department Trauma System Administrator (TSA) concurs with the request;

6. The State Health Officer (SHO) or designee issues the new designation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.16. A Trauma Center may make a request to change its designation by sending a letter of intent to the appropriate Trauma Care Region.

1. The Trauma Center will submit an application for the new designation level. *(Note: If the Trauma Center has a current application and inspection report on file with the Department, for a level equal to or higher than the requested level, they will not be required to submit another application.)*

2. The Board of Directors of the Trauma Care Region will review the request, and will recommend approval/disapproval to the Department, along with any conditions.

3. The Department will forward the Region's letter, application package, and inspection report (if applicable) to the Trauma Consultant for review. The consultant will prepare a written report which will include any anticipated positive/negative impacts to the Region and/or Trauma Care System as a result of this action. The Trauma Consultant will also determine if a new inspection is required to substantiate this request, or will prepare a report of inspection compliance based on the file inspection report.

4. The TSA will consolidate all documentation and include the request on the agenda for the next MTAC meeting. The TSA will also include the Department's concurrence or non-concurrence with justification. A representative(s) of the Trauma Center and the Region will be invited to present the request to the MTAC. If a representative of the requesting Trauma Center is not present at the MTAC, the request will be tabled to the next meeting. If the Trauma Center representative does not appear at two consecutive MTAC meetings, the request will be dismissed without action.

5. If the MTAC approves the request, the TSA will forward a letter to the SHO requesting designation of the Trauma Center to the new level. If a non-participation fee is required for the new designation, an invoice will be prepared and sent to the Trauma Center. Designation will only occur after receipt of the non-participation fee.

6. If the MTAC does not approve the request, the TSA will return the application package to the Trauma Center and the Region via certified mail. The Trauma Center will have twenty (20) days after receipt of the returned application to file an appeal with the Department.

Source: Miss. Code Ann. § 41-59-5

Rule 1.2.17. Partial Capability: Any Trauma Center that chooses to offer patient care services that are above the level of their Trauma Center designation, must comply with the

standards for the higher level of designation, including response times for physician specialties, protocols and procedures, performance improvement processes, and equipment, training, and personnel as listed on the Essentials and Desirables ("E&D") chart of the appropriate Trauma Center level. Additionally, the higher patient care must be reviewed by both the hospital and regional PI process.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Financial Support for the Trauma Care System

Rule 1.3.1. Trauma Care Trust Fund: The Trauma Care Trust Fund (TCTF) shall serve as the financial support mechanism for development of the Mississippi Trauma Care System. The Department shall contract with designated Trauma Care Regions for trauma systems development and regional operations. Contracts with each designated Trauma Care Region include financial support for: Administration of regions (including, but not limited to, regional medical director, regional administrative support, telephone, regional trauma committees, hospital trauma registry staff, and trauma registry computer hardware) and funding of documented trauma care (hospitals, physicians, and licensed ambulance services) as defined by regulation.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.2. The TCTF is created from multiple funding sources including:

1. Assessment on moving traffic violations as noted in Miss. Ann Code §41-59-75;

2. Assessment on speeding, reckless and careless driving violations as noted in Miss. Ann Code §99-19-73;

3. Assessment on license tags (issuance and renewal) as noted in Miss. Ann Code §27-19-43;

4. Point of sale fee on all terrain vehicles, motorcycles, and boats as noted in Miss. Ann Code §99-19-73; and

5. Funds appropriated by the Legislature from the Health Care Expendable Fund.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.3. Trauma Care Trust Fund Eligibility

1. Trauma Care Trust Fund (TCTF) distribution shall be provided to designated Level I, II, and III Trauma Centers, designated Burn Centers, eligible physicians and eligible licensed ambulance through the Trauma Care Regions. Designated Level IV Trauma Centers shall not receive reimbursement for trauma care,

however, will receive an annual stipend for satisfactory participation in the Mississippi Trauma Care System.

2. Level I Trauma Centers and stand-alone Tertiary Pediatric Trauma Centers located in a state contiguous to the State of Mississippi that participate in the Mississippi Trauma Care System and have been designated by the Department shall be eligible to receive distributions from the TCTF.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.4. Trauma Care Trust Fund Distribution Formula

1. Funds for the administration and development of the Trauma Care System will be budgeted from available funds from the TCTF. Examples of administrative and development costs are, but are not limited to, salaries and benefit costs for personnel (full-time and part-time equivalents) who expend a portion of their time in trauma care administration and/or development, travel and training costs for such personnel, use of trauma care physicians and/or other trauma professionals used in the development and/or maintenance of the trauma care system, development and/or maintenance of accounting and auditing of the use and distribution of the TCTF, administrative costs for designated trauma care regions, and the costs associated with the development and/or implementation of the Trauma Care System (i.e., telecommunication systems, data storage and/or retrieval systems, advertising, equipment, etc.)

2. Eighty-five percent (85%) of the remaining funds from the TCTF are allocated to participating Trauma and Burn Centers which shall further allocate at least thirty percent (30%) of the funds received by Level I, II, and III Trauma Centers and Burn Centers to eligible physicians.

3. Fifteen percent (15%) of the remaining funds from the TCTF are allocated to eligible licensed ambulance services that provide pre-hospital care to trauma victims.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.5. Trauma Care Trust Fund Distribution Calculation: Amounts to be disbursed from the Trauma Care Trust Fund (TCTF) shall be calculated as follows:

1. On or about April 1 and October 1 of each year, or at such other times as the State Health Officer may direct, the Trauma System Administrator (TSA) shall obtain a Treasury report showing the fund balance in the TCTF.

2. To obtain the amount to be distributed, the following amounts will be subtracted from the fund balance:

a. One half of an amount to be determined by the Department for administrative expenses of the Department Division of Trauma as of the date of the calculation;

b. One half of an amount not to exceed Ten Thousand Dollars ($10,000) for each Level IV Trauma Center which has completed at least one year of satisfactory participation in the Mississippi Trauma Care System as of the date of the calculation (annual stipend);

c. One half of an amount not to exceed Ten Thousand Dollars ($10,000) for each Level IV Trauma Center which has completed at least one year of satisfactory participation in the Mississippi Trauma Care System as of the date of the calculation (educational grant); and

d. One half of an amount to be determined by the Department, and approved by the MTAC, for administrative expenses for each Trauma Care Region, as of the date of the calculation.

3. The amount remaining after the above administrative payments have been calculated, reserved and/or expended, shall be distributed according to the TCTF formula (refer to Appendix A for a graphic representation).

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.6. Trauma Card Trust Fund Ambulance Service Distribution

1. Fifteen percent (15%) of the amount remaining after administrative expenses shall be distributed to the Trauma Regions for further distribution to eligible licensed ambulance services. Eligible licensed ambulance services shall be those basic or advanced life support ambulance services licensed by the Bureau of Emergency Medical Services who are active participants in their local trauma region. In the event there is more than one eligible licensed ambulance service active in one county, funding for that county shall be distributed to both services based on call volume or other appropriate criteria as determined by the Trauma Care Region.

2. For purposes of determining amounts to be distributed to licensed ambulance services pursuant to this rule, the following definitions shall apply:

a. Census - the most recent decennial United States Census

b. Small Counties - those counties with a population of less than 15,000 as identified in the most recent Census.

c. Large Counties - those counties with a population greater than or equal to 15,000 as identified in the most recent Census.

d. Total Fund Balance - that portion of the TCTF that is allocated to licensed ambulance services.

e. Small County Population Percentage – the sum of Small Counties population as a percent of the total state population as reflected by the Census.

f. Per Capita Portion - the portion of a Small County's disbursement that is calculated by multiplying that county's Small County Population Percentage by the Total Fund Balance.

g. Dedicated Portion - the portion of a Small County's disbursement that is calculated by subtracting an amount from the Total Fund Balance and dividing among the Small Counties so that each Small County receives an equal disbursement that is equal to or less than the Large County with the lowest population.

h. Adjusted Population is determined by adding the population from the Small Counties and subtracting that sum from the state's total population.

i. Adjusted Fund Balance - calculated by subtracting the amount dedicated for the smaller counties from the total fund balance.

Per Capita Portion:
Multiply the Small Counties Population Percentage by the Total Fund Balance.

Per Capita portion = (Small Counties Population Percentage X Total Fund Balance)

Dedicated Portion:
The Dedicated Portion is calculated by subtracting an amount from the Total Fund Balance and adding it to the Per Capita Portion so that the sum of the Per Capita Portion plus the Dedicated Portion is divided by the number of Small Counties, AND the result is less than or equal to the Disbursement received by the Large County with the population closest to or equal to 15,000.

Dedicated Portion = [(Per Capita Disbursement + Dedicated Portion) / (Number of Small Counties)] < / = Disbursement of the Large County with lowest population

The Disbursement for small counties is calculated by adding the Per Capita and Dedicated Portions.

Disbursement (for Small Counties) = (Per Capita Portion) + (Dedicated Portion)

The amount to be disbursed for each Large County is calculated as follows:
Disbursement = (census population) / (Adjusted population) X (Adjusted Fund Balance)

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.7. Trauma Card Trust Fund Hospital Fixed Distribution

1. Eighty-five percent (85%) of the amount remaining after administrative expenses shall be distributed to the Trauma Regions for further distribution to participating Trauma Centers.

2. Thirty percent (30%) of the amount reserved for distribution to hospitals shall be distributed according to a "Fixed Distribution," based on the designated level of each eligible Trauma center.

3. For purposes of determining amounts to be distributed to Trauma Centers pursuant to this rule, the following definitions shall apply:

    a. Number of Facilities – the number of licensed acute care facilities designated as a Level I, Level II or Level III Trauma Centers

    b. Relative Weights – Level I shall equal 100%; Level II shall equal 87.5%; Level III shall equal 62.5%

    c. Calculated Weight – Equals the number of facilities designated at a particular level of trauma center multiplied by the relative weight.

    d. Total Weight – equals the sum of calculated weights

    e. Disbursement by Hospital Type – equals Total Hospital Fixed Fund / Total Weight X Relative Weight

    f. Total Disbursement by Hospital Type – equals the sum of Disbursement by Hospital Type

4. To calculate the Hospital Fixed Distribution, the following formula is used (refer to Appendix A for a graphic representation):

    a. Multiply the number of facilities in each category (Level I, Level II and Level III) by the relative weights of each category. The product of this operation shall be the calculated weight of each type facility.

    b. Sum the relative weights to obtain the "calculated weight."

    c. Divide the total Hospital Fixed Distribution amount by the product of the sum of the relative weights ("calculated weight") and the relative weight assigned to that category.

    d. The result is the amount to be distributed to each facility of that particular type (Level I, Level II or Level III).

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.8. Trauma Card Trust Fund Hospital Variable Distribution

1. Fifty percent (50%) of the amount reserved for distribution to hospitals shall be distributed according to a "Variable Distribution" formula.

2. Using patient data collected in the Trauma Registry, assign all trauma cases of each Level I, Level II, and Level II Trauma Center an ISS severity index and category of A, B, C, or D according to the following table:

ISS	ISS Severity Index	ISS Severity Category
1-9	1.02	A
10-15	2.02	B
16-24	3.80	C
>24	6.57	D

3. Using patient data collected in the Trauma Registry, Calculate the number of cases treated by each trauma center which fall within each ISS Severity Category.

4. Multiply the total number of ISS Severity Category A cases by the relative value assignment of 1.02 to arrive at the total number of Category A points.

5. Multiply the total number of ISS Severity Category B cases by the relative value assignment of 2.02 to arrive at the total number of Category B points.

6. Multiply the total number of ISS Severity Category C cases by the relative value assignment of 3.80 to arrive at the total number of Category C points.

7. Multiply the total number of ISS Severity Category D cases by the relative value assignment of 6.57 to arrive at the total number of Category D points.

8. Add the points from Categories A, B, C, and D to arrive at a total number of points for each trauma center.

9. Sum the number of points from all categories and all hospitals to arrive at a total number of points for all trauma centers.

10. Take the number of points for each hospital and multiply that number by the total dollar amount for the 50 percent of the TCTF available for distribution to participating, eligible trauma centers. Take the product of that calculation and divide the resulting number by the total number of points for all trauma centers.

11. The resulting quotient is the dollar amount of the Hospital Variable Fund to be distributed to that trauma center.

12. Sum all the amounts to be distributed pursuant to the Hospital Variable Fund Calculation. The sum of all distributions should not exceed fifty percent (50%) of the eighty-five percent (85%) of the TCTF available for distribution to hospitals.

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.9. Trauma Care Trust Fund Burn Center Distribution: Five percent (5 %) of the amount reserved for distribution to hospitals shall be distributed to designated burn centers within the Trauma Care System. If more than one burn center is operating within the system, the 5% will be distributed based on a pro-rata share of patients as determined by Trauma Registry inputs. *(Note: Trauma patients counted toward burn center distribution cannot be used to determine hospital variable distribution.) If no hospital has been designated as a burn center at the time of the distribution, the 5% shall be included in the Hospital Fixed Distribution.*

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.10. Play or Pay General Requirements:

1. Every Mississippi licensed acute care facility (hospital) having an organized emergency service or department shall participate in the Mississippi Statewide Trauma Care System. Every hospital having an organized emergency service or department shall submit data to the Trauma Registry.

2. Hospitals with the potential to serve as Level I, II, or III Trauma Centers must participate at the highest trauma designation level consistent with its capabilities as assessed by the Department.

3. Any hospital determined capable of participating as a Level IV Trauma Center may make application to be designated as a Level IV Trauma Center. A Level IV Trauma Center is required to submit data to the Trauma Registry and is eligible for $10,000 for administrative costs and a $10,000 educational credit as a participant in the Trauma Care System.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.11. Annual Capability Assessment:

1. Each year, all licensed acute care facilities shall complete a survey on forms provided by the Department. The facility will attest to the presence or absence of clinical services. Based on the facility's response, as well as other supporting

evidence, the Department shall render an assessment of the facility's potential to participate in the Trauma Care System.

2. Each facility shall receive a pre-assessment survey during the first week of July of each year to be completed and returned to the appropriate Trauma Care Region by the first week of August.

3. Each Trauma Care Region will review the survey of each facility within the region, and will forward comments on the Department approved form, detailing the level that each facility is capable of participating in the Trauma Care System by the first week of September.

4. On or about the third week in September an invoice and application (as applicable) will be sent by the Department to each facility in response to their respective survey.

Source: Miss. Code Ann. § 41-59-5

Rule 1.3.12. Annual Assessment Criteria: **For the purposes of the annual assessment, clinical services must be available 24 hours per day, seven days per week to be considered.**

1. Level I Trauma Center required services:

   a. Emergency Medicine

   b. General Surgery

   c. Orthopedic Surgery

   d. Neurological Surgery

   e. Anesthesia

   f. Post Anesthesia Care Unit (PACU)

   g. Intensive Care Unit (ICU)

   h. Surgical Residency Program

2. Level II Trauma Center required services:

   a. Emergency Medicine

   b. General Surgery

c. Orthopedic Surgery

d. Neurological Surgery

e. Anesthesia

f. Post Anesthesia Care Unit (PACU)

g. Intensive Care Unit (ICU)

3. Level III Trauma Center required services:

a. Emergency Medicine

b. General Surgery

c. Orthopedic Surgery

d. Anesthesia

e. Post Anesthesia Care Unit (PACU)

f. Intensive Care Unit (ICU)

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.13. Play or Pay Non-Participation Fee

1. Any hospital that chooses not to participate in the Trauma Care System as a Level I, II, or III Trauma Center, or participates at a level lower than the level at which it is capable of participating, as determined by the Department, or fails to maintain or becomes incapable of maintaining its designation as a Level I, II or III Trauma Center, or has its designation as a Level I, II, or III Trauma Center suspended by the Department, or becomes "non-designated" as a Level I, II, or III Trauma Center, shall be assessed and shall pay a non-participation fee as defined by this regulation.

2. All fees are due and payable annually before January 1 of each year. Any event above, occurring during the calendar year shall result in the hospital owing a pro-rata portion of the fee. The fee assessed shall be pro-rated on a monthly basis. The fee shall be paid in full upon written notification from the Department.

3. The fee schedule shall be reassessed and adjusted, as necessary, each year by the Mississippi Trauma Advisory Committee.

4. The fee schedule is as follows:

Current Level	Projected Level	Fee for Non Participation
Non Designated	Level II	$1,492,000.00
Non Designated	Level III	$ 758,000.00
Level III to	Level II	$ 423,500.00
Level IV to	Level II	$1,492,000.00
Level IV to	Level III	$ 758,000.00

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.14. Play or Pay Appeal Process

1. Following the receipt of an invoice from the Department for a Non-Participation fee, the hospital assessed the fee may request a due process hearing on the assessment. Any such request for hearing must be filed by the assessed facility with the Director of Emergency Medical Services, Mississippi State Department of Health, within twenty (20) days of the date of the assessment.

2. The date of the assessment is defined as the date which the assessment is placed in the United States Mail, postage pre-paid, addressed to the facility assessed, at the address furnished by the hospital to Trauma Registry, or to the address published by the party as its usual and customary business address. The date of the postmark shall be prima facie evidence of the date of the assessment.

3. The Director of Emergency Medical Services, upon receipt of a valid, timely request for a hearing, shall set a date no more than ten (10) calendar days from the receipt of the request for hearing.

4. The hearing officer appointed to conduct the hearing shall be a person chosen or appointed by the Director of the Office of Health Protection. A stenographic record of the hearing shall be made by a certified reporter/stenographer. The record shall consist of all sworn testimony taken, written, documentary or other relevant evidence taken at said hearing.

5. The only issues for adjudication are:

    a. The timeliness of notice of the assessment and delivery of the same;

    b. The trauma classification of the party; and

    c. The calculation of the amount of the assessment.

6. Within twenty (20) days of the receipt by the hearing officer of the certified record, he or she shall render findings of fact and conclusions of law contained in an order. The order so produced by the hearing officer shall be the final order of the Mississippi State Department of Health and shall be appealable to a court of competent jurisdiction.

7. If no appeal from the final order is taken within twenty (20) days of the date of the order, the party assessed shall pay on or before the twentieth (20th) day following the date of the order, the entire fee assessed.

Source: Miss. Code Ann. § 41-59-75

Rule 1.3.15. Delinquent Payments to the Trauma Care Trust Fund:

1. If a hospital fails to submit an application for designation as a Trauma Center and fails to pay the required fee for Non-Participation by January 1, a letter from the Department will be sent via certified mail to the administrator of the hospital and the Trauma Region administrator informing them that payment is due no later than 20 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 20 days from the delivery date of the letter.

2. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Division of Trauma to the Bureau of Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator and the Trauma Region administrator via certified mail.

3. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s). If a finding of Substantiated is returned, the Division of Trauma will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail. A copy of recommendation will also be sent to CMS.

4. Once the hospital has satisfied the requirements of this Sub-chapter, the Division of Trauma will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions, as appropriate. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail and to CMS.

5. If a hospital elects to participate at a level lower than the assessed capability and fails to pay the required fee for Non-participation by January 1, a letter from the Department will be sent via certified mail to the administrator of the hospital and the Trauma Region administrator informing them that payment is due no later than 20 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 20 days from the delivery date of the letter.

6. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Division of Trauma to the Bureau of

Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator and the Trauma Region administrator via certified mail.

7. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s) and if a finding of Substantiated is returned, the Division of Trauma will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail. A copy of recommendation will also be sent to CMS.

8. Once the hospital has satisfied the requirements of this Sub-chapter, the Division of Trauma will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions as appropriate. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail and to CMS.

9. If a hospital fails to maintain designation as a Trauma Center:

    a. The hospital must immediately notify the Department and the Trauma Region administrator when the loss of capability is experienced, and must present, within 20 days of the event, supporting documentation of the loss of capability and the proposed corrective action.

    b. The Division of Trauma will review the documentation and corrective action plan, and will determine the effective date of pro-ration of the fee for Non-participation.

    c. The Department will send a letter via certified mail to the hospital administrator and the Trauma Region administrator informing them that payment is due no later than 20 days from the delivery date of the letter, or that the a request for a due process hearing must be received at the Department no later than 20 days from the delivery date of the letter.

    d. If the administrator fails to respond, or comply with the requirements of the certified letter, a letter will be sent by the Division of Trauma to the Bureau of Health Facilities Licensure and Certification documenting an alleged violation of the Minimum Standards for the Operation of Mississippi Hospitals, specifically that the governing body of the hospital, through its administrator, failed to take all reasonable steps to comply with all applicable federal, state and local laws and regulations. A copy of the letter will be sent to the hospital administrator and the Trauma Region administrator via certified mail.

e. The Bureau of Health Facilities Licensure and Certification will conduct an investigation of the alleged violation(s) and if a finding of Substantiated is returned, The Division of Trauma will recommend to Licensure and Certification that the hospital's license be revoked. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail. A copy of recommendation will also be sent to CMS.

f. Once the hospital has satisfied the requirements of this Sub-chapter, the Division of Trauma will send a letter to License and Certification recommending reinstatement of the hospital's license with/without restrictions as appropriate. A copy of this recommendation will be sent to the hospital administrator and the Trauma Region administrator via certified mail and to CMS.

Source: Miss. Code Ann. § 41-59-75

Subchapter 4 Mississippi State Trauma Registry

Rule 1.4.1. Applicability to Hospitals and Pre-Hospital Providers

1. All Mississippi-licensed hospitals which have an emergency service or department shall participate in the Trauma Registry data collection process, whether or not they participate in the Trauma Care System. All out-of-state hospitals designated as Mississippi Trauma Centers shall participate in the Trauma Registry. Specialized treatment centers, either in-state or out-of-state, that have contracts with the Department to provide care to Mississippi trauma/burn patients, shall participate in the Trauma Registry.

2. All trauma data collection instruments shall include the collection of both pre-hospital and hospital patient care data, and shall be integrated into the Department's data management systems.

Source: Miss. Code Ann. § 41-59-75

Rule 1.4.2. Timeliness of Submissions: Trauma Registry data shall be submitted by all hospitals to the Department no later than one (1) month plus six (6) days after the end of the current month. For example, Trauma Registry data for the month of January is due on March 6th.

Source: Miss. Code Ann. § 41-59-75

Subchapter 5 Trauma Care Regions

Rule 1.5.1. Implementation of a Regional Trauma Care System

1. The Mississippi Trauma Care Plan documents the need for a regional approach toward the development of a statewide trauma care system. This regional development will be coordinated and supported by the legislatively designated "lead trauma agency," the Mississippi State Department of Health.

2. The Mississippi Trauma Care Plan recognizes the uniqueness within differing parts of the state with regard to personnel, resources, environmental issues, distance to tertiary care and population. Accordingly, the Mississippi Trauma Care Plan provides for a system that allows for flexibility at the regional level, incorporates the use of regional leadership to establish regional/local guidelines, and is sensitive to regional needs and resources. As a result the Mississippi Trauma Care Plan ensures a statewide trauma system design that is based on the resources available within each region, while ensuring optimal care to the trauma victim through transfer agreements when resources may not be available within a certain geographical area.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.2. Designation of Trauma Care Regions: To receive state designation as a Trauma Care Region, the hospitals and their respective medical staffs intending to establish the Trauma Care Region shall send a letter of intent to the Department which includes:

1. A description of the area to be served;

2. The names of all Trauma Centers and hospitals participating in the region; and

3. The form of regional administration for the proposed Trauma Care Region.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.3. Establishment of a Region Board of Directors

1. All Trauma Care Regions designated by the Department shall establish a Board of Directors, which shall be recognized as the lead administrative body of that Region. Board members shall be representative(s) of participating and designated trauma care centers, physicians, or any other person deemed appropriate by the Board. The Board shall have administrative authority over the operation of the Trauma Care Region and subsequent trauma system programs.

2. Trauma Care Region boards are authorized to receive funds and to expend funds as may be available for any necessary and proper trauma care program purposes in the manner provided for in these Regulations or in law. Non compliance will result in loss of funding to the region for each corresponding activity.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.4. Administration of the Trauma Care Region

1. After formation of a Trauma Care Region board, the board shall appoint an administrator who shall have authority over the operation of the Trauma Care Region and subsequent trauma care programs, all under the direction of the Trauma Care Region board. Such management may be carried out by an appointed executive manager, by contracting for management services, or by some other means, to be approved by the Department.

2. The functions of a Trauma Care Region include, but are not limited to, the following:

3. Track and assist in the distribution of the Trauma Care Trust Fund to hospitals, physicians, and EMS agencies;

4. Maintain a regional database including, but not limited to, hospitals in the region, designation status, and expiration date;

5. Monitor pre-hospital triage and transport of the trauma patient;

6. Maintain and ensure compliance of the Regional Trauma Plan;

7. Provide training opportunities for physicians, nurses, and EMS and support personnel, maintain a schedule, and ensure notification to qualifying personnel;

8. Monitor the ongoing PI program of each trauma program in the respective region; and

9. Other such activities as may be required by the Department in the annual contractual agreement.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.5. Performance of each trauma region shall be evaluated annually with continued financial support contingent on adequate performance based on outcome measures.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.6. Region Trauma Plans:

1. A Trauma Care Region intending to implement a trauma care system shall submit its Regional Trauma Plan to the Department and have it approved prior to implementation. Within 30 days of receiving the plan, the Department shall provide written notification to the Trauma Care Region of the following:

a. That the plan has been received by the Department;

b. Whether the Department approves or disapproves of its Regional Trauma Plan; and

c. If disapproved, the reason for disapproval of the Regional Trauma Plan;

2. Revisions in the approved Regional Trauma Plan must be submitted prior to implementation.

3. Regional Trauma Plans shall be updated and submitted to the Department every three (3) years.

4. The Trauma Care Region shall certify annually to the Department that its approved Regional Trauma Plan is functioning as described.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.7. Required Elements of a Region Trauma Plan: The Region Trauma Plan shall be comprehensive and the objectives shall be clearly outlined. The Plan shall contain, at the minimum, the following elements:

1. Table of contents;

2. Plan summary;

3. Objectives;

4. Implementation schedule;

5. Administrative structure;

6. Medical organization and management;

7. Inclusive regional design which includes all facilities involved in the care of acutely injured patients, including coordination with neighboring Trauma Care Regions;

8. Documentation of all inter-facility transfer protocols;

9. Written documentation of participation (hospital/medical staff);

10. System design which addresses the implementation of the policies developed;

11. Description of the critical care capability within the Region including but not limited to burns, spinal cord injury, rehabilitation, and pediatrics;

12. Performance improvement process; and

13. General policies of the Trauma Care Region Board of Directors.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.8. General Policies of the Trauma Care Region: A designated Trauma Care Region shall develop policies which provide a clear understanding of the structure of the trauma system and the manner in which it utilizes the resources available to it. Those policies shall address the following:

1. System organization and management;

2. Trauma care coordination within the Region;

3. Trauma care coordination with neighboring Regions and/or jurisdictions, including designated Trauma Care Region agreements;

4. Data collection and management;

5. Coordination of designated Trauma Care Regions and trauma systems for transportation including inter-Trauma Center transfers, and transfers from a receiving hospital to a Trauma Center;

6. The integration of pediatric hospitals, including pediatric triage criteria;

7. Availability of Trauma Center equipment;

8. Availability of trauma team personnel;

9. Criteria for activation of trauma team;

10. Mechanisms for availability/response of clinical specialists;

11. Performance improvement and system evaluation to include responsibilities of the Multidisciplinary Trauma/Peer Review Committee;

12. Training of pre-hospital personnel to include trauma triage;

13. Public information and education about the trauma system;

14. Lay and professional education about the trauma system;

15. Coordination with public and private agencies and Trauma Centers in injury prevention programs; and

16. Expected participation in regional operations by pre-hospital providers and hospitals.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.9. Additional Standards and Prohibitions

1. No health care facility within a Region shall advertise in any manner or otherwise hold itself out to be a Trauma Center unless so designated by the Department.

2. No pre-hospital provider shall advertise in any manner or otherwise hold itself out to be affiliated with the trauma system or a Trauma Center unless the provider of has been so designated or licensed by the Department.

3. All participating hospitals and licensed EMS providers in each Region shall abide by the Region Trauma Plan and policies.

4. Documentation of a pre-hospital provider's Medical Control Plan review and compliance must be submitted to BEMS and the Trauma Care Region annually

5. A Trauma Care Region shall withhold Trauma Care Trust Fund distributions from participating hospitals and licensed EMS providers for non-compliance with Mississippi Trauma Care System Regulations and regional plans and policies.

Source: Miss. Code Ann. § 41-59-75

Rule 1.5.10. Level IV Trauma Center Site Visits: At least once during each three (3) year designation period, the Trauma Care Region shall conduct a Site Visit at each Level IV Trauma Center. The primary purpose of this visit will be to ensure compliance with the regulations, with particular emphasis on practitioner training; protocols and procedures; and Performance Improvement. A written report of any deficiencies shall be forwarded to the Department with 30 days of the visit.

Source: Miss. Code Ann. § 41-59-75

Subchapter 6 Inter-facility Transfers Of Trauma Patients

Rule 1.6.1. Inter-facility Transfers

1. Patients may be transferred from Trauma Centers to other Trauma Centers and/or specialty referral centers provided that any such transfer is medically prudent, as determined by the transferring Trauma Center physician of record.

2. All designated Trauma Centers, Pediatric Trauma Centers, and Burn Centers shall accept patients transferred from Trauma Centers of equal or lower levels of designation without regard to the patient's ability to pay for treatment.

Source: Miss. Code Ann. § 41-59-75

Rule 1.6.2. Inter-facility Transfer Policies

1. Trauma Center hospitals shall develop written criteria for consultation and transfer of patients needing a higher/specialty level of care. Trauma Center/specialty referral centers that repatriate trauma patients shall provide data required by the Trauma Registry to the receiving Trauma Center.

2. Trauma Centers/specialty hospitals receiving transferred trauma patients shall provide written feedback to the transferring facility and shall participate in the regional and state performance improvement process.

Source: Miss. Code Ann. § 41-59-75

Chapter 2 Level I Trauma Centers

Subchapter 1 Hospital Organization

Rule 2.1.1. General

1. Level I Trauma Centers shall act as regional tertiary care facilities at the hub of the trauma care system. The facility must have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. As a tertiary facility, the Level I Trauma Center must have adequate depth of resources and personnel.

2. The Level I Trauma Centers in the State of Mississippi have the responsibility of providing leadership in education, trauma prevention, research and system planning.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.2. Hospital Departments/Divisions/Sections

1. The Level I Trauma Center must have the following departments, divisions, or sections:

   a. Emergency Medicine

   b. General Surgery

   c. Orthopedic Surgery

   d. Neurological Surgery

   e. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.3. Trauma Program

1. There shall be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such, together with a written commitment of the hospital's chief executive officer, to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a board-certified surgeon with special interest in trauma care. An identified hospital administrative leader must work closely with the trauma medical director to establish and maintain the components of the trauma program including appropriate financial support. The trauma program location in the organizational structure of the hospital must be such that it may interact effectively with at least equal authority with other departments providing patient care. The administrative structure should minimally include an administrator, medical director, trauma program manager (TPM), trauma registrar and the appropriate support staff. Administrative support includes human resources, education activities, community outreach activities, and research. The trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care should be extended to all the involved departments.

2. Compliance with the above will be evidenced by but not limited to:

   a. Governing authority and medical staff letter of commitment in the form of a resolution;

   b. Written policies and procedures and guidelines for care of the trauma patient;

   c. Defined trauma team and written roles and responsibilities;

   d. Appointed Trauma Medical Director with a written job description;

   e. Appointed Trauma Program Manager with a written job description;

   f. A written Trauma Performance Improvement plan; and

   g. Documentation of Trauma Center representative attendance at the Regional Trauma meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.4. Trauma Service: The trauma service shall be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service will vary in each organization depending on the needs of the patient and the resources

available. The trauma service shall come under the organization and direction of a surgeon who is board certified with special interest in trauma care. All patients with multiple system trauma or major injury shall be evaluated by the trauma service. The surgeon responsible for the overall care of the patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.5. Trauma Medical Director (TMD): Level I Trauma Centers shall have a physician director of the trauma program. The medical director plays an important administrative role. The medical director must be a board-certified surgeon with special interest in trauma care. The medical director will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the trauma program. The medical director must be given administrative support to implement the requirements specified by the state trauma plan. The director is responsible for working with the credentialing process of the hospital, and in consultation with the appropriate service chiefs, for recommending appointment and removal of physicians from the trauma team. He should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The director in collaboration with the Trauma Program Manager(TPM) should coordinate the budgetary process for the trauma program. The director must be currently certified in Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The trauma director must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.6. Trauma Program Manager (TPM)

1. Level I Trauma Centers must have a registered nurse working full time in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.

2. The TPM or his/hers designee should offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, Trauma Care Region and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.7. Trauma Team: There shall be identified members of the trauma team. Policies should be in place describing the respective role of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of the hospital and its staff. In some instances, a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians. Composition of the trauma team for a severely injured patient includes:

1. Emergency Physician and/or mid-level providers (Physician Assistant/Nurse Practitioner)*
2. General/Trauma Surgeon*
3. Physician Specialist
4. Anesthesiologist
5. Pediatrician
6. Nurses: ED*, OR, ICU, etc.
7. Laboratory Technicians as dictated by clinical needs
8. Mental Health/Social Services/Radiology Technicians
9. Pastoral Care
10. Respiratory Therapist
11. Security officers

* Mandatory for all Alpha and Bravo Alerts/Activations.

Source: Miss. Code Ann. § 41-59-5

Rule 2.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. Each trauma center may choose to have one or more committees as needed to accomplish the task. One committee should be multi-disciplinary and focus on program oversight and leadership. The major focus will be on PI

activities, policy development, communication among all team members, and establishment of standards of care, and education and outreach programs for injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

a. Emergency Medicine

b. General Surgery

c. Orthopedics

d. Neurosurgery

e. Anesthesia

f. Operating Room

g. Intensive Care

h. Respiratory Therapy

i. Radiology

j. Laboratory

k. Rehabilitation

l. Pre-hospital Care Providers

m. Administration

n. Pediatrics

o. Nursing

p. Trauma Program Manager

2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.

3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 2.2.1. Required Components: Level I trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

2. Trauma/General Surgery (In-house 24/hours). The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. This may allow the attending surgeon to take call from outside the hospital. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure early notification of the on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes and starts at patient arrival or EMS notification, whichever is shorter.

3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.

4. Neurologic Surgery. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

6. The following specialists must be on-call and promptly available 24 hours/day:

   a. Cardiac Surgery*

   b. Cardiology

   c. Critical Care Medicine

   d. Hand Surgery

   e. Infectious Disease

   f. Microvascular Surgery

   g. Nephrology

   h. Nutritional Support

   i. Obstetrics/Gynecologic Surgery

   j. Ophthalmic Surgery

   k. Oral/Maxillofacial

   l. Pediatrics

   m. Plastic Surgery

   n. Pulmonary Medicine

   o. Radiology

   p. Thoracic Surgery*

   *A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries.

If this is not the case, the facility should have a board-certified cardiac/thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program

8. Polices and condition.

Source: Miss. Code Ann. § 41-59-5

Rule 2.2.2. Qualifications of Surgeons on the Trauma Team

1. Basic to qualification for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the Royal College of Physicians, the American Dental Association and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.

2. Alternate criteria in lieu of board certification are as follows:

   a. A non-board certified general surgeon must have completed a surgical residency program.

   b. He/she must be licensed to practice medicine.

   c. He/she must be approved by the hospital's credentialing committee for surgical privileges.

   d. The surgeon must meet all criteria established by the trauma director to serve on the trauma team.

   e. The surgeons' experience in caring for the trauma patient must be tracked by the PI program.

   f. The TMD must attest to the surgeons' experience and quality as part of the recurring granting of trauma team privileges.

   g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.

3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care.

The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level I facility) and determine if the patient needs transport to a higher lever of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level I trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patients should be admitted to the Level I trauma center or which patients should be considered for transfer to a higher level of care.

4. The general surgery liaison, orthopedic liaison, and neurosurgery liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. General Surgery physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other surgeons on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 2.2.3. Qualification of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.

2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:

   a. He/she must be licensed to practice medicine

   b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.

   c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.

   d. The physician's experience in caring for the trauma patient must be tracked by the PI program.

   e. The trauma and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.

f. Residency in Emergency Medicine is desirable.

3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other physicians on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 2.3.1. Emergency Department

1. The facility must have an emergency department, division, service, or section staffed so trauma patients are assured immediate and appropriate initial care. The emergency physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.

2. The director of the emergency department, along with the Trauma Medical Director, will establish trauma-specific credentials that should exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification and specialty board certification.

3. The emergency medicine physician will be responsible for activating the trauma team based on predetermined response protocols. He will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the Multidisciplinary Trauma Committee and the trauma PI process.

4. There shall be an adequate number of RN's staffing the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) and participate in the ongoing PI process of the trauma program. There must be a

written plan ensuring nurses maintain ongoing trauma specific education. Nurses must obtain TNCC within 18 months of assignment to the ER.

5. The list of required equipment necessary for the ED can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 2.3.2. Surgical Suites/Anesthesia

1. The operating room (OR) must be staffed and available in-house 24 hours/day.

2. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.

3. The surgical nurses are an integral member of the trauma team, and must participate in the ongoing PI process of the trauma program and be represented on the Multidisciplinary Trauma Committee.

4. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.

5. The anesthesia department in a Level I Trauma Center should be ideally organized and run by an anesthesiologist who is highly experienced and devoted to the care of the injured patient. If this is not the director, an anesthesiology liaison with the same qualifications should be identified. Anesthesiologists on the trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialties and have board certification in anesthesia. One anesthesiologist should maintain commitment to education in trauma related anesthesia.

6. Anesthesia must be available in-house 24 hours/day with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia requirements may be fulfilled by anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNA) who are capable of assessing emergent situations in trauma patients and of providing indicated treatment, including initiation of surgical anesthesia. When the CRNA or chief resident is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documented and monitored by the PI process. The anesthesiologist participating on the trauma team must participate in the Multidisciplinary Trauma Committee and the trauma PI process.

7. The list of required equipment necessary for Surgery can be found at the end of this chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 2.3.3. Post Anesthesia Care Unit (PACU)

1. Level I trauma centers must have a PACU staffed 24 hours/day and available to the postoperative trauma patient. Frequently it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.

2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education.

3. PACU staffing should be in sufficient numbers to meet the critical needs of the trauma patient.

4. The list of required equipment necessary for PACU can be found at the end of this chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 2.3.4. Intensive Care Unit (ICU)

1. Level I trauma centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.

2. The surgical director for the ICU – which houses trauma patients - must have obtained critical care training during residency or fellowship and must have expertise in the preoperative and post injury care of the injured patient. This is best demonstrated by a certificate of added qualification in surgical critical care from the American Board of Surgery and may also be fulfilled by documentation of active participation during the preceding 12 months in trauma patients' ICU care and ICU administration and critical care-related continuing medical education. The director is responsible for the quality of care and administration of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.

3. The trauma service assumes and maintains responsibility for the care of the multiple injured patient. A surgically directed ICU physician team is essential. The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties, but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution.

4. There must be in-house physician coverage for the ICU at all times. A physician credentialed by the facility for critical care should be promptly available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.

5. The trauma service should maintain the responsibility for the care of the patient as long as the patient remains critically ill. The trauma service must remain in charge of the patient and coordinate all therapeutic decisions. The responsible trauma surgeon or designee should write all orders. The trauma surgeon should maintain control over all aspects of care, including but not limited to respiratory care and management of mechanical ventilation; placement and use of pulmonary catheters; management of fluid and electrolytes, antimicrobials, and enteral and parenteral nutrition.

6. Level I Trauma Centers must provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. ICU nurses are integral part of the trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.

7. There is a complete list of necessary equipment for the ICU at the end of this chapter.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 2.4.1. Respiratory Therapy Service: The service must be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatment for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.2. Radiological Service

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. Sonography, angiography, and MRI must be available to the trauma team. A technician must be in-house and immediately available for computerized tomography (CT) for both head and body. Specialty procedures such as angiography, MRI, and sonography may be covered with a technician on-call. If the technician is not in-house 24 hours/day for special procedures the performance improvement process must document and monitor that the procedure is promptly available.

2. A board-certified radiologist should administer the department and participate actively in the trauma education and PI process. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must insure the preliminary interpretations are promptly reported to the trauma team and the PI program must monitor all changes in interpretation.

3. Written policy should exist delineating the prioritization/availability of the CT scanner for trauma patients. The PI process must ensure that trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transportation to and while in the radiology department.

4. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and the PI Program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.3. Clinical Laboratory Service

1. Clinical laboratory service must have the following services available in-house 24 hours/day:

   a. Access to a blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and cross-match capabilities must be readily available.

   b. Standard analysis of blood, urine and other body fluids including micro-sampling when appropriate.

   c. Blood gas and PH determinations (this function may be performed by services other than the clinical laboratory service, when applicable.)

   d. Alcohol screening is required, and drug screening is highly recommended.

   e. Coagulation studies.

   f. Microbiology

2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.4. Acute Hemodialysis: Level I Trauma Centers must have Acute Hemodialysis services. There must be a written protocol to transfer the patient to a facility that

provides this service if this service if it is not available at the Level I Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level I Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.6. Rehabilitation/Social Services

1. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include; Occupational Therapy, Physical Therapy, and Speech Pathology.

2. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout the continuum of recovery. Adequate number of trained personnel must be readily available to the trauma patients and family. Programs must be available to meet the unique need of the trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.7. Prevention/Public Outreach

1. Level I trauma centers will be responsible for taking a lead role in coordination of appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the region. The trauma registry data must be utilized to identify injury trends and focus prevention needs.

2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at a Level I trauma center must provide consultation to staff members of other level facilities. For example: Advanced Trauma Life Support (ATLS), Pre Hospital Trauma Life Support (PHTLS), Trauma Nurse Curriculum Course (TNCC), and Transport Nurse Advanced Trauma Course (TNATC) courses can be coordinated by the trauma center. Trauma physicians must provide a formal follow up to referring physicians/designee about specific patients to educate the practitioner for the benefit of further injured patients.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.8. Transfer Guidelines: Level I Trauma Centers shall work in collaboration with the referral trauma facilities in the system and develop inter-facility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.9. Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential as provided in Miss. Code Ann.§41-59-77. Level I trauma facilities may be responsible for direct assistance to all other levels of referring facilities in providing data for inclusion in the registry.

2. Each trauma center must develop an internal trauma specific Performance Improvement (PI) plan that minimally addresses the following key components and is fully integrated into the hospital wide program:

   a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).

   b. Clearly defined authority and accountability for the program.

   c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.

d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.

e. Explicit definitions of outcomes derived from institutional standards.

f. Documentation system to monitor performance, corrective action and the result of the actions taken.

g. A process to delineate credentialing of all trauma service physicians.

h. An informed peer review process utilizing a multidisciplinary method.

i. A method for comparing patient outcomes with computed survival probability.

j. Autopsy information on all deaths when available.

k. Review of pre-hospital care.

l. Review of times and reasons for trauma bypass.

m. Review of times and reasons for trauma transfers.

n. Audit of trauma deaths.

o. Morbidity and Mortality review.

3. Representatives from the Level I Trauma Center shall participate in the Trauma Care Region and statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.10. Education

1. Level I Trauma Centers must have medical education programs including educational training in trauma for physicians, nurses and pre-hospital providers. The Level I trauma centers must take a leadership role in providing educational activities. Education can be accomplished via many mechanisms (i.e. classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens etc).

2. The Level I trauma center is expected to support a surgical residency program. Additionally there should be a senior resident rotation in at least one of the following disciplines: emergency medicine, general surgery, orthopedic surgery, neurosurgery or support a trauma fellowship consistent with the educational requirements of the American Association for the Surgery of Trauma (AAST). The Level I should provide ATLS courses for the region.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.11. Research

1. A trauma research program must be designed to produce new knowledge applicable to the care of the injured patient. The research may be conducted in a number of ways including traditional laboratory and clinical research, reviews of clinical series, and epidemiological or other studies. Publication of articles in peer-review journals as well as presentations of results at local, regional and national meetings and ongoing studies approved by human and animal research review boards are expected from productive programs. The program should have an organized structure that fosters and monitors ongoing productivity.

2. The research program must be balanced to reflect a number of different interests. There must be a research committee, and identifiable Institutional Review Board process, active research protocols, surgeons involved in extramural educational presentations and adequate number of peer reviewed scientific publications. Publications should appear in peer-reviewed journals. In a three-year cycle, the suggested minimum activity is ten publications (per review cycle) from the physicians representing any of the four following specialties: emergency medicine, general surgery, orthopedic surgery, and neurosurgery.

Source: Miss. Code Ann. § 41-59-5

Rule 2.4.12. Essential and Desirable Chart for Level 1 Trauma Center (Reserved)

Chapter 3 Level II Trauma Centers

Subchapter 1 Hospital Organization

Rule 3.1.1. General : A Level II Trauma Center is an acute care facility with the commitment, resources and specialty training necessary to provide sophisticated trauma care.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.2. Hospital Departments/Divisions/Sections: The Level II Trauma Center must have the following departments, divisions, or sections:

1. Emergency Medicine
2. Trauma/General Surgery
3. Orthopedic Surgery
4. Neurological Surgery

5. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.3. Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a board-certified surgeon with special interest in trauma care. An identified hospital administrative leader must work closely with the trauma medical director to establish and maintain the components of the trauma program including appropriate financial support. The trauma program location in the organizational structure of the hospital must be placed so that it may interact effectively with at least equal authority with other departments providing patient care. An administrative structure should minimally include an administrator, medical director, trauma program manager (TPM), trauma registrar and the appropriate support staff. Administrative support includes human resources, educational activities, community outreach activities, and research. The trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care should extend to all the involved departments.

2. Compliance with the above will be evidenced by, but not limited to:

   a. Governing authority and medical staff letter of commitment in the form of a resolution;

   b. Written policies and procedures and guidelines for care of the trauma patient;

   c. Defined trauma team and written roles and responsibilities;

   d. Appointed Trauma Medical Director with a written job description;

   e. Appointed Trauma Program Manager with a written job description;

   f. A written Trauma Performance Improvement plan;

   g. Documentation of trauma center representative attendance at the regional trauma advisory committee meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.4. Trauma Service: The trauma service must established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured patient. The trauma service will vary in each organization depending on the needs of the patient and the resources available. The trauma service must come under the organization and direction of a surgeon who is board certified with special interest in trauma care. All patients with multiple system trauma or major injury must be evaluated by the trauma service. The surgeon responsible for the overall care of the patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.5. Trauma Medical Director (TMD): Level II Trauma Centers must have a physician director of the trauma program. The trauma program medical director plays an important administrative role. The medical director must be a board-certified surgeon with special interest in trauma care. The medical director will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the trauma program. The medical director must be given administrative support to implement the requirements specified by the State trauma plan. The director is responsible for working with the credentialing process of the hospital, and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the trauma team. He should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The director in collaboration with the trauma program manager/TPM should coordinate the budgetary process for the trauma program. The director must be currently certified in Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The trauma director must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.6. Trauma Program Manager (TPM)

1. Level II Trauma Centers must have a registered nurse working full time in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.

2. The TPM or his/hers designee should offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, Trauma Care Region(s) and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.7. Trauma Team*:* The team approach is optimal in the care of the multiple injured patient. There must be identified members of the trauma team. Policies should be in place describing the respective role of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its staff. In some instances, a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. The team leader must be a qualified general surgeon. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians. Composition of the trauma team for a severely injured patient shall include:

1. Emergency Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)*
2. General/Trauma Surgeon*
3. Physician Specialist
4. Anesthesiologist
5. Pediatricians
6. Nurses: ED*, OR, ICU, etc.
7. Laboratory Technicians as dictated by clinical needs
8. Mental Health/Social Services/ Radiology Technicians
9. Pastoral Care
10. Respiratory Therapists
11. Security Officers

* Mandatory for all Alpha and Bravo Alerts/Activations.

Source: Miss. Code Ann. § 41-59-5

Rule 3.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. Each trauma center may choose to have one or more committee to accomplish the tasks necessary. One committee should be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, establishment of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives from:

   a. Emergency Medicine

   b. General Surgery

   c. Orthopedics

   d. Neurosurgery

   e. Anesthesia

   f. Operating Room

   g. Intensive Care

   h. Respiratory Therapy

   i. Radiology

   j. Laboratory

   k. Rehabilitation

   l. Pre-hospital Care Providers

   m. Administration

   n. Pediatrics

   o. Nursing

   p. Trauma Program Manager

2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.

3. The trauma center may wish to accomplish performance improvement activities at this same committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. This committee must be multidisciplinary, meet regularly, and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 3.2.1. Required Components : Level II Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

2. Trauma/General Surgery. The trauma surgeon on-call must be unencumbered and immediately available to respond to the trauma patient. The general surgeon is expected to be in the emergency department upon arrival of the seriously injured patient. Hospital policy must be established to define conditions requiring the trauma surgeon's presence with the clear requirement on the part of the hospital and surgeon that the surgeon will participate in the early care of the patient. The trauma surgeon's participation in major therapeutic decisions, presence in the emergency department for major resuscitation and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. It is desirable that the on-call surgeon be dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system must be developed to assure early notification of the on-call to any other hospital while on trauma call. A system must be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.

3. Orthopedic Surgery. The orthopedic surgeons on the trauma team must be board certified. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.

4. Neurologic Surgery. The neurosurgeons on the trauma team must be board certified. It is desirable to have the neurosurgeon dedicated to the trauma center solely while on-call or a back up schedule should be available. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

5. Anesthesia (In-house 24 hours/day) Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

6. The following specialists must be on-call and promptly available 24 hours/day:

   a. Critical Care Medicine

   b. Hand Surgery

   c. Infectious Disease

   d. Microvascular Surgery

   e. Obstetrics/Gynecologic Surgery

   f. Ophthalmic Surgery

   g. Oral/Maxillofacial

   h. Plastic Surgery

   i. Radiology

   j. Thoracic Surgery*

   *A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. Recognizing that early rehabilitation is imperative for the trauma patient, a physical medicine and rehabilitation specialist must be available for the trauma program

8. Polices and procedures should exist to notify the patient's primary physician of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.2. Qualifications of Surgeons on the Trauma Team

1. Basic to qualification for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the American Dental Association, the Royal College of Physicians and Surgeons of Canada or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.

2. Alternate criteria in lieu of board certification are as follows:

   a. A Non-board certified general surgeon must have completed a surgical residency program.

   b. He/she must be licensed to practice medicine.

   c. He/she must be approved by the hospital's credentialing committee for surgical privileges.

   d. The surgeon must meet all criteria established by the TMD to serve on the trauma team.

   e. The surgeon's experience in caring for the trauma patient must be tracked by the PI program.

   f. The TMD must attest to the surgeon's experience and quality as part of the recurring granting of trauma team privileges.

   g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.

3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level II facility) and determine if the patient needs transport to a higher lever of care. If

transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level II trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patients should be admitted to the Level II trauma center or which patients should be considered for transfer to a higher level of care.

4. The general surgery liaison, orthopedic liaison, and neurosurgery liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. General Surgery physicians must be currently certified in ATLS; ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians, and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other surgeons on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 3.2.3. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.

2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:

   a. He/she must be licensed to practice medicine.

   b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.

   c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.

   d. The physician's experience in caring for the trauma patient must be tracked by the PI program.

   e. The trauma and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.

   f. Residency in Emergency Medicine is desirable.

3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other physicians on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 3.3.1. Emergency Department

1. The facility must have an emergency department, division, service, or section staffed so trauma patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.

2. The director of the emergency department, along with the trauma director, will establish trauma-specific credentials that should exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification and specialty board certification. ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.

3. The emergency medicine physician or designee will be responsible for activating the trauma team based on predetermined response protocols. He will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the Multidisciplinary Trauma Committee and the trauma PI process.

4. There should be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) and participate in the ongoing PI process of the trauma program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. Nurses must obtain TNCC within 18 months of assignment to the ER.

5. The list of required equipment necessary for the ED can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.2. Surgical Suites/Anesthesia

1. It is recommended that the OR be staffed and available in-house 24 hours/day. If the staff is not in-house, hospital policy must be written to assure notification and prompt response. The PI process must document and monitor the ongoing availability of OR crews and absence of delay.

2. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.

3. The surgical nurses are an integral member of the trauma team and must participate in the ongoing PI process of the trauma program and must be represented on the Multidisciplinary Trauma Committee.

4. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma patient during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.

5. The anesthesia department in a Level II trauma center should be ideally organized and run by an anesthesiologist who is experienced and devoted to the care of the injured patient. If this is not, the director, an anesthesiologist liaison with the same qualifications should be identified. Anesthesiologists on the trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialties, or the American Osteopathic Board and should have board certification in anesthesia. One anesthesiologist should maintain commitment to education in trauma related anesthesia. Anesthesiologists must demonstrate evidence of participation in the internal trauma education plan.

6. Anesthesia must be available 24 hours/day with a mechanism established to ensure notification of the on-call anesthesiologist. Anesthesia requirements may be fulfilled by anesthesia chief residents or Certified Registered Nurse Anesthetists (CRNAs) who are capable of assessing emergent situations in trauma patients and of providing an indicated treatment, including initiation of surgical anesthesia. When the CRNA or chief resident is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient. The availability of the

anesthesiologist and the absence of delays in operative anesthesia must be documented and monitored by the PI process. The anesthesiologist participating on the trauma team should have the necessary educational background in the care of the trauma patient; participate in the Multidisciplinary Trauma Committee and the trauma PI process.

7. The list of required equipment necessary for Surgery and Anesthesia can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.3. Post Anesthesia Care Unit (PACU)

1. It is essential to have a PACU staffed 24 hours/day and available to the postoperative trauma patient. If the staff is not in-house, Hospital policy must be written to assure early notification and prompt response. The PI process must document and monitor the ongoing availability of OR crews and absence of delay. Frequently it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.

2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education.

3. PACU staffing should be in sufficient numbers to meet the critical needs of the trauma patient.

4. The list of required equipment necessary for the PACU can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 3.3.4. Intensive Care Unit (ICU)

1. Level II trauma centers must have an Intensive Care Unit (ICU) that meets the needs of the adult trauma patient.

2. The surgical director for the ICU – which houses trauma patients - must have obtained critical care training during residency or fellowship and must have expertise in the preoperative and post injury care of the injured patient. This is best demonstrated by a certificate of added qualification in surgical critical care from the American Board of Surgery and may also be fulfilled by documentation of active participation during the preceding 12 months in trauma patients' ICU care and ICU administration and critical care-related continuing medical education. The director is responsible for the quality of care and administration

of the ICU and will set policy and establish standards of care to meet the unique needs of the trauma patient.

3. The trauma service assumes and maintains responsibility for the care of the multiple injured patient. A surgically directed ICU physician team is desirable. The team will provide in-house physician coverage for all ICU trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialties, but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution.

4. There should be physician coverage for the ICU at all times. A physician credentialed by the facility for critical care should be promptly available to the trauma patient in the ICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.

5. The trauma service should maintain the responsibility for the care of the patient as long as the patient remains critically ill. The trauma service must remain in charge of the patient and coordinate all therapeutic decisions. The responsible trauma surgeon or designee should write all orders. The trauma surgeon should maintain control over all aspects of care, including but not limited to respiratory care and management of mechanical ventilation; placement and use of pulmonary catheters; management of fluid and electrolytes, antimicrobials, and enteral and parenteral nutrition.

6. Level II trauma centers must provide staffing in sufficient numbers to meet the critical needs of the trauma patient. Critical care nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing critical care education. ICU nurses are an integral part of the trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.

7. The list of required equipment necessary for the PACU can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 3.4.1. Respiratory Therapy Service: the service should be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatments for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.2. Radiological Service

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. It is desirable to have a technician in-house and immediately available for computerized tomography (CT) for both head and body. If the technician is not in-house 24 hours/day for special procedures the performance improvement process must document and monitor that the procedure is promptly available.

2. Sonography and Angiography must be available to the trauma team. It is desirable that MRI services be available to the trauma team. Specialty procedures such as angiography and sonography may be covered with a technician on-call.

3. A board-certified radiologist should administer the department and participate actively in the trauma education and PI process. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must insure the preliminary interpretations are promptly reported to the trauma team and the PI program must monitor all changes in interpretation.

4. Written policy should exist delineating the prioritization/availability of the CT scanner for trauma patients. The PI process must endure that trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transportation to and while in the radiology department.

5. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and the PI Program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.3. Clinical Laboratory Service

1. A clinical laboratory service must have the following services available in-house 24 hours/day:

    a. Access to a blood bank and adequate storage facilities. Sufficient quantities of blood and blood products should be maintained at all times. Blood typing and cross-match capabilities must be readily available.

    b. Standard analysis of blood, urine, and other body fluids including microsampling when appropriate.

c. Blood gas and pH determinations (this function may be performed by services other than the clinical laboratory service, when applicable).

d. Alcohol screening is required and drug screening is highly recommended.

e. Coagulation studies

f. Microbiology

2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.4. Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the Level II Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level II Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.6. Rehabilitation/Social Services

1. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include; Occupational Therapy, Physical Therapy, and Speech Pathology.

2. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout the continuum of recovery. Adequate numbers of trained personnel should be readily available to the trauma patients and family. Programs must be available to meet the unique needs of the trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.7. Prevention/Public Outreach

1. Level II Trauma Centers will be responsible for participating with appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the region. The trauma registry data should be utilized to identify injury trends and focus prevention needs.

2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at the Level II trauma center should provide consultation to staff members at other facilities in the region. Advanced Trauma Life Support (ATLS), Pre Hospital Trauma Life Support (PHTLS), Trauma Nurse Curriculum Course (TNCC), and Transport Nurse Advanced Trauma Course (TNATC) courses for example can be coordinated by the trauma center. Trauma physicians should provide a formal follow up to referring physicians/designee about specific patients to educate he practitioner for the benefit of further injured patients.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.8. Transfer Guidelines: Level II Trauma Centers shall work in collaboration with the referral trauma facilities in the system and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.9. Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate

and improve the quality of health care services, this data is confidential as provided in Miss. Code Ann.§41-59-77. Level II trauma facilities may be responsible for direct assistance to all other levels of referring facilities in providing data for inclusion in the registry.

2. Each trauma center must develop an internal Performance Improvement plan that minimally addresses the following key components and is fully integrated into the hospital wide program:

   a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).

   b. Clearly defined authority and accountability for the program.

   c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.

   d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.

   e. Explicit definitions of outcomes derived from institutional standards

   f. Documentation system to monitor performance, corrective action and the result of the actions taken.

   g. A process to delineate privileges credentialing all trauma service physicians.

   h. An informed peer review process utilizing a multidisciplinary method.

   i. A method for comparing patient outcomes with computed survival probability.

   j. Autopsy information on all deaths when available.

   k. Review of prehospital care.

   l. Review of times and reasons for trauma bypass.

   m. Review of times and reasons for trauma transfers.

   n. Audit all trauma deaths.

   o. Morbidity and Mortality review.

3. Representatives from the Level II trauma center shall participate in the Trauma Care Region and statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.10. Education: Level II Trauma Centers must have medical education programs including educational training in trauma for physicians, nurses and prehospital providers. The Level II trauma centers assist and cooperate with the Level I trauma center in providing educational activities. Education may be accomplished via many mechanisms (i.e. classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens, etc.)

Source: Miss. Code Ann. § 41-59-5

Rule 3.4.11. Essential and Desirable Chart for Level II Trauma Centers (Reserved)

Chapter 4 Level III Trauma Centers

Subchapter 1 Hospital Organization

Rule 4.1.1. General: A Level III trauma center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the trauma patient. Generally, a Level III trauma center is expected to provide initial resuscitation of the trauma patient and immediate operative intervention to control hemorrhage and to assure maximal stabilization prior to referral to a higher level of care. In many instances, patients will remain in the Level III Trauma Center unless the medical needs of the patient require secondary transfer. The decision to transfer a patient rests with the physician attending the trauma patient. All Level III Trauma Centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.2. Hospital Departments/Divisions/Sections: The Level III Trauma Center must have the following departments, divisions, or sections:

1. Emergency Medicine

2. Trauma/General Surgery

3. Orthopedic Surgery

4. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.3. Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. The trauma program must be established and recognized by the medical staff and hospital administration. The trauma program must come under the direction of a board-certified surgeon with special interest in trauma care. An administrative structure should ideally include an administrator, medical director, trauma program manager, trauma registrar and other appropriate staff. At minimum, an identified hospital administrative leader should work closely with the trauma medical director to establish and maintain the components of the trauma program including appropriate financial support. The trauma program location in the organizational structure of the hospital should be placed so that it may interact effectively with at least equal authority with other departments providing patient care. The trauma program should be multidisciplinary in nature and the performance improvement evaluation of this care must extend to all the involved departments.

2. Compliance with the above will be evidenced by but not limited to:

    a. Governing authority and medical staff letter of commitment in the form of a resolution;

    b. Written policies and procedures and guidelines for care of the trauma patient;

    c. Defined trauma team and written roles and responsibilities;

    d. Appointed Trauma Medical Director with a written job description;

    e. Appointed Trauma Program Manager with a written job description;

    f. A written Trauma Performance Improvement plan;

    g. Documentation of trauma center representative attendance at the regional trauma advisory committee meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.4. Trauma Service: A trauma service is an organized structure of care for the patient. The Trauma Service must be established and recognized by the medical staff. The service includes personnel and resources necessary to ensure the appropriate efficient care delivery. The composition of the service will vary depending on the nature of the medical center, available resources and personnel and patient clinical need. The trauma service must come under the organization and direction of a surgeon who is board certified with special interest in trauma care. All patients with multiple system trauma or major injury must be evaluated by the trauma service. Injured patients may be admitted to individual surgeons.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.5. Trauma Medical Director (TMD)

1. Level III Trauma Centers must have a physician director of the trauma program. The TMD plays an important administrative role. The TMD must be a board-certified surgeon with special interest in trauma care. The TMD will be responsible for developing a performance improvement process and, through this process, will have overall accountability for all trauma patients and administrative authority for the hospital's trauma program. The TMD must be given administrative support to implement the requirements specified by the state trauma plan. The TMD is responsible for working with the credentialing process of the hospital and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the trauma team. He should cooperate with nursing administration to support the nursing needs of the trauma patient and develop treatment protocols for the trauma patients. The TMD in collaboration with the Trauma Program Manager (TPM) should coordinate the budgetary process for the trauma program

2. The TMD must be currently certified by the American College of Surgeons Advanced Trauma Life Support (ATLS), maintain personal involvement in care of the injured, maintain education in trauma care, and maintain involvement in professional organizations. The TMD, or his designee, must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.6. Trauma Program Manager (TPM)

1. Level III trauma centers must have a registered nurse working in the role of Trauma Program Manager (TPM). Working in conjunction with the TMD, the TPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The TPM is responsible for working with the trauma team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.

2. The TPM or his/hers designee should offer or coordinate services for trauma education. The TPM should liaison with local EMS personnel, the Department, Trauma Care Regions(s) and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.7. Trauma Team: The team approach is optimal in the care of the multiple injured patients. There must be identified members of the trauma team. Policies should be in place describing the roles of all personnel on the trauma team. The composition of the trauma team in any hospital will depend on the characteristics of that hospital and its resources. In some instances, a tiered response may be appropriate. If a tiered response is employed written policy must be in place and the system monitored by the PI process. The team leader must be a qualified general surgeon. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians. Composition of the trauma team for severely injured patients includes:

1. Emergency Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)*

2. General/Trauma Surgeons*

3. Physician Specialists

4. Laboratory Technicians as dictated by clinical needs

5. Nursing: ED*, OR, ICU, etc.

6. Auxiliary Support Staff

7. Respiratory Therapists

8. Security Officers

* Mandatory for all Alpha and Bravo Alerts/Activations.

Source: Miss. Code Ann. § 41-59-5

Rule 4.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. The major focus will be on PI activities, policy development,

communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives (if available in the community) from:

a. Emergency Medicine

b. General Surgery

c. Orthopedics

d. Neurosurgery

e. Anesthesia

f. Operating Room

g. Intensive Care

h. Respiratory Therapy

i. Radiology

j. Laboratory

k. Rehabilitation

l. Pre-hospital Care Providers

m. Administration

n. Pediatrics

o. Nursing

p. Trauma Program Manager

2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.

3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 4.2.1. Required Components: Level III Trauma Centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

1. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

2. Trauma/General Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the trauma center and not on-call to any other hospital while on trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is sooner. Response time for Bravo Alerts/Activations is 45 minutes from the time notified to respond.

3. Orthopedic Surgery. It is desirable to have the orthopedists dedicated to the trauma center solely while on-call. The maximum response time for all trauma patients is 60 minutes from the time notified to respond.

4. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

5. The following specialists must be on-call and promptly available 24 hours/day: Radiology

6. It is desirable (although not required) to have the following specialist available to a Level III Trauma Center:

    a. Hand Surgery

    b. Obstetrics/Gynecology Surgery

    c. Ophthalmic Surgery

d. Oral/Maxillofacial Surgery

e. Plastic Surgery

f. Critical Care Medicine

g. Thoracic Surgery*

h. Microvascular Surgery

*A trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available (within 30 minutes of the time notified to respond).

7. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.

8. Polices and procedures should exist to notify the patient's primary physician of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 4.2.2. Qualifications of Surgeons on the Trauma Team

1. Basic to qualification for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, the American Dental Association, the Royal College of Physicians and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.

2. Alternate criteria in lieu of board certification are as follows:

a. Non-board certified general surgeon must have completed a surgical residency program.

b. He/she must be licensed to practice medicine.

c. He/she must be approved by the hospital's credentialing committee for surgical privileges.

d. The surgeon must meet all criteria established by the TMD to serve on the trauma team.

e. The surgeon's experience in caring for the trauma patient must be tracked by the PI program.

f. The TMD must attest to the surgeons' experience and quality as part of the recurring granting of trauma team privileges.

g. The TMD, using the trauma PI program, is responsible for determining each general surgeon's ability to participate on the trauma team.

3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured patient to make key decisions about the management of the trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a Level III facility) and determine if the patient needs transport to a higher lever of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the Level III trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patients should be admitted to the Level III trauma center or which patients should be considered for transfer to a higher level of care.

4. The general surgery and orthopedic liaisons must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. General Surgery physicians must be currently certified in ATLS; ATLS requirements are waived for Board Certified General Surgery physicians, and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other surgeons on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 4.2.3. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.

2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:

a. He/she must be licensed to practice medicine.

b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.

c. The physician must meet all criteria established by the trauma and emergency medical director to serve on the trauma team.

d. The physician's experience in caring for the trauma patient must be tracked by the PI program.

e. The TMD and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of trauma team privileges.

f. Residency in Emergency Medicine is desirable.

3. The emergency medicine liaison must participate in a multi-disciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent (50%) over a year's period of time. Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related continuing education (CME) every 3 years. As a minimum, all other physicians on the trauma team must participate in the hospital's internal education plan.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 4.3.1. Emergency Department

1. The facility must have an emergency department, division, service or section staffed so those trauma patients are assured immediate and appropriate initial care. The emergency physician and/or mid level providers must be in-house 24 hours/day, immediately available at all times, and capable of evaluating trauma patients and providing initial resuscitation. The emergency medicine physician will provide team leadership and care for the trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the adult and pediatric trauma patient. The medical director for the department, or his designee, must participate with the Multidisciplinary Trauma Committee and the trauma PI process.

2. The director of the emergency department, along with the TMD, may establish trauma-specific credentials that should exceed those that are required for general hospital privileges (i.e., ATLS verification).

3. There should be an adequate number of RN's staffed for the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of TNCC and participate in the ongoing PI process of the trauma program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. Nurses must obtain TNCC within 18 months of assignment to the ER.

4. The list of required equipment necessary for the ED can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.2. Surgical Suites/Anesthesia

1. The surgical team must be on-call with a well-defined mechanism for notification to expedite transfer to the operating room if the patient's condition warrants. The process should be monitored by trauma PI program.

2. The OR nurses should participate in the care of the trauma patient and be competent in the surgical stabilization of the major trauma patient.

3. The surgical nurses are integral members of the trauma team and must participate in the ongoing PI process of the trauma program and must be represented on the Multidisciplinary Trauma Committee.

4. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent trauma patient during a busy operative schedule.

5. Anesthesia must be promptly available with a mechanism established to ensure notification of the on-call anesthesiologist. The Level III trauma center must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient.

6. Anesthesiologists on the trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialties, or the American Osteopathic Board and should have board certification in anesthesia.

7. Anesthesia requirements may be fulfilled by Certified Registered Nurse Anesthetists (CRNAs) and/or anesthesia residents who are capable of assessing emergent situations in trauma patients and of providing an indicated treatment, including initiation of surgical anesthesia. When the CRNA is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be

documented and monitored by the PI process. The anesthesiologist participating on the trauma team should have the necessary educational background in the care of the trauma patient; participate in the Multidisciplinary Trauma Committee and the trauma PI process.

8. The list of required equipment necessary for Surgery and Anesthesiology the ED can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.3. Post Anesthesia Care Unit (PACU)

1. A Level III trauma center must have a PACU available 24 hours/day to the postoperative trauma patient. Hospital policy must be written to assure early notification and prompt response. Frequently, it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.

2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing critical care education. PACU staffing should be in sufficient numbers to meet the critical need of the trauma patient.

3. The list of required equipment necessary for the PACU can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Rule 4.3.4. Intensive Care Unit (ICU)

1. The ICU must have a surgical director or surgical co-director who is responsible to set policy and administration and establish standards of care to meet the unique needs of the trauma patient. He/she is responsible for the quality of care and administration of the ICU. The trauma medical director must work to assure trauma patients admitted to the ICU will be admitted under the care of a general surgeon or appropriate surgical subspecialists. In addition to overall responsibility for patient care by the primary surgeon, it is desirable to have in-house physician coverage for the ICU at all times. This may be provided by a hospitalist or emergency physician.

2. Level III Trauma Center should provide staffing in sufficient numbers to meet the needs of the trauma patient. There must be a written plan ensuring nurses maintain ongoing critical care education. ICU nurses are an integral part of the trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.

3. ICU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education.

4. The list of required equipment necessary for the ICU can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 4.4.1. Respiratory Therapy Service: The service must be staffed with qualified personnel on-call 24 hours/day to provide the necessary treatments for the injured patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.2. Radiological Service

1. A board-certified radiologist should administer the department and participate actively in the trauma PI process. The radiologist is a key member of the trauma team and should be represented on the Multidisciplinary Trauma Committee. A certified radiological technician must be available in-house 24 hours/day to meet the immediate needs of the trauma patient for general radiological procedures. Sonography should be available to the trauma team. If the radiology technician and the specialty technician are on-call from home, a mechanism must be in place to assure the technicians are available. The performance improvement process must verify that radiological services are promptly available. Written policy should exist delineating the prioritization/availability of the CT scanner for trauma patients. The use of teleradiology is acceptable. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

2. The PI process must ensure that trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transportation to and while in the radiology department.

3. The radiologist must ensure the preliminary interpretations are promptly reported to the trauma team and the PI Program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.3. Clinical Laboratory Service

1. The clinical laboratory service shall have the following services available in-house 24 hours/day:

a. Access to a community central blood bank and adequate storage facilities. Sufficient quantities of blood and blood products should be maintained at all times. Blood typing and cross-match capabilities must be readily available.

b. Standard analysis of blood, urine, and other body fluids includes microsampling when appropriate.

c. Blood gas and Ph determinations (this function may be performed by services other than the clinical laboratory service, when applicable).

d. Alcohol screening is required and drug screening is highly recommended.

e. Coagulation studies.

f. Microbiology

2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.4. Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the Level III Trauma Center.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.5. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level III Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.6. Rehabilitation/Social Services:

1. The rehabilitation of the trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the trauma patient, at the earliest stage possible after admission to the trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care

facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include; Occupational Therapy, Physical Therapy, and Speech Pathology.

2. The nature of traumatic injury requires that the psychological needs of the patient and family are considered and addressed in the acute stages of injury and throughout recovery. A Level III Trauma Center may utilize community resources as appropriate to meet the needs of the trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.7. Prevention/Public Outreach

1. Level III Trauma Centers must work cooperatively with referral facilities to develop and implement an outreach program for trauma care in the region. The Level III Trauma Center will work to plan, facilitate and provide professional education programs for the pre-hospital care providers, nurses and physicians, from referral facilities in their region. Prevention programs should be specific to the needs of the region. The trauma registry data should be utilized to identify injury trends and focus prevention needs.

2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills.

3. he Level III Trauma Center is responsible for working with the other centers to develop education and prevention programs for the public and professional staff. The plan must include implementation strategies to assure information dissemination to all residents in the region.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.8. Transfer Guidelines: The Level III trauma center will have transfer guidelines in place for Level I and Level II Trauma Centers, as well as for specialty referral centers (such as burn, pediatrics, spinal cord injury and rehabilitation) when these services are not available at the trauma center. Level III Trauma Centers should work in collaboration with the referral trauma facilities in their region and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the trauma victim regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.9. Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential as provided in Miss. Code Ann.§41-59-77. Level I and II trauma facilities may be responsible for direct assistance to Level III Trauma Center, referring facilities in providing data for inclusion in the registry.

2. Each trauma center must develop an internal Performance Improvement plan that minimally addresses the following key components:

    a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).

    b. Clearly defined authority and accountability for the program.

    c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.

    d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.

    e. Explicit definitions of outcomes derived from institutional standards.

    f. Documentation system to monitor performance, corrective action and the result of the actions taken.

    g. A process to delineate privileges credentialing all trauma service physicians.

    h. An informed peer review process utilizing a multidisciplinary method.

    i. A method for comparing patient outcomes with computed survival probability.

    j. Autopsy information on all deaths when available.

    k. Review of prehospital care.

    l. Review of times and reasons for trauma bypass.

    m. Review of times and reasons for trauma transfers.

    n. Audit of all trauma deaths.

o. Morbidity and Mortality review.

3. Representatives from the Level III Trauma Center shall participate in the Trauma Care Region and the statewide performance review process.

Source: Miss. Code Ann. § 41-59-5

Rule 4.4.10 Essential and Desirable Chart for Level III Trauma Centers (Reserved)

Chapter 5 Level IV Trauma Centers

Subchapter 1 Hospital Organization

Rule 5.1.1. General

1. Level IV Trauma Centers are generally licensed, small, rural facilities with a commitment to the resuscitation of the trauma patient and written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. These facilities may be staffed by a physician, or a licensed mid-level practitioner (i.e., Physician Assistant or Nurse Practitioner) or Registered Nurse. The major trauma patient will be resuscitated and transferred.

2. This designation does not contemplate that Level IV Trauma Centers will have resources available for emergency surgery for the trauma patient.

3. Level IV Trauma Centers may meet the following standards in their own facility or through a formal affiliation with another trauma center.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.2. Hospital Departments/Divisions/Sections: The Level IV Trauma Center must have the following departments, divisions, or sections: Emergency Medicine

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.3. Trauma Program/Service

1. There must be a written commitment letter from the Board of Directors and the medical staff on behalf of the entire facility which states the facility's commitment to compliance with the Mississippi Trauma Care Regulations. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital’s chief executive officer to the establishment of a trauma care program may be sufficient. A trauma program must be established and recognized by the organization. Compliance with the above will be evidenced by:

a. Board of Director's and medical staff letter of commitment;

b. Written policies, procedures and guidelines for care of the trauma patient;

c. A defined Trauma Team with written roles and responsibilities;

d. Appointed Trauma Medical Director with a written job description;

e. A written Trauma Performance Improvement Plan;

f. Appointed Trauma Program Manager with a written job description;

g. Documentation of trauma center representative's attendance at the Trauma Care Region meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.4. Trauma Medical Director (TMD)

1. The Level IV Trauma Center must have a physician director of the trauma program. In this instance, the physician is responsible for working with all members of the trauma team, and overseeing the implementation of a trauma specific performance improvement process for the facility. Through this process, he/she should have overall responsibility for the quality of trauma care rendered at the facility. The director must be given administrative support to implement the requirements specified by the Mississippi Trauma Plan. The director should assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director must have current verification in ATLS. ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.

2. Compliance with the above will be evidenced by:

   a. Chairing and participating in the committee where trauma performance improvement is presented;

   b. Administrative support can be documented in the organizational chart which depicts the reporting relationship between the trauma program medical director and administration;

   c. Trauma specific policies, procedures and guidelines approved by the TMD.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.5. Trauma Program Manager (TPM)

1. The trauma center must have a person to act as a liaison to the regional evaluation process to conduct many of the administrative functions required by the trauma program. It is not anticipated that this would be a full-time role. Specifically, this person is responsible, with the TMD, for coordinating optimal patient care for all injured victims. This position will ideally serve as liaison with local EMS personnel, the Trauma Care Region, and other trauma centers.

2. Compliance with the above will be evidenced by:

   a. Attendance at and participation in the committee where trauma performance improvement is presented;

   b. A written job description of roles and responsibilities to the trauma program which include: management of the trauma program, monitoring of clinical activities on trauma patients, providing staff with trauma related education, implementation of trauma specific performance improvement and supervision of the trauma registry;

   c. Documentation of collaboration with TMD in the development and implementation of trauma specific policies, procedures and guidelines.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.6. Trauma Team

1. The team approach is optimal in the care of the multiple injured patients. The trauma center must have a written policy for notification and mobilization of an organized trauma team to the extent that one is available. The Trauma Team may vary in size and composition when responding to the trauma activation. The physician leader or mid-level provider on the trauma team is responsible for directing all phases of the resuscitation in compliance with ATLS protocol. Suggested composition of the trauma team includes, if available:

   a. Physicians and/or mid-level providers

   b. Laboratory Technicians

   c. Nursing

   d. Ancillary Support Staff

2. Compliance with the above will be evidenced by:

   a. A written resuscitation protocol which adheres to the principles of ATLS;

b. A written trauma team activation criteria policy which includes physiologic, anatomic and mechanism of injury criteria.

Source: Miss. Code Ann. § 41-59-5

Rule 5.1.7. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the system. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Membership for the committee includes representatives (if available in the community) from:

   a. Emergency Medicine

   b. Respiratory Therapy

   c. Radiology

   d. Laboratory

   e. Rehabilitation

   f. Pre-hospital Care Providers

   g. Administration

   h. Nursing

   i. Trauma Program Manager

2. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.

3. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 5.2.1. Rule 5.2.1 Required Components

1. The trauma center must maintain published on-call schedules for physicians and/or mid-level providers on-call to the facility.

2. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 5.3.1. Emergency Department

1. The facility must have an emergency department staffed so trauma patients are assured immediate and appropriate initial care. There must be a designated physician director. It is not anticipated that a physician will be available on-call to an emergency department in a Level IV Trauma Center; however it is a desirable characteristic of a Level IV. The on-call practitioner must respond to the emergency department based on local written criteria. A system must be developed to assure early notification of the on-call practitioner. Compliance with this criterion must be documented and monitored by the Trauma Performance Improvement process.

2. All physicians and mid-level providers (Physician Assistant/Nurse Practitioner) on the trauma team responsible for directing the initial resuscitation of the trauma patients must be currently certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.

3. Emergency nurses staffing the trauma resuscitation area must be a current provider in TNCC. Nurses must obtain TNCC within 18 months of assignment to the ER. Adequate numbers of nurses must be available in-house 24 hours/day, to meet the need of the trauma patient. The nurse may perform other patient care activities within the hospital when not needed in the emergency department.

4. Compliance with the above will be evidenced by:

    a. Published on-call list of practitioners to the Emergency Department;

    b. Written trauma specific education plan for nurses;

    c. Documentation of nursing staffing patterns to assure 24-hour coverage.

d. The list of required equipment necessary for the ED can be found at the end of this Chapter.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 5.4.1. General

1. It is not anticipated that Level IV Trauma Centers have any of the following services available:

   a. Respiratory Therapy Services

   b. Radiology Services

   c. Clinical Laboratory Services

   d. Acute Hemodialysis

2. There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the Level IV Trauma Center.

3. Should any of these services be available, the facility should make them available to the trauma patient as necessary and within the capabilities of the facility.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.2. Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the Level IV Trauma Center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.3. Prevention/Public Outreach

1. The Level IV Trauma Center is responsible for working with other trauma centers and the Trauma Care Region to develop education and prevention programs for the public and professional staff.

2. Compliance with the above will be evidenced by documentation of collaborative efforts of trauma specific education and injury prevention programs with other trauma centers and/or the Trauma Care Region.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.4. Transfer Guidelines: All facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. The transfer guidelines shall make certain that feedback is provided to the facilities and assure that this information becomes part of the trauma registry. All designated facilities will agree to provide service to the trauma patient regardless of their ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.5. Performance Improvement/Evaluation

1. The trauma center must develop and implement a trauma specific performance improvement plan. Key elements in trauma system planning are evaluation, measurement and improvement of performance. The goal is to decrease variation in care and improve patient outcomes.

2. Compliance with the above will be evidenced by:

    a. Review of compliance with EMS Triage Guidelines and Protocols;

    b. Compliance with written Trauma Team Activation Criteria;

    c. Compliance with the principles of ATLS;

    d. Peer Review of all trauma deaths to determine timeliness and appropriateness of care and preventability of death;

    e. Review of trauma related morbidities for appropriateness of care and preventability;

    f. Nursing Audit (clinical review of nursing documentation and quality of care rendered to trauma patients);

    g. Review of timeliness and appropriateness of all transfers out;

    h. Review of prehospital trauma care;

    i. Review of times/reasons for trauma-related bypass;

3. This information must be documented and reported at a trauma specific meeting or in conjunction with other ongoing performance improvement committees in the facility.

Source: Miss. Code Ann. § 41-59-5

Rule 5.4.6. Essential and Desirable Chart for Level IV Trauma Centers (Reserved)

Chapter 6 Pediatric Trauma Centers

Subchapter 1 Tertiary Pediatric Trauma Centers

Rule 6.1.1. General

1. Tertiary Pediatric Trauma Centers shall act as regional tertiary care facilities at the hub of the trauma care system for injured pediatric patients. The facility shall have the ability to provide leadership and total care for every aspect of injury from prevention to rehabilitation. The Tertiary Pediatric Trauma Center must have adequate depth of resources and personnel.

2. A stand-alone Pediatric Trauma Center provides tertiary pediatric trauma care without sharing resources with another facility (i.e., CT scanner, radiology, surgeons, etc). Only Level I Trauma Centers and Stand-alone pediatric hospitals may qualify as a tertiary Pediatric Trauma Center.

3. The Tertiary Pediatric Trauma Centers have the responsibility of providing leadership in pediatric trauma education, trauma prevention, pediatric trauma research, and system planning.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.2. Hospital Departments/Divisions/Sections

1. The Tertiary Pediatric Trauma Center must have the following department, divisions, or sections:

    a. Emergency medicine

    b. General surgery (not required for stand-alone Pediatric Trauma enter)

    c. Pediatric surgery

    d. Orthopedic surgery

    e. Neurological surgery

    f. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.3. Pediatric Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of pediatric trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a pediatric trauma care program is sufficient. The pediatric trauma program must be established and recognized by the medical staff and hospital administration. The pediatric trauma program must come under the direction of a board-certified surgeon with special interest in pediatric trauma care. An identified hospital administrative leader must work closely with the pediatric trauma medical director to establish and maintain the components of the pediatric trauma program including appropriate financial support. The pediatric trauma program location in the organizational structure of the hospital must be under the overall adult trauma program and must be such that it may interact effectively with at least equal authority with other departments providing pediatric patient care. The administrative structure should minimally include an administrator, pediatric medical director, trauma program manager, trauma registrar, and the appropriate support staff. These resources must be captured under the organization of the adult trauma program. The pediatric trauma program must be multidisciplinary in nature and the performance improvement evaluation of this care should be extended to all the involved departments.

2. Compliance with the above will be evidenced by but not confined to:

    a. Governing authority and medical staff letter of commitment in the form of a resolution;

    b. Written policies and procedures and guidelines for care of the pediatric trauma patient;

    c. Defined pediatric trauma team and written roles and responsibilities;

    d. Appointed pediatric trauma medical director with a written job description;

    e. Appointed pediatric trauma program manager with a written job description;

    f. A written pediatric trauma performance improvement plan;

    g. Documentation of pediatric trauma center representative attendance at the regional trauma advisory committee meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.4. Pediatric Trauma Service: The pediatric trauma service must be established and recognized by the medical staff and be responsible for the overall coordination and management of the system of care rendered to the injured pediatric patient. The pediatric trauma service will vary in each institution depending on the needs of the pediatric patient and the resources available. The pediatric trauma service must come under the organization of the adult trauma program (not required for a stand-alone facility) and direction of a surgeon who is board certified with special interest in pediatric trauma care. All pediatric patients with multiple system trauma or major injury must be evaluated by the pediatric trauma service. The surgeon responsible for the overall care of the pediatric patient must be identified.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.5. Pediatric Trauma Medical Director (TMD): Tertiary pediatric trauma centers must have a physician director of the pediatric trauma program. This role can be filled by the TMD of the adult trauma center. The pediatric TMD plays an important administrative role. The pediatric TMD must be a board-certified surgeon with a special interest in pediatric trauma care. The pediatric TMD will be responsible for developing a performance improvement process and will have overall accountability and administrative authority for the pediatric trauma program. The pediatric TMD must be given administrative support to implement the requirements specified by the State trauma plan. The pediatric TMD is responsible for working with the credentialing process of the hospital, and in consultation with the appropriate service chiefs, for recommending appointment and removal of physicians from the pediatric trauma team. He/she should cooperate with nursing administration to support the nursing needs of the pediatric trauma patient and develop treatment protocols for the pediatric trauma patient. The pediatric trauma medical director, in collaboration with the trauma program manager, should coordinate the budgetary process for the trauma program. The director must be currently certified in ATLS, maintain personal involvement in care of the injured pediatric patient, maintain education in pediatric trauma care, and maintain involvement in professional organizations. The pediatric TMD must be actively involved with the trauma system development at the community, regional, and state levels.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.6. Pediatric Trauma Program Manager

1. Tertiary pediatric trauma centers must have a registered nurse working in the role of the TPM. The TPM of the adult trauma center may assume this additional role; however, if a pediatric TPM is utilized, the pediatric TPM is to report and be held accountable by the adult TPM. Working in conjunction with the pediatric trauma medical director, the pediatric TPM is responsible for organization of the pediatric trauma program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The pediatric TPM is responsible for working with the pediatric trauma team to assure optimal patient care. There are

many requirements for data coordination, PI, education, and prevention activities incumbent upon this position.

2. The pediatric TPM/designee should offer or coordinate services for pediatric trauma education. The pediatric TPM should liaison with local EMS personnel, the Department, the Trauma Care Regions, and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.7. Pediatric Trauma Team: The team approach is optimal in the care of the multiple injured pediatric patient. There must be identified members of the pediatric trauma team. Policies should be in place describing the respective role of all personnel on the pediatric trauma team. The composition of the pediatric trauma team will depend of the characteristics of the hospital and its staff. In some instances a tiered response may be appropriate. If a tiered response is employed written policy must be in place and the system monitored by the PI process. All physicians and/or mid-level providers on the pediatric trauma team responsible for directing the initial resuscitation of the pediatric trauma patient must be certified in The American College of Surgeons Advanced Trauma Life Support (ATLS). ATLS requirement is waived for Board Certified Emergency Medicine and Board Certified General Surgery physicians. A pediatric ED physician and pediatric general/trauma surgeon are required members of the team. Additional members may include:

1. Anesthesiologist
2. Pediatricians
3. Laboratory technicians as dictated by clinical needs
4. Mental health/social services/radiology technicians
5. Pastoral care
6. Respiratory therapist
7. Nurses: ED, OR, ICU, etc.
8. Police/Security officers

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program including the pediatric trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the region. Each trauma center may choose to have

one or more committees as needed to accomplish this task. One committee should be multidisciplinary and focus on pediatric trauma program oversight and leadership. The major focus will be on performance improvement (PI) activities, pediatric trauma policy development, communication among all pediatric trauma team members, and establishment of pediatric trauma standards of care, education, and outreach programs for pediatric injury prevention. The committee has administrative and systematic control and oversees implementation of all pediatric trauma program services, meets regularly, takes attendance, maintains minutes, and works to correct overall pediatric trauma program deficiencies to optimize pediatric patient care. Suggested membership for the committee includes representatives from:

a. Pediatric Emergency Medicine

b. Pediatric Surgery

c. Pediatric Orthopedics

d. Pediatric Neurosurgery

e. Anesthesia

f. Operating room

g. Intensive care

h. Respiratory Therapy

i. Radiology

j. Laboratory

k. Pediatric Rehabilitation

l. Pre-hospital care providers

m. Administration

n. Pediatrics

o. Nursing

p. Trauma Program Manager

q. Clinical managers (or designees) of the departments involved with pediatric trauma care should plan an active role with the committee

2. The pediatric trauma center may wish to accomplish PI activities in this committee or develop a separate peer review committee. This committee should

handle peer review independent from departmental based review. This committee must meet regularly, maintain attendance, and maintain minutes. This committee must report findings to the overall multidisciplinary trauma committee and hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.9. Required Clinical Components

1. Tertiary pediatric trauma centers must maintain published call schedules and have the following physician coverage immediately available 24 hours/day:

2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival. The ED liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee.

3. Trauma/General/Pediatric Surgery (in-house 24 hours/day). The surgeon covering pediatric trauma call must be unencumbered and immediately available to respond to the pediatric trauma patient. The 24 hour-in-house availability of the attending surgeon is the most direct method for providing this involvement. A PGY 4 or 5 resident may be approved to begin the resuscitation while awaiting the arrival of the attending surgeon but cannot be considered a replacement for the attending surgeon in the ED. The surgeon is expected to be in the ED upon arrival of the seriously injured pediatric patient. The surgeon's participation in major therapeutic decisions, presence in the ED for major resuscitation, and presence at operative procedures is mandatory. There must be a back-up surgeon schedule published. The surgeon on-call must be dedicated to the trauma center and not on-call at any other hospital while on trauma call. A system must be developed to assure early notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. The surgery liaison on the trauma team must be board certified, maintain 48 hours of trauma related CME over a three year period, and must maintain current ATLS certification. The liaison must attend a minimum of 50% of peer review committee meetings annually and must participate in the Multidisciplinary Trauma Committee. Response time for Alpha Alert/Activations is 15 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 20 minutes from patient arrival.

4. Orthopedic Surgery. The pediatric orthopedic liaison on the pediatric trauma team must be board certified, maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The orthopedic liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee.

It is desirable to have the orthopedic surgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.

5. Neurological Surgery. The neurosurgeons on the pediatric trauma team must be board certified. The pediatric neurosurgery liaison must maintain 48 hours of trauma related CME over 3 years, and it is desirable to maintain current ATLS certification. The pediatric neurosurgeon liaison to the pediatric trauma team must attend a minimum of 50% of the peer review committees annually and participate in the Multidisciplinary Trauma Committee. It is desirable to have the neurosurgeon dedicated to the pediatric trauma center solely while on-call, but if not dedicated, a published back-up call schedule must be available. Response time for all trauma activations is 60 minutes from the time notified to respond.

6. Anesthesia (in-house 24 hours/day). Anesthesia must be available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be in-house and available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

7. The following specialists must be committed to pediatric trauma care, on-call and promptly available 24 hours/day:

   a. Cardiac Surgery

   b. Cardiology

   c. Critical Care Medicine

   d. Hand Surgery

   e. Infectious Disease

   f. Microvascular Surgery

   g. Nephrology

   h. Nutritional support

   i. Obstetrics/Gynecologic Surgery

j. Ophthalmic Surgery

k. Oral/Maxillofacial

l. Pediatrics

m. Pediatric Critical Care Medicine

n. Pediatric Rehabilitation

o. Plastic Surgery

p. Pulmonary Medicine

q. Radiology

r. Thoracic Surgery*

s. Child Life or Family Support Programs

* The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).

8. Recognizing that early rehabilitation is imperative for the pediatric trauma patient, a physical medicine and pediatric rehabilitation specialist must be available for the pediatric trauma team.

9. Policies and procedures should exist to notify the patient's primary physician of the patient's condition.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.10. Qualifications of Surgeons on the Trauma Team

1. Basic qualifications for pediatric trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialties, the Advisory Board of Osteopathic Specialties, the Royal College of Physicians, the American Dental Association and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognition by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.

2. Alternate criteria in lieu of board certification are as follows:

a. A non-board certified general surgeon must have completed a surgical residency program.

b. He/she must be licensed to practice medicine.

c. He/she must be approved by the hospital's credentialing committee for surgical privileges.

d. The surgeon must meet all criteria established by the pediatric trauma medical director to serve on the pediatric trauma team.

e. The surgeon's experience in caring for the pediatric trauma patient must be tracked by the trauma PI program.

f. The pediatric trauma medical director must attest to the surgeon's experience and quality as part of the recurring granting of pediatric trauma team privileges.

g. The pediatric trauma medical director using the trauma PI program is responsible for determining each general surgeon's ability to participate on the pediatric trauma team.

3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured pediatric patient to make key decisions about the management of the pediatric trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation, and rehabilitation (as appropriate in a tertiary pediatric trauma center), and determine if the patient needs transport to a higher level of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the patient is to be admitted to the tertiary pediatric trauma center, the surgeon is the admitting physician and will coordinate the patient care while hospitalized. Guidelines should be written at the local level to determine which types of patient should be admitted to the tertiary pediatric trauma center or which patients should be considered for transfer to a higher level of care.

4. The pediatric surgeon liaison and general surgeon liaison (not required for stand-alone pediatric trauma center) must participate in a multidisciplinary trauma committee, the PI process, maintain peer review committee attendance greater than fifty percent (50%) over a year's period of time, and maintain 16 hours of trauma related CME each year. General Surgery and Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related CME every 3 years and must actively participate in an internal trauma education process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.11. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, emergency medicine physicians who are boarded in a specialty recognized by the American Board of Medical Specialists, a Canadian Board or other equivalent foreign board meets the requirements.

2. Alternate criteria for the non-boarded physician working in the Emergency Department are as follows:

    a. He/she must be licensed to practice medicine.

    b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.

    c. The physicians meet all criteria established by the pediatric trauma and emergency medicine directors to serve on the pediatric trauma team.

    d. The physician's experience in caring for the pediatric trauma patient must be tracked by the trauma PI program.

    e. The pediatric trauma and emergency medicine directors must attend to the physician's experience and quality as part of the recurring granting of pediatric trauma team privileges.

    f. Residency in Emergency Medicine is desirable.

3. The emergency medicine liaison must participate in a multidisciplinary trauma committee, the PI process, maintain peer review committee attendance greater than fifty percent (50%) over a year's period of time, and maintain 16 hours of trauma related CME each year. General Surgery and Emergency physicians must be currently certified in ATLS (ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery physicians), and it is desirable that they be involved in at least forty eight (48) hours of trauma related CME every 3 years and must actively participate in an internal trauma education process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.12. Facility Standards-Emergency Medicine

1. The facility must have a dedicated pediatric emergency department so pediatric patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day and immediately available at all times. The emergency department medical director must meet the recommended

requirements related to commitment, experience, continuing education, ongoing credentialing, and board certification in emergency medicine.

2. The director of the emergency department, along with the pediatric trauma medical director, will establish trauma-specific credentials that should exceed those that are required for general hospital privileges. Examples of credentialing requirements would include skill proficiency, training requirements, conference attendance, education requirements, ATLS verification, and specialty board certification.

3. The emergency medicine physician will be responsible for activating the pediatric trauma team based on predetermined response protocols. He will provide trauma leadership and care for the pediatric trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the pediatric trauma patient. The emergency department medical director, or his/her designee, must act as a liaison and participate with the Multidisciplinary Trauma Committee and the trauma PI process.

4. There should be an adequate number of RN's staffing the trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the trauma resuscitation area must be a current provider of Trauma Nurse Core Curriculum (TNCC) and participate in the ongoing PI process of the trauma program. Nurses must obtain TNCC within 18 months of assignment to the ER. There must be a written plan ensuring nurses maintain ongoing trauma specific education.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.13. Facility Standards-Surgical Suites/Anesthesia

1. The operating room (OR) must be staffed and available in-house 24 hours/day.

2. The Surgical nurses should participate in the care of the pediatric trauma patient and be competent in the surgical stabilization of the major pediatric trauma patient. The Surgical nurses are an integral member of the trauma team and must participate in the ongoing PI process of the pediatric trauma program and be represented on the Multidisciplinary Trauma Committee.

3. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergency pediatric patient during a busy operative schedule. There must be an on-call system for additional personnel for multiple patient admissions.

4. The anesthesia department in a tertiary pediatric trauma center must be organized and run by an anesthesiologist who has a special interest in the care of the injured pediatric patient. If this is not the director, an anesthesiologist liaison with the same qualifications should be identified. Anesthesiologist on the pediatric trauma

team must have successfully completed an anesthesia residency program approved by the Accreditation Council of Graduate Medical Education or the American Board of Osteopathic Specialists and have board certification in anesthesia.

5. Anesthesia must be available in-house 24hours/day with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia requirements may be fulfilled by anesthesia chief residents or Certified Registered Nurse Anesthetist (CRNAs) who are capable of assessing emergency situations in pediatric trauma patient and of providing indicated treatment, including initiation of surgical anesthesia. When the CRNA or chief resident is used to meet this requirement, the staff Anesthesiologist will be advised and promptly available at all times and present for operations. Tertiary pediatric trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the pediatric trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documents and monitored by the trauma PI process. The anesthesiologist liaison participating on the pediatric trauma team must participate in the Multidisciplinary Trauma Committee and the trauma PI process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.14. Facility Standards-PACU

1. Tertiary pediatric trauma centers must have a PACU staffed 24 hours/day and available to the postoperative pediatric trauma patient. Frequently it is advantageous to bypass the PACU and directly admit to the PICU. In this instance, the pediatric intensive care unit may meet these requirements.

2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. PACU staffing should be in sufficient number to meet the critical needs of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.15. Facility Standards-Pediatric ICU (PICU)

1. Tertiary pediatric trauma centers must have a PICU that meets the needs of the pediatric trauma patient.

2. The surgical director for the PICU must have obtained critical care training during a residency or fellowship and must have expertise in the preoperative and post injury care of the injured pediatric patient. This is best demonstrated by a certificate of added qualifications in surgical critical care from the American Board of Surgery and may also be fulfilled by documentation of active participation during the preceding 12 months in pediatric trauma patient PICU

care and PICU administrative and critical care-related continuing medical education. The director is responsible for the quality of care and administration of the PICU and will set policy and establish standards of care to meet the unique needs of the pediatric trauma patient.

3. The pediatric trauma service assumes and maintains responsibility for the care of the multiple injured pediatric patient. A surgically directed PICU physician team is essential. The team will provide in-house physician coverage for all PICU pediatric trauma patients at all times. This service can be staffed by appropriately trained physicians from different specialists, but must be led by a qualified surgeon as determined by critical care credentials consistent with the medical staff privileging process of the institution.

4. There must be in-house physician coverage for the PICU at all times. A physician credentialed by the facility for critical care must be immediately available to the pediatric trauma patient in the PICU 24 hours/day. This coverage is for emergencies only and is not intended to replace the primary surgeon but rather is intended to ensure that the patient's immediate needs are met while the surgeon is contacted.

5. The pediatric trauma service must maintain the responsibility for the care of the patient as long as the patient remains critically ill. The pediatric trauma service must remain in charge of the patient and coordinate all therapeutic decisions. The responsible trauma surgeon or designee should write all orders, maintain control over all aspects of care, including but not limited to respiratory care and management of mechanical ventilation, placement and use of pulmonary catheters, management of fluid and electrolytes, antimicrobials, and enteral and parenteral nutrition.

6. Tertiary pediatric trauma centers must provide staffing in sufficient numbers to meet the critical needs of the pediatric trauma patient. Critical care nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing trauma specific education. PICU nurses are an integral part of the pediatric trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the trauma program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.16. Clinical Support Services-Respiratory Therapy: The service must be staffed with qualified personnel in-house 24 hours/day to provide the necessary treatment for the injured pediatric patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.17. Clinical Support Services-Radiological Services

1. A radiological service must have a certified radiological technician in-house 24 hours/day and immediately available at all times for general radiological procedures. Sonography, angiography, and MRI must be available to the pediatric trauma team. A technician must be in-house and immediately available for computerized tomography (CT) for both head and body. Specialty procedures such as angiography, MRI, and sonography may be covered with a technician on-call. If the technician is not in-house 24 hours/day for special procedures, the trauma PI process must document and monitor that the procedure is promptly available.

2. A board-certified radiologist should administer the department and participate actively in the trauma education and PI process. A staff radiologist must be promptly available, when requested, for the interpretation of radiographs, performance of complex imaging studies or interventional procedures. The radiologist must ensure the preliminary interpretations are promptly reported to the pediatric trauma team and the trauma PI program must monitor all changes in interpretations.

3. Written policy should exist delineating the prioritization/availability of the CT scanner for pediatric trauma patients. The trauma PI process must ensure that pediatric trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transport to and while in the radiology department.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.18. Clinical Support Services-Laboratory Services

1. Clinical laboratory service must have the following services available in-house 24 hours/day:

    a. Access to blood bank and adequate storage facilities. Sufficient quantities of blood and blood products must be maintained at all times. Blood typing and cross-match capabilities must be readily available.

    b. Standard analysis of blood, urine and other body fluids including micro-sampling when appropriate.

    c. Blood gas and pH determinations (this function may be performed by services other than the clinical laboratory service, when applicable).

    d. Alcohol screening is required and drug screening is highly recommended.

    e. Coagulation studies.

f. Microbiology.

2. Sufficient numbers of clinical laboratory technologists shall be in-house 24 hours/day and promptly available at all times. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.19. Clinical Support Services-Acute Hemodialysis: Tertiary pediatric trauma centers must have Acute Hemodialysis services.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.20. Clinical Support Services-Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the tertiary pediatric trauma center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.21. Clinical Support Services-Rehabilitation/Social Services

1. The rehabilitation of the pediatric trauma patient and the continued support of the family members are an important part of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the pediatric trauma patient, at the earliest stage possible after admission to the tertiary pediatric trauma center. Hospitals will be required to identify a mechanism to initiate rehabilitation services and/or consultation in a timely manner as well as policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services should minimally include: occupational therapy, physical therapy, and speech pathology.

2. The nature of traumatic injury requires that the psychological needs of the pediatric patient and family are considered and addressed in the acute stages of injury and throughout the continuum of recovery. Adequate number of trained personnel must be available to the pediatric trauma patient and family. Programs, such as Child Life, must be available to meet the unique needs of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.22. Clinical Support Services-Prevention/Public Outreach

1. Tertiary pediatric trauma centers will be responsible for taking a lead role in coordination of appropriate agencies, professional groups, and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the trauma system, access to the system, public support for the system, as well as specific prevention strategies. Prevention program must be specific to the needs of the region. The trauma registry data must be utilized to identify injury trends and focus prevention needs.

2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills. Staff members at the tertiary pediatric trauma center must provide consultation to staff members of other level facilities. For example ATLS, Pre-Hospital Trauma Life Support (PHTLS), TNCC, and Transport Nurse Advance Trauma Course (TNATC) courses can be coordinated by the tertiary pediatric trauma center. Trauma physicians must provide a formal follow-up to referring physicians/designee about specific patients to educate the practitioners for the benefit of trauma injured pediatric patients.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.23. Clinical Support Services-Transfer Guidelines: Tertiary pediatric trauma centers should work in collaboration with the referral facilities in the system and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk pediatric trauma patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the pediatric trauma patient regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.24. Clinical Support Services-Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional, and state levels. Since these data relate to the specific trauma patients and are used to evaluate and improve the quality of health care services, the data is confidential as provided in Miss. Code An. 41-59-77.

2. The tertiary pediatric trauma center must develop an internal trauma specific Performance Improvement (PI) plan that is pediatric specific and must minimally address the following key components. The pediatric PI plan must be fully integrated into the hospital wide PI program:

3. An organized structure that facilitates performance improvement. (Multidisciplinary Trauma Committee)

   a. Clearly defines authority and accountability for the program.

   b. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.

   c. Development of expectations (criteria) from evidence based guidelines, pathways and protocols.

   d. These should be appropriate, objectively defined standards to determine quality of care.

   e. Explicit definitions of outcomes derived from institutional standards.

   f. Documentation system to monitor performance, corrective action, and the result of the actions taken.

   g. A process to delineate credentialing of all trauma service physicians.

   h. An informed peer review process utilizing a multidisciplinary method.

   i. A method of comparing patient outcomes with computed survival probability.

   j. Autopsy information on all deaths when available.

   k. Review of pre-hospital care.

   l. Review of times and reasons for trauma bypass.

   m. Review of times and reasons for trauma transfers.

   n. Morbidity and mortality review.

4. Representatives from the tertiary pediatric trauma center shall participate in the Trauma Care Region(s) and statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.25. Clinical Support Services-Education: Tertiary pediatric trauma centers must have medical education programs including educational training in pediatric trauma for physicians, nurses, and pre-hospital providers. The tertiary pediatric trauma center must take a leadership role in providing educational activities. Education can be accomplished via many mechanisms (i.e., classic CME, preceptorships, fellowships, clinical rotations, telecommunications or providing locum tenens, etc.)

Source: Miss. Code Ann. § 41-59-5

Rule 6.1.26. Clinical Support Services-Research

1. The trauma research program must be designated to produce new knowledge applicable to the care of the injured patients. The research may be conducted in a number of ways including traditional laboratory and clinical research, reviews of clinical series, and epidemiological or other studies. Publications of articles in peer-review journals as well as presentations of results in local, regional, and national meetings and ongoing studies approved by human and animal research review boards are expected from productive programs. The program should have an organized structure that fosters and monitors ongoing productivity.

2. The research program must be balanced to reflect the number of different interests. There must be a research committee, and identifiable Institutional Review Board process, active research protocols, surgeons involved in extramural educational presentations and adequate number of peer reviewed scientific publications. Publications should appear in peer-reviewed journals. In a three-year cycle, the suggested minimum activity is ten publications (per review cycle) from the physicians representing the membership of the Trauma Team.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Secondary Pediatric Trauma Center

Rule 6.2.1. General

1. A secondary pediatric trauma center is an acute care facility with the commitment, medical staff, personnel and specialty training necessary to provide initial resuscitation of the pediatric trauma patient. Pediatric patients should remain at the secondary pediatric trauma center only for orthopedic injuries. The decision to transfer a pediatric patient rests with the physician attending the pediatric trauma patient. All secondary pediatric trauma centers will work collaboratively with other trauma facilities to develop transfer protocols and a well-defined transfer sequence.

2. As a minimum, only Level III or higher adult trauma centers may qualify as a Secondary Pediatric Trauma Center. All pediatric trauma admissions will be reviewed by the PI process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.2. Hospital Departments/Divisions/Sections: The secondary pediatric trauma center must have the following departments, divisions, or sections:

1. Emergency Medicine

2. General Surgery

3. Orthopedic Surgery

4. Anesthesia

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.3. Pediatric Trauma Program

1. There must be a written commitment on behalf of the entire facility to the organization of pediatric trauma care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a pediatric trauma care program may be sufficient. The pediatric trauma program must be established and recognized by the medical staff and hospital administration. The pediatric trauma program must come under the direction of a board-certified surgeon with a special interest in trauma care. An administrative structure should ideally include an administrator, medical director, trauma program manager, trauma registrar, and other appropriate staff. As minimum, an identified hospital administrative leader should work closely with the pediatric trauma medical director to establish and maintain the components of the pediatric trauma program including appropriate financial support. The pediatric trauma program location in the organizational structure of the hospital should be placed so that it may interact effectively with at least equal authority with other departments providing patient care. The pediatric trauma program should be multidisciplinary in nature and the performance improvement evaluation of this care must extend to all the involved departments.

2. Compliance with the above will be evidenced by but not limited to:

    a. Governing authority and medical staff letter of commitment in the form of a resolution;

    b. Written policies and procedures and guidelines for care of the pediatric trauma patient;

    c. Defined trauma team and written roles and responsibilities;

    d. Appointed Trauma Medical Director with a written job description;

    e. Appointed Trauma Program Manager with a written job description;

    f. A written Trauma Performance Improvement plan;

    g. Documentation of trauma center representative attendance at the Trauma Care Region(s) meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.4. Pediatric Trauma Service: A Pediatric Trauma Service is an organized structure of care for the pediatric patient. The Pediatric Trauma Service must be established and recognized by the medical staff. The service includes personnel and resources necessary to ensure the appropriate efficient care delivery. The composition of the service will vary depending on the nature of the medical center, available resources and personnel and patient clinic need. The Pediatric Trauma Service must come under the organization and direction of a surgeon who is board certified with special interest in pediatric trauma care. All pediatric patients with multiple system trauma or major injury must be evaluated by the Pediatric Trauma Service. Injured pediatric patients may be admitted to individual surgeons.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.5. Pediatric Trauma Medical Director

1. Secondary pediatric trauma centers must have a physician director of the pediatric trauma program. The pediatric trauma medical director plays an important administrative role. The pediatric trauma medical director must be a board-certified surgeon with special interest in pediatric trauma care. The pediatric trauma medical director will be responsible for developing a performance improvement process and, through this process, will have overall accountability for all pediatric trauma patients and administrative authority for the hospital's pediatric trauma program. The pediatric trauma medical director must be given administrative support to implement the requirements specified by the State Trauma Plan. The director is responsible for working with the credentialing process of the hospital and, in consultation with the appropriate service chiefs, recommending appointment and removal of physicians from the pediatric trauma team. He/she should cooperate with nursing administration to support the nursing needs of the pediatric trauma patient and develop treatment protocols for the pediatric trauma patients. The director in collaboration with the Trauma Program Manager/TPM should coordinate the budgetary process for the pediatric trauma program.

2. The pediatric trauma medical director must be currently certified by the American College of Surgeons Advanced Trauma Life Support (ATLS), maintain personal involvement in the care of the inured pediatric patient. The pediatric trauma medical director, or designee, must be actively involved with the trauma system development at the community, regional and state level.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.6. Pediatric Trauma Program Manager (TPM)

1. Secondary pediatric trauma centers must have a registered nurse working in the role of the TPM. The TPM of the adult trauma center may assume this additional role; however, if a pediatric TPM is utilized, the pediatric TPM is to report and be held accountable by the adult TPM. Working in conjunction with the pediatric trauma medical director, the pediatric TPM is responsible for organization of the pediatric trauma program and all systems necessary for the multidisciplinary approach throughout the continuum of trauma care. The pediatric TPM is responsible for working with the pediatric trauma team to assure optimal patient care. There are many requirements for data coordination, PI, education, and prevention activities incumbent upon this position.

2. The pediatric TPM/designee should offer or coordinate services for pediatric trauma education. The pediatric TPM should liaison with local EMS personnel, the Department, the Trauma Care Regions, and other trauma centers.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.7. Pediatric Trauma Team

1. The team approach is optimal in the care of the multiple injured pediatric patients. There must be identified members of the pediatric trauma team. Policies shall be in place describing the roles of all personnel on the pediatric trauma team. The composition of the pediatric trauma team in any hospital will depend on the characteristics of that hospital and its resources. In some instances, a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. The team leader must be a qualified general and/or pediatric surgeon. All physicians and mid-level providers on the pediatric trauma team responsible for directing any phase of the resuscitation must be currently certified in ATLS. ATLS requirement is waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.

2. Recommended composition of the pediatric trauma team for severely injured pediatric patients may include:

   a. Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)

   b. Specialists

   c. Laboratory Technicians as dictated by clinical needs

   d. Nursing, ED, OR, ICU, etc

   e. Auxiliary Support Staff

f. Respiratory Therapists

g. Security Officers

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.8. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated pediatric trauma center in the system. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee has administrative and systematic control and oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize pediatric patient care. Suggested membership for the committee includes representatives (if available in the community) from:

   a. Administration

   b. Orthopedics

   c. Anesthesia

   d. Pediatrics

   e. Emergency Department

   f. Prehospital Care Providers

   g. General and Pediatric Surgery

   h. Radiology

   i. Intensive Care

   j. Rehabilitation

   k. Laboratory

   l. Respiratory Therapy

   m. Nursing

   n. Trauma Program Manager/TPM

   o. Operating Room

2. The clinical managers (or designees) of the departments involved with pediatric trauma care should plan an active role with the committee.

3. The pediatric trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.9. Required Clinical Components

1. Secondary pediatric trauma centers must have published on-call schedules and have the following medical specialists immediately available 24 hours/day to the injured pediatric patient:

2. Pediatric Emergency Medicine (in-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

3. Trauma/General or Pediatric Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for Alpha Alert/Activations is 30 minutes and starts at patient arrival or EMS notification, whichever is shorter. Response time for Bravo Alerts/Activations is 60 minutes from patient arrival.

4. Orthopedic Surgery. It is desirable that a back up surgeon schedule is published. It is desirable that the surgeon on-call is dedicated to the pediatric trauma center and not on-call to any other hospital while on pediatric trauma call. A system should be developed to assure notification of the on-call surgeon and compliance with these criteria and their appropriateness must be documented and monitored by the PI process. Response time for all trauma activations is 60 minutes from the time notified to respond.

5. Anesthesia. Anesthesia must be immediately available with a mechanism established to ensure early notification of the on-call anesthesiologist. Anesthesia must be available 24 hours/day. Anesthesia chief residents or certified nurse anesthetist (CRNA) may fill this requirement. When residents or CRNAs are utilized, the staff anesthesiologist on-call will be advised, promptly available, and present for all operations. Hospital policy must be established to determine when the anesthesiologist must be immediately available for airway control and

assisting with resuscitation. The availability of the anesthesiologist and the absence of delays in airway control or operative anesthesia must be documented and monitored by the PI process. The maximum response time for all trauma patients is 30 minutes from the time notified to respond.

6. The following specialists must be on-call and promptly available:

   a. Pediatrics

   b. Radiology

7. It is desirable (although not required) to have the following specialists available to the secondary pediatric trauma center:

   a. Hand Surgery

   b. Obstetrics/Gynecology Surgery

   c. Ophthalmic Surgery

   d. Oral/Maxillofacial Surgery

   e. Plastic Surgery

   f. Critical Care Medicine

   g. Thoracic Surgery*

   * The trauma surgeon is presumed to be qualified and have privileges to provide emergency thoracic surgical care to pediatric patients with thoracic injuries. If this is not the case, the facility should have a board-certified thoracic surgeon immediately available for the injured pediatric patient (within 30 minutes of the time notified to respond).

8. The staff specialist on-call will be notified at the discretion of the trauma surgeon and will be promptly available. The PI program will continuously monitor this availability.

9. Policies and procedures should exist to notify the patient's primary physician of the patient's condition at an appropriate time.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.10. Qualifications of Surgeons on the Trauma Team

1. Basic to qualifications for trauma care for any surgeon is Board Certification in a surgical specialty recognized by the American Board of Medical Specialists, the Advisory Board of Osteopathic Specialists, the American Dental Association, the

Royal College of Physicians and Surgeons of Canada, or other appropriate foreign board. Many boards require a practice period. Such an individual may be included when recognized by major professional organizations has been received in their specialty. The board certification criteria apply to the general surgeons, orthopedic surgeons, and neurosurgeons.

2. Alternate criteria in lieu of board certifications are as follows:

   a. Non-board certified general surgeons must have completed a surgical residency program.

   b. He/she must be licensed to practice medicine.

   c. He/she must be approved by the hospital's credentialing committee for surgical privileges.

   d. The surgeon must meet all criteria established by the pediatric trauma medical director to serve on the pediatric trauma team.

   e. The surgeon's experience in caring for the pediatric trauma patient must be tracked by the PI program.

   f. The pediatric trauma medical director must attest to the surgeon's experience and quality as part of the recurring granting of pediatric trauma team privileges.

   g. The pediatric trauma medical director, using the pediatric trauma PI plan is responsible for determining each general surgeon's ability to participate on the pediatric trauma team.

3. The surgeon is expected to serve as the captain of the resuscitating team and is expected to be in the emergency department upon arrival of the seriously injured pediatric patient to make key decisions about the management of the pediatric trauma patient's care. The surgeon will coordinate all aspects of treatment, including resuscitation, operation, critical care, recuperation and rehabilitation (as appropriate in a secondary pediatric trauma center) and determine if the pediatric patient needs transport to a higher level of care. If transport is required he/she is accountable for coordination of the process with the receiving physician at the receiving facility. If the pediatric patient is to be admitted to the secondary pediatric trauma center, the surgeon is the admitting physician and will coordinate the pediatric patient care while hospitalized. Guidelines should be written at the local level to determine which types of pediatric patients should be admitted to the secondary pediatric trauma center or which pediatric patient should be considered for transfer to a higher level of care.

4. The general surgeons and emergency physicians must participate in a multidisciplinary trauma committee and the PI process. Peer review committee attendance must be greater than fifty percent over a year's period of time. General

surgeons and emergency physicians must demonstrate evidence of participation in the internal trauma education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.11. Qualifications of Emergency Physicians

1. For those physicians providing emergency medicine coverage, board certification in Emergency Medicine is desirable. However, career emergency medicine physicians who are board certified in a specialty recognized by the American Board of Medical Specialties, a Canadian Board or other equivalent foreign board meets the requirements.

2. Alternative criteria for the non-boarded physician working in the Emergency Department are as follows:

    a. He/she must be licensed to practice medicine.

    b. He/she must be approved by the hospital's credentialing committee for emergency medicine privileges.

    c. The physicians must meet all criteria established by the pediatric trauma and emergency medical director to serve on the pediatric trauma team.

    d. The physician's experience in caring for the pediatric trauma patient must be tracked by the PI program.

    e. The pediatric trauma and emergency medical director must attest to the physician's experience and quality as part of the recurring granting of pediatric trauma team privileges.

    f. Residency in Emergency Medicine is desirable.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.12. Facility Standards-Emergency Medicine

1. The facility must have an emergency department, division, service or section staffed so those trauma patients are assured immediate and appropriate initial care. The facility should have a dedicated pediatric emergency area so pediatric patients are assured immediate and appropriate initial care. The emergency physician must be in-house 24 hours/day, immediately available at all times, and capable of evaluating pediatric trauma patients and providing initial resuscitation. The emergency medicine physician will provide team leadership and care for the pediatric trauma patient until the arrival of the surgeon in the resuscitation area. The emergency department must have established standards and procedures to ensure immediate and appropriate care for the pediatric trauma patient. The

medical director for the department, or designee, must participate with the Multidisciplinary Trauma Committee and the pediatric trauma PI process.

2. The director of the emergency department, along with the pediatric trauma medical director, may establish trauma-specific credentials that should exceed those that are required for general hospital privileges (i.e. ATLS verification).

3. There should be an adequate number of RNs staffed for the pediatric trauma resuscitation area in-house 24 hours/day. Emergency nurses staffing the pediatric trauma resuscitation area must be a current provider of TNCC and participate in the ongoing PI process of the trauma program. Nurses must obtain TNCC within 18 months of assignment to the ER. There must be a written plan ensuring nurses maintain ongoing trauma specific education.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.13. Facility Standards-Surgical Suites/Anesthesia

1. The surgical team must be on-call with a well-defined mechanism for notification to expedite transfer to the operating room if the pediatric patient's condition warrants. The process should be monitored by the pediatric trauma PI program.

2. The OR nurses should participate in the care of the pediatric trauma patient and be competent in the surgical stabilization of the major pediatric trauma patient. The surgical nurses are integral members of the pediatric trauma team and must participate in the ongoing PI process of the pediatric trauma program and must be represented on the Multidisciplinary Trauma Committee.

3. The OR supervisor must be able to demonstrate a prioritization scheme to assure the availability of an operating room for the emergent pediatric trauma patient during a busy operative schedule.

4. Anesthesia must be promptly available with a mechanism established to ensure notification of the on-call anesthesiologist. The secondary pediatric trauma center must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the pediatric trauma patient.

5. Anesthesiologists on the pediatric trauma team must have successfully completed an anesthesia residency program approved by the Accreditation Council for Graduate Medical Education, the American Board of Osteopathic Specialists, or the American Osteopathic Board and should have board certification in anesthesia.

6. Anesthesia requirements may be fulfilled by Certified Registered Nurse Anesthetists (CRNAs) and/or anesthesia residents who are capable of assessing emergency situations in pediatric trauma patients and of providing an indicated treatment, including initiation of surgical anesthesia. When the CRNA is used to

meet this requirement, the staff anesthesiologist will be advised and promptly available at all times and present for operations. Secondary pediatric trauma centers must document conditions when the anesthesiologist must be immediately available for airway emergencies and operative management of the pediatric trauma patient. The availability of the anesthesiologist and the absence of delays in operative anesthesia must be documented and monitored by the PI process. The anesthesiologist participating on the pediatric trauma team should have the necessary educational background in the care of the pediatric trauma patient and must participate in the Multidisciplinary Trauma Committee and the pediatric trauma PI process.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.14. Facility Standards-PACU

1. A secondary pediatric trauma center must have a PACU available 24 hours/day to the postoperative pediatric trauma patient. Hospital policy must be written to assure early notification and prompt response. Frequently it is advantageous to bypass the PACU and directly admit to the ICU. In this instance, the ICU may meet these requirements.

2. PACU nurses must show evidence of completion of a structured in-service program. There must be a written plan ensuring nurses maintain ongoing critical care education. PACU staffing should be in sufficient numbers to meet the critical need of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.15. Facility Standards-ICU

1. The ICU must have a surgical director or a surgical co-director who is responsible to set policy and administration and establish standards of care to meet the unique needs of the pediatric trauma patient. He/she is responsible for the quality of care and administration of the ICU. The pediatric trauma medical director must work to assure pediatric trauma patients admitted to the ICU will be admitted to the care of the general surgeon or appropriate surgical subspecialists. In addition to overall responsibility for pediatric patient care by the primary surgeon, it is desirable to have in-house physician coverage for the ICU at all times. This may be provided by a hospitalist or emergency physician.

2. Secondary pediatric trauma centers should provide staffing in sufficient numbers to meet the needs of the pediatric trauma patient. There must be a written plan ensuring nurses maintain ongoing critical care education. ICU nurses are an integral part of the pediatric trauma team and as such, should be represented on the Multidisciplinary Trauma Committee and participate in the PI process of the pediatric trauma program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.16. Clinical Support Services-Respiratory Therapy: The service must be staffed with qualified personnel on-call 24 hours/day to provide the necessary treatments for the injured pediatric patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.17. Clinical Support Services-Radiological Services

1. A board-certified radiologist should administer the department and participate actively in the pediatric trauma PI process. The radiologist is a key member of the pediatric trauma team and should be represented on the Multidisciplinary Trauma Committee. A certified radiologist technician must be available in-house 24 hours/day to meet the immediate needs of the pediatric trauma patient for general radiological procedures. Sonography should be available to the pediatric trauma team. If the radiology technician and the specialty technician are on-call from home, a mechanism must be in place to assure the technicians are available. The PI process must verify that radiological services are promptly available. Written policy should exist delineating the prioritization/availability of the CT scanner for pediatric trauma patients. The use of teleradiology is acceptable. It is anticipated that facilities may cross-train personnel for other roles. This is acceptable as long as there is no response delay.

2. The PI process must ensure that pediatric trauma patients are accompanied by appropriately trained licensed providers and that the appropriate resuscitation and monitoring are provided during transportation to and while in the radiology department.

3. The radiologist must ensure the preliminary interpretations are promptly reported to the pediatric trauma team and the PI program must monitor all changes in interpretation.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.18. Clinical Support Services-Laboratory Services: The clinical laboratory service shall have the following services available in-house 24 hours/day:

1. Access to a community central blood bank and adequate storage facilities. Sufficient quantities of blood and blood products should be maintained at all times. Blood typing and cross-match capabilities must be readily available.

2. Standard analysis of blood, urine, and other body fluids includes micro-sampling when appropriate.

3. Blood gas and pH determination (this function may be performed by services other than the clinical laboratory service, when applicable).

4. Alcohol screening is required and drug screening is highly recommended.

5. Coagulation studies.

6. Microbiology.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.19. Clinical Support Services-Acute Hemodialysis: There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the secondary pediatric trauma center.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.20. Clinical Support Services-Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the secondary pediatric trauma center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient. The transfer protocols must include a feedback loop so that the primary provider has a good understanding of the patient outcome.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.21. Clinical Support Services-Rehabilitation/Social Services

1. The rehabilitation of the pediatric trauma patient and the continued support of the family members are important parts of the trauma system. Each facility will be required to address a plan for integration of rehabilitation into the acute and primary care of the pediatric trauma patient at the earliest stage possible after admission to the secondary pediatric trauma center. Secondary pediatric trauma centers will be required to identify a mechanism to initiate rehabilitation services and/or consultations in a timely manner, as well as to develop policies regarding coordination of the Multidisciplinary Rehabilitation Team. Policies must be in place to address the coordination of transfers between acute care facilities and approved rehabilitation facilities, and shall include a feedback mechanism for the acute care facilities to update the health care team on the patient's progress and outcome for inclusion in the trauma registry. The rehabilitation services must include Physical Therapy and Social Service. It is desirable to have Occupational and Speech Therapy.

2. The nature of traumatic injury requires that the psychological needs of the pediatric trauma patient and family are considered and addressed in the acute states of injury and throughout recovery. A secondary pediatric trauma center may utilize community resources as appropriate to meet the needs of the pediatric trauma patient.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.22. Clinical Support Services-Prevention/Public Outreach

1. Secondary pediatric trauma centers must work cooperatively with referral facilities to develop and implement an outreach program for pediatric trauma care in the region. The secondary pediatric trauma center will work to plan, facilitate and provide professional education programs for the pre-hospital care providers, nurses and physicians, from referral facilities in their region. Prevention programs should be specific to the needs of the region. The trauma registry data should be utilized to identify injury trends and focus prevention needs.

2. Outreach is the act of providing resources to individuals and institutions that do not have the opportunities to maintain current knowledge and skills.

3. The secondary pediatric trauma center is responsible for working with other centers to develop education and prevention programs for the public and professional staff. The plan must include implementation strategies to assure information dissemination to all residents in the region.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.23. Clinical Support Services-Transfer Guidelines: The secondary pediatric trauma center will have transfer guidelines in place with tertiary pediatric trauma centers, as well as all specialty referral centers (such as burns, spinal cord injury and rehabilitation) when these services are not available at the secondary pediatric trauma center. Secondary pediatric trauma centers should work in collaboration with the referral trauma facilities in the system and develop interfacility transfer guidelines. These guidelines must address criteria to identify high-risk pediatric patients that could benefit from a higher level of trauma care. All designated facilities will agree to provide services to the pediatric trauma patient regardless of his/her ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.2.24. Clinical Support Services-Performance Improvement/Evaluation

1. A key element in trauma system planning is evaluation. All licensed hospitals which have organized emergency services or departments will be required to participate in the statewide trauma registry for the purpose of supporting peer review and performance improvement activities at the local, regional and state levels. Since these data relate to specific trauma patients and are used to evaluate and improve the quality of health care services, the data is confidential as provided by Mss. Code Ann.§41-59-77. Tertiary pediatric trauma facilities may be responsible for direct assistant to primary and secondary pediatric trauma centers, referring facilities in providing data for inclusion in the registry. All

pediatric admissions that meet Trauma Registry inclusion criteria shall be reviewed by the PI process.

2. Each trauma center must develop an internal Pediatric Performance Improvement plan that minimally addresses the following key components:

   a. An organizational structure that facilitates performance improvement (Multidisciplinary Trauma Committee).

   b. Clearly defined authority and accountability for the program.

   c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.

   d. Development of expectations (criteria) from evidence based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.

   e. Explicit definitions of outcomes derived from institutional standards.

   f. Documentation system to monitor performance, corrective action and the result of actions taken.

   g. A process to delineate privileges credentialing all trauma service physicians.

   h. An informed peer review process utilizing a multidisciplinary method.

   i. A method for comparing patient outcomes with computed survival probability.

   j. Autopsy information on all deaths when available.

   k. Review of prehospital care.

   l. Review of times and reasons for trauma bypass.

   m. Review of times and reasons for trauma transfers.

   n. Audit of all trauma deaths.

   o. Morbidity and Mortality review.

3. Representatives from the secondary pediatric trauma center shall participate in the Trauma Care Region(s) and the statewide performance review process.

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Primary Pediatric Trauma Center

Rule 6.3.1. General: Primary pediatric trauma centers are facilities with a commitment to the resuscitation of the pediatric trauma patient and have written transfer protocols in place to assure those patients who require a higher level of care are appropriately transferred. All designated Trauma Centers shall, as a minimum, be designated as a Primary Pediatric Trauma Center as a condition of designation in the Mississippi Trauma Care System.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.2. Hospital Departments/Divisions/Sections: The Primary Pediatric Trauma Center must have the following departments, divisions, or sections: Emergency Medicine

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.3. Trauma Program/Service

1. There must be a written commitment letter from the Board of Directors and the medical staff on behalf of the entire facility which states the facility's commitment to compliance with the Mississippi Trauma Care Regulations. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. Should the business organization be other than a corporation, a letter explaining such together with a written commitment of the hospital's chief executive officer to the establishment of a trauma care program may be sufficient. A trauma program must be established and recognized by the organization. Compliance with the above will be evidenced by:

a. Board of Director's and medical staff letter of commitment;

b. Written policies, procedures and guidelines for care of the adult and pediatric trauma patient;

c. A defined Trauma Team with written roles and responsibilities;

d. Appointed Trauma Medical Director with a written job description;

e. A written Trauma Performance Improvement Plan which includes pediatric trauma indicators;

f. Appointed Trauma Program Manager with a written job description;

g. Documentation of trauma center representative's attendance at the Trauma Care Region meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.4. Trauma Medical Director (TMD)

1. The Primary Pediatric Trauma Center must have a physician director of the trauma program. In this instance, the physician is responsible for working with all members of the trauma team, and overseeing the implementation of a trauma specific performance improvement process for the facility. Through this process, he/she should have overall responsibility for the quality of trauma care rendered at the facility, both adult and pediatric. The director must be given administrative support to implement the requirements specified by the Mississippi Trauma Plan. The director should assist in the development of standards of care and assure appropriate policies and procedures are in place for the safe resuscitation and transfer of trauma patients. The physician director must have current verification in ATLS. ATLS requirements are waived for Board Certified Emergency Medicine and Board Certified General Surgery Physicians.

2. Compliance with the above will be evidenced by:

    a. Chairing and participating in the committee where trauma performance improvement is presented;

    b. Administrative support can be documented in the organizational chart which depicts the reporting relationship between the trauma program medical director and administration;

    c. Trauma specific policies, procedures and guidelines approved by the TMD.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.5. Rule 6.3.5 Trauma Program Manager (TPM)

1. The Primary Pediatric Trauma Center must have a person to act as a liaison to the regional evaluation process to conduct many of the administrative functions required by the trauma program. It is not anticipated that this would be a full-time role. Specifically, this person is responsible, with the TMD, for coordinating optimal patient care for all injured victims, both adult and pediatric. This position will ideally serve as liaison with local EMS personnel, the Trauma Care Region, and other trauma centers.

2. Compliance with the above will be evidenced by:

    a. Attendance at and participation in the committee where trauma performance improvement is presented;

    b. written job description of roles and responsibilities to the trauma program which include: management of the trauma program, monitoring of clinical activities on trauma patients, providing staff with trauma related

education, implementation of trauma specific performance improvement and supervision of the trauma registry;

c. Documentation of collaboration with TMD in the development and implementation of trauma specific policies, procedures and guidelines.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.6. Trauma Team

1. The team approach is optimal in the care of the multiple injured patients. The trauma center must have a written policy for notification and mobilization of an organized trauma team to the extent that one is available. The Trauma Team may vary in size and composition when responding to the trauma activation. The physician leader or mid-level provider on the trauma team is responsible for directing all phases of the resuscitation in compliance with ATLS protocol. Suggested composition of the trauma team includes, if available:

   a. Physicians and/or mid-level providers

   b. Laboratory Technicians

   c. Nursing

   d. Ancillary Support Staff

2. Compliance with the above will be evidenced by:

   a. A written resuscitation protocol which adheres to the principles of ATLS;

   b. A written trauma team activation criteria policy which includes physiologic, anatomic and mechanism of injury criteria for both adult and pediatric patients.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.7. Multidisciplinary Trauma Committee

1. The purpose of the committee is to provide oversight and leadership to the entire trauma program. The exact format will be hospital specific and may be accomplished by collaboration with another designated trauma center in the system. The major focus will be on PI activities, policy development, communication among all team members, development of standards of care, education and outreach programs, and injury prevention. The committee oversees the implementation of the process which includes all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Required membership for the committee includes representatives (if available in the community) from:

a. Administration

b. Emergency Department

c. Prehospital Care Providers

d. Radiology

e. Rehabilitation

f. Laboratory

g. Respiratory Therapy

h. Nursing

i. Trauma Program Manager

j. The clinical managers (or designees) of the departments involved with trauma care should play an active role with the committee.

2. The trauma center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.8. Required Clinical Components/Facility Standards-Emergency Medicine

1. The trauma center must maintain published on-call schedules for physicians and/or mid-level providers on-call to the facility.

2. Emergency Medicine (In-house 24 hours/day). Emergency Physician and/or mid-level provider (Physician Assistant/Nurse Practitioner) must be in the specified trauma resuscitation area upon patient arrival.

3. The facility must have an emergency department staffed so trauma patients are assured immediate and appropriate initial care. There must be a designated physician director. It is not anticipated that a physician will be available on-call to an emergency department in a Primary Pediatric Trauma Center; however it is a desirable characteristic. The on-call practitioner must respond to the emergency department based on local written criteria. A system must be developed to assure early notification of the on-call practitioner. Compliance with this criterion must be documented and monitored by the Trauma Performance Improvement process.

4. Emergency nurses staffing the trauma resuscitation area must be a current provider in TNCC. Nurses must obtain TNCC within 18 months of assignment to the ER. Adequate numbers of nurses must be available in-house 24 hours/day, to meet the need of the trauma patient. The nurse may perform other patient care activities within the hospital when not needed in the emergency department.

5. Compliance with the above will be evidenced by:

    a. Published on-call list of practitioners to the Emergency Department;

    b. Written trauma specific education plan for nurses;

    c. Documentation of nursing staffing patterns to assure 24-hour coverage.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.9. Clinical Support Services-General

1. It is not anticipated that a Primary Pediatric Trauma Centers have any of the following services available:

    a. Respiratory Therapy Services

    b. Radiology Services

    c. Clinical Laboratory Services

    d. Acute Hemodialysis

2. There must be a written protocol to transfer the patient to a facility that provides this service if this service if it is not available at the primary pediatric trauma center.

3. Should any of these services be available, the facility should make them available to the pediatric trauma patient as necessary and within the capabilities of the facility.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.10. Clinical Support Services-Burn Care: There must be a written protocol to transfer the patient to a Burn Center that provides this service if this service if it is not available at the primary pediatric trauma center. Policies and procedures shall be in place to assure the appropriate care is rendered during the initial resuscitation and transfer of the patient. The transfer protocols must include a feedback loop so that the primary provider has a good understanding of the patient outcome.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.11. Clinical Support Services-Prevention/Public Outreach

1. The Primary Pediatric Trauma Center is responsible for working with other trauma centers and the Trauma Care Region to develop education and prevention programs for the public and professional staff.

2. Compliance with the above will be evidenced by documentation of collaborative efforts of trauma specific education and injury prevention programs with other trauma centers and/or the Trauma Care Region.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.12. Clinical Support Services-Transfer Guidelines: All pediatric trauma facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. The transfer guidelines shall make certain that feedback is provided to the facilities and assure that this information becomes part of the trauma registry. All designated facilities will agree to provide service to the trauma patient regardless of their ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 6.3.13. Clinical Support Services-Performance Improvement/Evaluation

1. The trauma center must develop and implement a trauma specific performance improvement plan. Key elements in trauma system planning are evaluation, measurement and improvement of performance. The goal is to decrease variation in care and improve patient outcomes. All pediatric admissions that meet Trauma Registry inclusion criteria shall be reviewed by the hospital and Trauma Region PI process.

2. Compliance with the above will be evidenced by:

   a. Review of compliance with EMS Triage Guidelines and Protocols;

   b. Compliance with written Trauma Team Activation Criteria;

   c. Compliance with the principles of ATLS;

   d. Peer Review of all trauma deaths to determine timeliness and appropriateness of care and preventability of death;

   e. Review of trauma related morbidities for appropriateness of care and preventability;

   f. Nursing Audit (clinical review of nursing documentation and quality of care rendered to trauma patients);

g. Review of timeliness and appropriateness of all transfers out;

h. Review of prehospital trauma care;

i. Review of times/reasons for trauma-related bypass;

3. This information must be documented and reported at a trauma specific meeting or in conjunction with other ongoing performance improvement committees in the facility.

Source: Miss. Code Ann. § 41-59-5

Chapter 7 Burn Centers

Subchapter 1 Hospital Organization

Rule 7.1.1. General: The burn center must be an acute care facility licensed in Mississippi. The burn center must have a medical and an administrative commitment to the care of patients with burns. There must be a written commitment on behalf of the entire facility to the organization of burn care. The written commitment shall be in the form of a resolution passed by an appropriate quorum of the members of the governing authority. The burn center must have written guidelines for the triage, treatment, and transfer of burned patients from other facilities. The burn center must maintain an organizational chart relating personnel within the burn center and the hospital. The burn center must maintain current accreditation by the Joint Commission (TJC) or other recognized accrediting organization(s).

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.2. Burn Program

1. The burn center hospital must formally establish and maintain an organized burn program that is responsible for coordinating the care of burned patients. Compliance will be evidenced by, but not limited to:

a. Governing authority and medical staff letter of commitment in the form of a resolution;

b. Written policies and procedures and guidelines for care of the burn patient;

c. Defined burn team and written roles and responsibilities;

d. Appointed Burn Center Medical Director with a written job description;

e. Appointed Burn Center Program Manager with a written job description;

f. A written Burn Center Performance Improvement plan;

g. Documentation of burn center representative attendance at the regional trauma care meetings.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.3. Burn Center Director

1. The burn center director must be a surgeon with board certification by the American Board of Surgery or American Board of Plastic Surgery; certification of special qualifications in surgical critical care is desirable. The burn center director must have completed a one-year fellowship in burn treatment or must have experience in the care of patients with acute burn injuries for two or more years during the previous five years. The burn center director must participate in continuing medical education in burn treatment (48 hours of burn/trauma related CME in a 3 year period) and must demonstrate ongoing involvement in burn-related research and community education in burn care and/or prevention.

2. Responsibilities of the burn center director must include, but not be limited to, the following:

   a. creation of policies and procedures within the burn center that specify the care of burned patients;

   b. Creation of policies and protocols for use throughout the burn care system for referral care, triage, and transport of burn patients;

   c. Cooperation with the Trauma Care Region in all aspects of patient treatment;

   d. Communications on a regular basis with physicians and other authorities about patients who have been refused;

   e. Direction of the burn center administrative functions, including approval of medical staff credentialing;

   f. Direction and active participation in the burn center performance improvement program;

   g. Liaison with adjacent and regional burn centers; and

   h. Development and participation in internal and external continuing medical education programs in the care and prevention of burn injuries.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.4. Burn Program Manager (BPM)

1. Burn Centers must have a registered nurse, with two (2) or more years of experience as a nurse in a burn center, working full time in the role of Burn Program Manager (BPM), who is administratively responsible for the burn center. The BPM must have at least two (2) years or more of experience in acute burn care and six (6) months or more managerial experience. Working in conjunction with the Burn Center Director, the BPM is responsible for organization of the program and all systems necessary for the multidisciplinary approach throughout the continuum of burn care. The BPM is responsible for working with the burn team to assure optimal patient care. There are many requirements for data coordination and performance improvement, education and prevention activities incumbent upon this position.

2. The BPM or his/her designee should offer or coordinate services for burn education. The BPM should liaison with local EMS personnel, the Department, Regional Trauma Care committee(s), trauma centers, and other burn centers.

3. The BPM must participate in 16 or more hours of burn-related education (can be met by attendance at the annual meetings of the American Association for the Surgery of Trauma, ABA, or any ABA-endorsed meetings or continuing education programs, such as ABLS or ABLS Now) each year or 48 hours in a three year period.

4. There must be an organizational chart relating the nurse manager to the burn service and other members of the burn team.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.5. Burn Team: The team approach is optimal in the care of the multiple injured patient. There must be identified members of the burn team. Policies should be in place describing the respective role of all personnel on the team. The composition of the team in any hospital will depend on the characteristics of the hospital and its staff. In some instances a tiered response may be appropriate. If a tiered response is employed, written policy must be in place and the system monitored by the PI process. Composition of the burn team for an injured patient shall include:

1. Emergency Physicians and/or mid-level providers (Physician Assistant/Nurse Practitioner)

2. General/Trauma Surgeon

3. Physician Specialists

4. Anesthesiologist

5. Laboratory Technicians as dictated by clinical needs

6. Nursing: ED, OR, ICU, etc.

7. Auxiliary Support Staff

8. Respiratory Therapist

9. Security Officers

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.6. Multidisciplinary Burn Care Committee

1. The purpose of the committee is to provide oversight and leadership to the entire burn program. The exact format will be hospital specific and may be accomplished by collaboration with another designated burn center. Each burn center may choose to have one or more committees as needed to accomplish the task. One committee should be multidisciplinary and focus on program oversight and leadership. The major focus will be on PI activities, policy development, communication among all team members, and establishment of standards of care, and education and outreach programs for injury prevention. The committee has administrative and systematic control and oversees implementation of all program related services, meets regularly, takes attendance, maintains minutes and works to correct overall program deficiencies to optimize patient care. Suggested membership for the committee includes representatives from:

    a. Administration

    b. Operating Room

    c. Anesthesia

    d. Plastic Surgery

    e. Orthopedics

    f. Emergency Medicine

    g. General Surgery

    h. Pre-hospital providers

    i. Intensive Care

    j. Radiology

    k. Laboratory

l. Rehabilitation

m. Neurosurgery

n. Respiratory Therapy

o. Nursing

p. Burn Program Manager/BPM

2. The clinical managers (or designees) of the departments involved with burn care should play an active role with the committee.

3. The burn center may wish to accomplish performance improvement activities in this committee or develop a separate peer review committee. This committee should handle peer review independent from department based review. The committee must meet regularly and maintain attendance and minutes. This committee must report findings to the overall hospital performance improvement program.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.7. Policies and Procedures: The burn center must maintain an appropriate policy and procedure manual that is reviewed annually by the burn center director and the nurse manager. The policy and procedure manual must contain, at a minimum, the following policies addressing the following:Administration of the burn center.

1. Staffing of the burn center.

2. Criteria for admission to the burn center by the burn service.

3. Use of burn center beds by other medical or surgical services.

4. Criteria for discharge and follow-up care.

5. Availability of beds and the transfer of burn patients to other medical or surgical units within the hospital.

6. Care of patients with burns in areas of the burn center hospital other than the burn center.

Source: Miss. Code Ann. § 41-59-5

Rule 7.1.8. Personnel: The burn center must be granted the necessary authority to direct and coordinate all services for patients admitted to the burn service. The burn center director must make sure that medical care conforms to the burn center protocols. Privileges for physicians participating in the burn service must be determined by

the medical staff credentialing process and approved by the burn center director. Qualifications for surgeons who are responsible for the care of burned patients must conform to criteria documenting appropriate training, patient care experience, continuing medical education, and commitment to teaching and research in the care of burned patients.

Source: Miss. Code Ann. § 41-59-5

Subchapter 2 Clinical Components

Rule 7.2.1. Trauma Evaluation: Patients with burns and trauma must be evaluated and/or stabilized at a trauma center before transfer to a burn center. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.2. Burn Service Coverage: The burn service must maintain an on-call schedule for attending staff surgeons who are assigned to the burn service. The staff surgeons must be promptly available on a 24-hour basis.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.3. Qualifications of Attending Staff Surgeons: The Burn Center Director must appoint qualified attending staff surgeons to participate in the care of patients on the burn service. Attending staff surgeons must be board-certified or board eligible with current Advanced Burn Life Support (ABLS). Certification of special qualifications in critical care is desirable. The attending staff surgeon must have demonstrated expertise in burn treatment. Attending staff surgeons must participate in continuing medical education in burn treatment. Other attending surgeons must demonstrate participation in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.4. Nursing staff: There must be a patient care system in effect that is used to determine nurse staffing for each patient in the burn center. This system must be used to determine daily staffing needs. There must be a burn center orientation program that documents nursing competencies specific to the care and treatment of burn patients, including critical care, wound care, and rehabilitation. Burn center nursing staff must be provided with a minimum of two (2) burn-related continuing education opportunities annually.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.5. Mid-Level Providers: Appropriate credentialed mid-level providers may be used as members of the burn team. These individuals may include, but are not limited

to, physician assistants, surgical assistants, or nurse practitioners. They may augment but do not replace the physician member of the team.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.6. Burn Center Referral Criteria

1. Burn injuries that should be referred to a burn center include, but are not limited to the following:

    a. Partial-thickness burns of greater than 10% of the total body surface area;

    b. Burns that involve the face, hands, feet, genitalia, perineum, or major joints;

    c. Third-degree burns;

    d. Electrical burns, including lightning injury;

    e. Chemical burns;

    f. Inhalation injury;

    g. Burn injury in patients with pre-existing medical disorders that could complicate management, prolonged recovery, or affect mortality;

    h. Burn injury in patients who will require special social, emotional, or rehabilitative intervention.

Source: Miss. Code Ann. § 41-59-5

Rule 7.2.7. Specialty Services: The following specialists must be available for consultation:

1. General surgery
2. Cardiothoracic surgery
3. Neurological surgery
4. Obstetrics/gynecology
5. Ophthalmology
6. Anesthesiology
7. Pediatrics
8. Orthopedic surgery

9. Otolaryngology

10. Plastic surgery

11. Urology

12. Pulmonary

13. Radiology

14. Nephrology

15. Psychiatry

16. Cardiology

17. Gastroenterology

18. Hematology

19. Neurology

20. Pathology

21. Infectious disease

Source: Miss. Code Ann. § 41-59-5

Subchapter 3 Facility Standards

Rule 7.3.1. Emergency Department: The emergency department must have written protocols mutually developed with the burn service for the care of acutely burned patients.

Source: Miss. Code Ann. § 41-59-5

Rule 7.3.2. Surgical Suites: The burn center hospital must have operating rooms available 24 hours a day. Source: Miss. Code Ann. § 41-59-5

Source: Miss. Code Ann. § 41-59-5

Rule 7.3.3. Allograft Use: The burn center hospital's policies and procedures for the use of allograft tissues must be in compliance with all federal, state, and the Joint Commission/other recognized accrediting organizations' requirements, and with standards of the American Association of Tissue Banks.

Source: Miss. Code Ann. § 41-59-5

Subchapter 4 Clinical Support Services

Rule 7.4.1. Respiratory Therapy Service: Respiratory therapists must be available for the assessment and management of patients on the burn service on a 24-hour basis. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.2. Renal Dialysis, Radiological Services, and Clinical Laboratory: Renal dialysis, radiological services (including computed tomography scanning), and clinical laboratory services must be available 24 hours per day.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.3. Rehabilitation/Social Services

1. There must be a rehabilitation program designed for burned patients that identifies specific goals.

2. The primary burn care therapist must have annual participation in 16 hours or more of burn-related education (can be met by attendance at the annual meetings of the American Association for the Surgery of Trauma, American Burn Association (ABA), or any ABA-endorsed meetings or continuing education programs, such as ABLA or ABLS Now) each year or 48 hours over a three (3) year period.

3. Social service consultation must be available to the burn service. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.4. Nutritional Support: A dietician must be available on a daily basis for consultation. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.5. Pharmacy: A pharmacist who has at least six (6) months of experience in critical care and the pharmacokenetics implications for patients with acute burn injuries must be available on a 24-hour basis. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.6. Clinical Psychiatry: A psychiatrist or clinical psychologist should be available for consultation by the burn service on a 24-hour basis. Members must participate in an internal education plan.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.7. Continuity of Care Program: The burn center must provide the following services:

1. Patient and family education in rehabilitation programs;
2. Support for family members or other significant persons;
3. Coordinated discharge planning;
4. Follow-up after hospital discharge;
5. Access to community resources;
6. Evaluation of the patient's physical, psychological, developmental, and vocational status;
7. Planning for future rehabilitative and reconstructive needs.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.8. Weekly Patient Care Conferences: Patient care conferences must be held at least weekly to review and evaluate the status of each patient admitted to the burn center. Each clinical discipline should be represented to appropriately contribute to the treatment plan for each patient. Patient care conferences must be documented in the progress notes of each patient and/or in minutes of the conference.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.9. Infection Control Program: The burn center must have effective means of isolation that are consistent with principles of universal precautions and barrier techniques to decrease the risk of cross-infection and cross-contamination. The burn center hospital must provide ongoing review and analysis of nosocomial infection data and risk factors that relate to infection prevention and control for burn patients. This data must be available to the burn team to assess infection risk factors that relate to infection prevention and control for burn patients.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.10. Mass Casualty Plan: The burn center must have a written multiple-casualty plan for the triage and treatment of patients burned in a multiple casualty incident occurring within its service area. The multiple casualty plan must be reviewed and updated as needed, and on an annual basis by EMS representatives and the burn center director.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.11. Burn Prevention: The burn center will be responsible for taking a lead role in coordination of appropriate agencies, professional groups and hospitals in their region to develop a strategic plan for public awareness. This plan must take into consideration public awareness of the burn system, access to the system, public support for the system, as well as specific prevention strategies. Prevention programs must be specific to the needs of the region. The trauma registry data must be utilized to identify injury trends and focus prevention needs.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.12. Trauma Registry:

1. All facilities designated as burn centers in Mississippi must participate in the statewide Trauma Registry for the purpose of supporting peer review and performance improvement activities at the local, regional, and state levels. Since this data relates to specific trauma patients and are used to evaluate and improve the quality of health care services, this data is confidential and will be governed by the Miss. Code Ann. §41-59-77.

2. This database must include all patients who are admitted to the burn center hospital for acute burn care treatment. Compliance with the above will be evidenced by:

3. Documentation of utilization of the Trauma Registry data in the trauma/burn performance improvement process.

4. Timely submission of Trauma Registry Data to the Department and the appropriate Trauma Region.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.13. Transfer Guidelines: All facilities will work together to develop transfer guidelines indicating which patients should be considered for transfer and procedures to ensure the most expedient, safe transfer of the patient. The transfer guidelines shall make certain that feedback is provided to the facilities and assure that this information becomes part of the trauma registry. All designated facilities will agree to accept and provide service to the trauma/burn patient regardless of their ability to pay.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.14. Performance Improvement/Evaluation

1. The burn program must have a performance improvement program that is multidisciplinary. The burn center director must be responsible for the

performance improvement program. The burn center multi-disciplinary committee, which oversees the performance improvement program, must meet at least quarterly. Sufficient documentation must be maintained to verify problems, identify opportunities for improvement, take corrective actions, and resolve problems. Morbidity and mortality conferences must be held at least monthly with physicians other than the immediate burn care team to ensure objective review of the presentations. Attendees at this conference must include specialist staff members other than those practicing in the burn center. All significant complications and deaths must be discussed. Actions recommended must also be documented, and there must be documentation of loop closure. Records of this conference must be kept.

2. The burn center must develop an internal, specific Performance Improvement (PI) plan that minimally addresses the following key components and is fully integrated into the hospital wide program:

   a. An organizational structure that facilitates performance improvement (Multidisciplinary Committee).

   b. clearly defined authority and accountability for the program.

   c. Clearly stated goals and objectives one of which should be reduction of inappropriate variations in care.

   d. Development of expectations (criteria) from evidenced based guidelines, pathways and protocols. These should be appropriate, objectively defined standards to determine quality of care.

   e. Explicit definitions of outcomes derived from institutional standards.

   f. Documentation system to monitor performance, corrective action and the result of the actions taken.

   g. A process to delineate credentialing of all burn service physicians.

   h. An informed peer review process utilizing a multidisciplinary method.

   i. A method for comparing patient outcomes with computed survival probability.

   j. Autopsy information on all deaths when available.

   k. Review of pre-hospital care.

   l. Review of times and reasons for burn bypass.

   m. Review of times and reasons for burn transfers.

n. Audit of burn deaths.

o. Morbidity and Mortality review.

p. Feedback process with the referring hospital/physician.

3. Representatives from the burn center shall participate in the Trauma Region committees and the statewide performance improvement process.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.15. Education

1. The burn center must be actively engaged in promoting Advanced Burn Life Support (ABLS) courses in its region. It is desirable for the director to be an ABLS instructor and essential that the director is current in ABLS. The unit should have one or more employees who are ABLS instructors.

2. The burn center must offer education on the current concepts in emergency and inpatient burn care treatment to pre-hospital and hospital care providers within its service area.

3. The burn center must have an internal burn education plan for the staff.

Source: Miss. Code Ann. § 41-59-5

Rule 7.4.16. Research: The burn center must participate in basic, clinical, and health sciences research. The medical director must demonstrate ongoing involvement in burn-related research.

Source: Miss. Code Ann. § 41-59-5

APPENDIX I – MEDICAL DIRECTION: STANDARD PRACTICE FOR QUALIFICATIONS, RESPONSIBILITIES, AND AUTHORITY

Medical Direction (pre-hospital Emergency Medical Services)

All aspects of the organization and provision of emergency medical services (EMS), including both basic and advanced life support, require the active involvement and participation of physicians. These aspects should incorporate design of the EMS system prior to its implementation; continual revisions of the system; and operation of the system from initial access, to pre-hospital contact with the patient, through stabilization in the emergency department. All pre-hospital medical care may be considered to have been provided by one or more agents of the physician who controls the pre-hospital system, for this physician has assumed responsibility for such care.

Implementation of this standard practice will insure that the EMS system has the authority, commensurate with the responsibility, to insure adequate medical direction of all pre-hospital providers, as well as personnel and facilities that meet minimum criteria to implement medical direction of pre-hospital services.

Medical Direction (Off-Line A.K.A. System Medical Director)

Each EMS agency providing pre-hospital care shall be licensed by the Mississippi State Department of Health, BEMS, and shall have an identifiable Medical Director who after consultation with others involved and interested in the agency is responsible for the development, implementation and evaluation of standards for provision for medical care within the agency.

All pre-hospital providers (including EMT-Bs) shall be medically accountable for their actions and are responsible to the Medical Director of the licensed EMS agency that approves their continued participation. All pre-hospital providers, with levels of certification EMT-B or above, shall be responsible to an identifiable physician who directs their medical care activity. The Medical Director shall be appointed by, and accountable to, the appropriate licensed EMS agency.

The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to EMS personnel on board any permitted unit at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

Requirements of a Medical Director

The medical aspects of an emergency medical service system shall be managed by physicians who meet the following requirements:

Mississippi licensed physician, M.D. or D.O.

Experience in, and current knowledge of, emergency care of patients who are acutely ill or traumatized.

Knowledge of, and access to, local mass casualty plans.

Familiarity with base station operations where applicable, including communication with, and direction of, pre-hospital emergency units.

Active involvement in the training of pre-hospital personnel.

Active involvement in the medical audit, review and critique of medical care provided by pre-hospital personnel.

Knowledgeable of the administrative and legislative process affecting the local, regional and/or state pre-hospital EMS system.

Knowledgeable of laws and regulations affecting local, regional and state EMS.

Approved by the State EMS Medical Director

Authority of a Medical Director includes, but is not limited to:

Establishing system-wide medical protocols in consultation with appropriate specialists.

Establishment of system-wide trauma protocols as delineated by the State Trauma Care Plan.

Recommending certification or decertification of non-physician pre-hospital personnel to the appropriate certifying agencies. Every licensed agency shall have an appropriate review and appeals mechanism, when decertification is recommended, to assure due process in accordance with law and established local policies. The Director shall promptly refer the case to the appeals mechanism for review, if requested.

Requiring education to the level of approved proficiency for personnel within the EMS system. This includes all pre-hospital personnel, EMTs at all levels, pre-hospital emergency care nurses, dispatchers, educational coordinators, and physician providers of on-line direction.

Suspending a provider from medical care duties for due cause pending review and evaluation. Because the pre-hospital provider operates under the license (delegated practice) or direction of the Medical Director, the Director shall have ultimate authority to allow the pre-hospital provider to provide medical care within the pre-hospital phase of the EMS system.

Establishing medical standards for dispatch procedures to assure that the appropriate EMS response unit(s) is dispatched to the medical emergency scene when requested, and the duty to evaluate the patient is fulfilled.

Establishing under which circumstances a patient may be transported against his will; in accordance with, state law including, procedures, appropriate forms and review process.

Establishing criteria for level of care and type of transportation to be used in pre-hospital emergency care (i.e., advanced life support vs. basic life support, ground air, or specialty unit transportation).

Establishing criteria for selection of patient destination.

Establishing educational and performance standards for communication resource personnel.

Establishing operational standards for communication resource.

Conducting effective system audit and quality assurance. The Medical Director shall have access to all relevant EMS records needed to accomplish this task. These documents shall be considered quality assurance documents and shall be privileged and confidential information.

Insuring the availability of educational programs within the system and that they are consistent with accepted local medical practice.

May delegate portions of his/her duties to other qualified individuals.

The owner, manager or medical director of each publicly or privately owned ambulance service shall inform the State Department of Health, Bureau of EMS of the termination of service in a licensed county or defined service area no less than 30 days prior to ceasing operations. This communication should also be sent by the owner, manager or medical director of each publicly or privately owned ambulance service to related parties and local governmental entities such as, but not limited to, emergencies management agency, local healthcare facilities, and the public via mass media.

Medical direction with concurrent and retrospective oversight supervision;

Standardized protocols;

Actively engaged in a continuous quality assurance, quality control, performance review, and when necessary, supplemental training.

Medical Direction (Online, Direct Medical Control)

The practice of on-line medical direction shall exist and be available within the EMS system, unless impossible due to distance or geographic considerations. All pre-hospital providers, above the certification level of EMT, shall be assigned to a specific on-line communication resource by a predetermined policy and this shall be included in the application for ALS licensure.

When EMS personnel are transporting patients to locations outside of their geographic medical control area, they may utilize recognized communication resources outside of their own area.

Specific local protocols shall exist which define those circumstances under which on-line medical direction is required.

On-line medical direction is the practice of medicine and all orders to which the pre-hospital provider shall originate from/or be under the direct supervision and responsibility of a physician.

The receiving hospital shall be notified prior to the arrival of each patient transported by the EMS system unless directed otherwise by local protocol.

Requirements of a Medical Director

This physician shall be approved to serve in this capacity by system (Off-Line) Medical Director.

This physician shall have received education to the level of proficiency approved by the off-line Medical Director for proper provision of on-line medical direction, including communications equipment, operation and techniques.

This physician shall be appropriately trained in pre-hospital protocols, familiar with the capabilities of the pre-hospital providers, as well as local EMS operational policies and regional critical care referral protocols.

This physician shall have demonstrated knowledge and expertise in the pre-hospital care of critically ill and injured patients.

This physician assumes responsibility for appropriate actions of the pre-hospital provider to the extent that the on-line physician is involved in patient care direction.

The on-line physician is responsible to the system Medical Director (off-line) regarding proper implementation of medical and system protocols.

The licensee's off-line medical director shall ensure that there is a capability and method to provide on-line medical control to air medical personnel on board any of its air ambulance aircraft at all times. If patient specific orders are written, there shall be a formal procedure to use them. In addition to on-line medical control capabilities, the licensee shall have a written plan, procedure and resources in place for off-line medical control. This may be accomplished by use of comprehensive written, guidelines, procedures or protocols.

There must be – at all times - Medical direction with concurrent and retrospective oversight supervision; Standard Protocols; Continuing quality assurance, quality control, performance review, and when necessary, supplemental training.

Authority for Control of Medical Services at the Scene of Medical Emergency.

Authority for patient management in a medical emergency shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.

When an advanced life support (ALS) squad, under medical direction, is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction.

The pre-hospital provider is responsible for the management of the patient and acts as the agent of medical direction.

Authority for Scene Management.

Authority for the management of the scene of a medical emergency shall be vested in appropriate public safety agencies. The scene of a medical emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious risks to life and health. Public safety personnel shall ordinarily consult emergency medical services personnel or other authoritative medical professionals at the scene in the determination of relevant risks.

Patient's Private Physician Present

The EMT should defer to the orders of the private physician. The base station should be contacted for record keeping purposes if on-line medical direction exists. The ALS squad's responsibility reverts back to medical direction or on-line medical direction at any time when the physician is no longer in attendance.

Intervener Physician Present and Non-Existent On-Line Medical Direction

When the intervener physician has satisfactorily identified himself as a licensed physician and has expressed his willingness to assume responsibility and document his intervention in a manner acceptable to the local emergency medical services system (EMSS); the pre-hospital provider should defer to the orders of the physician on the scene if they do not conflict with system protocol.

If treatment by the intervener physicians at the emergency scene differs from that outlined in a local protocol, the physician shall agree in advance to assume responsibility for care, including accompanying the patient to the hospital. In the event of a mass casualty incident or disaster, patient needs may require the intervener physician to remain at the scene.

Intervener Physician Present and Existent On-Line Medical Direction

If an intervener physician is present and on-line medical direction does exist the on-line physician should be contacted and the on-line physician is ultimately responsible.

The on-line physician has the option of managing the case entirely, working with the intervener physician, or allowing him to assume responsibility.

If there is any disagreement between the intervener physician and the on-line physician, the pre-hospital provider should take orders from the on-line physician and place the intervener physician in contact with on-line physician.

In the event the intervener physician assumes responsibility, all orders to the pre-hospital provider shall be repeated to the communication resource for purposes of record-keeping.

The intervener physician should document his intervention in a manner acceptable to the local EMS system.

The decision of the intervener physician to accompany the patient to the hospital should be make in consultation with the on-line physician. Nothing in this section implies that the pre-hospital provider CAN be required to deviate from system protocols.

Communication Resource

A communication resource is an entity responsible for implementation of direct (on-line) medical control. This entity/facility shall be designated to participate in the EMS system according to a plan developed by the licensed ALS provider and approved by the system (off-line) medical director and the State Department of Health, BEMS.

The communication resource shall assure adequate staffing for the communication equipment at all times by health care personnel who have achieved a minimal level of competence and skill and are approved by the system medical director.

The communication resource shall assure that all requests for medical guidance assistance or advice by pre-hospital personnel will be promptly accommodated with an attitude of utmost participation, responsibility and cooperation.

The communication resource shall provide assurance that they will cooperate with the EMS system in collecting and analyzing data necessary to evaluate the pre-hospital care program as long as patient confidentiality is not violated.

The communication resource will consider the pre-hospital provider to be the agent of the on-line physician when they are in communication, regardless of any other employee/employer relationship.

The communication resource shall assure that the on-line physicians will issue transportation instructions and hospital assignments based on system protocols and objective analysis of patient's needs and facility capability and proximity.

No effort will be made to obtain institutional or commercial advantages through use of such transportation instructions and hospital assignments.

When the communication resource is acting as an agent for another hospital, the information regarding patient treatment and expected time of arrival will be relayed to the receiving hospital in an accurate and timely fashion.

Communication resource shall participate in regular case conferences involving the on-line physicians and pre-hospital personnel for purposes of problem identification and provide continuing education to correct any identified problems.

If the communication resource is located within a hospital facility, the hospital shall meet the requirements listed herein and the equipment used for on-line medical direction shall be located within the emergency department.

Educational Responsibilities

Because the on-line and off-line medical directors allow the use of their medical licenses, specific educational requirements should be established. This is not only to insure the best available care, but also to minimize liability. All personnel brought into the system must meet minimum criteria established by state law for each level; however, the law should in no way preclude a medical director from enforcing standards beyond this minimum.

Personnel may come to the system untrained (in which case the medical director will design and implement the educational program directly or through the use of ancillary instructors), or they may have previous training and/or experience. Although the Department of Transportation has defined curricula for training, the curricula are not standardized nationally, and often are not standardized within a state or county. Certification or licensure in one locale does not automatically empower an individual to function as an EMT within another system. The medical director must evaluate applicants trained outside the system in order to determine their level of competence. Such evaluation may be made in the form of written examinations, but should also include practical skills and a field internship with competent peers and time spent with the medical director.

The educational responsibilities of the medical director do not end with initial training; skills maintenance must be considered. To insure the knowledge does not stagnate, programs should cover all aspects of the initial training curriculum on a cyclical basis. Continuing education should comprise multiple formats, including lectures, discussions and case presentations, as well as practical situations that allow the EMT to be evaluated in action. The continuing education curriculum should also include topics suggested by audits, and should be utilized to introduce new equipment or skills.

Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.

Review and Audit

Personnel may be trained to the highest standards and many protocols may be written, but if critical review is not performed, the level of patient care will deteriorate. Review is intended to determine inadequacies of the training program and inconsistencies in the protocols. The data base required includes pre-hospital care data, emergency department and inpatient (summary) data, and autopsy findings as appropriate. The cooperation of system administrators, hospital administrators, and local or state medical societies must be elicited. On occasion, the state legislature may be required to provide access to vital information.

The medical director or a designated person should audit pre-hospital run records, either randomly or inclusively. The data must be specifically evaluated for accuracy of charting and assessment; appropriateness of treatment; patterns of error, morbidity, and mortality; and need for protocol revision.

It cannot be assumed that all pre-hospital care will be supervised by on-line physicians. When proper or improper care is revealed by the audit process, prompt and appropriate praise or

censorship should be provided by the medical director after consultation with the system administrator.

Individual Case Review.

Compliance with system rules and regulations is most commonly addressed by state and regional EMS offices. Audit by individual case review requires a more detailed plan. Each of the components defined in detail by the individual EMS system must be agreed on prior to the institution of any case review procedures. Case review may involve medical audit, including reviews of morbidity and mortality data (outcome-oriented review), and system audit, including compliance with rules and regulations as well as adherence to protocols and standing orders (process-oriented review). The personnel to be involved in a given case review process should include the off-line medical director; emergency department and critical care nurses; and EMS, technical and other support personnel who were involved in the specific cases.

The following must be written and agreed to in advance:

Procedural guidelines of how the individuals will interact during meetings.

Because considerations of medical malpractice may be present when issues concerning appropriateness of care and compliance with guidelines are raised, legal advice for procedural guidelines must be obtained prior to the institution of any medical audit program in order that medical malpractice litigation will neither result from nor become the subject of the meeting.

Confidentiality of case review in terms of local open meeting laws and public access to medical records and their distribution.

Format for recording the meeting and its outcome.

Access to overall system performance records, both current and historical, to allow comparison.

Overall outcome data (morbidity and mortality) and individual, unit-specific, and system-wide performance can be measured by the following means:

The severity of presentation of patients must be known, and a scale for that measurement must be agreed on, included in all EMT education, and periodically checked for reliability.

Appropriate treatment on scene and in transit should be recorded and subsequently evaluated for its effect on overall patient outcome.

At the emergency department, the severity of cases presenting (according to a severity scoring technique) and treatment needed should be recorded in detail.

An emergency department diagnosis and outcome in terms of admission to a general medical bed, critical care unit, or morgue must be known. The length of stay in the hospital, cost of stay, discharge status, and pathologic diagnosis should be made available.

APPENDIX 2 - PROTOCOLS

General Provisions

Protocols are designed by the off-line (system) medical control system to provide a standardized approach to each commonly encountered patient problem. This provides a consistently defined level of pre-hospital care. When treatment is based on such protocols, the on-line physician assists the pre-hospital personnel in their interpretation of the patient's complaint, the findings of their evaluation, and the application of the appropriate treatment protocol. The process should be reviewed periodically in order to consider changing medical standards, new therapies, and data generated from audits of patient care.

In the realm of pre-hospital emergency medicine, there are a limited number of interventions to cover the myriad of problems that may be present. Although advanced life support may be skilled in many maneuvers, there are limitations on what they can accomplish in the pre-hospital setting. Basic life support personnel can do even less. The goal of pre-hospital care is to respond correctly and consistently.

Because the types of illnesses and inquiries commonly encountered in a given EMS system may be grouped into broad categories, protocols and standing orders may be established to help accomplish this goal. There are three major advantages to using protocols:

Pre-hospital personnel may be trained to respond to a given medical problem in a defined manner. Regardless of the weather, the hostility of the crowd, the immediate danger of any other outside stress, the pre-hospital personnel can consistently treat the problem in a defined manner with minimal chance of omission.

The EMS system will have a set standard by which care may be audited. The system and its successes or failures may be measured against consistent standards allowing for necessary change and improvement based on documented evidence, and not on the notion of this year's medical director or any other outside influence not based in fact and logic.

Protocols provide a standard of medical treatment for each patient problem so that individual variations necessary for non-routine patient problems may have a context to aid the on-line physician in a complex treatment regimen.

Protocol Development

The development of protocols may include the following steps:

List the common illnesses and injuries that are currently encountered by the local EMS system. A chart review on a random basis for all months of the preceding year should suffice. All months are important, for there may be significant seasonal variations with particular illnesses or injuries.

This list must also include any life-threatening problems that can be affected positively in the pre-hospital setting, but that are not seen routinely (e.g., anaphylaxis, snake bite).

This list may be divided into two general categories-pediatric problems and adult problems-even though there will be duplication within these two lists. Asthma, seizures, trauma, and other illnesses and injuries are common to both groups, but the physical interventions and medications are sufficiently different to justify this separation.

Similar problems (e.g., cardiopulmonary, trauma, poisons/overdose, etc.) may be combined into groups.

Some problems that will not fit easily into groupings (e.g., hypothermia) may be listed separately or included in a miscellaneous group called "other."

In each of these groups, there will be common parameters, such as the ABCs, vital signs, history of the current illness/injury, medical history, and medications, allergy history.

For each of the problems within the group, additional parameters or interventions may be added to further reduce the patient's morbidity or mortality.

Additional treatments for special cases may be added to create a more specifically detailed protocol.

For a given region, the level of training of the pre-hospital personnel involved, the capabilities of the EMS response system as a whole, the capabilities of the receiving hospital and the medical opinion in the region must be considered before applying protocols synthesized outside the EMS system.

Protocol Implementation

Protocols are the responsibility of the medical director, who often delegates their development to a committee consisting of emergency physicians and other appropriate physicians. This committee implements the protocols, which reflect the currently optimal method for pre-hospital treatment of the defined problems. All levels of controllers, the medical director and off-line and on-line physicians, must be cognizant of the adopted protocols, and must agree to function "by the book."

Discrepancies of disagreements that evolve should be brought back to the committee for consideration.

Pre-hospital personnel are then trained in the use of the protocols and held accountable through the audit and review process. Variance from protocol must be clearly documented and justified.

Consistently occurring variances, whether or not justified and documented, should induce review of that protocol. Even when no problems emerge, the committee should review all protocols at least annually in light of past experience and new medical insight.

APPENDIX 3 – EMS DRIVER TRANING PROGRAMS

State Approval Process

Each EMS Driver Training Program must be formally approved by the Mississippi State Board of Health. The Mississippi EMS Advisory Council and the BEMS jointly reviews all proposals for BEMS training. Affirmative reviews are submitted as recommendations to the Board for adoption (state approval). All inquiries relative to EMS Driver Training and/or requests for state approval for the establishment of EMS Driver Training programs should be submitted in triplicate as follows:

Address

Mississippi State Department of Health

Bureau of Emergency Medical Services

P.O. Box 1700

Jackson, Mississippi 39215-1700

Format (application content)

As governed by state regulations, all applications for the establishment of Emergency Medical Services Driver Training Programs must demonstrate adherence to the Department of Transportation's Training Program for Operation of Emergency Vehicles as a minimum. The skid pad requirement is not required. The proposal for training must include as a minimum the following requirements:

Faculty profile - Provide names and resumes of all faculty (include instructor training obtained); indicate whether faculty are full-time, part-time, or consultants; and indicate those that are classroom vs. field preceptors.

Entry requirements - Taking all applicable state requirements into consideration, list all additional student selection criteria.

Class size - Indicate minimum and maximum numbers of students per class.

Facilities - Name and describe all facilities used for classroom and field training.

Course Implementation - Provide copies of all instructor lesson plans; provide testing and evaluation of student competencies and skills.

Budget - List sources of funds supporting the training program.

Equipment - Identify equipment and training materials available.

APPENDIX 5 – EMERGENCY TRANSPORT TO MEDICAL FACILITIES

Emergency Ambulance Transport To Medical Facilities

Patients who are transported under the direction of an emergency medical service system should be taken whenever possible to an in hospital facility that meets the Emergency Care Guidelines of the American College of Emergency Physicians.

The EMS Medical Control Authority should have the discretion to authorize transport to non-in hospital medical facilities that meet the Emergency Care Guidelines under that extraordinary circumstance when lack of timely availability of such an in hospital facility necessitates earlier patient stabilization.

If an area does not have a facility that meets the Emergency Care Guidelines, it may be necessary for the responsible EMS Medical Control Authority to designate some medical facility to receive patients by ambulance. The American College of Emergency Physicians strongly encourages the modification of such facilities to meet the Emergency Care Guidelines of the College, so that every area has a facility capable of providing emergency care.

APPENDIX 6 – TRANSFERS: INTERHOSPITAL AND OTHER MEDICAL FACILITIES

Definitions - Inter-Hospital And Other Medical Facilities

Appropriate Transfer - An appropriate transfer to a medical facility is a transfer

in which the receiving facility: a) has available space and qualified personnel for the treatment of the patient, and b) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

in which the transferring hospital provides the receiving facility with appropriate medical records of the examination and treatment effected at the transferring hospital;

In which the transfer is affected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.

Medical Control During Interhospital Transfers

Once an emergency patient arrives for initial evaluation at a medical facility the patient becomes the responsibility of that facility, and its medical staff. This responsibility continues until the patient is appropriately discharged, or until the patient is transferred and the responsibility is assumed by personnel and a facility of equal or greater capability for the patient's existing condition.

Routine Interhospital Transfers

If a transfer is being made for the convenience of the patient or patient's physicians, and the patient is not receiving treatment, and is expecting to remain stable during transport, the transfer may be conducted by and appropriately trained medical provider (EMT-Basic or higher).

Emergency Interhospital Transfers Conducted by the Transferring Facility

If the patient is being transferred to another facility for other convenience, is receiving treatment, is medically unstable, or is potentially unstable, it is the responsibility of the transferring physician and hospital to provide medical records and assure that appropriately qualified personnel and transportation equipment are utilized.

The transferring personnel will act as the agents of the transferring hospital and the physician approving the transfer, regardless of any other employer/employee relationship.

The transferring physician must provide written orders to non-physician personnel for use during the interhospital transfer.

If the patient experiences complications beyond situations addressed in these written orders, the provider should, if possible.

Contact the transferring hospital or the receiving facility for additional orders or, if necessary, contact a recognized communications resource for medical direction.

Emergency Interhospital Transfers Conducted by Receiving Facility

(Transferring personnel are agents of the receiving hospital)

If the transferring personnel include a physician, the patient becomes the responsibility of the receiving facility as soon as the patient leaves the transferring facility.

If the transferring team does not include a physician, the responsibility for the patient's well being may be shared between the receiving and transferring facility. The transferring facility retains the responsibility to assure that the transport agency has qualified personnel and transportation equipment.

Critical Care Transfers

If the patient is receiving treatment beyond the scope of practice of available transferring non-physician providers or if the patient’s needs or reasonably perceived needs cannot be managed within the scope of practice of non-physician personnel, the transfer shall be managed by an appropriately trained physician.

APPENDIX 8 – RELATED OSHA REGULATIONS

General Industry

Part 1910 of title 29 of the Code of Federal Regulations is amended as follows:

PART 1910-[AMENDED]

Subpart Z-[Amended]

The general authority citation for subpart Z of 29 CFR part 1910 continues to read as follows and a new citation for 1910.1030 is added:

Authority: Sec. 6 and 8, Occupational Safety and Health Act, 29 U.S.C. 655.657. Secretary of Labor's Orders Nos. 12-71 (36 FR 8754). 8-76 (41 FR 25059), or 9-83 (48 FR 35736), as applicable; and 29 CFR part 1911.

Section 1910.1030 also issued under 29 U.S.C. 653.

Section 1910.1030 is added to read as follows:

1910.1030 Blood borne Pathogens.

Scope and Application. This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

Definitions. For purposes of this section, the following shall apply:

Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

Blood means human blood, human blood components, and products made from human blood.

Blood borne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials on an item or surface.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to removed, inactivate, or destroy blood borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles) that isolate or remove the blood borne pathogens hazard for the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties.

Handwashing Facilities means a facility providing an adequate supply of running potable water soap and single use towels or hot air drying machines.

Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

HBV means hepatitis B virus.

HIV means human immunodeficiency virus.

Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Materials means

The following human blood fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts or blouses) not

intended to function as protection against a hazard is not considered to be personal protective equipment.

Production Facility means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or potentially infectious materials are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

Research Laboratory means a laboratory producing or using research laboratory-scale amounts of HIV or HBV. Research laboratories may product high concentrations of HIV or HBV but not in the volume found in production facilities.

Source Individual means any individual living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include but are not limited to hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if know to be infectious for HIV, HBV, and other blood borne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

EXPOSURE CONTROL

Exposure Control Plan: Each employer having an employee(s), with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

The Exposure Control Plan shall contain at least the following elements;

The exposure determination required by paragraph(c)(2).

The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-

Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Recordkeeping, of this standard and

The procedure for the evaluation of circumstances surrounding exposure incidents as required by paragraph(f)(3)(i) of this standard.

Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with 29 CFR 1910.20(e).

The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which effect occupational exposure and to reflect new or revised employee positions with occupational exposure.

The Exposure Control Plan shall be made available to the Assistant Secretary and the Director upon request for examination and copying.

Exposure determination.

Each employer who has an employee(s) with occupational exposure as defined by paragraph (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

A list of all job classifications in which all employees in those job classifications have occupational exposure;

A list of job classifications in which some employees have occupational exposure, and

A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classifications listed in accordance with the provisions of paragraph(c)(2)(i)(B) of this standard.

This exposure determination shall be made without regard to the use of personal protective equipment.

METHODS OF COMPLIANCE

General-Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

Engineering and work practice controls.

Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls personal protective equipment shall also be used.

Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

Employees shall provide handwashing facilities which are readily accessible to employees.

When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleaners or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

Employers shall ensure that employees wash their hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

Contaminated needles and other contaminated sharps shall not be net, recapped, or removed except as noted in paragraphs (d)(2)(vii)(A) and (d)(2)(vii)(B) below. Shearing or breaking of contaminated needles is prohibited.

Contaminated needles and other contaminated sharps shall not be recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure.

Such recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.

Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly processed. These containers shall be:

Puncture resistant;

Labeled or color-coded in accordance with this standard;

Leak proof on the sides and bottom; and

In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

Eating, drinking, smoking applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.

All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport or shipping.

The container for storage, transport, or shipping shall be labeled or color-coded according to paragraph(g)(1)(i) and closed prior to being stored, transported, or shipped. When a facility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens. This exemption only applies while such specimens/containers remain within the facility. Labeling or color-coding in accordance with paragraph(g)(1)(i) is required when such specimens/containers leave the facility.

If outside contaminations of the primary container occurs, the primary container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded according to the requirements of this standard.

If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment is not feasible.

A readily observable label in accordance with paragraph (g)(1)(i)(H) shall be attached to the equipment stating which portions remain contaminated.

The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate prior to handling, servicing, or shipping so that appropriate precautions will be taken.

Personal protective equipment-

Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances

shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by paragraphs(d) and (e) of this standard, at not cost to the employee.

Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible.

All personal protective equipment shall be removed prior to leaving the work area .

When personal protective equipment is removed prior to leaving the work site.

When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage or disposal.

Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and on-intact skin; when performing vascular access procedures except as specified in paragraph(d)(3)(ix)(D); and when handling or touching contaminated items or surfaces.

Disposal (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

Disposable (single use) gloves shall not be washed or decontaminated for re-use.

Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

Periodically reevaluate this policy;

Make gloves available to all employees who wish to use them for phlebotomy; and

Require that gloves be used for phlebotomy in the following circumstances:

When the employee has cuts, scratches, or other breaks in his or her skin;

When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual; and

When the employee is receiving training in phlebotomy.

Make, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

Gowns, Aprons, and Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopedic surgery).

Housekeeping.

General. Employers shall ensure that the worksite is maintained in a clean and sanitary condition. The employer shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the work shift if they may have become contaminated during the shift.

All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

Regulated Waste.

Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:

Closable;

Puncture resistant;

Leakproof on sides and bottom; and

Labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard.

During use, containers for contaminated sharps shall be:

Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries);

Maintained upright throughout use; and

Replaced routinely and not be allowed to overfill.

When moving containers of contaminated sharps from the area of use, the containers shall be:

Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping;

Placed in a secondary container if leakage is possible. The second container shall be:

Closable;

Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping; and

Labeled or color-coded according to paragraph(g)(1)(i) of this standard.

Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

Regulated waste shall be placed in containers which are:

Closable;

Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

Labeled or color-coded in accordance with paragraph(g)(1)(i) this standard; and

Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

If outside contamination of the regulated waste container occurs, it shall be placed in a second container. The second container shall be:

Closable;

Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

Labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard; and

Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

Laundry.

Contaminated laundry shall be handled as little as possible with a minimum of agitation.

Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard. When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the container as requiring compliance with Universal Precautions.

Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from the bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with paragraph(g)(1)(i).

HIV and HBV Research Laboratories and Production Facilities.

This paragraph applies to research laboratories and production facilities engaged in the culture, production, concentration, experimentation, and manipulation of HIV and HBV. It does not apply to clinical or diagnostic laboratories engaged solely in the analysis of blood, tissues, or organs. These requirements apply in addition to the other requirements of the standard.

Research laboratories and production facilities shall meet the following criteria:

Standard microbiological practices. All regulated waste shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy blood borne pathogens.

Special practices.

Laboratory doors shall be kept closed when work involving HIV or HBV is in progress.

Contaminated materials that are to be decontaminated at a site away from the work area shall be placed in a durable, leak proof, labeled or color-coded container that is closed before being removed from the work area.

Assess to the work area shall be limited to authorized persons. Written policies and procedures shall be established whereby only persons who have been advised of the potential biohazard, who meet any specific entry requirements, and who comply with all entry and exit procedures shall be allowed to enter the work areas and animal rooms.

When other potentially infectious materials or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph(g)(1)(ii) of this standard.

All activities involving other potentially infectious materials shall be conducted in biological safety cabinets or other physical-containment devices within the containment module. No work with these other potentially infectious materials shall be conducted on the open bench.

Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in the work area and animal rooms. Protective clothing shall not be worn outside of the work area and shall be decontaminated before being laundered.

Special care shall be taken to avoid skin contact with other potentially infectious materials. Gloves shall be worn when handling infected animals and when making band contact with other potentially infectious materials is unavoidable.

Before disposal all waste from work areas and from animal rooms shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy blood borne pathogens.

Vacuum lines shall be protected with liquid disinfectant traps and high-efficiency particulate air (HEPA) filters or filters of equivalent or superior efficiency and which are checked routinely and maintained or replaced as necessary.

Hypodermic needles and syringes shall be used only for parenteral injection and aspiration of fluids from laboratory animals and diaphragm bottles. Only needle-locking units (i.e., the needle is integral to the syringe) shall be used for the injection or aspiration of other potentially infectious materials. Extreme caution shall be used when handling needles and syringes. A needle shall not be bent, sheared, replaced in the sheath or guard, or removed from the syringe following use. The needle and syringe shall be promptly placed in a puncture-resistant container and autoclaved or decontaminated before reuse or disposal.

All spills shall be immediately contained and cleaned up by appropriate professional staff or others properly trained and equipped to work with potentially concentrated infectious materials.

A spill or accident that results in an exposure incident shall be immediately reported to the laboratory director or other responsible person.

A biosafety manual shall be prepared or adopted and periodically reviewed and updated at least annually or more often if necessary. Personnel shall be advised of potential hazards, shall be required to read instructions on practices and procedures, and shall be required to follow them.

Containment equipment.

Certified biological safety cabinets (Class I, II, or III) or other appropriate combinations of personal protection or physical containment devices, such as special protective clothing, respirators, centrifuge safety cups, sealed centrifuge rotors, and containment caging for animals, shall be used for all activities with other potentially infectious materials that pose a threat of exposure to droplets, splashes, spills, or aerosols.

Biological safety cabinets shall be certified when installed, whenever they are moved and at least annually.

HIV and HBV research laboratories shall meet the following criteria:

Each laboratory shall contain a facility for hand washing and an eye wash facility which is readily available within the work area.

An autoclave for decontamination of regulated waste shall be available.

HIV and HBV production facilities shall meet the following criteria:

The work areas shall be separated from areas that are open to unrestricted traffic flow within the building. Passage through two sets of doors shall be the basic requirement for entry into the work area from access corridors or other contiguous areas. Physical separation of the high-containment work area from access corridors or other areas or activities may also be provided by a double-doored clothes-change room (showers may be included), airlock, or other access facility that requires passing through two sets of doors before entering the work area.

The surfaces of doors, walls, floors and ceilings in the work area shall be water resistant so that they can be easily cleaned. Penetrations in these surfaces shall be sealed or capable of being sealed to facilitate decontamination.

Each work area shall contain a sink for washing hands and a readily available eye wash facility. The sink shall be foot, elbow, or automatically operated and shall be located near the exit door of the work area.

Access doors to the work area or containment module shall be self-closing.

An autoclave for decontamination of regulated waste shall be available within or as near as possible to the work area.

A ducted exhaust-air ventilation system shall be provided. This system shall create directional airflow that draws air into the work area through the entry area. The exhaust air shall not be recirculated to any other area of the building, shall be discharged to the outside, and shall be dispersed away from occupied areas and air intakes. The proper direction of the airflow shall be verified (i.e., into the work area).

Training Requirements. Additional training requirements for employees in HIV and HBV research laboratories and HIV and HBV production facilities are specified in paragraph(g)(2)(ix).

Hepatitis B vaccination and post-exposure evaluation and follow-up-

General.

The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and pot-exposure evaluation and follow-up to all employees who have had an exposure incident.

The employer shall ensure that all medical evaluations and procedures including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis are:

Made available at not cost to the employee;

Made available to the employee at a reasonable time and place;

Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified by this paragraph(f).

The employers hall ensure that all laboratory at no cost to the employee.

Hepatitis B Vaccination

Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 workings days of initial assignment to all employees who have occupational exposure unless the employee has previously received the complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

The employee shall not make participation in a pre-screening program a prerequisite for receiving hepatitis B vaccination.

If the employee initially declines Hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available hepatitis B vaccination at that time.

The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in appendix A.

If a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section(f)(1)(ii).

Post-exposure Evaluation and Follow-up. Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred;

Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law;

The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

When the source individual is already known to be infected with HBV or HIV, testing for source individual's known HBV or HIV status need not be repeated.

Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

Collection and testing of blood for HBV and HIV serological status;

The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If within 90 days of the exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

Post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;

Counseling; and

Evaluation of reported illnesses.

Information Provided to the Healthcare Professional.

The employer shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information:

A copy of this regulation;

A description of the exposed employee's duties as they relate to the exposure incident:

Documentation of the route(s) of exposure and circumstances under which exposure occurred;

Results of the source individual's blood testing, if available; and

All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.

Healthcare Professional's Written Opinion. The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

That the employee has been informed of the results of the evaluation; and

That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

All other findings or diagnoses shall remain confidential and shall not be included in the written report.

Medical recordkeeping. Medical records required by this standard shall be maintain in accordance with paragraph(h)(1) of this section.

Communication of hazards to employees- Labels and signs.

Labels. Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious material; except as provided in paragraph(g)(1)(i)(E), (F) and (G).

Labels required by this section shall include the following legend: Biohazard

These labels shall be fluorescent orange or orange-red or predominantly so, with lettering or symbols in contrasting color.

Labels required by affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

Red bags or red containers may be substituted for labels.

Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements of paragraph (g).

Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment or disposal are exempted from the labeling requirement.

Labels required for contaminated equipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated.

Regulated waste that has been decontaminated need not be labeled or color-coded.

Signs. The employer shall post signs at the entrance to work areas specified in paragraph(e), HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:

Biohazard

(Name of the Infectious Agent)

(Special requirements for entering the area)

(Name, telephone number of the laboratory director or other responsible person).

These signs shall be fluorescent orange-red or predominantly so, with lettering or symbols in a contrasting color.

Information and Training. Employers shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours.

Training shall be provided as follows:

At the time of initial assignment to tasks where occupational exposure may take place;

Within 90 days after the effective date of the standard; and

At least annually thereafter.

For employees who have received training on blood borne pathogens in the year preceding the effective date of the standard, only training with respect to the provisions of the standard which were not included need be provided.

Annual training for all employees shall be provided within one year of their previous training.

Employers shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.

The training program shall contain at a minimum the following elements;

Inaccessible copy of the regulatory text of this standard and an explanation of its contents;

A general explanation of the epidemiology and symptoms of blood borne diseases;

An explanation of the modes of transmission of blood borne pathogens;

An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment;

Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

An explanation of the basis for selection of personal protective equipment;

Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following and exposure incident;

An explanation of the signs and label and/or color coding required by paragraph(g)(1); and

An opportunity for interactive questions and answers with the person conducting the training session.

The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

Additional Initial Training for Employees in HIV and HBV Laboratories and Production Facilities. Employees in HIV or HBV research laboratories and HIV or HBV production facilities shall receive the following initial training in addition to the above training requirements.

The employer shall assure that employees demonstrate proficiency in standard microbiological practices and techniques and in the practices and operations specific to the facility before being allowed to work with HIV or HBV.

The employer shall assure that employees have prior experience in the handling of human pathogens or tissue cultures before working with HIV or HBV.

The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as technique are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

Recordkeeping-

Medical Records. The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with 29 CFR 1910.20. This record shall include:

The name and social security number of the employee;

A copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by paragraph(f)(2);

A copy of all results of examinations, medical testing, and follow-up procedures as required by paragraph (f)(3);

The employer's copy of the healthcare professional's written opinion as required by paragraph (f)(5); and

A copy of the information provided to the healthcare professional as required by paragraphs (f)(4)(ii)(B)(C) and (D).

Confidentiality. The employer shall ensure that employee medical records required by paragraph (h)(1) are:

Kept confidential; and

Are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this section or as may be required by law.

The employer shall maintain the records required by paragraph(h) for at least the duration of employment plus 30 years in accordance with 29 CFR 1910.20.

Training Records.

Training records shall include the following information: The dates of the training sessions; The contents or a summary of the training sessions; The names and qualifications of persons conducting the training; and The names and job titles of all persons attending the training sessions.

Training records shall be maintained for 3 years from the date on which the training occurred.

Availability.

The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Assistant Secretary and the Director for examination and copying.

Employee training records required by this paragraph shall be provided upon request for examination and copying to employees, to employee representatives, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

Employee medical records required by this paragraph shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

Transfer of Records.

The employer shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.20(h).

If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Director, at least three months prior to their disposal and transmit them to the Director, if required by the Director to do so, within that three month period.

Dates-

Effective Date. The standard shall become effective on March 6, 1992.

The Exposure Control Plan required by paragraph(c)(2) of this section shall be completed on or before May 5, 1992.

Paragraph (g)(2) Information and Training and (h) Recordkeeping shall take effect on or before June 4, 1992.

Paragraphs (d)(2) Engineering and Work Practice Controls, (d)(3) Housekeeping, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, and (g) (1) Labels and Signs, shall take effect July 6, 1992.

Appendix A to Section 1910.1030-Hepatitis B Vaccine Declination (Mandatory)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV)a infection, I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

(FR Doc.91-28886 Filed 12-2-91; 8:45 am) Billing Code 4510-26-M

APPENDIX 9 – RELATED COBRA REGULATIONS H.R. 3128-83 Subpart B-Miscellaneous Provisions Sec. 9121. Responsibilities of Medicare Hospitals in Emergency Cases.

Requirement of Medicare Hospital Provider Agreements.-Section 1866(a)(1) of the Social Security Act (42 USC 1395cc (a)(1) is amended-

by striking out "and" at the end of subparagraph (G),

by striking out the period at the end of subparagraph (H) and inserting in lieu thereof", and ", and

by inserting after subparagraph (H) the following new subparagraph: "(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable."

Requirements-Title XVIII of such Act is amended by inserting after section 1866 the following new section:

Examination and Treatment for Emergency Medical Conditions and Women in Active Labor: "Spec. 1867 (a) Medical Screening Requirement.-In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (3)(1) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

Necessary Stabilizing Treatment for Emergency Medical Conditions and Active Labor.- In general.-If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either-

within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

for transfer of the individual to another medical facility in accordance with subsection (c).

Refusal to Consent to Treatment - A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

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Refusal to Consent to Transfer - A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

Restricting Transfers Until Patient Stabilized -

Rule. - If a patient at a hospital has an emergency medical condition which has not been stabilized (with the meaning of subsection (e)(4)(B) or is in active labor, the hospital may transfer the patient unless-

(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

a physician (within the meaning of section 1861(r)(1), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

Enforcement-

As Requirement of Medicare Provider Agreement. - If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to-

termination of its provider agreement under this title in accordance with section 1866(b), or

at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

Civil Monetary Penalties. - In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation. As used in the previous sentence, the term "responsible physician" means, with respect to a hospital's, a physician who-

is employed by, or under contract with, the participating hospital, and

acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

Civil Enforcement-

Personal Harm.- Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as appropriate.

Financial Loss To Other Medical Facility.- Any medical facility that suffers a financial loss as a direct result of participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

Limitations On Actions.- No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

Definitions.- In this section:

The term `emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

The term `participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

(A) The term `to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

The term `stabilized' means with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

The term `transfer' means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

Preemption.- The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

Effective Date.- The amendments made by this section shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act.

Report.- The Secretary of Health and Human Services shall, not later than 6 months after the effective date described in subsection (c), report to Congress on the methods to be used for monitoring and enforcing compliance with section 1867 of the Social Security Act.

Sec. 9122. Requirement For Medicare Hospitals for Participate In Champus and Champva Programs.

In General.- Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1) is amended-

by striking out "and" at the end of subparagraph (H),

by striking out the period at the end of subparagraph (I) and inserting in lieu thereof", and", and

by inserting after subparagraph (I) the following new subparagraph:

in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code."

Effective Date.- The amendments made by subsection (a) shall apply to agreements entered into our renewed on or after the date of the enactment of this Act, but shall apply only to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

Reference to Study Required.- For a study of the use by Champus of the Medicare prospective payment system, see section 634 of the Department of Defense Authorization Act, 1985 (Public Law 98-525), the deadline for which is extended under section 2002 of this Act.

Report.- The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act as a result of the additional conditions imposed under the amendments made by subsection(a).

APPENDIX 10 – DEATHS - PRONOUNCEMENTS/REPORTING/MOVING BODIES/PENALTIES FOR VIOLATIONS

When to resuscitate

The statute in no way attempts to define when resuscitation should be initiated or withheld. This always has been and still is a medical and not a legal decision. The American Heart Association has established guidelines on decision-making and CPR, and the National Registry of Emergency Medical Technicians recognizes these as acceptable standards. They are as follows:

Few reliable criteria exist by which death can be defined immediately.

Decapitation, rigor mortis, and evidence of tissue decomposition and dependent lividity are reliable criteria. In the absence of such findings, CPR generally should be initiated immediately unless there is an acceptable reason to withhold it. If the decision not to initiate CPR is made by medical professional functioning in his professional capacity, the basis of the decision should not be arbitrary. The reason to withhold CPR should be sufficiently firm so that, should it later be subject to question, a decision can be effectively supported. Contact Medical Control in any questionable decision.

Laws As They Relate To Emergency Medical Services

The source of the laws which pertain to death is the Medical Examiners Act of 1986 and its revisions. For the purpose of this appendix only the portions of the laws that directly effect EMS will be quoted.

It should be pointed out that in any case and under any circumstances, if it is felt by EMS personnel that the patient is resuscitable, neither the Medical Examiner nor Law Enforcement personnel can force the withholding of treatment.

APPENDIX 11 - GLOSSARY

"Advanced life Support" - shall mean a sophisticated level of pre-hospital and interhospital emergency care which includes basic life support functions including cardiopulmonary resuscitation (CPR), plus cardiac defibrillation, telemetered electrocardiography, administration of antiarrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures.

"Advanced life support personnel" - shall mean persons other than physicians engaged in the provision of advanced life support, as defined and regulated by rules and regulations promulgated pursuant to Section 41-60-13.

"Advanced Life Support Services" - shall mean implementation of the 15 components of an EMS system to a level capability which provides noninvasive and invasive emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Services shall include use of sophisticated transportation vehicles, a communications capability (two-way voice and/or biomedical telemetry) and staffing by Emergency Medical Technician-Intermediates or Emergency Medical Technician-Paramedics providing on-site, pre-hospital mobile and hospital intensive care under medical control.

"Ambulance" - shall mean any privately or publicly owned land or air vehicle that is especially designed, constructed, modified or equipped to be used, maintained and operated upon the streets, highway or airways of this state to assist persons who are sick, injured, wounded or otherwise incapacitated or helpless.

"Ambulance Placement Strategy (System Status Plan)" - a planned outline or protocol governing the deployment and event-driven redeployment of the ambulance service's resources, both geographically and by time-of-day/day-of-week. Every system has a plan; the plan may be written or not, elaborate or simple, efficient or wasteful, effective or deadly.

"Ambulance Post" - a designated location for ambulance placement within the system status plan. Depending upon its frequency and type of use, a "post" may be a facility with sleeping quarters or day rooms for crews, or simply a street-corner or parking lot location to which units are sometimes deployed.

"Ambulance Service Area" - the geographic response area of the licensed ambulance service. The service area must correspond to each individual service license. The service's employee staffing plan, ambulance placement strategy and available resources must be commensurate with the service area.

"Area wide EMS System" - is an emergency medical service area (trade, catchment, market, patient flow) that provides essentially all of the definitive emergency medical care (95%) for all emergencies, including the most critically ill and injured patients. Only highly specialized and limited-use services may need to be obtained outside of the area. The area must contain adequate population and available medical resources to implement and sustain an EMS operation. At least three major modes exist: (a) multiple urbanized communities and their

related suburbs; (b) a metropolitan center and its surrounding rural areas; and (c) a metropolitan center and extreme rural-wilderness settings. The areas may be inter- or intra-state.

"Associate/Receiving Hospital" - is a designated participating hospital working in conjunction with and under the supervision of the Resource Hospital to carry out the system implementation. They shall have an emergency department/service which offers emergency care 24 hours a day, with at least one physician available to the emergency care area within approximately 30 minutes through a medical staff call roster. Specialty consultation must be available by request of the attending medical staff member or by transfer to a designated hospital where definitive care can be provided. They must be capable of providing 24-hour-a-day acute care to critically ill patients. They do not, however, have to be equipped with biomedical telemetry within its confines.

"Automated External Defibrillator (AED)" - means a defibrillator which: a) is capable of cardiac rhythm analysis; b) will charge and deliver a shock after electrically detecting the presence of a cardiac dysrhythmia or is a shock-advisory device in which the defibrillator will analyze the rhythm and display a message advising the operator to press a "shock" control to deliver the shock; c) must be capable of printing a post event summary (at a minimum the post event summary should include times, joules delivered, ECG) and d) an on screen display of the ECG. (optional)

"Base Station Hospital" - is designated participating hospital working in conjunction with and under the supervision of the Resource Hospital to carry out the systems implementation. These hospitals may function as a pre-hospital Communications Resource as defined in the section on Medical Direction. The hospitals may participate in training and evaluation of ALS personnel. They must have emergency department’s staffed 24-hours-a-day by critical care nurses and at least one emergency physician or physicians under the direction and supervision of a physician totally versed and committed to emergency medicine. It must have specialty consultation available within approximately 30 minutes by members of the medical staff or by senior-level residents. Pre-hospital ALS personnel transmit patient information to the Base Station Hospitals and receive appropriate medical directions from them. The hospitals should be equipped with voice and biomedical telemetry equipment. Each Base Station Hospital must have an On-Line Medical Director.

"Basic Life Support Services (BLS)" - Implementation of the 15 components of and EMS system to a level of capability which provides pre-hospital noninvasive emergency patient care designed to optimize the patient's chance of surviving the emergency situation. There would be universal access to and dispatch of national standard ambulances, with appropriate medical and communication equipment operated by Emergency Medical Technicians-Ambulance. Regional triage protocols should be used to direct patients to appropriately categorized hospitals.

"Board" means the State Board of Health;

“Bypass” (diversion) - A medical protocol or medical order for the transport of an EMS patient past a normally used EMS receiving facility to a designated medical facility for the purpose for accessing more readily available or appropriate medical care.

"Certificate” means official acknowledgment that an individual has successfully completed (i) the recommended basic emergency medical technician training course referred to in this chapter which entitles that individual to perform the functions and duties of an emergency medical technician, or (ii) the recommended medical first responder training course referred to in this chapter which entitles that individual to perform the functions and duties of a medical first responder;

"Critical Care Units (Centers)" - are sophisticated treatment facilities in large medical centers and hospitals that provide advanced definitive care for the most critically ill patients. The units are available for the diagnosis and care of specific patient problems including major trauma, burn, spinal cord injury, poisoning, acute cardiac, high risk infant and behavioral emergencies.

"Communication Resource" - an entity responsible for implementation of direct medical control (See detailed description in section on Medical Direction).

"Delegated Practice" - Only physicians are licensed to practice medicine. Pre-hospital providers must act only under the medical direction of a physician.

“Department” - the Mississippi State Department of Health, Bureau of Emergency Medical Services.

"Direct Medical Control" - When a physician provides immediate medical direction to pre-hospital providers in remote locations.

“Diversion” - see "Bypass."

"DOT" - shall mean United States Department of Transportation.

"Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, psychiatric disturbances and/or symptoms of substance abuse, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part;

"Emergency Medical Services (EMS)" - Services utilized in responding to a perceived individual's need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury.

"EMS Personnel" - Key individual EMS providers. This includes physician, emergency and critical care nurse, EMT-Basic, EMT-Intermediate, EMT-Paramedic, dispatchers, telephone screeners, first aid responders, project administrators and medical consultants and system coordinators.

"EMS System" - A system which provides for the arrangement of personnel, facilities, and equipment of the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions (occurring as a result of the patient's condition or

because of natural disasters or similar conditions). The system is managed by a public or nonprofit private entity. The components of an EMS System include:

manpower

training

communications

transportation

facilities

critical care units

public safety agencies

consumer participation

access to care

patient transfer

coordinated patient recordkeeping

public information and education

review and evaluation

disaster plan

mutual aid

"Emergency medical technician" - shall mean an individual who possesses a valid emergency medical technicians certificate issued pursuant to the provisions of this chapter.

"Emergency medical technician-intermediate" - shall mean a person specially trained in advanced life support modules as authorized by the Mississippi State Department of Health.

"Emergency medical technician-paramedic" - shall mean a person specially trained in an advanced life support training program authorized by the Mississippi State Department of Health.

"Emergency mode" means an ambulance or special use EMS vehicle operating with emergency lights and warning siren (or warning siren and air horn) while engaged in an emergency medical call.

"Emergency response" means responding immediately at the basic life support or advanced life support level of service to an emergency medical call. An immediate response is one in which

the ambulance supplier begins as quickly as possible to take the steps necessary to respond to the call;

"Emergency medical call" means a situation that is presumptively classified at time of dispatch to have a high index of probability that an emergency medical condition or other situation exists that requires medical intervention as soon as possible to reduce the seriousness of the situation, or when the exact circumstances are unknown, but the nature of the request is suggestive of a true emergency where a patient may be at risk;

"Executive officer" - shall mean the executive officer of the State Department of Health or his designated representative.

“Field Categorization” (classification) - a medical emergency classification procedure for patients that is applicable under conditions encountered at the site of a medical emergency.

“Field Triage” - Classification of patients according to medical need at the scene of an injury or onset of an illness.

"First responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons

"Medical first responder" means a person who uses a limited amount of equipment to perform the initial assessment of and intervention with sick, wounded or otherwise incapacitated persons who (i) is trained to assist other EMS personnel by successfully completing, and remaining current in refresher training in accordance with, an approved "First Responder: National Standard Curriculum" training program, as developed and promulgated by the United States Department of Transportation, (ii) is nationally registered as a first responder by the National Registry of Emergency Medical Technicians; and (iii) is certified as a medical first responder by the State Department of Health, Division of Emergency Medical Services.

“Implementation” (or "implemented") - the development and activation of a Regional Trauma Plan by a designated Trauma Care Region including the triage, transport and treatment of trauma patients in accordance with the plan.

“Inclusive Trauma Care System” - a trauma care system that incorporates every health care facility in a community in a system in order to provide a continuum of services for all injured persons who require care in an acute care facility; in such a system, the injured patient's needs are matched to the appropriate hospital resources.

"Implied Consent" - shall mean legal position that assumes an unconscious patient, or one so badly injured or ill that he cannot respond, would consent to receiving emergency care. Implied consent applies to children when parent or guardian is not at the scene.

"Intervener Physicians" - A licensed M.D. or D.O., having not previously established a doctor/patient relationship with the emergency patient and willing to accept responsibility for a medical emergency scene, and can provide proof of a current Medical Licensure.

"Lead Agency" - is an organization which has been delegated the responsibility for coordinating all component and care aspects for an EMS system.

“Level I” - Hospitals that have met the requirements for Level I as stated in the Mississippi Trauma Rules and Regulations.

“Level II” - Hospitals that have met the requirements for Level II as stated in Mississippi Trauma Rules and Regulations.

“Level III” - Hospitals that have met the requirements for Level III as stated in Mississippi Trauma Rules and Regulations.

“Level IV” - Hospitals that have met the requirements for Level IV as stated in Mississippi Trauma Rules and Regulations.

"Licensure" - shall mean an authorization to any person, firm, cooperation, or governmental division or agency to provide ambulance services in the State of Mississippi.

"License Location" - shall be defined as a fixed location where the ambulance service conducts business or controls the deployment of ambulances to the service area.

“Major Trauma” - that subset of injuries that encompasses the patient with or at risk for the most severe or critical types of injury and therefore requires a system approach in order to save life and limb.

“Major Trauma Patient” (or "major trauma" or " critically injured patient") - a person who has sustained acute injury and by means of a standardized field triage criteria (anatomic, physiology, and mechanism of injury) is judged to be at significant risk of mortality or major morbidity.

“Mechanism of Injury” - the source of forces that produce mechanical deformations and physiological responses that cause an anatomic lesion of functional change in humans.

"Medical Control" - shall mean directions and advice provided from a centrally designated medical facility staffed by appropriate personnel, operating under medical supervision, supplying professional support through radio or telephonic communication for on-site and in-transit basic and advanced life support services given by field and satellite facility personnel.

"Medical Direction" - (medical accountability) - When a physician is identified to develop, implement and evaluate all medical aspects of an EMS system.

"Medical Director" - (off line, administrative) should be a physician both credible and knowledgeable in EMS systems planning, implementation, and operations. This off-line physician assumes total responsibility for the system's activities. He is appointed by the local EMS lead agency. The administrative medical director works in close liaison with government agencies, public safety and disaster operations, legislative and executive offices, professional societies, and the public. Off-line program activities include liaison with other state and regional EMS medical directors to conceptualize clinical and component system designs, establish standards, monitor and evaluate the integration of component and system activities.

This off-line physician assures medical soundness and appropriateness of all aspects of the program and is responsible for the conceptual and systems design and overall supervision of the EMS program.

The administrative (off-line) medical director in conjunction with the supervisory ALS (on-line) medical directors of each Base Station Hospital, medical directors for paramedic services, medical director for EMS training, and critical care consultants develop all area protocols. These protocols serve as the basis for EMS system role definition of ALS personnel, curriculum development, competency determination, and maintenance, monitoring, and evaluation.

The off-line medical director meets on a regular basis with on-line medical directors and the EMS training director to evaluate on-line system performance, to review problems, and suggest changes in treatment, triage, or operational protocols. All on-line medical directors must be approved by the off-line medical director.

“Mississippi Trauma Advisory Committee” (MTAC) - (See Appendix A) advisory body created by legislature for the purpose of providing assistance in all areas of trauma care system development and technical support to the Department of Health; members are comprised of EMS Advisory Council members appointed by the chairman.

“Mississippi Trauma Care System Plan” (State Trauma Plan) - a formally organized plan developed by the Department of Health, pursuant to legislative directive, which sets out a comprehensive system of prevention and management of major traumatic injuries.

"On-Line (Supervising ALS) Medical Director" - On-Line medical control is provided through designated Primary Resource and Base Station Hospitals under the area direction of a supervisory ALS medical director who is on-line to the pre-hospital system stationed at the designated Base Station Hospital. Each provider of ALS must also have an on-line medical director. The system must also have an on-line medical director for EMS training. These supervisory medical directors are organizationally responsible to the administrative (off-line medical director of the local EMS lead agency for program implementation and operations within his area of jurisdiction).

The ALS (on-line) medical director supervises the advanced life support, pre- and inter-hospital system and is responsible for the actual day-to-day operation of the EMS system. He carries out the "EMS systems design" in terms of pre-and inter-hospital transportation care and provides ALS direction to EMS providers depending on the transportation care and provides ALS direction to EMS providers depending on the system's configuration. He monitors all pre-hospital ALS activities within that system's region or area of responsibility. The ALS physician must review and monitor compliance to protocols for both the pre-and inter-hospital settings.

The ALS (on-line) medical director in conjunction with the EMS training medical director reviews paramedics, intermediates, mobile intensive care nurses, and physician competencies and recommends certification, re-certification, and decertification of these personnel to the EMS health officer of the lead agency responsible for the certification decertification, and recertification of EMS personnel. Monitoring the competency of all pre-hospital EMS personnel activities is within his responsibility.

He attends medical control meetings where area system performance and problems are discussed and recommendations to the administrative off-line director are made. He also conducts regular case reviews and other competency evaluation and maintenance procedures and reports back to the administrative (off-line) medical director.

This ALS (on-line) physician assumes the supervision and responsibility for all advanced care rendered in an emergency at the scene of an accident and en route to the hospital under his area jurisdiction. Each on-line medical director representing the hospitals providing medical control has the authority to delegate his duties to other emergency department physicians who may be on duty and placed in a position of giving medical direction to pre-hospital ALS personnel.

“Pediatric Trauma Center” - Either (a) a licensed acute care hospital which typically treats persons fourteen (14) years of age or less, which meets all relevant criteria contained in these Regulations and which has been designated as a pediatric Trauma Center; or (b) the pediatric component of a Trauma Center with pediatric specialist and a pediatric intensive care unit.

“Performance Improvement” (or "quality improvement") - a method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome.

"Permit" - shall mean an authorization issued for an ambulance vehicle as meeting the standards adopted pursuant to this chapter.

"Pre-hospital Provider" - all personnel providing emergency medical care in a location remote from facilities capable of providing definitive medical care.

"Primary Resource Hospital" - The Primary Resource Hospital (PRH) is responsible for implementing the medical control design of the ALS system. It has the major functional responsibility for implementing protocols (treatment, triage, and operations) and the monitoring of program compliance to these by on-line medical supervision. This hospital must be an acute general care facility equipped with voice and biomedical telemetry equipment. It should be staffed with critical care nurses and emergency physicians, or physicians under the direction and supervision of physicians totally versed and committed to emergency medicine. It must be capable of functioning as a Communications Resource as described in the section on Medical Direction and pre-hospital ALS personnel should be able to receive medical control and direction from this facility anywhere within the district. It is also understood that this facility is responsible for overall supervision of medical directions that may be issued by other participating hospitals within the district.

This hospital provides and coordinates interdisciplinary training for ALS providers within the district. The lead agency may choose to delegate or contract this responsibility to other institutions."

“Protocols” - standards for EMS practice in a variety of situations within the EMS system.

“Regional Trauma Plan” - a document developed by the various Trauma Care Regions, and approved by the Department of Health, which describes the policies, procedures and protocols

for a comprehensive system of prevention and management of major traumatic injuries in that Trauma Care Region.

“Regionalization” - the identification of available resources within a given geographic area, and coordination of services to meet the need of a specific group of patients.

“Service Area” (or "catchment area") - that geographic area defined by the local EMS agency in its Regional Trauma Plan as the area served by a designated Trauma Center.

“Specialty Care Facility” - an acute care facility that provides specialized services and specially trained personnel to care for a specific portion of the injured population, such as pediatric, burn injury, or spinal cord injury patients.

“Surveillance” - the ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event.

“Trauma” - a term derived from the Greek for "wound"; it refers to any bodily injury (see "Injury").

“Trauma Care Facility” (or "trauma center") - a hospital that has been designated by the department to perform specified trauma care services within a Trauma Care Region pursuant to standards adopted by the department.

“Trauma Care Region” - Trauma Care Region is a geographic area of the state formally organized, in accordance with standards promulgated by the department and has received designation from the department, for purposes of developing and inclusive care system.

“Trauma Care System Planning and Development Act of 1990” - The federal law that amended the Public Health Service Act to add Title XII - Trauma Programs. The purpose of the legislation being to assist State governments in developing, implementing and improving regional systems of trauma care, and to fund research and demonstration projects to improve rural EMS and trauma.

“Trauma Care System” - an organized approach to treating patients with acute injuries; it provides dedicated (available 24 hours a day) personnel, facilities, and equipment for effective and coordinated trauma care in an appropriate geographical region, known as a Trauma Care Region.

“Trauma Center Designation” - the process by which the Department identifies facilities within a Trauma Care Region.

“Trauma Program Manager” - a designated individual with responsibility for coordination of all activities on the trauma service and works in collaboration with the trauma service director.

“Standing Orders” - are those specific portions of the treatment protocols that may be carried out by ALS personnel without having to establish contact with medical control facility. These standing orders represent nationally recognized treatment modalities and allow the ALS personnel to treat life-threatening problems without delay.

“State EMS Medical Director” – A Mississippi licensed physician, employed by the Mississippi Department of Health, who is responsible for the development, implementation, and evaluation of standards and guidelines for the provision of emergency medical services and EMS medical direction in the state. This physician must have experience in EMS medical direction and be board certified in emergency medicine. This physician must be experienced with EMS systems, EMS medical direction, evaluation processes, teaching, and curriculum development. It is the goal of the State EMS Medical Director to ensure the care delivered by EMS systems in the state is consistent with recognized standards and that quality is maintained in a manner that assures professional and public accountability. The State EMS Medical Director must serve as an advocate for efficient and effective emergency medical services throughout the state.

The Responsibilities of the State EMS Medical Director include but are not limited to:

* Oversight of all aspects of EMS Medical direction in the state

* Oversight of the of standards and minimum qualifications for EMS Medical Directors

* Approval of System Medical Directors for ambulance services

* Approval of protocols for ambulance services

* Approve training programs, training standards, and curricula for EMS providers and medical directors.

* Oversight of all aspects of EMS quality assurance and performance improvement in the state

* Approval of the Quality Assurance and Performance Improvement plans for ambulance services

* Serve as Chairman of the Committee on Medical Direction, Training, and Quality Assurance

* Serve as Chairman of the EMS Performance Improvement Committee

* Serve as Chairman of the EMS Protocol Committee

* Act as a liaison with public safety and disaster planning agencies

* Act as a liaison with national EMS agencies

* Oversight of issues related to complaints, investigations, disciplinary procedures involving patient care, performance standards, and medical direction

“State Trauma Plan” – See Mississippi Trauma Care Plan

"Transfer" - The movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly with) the hospital, but does not include such a movement of a patient who (a) has been declared dead, or (b) leaves the facility without the permission of any such person.

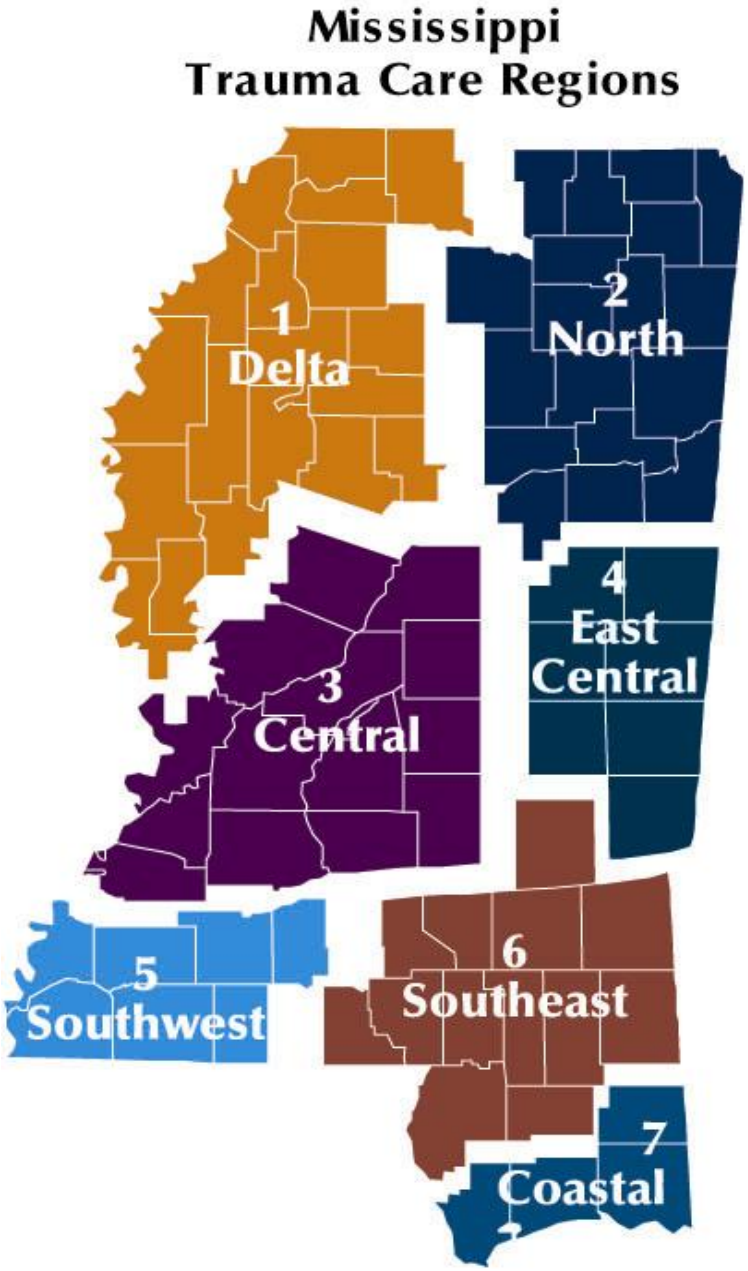
"Treatment Protocols" - are written uniform treatment and care plans for emergency and critical patients. These treatment plans must be approved and signed by the off-line medical director and/or medical groups. (Appendix 2)

“Triage” - the process of sorting injured patients on the basis of the actual or perceived degree of injury and assigning them to the most effective and efficient regional care resources, in order to insure optimal care and the best chance of survival.

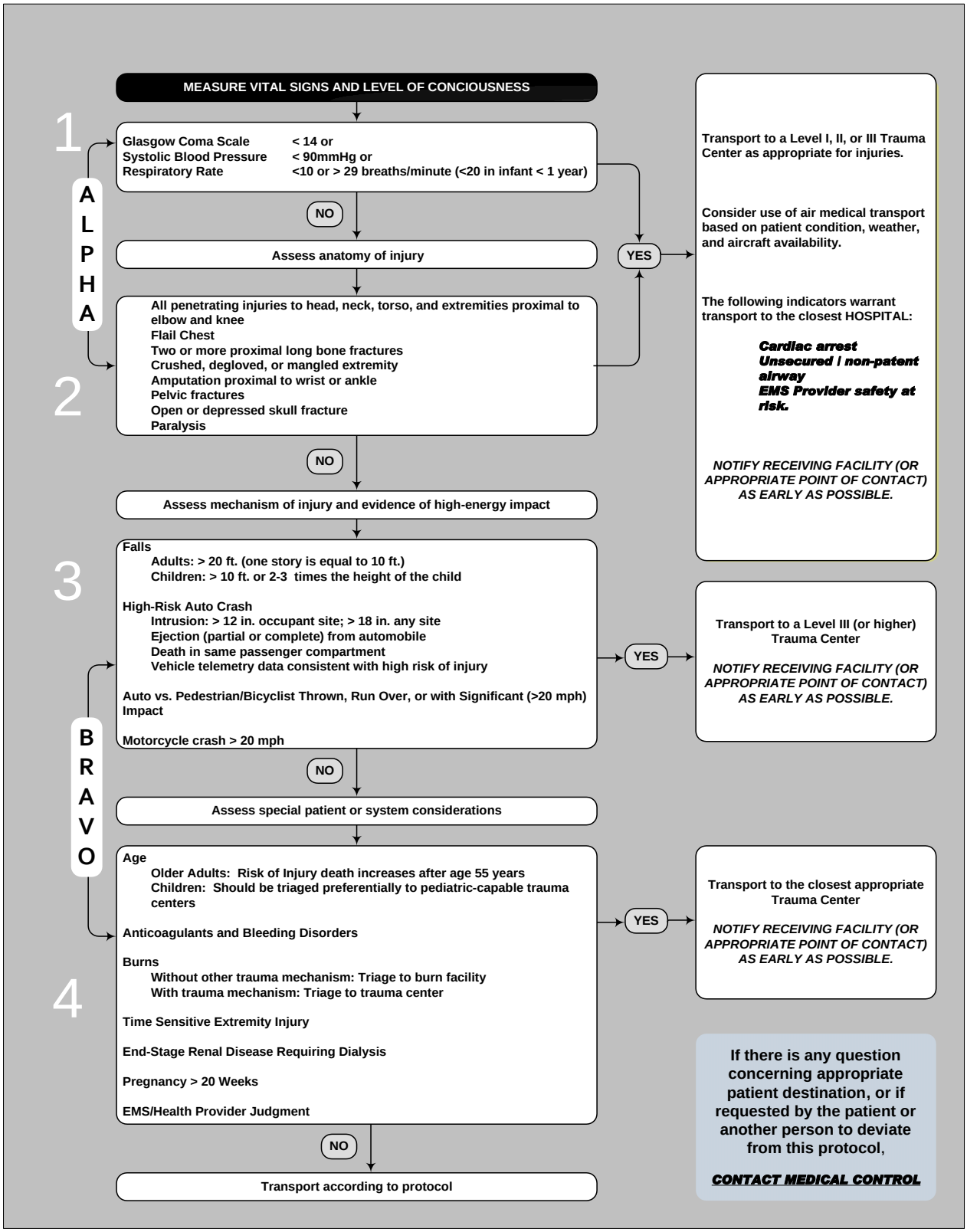
“Triage Criteria” - a measure or method of assessing the severity of a person's injuries that is used for patient evaluation, especially in the prehospital setting, and that utilizes anatomic or physiologic considerations or mechanism of injury.

"Triage Protocols" - are region wide plans for identifying, selecting and transporting specific critical patients to appropriate, designated treatment facilities.

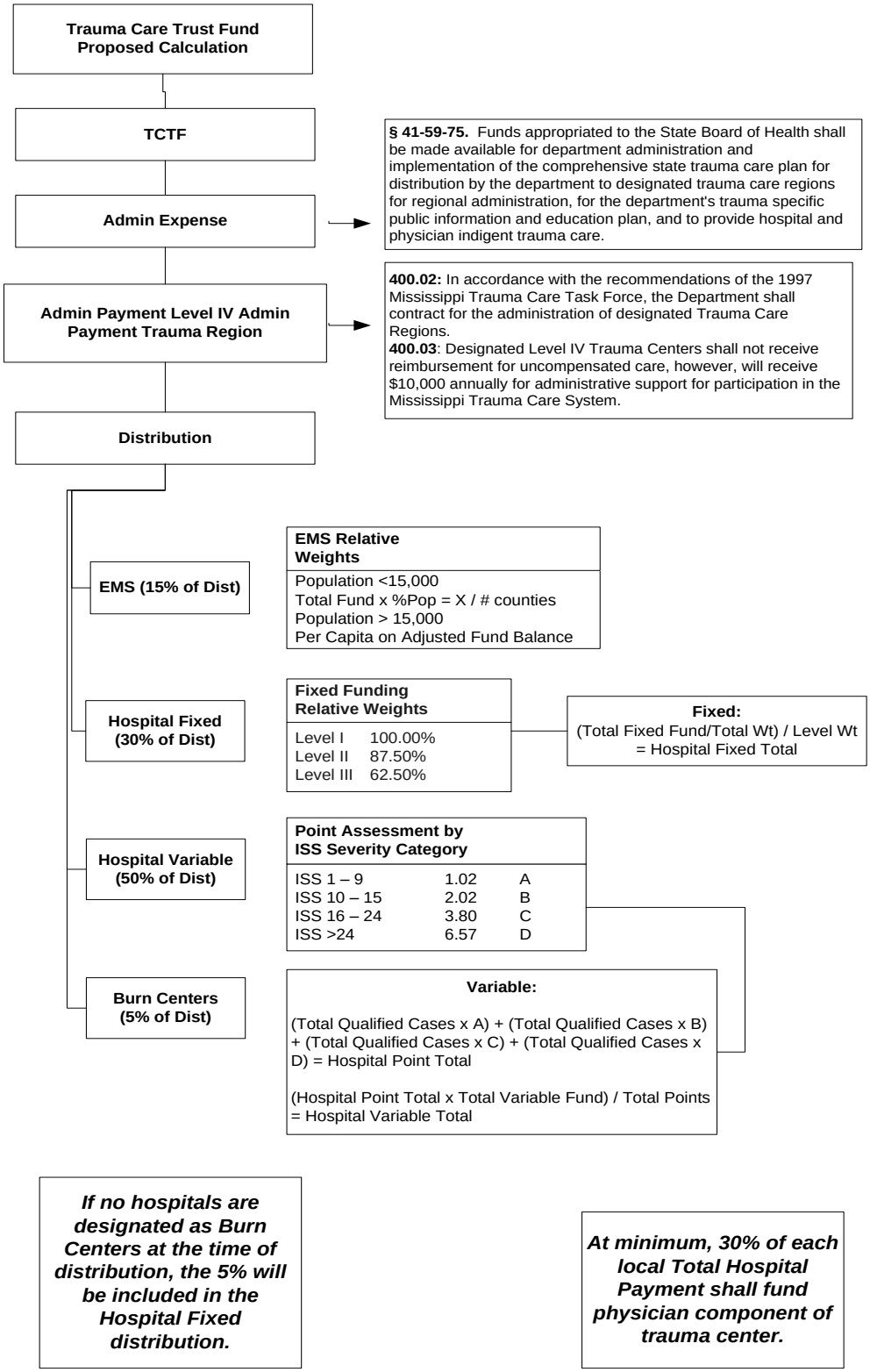
Appendix A – Trauma Care Regions Map



Appendix B – Consolidated Trauma Activation Criteria and Destination Guidelines



Appendix C – Trauma Care Trust Fund Distribution Model



If no hospitals are designated as Burn Centers at the time of distribution, the 5% will be included in the Hospital Fixed distribution.

At minimum, 30% of each local Total Hospital Payment shall fund physician component of trauma center.