Summary of Changes to:

Title 15 - Mississippi Department of Health

Part III – Office of Health Protection

Subpart 31 – Bureau of Emergency Medical Services

AMBULANCE SERVICE LICENSURE

- **Chapter 1, Section 100.05 – Suspension or revocation of license; renewal**
- **Chapter 1, Section 101.1 – Ownership Changes**

AERO MEDICAL EMERGENCY MEDICAL SERVICES

- **Chapter 3, Section 101.01 – Air Ambulance Licensure**

APPENDIX I – MEDICAL DIRECTION

- **Section 102.03 – Authority of Medical Director**

100 Ambulance Service Licensure

100.01 §41-59-9. License and permit required.

From and after October 1, 1974, no person, firm, corporation, association, county, municipality, or metropolitan government or agency, either as owner, agent or otherwise, shall hereafter furnish, operate, conduct, maintain, advertise or otherwise engage in the business of service of transporting patients upon the streets, highways or airways of Mississippi unless he holds a currently valid license and permit, for each ambulance, issued by the board.

SOURCES: Laws, 1974, ch. 507, § 5(1), eff from and after passage (approved April 3, 1974).

100.02 §41-59-11. Application for license.

1. Application for license shall be made to the board by private firms or nonfederal governmental agencies. The application shall be made upon forms in accordance with procedures established by the board and shall contain the following:

    a. The name and address of the owner of the ambulance service or proposed ambulance service;

    b. The name in which the applicant is doing business or proposes to do business;

    c. A description of each ambulance including the make, model, year of manufacturer, motor and chassis numbers, color scheme, insignia, name, monogram, or other distinguishing characteristics to be used to designate applicant's ambulance;

    d. The location and description of the place or places from which the ambulance service is intended to operate; and

    e. Such other information as the board shall deem necessary.

2. Each application for a license shall be accompanied by a license fee to be fixed by the board, which shall be paid to the board

    SOURCES: Laws, 1974, ch. 507, § 5(2); 1979, ch. 445, § 1; 1982, ch. 345, § 1; 1991, ch. 606, § 3, eff from and after July 1, 1991.

100.03 §41-59-13. Issuance of license.

The board shall issue a license which shall be valid for a period of one (1) year when it determines that all the requirements of this chapter have been met.

SOURCES: Laws, 1974, ch. 507, § 5(3), eff from and after passage (approved April 3, 1974).

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.

1. 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.

2. 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).

3. 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.

4. 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. 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.

   a. 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.

b. 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.

c. 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.*

d. 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

100.04 §41-59-15. Periodic inspections.

Subsequent to issuance of any license, the board shall cause to be inspected each ambulance service, including ambulances, equipment, personnel, records, premises and operational procedures whenever such inspection is deemed necessary, but in any event not less than two (2) times each year. The periodic inspection herein required shall be in addition to any other state or local safety or motor vehicle inspections required for ambulances or other motor vehicles provided by law or ordinance.

SOURCES: Laws, 1974, ch. 507, § 5(4), eff from and after passage (approved April 3, 1974)

"It shall be a regulation of the State Board of Health that during the inspection of emergency and/or invalid vehicles the owner, or an employee of the particular ambulance company, be present during the inspection and where necessary be subject to demonstrating certain equipment items."

Policy for Administration

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.

100.05 §41-59-17. Suspension or revocation of license; renewal

1. The board is hereby authorized to suspend or revoke a license whenever it determines that the holder no longer meets the requirements prescribed for operating an ambulance service.

2. A license issued under this chapter may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board. Renewal of any license issued under the provisions of this chapter shall require conformance with all the requirements of this chapter as upon original licensing.

SOURCES: Laws, 1974, ch. 507, § 5(5, 6); 1979, ch. 445, § 2; 1982, ch. 345, § 2; 1991, ch. 606, § 4, eff from and after July 1, 1991.

3. 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.

4. 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.

5. 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.

6. Other common grounds for suspension or revocation are for example, but not limited to:

   a. Lack of State certified EMT attending patient.

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

   c. Lack of proper equipment required by law.

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

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

   f. Failure to maintain proper insurance required by law.

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.

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.

Other Information

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

101 OWNERSHIP CHANGES

101.01 §41-59-19. Changes of ownership.

1. The board is authorized to provide for procedures to be utilized in acting on changes of ownership in accordance with regulations established by the board.

2. 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.

SOURCES: Laws, 1974, ch. 507, § 5(7), eff from and after passage (approved April 3, 1974).

Policy and Administration

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).

102 CONFORMANCE WITH LOCAL LAWS

102.01 §41-59-21. Licensee to conform with local laws or regulations.

1. The issuance of a license shall not be construed to authorize any person, firm, corporation or association to provide ambulance services or to operate any ambulance not in conformity with any ordinance or regulation enacted by any county, municipality or special purpose district or authority.

SOURCES: Laws, 1974, ch. 507, § 5(8), eff from and after passage (approved April 3, 1974).

103 PERMITS, ALL VEHICLES

103.01 §41-59-23. Ambulance permit.

1. Before a vehicle can be operated as an ambulance, its licensed owner must apply for and receive an ambulance permit issued by the board for such vehicle. Application shall be made upon forms and according to procedures established by the board. Each application for an ambulance permit shall be accompanied by a permit fee to be fixed by the board, which shall be paid to the board. Prior to issuing an original or renewal permit for an ambulance, the vehicle for which the permit is issued shall be inspected and a determination made that the vehicle meets all requirements as to vehicle design, sanitation, construction, medical equipment and supplies set forth in this chapter and regulations promulgated by the board. Permits issued for ambulance shall be valid for a period not to exceed one (1) year.

2. The board is hereby authorized to suspend or revoke an ambulance permit any time it determines that the vehicle and/or its equipment no longer meets the requirements specified by this chapter and regulations promulgated by the board.

3. The board may issue temporary permits valid for a period not to exceed ninety (90) days for ambulances not meeting required standards when it determines the public interest will thereby be served.

4. When a permit has been issued for an ambulance as specified herein, the ambulance records relating to maintenance and operation of such ambulance shall be open to inspection by a duly authorized representative of the board during normal working hours.

5. An ambulance permit issued under this chapter may be renewed upon payment of a renewal fee to be fixed by the board, which shall be paid to the board. Renewal of any ambulance permit issued under the provisions of this chapter shall require conformance with all requirements of this chapter.

   SOURCES: Laws, 1974, ch. 507, § 6; 1979, Ch. 445, § 3; 1982, ch. 345, Section 3; 1991, ch. 606, Section 5, eff from and after July 1, 1991.

Policy for Administration

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.

2. Permits issued shall expire concurrently with the service license.

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

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.

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.

6. Common grounds for suspension or revocation of vehicle permit are, for example:

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

b. Sanitary requirements not maintained

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

d. Failure to maintain insurance as required

e. Change in location of vehicle

f. Failure to carry BEMS issued permit card on vehicle

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

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

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

104 VEHICLE STANDARDS

104.01 §41-59-25. Standards for ambulance vehicles.

1. Standards for the design, construction, equipment, sanitation and maintenance of ambulance vehicles shall be developed by the board with the advice of the advisory council. Each standard may be revised as deemed necessary by the board when it determines, with the advice of the advisory council, that such will be in the public interest. However, standards for design and construction shall not take effect until July 1, 1979; and such standards when promulgated shall substantially conform to any pertinent recommendations and criteria established by the American College of Surgeons and the National Academy of Sciences, and shall be based on a norm that the ambulance shall be sufficient in size to transport one (1) litter patient and an emergency medical technician with space around the patient to permit a technician to administer life supporting treatment to at least one (1) patient during transit.

2. On or after July 1, 1975, each ambulance shall have basic equipment determined essential by the board with the advice of the advisory council.

3. Standards governing the sanitation and maintenance of ambulance vehicles shall require that the interior of the vehicle and the equipment therein be maintained in a manner that is safe, sanitary, and in good working order at all times.

4. Standards for the design, construction, equipment and maintenance of special use EMS vehicles shall be developed by the board with advice of the advisory council.

SOURCES: Laws, 1974, ch. 507, § 7(1-3); 1991, ch. 482, § 2, eff from and after July 1, 1991.

Cross references -Definition of authorized emergency vehicles, see § 63-3-103. Lights required on emergency vehicles, see § 63-7-19.

Rules and Regulations

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

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:

3. Height

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

4. Color Paint and Finish

   a. 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.

5. **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.

6. **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.

7. **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.

8. **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.

9. 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.

10. Suction aspirator system

a. 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.

11. Portable suction aspirator

a. 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.

12. Two-way (mobile) radio equipment

a. One two-way radio (155.340 MHZ) or acceptable alternative that is compatible or interoperable for communication on radio frequency 155.340.

13. Standard mandatory miscellaneous equipment

a. Unless otherwise precluded elsewhere in this specification, each ambulance shall be equipped with, but not limited to, the following:

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

15. **Medical, surgical, and bio-medical equipmen**t

a. When specified, the ambulance shall be equipped with, but not limited to, the following:

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

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

d. 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.

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

f. One oxygen mask, child.

g. One oxygen mask, infant.

h. Three oxygen bi-pronged nasal cannulas.

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

j. One bag-valve-mask device, adult, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

k. One bag-valve-mask device, pediatric, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

l. One bag-valve-mask device, infant, without pop-off valve, with oxygen reservoir capable of delivering 80-100 percent oxygen.

m. Two adult oropharyngeal airways.

n. Two child oropharyngeal airways.

o. Two infant oropharyngeal airways.

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

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

r. One bite stick.

s. Six large, sterile, individually wrapped, trauma dressings (minimal six 8" x 10").

t. Twelve sterile, individually wrapped (or in two's), dressings 4" x 4".

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

v. Three triangular bandages or commercial arm slings.

w. Two rolls adhesive tape, 2" or larger.

x. One pair of shears for bandages.

y. One sterile, Vaseline gauze, 3" x 8" or larger.

z. One rigid cervical collar, large.

aa. One rigid cervical collar, medium.

bb. One rigid cervical collar, small.

NOTE: Two adjustable, rigid collars may be substituted for items 1.7.1.7.25., 1.7.1.7.26., and 1.7.1.7.27.

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

dd. 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.).

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

ff. Two long spine boards with accessories.

gg. 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.

hh. Two blanket rolls or commercial equivalent.

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

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

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

ll. Two blankets.

mm. One sterile OB kit.

nn. One adult blood pressure cuff with aneroid gauge.

oo. One pediatric blood pressure cuff with aneroid gauge.

pp. One stethoscope.

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

rr. Infant blood pressure cuff with aneroid gauge.

ss. One penlight/flashlight.

tt. Two liters sterile water for irrigation.

NOTE: Sterile saline may be substituted. Unbroken seal required.

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

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

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

xx. 50g. activated charcoal.

yy. Infectious disease precaution materials

zz. Disposable latex gloves (6 pair)

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

bbb. Impervious gown or apron (2)

ccc. Disinfectant for hands and equipment

ddd. Sharps container (see OSHA regulations in Appendix 8)

eee. Two leakproof plastic bags for contaminated waste.

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

ggg. Two of each size sterile disposable suction catheters

i. (2 each - 5-6 fr.)

ii. (2 each - 8-10 fr.)

iii. (2 each - 14-18 fr.)

hhh. One bedpan, one urinal, and one emesis basin or commercial equipment.

iii. Automated external defibrillator (AED) (Basic Level Ambulance Only)

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.

104.02 EMT- Intermediate

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), ringers lactate and/or normal saline (4000 ML minimum), dextrose (5% in water 250 cc bags, 2 each minimum), intravenous administration set (3 each), intravenous catheter with needle (1"-3" in length; 22, 20, 18, 16, 14 gauge, 6 each minimum), venous tourniquet, antiseptic solution, IV pole or roof hook.

2. Airway

a. Esophageal obturator airway or esophageal gastric tube airway with mask, 35cc syringe, stethoscope. (NOTE: May utilize either EOA, EGTA, PTL, or combitube.)

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

3. Cardiac

4. **Manual monitor defibrillator** (with tape write-out), Defibrillation pads or jell, quick-look paddles, EKG leads, Chest attachment pads (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)

104.03 EMT-Paramedic

All the equipment and supplies listed above plus the following additional equipment and supplies:

1. Airway

Endotracheal tube (adult, child, and infant sizes), 10cc syringes, stylets, laryngoscope handle, blades (adult, child, and infant sizes, curved and/or straight), end-tidal CO2 detector (adult and pediatric).

2. Manual cardiac monitor defibrillator with tape write-out and synchronization capabilities.

3. **Drugs**:

a. 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.

104.04 Sanitation regulations

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.

Other Information

1. Narcotics

a. 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.

b. 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.

c. 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.

d. 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:

i. Date of administration

ii. Time of administration

iii. Amount administered

iv. Amount wasted

v. Witness to wasted amount

vi. Patient's name

vii. Call number

viii. Ordering physician

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

104.05 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.

104.06 Storage of Prescription Items

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.

1. 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.

105 SPECIAL USE EMS VEHICLES

105.01 §41-59-3 Special Use Vehicles

Definitions As used in this chapter, unless the context otherwise requires, the term:

1. **"Ambulance"** means 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, highways or airways of this state to assist persons who are sick, injured, wounded, or otherwise incapacitated or helpless;

2. **"Permit"** means an authorization issued for an ambulance vehicle and/or a special use EMS vehicle as meeting the standards adopted under this chapter;

3. **"License"** means an authorization to any person, firm, corporation, or governmental division or agency to provide ambulance services in the State of Mississippi;

4. **"Emergency medical technician"** means an individual who possesses a valid emergency medical technician's certificate issued under the provisions of this chapter;

5. **"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;

6. **"Board"** means the State Board of Health;

7. **"Department"** means the State Department of Health, Division of Emergency Medical Services;

8. **"Executive officer"** means the Executive Officer of the State Board of Health, or his designated representative;

9. **"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;

10. **"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;

11. **"Invalid vehicle"** means any privately or publicly owned land or air vehicle that is maintained, operated and used only to transport persons routinely who are convalescent or otherwise nonambulatory and do not require the service of an emergency medical technician while in transit;

12. **"Special use EMS vehicle"** means any privately or publicly owned land, water or air emergency vehicle used to support the provision of emergency medical services. These vehicles shall not be used routinely to transport patients;

13. **"Trauma care system"** or "trauma system" means a formally organized arrangement of health care resources that has been designated by the department by which major trauma victims are triaged, transported to and treated at trauma care facilities;

14. **"Trauma care facility"** or **"trauma center"** means a hospital located in the State of Mississippi or a Level I trauma care facility or center located in a state contiguous to the State of Mississippi that has been designated by the department to perform specified trauma care services within a trauma care system pursuant to standards adopted by the department. Participation in this designation by each hospital is voluntary;

15. **"Trauma registry"** means a collection of data on patients who receive hospital care for certain types of injuries. Such data are primarily designed to ensure quality trauma

care and outcomes in individual institutions and trauma systems, but have the secondary purpose of providing useful data for the surveillance of injury morbidity and mortality;

16. **"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;

17. **"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;

18. **"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;

19. **"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.

105.02 §63-7-19. Lights on police and emergency vehicles; lights on rural mail carrier vehicles.

Except as otherwise provided for unmarked vehicles under Section 19-25-15 and Section 25-1-87, every police vehicle shall be marked with blue lights. Every ambulance and special use EMS vehicle as defined in Section 41-59-3 shall be marked with red lights front and back and also may be marked with white and amber lights in addition to red lights. Every emergency management/civil defense vehicle, including emergency response vehicles of the Department of Environmental Quality, shall be marked with blinking, rotating or oscillating red lights. Official vehicles of a 911 Emergency Communications District may be marked with red and white lights. Every wrecker or other vehicle used for emergency work, except vehicles authorized to use blue or red lights, shall be marked with blinking, oscillating or rotating amber colored lights to warn other vehicles to yield the right-of-way, as provided in Section 63-3-809. Only police vehicles used for emergency work may be marked with blinking, oscillating or rotating blue lights to warn other vehicles to yield the right-of-way. Only law enforcement vehicles, fire vehicles, private or department-owned vehicles used by firemen of volunteer fire departments which receive funds pursuant to Section 83-1-39 when responding to calls, emergency management/civil defense vehicles, emergency response vehicles of the Department of Environmental Quality, ambulances used for emergency work, and 911 Emergency Communications District vehicles may be marked with blinking, oscillating or rotating red lights to warn other vehicles to yield the right-of-way. This section shall not apply to school buses carrying lighting devices in accordance with Section 63-7-23.

Any vehicle referred to in subsection (1) of this section also shall be authorized to use alternating flashing headlights when responding to any emergency.

Any vehicle operated by a United States rural mail carrier for the purpose of delivering United States mail may be marked with two (2) amber colored lights on front top of the vehicle and two (2) red colored lights on rear top of the vehicle so as to warn approaching travelers to decrease their speed because of danger of colliding with the mail carrier as he stops and starts along the edge of the road, street or highway.

Rules and Regulations

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

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

3. 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."

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

Policy for Administration

1. 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.

2. Permits issued shall expire concurrently with the service license.

3. 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.

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

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

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

7. 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.

106 REQUIRED PERSONNEL.

106.01 §41-59-29. Personnel required for transporting patients.

From and after January 1, 1976, every ambulance, except those specifically excluded from the provisions of this chapter, when transporting patients in this state, shall be occupied by at least one (1) person who possesses a valid emergency medical technician state certificate or medical/nursing license and a driver with a valid resident driver's license.

SOURCES: Laws, 1974, ch. 507, § 8(1), eff from and after passage (approved April 3, 1974).

Rules and Regulations

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.

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.

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.

Other Information

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

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

b. 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.

107 INSURANCE REQUIREMENTS

107.01 §41-59-27. Insurance.

1. There shall be at all times in force and effect on any ambulance vehicle operating in this state insurance issued by an insurance company licensed to do business in this state, which shall provide coverage:

2. For injury to or death of individuals resulting from any cause for which the owner of said ambulance would be liable regardless of whether the ambulance was being driven by the owner or his agent; and

3. Against damage to the property of another, including personal property.

4. The minimum amounts of such insurance coverage shall be determined by the board with the advice of the advisory council, except that the minimum coverage shall not be less than twenty-five thousand dollars ($25,000.00) for bodily injury to or death of one (1) person in any one (1) accident, fifty thousand dollars ($50,000.00) for bodily injury to or death of two (2) or more persons in any one (1) accident, and ten thousand dollars ($10,000.00) for damage to or destruction of property of others in any one (1) accident.

SOURCES: Laws, 1974, ch. 507, § 7(4), eff from and after passage (approved April 3, 1974).

Annotations -

Liability of operator of ambulance service for personal injuries to person being transported. 21 ALR2d 910.

108 RECORD KEEPING

108.01 §41-59-41. Records

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

SOURCES: Laws, 1974, ch. 507, § 10, eff from and after passage (approved April 3, 1974).

Rules and Regulations

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.

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.

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

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.

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.

109 INVALID VEHICLES

109.01 §41-59-39. Standards for invalid vehicles.

The board after consultation with the emergency medical services advisory council, shall establish minimum standards which permit the operation of invalid vehicles as a separate class of ambulance service.

SOURCES: Laws, 1974, ch . 507 § 9, eff from and after passage (approved April 13, 1974).

Rules and Regulations

1. **Standards**.

   a. 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.

   b. 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.

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

2. **Required equipment**.

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

   b. 5 pound dry chemical fire extinguisher

   c. 1 box disposable tissues

   d. 1 bed pan (fracture type acceptable)

   e. 1 emesis basin

   f. 2 towels

   g. 1 blanket

   h. 4 sheets

   i. 2 pillow cases

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

   k. wheeled cot retention system as determined by BEMS

   l. detachable safety retaining strap for wheeled cot

   m. Vehicle Standards

   n. Patient Compartment:

   o. 42" high, floor to ceiling

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

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

3. Emblems and markings

a. The name of the company shall be printed on each side of the vehicle or the cab doors of the vehicle.

110 LICENSE NOT REQUIRED

110.01 §41-59-43. Exemptions.

1. The following are exempted from the provisions of this chapter:

   a. The occasional use of a privately and/or publicly owned vehicle not ordinarily used in the business of transporting persons who are sick, injured, wounded, or otherwise incapacitated or helpless, or operating in the performance of a lifesaving act.

   b. A vehicle rendering services as an ambulance in case of a major catastrophe or emergency.

   c. Vehicles owned and operated by rescue squads chartered by the state as corporations not for profit or otherwise existing as nonprofit associations which are not regularly used to transport sick, injured or otherwise incapacitated or helpless persons except as a part of rescue operations.

   d. Ambulances owned and operated by an agency of the United States Government.

SOURCES: Laws, 1974, ch. 507, § 11, eff from and after passage (approved April 3, 1974).

111 PENALTIES

111.01 §41-59-45. Penalties; injunctive relief

1. It shall be the duty of the licensed owner of any ambulance service or employer of emergency medical technicians for the purpose of providing basic or advanced life support services to insure compliance with the provisions of this Chapter 59 and Chapter 60 and all regulations promulgated by the board.

2. Any person, corporation or association that violates any rule or regulation promulgated by the board pursuant to these statues regarding the provision of ambulance services or the provision of basic or advanced life support services by emergency medical technicians shall, after due notice and hearing, be subject to an administrative fine not to exceed One Thousand Dollars ($1,000.00) per occurrence.

3. Any person violating or failing to comply with any other provisions of this Chapter 59 and Chapter 60 shall be deemed guilty of a misdemeanor, and upon conviction thereof shall be fined an amount not to exceed fifty dollars ($50.00) or be imprisoned for a period not to exceed thirty (30) days, or both, for each offense.

4. The board may cause to be instituted a civil action in the chancery court of the county in which any alleged offender of this chapter may reside or have his principal place of business for injunctive relief to prevent any violation of any provision of this Chapter

59 and Chap, or any rules or regulation adopted by the board pursuant to the provisions of this chapter.

5. Each day that any violation or failure to comply with any provision of this chapter or any rule or regulation promulgated by the board thereto is committed or permitted to continue shall constitute a separate and distinct offense under this section, except that the court may, in its discretion, stay the cumulation of penalties.

6. It shall not be considered a violation of this Chapter 59 and Chapter 60 for a vehicle domiciled in a nonparticipating jurisdiction to travel in a participating jurisdiction.

SOURCES: Laws, 1974, ch. 507, § 12; 2001, ch. 542, § 2, eff from and after July 1, 2001.

Cross reference -

Imposition of standard state assessment in addition to all court imposed fines or other penalties for any misdemeanor violation, see § 99-19-73.

112 PARTICIPATION, OPTIONS

112.01 §41-59-47. Options of counties and municipalities as to participation.

1. The provisions of this chapter shall apply to all counties and incorporated municipalities except those counties and incorporated municipalities electing not to comply as expressed to the board in a written resolution by the governing body of such county or incorporated municipality. The election of any county to be included or excluded shall in no way affect the election of any incorporated municipality to be included or excluded. If any county or municipality elects to be excluded from this chapter, they may later elect to be included by resolution.

2. All financial grants administered by the state for emergency medical services pertaining to this chapter shall be made available to those counties and incorporated municipalities which are governed by the provisions of this chapter.

SOURCES: Laws, 1974, ch. 507, § 13, eff from and after passage (approved April 3, 1974).

113 APPEAL PROCESS

113.01 § 41-59-49. Appeal from decision of board.

Any person, firm, corporation, association, county, municipality or metropolitan government or agency whose application for a permit or license has been rejected or whose permit or license is suspended or revoked by the board shall have the right to appeal such decision, within thirty (30) days after receipt of the board's written decision, to the chancery court of the county where the applicant or licensee is domiciled. The appeal before the chancery court shall be de novo and the decision of the chancery court may be appealed to the supreme court in the manner provided by law.

SOURCES: Laws, 1974, ch. 507, § 14, eff from and after passage (approved April 3, 1974).

Other Information

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.

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.

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.

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.

114 SUBSCRIPTION SERVICES

114.01 §41-59-63. Membership subscription programs for prepaid ambulance service not to constitute insurance.

The solicitation of membership subscriptions, the acceptance of membership applications, the charging of membership fees, and the furnishing of prepaid or discounted ambulance service to subscription members and designated members of their households by either a public or private ambulance service licensed and regulated by the State Board of Health pursuant to Section 41-59-1 et seq. shall not constitute the writing of insurance and the agreement under and pursuant to which such prepaid or discounted ambulance service is provided to the subscription members and to designated members of their households shall not constitute a contract of insurance.

SOURCES: Laws, 1988, ch; 541, § 1; reenacted, 1991, ch. 348, § 1; reenacted, 1992, ch. 327, § 1, eff from and after July 1, 1992 .

114.02 §41-59-65. Application for permit to conduct membership subscription program; fees; renewals.

1. Either a public or private ambulance service licensed and regulated by the State Board of Health desiring to offer such a membership subscription program shall make application for permit to conduct and implement such program to the State Board of Health. The application shall be made upon forms in accordance with procedures established by the board and shall contain the following:

   a. The name and address of the owner of the ambulance service;

   b. The name in which the applicant is doing business;

c. The location and description of the place or places from which the ambulance service operates;

d. The places or areas in which the ambulance service intends to conduct and operate a membership subscription program; and

e. Such other information as the board shall deem necessary.

f. Each application for a permit shall be accompanied by a permit fee of Five Hundred Dollars ($500.00), which shall be paid to the board. The permit shall be issued to expire the next ensuing December 31. The permit issued under this section may be renewed upon payment of a renewal fee of Five Hundred Dollars ($500.00), which shall be paid to the board. Renewal of any permit issued under this section shall require conformance with all requirements of this chapter.

SOURCES: Laws, 1988, ch. 541, § 2; reenacted, 1991, ch. 348, § 2; reenacted, 1992, ch. 327, § 2, eff from and after July 1, 1992.

Policy for Administration

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.

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

114.03 §41-59-67 Program Requirements

Requirements for issuance of permit; reserve fund; ambulance service to pay cost of collection of judgment against fund.

1. The issuance of a permit to conduct and implement a membership subscription program shall require the following:

   a. The posting of a surety bond with one or more surety companies to be approved by the State Board of Health, in the amount of Five Thousand Dollars ($5,000.00) for every one thousand (1,000) subscribers or portion thereof; and

   b. The establishment of a reserve fund to consist of a deposit to the reserve fund with any depository approved by the state for the benefit of the subscription members in the amount of Three Dollars ($3.00) for each subscription member currently subscribing to the subscription program, but not for the designated members of the subscribing member's household, to guarantee perpetuation of the subscription membership program until all memberships are terminated; and

   c. No further deposits shall be required to be made by the ambulance service to the reserve fund after the aggregate sum of the principal amount of said surety bond plus the deposits in the reserve fund is equal to Two Hundred Thousand Dollars ($200,000.00).

2. In any action brought by a subscriber against the surety bond or the reserve fund, the cost of collection upon a judgment rendered in favor of the subscriber, including attorney's fees, shall be paid by the ambulance service.

SOURCES: Laws, 1988, ch. 541, § 3; re-enacted, 1991, ch. 348, § 3; re-enacted, 1992, ch. 327, § 3, eff from and after July 1, 1992.

Policy for Administration

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.

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 statement's of cash balances must be forwarded to BEMS by either the EMS provider and/or the bank in which the reserve account is established.

115 ANNUAL REPORTS

115.01 §41-59-69. Annual report of ambulance service conducting subscription program.

1. Annual reports shall be filed with the State Board of Health by the ambulance service permitted to conduct and implement a membership subscription program in the manner and form prescribed by the State Board of Health, which report shall contain the following:

   a. The name and address of the ambulance service conducting the program;

   b. The number of members subscribing to the subscription program;

   c. The revenues generated by subscriptions to the program; and

   d. The name and address of the depository bank in which the reserve fund is deposited and the amount of deposit in said reserve fund.

SOURCES: Laws, 1988, ch. 541, § 4; re-enacted, 1991, ch. 348, § 4; re-enacted, 1992, ch. 327, § 4, eff from and after July 1, 1992.

Policy for Administration

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).

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

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

116 SOLICITATION OF MEMBERSHIP

116.01 §41-59-71. Methods of soliciting members; license not required.

Solicitation of membership in the subscription program may be made through direct advertising, group solicitation, by officers and employees of the ambulance service or by individuals without the necessity of licensing of such solicitors.

SOURCES: Laws, 1988, ch. 541, § 5; reenacted, 1991, ch. 348, § 5, re-enacted, 1992, ch. 327, § 5, eff from and after July 1, 1992

100 AERO MEDICAL SERVICES

§41-59-9. License and permit required.

From and after October 1, 1974, no person, firm, corporation, association, county, municipality, or metropolitan government or agency, either as owner, agent or otherwise, shall hereafter furnish, operate, conduct, maintain, advertise or otherwise engage in the business of service of transporting patients upon the streets, highways or airways of Mississippi unless he holds a currently valid license and permit, for each ambulance, issued by the board.

SOURCES: Laws, 1974, ch. 507, § 5(1), eff from and after passage (approved April 3, 1974).

100.01 Definitions Relative to Aero Medical EMS:

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.

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.

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.

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.

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.

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.

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

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.

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

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.

11. **FAA** - Means the Federal Aviation Administration.

12. **FAR** - Means the Federal Aviation Regulation.

13. **FCC** - Means the Federal Communications Commission.

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 air

array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.

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.

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. who on or before July 1, 2005 has completed a state approved medical director training course or 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 that must practice within the designated trauma care region or legal EMS district within which he/she is providing medical control. (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.

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

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.

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.

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

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.

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.

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.

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.

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.

    Note: 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.

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.

101 LICENSING

101.01 Air Ambulance Licensure

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.

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.

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

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.

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

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).

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.

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

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

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

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.

102 RECIPROCITY

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.

102.01 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.

102.02 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.

   The report shall:

   a. Set forth the specific violations found;

   b. Establish a specific period of time for the correction of the violation(s) found, in accordance with the provisions in Violations.

102.03 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 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.

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.

102.04 Location indentification

1. 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.

103 ADVERTISING

103.01 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.

104 REQUIRED INSURANCE COVERAGE

104.01 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.

104.02 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.

105 AIRCRAFT PERMITS

105.01 Aircraft Permits Required

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:

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

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

   c. 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.

   d. 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.

2. When such a substitution is made, the following information shall be maintained by the licensee and shall be accessible to BEMS:

   a. Registration number of permitted aircraft taken out of service.

   b. Registration number of substitute aircraft.

   c. 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.

3. Aircraft permits are not transferable.

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.

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.

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.

106 MEDICAL DIRECTION

106.01 Off-Line Medical Direction

1. Qualifications

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

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

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

d. 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.

e. Must be a Mississippi licensed physician, M.D. or D.O. who on or before July 1, 2005 has completed a state approved medical director training course or 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 that must practice within the designated trauma care region or legal EMS district within which he/she is providing medical control. (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 Air Ambulance Service Medical Director must be approved by the State EMS Medical Director.

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

2. Responsibilities

a. 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.

b. 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.

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

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

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

f. 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.

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

h. 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.

i. 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.

j. 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.

k. 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.

106.02 <u>On-line Medical Control</u>

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.

107 CONTINUOUS QUALITY IMPROVEMENT (CQI) PROGRAM

116.02 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.

108 AIR MEDICAL PERSONNEL

108.01 Licensing of Air Medical Personnel

6. 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:

7. 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.

   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.

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

9. 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.

10. 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.

5. 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.

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

7. 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:

    a. Fixed-wing air ambulance

    i. Has accumulated at least 2000 hours total time as a pilot.

    ii. Has accumulated at least 1000 hours as pilot in command of an airplane.

    iii. Must have accumulated at least 500 hours as pilot of a multi-engine aircraft.

    iv. Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance.

    v. Possess an Airline Transport certificate.

    b. Rotor-wing air ambulance

    i. Has accumulated at least 2000 rotor craft flight hours total time as a pilot.

ii. At least 1000 of those hours must be as pilot in command.

iii. At least 100 of those hours must be night-flight time.

iv. Factory school or equivalent in aircraft type (ground and flight).

v. 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.

vi. 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.

vii. Must possess at least a commercial rotor craft-helicopter rating.

8. ATP certificate is encouraged.

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

a. Fixed-wing air ambulance

i. Has accumulated at least 500 hours total time as a pilot.

ii. Must have accumulated at least 100 hours as pilot of a multi-engine aircraft.

iii. Has accumulated at least 25 hours as pilot in command of the specific make and model of aircraft being used as an air ambulance.

iv. Possess a Commercial Pilot certificate.

b. Rotor-wing air ambulance

i. Has accumulated at least 500 rotor craft flight hours total time as a pilot.

ii. Factory school or equivalent in aircraft type (ground and flight).

iii. Must possess at least a commercial rotor craft-helicopter rating.

109 TRAINING

109.01 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:

a. Aeromedical physiology, gas laws and stressors of flight.

b. Aircraft familiarization and flight safety.

i. aircraft and cabin systems familiarization.

ii. operation of emergency exits, evacuation procedures and use of emergency equipment.

c. location of medical equipment and supplies.

d. enplaning, deplaning and securing of patients for flight.

e. In flight procedures for normal conditions and emergencies such as cabin depressurization, smoke or fire in the cabin, fire suppression, electrical failures.

f. Medical equipment familiarization.

g. Patient care policies, procedures and protocols, standards of care, and patient assessment.

h. Documentation.

i. Local EMS system communication and medical conventions.

j. Survival.

k. Infection control including OSHA blood borne pathogens.

l. Pharmacology.

m. Hazardous materials.

n. 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.

109.02 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.

d. Baggage and equipment handling (pressurized and non-pressurized compartments)(fixed-wing pilots)

e. Patient enplaning - passenger briefing. (fixed-wing pilots)

f. Coordination of aircraft movement with air medical personnel activities prior to taxi to ensure their safety.

g. 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.

h. Intermediate stop procedures - (fueling, fire equipment standby, customs).

i. Medical emergencies during flight.

j. Aircraft emergency procedures - evacuations including patient.

k. 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 are 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.

110 COMMUNICATIONS

110.01 <u>Activation Capability</u>

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.

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

2. **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.

3. **Documentation** - The licensee shall record the chronological events of each transport. The following data elements shall be included:

    a. Time of initial request

    b. Time of aircraft liftoff

    c. Time of aircraft arrival at pickup point

    d. Time of aircraft liftoff

    e. Time of any intermediate aircraft stops

    f. Time of aircraft arrival at destination

    g. Time aircraft and crew are returned to service and available.

110.02 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.

110.03 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.

110.04 Requirements For Aircraft

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.

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.

4. 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.

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

6. 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.

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

8. 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.

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

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

11. 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.

12. 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)

13. 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)

111 MEDICAL EQUIPMENT & SUPPLIES

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.

111.01 Required Equipment for All Levels of Care

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 patients 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.

111.02 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.

111.03 Patient Assessment Equipment

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

a. Stethoscope.

b. Penlight/Flashlight.

c. Bandage scissors, heavy duty.

d. Pulse Oximeter

e. Bandages & Dressings

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

g. Bandages such as Kerlix, Kling.

h. Tape - various sizes.

111.04 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.

111.05 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:

a. Latex gloves.

b. Protective gowns.

c. Protective goggles.

d. Protective face masks.

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

f. Hand washing capabilities or antiviral towellets.

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

h. 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:

i. Instruction manual.

j. Water.

k. Shelter - space blanket.

l. Knife.

m. Signaling device - mirror, whistle, flares, dye marker.

n. Compass.

o. Fire starting items - matches, candle, flint, battery.

111.06 ALS level equipment

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

1. Endotracheal Intubation Equipment:

a. Laryngoscope handle.

b. One each adult, pediatric and infant blades.

c. 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.

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

e. Alternate airway management equipment.

2. IV Equipment and Supplies

a. Sterile crystalloid solutions in plastic containers, IV catheters, and administration tubing sets.

b. Hanger for IV solutions.

c. A device for applying external pressure to a flexible IV fluid containers.

d. Tourniquets, tape, dressings.

e. Suitable equipment and supplies to allow for collection and temporary storage of two blood samples.

f. 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.

Medication Inventory:

Quantity	Medication	Concentration
2	Atropine	1mg/10ml
2	Benadryl	5mg/ml
2	Bretylium	500mg/10ml
2	Calcium Chloride	1mg/10ml
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 or1	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.

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

5. External Cardiac Pacing Device

6. Non-Invasive Automatic Blood Pressure Monitor

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

8. **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.

111.07 <u>To function at the CCLS or SPECIALTY level of care</u>

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.

111.08 <u>Equipment Maintenance and Inspection Program</u>

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:

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

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

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

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

112 VIOLATIONS

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

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

112.01 Category "A" Violations

1. 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:

    a. Missing equipment or disposable supply items.

    b. Insufficient number of trained air medical personnel to fill the services staffing requirements.

    c. The provider has no medical director.

    d. Violation or non-compliance of FAR or OSHA mandates.

112.02 Category "B" Violations

1. 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:

    a. Unclean or unsanitary equipment or aircraft environment.

    b. Non-functional or improperly functioning equipment.

    c. Expired shelf life of supplies such as medications, IV fluids and items having limited shelf life.

    d. Package integrity of sealed or sterile items is compromised.

e. Failure to produce requested documentation of patient records, attendant training or other reports required by BEMS.

113 SUSPENSION; REVOCATION OF LICENSE

113.01 Suspension, Revocation of License

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.

117 STANDARD PRACTICE FOR QUALIFICATIONS, RESPONSIBILITIES, AND AUTHORITY

117.01 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.

118 OFF-LINE MEDICAL DIRECTION

118.01 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.

118.02 Requirements of a Medical Director

The medical aspects of an emergency medical service system shall be managed by physicians who meet the following requirements:

1. Mississippi licensed physician, M.D. or D.O.

2. Experience in, and current knowledge of, emergency care of patients who are acutely ill or traumatized.

3. Knowledge of, and access to, local mass casualty plans.

4. Familiarity with base station operations where applicable, including communication with, and direction of, pre-hospital emergency units.

5. Active involvement in the training of pre-hospital personnel.

6. Active involvement in the medical audit, review and critique of medical care provided by pre-hospital personnel.

7. Knowledgeable of the administrative and legislative process affecting the local, regional and/or state pre-hospital EMS system.

8. Knowledgeable of laws and regulations affecting local, regional and state EMS.

9. Approved by the State EMS Medical Director

118.03 <u>Authority of a Medical Director includes, but is not limited to:</u>

1. Establishing system-wide medical protocols in consultation with appropriate specialists.

2. Establishment of system-wide trauma protocols as delineated by the State Trauma Care Plan.

3. 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.

4. 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.

5. 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.

6. Establishing medical standards for dispatch procedures to assure that the appropriate EMS response unit(s) are dispatched to the medical emergency scene when requested, and the duty to evaluate the patient is fulfilled.

7. Establishing under which circumstances a patient may be transported against his will; in accordance with, state law including, procedures, appropriate forms and review process.

8. 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).

9. Establishing criteria for selection of patient destination.

10. Establishing educational and performance standards for communication resource personnel.

11. Establishing operational standards for communication resource.

12. 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.

13. Insuring the availability of educational programs within the system and that they are consistent with accepted local medical practice.

14. May delegate portions of his/her duties to other qualified individuals.

15. 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.

119 ON-LINE MEDICAL DIRECTION (DIRECT MEDICAL CONTROL)

119.01 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-B, 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.

1. Requirements of a Medical Director

   a. This physician shall be approved to serve in this capacity by system (Off-Line) Medical Director.

   b. 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.

c. 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.

d. This physician shall have demonstrated knowledge and expertise in the pre-hospital care of critically ill and injured patients.

e. 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.

f. The on-line physician is responsible to the system Medical Director (off-line) regarding proper implementation of medical and system protocols.

120 AUTHORITY / CONTROL OF MEDICAL SERVICES

120.01 Authority for Control of Medical Services at the Scene of Medical Emergency.

1. 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.

   a. 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.

   b. The pre-hospital provider is responsible for the management of the patient and acts as the agent of medical direction.

120.02 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.

120.03 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.

120.04 Intervener Physician Present and Non-Existent On-Line Medical Direction

1. 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.

2. 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.

120.05 Intervener Physician Present and Existent On-Line Medical Direction

1. 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.

2. The on-line physician has the option of managing the case entirely, working with the intervener physician, or allowing him to assume responsibility.

3. 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.

4. 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.

5. The intervener physician should document his intervention in a manner acceptable to the local EMS system.

6. 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.

121 COMMUNICATIONS

121.01 Communication Resource

1. 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.

    a. 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.

    b. 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.

    c. 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.

d. 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.

e. 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.

f. No effort will be made to obtain institutional or commercial advantages through use of such transportation instructions and hospital assignments.

g. 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.

h. 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.

i. 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.

122 EDUCATION AND TRAINING

122.01 Educational Responsibilities

1. 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.

2. 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.

3. 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.

123 REVIEW AND AUDIT

123.01 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.

1. Individual Case Review.

a. 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.

b. The following must be written and agreed to in advance:

i. Procedural guidelines of how the individuals will interact during meetings.

ii. 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.

iii. Confidentiality of case review in terms of local open meeting laws and public access to medical records and their distribution.

iv. Format for recording the meeting and its outcome.

v. Access to overall system performance records, both current and historical, to allow comparison.

2. Overall outcome data (morbidity and mortality) and individual, unit-specific, and system-wide performance can be measured by the following means:

   a. 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.

   b. Appropriate treatment on scene and in transit should be recorded and subsequently evaluated for its effect on overall patient outcome.

   c. At the emergency department, the severity of cases presenting (according to a severity scoring technique) and treatment needed should be recorded in detail.

   d. 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.