Title 15: Mississippi Department of Health

Part 12: Bureau of Emergency Medical Services

Subpart 31: Emergency Medical Services

Chapter 1 AMBULANCE SERVICE LICENSURE

Subchapter 1 Ambulance Service Licensure

Rule 1.1.1 Legal Authority: The Mississippi State Department of Health (the Department), and specifically, the Bureau of Emergency Medical Services (BEMS), is assigned responsibility for implementing and conducting the statewide emergency medical services (EMS) program under the direction of the State Health Officer (SHO) of the State Board of Health (the Board). BEMS provides the functional services required for implementing and conducting the same, including regulation and licensing of ambulance services; ensuring quality and compliance in matters related to ambulance licensure; inspection and issuance of permits for ambulances, special use vehicles, and non-emergency medical transport vehicles; approving EMS training and ensuring compliance in matters related to EMS education; certifying EMS personnel, including non-transport EMS personnel; ensuring quality and compliance in matters related to EMS certification; developing and maintaining the statewide EMS records program; ensuring the coordination of EMS communication systems, other related EMS activities, and implementing the regulations prescribed in this document (Title 15, Part 12, Subpart 31).

BEMS licenses ambulance services by location and issues permits for vehicles operated by respective licensed ambulance services for use at specific locations. Licenses are not required for ambulance services intermittently stationing ambulance employees and vehicles, and which do not serve as points of contact for public business or for deployment. However, ambulance services which routinely operate across multiple and/or adjacent counties require an ambulance service license for each county. In these instances, licensure is required though there may not be a fixed identifiable location in each county. BEMS may, at its discretion, allow for exceptions, i.e. when an ambulance service from a single control point provides coverage for only portions of counties that are adjacent, only one license is required.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.2 **Definitions.**

EMS Provider Levels of Care

MS EMS provider levels of care, their definitions, and respective scope of practice shall follow nationally recognized levels of care in the field of Emergency Medical Services, as defined in the current iteration of the National EMS Scope of Practice Model. Approved MS EMS education programs shall educate EMS providers in competencies for each respective level of care as prescribed in the current iteration of the National EMS Education Standards. The State EMS Medical Director may approve EMS protocols for ambulance services and Non-Transport EMS entities that follow the National Model EMS Clinical Guidelines. EMS protocols submitted to BEMS for approval shall delineate emergency care authorized for each respective level of EMS provider, not to exceed the National EMS Scope of Practice Model and National Model EMS Clinical Guidelines. State approved nationally recognized levels of EMS provider include:

1. Emergency Medical Responder (titled Medical First Responder)

2. Emergency Medical Technician (EMT)

3. Advanced EMT (AEMT)

4. Paramedic

On request of the off-line medical director, and approval of MDTQA, skills beyond those prescribed in the National EMS Scope of Practice Model may be approved at any of the preceding provider levels through the adoption of approved clinical standards; however, the off-line medical director must verify skill competencies annually for any skill approved by MDTQA beyond those included in the National EMS Scope of Practice Model. BEMS shall publish the list of any skills and clinical standards approved beyond those included in the National EMS Scope of Practice Model along with the expected competencies to be verified annually.

MS EMS provider levels shall also include EMS Driver and Critical Care Paramedic (as defined in this Part).

The following terms shall have the following meanings as used in this Part:

1. **"Advanced Life Support"** means the provision of an ALS assessment by ALS personnel or the provision of at least one ALS intervention which includes basic life support functions including cardiopulmonary resuscitation(CPR), plus cardiac defibrillation, telemetered electrocardiography, administration antiarrhythmic agents, intravenous therapy, administration of specific medications, drugs and solutions, use of adjunctive ventilation devices, trauma care and other authorized techniques and procedures. Advanced life support (ALS) assessment is an assessment performed by an ALS crew as part of an emergency response that was necessary because the

patient's reported condition at the time of dispatch was such that only an ALS crew was qualified to perform the assessment. An ALS assessment does not necessarily result in a determination that the patient requires an ALS level of service. In the case of an appropriately dispatched ALS emergency service, if the ALS crew completes an ALS assessment, the services provided are at the ALS emergency level. This is regardless of whether the patient required ALS intervention services during the transport and provided the ambulance transportation itself was medically reasonable.

2. **"Advanced Life Support personnel"** means persons other than physicians engaged in the provision of advanced life support, as defined, and regulated by rules and regulations promulgated pursuant to Section 41-60-13.

3. **"Advanced Life Support services"** means implementation of the 15 components of an EMS system to a level capability which provides noninvasive and invasive emergency patient care designed to optimize the patient's chances of surviving the emergency situation. Services shall include use of sophisticated transportation vehicles, a communications capability (two-way voice and/or biomedical telemetry) and staffing by Advanced EMTs and Paramedics providing on-site, pre-hospital mobile and hospital intensive care under medical control.

4. **"Ambulance"** means any privately or publicly owned land or air vehicle that is specially designed, constructed, modified, or equipped to be used, maintained and operated upon the streets, highway or airways of this state to assist persons who are sick, injured, wounded or otherwise incapacitated or helpless, and as required by this Part properly licensed by BEMS.

5. **"Ambulance Placement Strategy (System Status Plan)"** means a planned outline or protocol governing the deployment and event-driven redeployment of the ambulance service's resources, both geographically and by time-of-day/day-of-week.

6. **"Ambulance Post"** means a designated location for ambulance placement within the system status plan. Depending upon its frequency and type of use, a "post" may be a facility with sleeping quarters, and/or day rooms for crews, or simply a street-corner or parking lot location to which units are sometimes deployed.

7. **"Ambulance Service Area"** means the geographic response area of the licensed ambulance service. The service area must correspond to each

individual service license. The service's employee staffing plan, ambulance placement strategy, and available resources must be commensurate with the service area.

8. **"Area wide EMS System"** means an emergency medical service area (trade, catchment, market, patient flow) that provides essentially all the definitive emergency medical care (95%) for all emergencies, including the most critically ill and injured patients. Only highly specialized and limited-use services may need to be obtained outside of the area. The area must contain adequate population and available medical resources to implement and sustain an EMS operation. At least three major modes exist: (a) multiple urbanized communities and their related suburbs; (b) a metropolitan center and its surrounding rural areas; and (c) a metropolitan center and extreme rural-wilderness settings. The areas may be inter- or intra-state.

9. **"Automated External Defibrillator (AED)"** means a defibrillator which: a) is capable of cardiac rhythm analysis; b) will charge and deliver a shock after electrically detecting the presence of a cardiac dysrhythmia or is a shock-advisory device in which the defibrillator will analyze the rhythm and display on-screen advising the operator to press a "shock" control to deliver the shock; c) must be capable of printing a post event summary (at a minimum the post event summary should include times, joules delivered, ECG), and d) an on screen display of the ECG (optional).

10. **"Basic Life Support Services (BLS)"** means implementation of the 15 components of and EMS system to a level of capability which provides pre-hospital noninvasive emergency patient care designed to optimize the patient's chance of surviving the emergency situation. There would be universal access to and dispatch of national standard ambulances, with appropriate medical and communication equipment operated by Emergency Medical Technicians-Ambulance. Regional triage protocols should be used to direct patients to appropriately categorized hospitals.

11. **"Board"** means the Mississippi State Board of Health.

12. **"Bypass"** (diversion) means a medical protocol or medical order for the transport of an EMS patient past a normally used EMS receiving facility to a designated medical facility for the purpose for accessing more readily available or appropriate medical care.

13. **"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.

14. **"Critical Care Units (Centers)"** means sophisticated treatment facilities in large medical centers and hospitals that provide advanced definitive care for the most critically ill patients. The units are available for the diagnosis and care of specific patient problems including major trauma, burn, spinal cord injury, poisoning, acute cardiac, high-risk infant, and behavioral emergencies.

15. **"Communication Resource"** means an entity responsible for implementation of direct medical control (See detailed description in section on Medical Direction).

16. **"Delegated Practice"** means only physicians are licensed to practice medicine. Pre-hospital providers must act only under the medical direction of a physician.

17. **"Department"** means the Mississippi State Department of Health, Bureau of Emergency Medical Services.

18. **"Direct Medical Control"** means when a physician provides immediate medical direction to pre- hospital providers in remote locations.

19. **"Diversion"** - see "Bypass."

20. **"DOT"** means the United States Department of Transportation.

21. **"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;

22. **"Emergency Medical Services (EMS)"** means services utilized in responding to a perceived individual's need for immediate medical care to prevent death or aggravation of physiological or psychological illness or injury.

23. **"EMS Personnel"** means key individual EMS providers. This includes physician, emergency, and critical care nurse, EMT, Advanced EMT, Paramedic, dispatchers, telephone screeners, first

aid responders, project administrators and medical consultants and system coordinators.

24. **"EMS System"** means a system which provides for the arrangement of personnel, facilities, and equipment of the effective and coordinated delivery of health care services in an appropriate geographical area under emergency conditions (occurring as a result of the patient's condition or because of natural disasters or similar conditions). The system is managed by a public or nonprofit private entity. The components of an EMS System include:

    A. Manpower

    B. Training

    C. Communications

    D. Transportation

    E. Facilities

    F. Critical Care Units

    G. Public Safety Agencies

    H. Consumer Participation

    I. Access to Care

    J. Patient Transfer

    K. Coordinated Patient Recordkeeping

    L. Public Information and Education

    M. Review and Evaluation

    N. Disaster Plan

    O. Mutual Aid

25. **"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.

26. **"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.

27. **"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.

28. **"Executive officer"** means the executive officer of the State Department of Health or his designated representative.

29. **"Field Categorization"** (classification) means a medical emergency classification procedure for patients that is applicable under conditions encountered at the site of a medical emergency.

30. **"Field Triage"** means classification of patients according to medical need at the scene of an injury or onset of an illness.

31. **"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.

32. **"Inclusive Trauma Care System"** means a trauma care system that incorporates every health care facility in a community in a system in order to provide a continuum of services for all injured persons who require care in an acute care facility; in such a system, the injured patient's needs are matched to the appropriate hospital resources.

33. **"Implied Consent"** means legal position that assumes an unconscious patient, or one so badly injured or ill that he cannot respond, would consent to receiving emergency care. Implied consent applies to children when a parent or guardian is not at the scene.

34. **"Intervener Physicians"** means a licensed M.D. or D.O., having not previously established a doctor/patient relationship with the emergency patient and willing to accept responsibility for a medical emergency scene, and can provide proof of a current Medical Licensure.

35. **"Lead Agency"** means an organization which has been delegated the responsibility for coordinating all components and care aspects for an EMS system.

36. **"Level I"** means hospitals that have met the requirements for Level I as stated in the Mississippi Trauma Rules and Regulations.

37. **"Level II"** means hospitals that have met the requirements for Level II as stated in Mississippi Trauma Rules and Regulations.

38. **“Level III”** means hospitals that have met the requirements for Level III as stated in Mississippi Trauma Rules and Regulations.

39. **“Level IV”** means hospitals that have met the requirements for Level IV as stated in Mississippi Trauma Rules and Regulations.

40. **"Licensure"** means an authorization to any person, firm, cooperation, or governmental division or agency to provide ambulance services in the State of Mississippi.

41. **"License Location"** means a fixed location where the ambulance service conducts business or controls the deployment of ambulances to the service area.

42. **“Major Trauma”** means that subset of injuries that encompasses the patient with or at risk for the most severe or critical types of injury and therefore requires a system approach in order to save life and limb.

43. **“Major Trauma Patient”** (or "major trauma" or " critically injured patient") means a person who has sustained acute injury and by means of a standardized field triage criteria (anatomic, physiology, and mechanism of injury) is judged to be at significant risk of mortality or major morbidity.

44. **“Mechanism of Injury”** means the source of forces that produce mechanical deformations and physiological responses that cause an anatomic lesion of functional change in humans.

45. **"Medical Control"** means directions and advice provided from a centrally designated medical facility staffed by appropriate personnel, operating under medical supervision, supplying professional support through radio or telephonic communication for on-site and in-transit basic and advanced life support services given by field and satellite facility personnel. Statewide medical control may be approved by BEMS for Primary Agencies of Emergency Support Function 8 (ESF-8) in the Mississippi Comprehensive Emergency Management Plan.

46. **"Medical Direction"** - (medical accountability) means when a physician is identified to develop, implement, and evaluate all medical aspects of an EMS system.

47. **"Medical Director"** means (offline, administrative) should be a physician both credible and knowledgeable in EMS systems planning, implementation, and operations. This off-line physician assumes total responsibility for the system's activities. He is appointed by the local EMS lead agency. The administrative medical director works in close

liaison with government agencies, public safety and disaster operations, legislative and executive offices, professional societies, and the public. Off-line program activities include liaison with other state and regional EMS medical directors to conceptualize clinical and component system designs, establish standards, monitor, and evaluate the integration of component and system activities.

A. This off-line physician assures medical soundness and appropriateness of all aspects of the program and is responsible for the conceptual and systems design and overall supervision of the EMS program.

B. The administrative (off-line) medical director develops all area protocols. These protocols serve as the basis for EMS system role definition of EMS personnel, curriculum development, competency determination, and maintenance, monitoring, and evaluation.

C. The off-line medical director meets on a regular basis with on-line medical directors and the EMS training director to evaluate on-line system performance, to review problems, and suggest changes in treatment, triage, or operational protocols. All on-line medical directors must be approved by the off-line medical director.

48. **"Mississippi Trauma Advisory Committee" (MTAC)** - (See Appendix A) means the advisory body created by legislature for the purpose of providing assistance in all areas of trauma care system development and technical support to the Department of Health; members are comprised of EMS Advisory Council members appointed by the chairman.

49. **"Mississippi Trauma Care System Plan"** (State Trauma Plan) means a formally organized plan developed by the Mississippi State Department of Health, pursuant to legislative directive, which sets out a comprehensive system of prevention and management of major traumatic injuries.

50. **"On-Line (Supervising ALS) Medical Director"** means On-Line medical control is provided through designated Primary Resource and Base Station Hospitals under the area direction of a supervisory ALS medical director who is on-line to the pre-hospital system stationed at the designated Base Station Hospital. Each provider of ALS must also have an on-line medical director. The system must also have an on-line medical director for EMS training. These

supervisory medical directors are organizationally responsible to the administrative off-line medical director of the local EMS lead agency for program implementation and operations within his area of jurisdiction.

A. The ALS (on-line) medical director supervises the advanced life support, pre- and inter-hospital system and is responsible for the actual day-to-day operation of the EMS system. He carries out the "EMS systems design" in terms of pre-and inter-hospital transportation care and provides ALS direction to EMS providers depending on the transportation care and provides ALS direction to EMS providers depending on the system's configuration. He monitors all pre- hospital ALS activities within that system's region or area of responsibility. The ALS physician must review and monitor compliance to protocols for both the pre-and inter-hospital settings.

B. The ALS (on-line) medical director in conjunction with the EMS training medical director reviews paramedics, Advanced EMTs, EMTs, mobile intensive care nurses, and physician competencies and recommends certification, re-certification, and decertification of these personnel to the EMS health officer of the lead agency responsible for the certification decertification, and recertification of EMS personnel. Monitoring the competency of all pre- hospital EMS personnel activities is within his responsibility.

C. He or she attends medical control meetings where area system performance and problems are discussed and recommendations to the administrative off-line director are made. He also conducts regular case reviews and other competency evaluation and maintenance procedures and reports back to the administrative (off-line) medical director.

D. This ALS (on-line) physician assumes the supervision and responsibility for all advanced care rendered in an emergency at the scene of an accident and en route to the hospital under his area jurisdiction. Each on-line medical director representing the hospitals providing medical control has the authority to delegate his duties to other emergency department physicians who may be on duty and placed in a position of giving medical direction to pre-hospital ALS personnel.

51. **“Pediatric Trauma Center”** means either (a) a licensed acute care hospital which typically treats persons fourteen (14) years of age or less, which meets all relevant criteria contained in these Regulations and which has been designated as a pediatric Trauma Center; or (b) the pediatric component of a Trauma Center with pediatric specialist and a pediatric intensive care unit.

52. **“Performance Improvement”** (or "quality improvement") means a method of evaluating and improving processes of patient care which emphasizes a multi-disciplinary approach to problem solving, and focuses not on individuals, but systems of patient care which might cause variations in patient outcome.

53. **"Permit"** means an authorization issued for an ambulance vehicle as meeting the standards adopted pursuant to this chapter.

54. **"Pre-hospital Provider"** means all personnel providing emergency medical care in a location remote from facilities capable of providing definitive medical care.

55. **“Protocols”** means standards for EMS practice in a variety of situations within the EMS system.

56. **“Service Area”** (or "catchment area") means that geographic service area defined by the local EMS agency licensure. Statewide medical control may be approved by BEMS for Primary Agencies of Emergency Support Function 8 (ESF-8) in the Mississippi Comprehensive Emergency Management Plan.

57. **“Standing Orders”** are those specific portions of the treatment protocols that may be carried out by ALS personnel without having to establish contact with medical control facility. These standing orders represent nationally recognized treatment modalities and allow the ALS personnel to treat life-threatening problems without delay.

58. **“State EMS Medical Director”** means a Mississippi licensed physician, employed by the Mississippi Department of Health, who is responsible for the development, implementation, and evaluation of standards and guidelines for the provision of emergency medical services and EMS medical direction in the state. This physician must have experience in EMS medical direction and be board certified in emergency medicine. This physician must be experienced with EMS systems, EMS medical direction, evaluation processes, teaching, and curriculum development. It is the goal of the State EMS Medical Director to ensure the care delivered by EMS systems in the state is consistent with recognized standards and that quality is maintained in a manner that assures professional and public accountability. The State EMS Medical Director must serve as an advocate for efficient and effective emergency medical services

throughout the state.

The Responsibilities of the State EMS Medical Director include but are not limited to:

A. Oversight of all aspects of EMS Medical direction in the state Oversight of the of standards and minimum qualifications for EMS Medical Directors

B. Approval of Offline Medical Directors for ambulance services

C. Approval of protocols for ambulance services

D. Approve training programs, training standards, and curricula for EMS providers and medical directors

E. Oversight of all aspects of EMS quality assurance and performance improvement in the state

F. Approval of the Quality Assurance and Performance Improvement plans for ambulance services

G. Serve as Chairman of the Committee on Medical Direction, Training, and Quality Assurance

H. Serve as Chairman of the EMS Performance Improvement Committee

I. Serve as Chairman of the EMS Protocol Committee

J. Act as a liaison with public safety and disaster planning agencies

K. Act as a liaison with national EMS agencies

L. Oversight of issues related to complaints, investigations, disciplinary procedures involving patient care, performance standards, and medical direction

59. **“State Trauma Plan”** – See Mississippi Trauma Care Plan

60. **“Subscription”** means a program that allows customers to pay an up-front established fee to offset any future emergency medical transport expenses.

61. **“Surveillance”** means the ongoing and systematic collection, analysis, and interpretation of health data in the process of describing and monitoring a health event. “Trauma” - a term derived from the Greek for "wound"; it refers to any bodily injury (see "Injury").

62. **“Trauma Care Facility”** (or "trauma center") means a hospital that has been designated by the department to perform specified trauma care services within a Trauma Care Region pursuant to standards adopted by the department.

63. **“Trauma Care System Planning and Development Act of 1990”** means the federal law that amended the Public Health Service Act to add Title XII - Trauma Programs. The purpose of the legislation being to assist State governments in developing, implementing, and improving regional systems of trauma care, and to fund research and demonstration projects to improve rural EMS and trauma.

64. **“Trauma Care System”** means an organized approach to treating patients with acute injuries; it provides dedicated (available 24 hours a day) personnel, facilities, and equipment for effective and coordinated trauma care in an appropriate geographical region, known as a Trauma Care Region.

65. **“Trauma Center Designation”** means the process by which the Department identifies facilities within a Trauma Care Region.

66. **“Trauma Program Manager”** means a designated individual with responsibility for coordination of all activities on the trauma service and works in collaboration with the trauma service director.

67. **"Transfer"** - The movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly with) the hospital, but does not include such a movement of a patient who (a) has been declared dead, or (b) leaves the facility without the permission of any

such person.

68. **"Treatment Protocols"** means written uniform treatment and care plans for emergency and critical patients. These treatment plans must be approved and signed by the off-line medical director and/or medical groups. (Appendix 2)

69. **"Triage"** means the process of sorting injured patients on the basis of the actual or perceived degree of injury and assigning them to the most effective and efficient regional care resources, in order to insure optimal care and the best chance of survival.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.3 To apply for ambulance licensure an applicant service must complete and submit the following:

1. Application for Ambulance Service Licensure;

2. Roster of all proposed employees, including Emergency Vehicle Operators (EMS-Driver), EMTs, AEMTs, Paramedics, Critical Care Paramedics, RNs and Emergency Medical Dispatchers, and others if appropriate (this list must include state-issued certification and/or license numbers where applicable);

3. The proposed medical control plan, including protocols (at least 30 days prior to intended service start date);

4. Patient destination guidelines which comply with all state approved system of care plans and standards;

5. Documentation describing communications capabilities, including capability to communicate with dispatch and primary resource hospital;

6. Documentation describing the methods to be used for communicating with on-line medical control, conducting quality assurance and ensuring skill maintenance;

7. Letter of attestation from the off-line medical director approving of the proposed medical control plan, approving of the proposed the ambulance provider's protocols, and acknowledging he/she understands his/her responsibilities as prescribed in this document (Title 15, Part 12, Subpart 31); and

8. Letter of attestation from the ambulance owner acknowledging intent to provide 24/7 coverage, providing evidence of capabilities, describing

staffing patterns, providing plans for backup, and listing mutual aid agreements.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.4 Proposed off-line/on-line medical directors must provide documentation including:

1. Proof of physician credentials;
2. Proof of Mississippi physician licensure; and
3. Documentation required for control substances, including relevant DEA documentation and registration number.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.5 The overall application for ambulance licensure must be approved by the State EMS Director and State EMS Medical Director and requires a successful on-site inspection of the ambulance service operations site. BEMS may immediately issue licensure following a successful on-site inspection. BEMS will issue an official license within thirty (30) days; however, BEMS will issue a temporary document to serve as proof of licensure until the ambulance service receives the official license. Ambulance service licensure is valid for one (1) year from date of issuance. Revisions to the medical control plan must be submitted prior to implementation. At a minimum, medical control plans shall be resubmitted to the BEMS every three (3) years for approval.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.6 Licensed ambulance services shall submit Mississippi Uniform Accident Reports for any EMS permitted vehicles involved in an accident within thirty (30) days.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.1.7 911 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.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 Periodic inspections.

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.4 The owner/manager or medical director of each publicly or privately owned ambulance service shall immediately inform the State Department of Health, Bureau of EMS of the termination or other disciplinary action taken against an employee for any of the following:

1. Fraud or any misstatement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representative.

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty.

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

7. Failure to maintain current registration by National Registry of EMTs.

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

9. The commission of any fraudulent dishonest, or corrupt act which is

substantially related to the qualifications, functions, and duties of the pre-hospital personnel.

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

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

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

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

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

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

16. Suspension or revocation of any BEMS issued certification may affect other BEMS issued certifications at all levels.

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

18. Failure to wear high visibility apparel that meets the requirements of the American National Standards for High Visibility Apparel (ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/IseA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present.

19. Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

    a. Assault
    b. Stalking
    c. False imprisonment
    d. Sexual assault or battery
    e. Crimes against a vulnerable person

20. Failure to comply with reporting requirements for submission of Patient Care Report to the BEMS containing Mississippi minimum EMS data set.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.5 A Mississippi licensed EMS Agency shall comply with the mandatory system of care plans as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services.

SOURCE: Miss. Code Ann. §41-59-5

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

1. Lack of State certified EMT attending patient.
2. Lack of driver with valid driver's license and state EMS driver certification.
3. Lack of proper equipment required by law.
4. Not adhering to sanitation of vehicle and equipment requirements.
5. Failure to adhere to record keeping or reporting requirements required by BEMS.
6. Failure to maintain proper insurance required by law.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.2.10 To maintain situation awareness of coverage within Mississippi, 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 any assets being placed on alert and/or deployed as part of the Federal Emergency Management Agency National Ambulance Contract immediately upon written notification. #24068

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Ownership Changes

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Permits, All Vehicles

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.3 To apply for an EMS vehicle permit the owner or designated representative of the entity seeking permit must submit an Application for Permit and select one of the following options:

1. Ambulance;

2. Special use vehicle; or

3. Non-emergency medical transport vehicle.

Only complete applications will be accepted for review, and the owner or designated representative must sign the complete application.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.4.4 BEMS will conduct an inspection of vehicle prior to issuing the permit. BEMS may issue the permit immediately following successful inspection. BEMS will issue an official permit within thirty (30) days; however, BEMS will issue a temporary document to serve as proof of permit until the official license arrives.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

2. Sanitary requirements not maintained

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

4. Failure to maintain insurance as required

5. Change in location of vehicle

6. Failure to carry BEMS issued permit card on vehicle

7. Lack of properly functioning equipment. #22474

SOURCE: Miss. Code Ann. §41-59-5

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 Vehicle Standards

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.2 All new ambulance vehicles, before being issued an original ambulance permit as authorized by Mississippi Code 41-59-23, shall conform to current Federal Specification `Star-of-Life Ambulance' as published by the General Services Administration, Specification Section. Ambulances that were constructed prior to the

implementation of the current Federal Specifications shall conform to the applicable Federal Specifications that were in effect at the time of original construction. The following are exceptions and additions:

1. Height: Overall height of the ambulance at curb weight shall not exceed 110 inches, excluding roof-mounted light bars and communications accessories.
2. Color Paint and Finish: The base color(s) of the ambulance shall be determined by the licensed owner/operator. A retroreflective stripe, a combination of retroreflective stripes, or Battenburg markings shall be affixed to the ambulance in the following proportions:
    a. 25% of the length of each side of the cab surfaces when approached from each side,
    b. 75% of the length of each patient compartment side surfaces when approached from each side,
    c. 50% of the rear facing vertical surfaces, other than glass or lenses, visible when facing from the rear of the ambulance, shall be equipped with retroreflective material. Where chevrons are used, each stripe shall be 6-inches (152mm) in width, each stripe of the chevron shall be a single-color alternating between two high contrast colors.

   The stripe or combination of stripes shall be a minimum of 6 inches (152mm) in total vertical width and shall be a contrasting color from the base color of the ambulance. The stripe or combination of stripes shall be permitted to be interrupted by objects (e.g., receptacles, slats between roll-up doors), provided the full stripe is conspicuous as the ambulance is approached. A retroreflective graphic design shall be permitted to replace all or part of the required striping on the front or sides of the vehicle if the design or combination thereof cover at least the same surface area. A retroreflective "Star of Life" emblem shall be affixed to each side and rear of the vehicle.

3. Additional lettering and markings are allowed in, above and below the stripe.

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

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

6. The word "Ambulance" shall be displayed on each side, rear, and

front of the vehicle in a retroreflective contrasting color from the background. 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.

7. Emergency lighting shall be in accordance with Mississippi Code 63-7-19.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

2. Hazardous Material Reference Guide.

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.8 Medical, surgical, and bio-medical equipment for all levels: When specified, the ambulance shall be equipped with, but not limited to, the following: #24068

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

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

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

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

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

6. One oxygen mask, infant.

7. Three oxygen bi-pronged nasal cannulas.

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

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

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

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

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

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

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

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

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

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

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

19. Lubricating jelly (water soluble).

20. One bite stick.

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

22. Twelve sterile, individually wrapped (or in twos), dressings 4" x 4".

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

24. Three triangular bandages or commercial arm slings.

25. Adhesive tape

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

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

28. Arterial Tourniquet

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

30. Cold Packs

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

32. Cervical Collars; minimum one rigid for children ages 2 years or older; one each, child and adult sizes (small, medium, large). Other available

sizes are recommended. *NOTE: Two adjustable, rigid collars may be substituted*.

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

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

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

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

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

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

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

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

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

42. Two blankets.

43. Towels.

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

45. One sterile OB kit.

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

47. One Sphygmomanometer (pediatric).

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

49. One stethoscope.

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

51. Infant blood pressure cuff with aneroid gauge.

52. Flashlights (2).

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

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

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

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

57. 50g. activated charcoal.

58. Automated external defibrillator (AED) (EMT or AEMT Level Ambulance Only). AED shall have pediatric capabilities, including pediatric sized pads and cables as appropriate. #22474

59. Glucometer or blood glucose measuring device

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.9 Infectious disease precaution materials: *NOTE: Latex-free equipment should be available.* #24068

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

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

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

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

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

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

7. Two leak-proof plastic bags for contaminated or biohazard waste.

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

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

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

11. *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 AEMT or 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 vehicles. *NOTE: ALS services are required to have ALS equipment commensurate with the ALS staffing plan submitted as part of the application for service licensure*. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.5.10 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. *NOTE: An Offline 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.* #24068

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 Advanced EMT Required Equipment

Rule 1.6.1 For the AEMT all the equipment for the EMT as previously listed plus the following equipment and supplies: #24068

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

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

3. IV Pole or Roof Hook

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

5. Venous tourniquet.

6. Syringes, various sizes, including tuberculin.

7. Needles, various sizes (one at least 1 ½ "for IM injection

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

9. Intravenous arm boards (adult and pediatric)

10. Airway

    a. Rescue Airway (e.g. Combitube, Extraglottic Device) – Adult

    b. Rescue Airway (e.g. Combitube, Extraglottic Device) – Pediatric (AEMT Only)

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

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

11. Nebulizer (#22474)

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 Paramedic Required Equipment

Rule 1.7.1 All the equipment and supplies listed above plus the following additional equipment and supplies: #24068

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

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

3. Endotracheal tubes, 2 each, sizes 2.5 - 8 mm. Other sizes optional.

4. 10 cc non-Luer lock syringes.

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

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

7. End-tidal CO2 detection capability.

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 Sanitation regulations

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

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

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

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

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

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

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

7. Closed containers shall be provided for soiled supplies.

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

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

10. Implements inserted into the patient's nose or mouth shall be single service, wrapped and properly stored and handled. When multi-use items are used, the local health care facilities should be consulted for instructions in sanitation and handling of such items.

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 Storage of Prescription Items:

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.9.3 Narcotics: Certified ALS personnel (paramedics and RNs) functioning under approved medical control jurisdiction may be issued approved controlled substances for pre-hospital use upon the discretion of the off-line medical director. For ALS services that are not hospital-based, the Drug Enforcement Administration (DEA) requires the off-line medical director to secure a separate CONTROLLED SUBSTANCES REGISTRATION CERTIFICATE to store, issue and prescribe controlled substances to ALS personnel. This CERTIFICATE should list the medical director as a "practitioner" at the physical address of the ambulance service where the drugs are stored. The off-line medical director will determine who may issue and administer the controlled substances and who will have access to storage of these narcotics. #24068

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

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.9.4 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. #24068

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Special Use EMS Vehicles

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

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.10.9 High Visibility Safety Apparel for Staff: Each Special Use EMS Vehicle must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Required Personnel

Rule 1.11.1 Every ALS ambulance, when responding to and transporting patients requiring care beyond the basic life support level, must be occupied by a driver with a valid EMS driver's license and one (1) person who possesses a valid Advanced EMT or Paramedic state certificate or one (1) person who possesses a valid medical/nursing license. Specific considerations apply to tiered response. Tiered response may be used to maximize capabilities and improve outcomes. Tiered response requires the use of technology and resources to prioritize incoming EMS calls and assign the proper level of care response. Ambulance services proposing to operate tiered response shall meet the following criteria in order to be approved by BEMS:

1. Licensed 911 EMS providers may utilize tiered response protocols; however, said protocols must be approved by the ambulance service's off-line medical director and the State EMS Medical Director;

    a. Required documentation to be submitted to BEMS:

        i. A letter from the ambulance service's owner/operator requesting approval to operate tiered response;

        ii. A copy of the ambulance service's tiered response protocol with a letter from the ambulance service's off-line medical director verifying his/her approval of said protocol;

            1. Said protocol shall allow for paramedics, AEMTs or EMTs to respond to emergency calls, care for patients experiencing emergency conditions, transport patients experiencing emergency conditions, and transfer the care of patients experiencing said conditions to providers in the clinical setting;

            2. Said protocol shall include the use of computerized dispatch resources, and specifically for the purpose of prioritizing calls and assigning the proper level of care for response (services which do not possess this resource may partner with a third-party vendor for dispatch resources to meet this requirement); all incoming emergency calls must be screened at dispatch and assigned the most appropriate level of care response;

            3. Said protocols shall provide for on-line medical control guidance to field crews as needed during

response and operations;

2. Tiered response ambulance services shall provide one (1) paramedic capable unit for every 3-tiered response units in the event advanced life support proves necessary;

3. When paramedic level of care is warranted and initiated, the paramedic shall continue care until care is turned over to clinical staff of equal or greater level of training/education in the emergency department as required by regulation and local protocol;

4. Ambulance services utilizing tiered response shall provide specific performance improvement data relevant to tiered response as requested from BEMS;

5. While the rules in this Part provide an option for tiered response, each respective ambulance service is responsible for ensuring compliance with county contractual obligations.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

1. Current registration as an Advanced EMT or Paramedic by the National Registry of EMTs.

2. Letter/statement signed by the ambulance service owner/manager which attests to equivalency of training for each employee possessing a medical/nursing license. #22474/ #24068

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 12 Record Keeping

Rule 1.12.1 All licensed ambulance services operating in the State of Mississippi must submit electronically, the State of Mississippi minimum EMS data set and/or information contained on the form via network, or direct computer link, for each ambulance run made and/or for each patient transported. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.2 A completed copy of a Patient Care Report containing Mississippi minimum EMS data set shall be left with or electronically submitted to hospital staff for all patients delivered to licensed Hospitals. within 24 hours. Written exceptions may be submitted to the BEMS for consideration. #22474/ #24068

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.3 All Mississippi minimum EMS data set are due within fourteen (14) days to the BEMS office. More frequent submissions may be required by the State Health Officer or his/her designee for real time syndromic surveillance. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.4 All Mississippi minimum EMS data set 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. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.12.5 Returns may result in a penalty as outlined under Section 41-59-45, paragraph 3. #22474

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 Invalid Services

Rule 1.13.1 Standards for invalid vehicles: #22474

1. No vehicle used exclusively for invalid transfer is to have any markings, flashing lights, sirens, or other equipment that might indicate it is an Emergency Vehicle. The word "Ambulance" is not to appear on the vehicle. All advertising and vehicles used for invalid transfer shall display in a conspicuous manner a placard, visible from the exterior, or a notice on advertisements as follows: INVALID TRANSPORT – THIS SERVICE DOES NOT PROVIDE MEDICAL CARE.

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

3. To preclude substitution of services or the negligent or adverse delivery of medical transportation, after January 1, 2016, no ambulance service shall be authorized permits for invalid vehicles.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.2 Required equipment: #22474

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

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

3. 1 box disposable tissues

4. 1 bed pan (fracture type acceptable) and urinal as needed for personal hygiene during transport.

5. 1 emesis basin

6. 2 towels

7. 1 blanket

8. 4 sheets

9. 2 pillowcases

10. Communication equipment to notify emergency services in case of emergency. At minimum, shall have two-way (mobile) radio equipment: One two-way radio (155.340 MHZ) or acceptable alternative that is compatible or interoperable for communication on radio frequency 155.340.

11. Each vehicle shall have a crash stable device for securing the stretcher meeting all applicable standards. At minimum shall have one stretcher for primary patient as specified in current Federal Specifications for ambulances, dimensions as per KKK-A-1822. 5-point type restraining devices (chest, hip, knee, and shoulder) attached to stretcher. Straps shall not be less than two inches wide, nylon, and consist of quick release buckles.

12. Automated external defibrillator (AED) (Basic Level Ambulance Only). AED shall have pediatric capabilities, including pediatric sized pads and cables as appropriate.

13. Hazardous Material Reference Guide.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.3 Vehicle Standards:

1. Patient Compartment:

   a. 42" high, floor to ceiling

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.5 The invalid vehicle shall be used only for the transport of an "invalid". "Invalid" shall mean persons who are convalescent or otherwise non-ambulatory and do not require the service of an emergency medical technician while in transit. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.6 The following shall apply regarding sanitation standards for vehicles: #22474

1. The interior of the vehicle shall be sanitary and maintained in good working order at all times. (e.g. environmental system.)

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

3. Clean linen storage shall be provided on each vehicle.

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

5. Closed containers shall be provided for soiled supplies.

6. Exterior and interior surfaces of vehicle shall be cleaned routinely.

7. Blankets and hand towels used in any vehicle shall be clean.

8. All storage spaces used for storage of linens 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.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.7 Infectious disease precaution materials: *NOTE: Latex-free equipment should be available.* #22474

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

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

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

4. Two leak proof plastic bags for contaminated or biohazard waste.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.8 Permits for invalid vehicles are issued by BEMS to a licensed invalid service after an inspection of the vehicles has been completed and a determination made by BEMS that all requirements have been met. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.9 Permits issued shall expire concurrently with the service license. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.10 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. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.11 Payment of a renewal fee to be fixed by the Board, which shall be paid to the Board. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.12 Personnel operating invalid vehicles must possess a valid EMS-D in addition to a valid driver's license. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.13 Records for invalid transport shall be maintained as follows: #22474

1. Employee records for all drivers and attendant personnel.

2. Each licensee shall maintain accurate records and contain such information as may be required by BEMS concerning the transportation of each individual within this state and beyond its limits.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.14 Required personnel: In addition to vehicle operator, there shall be at least one person trained in adult and pediatric First Aid and AED/CPR in accordance with the standards of the American Heart Association or the American Red Cross available to attend the patient. Both will be needed to properly operate the loaded stretcher. #22474

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.13.15 License Requirements: Application for licensed to conduct invalid transport program shall be made to the Bureau by completion of forms with: #22474

1. The name and address of the owner of the service.

2. The name in which the applicant is doing business.

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

4. The location and description of the place or places from which the services are intended to operate.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 14 Complaints/Investigation Process

Rule 1.14.1 Complaints: All complaints concerning certified personnel or licensed service shall be reviewed by the BEMS. Each complaint shall be logged, recording at minimum the following information:

1. Date of Complaint Submission.
2. Name of the complainant with contact information (if known).
3. Nature of the complaint.

4. Date and Time of Event.
5. Brief statement of the complaint
6. Disposition

Rule 1.14.2 Investigations: All complaints will be thoroughly investigated and evaluated by the BEMS.

Subchapter 15 Appeal Process

Rule 1.15.1 The State Board of Health and the Bureau of EMS shall provide an opportunity for a fair hearing for every certified personnel or licensed ambulance service who is dissatisfied with administrative decisions made in the denial and/or suspension/revocation of a certificate or license.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.15.2 BEMS shall notify the certified personnel or licensed service by registered mail, the particular reason for denial or revocation/suspension of the certification or license, if requested in writing within ten (10) days of a notification receipt of a notice of revocation, non-renewal, or suspension. Upon written request of the certified personnel or licensed service, within ten (10) business 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. A hearing shall be held at the Mississippi State Department of Health. A hearing officer shall be appointed by the State Health Officer, and a court reporter shall transcribe the proceedings. The hearing shall be held within thirty (30) days of receipt of the request for such hearing, unless waived in writing by the certified personnel or licensed service.

The certified personnel or licensed service shall be entitled to legal representation at his or her own expense.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.15.3 Within thirty (30) calendar days of the hearing, or such period determined during the hearing, written findings of fact, together with a recommendation for action, shall be forwarded to the State Health Officer. The State Health Officer shall decide what, if any, action is to be taken on the recommendation within fourteen (14) days of receipt of the recommendation. Written notice of the decision of the State Health Officer shall be provided to the certified personnel or licensed service.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.15.4 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. The certified personnel or licensed service shall have the burden of proving that the decision of the State Health Officer was not in accordance with applicable law and these regulations.

If a certified personnel or licensed service is allowed to operate during the appeal process, they will remain under the regulation of MSDH and will be subject to all certification and licensure regulations.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 16 Subscription Services

Rule 1.16.1 All subscription permits issued are valid for a maximum period of one (1) year. This period is from January 1 through December 31. Regardless of date of issuance, all subscription permits expire on December 31 of each calendar year.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.16.2 The Five Hundred Dollars ($500.00) permit fee is in addition to the fee for BLS or ALS licensure.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 17 Program Requirements

Rule 1.17.1 Each membership subscription ambulance service provided must forward a copy (copies) of all surety bonds purchased along with an official statement of total subscribers covered. Such information is made part of the application for subscription permit. During the permit period, should bonds be cancelled, voided, or changed in any way, BEMS must be notified by the service provider.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.17.2 Proof of the establishment of a reserve fund must be provided to BEMS as a prerequisite to BEMS issuance of a subscription permit. Monthly reserve statements of cash balances must be forwarded to BEMS by either the EMS provider and/or the bank in which the reserve account is established.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 18 Annual Reports

Rule 1.18.1 Each subscription ambulance service must submit its annual report with all information as required in Section 41-59-69 within 45 days after the expiration of the subscription permit period (February 14).

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.18.2 The annual report may be submitted in letter form to BEMS with supporting documentation as is necessary.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.18.3 BEMS will suspend all subscription permits of ambulance services failing to file annual reports within the prescribed period.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 19 Patient Transfer

Rule 1.19.1 Transfer of patient care upon arrival at the Mississippi licensed hospital shall occur as timely as possible, but no longer than 30 minutes after arrival of the Mississippi licensed ambulance, to release the ambulance for 911 availability.

1. Upon delivery of a patient to a Mississippi licensed hospital, EMS personnel attending the patient shall find the most appropriate location to place the patient, which may include any space indicated by emergency room management, waiting room, disaster chair, disaster stretcher, or any other preidentified area of the emergency department.

2. Failure to abide by this requirement shall not be grounds for denial of application for certification or recertification of EMS personnel.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 20 Non-Transport EMS

Rule 1.20.1 BEMS will license non-transport EMS operators, including fire department and law enforcement agencies with statewide off-line medical control agreements. Said agencies must submit an application for licensure as a Non-Transport EMS site.

SOURCE: Miss. Code Ann. §41-59-3

Rule 1.20.2 To obtain license as a Non-Transport EMS Site, applicant sites must:

1. Submit an Application for Non-Transport EMS Site Licensure;

2. Submit a roster of all proposed employees who will require certification to practice as EMTs, AEMTs, and Paramedics at the site (to include NREMT certification numbers and state numbers for those already certified in MS as an EMS provider);

3. Submit a proposed medical control plan, including protocols (at least 30 days prior to intended service start date);

4. Submit documents specific to the proposed off/on-line medical control physician(s), including physician credentials, proof Mississippi physician licensure, and the control substances registration number;

5. Submit documentation describing proposed communications capabilities, including capability to communicate with responding ambulances and other emergency response agencies serving the primary service area and describe methods to be used for communicating with on-line medical control 24/7, conducting quality assurance, and ensuring skill maintenance;

6. Submit a letter of attestation from the off-line medical director approving of the proposed plan, approving of the proposed protocols, and acknowledging he/she understands responsibilities associated with serving as a Non-Transport EMS Off-Line Medical Director as prescribed in this document; and

7. Submit a letter of attestation from the fire chief, commanding officer, or person otherwise responsible for the Non-Emergency EMS site acknowledging intent to provide coverage in the prescribed coverage area (letter must also address evidence of capabilities).

SOURCE: Miss. Code Ann. §41-59-3

Rule 1.20.3 Final approval of non-transport EMS sites requires submission of the application outlined above and approval by the State EMS Director and State EMS Medical Director. Non-transport sites may be subject to inspection by BEMS. BEMS will issue an official license within thirty (30) days; however, BEMS will issue a temporary document to serve as proof of licensure until the Non-Transport EMS site receives the official license. Non-Transport EMS site licensure is valid for one (1) year from date of issuance.

SOURCE: Miss. Code Ann. §41-59-3

Rule 1.20.4 BEMS will collect, and process fees approved by the Board for Non-Transport EMS site licenses.

SOURCE: Miss. Code Ann. §41-59-3

Rule 1.19.5 Pharmaceuticals in the Non-Transport Setting: Non-Transport EMS protocols will be approved as prescribed in this Chapter.

SOURCE: Miss. Code Ann. §41-59-3

Subchapter 21 Non-emergency Medical Transport (NEMT or NET)

Rule 1.21.1 BEMS will regulate non-emergency medical transport and issue permits to entities or persons seeking to operate non-emergency medical transport within the

state of Mississippi. BEMS will issue permits to entities or persons, who have completed an application to offer said services, providing the application is found to be complete, without error, and is not otherwise found to be misleading or non-factual, and after inspection of the operation site and vehicles listed on the application. The application requires information on the entity or person proposing to offer said services, a complete list of vehicles to be used in transporting patients, and a complete list of proposed drivers. Non-emergency medical transport services issued vehicle permits under these rules shall not put new vehicles in service until issuance of permit or allow new hire drivers to drive before submitting an updated driver list and obtaining BEMS approval for said drivers listed on the updated list.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.2 Non-emergency medical transport services must comply with the standards for drivers included in this document (Title,15, Part 12, Subpart 31). Failure to do so may result in suspension or revocation of permit privileges in the state of Mississippi or a fine assessed as provided for by the Board.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.3 Non-emergency medical transport drivers must meet the following standards as verified by BACS:

1. Initial and annual criminal background check with fingerprint clearance processed through the Department's Healthcare Background Check process;

2. Initial and annual motor vehicle records (MVR) check clearance from the Department of Public Safety, verifying driving license at the level required for driving vehicles assigned to him/her;

3. Initial and annual negative result urine drug screen;

4. Initial and annual verification that the driver does not appear on the Office of Inspector General (OIG) exclusion list(s);

5. Initial and annual verification of appropriate training in use of the vehicle assigned to him/her, safety equipment recommended for the vehicle assigned to him/her; equipment installed in the vehicle assigned to him/her used in the transfer and/or transport of patients; and

6. Current certification in cardiopulmonary resuscitation.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.4 Permits issued to new applicants must include information on the operations site, initial roster of vehicles, and initial proposed list of drivers. The initial issuance of permit(s) to the new applicant requires visit of the proposed operations site by BEMS inspectors, inspection of proposed vehicles, and processing of proposed driver lists as prescribed in this subchapter. The State EMS Director must approve the initial request for Non-emergency Medical Transport Vehicle Permit(s). Thereafter, permits may be issued to a recognized operator on-site. On-site vehicle inspections may be offered at advertised locations or on-site at the operation site. Non-emergency medical transport vehicles shall display a placard on the exterior of each door and exterior rear of the vehicle a visible placard, visible from other vehicles, which states, specifically: NON-EMERGENCY MEDICAL TRANSPORT VEHICLE – THIS SERVICE DOES NOT PROVIDE MEDICAL CARE.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.5 Required minimum equipment:

1. Cell phone capability to access 911;
2. Two-way communications equipment to facilitate communications with operations base;
3. Fire extinguisher;
4. First aid kit;
5. Seat belt cutter;
6. Seat belt extender;
7. Wheelchair loading and transport system for vehicles transporting wheelchair patients; and
8. Pocket mask device for CPR.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.6 High Visibility Safety Apparel for Staff: Non-transport vehicles must be equipped with high visibility safety apparel for each person staffing or participating in the operation of the vehicle. All garments must meet the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.7 Permits are valid for a period of one (1) year from the date of issue. After initial permits are issued, permits are re-issued by BEMS following the respective annual inspection of each respective vehicle.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.8 Payment of the renewal fee for non-emergency medical transport vehicles permits will be fixed by the Board and paid through BEMS**.**

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.9 Non-emergency medical transport operators shall collect and maintain records accounting for all patients transported, including date of service, time of service, vehicle used, and driver in attendance. Relatedly, operators shall maintain employee records on all drivers for a period not less than five (5) years. Operators shall also maintain records related to the issuance of permits and present the same on request of BEMS staff.

SOURCE: Miss. Code Ann. §41-59-5

Rule 1.21.10 There shall be at least one person trained in adult and pediatric cardiopulmonary resuscitation in accordance with the standards of the American Heart Association or the American Red Cross available to attend the patient.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 2 TRANSFERS

Subchapter 1 General Information

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

2. a physician or other qualified medical personnel when a physician is not readily available, has verified that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risk to the individual's medical condition from effecting the transfer; or,

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.1.6 Interfacility transport is defined as the movement a patient from one licensed health care facility (hospitals, skilled nursing facilities, long term healthcare facilities) to another in a licensed ground or air ambulance. The transfer of patients between facilities is a fundamental component of the health care system.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 INTERFACILITY PATIENT TRANSFERS

Rule 2.2.1 Medical direction is a critical component of all ground and air ambulance services, including interfacility transfer services. Air and ground ambulances that transfer patients must be capable of providing emergency care during transport. Optimal planning for transfer considers individual patient medical requirements and an understanding of the capabilities of the personnel and system used for patient transfer. The system design, determination of the scope of practice of its providers, and the assurance that patient care is rendered consistent with this scope of practice, are essential medical direction functions.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.2.2 Medical direction of the transferred patient is a shared responsibility. The transferring physician is responsible under Federal laws for assuring that the patient is transferred by qualified personnel and appropriate equipment. The designation of on-line medical control for the interfacility transfer of patients is the responsibility of the EMS system and its off-line medical director.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Definitions - Inter-Hospital and Other Medical Facilities

Rule 2.3.1 Appropriate Transfer - An appropriate transfer to a medical facility is

1. A transfer in which the receiving facility: a) has available space and qualified personnel for the treatment of the patient, and b) has agreed to accept transfer of the patient and to provide appropriate medical treatment.

2. In which the transferring hospital provides the receiving facility with appropriate medical records of the examination and treatment effected at the transferring hospital.

3. In which the transfer is affected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.3.2 Medical Control During Interfacility Transfers

1. Once an emergency patient arrives for initial evaluation at a medical facility the patient becomes the responsibility of that facility, and its medical staff. This responsibility continues until the patient is appropriately discharged, or until the patient is transferred and the responsibility is assumed by personnel and a facility of equal or greater capability for the patient's existing condition.

2. Should questions or problems arise during transfer, or in event of an emergency, one of the following (whichever is most appropriate based on service's approved Medical Control Plan) shall be contacted for medical guidance, as outlined in

BEMS approved medical control plan: Online Medical Direction; Transferring Physician; or Receiving Physician.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Interhospital Transfers

Rule 2.4.1 If a transfer is being made for the convenience of the patient or patient's physicians, and the patient is not receiving treatment, and is expecting to remain stable during transport, the transfer may be conducted by and appropriately trained medical provider (EMT-Basic or higher).

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.4.2 Routinely, the transferring physician is responsible for securing the acceptance of the patient by an appropriate physician at the receiving facility. Care provided by the transferring facility may need to be continued during transport. The transferring physician in collaboration with the service's medical control will determine the treatment to be provided during the period of the patient transport.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.4.3 Should questions or problems arise during transfer, or in event of an emergency, one of the following (whichever is most appropriate based on service's approved Medical Control Plan) shall be contacted for medical guidance: Online Medical Direction; Transferring Physician; or Receiving Physician.

SOURCE: Miss. Code Ann. §41-59-5

Rule 2.4.4 Documentation must include the interventions performed en-route and by whom the intervention was performed, and condition of patient upon transfer to the receiving facility.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 Specialty Care Services

Rule 2.5.1 Specialty Care Services (SCS) shall provide 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. 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 vital signs, cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilator 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 patient's 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 patient's potential needs. These patients are considered at risk for de-compensation during transport which may require close attention or intervention.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 3 AERO MEDICAL SERVICES

Subchapter 1 Definitions Relative to Aero Medical EMS: #21600

Rule 3.1.1 Advanced Life Support Care (ALSC) - 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 an inter-hospital incident who is in a non-acute situation and is being cared for in an environment where monitoring of cardiac rhythm, neurological status, and/or continuous infusions of anti-arrhythmic and/or vasopressors, are part of the patient's care needs.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.8 Aviation Crew Member - (pilot, co-pilot, and flight crew) a pilot, co-pilot, flight engineer, or flight navigator assigned to duty in an aircraft cockpit.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.9 Critical Care Life Support (CCLS) - 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 Mississippi Critical Care Paramedic, registered nurse, or physician. This level of care requires specific monitoring and diagnostic equipment above the advanced level.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.10 FAA - the Federal Aviation Administration.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.11 FAR - the Federal Aviation Regulation.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.12 FCC - the Federal Communications Commission.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.13 Fixed-wing Air Ambulance - (fixed-wing) 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.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.14 Inter-facility Transfer - (transfer) the transportation of a patient, by an air ambulance service provider, initiating at a health care facility whose destination is another health care facility.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.15 Medical Director - a licensed physician (MD or DO) who is specifically designated by an air ambulance provider and has accepted the responsibility for providing medical direction to the air ambulance service. He or she must be a Mississippi licensed physician, M.D. or D.O., and show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have an Offline Medical Director whose primary practice is in Mississippi or at a Mississippi trauma center. (Air Ambulance provided from and based out-of-state must have a Offline Medical Director that is board certified in emergency medicine or board eligible in emergency medicine.) The medical director is ultimately responsible for all aspects of a service's operation which effect patient care. The medical director is responsible for assuring that appropriately trained medical personnel and equipment are provided for each patient transported and that individual aircraft can provide appropriate care environments for patients. The Air Ambulance Service Medical Director must be approved by the State EMS Medical Director.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.16 Patient - an individual who is sick, injured, or otherwise incapacitated or whose condition requires or may require skilled medical care for intervention.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.17 Permit - a document issued by BEMS indicating that the aircraft has been approved for use as an air ambulance vehicle by BEMS in the state of Mississippi.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.18 Physician - (doctor) a person licensed to practice medicine as a physician (MD or DO) by the state where the air ambulance service is located.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.19 Pilot - a person who holds a valid certificate issued by the FAA to operate an aircraft.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.20 Public Aircraft - an aircraft used only in the service of a government agency. It does not include government-owned aircraft engaged in carrying persons or property for commercial purposes.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.21 Reciprocal Licensing - (reciprocity) mutual acceptance of an air ambulance service provider's valid license to operate an air ambulance service in a state other than the one in which it is licensed.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.22 Registered Nurse - (RN) an individual who holds a valid license issued by the state licensing agency to practice professional nursing as a registered nurse.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.23 Rotor-wing Air Ambulance - (rotor-wing) a rotor-wing type aircraft that is constructed or modified to transport at least one sick or injured patient in the supine or prone position on a medically appropriate, FAA approved stretcher/litter (as per FAR Section 23.785 and 23.561). It also includes an array of medical equipment and an appropriate number of trained air medical personnel to care for the patient's needs.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.24 Specialty Care Transport (SCS) - the level of care (quantity and type of staff member(s), equipment, and procedures) that is consistent with a patient whose condition requires special care specific to their age and/or diagnosis. The patient may or may not be stable or in an acute situation prior to transport. The following patient categories are included: pediatric intensive care, maternal care, neonatal

intensive care and burn care. These patients are being cared for in an acute care facility environment such as the emergency department, coronary care unit, intensive care unit, pediatric or neonatal unit, burn care or other similar unit where continuous monitoring of vital signs, cardiac rhythm, oxygen saturation and maintenance of continuous infusions of IV medications or control of ventilator 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 patient's 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 patient's potential needs. These patients are considered at risk for de-compensation during transport which may require close attention or intervention.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.1.25 Stressors of Flight - the factors which humans may be exposed to during flight which can have an effect on the individual's physiologic state and ability to perform. The stressors include - hypoxia, barometric changes (expanding and contracting gas), fatigue (sometimes self induced), thermal variations (extremes of temperature), dehydration, noise, vibration, motion, and G-forces.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 Air Ambulance Licensure

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

SOURCE: Miss. Code Ann. §41-59-5

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

and State EMS Medical Director. The license shall automatically expire at the end of the licensing period.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.6 An air ambulance license is dependent on, and concurrent with, proper FAA certification of the aircraft operator(s) to concurrent with proper FAA certification of the aircraft operator(s) to conduct operations under the applicable parts of the Federal Aviation Regulations. Certificate holder must meet all national authority regulations specific to the operations of the medical service in the country of residence, as applicable. This includes a national authority regulator's certificate (public service medical transport agencies are included in this requirement) and Ambulance Operations Specifications specific to EMS operations. The transport service demonstrates compliance with the legal requirements and regulations of all local, state, and federal agencies under whose authority it operates. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.2.7 Current, full accreditation by the Certified Association of Air Medical Transport Services (CAMTS) or equivalent program will be accepted by BEMS as compliance with the requirements set forth. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 RECIPROCITY

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.3 Issuance of Notices.

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

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.4 Reports **#21600**

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 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.

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

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

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

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.6 Aero Medical Advertisement **#21600**

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. Clear identification of the FAA Part 135 Certificate Holder as the identity that is operating the aircraft is one the program's website, in marketing materials, and on the aircraft.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.7 Property & Casualty Liability

1. Every licensee or applicant shall ensure that the Part 135 Air Carrier Operating certificate holder operating the aircraft carries bodily injury and property damage insurance with solvent insurers licensed to do business in the state of Mississippi,

to secure payment for any loss or damage resulting from any occurrence arising out of or caused by the operation or use of any of the certificate holders aircraft. Each aircraft shall be insured for the minimum amount of $1,000,000 for injuries to, or death of, any one person arising out of any one incident or accident; the minimum amount of $3,000,000 for injuries to, or death of, more than one person in any one accident; and, for the minimum amount of $500,000 for damage to property from any one accident.

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.3.8 Professional Medical Liability (Malpractice) **#21600**

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 $1,000,000.

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Aircraft Permits Required

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

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.4.3 Aircraft permits are not transferable.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 Medical Direction

Rule 3.5.1 The medical director(s) of the program is a physician who is responsible and accountable for supervising and evaluating the quality of medical care provided by the medical personnel. The medical director ensures, by working with the clinical supervisor and by being familiar with the scope of practice of the

transport team members and the regulations in which the transport team practices, competency and currency of all medical personnel working with the service.
#21600

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

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

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

    c. 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.

    d. Must be a Mississippi licensed physician, M.D. or D.O., and show evidence of board certification in emergency medicine or board eligibility in emergency medicine. Air Ambulances which operate from or based in Mississippi, must have a Offline Medical Director whose primary practice is in Mississippi or at a Mississippi trauma center. (Air Ambulance provided from and based out-of-state must have a Offline 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.

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

    f. Beginning January 2013, all Mississippi Off-Line Medical Directors shall take Medical Director's course as prescribed by the Mississippi State Department of Health, Bureau of Emergency Medical Services and the Medical Direction, Training and Quality Assurance Committee.

SOURCE: Miss. Code Ann. §41-59-5

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

of the aircraft, medical staff, and equipment. The medical director shall be actively involved in the care of the critically ill and/or injured patient. **#21600**

1. The off-line medical director shall have access to consult with medical specialists for patient(s) whose illness and care needs are outside his/her area of practice. The medical director must have education experience in those areas of medicine that are commensurate with the mission statement of the medical transport service or utilize specialty physicians as consultants when appropriate.

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

3. The off-line medical director shall be involved in the selection, hiring, training and continuing education of all medical personnel. The medical director is actively involved in the hiring process, training, and continuing education of all medical personnel for the service that includes involvement in skills labs, medical protocol or guideline changes or additions.

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

5. The off-line medical director shall ensure that there is a plan to provide direction of patient care to the air medical personnel during transport. The system shall include on-line (radio/telephone) medical control, and/or an appropriate system for off-line medical control such as written guidelines, protocols, procedures patient specific written orders or standing orders. The medical director should maintain an open communication system with referring and accepting physicians and be accessible for concerns expressed by referring and accepting physicians regarding controversial issues and patient management.

6. The off-line medical director shall participate in any administrative decision-making processes that affects patient care. The medical director is actively involved in administrative decisions affecting medical care or the service.

7. The off-line medical director will ensure that there is an adequate method for on-line medical control, and that there is a well-defined plan or procedure and resources in place to allow off-line medical control. The medical director is actively involved in orienting physicians providing online medical direction according to the policies, procedures, and patient care protocols of the medical transport service.

8. In the case where written policies are instituted for medical control, the off-line medical director will oversee the review, revision, and validation of them annually. The medical director sets and annually reviews medical guidelines for current accepted medical practice, and medical guidelines are in a written format.

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

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

11. The transport service will know the capabilities and resources of receiving facilities and will transport patients to appropriate facilities within the service region based on direct referral, approved EMS plan, or services available when no direction is provided. Whenever possible, services that respond directly to the scene will transport patients to the nearest appropriate hospital.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.3 On-line Medical Control: **#21600**

1. 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.

2. All Mississippi On-Line Medical Directors are recommended and encouraged to take Medical Director's course as prescribed by the Mississippi State Department of Health, Bureau of Emergency Medical Services and the Medical Direction, Training and Quality Assurance Committee.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.4 Quality Management process **#21600**

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~~ Performance Improvement process.

6. The QM program has written objective evidence of actions taken in problem areas and the evaluation of the effectiveness of that action.

7. The QM program must be integrated and include activities related to patient care, communications and all aspects of transport operations and equipment maintenance pertinent to the service's mission statement.

8. QM plan should include the following components:

   a. Responsibility/assignment of accountability.

   b. Scope of care.

   c. Quality metrics that are identified, measured and compared to metrics/outcomes of evidence based standards.

   d. Indicators.

   e. Thresholds for evaluation, which are appropriate to the individual service.

   f. Methodology – the QI process and QI tools utilized; and

   g. Evaluation of the improvement process.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.5 Certification of Air Medical Personnel: There shall be at least one certified air medical provider on board an air ambulance to perform patient care duties on that air ambulance as certified by the Bureau of EMS. The requirements for air medical personnel shall consist of not less than the following:

1. A valid license or certificate to practice their level of care (MD, DO, RN, Advanced Practice Provider – Licensed Nurse Practitioner and Physician's Assistant, Critical Care Paramedic, Paramedic, RT) in the state~~.~~

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

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.6 Staffing must be commensurate with the mission statement and scope of care of the medical transport service. The aircraft or ambulance, by virtue of medical staffing and retrofitting of medical equipment becomes a patient care unit specific to the needs of the patient. A well-developed position description for each discipline is written. **#21600**

1. Advanced level care (ALS) – Paramedic: An advanced life support (ALS) mission is defined as the transport of a patient from emergency department, critical care unit or scene who receives care commensurate with scope of practice of a 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.

2. Critical care (CCLS): A critical care mission is defined as the transport of a patient from a scene or clinical setting whose condition warrants care commensurate with the scope of practice of critical care transport professionals. (i.e. physician or registered nurse)

    a. The medical team must – at minimum – consist of at least two patient care givers, one of which must be at least a Mississippi current certified Critical Care Paramedic, registered nurse, or physician.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.7 Additional medical staff not certified as air medical personnel can be added to or in place of licensed air medical personnel as long a s at least one certified air medical personnel with the highest level of certification (EMT-P, RN) required to care for the patient is also on board. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.5.9 The aircraft shall be operated by a pilot or pilots certified in accordance with applicable FAR's. The captain or pilot in command will meet the following requirements: **#21600**

1. Fixed-wing air ambulance:

a. The pilot-in-command must possess airplane flight hours, as outlined in the tables below, prior to assignment with a medical service. If the aircraft is to be operated using a single pilot-in-command, with no second in command, the following applies:

Cat/Class of Aircraft	Total Flight Exp	Multi Engine Exp	PIC Exp	Make/Model
Single Engine Turbo Prop	2500	N/A	1000	50
Multi Eng Piston	2500	500	1000	50
Multi Eng Turbo Prop	2500	500	1000	100

b. Must possess airplane flight hours as outline in the table below if the aircraft is to be operated with two fully trained and qualified pilots:

Cat/Class of Aircraft	Total Flight Exp	Multi Engine Exp	PIC Exp	SIC Total Exp
Single Engine Turbo Prop	2000	N/A	1000	500
Multi Eng Piston	2000	500	1000	500
Multi Eng Turbo Prop	2000	500	1000	800
Multi Eng Turbo Jet	2000	500	1500	1000

c. Possess an Airline Transport Pilot (ATP) certificate.

2. Rotor-wing air ambulance:

a. The pilot must possess at least a commercial rotorcraft-helicopter and instrument helicopter rating.

b. If not exceeded by applicable national authority regulations, the pilot in command must possess 2000 total flight hours prior to an assignment with a medical service with the following stipulations

i. A minimum of 1200 helicopter flight hours

ii. At least 1000 of those hours must be as Pilot in Command in rotorcraft.

iii. 100 hours unaided (if pilot is NOT assigned to a Night Vision Goggles (NVG) base/aircraft)

iv. 100 hours unaided or 50 hours unaided as long as the pilot has 100 hours aided (if assigned to an NVG base aircraft)

v. A minimum of 500 hours of turbine time – 1000 hours of turbine time strongly encouraged.

c. ATP certificate and instrument currency are strongly encouraged.

SOURCE: Miss. Code Ann. §41-59-5

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 Training

Rule 3.6.1 The orientation, training and continuing education must be directed and guided by the transport program's scope of care and patient population, mission statement and medical direction. **#21600**

1. Initial - The licensee shall ensure that all full-time and part-time Critical Care and ALS providers successfully complete a comprehensive training program as approved by the Bureau. Air medical personnel successfully complete initial training and orientation to their position including adequate instruction, practice, and drills.

2. Didactic Component of Initial Training must be specific and appropriate for the mission statement and scope of care of the medical transport service. Measurable objectives need to be developed and documented for each experience.

3. Continuing Education/Staff Development – must be provided and documented for all full time and part time Critical Care and ALS providers. These must be specific and appropriate for the mission statement and scope of care of the medical transport service.

    a. Didactic continuing education must include an annual review of Human factors; Infection Control; "Just Culture"; Sleep Deprivation; State EMS rules and regulations; Stress recognition and management; safety and risk management training.

    b. Clinical and laboratory continuing education must be developed and documented on an annual basis as pertinent to scope of care.

4. 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, and mock situational problem annually.

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

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

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

    c. Ground ambulance handling in direct vicinity of aircraft; Baggage and equipment handling (pressurized and non-pressurized compartments) (fixed-wing pilots); Patient enplaning - passenger briefing. (fixed-wing

pilots); Coordination of aircraft movement with air medical personnel activities prior to taxi to ensure their safety; Smooth and coordinated control of the aircraft when maneuvering, transition of control surface configurations and ground operations for patient, air medical personnel and passenger comfort; Intermediate stop procedures - (fueling, fire equipment standby, customs); Medical emergencies during flight; Aircraft emergency procedures - evacuations including patient; Cabin temperature control to maintain comfortable cabin temperature for the occupants.

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 Communications

Rule 3.7.1 Activation Capability: **#21600**

1. 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.

2. Pilot is able to control and override radio transmission from the cockpit in the event of an emergency situation.

3. Medical Team must be able to communicate with each other during flight.

4. If cellular phones are part of the onboard communications equipment, they are to be used in accordance with FCC regulations.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.5 Communications Continuity and Flight Following Capability: There shall be a well-defined process to track transport activities and provide the necessary support to efficiently follow aircraft, flight crews and air medical personnel movement. The licensee shall have a written emergency plan which addresses the actions to be taken in the event of an aircraft incident or accident, breakdown, or patient deterioration during transport operations. **#21600**

A readily accessible post accident/incident plan must be part of the transport following protocol so that appropriate search and rescue efforts may be initiated in the event the aircraft is overdue, radio communications cannot be established, nor location verified. There must be a written plan to initiate assistance in the event the ambulance is disabled.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.6 Communications Equipment: on the aircraft and ambulance – All communications must be maintained in full operating condition and in good repair. Radios on aircraft (as range permits) must be capable of transmitting and receiving the following: **#21600**

1. 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 hospitals net available for air crew member(s) in the patient area.

2. Communications Center

3. Air Traffic Control

4. Emergency Medical Services.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.7.7 There is a policy designed to discourage "shopping" by first responders and other requesting agents that specifically addresses how the program interfaces with other air medical services in the same coverage area to alert them of a weather turn-down. It is recognized that programs in a common geographic area may experience differing weather conditions and that programs may have differing capabilities. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 Requirements for Aircraft

Rule 3.8.1 When being used as an air ambulance, in addition to meeting other requirements set forth in these rules, and aircraft shall: **#21600**

1. The aircraft should be a twin-engine or turbine single engine aircraft appropriate to the mission statement and scope of care of the medical service and listed on the air carrier's Operations Specifications.

2. Pressurized aircraft with air conditioning are strongly preferred for medical transports. A physician familiar with altitude physiology must be consulted or written policies address altitude limits for specific disease processes of the patient to be transported in an unpressurized cabin.

3. Be equipped for Instrument Flight Rules (IFR) flight.

4. *Note: Fixed-wing aircraft should be equipped and rated for IFR operations in accordance with Federal Aviation Regulations (FAR)~~'s~~. Rotor-wing aircraft should be equipped for inadvertent IFR if operating as a Visual Flight Rules (VFR) operator.*

SOURCE: Miss. Code Ann. §41-59-5

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

The aircraft/ambulance configuration and patient placement allow for safe medical personnel egress. Doors must be fully operable from the interior. Doors must be capable of being opened fully and held by a mechanical device. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.4 Have a lighting system which can provide adequate intensity to illuminate the patient care area and an adequate method (curtain, distance) to limit the cabin light from entering the cockpit and impeding cockpit crew vision during night operations. Use of red lighting or low intensity lighting in the patient care area is acceptable if not able to isolate the patient care area from effects on the cockpit or on a driver. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.5 The interior of the aircraft must be climate controlled to avoid adverse effects on patients and personnel on board. Cabin temperatures must be measured and documented every 15 minutes during a patient transport until temperatures are maintained within the range of 50 – 95 degrees F (10 - 35 degrees C) for aircraft and range of 68-78 degrees F (20-25.5 degrees C) for ground vehicles. Thermometer is to be mounted inside the cabin. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.7 Have an electrical system capable of servicing the power needs of electrically powered on-board patient care equipment. Electric power outlet must be provided with an inverter or appropriate power source of sufficient output to meet the requirements of the complete specialized equipment package without compromising the operation of any electrical aircraft/ambulance equipment. Extra batteries are required for critical patient care equipment. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.8 All aircraft equipment (including specialized equipment) and supplies must be secured according to national aviation regulations. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.8.10 A fire extinguisher – fully charged with valid inspection - must be accessible to medical transport personnel and pilot/driver while in motion. If not accessible, two fire extinguishers are required.- **#21600**

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 Medical Equipment and Supplies

Rule 3.9.1 Medical transport personnel must ensure that all medical equipment is in working order and all equipment/supplies are validated through documented checklists for both the primary and backup aircraft/ambulance. 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. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.2 Medical Equipment for All Levels of Care Shall Include: **#21600**

1. STRETCHER - The aircraft/ambulance design and configuration must not compromise patient stability in loading, unloading or in-flight operations. There shall be 1 or more stretcher(s) installed in the aircraft cabin which meets the following criteria:

    a. The stretcher must be large enough to carry the 95th percentile adult patient, full length in the supine position. (Estimated 95th percentile adult American male is 6 ft. and 232 lbs. and may differ internationally.) Patients under 40 pounds must be provided with an appropriately sized restraining device (for patient's height and weight), which is further secured by a locking device. All patients from 10 to 40 pounds must be secured in a five-point safety strap device that allows good access to the patient from all sides and permits the patient's head to be raised at least 30 degrees. For infants up to 10 pounds, a baby pod or commercial equivalent may be used.

    b. Shall have at least two shoulder harnesses and three cross-body patient restraining straps, one of which secures the chest area and the other about the area of the knee and thigh area.

    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 restraint requirements.

e. The aircraft must have an entry that allows loading and unloading without excessive maneuvering (no more than 45 degrees about the lateral axis and 30 degrees about the longitudinal axis) of the patient, and does not compromise functioning of monitoring systems, intravenous lines, and manual or mechanical ventilation.

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 chest compressions 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 mattress must be sealed to prevent absorption of blood and other body fluids, easily cleanable and disinfected according to OSHA blood borne pathogens requirements.

i. The stretcher must be sturdy and rigid enough that it can support cardiopulmonary resuscitation. If a backboard or equivalent device is required to achieve this, such device will be readily available.

j. A supply of linen for each patient.

2. Use of occupant restraint devices:

a. Air medical personnel must be in seat belts (and shoulder harnesses if installed) that are properly worn and secured for all takeoffs and landings according to FAA regulations. A policy should be written that defines when seat belts/ shoulder harnesses can be unfastened.

b. Patients transported by air are restrained with a minimum of three cross straps. Cross straps are expected to restrain the patient at the chest, hips, and knees. Patients that are loaded head forward must additionally be restrained with a shoulder harness restraint.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.3 Respiratory Care **#21600**

1. OXYGEN - Oxygen is installed according to FAA regulations. Medical transport personnel can determine how oxygen is functioning by pressure gauges mounted in the patient care area.

a. There shall be 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.

b. 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.

c. Each gas outlet is clearly identified.

d. Oxygen flow can be stopped at or near the oxygen source from inside the aircraft.

e. The following indicators are accessible to medical transport personnel while enroute:

   i. Quantity of oxygen remaining

   ii. Measurement of liter flow

f. 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.*

g. 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. Two suction units are required, one of which is portable and both of which must deliver adequate suction. (Minimum required suction 300 mm Hg)

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

4. AIRWAY ADJUNCTS

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

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.4 Patient Assessment Equipment: **#21600**

1. Automatic blood pressure device, sphygmomanometer, doppler or arterial line monitoring capability onboard or immediately available to determine blood pressure of the adult, pediatric and infant patient(s) during flight, as appropriate.

2. Stethoscope.

3. Penlight/Flashlight.

4. Bandage scissors, heavy duty.

5. Pulse oximetry

6. Bandages & Dressings

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

8. Bandages such as Kerlix, Kling.

9. Tape - various sizes.

10. Devices for decompressing a pneumothorax and performing an emergency cricothyroidotomy available if applicable to scope of care of the medical transport service

11. Fetal (Doppler heart rate) monitoring required for high risk OB transports

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.5 Miscellaneous Equipment and Supplies

1. Potable or sterile water.

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.6 Infection control equipment. The licensee shall have a sufficient quantity of the following supplies for all air medical personnel, each flight crew member, and all

ground personnel with incidental exposure risks according to OSHA requirements, but is not limited to **#21600**

1. Protective gloves.

2. Protective gowns.

3. Protective eyewear.

4. Protective face masks.

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

6. Hand washing capabilities or antiviral towellets.

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.8 ALS level equipment: To function at the ALS level, the following additional equipment is required: **#21600**

1. Advanced Airway and Ventilatory Support Equipment:

   a. Laryngoscope and tracheal intubation supplies, including laryngoscope blades, bag-valve- mask and oxygen supplies, including PEEP valves; appropriate for ages and potential needs of patients transported. At minimum, one Laryngoscope handle; one each adult, pediatric and infant blades.

   b. 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.

   c. End-tidal CO2 detectors (may be made onto bag valve mask assemblies or separate); End-tidal CO2 continuous waveform monitoring capabilities available.

d. Alternate airway management equipment. Equipment for alternative airways on-board transport vehicles at all times and protocol for management of missed airway attempts.

2. IV Equipment and Supplies:

a. IV supplies and fluids are readily available.

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

c. Hanger for IV solutions or a mechanism to provide high flow fluids if needed; All IV hooks are padded, flush mounted, or so located to prevent head trauma to the medical transport personnel in the event of a hard landing in the aircraft.

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. Controlled substances are in a locked system and kept in a manner consistent with Drug Enforcement Agency (DEA) regulations and approved by the service's medical director. Medication inventory techniques and schedules shall be maintained in compliance with all applicable local, state, and federal drug laws.

4. Medications shall be easily accessible.

5. There is a method to check expiration dates of medications and supplies on a regular basis.

6. 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.

7. 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.ems.ms.gov). *NOTE: Offline 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.

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.

8. Cardiac Monitor-Defibrillator –

a. D.C. battery powered portable monitor/defibrillator with paper printout and spare batteries, accessories, and supplies.

b. 12-lead cardiac monitor, defibrillator and external pacemaker are secured and positioned so that displays are visible.

c. Extra batteries or power source are available for cardiac monitor/defibrillator or external pacemaker.

d. Defibrillator is secured and positioned for easy access.

e. Pediatric paddles/pads are available if applicable to the scope of care of the medical transport service.

f. A defibrillator with appropriate size pads and settings must be available for neonatal transports (if neonatal transports are conducted).

9. External pacemaker on board or immediately available as a carry-on item.

10. Non-Invasive Automatic Blood Pressure Monitor

11. IV Infusion Pump capable of strict mechanical control of an IV infusion drip rate. Passive devices such as dial-a-flows are not acceptable. A minimum of three IV infusion pumps (may be in the same device if individually metered lines with back up available) are on the aircraft or immediately available for critical care transports and as appropriate to the scope of care.

12. Electronic Monitoring Devices - Any electronic or electrically powered medical equipment to be used on board an aircraft should be tested prior to actual patient

use to insure that it does not produce Radio Frequency Interference (RFI) or Electro Magnetic Interference (EMI) which would interfere with aircraft radio communications or radio navigation systems. This may be accomplished by reference to test data from organizations such as the military or by actual tests performed by the licensee while airborne.

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.9.9 To function at the CCLS or SPECIALTY level of care the following additional equipment shall be available as required to the scope of care of the medical transport service: **#21600**

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

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

3. Intraaortic Balloon Pump (IABP)

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Equipment Maintenance and Inspection Program

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Violations

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 12 Suspension; Revocation of License

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 3.12.2 A Mississippi licensed ambulance service shall comply with the Mississippi State Trauma Plan as approved by the Mississippi State Department of Health, Bureau of Emergency Medical Services. Licensed service must follow the state patient destination criteria and treatment protocols for the patient as delineated by these regulations. All Medical Control Plans shall comply with the Mississippi State Trauma Plan and all other applicable system of care plans as directed by the Mississippi State Department of Health, Bureau of Emergency Medical Services. **#21600**

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 Medical Control: See Appendix 1.

Chapter 4 MEDICAL FIRST RESPONDER

Subchapter 1 Training Authority Medical First Responder

Rule 4.1.1 BEMS may approve Medical First Responder courses offered by a community college, Institutes of Higher Learning, Mississippi State Fire Academy, or an organized EMS district recognized by BEMS.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 2 Medical First Responder Curriculum

Rule 4.2.1 BEMS shall approve only proposed Medical First Response courses that meet or exceed the most recent National Emergency Medical Services Education Standards, as documented by the course's prescribed curriculum.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 3 Request for approval of Medical First Responder training programs

Rule 4.3.1 To obtain approval for a proposed Medical First Responder course, the requesting entity must submit the online request available via the BEMS website at least thirty (30) days prior to the proposed start date. A copy of the proposed curriculum with anticipated learning outcomes and the instruments used for documenting outcome assessment/evaluation must be included with the request to offer the proposed course.

Proposed Medical First Responder instructors must be state certified with at least two years of experience at the EMT level or a higher level as an EMS provider in Mississippi and possess current certification as a Healthcare Provider level CPR instructor.

Subchapter 4 Medical First Responder Training Programs:

Rule 4.4.1 Medical First Responder students shall receive a handbook or syllabus no later than the first session of their respective course that relates the days and hours of the course, objectives, expected outcomes, and information related to the methods used in determining grades, in addition to any mechanism for appeal of grades and any other practical course information. Conditions governing dismissal from the course must be included in the handbook or syllabus and distributed to the student before training begins. Any options for remediation shall also be included in the handbook or syllabus. Course coordinators and instructors are responsible for maintaining documentation including grades, documentation of assessments and evaluations, documentation of remediation, and documentation related to retention and NREMT pass rates. Course coordinators shall follow the policy of their entity in terms of the length of time related to document retention. Said documentation may be requested by BEMS staff in the course of an investigation. Medical First Responder curricula shall also include appropriate classroom, lab, and practicum learning that meets or exceeds the most recent National Emergency Medical Services Education Standards for "Emergency Medical Responder."

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.4.2 Healthcare Provider level CPR with AED that meets or exceeds current American Heart Association standards shall be a pre-requisite to Medical First Responder training in MS.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 5 Medical First Responder Classes, Initial Course Roster

Rule 4.5.1 Medical First Responder coordinators shall provide an initial roster of all student participants enrolled in their respective courses to BEMS prior to the third-class session using the Initial Program/Course Roster Form available via the BEMS website.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 6 Medical First Responder classes, Final Program/Course Roster

Rule 4.6.1 Medical First Responder coordinators shall provide a final roster of all student participants who completed their respective courses to BEMS within three (3) days of course completion using the Final Program/Course Roster Form available via the BEMS website.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 7 Medical First Responder Refresher Training

Rule 4.7.1 Medical First Responders, who meet prescribed recertification training and refresher requirements for Emergency Medical Responder (EMR) through the National Registry of EMTs (NREMT) and are currently certified as an EMR with the NREMT, meet all

satisfactory recertification training and refresher requirements for BEMS Medical First Responder re-certification.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.7.2 Prerequisite to MS certification as a Medical First Responder

1. National Registry certification at minimum level of Emergency Medical Responder.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 8 Medical First Responder Certification

Rule 4.8.1 Any person desiring certification as a Medical First Responder shall apply to the BEMS using forms provided via the MSDH BEMS website (Application for State EMS Provider Certification), submit a copy of current NREMT EMR certification and remit payment to BEMS, payable to MS State Department of Health – BEMS via electronic payment per the process described on the MSDH BEMS website.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 9 Grounds for Suspension or Revocation of Medical First Responder

Rule 4.9.1 Grounds for Suspension or Revocation include:

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

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty.

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

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

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

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

10. Conviction of any crime that is directly related to the qualifications, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction.

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

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

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

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

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

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

17. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. **(**Suspension only for first offense.)

18. Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

    a. Assault
    b. Stalking
    c. False imprisonment
    d. Sexual assault or battery
    e. Crimes against a vulnerable person

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.9.2 If BEMS finds that public health, safety, and welfare requires emergency action and a finding to that effect is incorporated in its order, summary suspension of a certification may be ordered pending proceedings for revocation or other action.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 10 Recertification of Medical First Responders

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

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.10.2 Any person desiring re-certification as a Medical First Responder shall apply to the BEMS using forms provided via the MSDH BEMS website (Application for State EMS

Provider Certification), submit a copy of current NREMT EMR certification and remit payment to BEMS, payable to MS State Department of Health – BEMS via electronic payment per the process described on the MSDH BEMS website.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.10.3 Medical First Responders failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired.

SOURCE: Miss. Code Ann. §41-59-81

Rule 4.10.4 Medical First Responder certificates shall be valid for a period not exceeding two and one-half (2 ½) years from date of issuance.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 11 Job Summary and Functional Description

Rule 4.11.1 Mississippi follows the summary and functional job description for Emergency Medical Responders (EMR) provided for in the National EMS Scope of Practice Model for the Medical First Responder certification level. Medical First Responders must possess the education, critical thinking skills, general aptitude, and physical requirements required for the various roles they occupy with paid and voluntary organizations as per the job descriptions of their respective organizations.

SOURCE: Miss. Code Ann. §41-59-81

Subchapter 12 Performance Standards for Medical First Responder

Rule 4.12.1 MS Medical First Responders' primary responsibility is to the patient and shall include appropriate patient assessment and care and in accordance with the National EMS scope of Practice Model.

SOURCE: Miss. Code Ann. §41-59-81

Chapter 5 EMERGENCY MEDICAL SERVICES (EMS) DRIVER

Subchapter 1 Training Authority

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

Mississippi. All EMS Driver training programs must have the BEMS approval prior to the start of class.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 EMS Driver Curriculum

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Request for Approval of EMS Driver training programs

Rule 5.3.1 *A list of BEMS approved EMS Driver training programs will be available at the BEMS office and BEMS web site. (www.ems.ms.gov)* **#18982**

SOURCE: Miss. Code Ann. §41-59-5

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 EMS Driving Training Programs

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.4.5 The student shall be informed about the methods and data used in determining grades and about the mechanism for appeal. Conditions governing dismissal from the program should be clearly defined in writing and distributed to the student at the beginning of the training program.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 EMS Driver classes, class approved

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 EMS Driver classes, final roster

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 EMS Driver Training Programs, minimum admittance criteria:

Rule 5.7.1 Possession of a valid driver's license

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.7.2 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 EMS Driver Refresher Training

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

Rule 5.9.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.9.3 Possession of valid driver's license.

SOURCE: Miss. Code Ann. §41-59-5

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

Rule 5.10.1 Age of at least 18 years.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.10.3 Possession of valid driver's license.

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Temporary EMS Driver Certification.

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

SOURCE: Miss. Code Ann. §41-59-5

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 12 EMS Driver Certification

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.12.2 An EMS Driver certificate shall be issued and may be renewed provided that the holder meets qualifications as required by the Board. The expiration date of each EMS Driver certificates shall be the same as the holder's driver's license.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 EMS Driver Re-certification

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

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 14 EMS Driver, Grounds for Suspension or Revocation.

Rule 5.14.1 Grounds for suspension or revocation include **#22087**

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

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

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

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

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

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

9. Conviction of any crime which is directly related to the qualification, functions, and duties of pre-hospital personnel, or the conviction of any felony. The record of conviction or a certified copy thereof will be conclusive evidence of such conviction.#24551

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

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

12. Unauthorized, misuse or excessive use of narcotics, dangerous drugs, or controlled substances or alcoholic beverages.

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

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

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

16. Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

a. Assault
b. Stalking
c. False imprisonment
d. Sexual assault or battery
e. Crimes against a vulnerable person

SOURCE: Miss. Code Ann. §41-59-5

Rule 5.14.2 If the Bureau finds that public health, safety, and welfare requires emergency action and a finding to that effect is incorporated in its order, summary suspension of a certification may me ordered pending proceedings for revocation or other action.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 6 EMERGENCY MEDIAL TECHNICIAN

Subchapter 1 Training Authority EMT

Rule 6.1.1 BEMS may approve Emergency Medical Technician (EMT) courses offered by a community college, Institutes of Higher Learning, Mississippi State Fire Academy, or an organized EMS district recognized by BEMS.

SOURCE: Miss. Code Ann. §41-59-5 & 45-11-12

Subchapter 2 EMT Curriculum

Rule 6.2.1 BEMS shall approve only proposed EMT courses that meet or exceed the most recent National Emergency Medical Services Education Standards, as documented by the course's prescribed curriculum.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Request for Approval of EMT training programs

Rule 6.3.1 To obtain approval for a proposed EMT course, the requesting entity must submit the online request available via the BEMS website at least thirty (30) days prior to the proposed start date. A copy of the proposed curriculum with anticipated learning outcomes and the instruments used for documenting outcome assessment/evaluation must be included with the request to offer the proposed course. Proposed EMT instructors must be state certified with at least two years of experience at the EMT level or a higher level as an EMS provider in Mississippi and possess current certification as a Healthcare Provider level CPR instructor.

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.3.2 Request for approval of EMT training programs not contained on the approved list shall be sent to BEMS with evidence and verification that: #24068 / #24988

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

2. EMT Instructors must be approved by the BEMS. Community college instructor standards may meet this requirement.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 EMT Training Programs

Rule 6.4.1 EMT students shall receive a handbook or syllabus no later than the first session of their respective course that relates the days and hours of the course, objectives, expected outcomes, and information related to the methods used in determining grades, in addition to any mechanism for appeal of grades and any other practical course information. Conditions governing dismissal from the course must be included in the handbook or syllabus and distributed to the student before training begins. Any options for remediation shall also be included in the handbook or syllabus. Course coordinators and instructors are responsible for maintaining documentation including grades, documentation of assessments and evaluations, documentation of remediation, and documentation related to retention and NREMT pass rates. Course coordinators shall follow the policy of their entity in terms of the length of time related to document retention. Said documentation may be requested by BEMS staff in the course of an investigation. Medical First Responder curricula shall also include appropriate classroom, lab, and practicum learning that meets or exceeds the most recent National Emergency Medical Services Education Standards for "Emergency Medical Responder."

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 EMT Classes, Initial Course Roster

Rule 6.5.1 EMT coordinators shall provide an initial roster of all student participants enrolled in their respective courses to BEMS prior to the third-class session using the Initial Program/Course Roster Form available via the BEMS website.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 EMT classes, Final Program/Course Roster

Rule 6.6.1 EMT coordinators shall provide a final roster of all student participants who completed their respective courses to BEMS within three (3) days of course completion using the Final Program/Course Roster Form available via the BEMS website.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 EMT Refresher Training

Rule 6.7.1 Emergency Medical Technicians who meet prescribed recertification training and refresher requirements for EMT through the National Registry of EMTs (NREMT) and are currently certified as an EMT with the NREMT, meet all satisfactory recertification training and refresher requirements for BEMS EMT re-certification.

Rule 6.7.2 All Refresher training classes shall conform to the National Continued Competency Program (NCCP) standards and approved by the BEMS and MDTQA.

Rule 6.7.3 The local component of the NCCP constitutes specific topic requirements decided by the BEMS and/or MDTQA shall be included. Examples include state protocols, areas of specialization, or tasks that require additional focus based on QA/QI.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 Prerequisites to certification and recertification as an EMT

Rule 6.8.1 Completion of the Board's approved Emergency Technician Training Program. #24988

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.8.2 Any person desiring certification as an EMT shall apply to the BEMS using forms provided via the MSDH BEMS website (Application for State EMS Provider Certification), submit a copy of current NREMT EMT certification and remit payment to BEMS, payable to MS State Department of Health – BEMS via electronic payment per the process described on the MSDH BEMS website.

Rule 6.8.3 EMTs failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired. #24988

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 EMT, Grounds for Suspension or Revocation.

Rule 6.9.1 Grounds for suspension or revocation include: #22087 / #24068

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

2. Gross negligence.

3. Repeated negligent acts.

4. Incompetence.

5. Disturbing the peace while on duty

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

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

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

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

10. Conviction of any crime which is directly related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction. #24551

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

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

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

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

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

16. Suspension or revocation of any BEMS issued certification may affect other BEMS issued certifications at all levels.

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

18. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. (Suspension only for first offense.)

19. Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

    a. Assault
    b. Stalking
    c. False imprisonment

d. Sexual assault or battery
e. Crimes against a vulnerable person

20. Failure to comply with reporting requirements for submission of Patient Care Report to the BEMS containing Mississippi minimum EMS data set. #24988

SOURCE: Miss. Code Ann. §41-59-5

Rule 6.9.2 If BEMS finds that public health, safety, and welfare requires emergency action and a finding to that effect is incorporated in its order, summary suspension of a certification may be ordered pending proceedings for revocation or other action.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Functional Job Analysis

Rule 6.10.1 Mississippi follows the summary and functional job description for Emergency Medical Technician (EMT) provided for in the National EMS Scope of Practice Model for the Emergency Medical Technician certification level. EMT's must possess the education, critical thinking skills, general aptitude, and physical requirements required for the various roles they occupy with paid and voluntary organizations as per the job descriptions of their respective organizations.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 7 Advanced Emergency Medical Technician (AEMT)

Subchapter 1 Training Authority AEMT

Rule 7.1.1 BEMS may approve Advanced Emergency Medical Technician (AEMT) courses offered by a community college, the Institutes of Higher Learning, Mississippi State Fire Academy, or an organized EMS district recognized by BEMS.

SOURCE: Miss. Code Ann. §41-59-5 & 45-11-12

Subchapter 2 AEMT Curriculum

Rule 7.2.1 BEMS shall approve only proposed AEMT courses that meet or exceed the most recent National Emergency Medical Services Education Standards, as documented by the course's prescribed curriculum.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Request for Approval of AEMT training programs

Rule 7.3.1 To obtain approval for a proposed AEMT course, the requesting entity must submit the online request available via the BEMS website at least thirty (30) days prior to the proposed start date. A copy of the proposed curriculum with anticipated learning outcomes and the instruments used for documenting outcome assessment/evaluation

must be included with the request to offer the proposed course. Proposed AEMT instructors must be state certified with at least two years of experience at the AEMT level or a higher level as an EMS provider in Mississippi and possess current certification as a Healthcare Provider level CPR instructor.

SOURCE: Miss. Code Ann. §41-59-5

Rule 7.3.2 Request for approval of AEMT training programs not contained on the approved list shall be sent to the BEMS with evidence and verification that:

1. AEMT training program meets, at minimum, the requirements of the National EMS Education Standards

2. AEMT Instructors *must be approved by* the BEMS.

3. AEMT Instructors must be approved by the BEMS. Community college instructor standards may meet this requirement. **#24988**

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 AEMT Training Programs

Rule 7.4.1 AEMT students shall receive a handbook or syllabus no later than the first session of their respective course that relates the days and hours of the course, objectives, expected outcomes, and information related to the methods used in determining grades, in addition to any mechanism for appeal of grades and any other practical course information. Conditions governing dismissal from the course must be included in the handbook or syllabus and distributed to the student before training begins. Any options for remediation shall also be included in the handbook or syllabus. Course coordinators and instructors are responsible for maintaining documentation including grades, documentation of assessments and evaluations, documentation of remediation, and documentation related to retention and NREMT pass rates. Course coordinators shall follow the policy of their entity in terms of the length of time related to document retention. Said documentation may be requested by BEMS staff in the course of an investigation. Advanced Emergency Medical Technician curricula shall also include appropriate classroom, lab, and practicum learning that meets or exceeds the most recent National Emergency Medical Services Education Standards for "Advanced Emergency Medical Technician."

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 AEMT Classes, Initial Course Roster

Rule 7.5.1 AEMT coordinators shall provide an initial roster of all student participants enrolled in their respective courses to BEMS prior to the third class session using the Initial Program/Course Roster Form available via the BEMS website.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 AEMT classes, ~~final roster~~ Final Program/Course Roster

Rule 7.6.1 AEMT coordinators shall provide a final roster of all student participants who completed their respective courses to BEMS within three (3) days of course completion using the Final Program/Course Roster Form available via the BEMS website.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 AEMT Refresher Training

Rule 7.7.1 AEMTs, who meet prescribed recertification training and refresher requirements for Advanced Emergency Medical Technician (AEMT) through the National Registry of EMTs (NREMT) and are currently certified as an AEMT with the NREMT, meet all satisfactory recertification training and refresher requirements for BEMS AEMT re-certification.

1. All Refresher training classes shall conform to the National Continued Competency Program (NCCP) standards.

2. The local component of the NCCP constitutes specific topic requirements decided by the BEMS and/or MDTQA shall be included. Examples include state protocols, areas of specialization, or tasks that require additional focus based on QA/QI.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 Prerequisites to certification and certification as an AEMT #24988

Rule 7.8.1 Any person desiring certification as a AEMT shall apply to the BEMS using forms provided via the MSDH BEMS website (Application for State EMS Provider Certification), submit a copy of current NREMT AEMT certification and remit payment to BEMS, payable to MS State Department of Health – BEMS via electronic payment per the process described on the MSDH BEMS website.

SOURCE: Miss. Code Ann. §41-59-5

Rule 7.8.2 AEMTs failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired. **#24988**

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 9 Functional Job Analysis

Rule 7.9.1 Mississippi follows the summary and functional job description for Advanced Emergency Medical Technician (AEMT) provided for in the National EMS Scope of Practice Model for the Emergency Medical Technician certification level. AEMT's must possess the education, critical thinking skills, general aptitude, and physical requirements required for the various roles they occupy with paid and voluntary organizations as per the job descriptions of their respective organizations.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 AEMT, Grounds for Suspension or Revocation.

Rule 7.10.1 Grounds for suspension or revocation include:

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

2. Fraud or any misstatement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

3. Gross negligence.

4. Repeated negligent acts.

5. Incompetence.

6. Disturbing the peace while on duty

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

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

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

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

11. Conviction of any crime which is directly related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction. **#24551**

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

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

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

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

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

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

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

19. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. (Suspension only for first offense)

20. Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

    a. Assault

    b. Stalking

    c. False imprisonment

    d. Sexual assault or battery

    e. Crimes against a vulnerable person

21. Failure to comply with reporting requirements for timely submission of Patient Care Report to the BEMS containing Mississippi minimum EMS data set.

SOURCE: Miss. Code Ann. §41-59-5

Rule 7.10.2 If BEMS finds that public health, safety, and welfare requires emergency action and a finding to that effect is incorporated in its order, summary suspension of a certification may be ordered pending proceedings for revocation or other action.

SOURCE: Miss. Code Ann. §41-59-5

Chapter 8 PARAMEDIC

Subchapter 1 Training Authority for Paramedic

Rule 8.1.1 BEMS may approve Paramedic courses offered by a community college, and the Institutes of Higher Learning.

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

Rule 8.1.2 BEMS is authorized to approve or disapprove in-state clinical and field practicum education activities for out-of-state CoAEMSP accredited paramedic programs. Out-of-state paramedic students participating in clinical or field practicum must be Mississippi certified at the EMT or AEMT level.

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

Subchapter 2 Paramedic Curriculum

Rule 8.2.1 BEMS shall approve only proposed Paramedic courses that meet or exceed the most recent National Emergency Medical Services Education Standards, as documented by the course's prescribed curriculum.

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

Subchapter 3 Request for Approval of Paramedic Training Programs

Rule 8.3.1 To obtain approval for a proposed Paramedic course, the requesting entity must submit the online request available via the BEMS website at least thirty (30) days prior to the proposed start date. A copy of the proposed curriculum with anticipated learning outcomes and the instruments used for documenting outcome assessment/evaluation must be included with the request to offer the proposed course. Proposed Paramedic instructors must be state certified with at least two years of experience at the Paramedic level or a higher level as an EMS provider in Mississippi and possess current certification as a Healthcare Provider level CPR instructor.

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

Rule 8.3.2 All BEMS approved Paramedic training programs must be accredited by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP). BEMS shall be present for any site visit conducted by the Committee on Accreditation of Education Programs for the EMS Professions (CoAEMSP). **#23517**

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

Rule 8.3.3 Programs seeking accreditation must first seek a Letter of Review (LOR) issued by COAEMSP. A copy of the Letter of Review Self Study Report (LSSR) must be submitted to the BEMS prior to submitting to COAEMSP. #24685

1. Upon receipt of the LOR, the Program must submit an official copy to the BEMS along with the start date of the next LOR class and the on-time end date of that class.

2. BEMS must be notified within ten (10) days of any suspension, revocation, or voluntary withdrawal of program LOR.

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

Rule 8.3.4 The following requirements are to be met and approved by the BEMS before the approval will be issued to begin the programs instructional component: **#23517**

1. Accredited programs or Letter of Review (LOR) programs adding or identifying a Lead Instructor/Program Director must fill the position with an individual meeting all qualifications prescribed under the current CAAHEP *Standards and Guidelines*. **Any personnel changes must be reported to the BEMS within fifteen (15) calendar days.**

2. Accredited programs or Letter of Review (LOR) programs adding or identifying a Medical Director must fill the position with an individual meeting all qualifications prescribed under the current CAAHEP *Standards and Guidelines*. **Any personnel changes must be reported to the BEMS within fifteen (15) calendar days.**

3. Accredited programs or Letter of Review (LOR) programs adding or identifying Instructional Faculty must fill the position with an individual meeting all qualifications prescribed under the current CAAHEP *Standards and Guidelines*. **Any personnel changes must be reported to the BEMS within fifteen (15) calendar days.**

4. Clinical Resources as prescribed under the current CAAHEP Standards and Guidelines. This must be verified by a copy of a contractual agreement from each site to the BEMS **#24685**

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

Rule 8.3.5 Before a consecutive class will be authorized to commence, the program shall adhere to all required CoAEMSP processes. Further, to maintain training authority, the programs must submit to BEMS: **#23517 #24685**

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

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

3. Proof of minimum acceptable pass rates determined by the BEMS and Medical Direction, Training and Quality Assurance Committee. Approved Instructors not meeting this requirement may be placed on probationary status by the BEMS.

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

Subchapter 4 Paramedic Classes, Initial Course Roster

Rule 8.4.1 Paramedic coordinators shall provide an initial roster of all student participants enrolled in their respective courses to BEMS prior to the third class session using the Initial Program/Course Roster Form available via the BEMS website.

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

Subchapter 5 Paramedic Classes, Final Program/Course Roster

Rule 8.5.1 Paramedic coordinators shall provide a final roster of all student participants who completed their respective courses to BEMS within three (3) days of course completion using the Final Program/Course Roster Form available via the BEMS website.

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

Subchapter 6 Paramedic Training Programs, minimum admittance criteria #23517

Rule 8.6.1 Must be a Mississippi certified EMT, or Advanced EMT

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

Subchapter 7 Paramedic Refresher Training #23517

Rule 8.7.1 Paramedics, who meet prescribed recertification training and refresher requirements for Paramedic through the National Registry of EMTs (NREMT) and are currently certified as a Paramedic with the NREMT, meet all satisfactory recertification training and refresher requirements for BEMS Paramedic re-certification.

1. All Refresher training classes shall conform to the National Continued Competency Program (NCCP) standards.

2. The local component of the NCCP constitutes specific topic requirements decided by the BEMS and/or MDTQA shall be included. Examples include state protocols, areas of specialization, or tasks that require additional focus based on QA/QI.

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

Subchapter 8 Prerequisites to certification and recertification as a Paramedic #23517 #24685

Rule 8.8.1 Any person desiring certification as a Paramedic shall apply to the BEMS using forms provided via the MSDH BEMS website (Application for State EMS Provider Certification), submit a copy of current NREMT Paramedic certification

and remit payment to BEMS, payable to MS State Department of Health – BEMS via electronic payment per the process described on the MSDH BEMS website.

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

Rule 8.8.2 All Paramedics failing to re-certify with BEMS on or before the expiration date of his/her certification period will be considered officially expired. #24685

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

Subchapter 9 Paramedic, Grounds for Suspension or Revocation. #23517

Rule 8.9.1 Grounds for suspension or revocation include: #24068

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

2. Fraud or any misstatement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

3. Gross negligence.

4. Repeated negligent acts.

5. Incompetence.

6. Disturbing the peace while on duty

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

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

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

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

11. Conviction of any crime which is directly related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction. #24551

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

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

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

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

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

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

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

19. Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. (Suspension for first offense)

20. Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

    a. Assault
    b. Stalking
    c. False imprisonment
    d. Sexual assault or battery
    e. Crimes against a vulnerable person

21. Failure to comply with reporting requirements for timely submission of Patient Care Report to the BEMS containing Mississippi minimum EMS data set

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

Rule 8.9.2 If the Bureau finds that public health, safety, and welfare requires emergency action and a finding to that effect is incorporated in its order, summary suspension of a certification may be ordered pending proceedings for revocation or other action.

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

Subchapter 10 Performance Standards for Paramedic #23517 #24685

Rule 8.10.1 Optional skills: Performances of these skills are optional however; they must be taught in all training programs. #24068

1. Drug Assisted Intubation, using MDTQA approved medications for this procedure, in strict adherence with the following measures:

    a. A specific verbal order from online medical direction must be obtained to institute DAI;

    b. Initiate and continue, before, during and after each DAI, continuous monitoring and recording of heart rate and rhythm, oxygen saturation, and end-tidal carbon dioxide using a capnography or capnometric device (to exclude colormetric only devices);

    c. Appropriate resources for drug storage and delivery must be present and used;

    d. DAI protocols must contain continuing quality assurance, quality control and performance review measures, and when indicated, supplemental training;

    e. DAI protocols must include requirements for initial training and continuing education in:

        i. Proper patient selection for DAI;

        ii. Demonstrating initial and continuing competency in the DAI procedure;

        iii. Confirming initial and verifying ongoing tube placement, including training in the utilization of appropriate instrumentation;

        iv. Airway management of patients who cannot be intubated;

        v. The use of backup rescue airway methods in the event of failed DAI;.

        vi. Every instance of the initiation or attempted initiation of an airway by DAI shall be reported to BEMS by the local EMS on forms or in a format approved by BEMS. Every instance of the institution or attempted institution of an airway by DAI shall be reviewed by the State Medical Director, who shall submit a quarterly report to MDTQA and the EMS Advisory Council.

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

Subchapter 11 Area and Scope of Practice of the Paramedic #23517

Rule 8.11.1 The paramedic scope of practice shall be defined as in Appendix

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

Rule 8.11.2 Paramedics may routinely or periodically participate in patient care in the emergency department of a licensed hospital. Their presence may be in the form of:

1. graduates participating in a clinical rotation for skill retention.

2. field units stationed out of the emergency department under direct physician supervision (i.e., hospital-based ALS services). BEMS Certified Paramedics will be able to function in the emergency service area of the hospital. They would also be permitted to function in life-threatening emergency situations in other areas of the hospital if directed to do so by the medical command authority.

3. providing assistance to the emergency department staff after delivering a patient.

   Paramedics *must, when functioning in the hospital, only do so under the direct supervision of a physician. This is necessary because the scope of practice of a* Paramedics *does not coincide with that of any other licensed personnel. Paramedics of a hospital owned and based ambulance service may function in the Emergency Department under the direct supervision of a Mississippi licensed physician, physically located in Mississippi, via telemedicine. Paramedics may not function in other areas of hospitals which do not have on-site 24-hour physician availability. #24685*

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

Rule 8.11.3 Because the Paramedic's primary responsibility is to respond to emergency situations outside the hospital, they cannot be utilized to replace any members of the hospital emergency service area staff but may be utilized to support and assist the staff in the care of patients in accordance with their performance standards. Since their scope of practice is limited to a number of specific procedures, which can only be performed under the direction of a physician, all emergency patients clearly require nursing intervention in order to ensure that all the patients' needs are met.

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

Rule 8.11.4 It is appropriate to transport patients whose urgent needs or reasonably perceived needs for care exceed the scope of practice for the EMS provider, if the following conditions are present:

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

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

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

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

Rule 8.11.5 EMS Providers of all levels, may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMS Providers scope of practice if:

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

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

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

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

Chapter 9 Emergency Medical Services Operating Fund (EMSOF)

Subchapter 1 Eligibility

Rule 9.1.1 Applicants are restricted to counties, municipalities and emergency medical service districts formed and recognized pursuant to §41-59-53 through §41-59-59. Political subdivisions are not eligible to receive Emergency Medical Services Operating Funds (EMSOF).

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.1.2 To be eligible for EMSOF, in part, governmental units must have expended from local funds directly to the ambulance service, at minimum, an amount equal to or greater than $0.15 per capita, with population computed from the most current federal census, in the year the EMSOF was collected. For governmental units that own and operate governmental ambulance service, to be eligible, in part, the governmental unit must show equal to or greater than $0.15 per capita, with population computed from the most current federal census, in the year the EMSOF fund was collected.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 Process

Rule 9.2.1 Applications for EMSOF will be forwarded to applicants receiving EMSOF funds for the prior year. Other counties, municipalities and legal EMS districts wishing to receive applications shall submit, in writing, a request for application on or before October 1 of the year in which they plan to request EMSOF. Original applications, as provided by BEMS, for EMSOF must be received at the Bureau of Emergency Medical Services office by 5:00 PM on the second Friday of November each year. Applications received after this date will not be processed.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.2.2 Applications for EMSOF must have satisfactory proof of the maintenance of the funding effort by the governmental unit in the form of a line item local fund expense for ambulance in the fiscal year in which EMSOF funds were collected. Satisfactory proof must also be provided in the form of a line item budget of local funds for ambulance in the fiscal year that EMSOF is being requested.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.2.3 It is important that applicants create their EMSOF applications with input from their licensed ambulance service provider and/or county EMS regulatory programs. Evidence of this collaboration will be a memorandum or letter of support for the application from the licensed ambulance service provider(s) and/or county EMS regulatory programs and must be attached to the EMSOF application. Applications received by BEMS without these memorandum or letters of support will be returned without action.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.2.4 Applications must be signed by:

1. Counties: Chancery Clerk, County Administrator or President Board of Supervisors

2. Municipalities: Mayor

3. EMS Districts: District Administer or President of the Board.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.2.5 Applicants are required to attend an "EMSOF grantee meeting" to be held in their public health region before grant approval.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.2.6 All EMSOF funds must be deposited into the governmental units' treasury. Items purchased with EMSOF funds must be purchased in the name of the

governmental unit. The Governmental unit must follow its existing rules for the purchasing, inventory, and disposal of these items. A sticker which states "This equipment purchased by the citizens of the State of Mississippi" shall identify equipment purchased with EMSOF funds.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Eligible Uses of EMSOF Funds

Rule 9.3.1 EMSOF must be used for improvements in the Bureau of Emergency Medical Services regulated Emergency Medical Services and may not be used for operating expenses. All EMSOF funds must be expended or escrowed by the end of the local fiscal year in which the EMSOF funds were disbursed to the governmental unit. "Escrow" is defined as depositing the funds in an interest-bearing account in accordance with Miss. Code Ann. §27-105-1, et seq. and applicable state fiscal and financial control regulations, said funds to be used only in accordance with the provisions of the EMSOF grant. No funds granted hereunder may be escrowed for more than three (3) years. All expenditures of funds from an EMSOF grant must be done in accordance with Mississippi purchasing and property accounting laws, rules, and regulations. A detailed justification for all EMSOF expenditures or funds escrowed, indicating their compliance with purchasing laws and regulations, as well as how they will improve local emergency medical services, must be provided.

1. EMSOF must be expended to the direct benefit of a Mississippi Licensed Ambulance Service (as described in Chapter 59 of the Mississippi Code Ann.). These funds may not be used in support of "EMS Support Services" including, but not limited to, the following

2. local or county fire service rescue operations, and

3. local or county first responders other than training, medical supplies, or medical equipment to be used for direct patient care.

4. Additionally, EMSOF may not be used for hospital equipment or supplies. If a licensed ambulance service is hospital-based, EMSOF funds can only be used for items that are to the direct benefit of the hospital-based licensed ambulance service. The director of the hospital-based licensed ambulance service must indicate by memorandum or letter of support that the request will provide direct benefit to the hospital-based licensed ambulance service.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.3.2 Personnel Expenses. EMSOF may be used to pay payroll and benefit differential pay for governmental units for the first year that a governmental unit applies to the BEMS to improve~~s~~ its' level of ambulance service licensure. No other personnel expenses are allowed under EMSOF.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.3.3 Regionalization. EMSOF may be used to pay dues to an EMS district formed and recognized pursuant to §41-59-53 through §41-59-59, for regional medical control, training, or improvements in Bureau of Emergency Medical Services. Based on support of the licensed ambulance service, EMSOF may also be used for governmental support of trauma care systems.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.3.4 Training. EMSOF may be used for initial training or continuing education of EMS Drivers, EMT-Basic, EMT-Intermediate, or EMT-Paramedic. EMSOF may not be used for the initial training of first responders. These funds may be used for re-certification of Medical First Responders (as regulated by the Bureau of EMS).

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.3.5 Commodities. EMSOF may be used for the purchase of commodities that improve local Emergency Medical Services. EMSOF may not be used to purchase any commodities that will be billed to a patient. Applicant must show that the requested commodity is a direct benefit to the licensed ambulance service. This must be acknowledged by the county recognized lead licensed ambulance service director by letter or memorandum of support.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.3.6 Equipment. EMSOF may be used to purchase equipment or capital outlay items that improve local Emergency Medical Services. Equipment purchased with EMSOF by a governmental unit must appear on the governmental units equipment inventory and be accounted for in accordance with State of Mississippi property inventory laws, rules and regulations. This is not intended to limit the temporary use of equipment in adjacent counties or jurisdictions within Mississippi or during patient transport either inside or outside the state. Applicant must show that the requested equipment is a direct benefit to the licensed ambulance service. This must be acknowledged by the county recognized lead licensed ambulance service director by letter or memorandum of support.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.3.7 Escrow. EMSOF may be escrowed (up to a maximum of three years) for local improvements in Emergency Medical Services regulated by the Bureau of Emergency Medical Services. (Example: Purchasing a new ambulance or radio system that cost more than grant amount.) Grant awards may be escrowed up to three years from the disbursement. All escrow amounts and interest must be fully expended by the end of the fourth grant year. (Example: ABC County received $10,000 in EMSOF for FY2008, $10,000 for FY2009 and $10,000 for FY2010 and wishes to replace a high mileage ambulance that will cost $40,400. ABC

County received $10,000 in EMSOF for FY 2011 and must fully expend the $40,000 plus interest accrued on escrowed amounts prior to the end of the governmental fiscal year for FY2011.) Escrow funds not fully expended by the end of the fourth grant year must be returned to the State. All interest posted must be reported and expended consistent with these regulations.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Reports

Rule 9.4.1 Prior to EMSOF proceeds being distributed to any governmental unit, proof, or proper expenditure of EMSOF in the previous year, if applicable, must be submitted to include the signature of the signing authority of the governmental unit indicating all expenditures were made properly.

SOURCE: Miss. Code Ann. §41-59-5

Rule 9.4.2 The director of the Bureau of Emergency Medical Services or his designee will perform random program reviews of governmental units to assure that EMSOF law, rules, regulations, and policies are followed.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 5 Appeal Process

Rule 9.5.1 Any county, municipality or organized medical service districts whose application for EMSOF has been rejected shall have the right to appeal such decision, within thirty (30) days after receipt of the Bureau of Emergency Medical Services' written decision, to a hearing officer who will make a final recommendation to the State Health Officer.

SOURCE: Miss. Code Ann. §41-59-5

1. **Chapter 10 Critical Care Paramedic**

Subchapter 1 Training Authority for Critical Care Paramedic

Rule 10.1.1 Critical Care Paramedic Program Coordinator: Must be an existing Accredited Mississippi ALS Program coordinator or Licensed or Certified Flight Paramedic (FP-C) or Critical Care Paramedic (CCP) for a minimum of three years. The Program Director and Instructors must be comfortable with the majority of the lecture components and skill stations and can answer questions with credibility. Instructors must be knowledgeable regarding new developments in emergency medical services and critical care through reading, research, professional organizations, and continuing academic training. They must be strong in oral and written communication skills and relate well to a variety of professional disciplines.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.1.2 Critical Care Paramedic training programs shall be advised regarding qualifications of program directors and instructors by a Critical Care Paramedic Advisory Committee as appointed by the Chairman of the Emergency Medical Services Advisory Council in consultation with the Chairman of the Medical Direction, Training and Quality Assurance.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 2 Request for Approval of Critical Care Paramedic Training Programs

Rule 10.2.1 Note: A list of BEMS approved Critical Care Paramedic training programs will be available at the BEMS office.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.2.2 Request for approval of Critical Care Paramedic training programs not contained on the approved list shall be sent to BEMS with evidence and verification that:

1. The education institution and its program director have been approved by the BEMS.

2. Critical Care Paramedic training programs meet, at minimum, the curriculum requirements set forth in this section.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.2.3 Mississippi Critical Care Paramedic (CCP) Educational Site Requirements: In order to qualify for approval to offer the Mississippi Critical Care Paramedic program, an educational institution must:

2. Be a BEMS approved Advanced Life Support (ALS) education site in good standing.

3. Have in place an adequate number of qualified faculty to offer the program. *Individual training programs will be responsible for credentialing their instructors. Individuals instructing within this curriculum must be knowledgeable in the area being presented. It is highly recommended that individual instructors have experience and expertise in their topic area. It is also recommended that instructors have Critical Care experience. A Critical Care Paramedic Program Coordinator must oversee all phases of the course.*

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.2.4 Instructor qualifications:

1. Instructor qualifications: Critical Care Paramedic Program Coordinator:

a. Must be an existing Accredited Mississippi ALS Program coordinator or Licensed or Certified Flight Paramedic (FP-C) or Registered Nurse with EMS experience or Critical Care Paramedic (CCP).

b. Minimum of three years' experience.

c. The Program Director and Instructors must be comfortable with the majority of the lecture components and skill stations and can answer questions with credibility.

d. The Program Coordinator should ensure instructors are knowledgeable regarding new developments in emergency medical services and critical care through reading, research, professional organizations, and continuing academic training. They must be strong in oral and written communication skills and relate well to a variety of professional disciplines.

2. Instructor qualifications: Physician instructor qualifications:

a. Emergency Medicine or Critical Care Medicine Board Certified or board eligible.

b. Minimum of three years clinical teaching experience.

3. Instructor qualifications: Nurse Practitioner/Physician Assistant instructor qualifications:

a. Minimum of five years emergency or critical care clinical experience.

b. Minimum of three years teaching experience.

c. Current certification in AHA ACLS; PEPP or AHA PALS course; Trauma Course (Trauma Nursing Core Course (TNCC), Course for Advanced Trauma Nursing (CATN), etc.

4. Instructor qualifications: Registered Nurse instructor qualifications

a. Minimum of five years critical care transport experience.

b. Minimum of three years teaching experience.

c. Current certification in AHA ACLS; PEPP or AHA PALS course; Trauma Course (TNCC, CATN, etc.)

d. Certified Flight Registered Nurse (CFRN), Critical Care Nursing Course (CCRN), Certified Transport Registered Nurse (CTRN), or Certified Emergency Nurse Certified Emergency Nurse (CEN) preferred.

5. Instructor qualifications: Paramedic instructor qualifications:

   a. Licensed or Certified Flight Paramedic (FP-C) or Critical Care Paramedic (CCP) for a minimum of two years.

   b. Minimum of five years' experience.

   c. Minimum of three years teaching experience.

   d. Current certifications in:

      i. AHA ACLS

      ii. AHA PALS, EPC or PEPP

      iii. PHTLS or equivalent course.

6. Instructor qualifications: Content Expert Instructor: Course Content Expert is an authority in a specific field of medicine. Experts must have a letter of recommendation or curriculum vitae (CV) detailing the extent and percentage of time spent in their area of expertise and must be approved by the program director of the sponsoring Advanced Life Support program. Each content expert can teach up to ten percent of the course.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.2.5 Facility Requirements

1. A designated medical director. The medical director must be board certified or board eligible in emergency medicine with optional co-medical director(s) in pediatric critical care medicine and/or adult critical care medicine.

2. Have adequate facilities to support the program.

3. Classroom and laboratory space adequate for the number of students enrolled.

4. A cadaver laboratory or high-fidelity simulation laboratory (may be on-site or offered through a hospital or other educational institution with which there is a formal agreement.) If a simulation laboratory is utilized, manikins must be capable of simulating a variety of critical care scenarios including, but not limited to, unstable angina, acute myocardial infarction, cardiogenic shock, dysrhythmias, aortic dissection, stroke, electrolyte disturbances, pediatric specific emergencies, and traumatic injuries for all age groups.

5. Have in effect formal agreement(s) with medical center(s) offering the following services:

   a. Current trauma center capability or designation of Level I or Level II;

b. Percutaneous Coronary Intervention (PCI) Center (with a 24-hour interventional cardiac catheterization laboratory);

c. A 24-hour emergency department staffed by full time board certified or board eligible emergency medicine physicians; and

d. Critical care units offering:

i. Insertion and maintenance of intra-aortic balloon pump and/or ventricular assist devices;

ii. Pulmonology;

iii. Neurology;

iv. Pediatric care

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 3 Critical Care Paramedic Training Programs

Rule 10.3.1 The programs must meet the same operational and record keeping standards for ALS training programs as established in these regulations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.3.2 The critical care paramedic curriculum must be approved and follow guidelines established by the Mississippi Community College Board (MCCB) the Mississippi Emergency Medical Services Advisory Council (EMSAC) and the Medical Direction, Training and Quality Assurance Committee (MDTQA).

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.3.3 The program shall consist of, at minimum, three components: didactic instruction, lab instruction, and hospital based clinical instruction. The time required to complete each component may vary, in part being dependent on the ability of students to demonstrate their mastery of the educational objectives by written, verbal, and practical examination. Students should demonstrate evidence of competency within the practice of Critical Care Transport Medicine.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.3.4 Faculty must be presented with the program's educational objectives for use in preparation of lectures and clinical rotations. The Critical Care Paramedic Program Coordinator must ensure that stated educational objectives are covered and should answer any questions from students or clarify information presented by a lecturer.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 4 Critical Care Paramedic Training Programs, minimum admittance criteria

Rule 10.4.1 Certified as a Mississippi Paramedic;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.4.2 No less than three years' experience as a nationally registered paramedic.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.4.3 Other licensed healthcare providers may be admitted on a case-by-case basis with approval of the Critical Care Paramedic Program Coordinator.

Subchapter 5 Prerequisites for certification and recertification as a Critical Care Paramedic

Rule 10.5.1 Must be currently certified as a Mississippi Paramedic in good standing.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.5.2 Completion of BEMS approved Critical Care Paramedic training program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.5.3 Must successfully complete International Board of Specialty Certifications as Flight Paramedic (FP-C) or Critical Care Paramedic (CCP-C) examination.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.5.4 Must possess at a minimum an associate's degree from a regionally accredited college/university.

Rule 10.5.5 Must demonstrate proof of continuing education requirements as defined by this chapter for recertification.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 6 Procedure to Obtain Certification and Recertification as Critical Care Paramedic

Rule 10.6.1 Must submit an application and fees to BEMS for certification and provide proof of:

1. Successful completion of a BEMS approved Critical Care Paramedic Training Program; prior Mississippi Critical Care Paramedic certification may serve as evidence of compliance for recertification.

2. An associate degree or higher from a regionally accredited college/university. Prior Mississippi Critical Care Paramedic

certification may serve as evidence of compliance for recertification.

3. Current certification (FP-C or CCP-C); must maintain certification through licensure period.

4. Must have Statewide or Jurisdictional Medical Control Agreement.

5. Must provide documentation of continuing education requirements as defined in the chapter for recertification.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.6.2 Critical care paramedic shall expire with the EMT-Paramedic certification.

Rule 10.6.3 Reciprocity for Critical Care Paramedic Certification

An individual holding a valid out-of-state Critical Care Paramedic certification may be granted reciprocity for Mississippi Critical Care Paramedic certification, provided the following conditions are met:

1. A current and unrestricted National Registry Paramedic (NRP) certification with a minimum of three (3) years of experience as a Nationally Registered Paramedic;
2. A current and unrestricted paramedic license or certification in good standing from the individual's home state;
3. A current and unrestricted Critical Care Paramedic license or certification in good standing from the individual's home state;
4. Completion of a Critical Care Paramedic training program that is approved by the EMS authority in the issuing state;
5. The training program must have included didactic instruction, laboratory skills, and clinical exposures;
6. The program must have consisted of a minimum of 150 hours of combined didactic and laboratory instruction, and at least 80 hours of clinical experience;
7. Submission of documentation demonstrating successful completion of the Critical Care Paramedic course;
8. Current certification as a Flight Paramedic-Certified (FP-C) or Critical Care Paramedic-Certified (CCP-C);
9. Jurisdictional Medical Control Agreement with a Mississippi-licensed physician who will serve as the applicant's offline medical director;
10. Prior to application for reciprocity, the agency's offline medical director shall evaluate the individual's cognitive and clinical competencies in critical care practice and validate the skills outlined in the Critical Care Paramedic Student Minimum Competency matrix as specified in Appendix;
11. Completion and submission of the Application for Mississippi EMS

Certification form, along with all required supporting documentation and applicable fees.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 7 Critical Care Paramedic Continuing Education Training

Rule 10.7.1 Continuing Education (CE) hours should have a clear and direct application to the practice of critical care medicine.

SOURCE: Miss. Code Ann. §41-59-5

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.7.2 Fifty Hours of critical care continuing education hours Bi-Annually.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.7.3 The EMS agency's off-line medical director shall sign off on each critical care paramedic continuing education requirement for submission to BEMS each certification period. A letter validating total number of continuing education hours, individual topic break down, and course dates signed by the medical director may serve as evidence of completion.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 8 Critical Care Paramedic, Grounds for Suspension or Revocation

The BEMS may suspend or revoke a certificate at any time it is determined that the holder no longer meets the prescribed qualifications.

Rule 10.8.1 Fraud or any misstatement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.2 Gross negligence.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.3 Repeated negligent acts.
SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.4 Incompetence.
SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.5 Disturbing the peace while on duty
SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.6 Recklessly disregarding the speed regulations prescribed by law while on duty.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.7 Failure to maintain current registration by the National Registry of EMTs and current state certifications (Paramedic and Critical Care Paramedic) through BEMS approved process.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.8 Failure to maintain all current Critical Care training standards as required by the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.9 The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.10 Conviction of any crime which is directly related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction. #24551

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.11 Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.12 Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.13 Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.14 Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.15 Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.16 Suspension or revocation of any BEMS issued certification may affect other BEMS issued certifications at all levels.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.17 Failure to comply with the requirements of a Mississippi EMS scholarship program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.18 Failure to comply with an employer's request for drug and alcohol testing.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.19 Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207- 2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.8.20 Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

a. Assault
b. Stalking
c. False imprisonment
d. Sexual assault or battery
e. Crimes against a vulnerable person

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

Rule 10.8.21 If the Bureau finds that public health, safety, and welfare requires emergency action and a finding to that effect is incorporated in its order, summary suspension of a certification may be ordered pending proceedings for revocation or other action.

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

Subchapter 9 Occupation and Scope of Practice of Critical Care Paramedic

Rule 10.9.1 The Scope of Practice for the Mississippi Critical Care Paramedic is defined in Appendix 9 of these Regulations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.9.2 Occupation:

1. The Critical Care Paramedic shall be utilized for critical care intervention and transport under the supervision of offline and/or online medical control.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 10 Procedure to Obtain Re-Certification as Critical Care Paramedic

Rule 10.10.1 Must submit an application and fees to BEMS for modification of the license by demonstrating:

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.10.2 Provide proof of current certification (FP-C or CCP-C); and,

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.10.3 Proof of completion of BEMS Approved CE Hours;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.10.4 Proof of completion of BEMS Approved 24 hour Critical Care Bi-Annual Refresher.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.10.5 Statewide or Jurisdictional Medical Control Agreement

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 11 Critical Care Paramedic, Grounds for Suspension or Revocation.: The BEMS may suspend or revoke a certificate at any time it is determined that the holder no longer meets the prescribed qualifications.

Rule 10.11.1 Fraud or any mis-statement of fact in the procurement of any certifications or in any other statement of representation to the Board or its representatives.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.2 Gross negligence.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.3 Repeated negligent acts.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.4 Incompetence.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.5 Disturbing the peace while on duty

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.6 Disregarding the speed regulations prescribed by law while on duty.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.7 Failure to maintain current registration by the National Registry of EMTs and current state certifications (Paramedic and Critical Care Paramedic) through BEMS approved process.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.8 Failure to maintain all current Critical Care training standards as required by the BEMS.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.9 The commission of any fraudulent dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of pre-hospital personnel.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.10 Conviction of any crime which is directly related to the qualification, functions, and duties of pre-hospital personnel. The record of conviction or certified copy thereof will be conclusive evidence of such conviction. #24551

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.11 Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this part of the regulations promulgated by the BEMS, pertaining to pre-hospital personnel.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.12 Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.13 Addiction to, excessive use of, or misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.14 Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by certification and license issued to the ALS provider.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.15 Permitting, aiding, or abetting an unlicensed or uncertified person to perform activities requiring a license or certification.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.16 Suspension or revocation of any BEMS issued certification may effect other BEMS issued certifications at all levels.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.17 Failure to comply with the requirements of a Mississippi EMS scholarship program.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.18 Failure to comply with an employer's request for drug and alcohol testing.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.19 Failure to wear high visibility safety apparel that meets the requirements of the American National Standard for High Visibility Apparel ANSI/ISEA 107-2004 Performance Class 2 or Performance Class 3, or the ANSI/ISEA 207-2006 Standard while functioning within the right-of-way of any road, street, highway, or other area where vehicle or machinery traffic is present. All garments must have labels, affixed by the manufacturer in accordance with the standard, that indicate compliance with the Performance Class 2, Performance Class 3, or 207-2006 standard.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.11.20. Any conduct, regardless of whether convicted, which constitutes a crime of violence, or which constitutes any of the following crimes:

a. Assault
b. Stalking
c. False imprisonment
d. Sexual assault or battery
e. Crimes against a vulnerable person

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

Rule 10.11.21. If the Bureau finds that public health, safety, and welfare requires emergency action and a finding to that effect is incorporated in its order, summary suspension of a certification may me ordered pending proceedings for revocation or other action.

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

Subchapter 12 Occupation and Competency of Critical Care Paramedic

Rule 10.12.1 Description of the Occupation and Competency of the Critical Care Paramedic is to provide for the on going care of a critically injured or ill patient during interfacility transport or while on duty aboard a Specialty Care licensed vehicle.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.2 Job Summary: The following skills shall be utilized for critical care transport under the supervision of offline and/or online medical control. Provide patient care during transport and in special situations.

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.3 *Note: Critical Care Paramedics may attend and transport by ambulance, patients who have pre-existing procedures or devices that are beyond the EMT's scope of practice if:*

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

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

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

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.4 Initiate and manage ventilators;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.5 Insert and/or manage surgical cricothyrotomy;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.6 Initiate (with direct verbal order from medical control) and manage chest tubes;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.7 Provide care for cardiac patients with, but not limited to, cardiac interventions and advanced therapeutic devices;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.8 Initiate (with direct verbal order from medical control), access, monitor and manage arterial lines, to include any necessary anchoring techniques;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.9 Access, monitor and manage central and arterial lines, to include hemodynamic monitoring;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.10 Rapid Sequence Induction;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.11 Initiate blood and blood products;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.12 Interpret laboratory results of blood and urine specimens;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.13 Initiate/administer, maintain and manage medications (excluding chemotherapeutic agents) required for the care of the critical care patient;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.14 Initiate and manage urinary draining devices;

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.15 Perform escharotomy/fasciotomy (with direct verbal order from medical control);

SOURCE: Miss. Code Ann. §41-59-5

Rule 10.12.16 Monitor and manage intracranial monitoring devices/drainage devices.

SOURCE: Miss. Code Ann. §41-59-5

Subchapter 13 Standards for the Critical Care Paramedic

Rule 10.13.1 The Critical Care Paramedic who functions within the State of Mississippi must be able to demonstrate the skills and understand the elements of total emergency care to the satisfaction of the local Critical Care Paramedic Program Coordinator.

SOURCE: Miss. Code Ann. §41-59-5

APPENDIX I – MEDICAL DIRECTION: STANDARD PRACTICE FOR QUALIFICATIONS, RESPONSIBILITIES, AND AUTHORITY #24068

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.

OFF-LINE (PROSPECTIVE AND RETROSPECTIVE) MEDICAL DIRECTION

Off-line medical direction includes the administrative promulgation and enforcement of accepted standards for out-of-hospital care. Off-line medical direction can be accomplished through both prospective and retrospective methods. Prospective methods include, but are not limited to, training, testing, and credentialing of providers, protocol development, operational policy and procedures development, and legislative activities. Off-line medical direction shall ensure the qualifications of out-of-hospital personnel involved in patient care and dispatch are maintained on an ongoing basis through education, testing, and credentialing as the local/state authorities have determined. Retrospective activities include, but are not limited to medical audit and review of care, (process improvement), direction of remedial education, and limitation of patient care functions if needed. Committees functioning under the medical director with representation from appropriate medical and provider personnel can perform various aspects of prospective and retrospective medical direction.

Each EMS agency providing pre-hospital care shall be licensed by the Mississippi State Department of Health, BEMS, and shall have an identifiable off-line 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 off-line 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 off-line Medical Director shall be appointed by, and accountable to, the appropriate licensed EMS agency.

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

Qualifications of a Medical Director

To optimize off-line medical direction of all out-of-hospital emergency medical services, these services should be managed by physicians who have demonstrated the following:

1. Mississippi licensed physician, M.D. or D.O.
2. Familiarity with the design and operation of out-of-hospital EMS systems.
3. Experience or training in the out-of-hospital emergency care of the acutely ill or injured patient.
4. Experience or training in medical direction of out-of-hospital emergency units.
5. Active participation or reasonable associated experience in the ED management of the acutely ill or injured patient.
6. Experience or training in the instruction of out-of-hospital personnel.
7. Active involvement in the training of pre-hospital personnel.
8. Experience or training in the EMS performance improvement process.
9. Active involvement in the medical audit, review and critique of medical care provided by pre-hospital personnel.
10. Knowledge of EMS laws and regulations.
11. Knowledge of EMS dispatch and communications.

12. Knowledge of local mass casualty and disaster plans including preparation for responding to terrorism and weapons of mass destruction.

13. By July 1, 2017, board certification in emergency medicine by the American Board of Emergency Medicine or the American Board of Osteopathic Emergency Medicine. Substitutions may be approved by the State Medical Director.

14. Completion of an EMS Medical Directors training course. (Effective January, 2013)

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

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

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

18. Approved by the State EMS Medical Director

Authority of an off-line Medical Director includes, but is not limited to:

Unless otherwise defined or limited by state or regional requirements, the medical director shall have authority over all clinical and patient care aspects of the EMS system including, but not limited to, the following:

1. Recommend certification, recertification, and decertification of non-physician out-of-hospital personnel to the appropriate certifying agency.

2. Establish, implement, revise, and authorize the use of system-wide protocols, policies, and procedures for all patient care activities from dispatch through triage, treatment, transport, and/or non-transport.

3. Establish criteria for determining patient destination in a non-discriminatory manner in compliance with state guidelines as appropriate.

4. Ensure the competency of personnel who provide on-line medical direction to out-of-hospital personnel including, but not limited to, physicians, EMTs, Advanced EMTs, Paramedics and nurses.

5. Establish the procedures or protocols under which non-transport of patients may occur.

6. Require education and testing to the level of proficiency approved for the following personnel within the EMS system:

a. EMTs

b. Advanced EMTs

c. Paramedics

d. Critical Care Paramedics

e. Nurses involved in out-of-hospital care

f. Dispatchers

g. Educational coordinators

h. On-line physicians

i. Off-line physicians

7. Implement and supervise an effective process improvement program. The medical director shall have access to all relevant records needed to accomplish this task.

8. Remove a provider from medical care duties for due cause, using an appropriate review and appeals mechanism.

9. Set or approve hiring standards for personnel involved in patient care.

10. Set or approve standards for equipment used in patient care.

11. Establishing system-wide medical and trauma protocols in consultation with appropriate specialists.

12. 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.

13. 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.

14. 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.

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

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

17. 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).

18. Establishing criteria for selection of patient destination.

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

20. Establishing operational standards for communication resource.

21. 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.

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

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

24. 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.

25. Medical direction with concurrent and retrospective oversight supervision;

26. Standardized protocols;

27. Actively engaged in a continuous quality assurance, quality control, performance review, and when necessary, supplemental training.

Medical Direction (Online, Direct Medical Control)

On-line medical direction is the medical direction provided directly to out-of-hospital providers by the medical director or designee, as defined in the BEMS approved medical control plan, generally in an emergency situation, either on-scene or by direct voice communication. The mechanism for this contact may be radio, telephone, or other means as technology develops, but must include person-to-person communication of patient status, and orders to be carried out. Ultimate authority and responsibility for concurrent medical direction rests with the off-line medical director.

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 credentialed pre-hospital providers shall be assigned to a specific on-line communication resource by a predetermined policy and this shall be included in the application for ALS licensure.

When EMS personnel are transporting patients to locations outside of their geographic medical control area, they may utilize recognized communication resources outside of their own area.

Specific local protocols shall exist which define those circumstances under which on-line medical direction is required.

On-line medical direction is the practice of medicine and all orders to which the pre-hospital provider shall originate from/or be under the direct supervision and responsibility of a physician.

The receiving hospital shall be notified prior to the arrival of each patient transported by the EMS system unless directed otherwise by local protocol.

Requirements of a Medical Director

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

2. 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. (January 2013) All Mississippi On-Line Medical Directors are encouraged to complete the Medical Director's course as prescribed by the Mississippi State Department of Health, Bureau of Emergency Medical Services and the Medical Direction, Training and Quality Assurance Committee.

3. 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.

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

5. 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.

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

7. 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.

8. There must be – at all times - Medical direction with concurrent and retrospective oversight supervision; Standard Protocols; Continuing quality assurance, quality control, performance review, and when necessary, supplemental training.

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

Authority for patient management in a medical emergency shall be the responsibility of the individual in attendance who is most appropriately trained and knowledgeable in providing pre-hospital emergency stabilization and transport.

When an advanced life support (ALS) squad, under medical direction, is requested and dispatched to the scene of an emergency, a doctor/patient relationship has been established between the patient and the physician providing medical direction.

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

Authority for Scene Management.

Authority for the management of the scene of a medical emergency shall be vested in appropriate public safety agencies. The scene of a medical emergency shall be managed in a manner designed to minimize the risk of death or health impairment to the patient and to other persons who may be exposed to the risks as a result of the emergency condition, and priority shall be placed upon the interests of those persons exposed to the more serious risks to life and health. Public safety personnel shall ordinarily consult emergency medical services personnel or other authoritative medical professionals at the scene in the determination of relevant risks.

Patient's Private Physician Present

The EMT should defer to the orders of the private physician. The base station should be contacted for record keeping purposes if on-line medical direction exists. The ALS squad's responsibility reverts back to medical direction or on-line medical direction at any time when the physician is no longer in attendance.

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

When the intervener physician has satisfactorily identified himself as a licensed physician and has expressed his willingness to assume responsibility and document his intervention in a manner acceptable to the local emergency medical services system (EMSS); the pre-hospital provider should defer to the orders of the physician on the scene if they do not conflict with system protocol.

If treatment by the intervener physicians at the emergency scene differs from that outlined in a local protocol, the physician shall agree in advance to assume responsibility for care, including accompanying the patient to the hospital. In the event of a mass casualty incident or disaster, patient needs may require the intervener physician to remain at the scene.

Intervener Physician Present and Existent On-Line Medical Direction

If an intervener physician is present and on-line medical direction does exist, the on-line physician should be contacted and the on-line physician is ultimately responsible.

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

If there is any disagreement between the intervener physician and the on-line physician, the pre-hospital provider should take orders from the on-line physician and place the intervener physician in contact with on-line physician.

In the event the intervener physician assumes responsibility, all orders to the pre-hospital provider shall be repeated to the communication resource for purposes of record-keeping.

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

The decision of the intervener physician to accompany the patient to the hospital should be make in consultation with the on-line physician. Nothing in this section implies that the pre-hospital provider CAN be required to deviate from system protocols.

Communication Resource

A communication resource is an entity responsible for implementation of direct (on-line) medical control. This entity/facility shall be designated to participate in the EMS system according to a plan developed by the licensed ALS provider and approved by the system (off-line) medical director and the State Department of Health, BEMS.

The communication resource shall assure adequate staffing for the communication equipment at all times by health care personnel who have achieved a minimal level of competence and skill and are approved by the system medical director.

The communication resource shall assure that all requests for medical guidance assistance or advice by pre-hospital personnel will be promptly accommodated with an attitude of utmost participation, responsibility, and cooperation.

The communication resource shall provide assurance that they will cooperate with the EMS system in collecting and analyzing data necessary to evaluate the pre-hospital care program as long as patient confidentiality is not violated.

1. 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.

2. 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.

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

4. 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.

5. 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.

6. If the communication resource is located within a hospital facility, the hospital shall meet the requirements listed herein and the equipment used for on-line medical direction shall be located within the emergency department.

Educational Responsibilities

Because the on-line and off-line medical directors allow the use of their medical licenses, specific educational requirements should be established. This is not only to insure the best available care, but also to minimize liability. All personnel brought into the system must meet minimum criteria established by state law for each level; however, the law should in no way preclude a medical director from enforcing standards beyond this minimum.

Personnel may come to the system untrained (in which case the medical director will design and implement the educational program directly or through the use of ancillary instructors), or they may have previous training and/or experience. Although the Department of Transportation has defined curricula for training, the curricula are not standardized nationally, and often are not

standardized within a state or county. Certification or licensure in one locale does not automatically empower an individual to function as an EMT within another system. The medical director must evaluate applicants trained outside the system in order to determine their level of competence. Such evaluation may be made in the form of written examinations, but should also include practical skills and a field internship with competent peers and time spent with the medical director.

The educational responsibilities of the medical director do not end with initial training; skills maintenance must be considered. To insure the knowledge does not stagnate, programs should cover all aspects of the initial training curriculum on a cyclical basis. Continuing education should comprise multiple formats, including lectures, discussions, and case presentations, as well as practical situations that allow the EMT to be evaluated in action. The continuing education curriculum should also include topics suggested by audits, and should be utilized to introduce new equipment or skills.

Paramedics are allowed to administer any pharmaceutical that is approved in these Rules and Regulations; through any route that falls within the skill set taught consistent with the National Standard Curriculum; and approved by off line medical director.

Review and Audit

Personnel may be trained to the highest standards and many protocols may be written, but if critical review is not performed, the level of patient care will deteriorate. Review is intended to determine inadequacies of the training program and inconsistencies in the protocols. The data base required includes pre-hospital care data, emergency department and inpatient (summary) data, and autopsy findings as appropriate. The cooperation of system administrators, hospital administrators, and local or state medical societies must be elicited. On occasion, the state legislature may be required to provide access to vital information.

The medical director or a designated person should audit pre-hospital run records, either randomly or inclusively. The data must be specifically evaluated for accuracy of charting and assessment; appropriateness of treatment; patterns of error, morbidity, and mortality; and need for protocol revision.

It cannot be assumed that all pre-hospital care will be supervised by on-line physicians. When proper or improper care is revealed by the audit process, prompt and appropriate praise or censorship should be provided by the medical director after consultation with the system administrator.

Individual Case Review.

Compliance with system rules and regulations is most commonly addressed by state and regional EMS offices. Audit by individual case review requires a more detailed plan. Each of the components defined in detail by the individual EMS system must be agreed on prior to the institution of any case review procedures. Case review may involve medical audit, including reviews of morbidity and mortality data (outcome-oriented review), and system audit, including compliance with rules and regulations as well as adherence to protocols and standing orders (process-oriented review). The personnel to be involved in a given case review process should

include the off-line medical director; emergency department and critical care nurses; and EMS, technical and other support personnel who were involved in the specific cases.

The following must be written and agreed to in advance:

Procedural guidelines of how the individuals will interact during meetings.

Because considerations of medical malpractice may be present when issues concerning appropriateness of care and compliance with guidelines are raised, legal advice for procedural guidelines must be obtained prior to the institution of any medical audit program in order that medical malpractice litigation will neither result from nor become the subject of the meeting.

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

Format for recording the meeting and its outcome.

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

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

The severity of presentation of patients must be known, and a scale for that measurement must be agreed on, included in all EMT education, and periodically checked for reliability.

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

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

An emergency department diagnosis and outcome in terms of admission to a general medical bed, critical care unit, or morgue must be known. The length of stay in the hospital, cost of stay, discharge status, and pathologic diagnosis should be made available.

Specialty Care Transport (SCT) Services

Specialty Care Transport (SCT) Services provide interfacility transportation of a critically injured or ill beneficiary by a ground ambulance vehicle including the provision of medically necessary supplies and services, at a level of service beyond the scope of the EMT-Paramedic. SCT is necessary when a beneficiary's condition requires ongoing care that must be furnished by one or more health professionals in an appropriate specialty area, for example, emergency or critical care nursing, emergency medicine, respiratory care, cardiovascular care, or a paramedic with additional training.

The off-line medical director for SCT agencies shall have access to consult with medical specialists for patient(s) whose illness and care needs are outside his/her area of practice. The medical director must have education experience in those areas of medicine that are

commensurate with the mission statement of the medical transport service or utilize specialty physicians as consultants when appropriate.

APPENDIX 2 - PROTOCOLS

General Provisions

Protocols are designed by the off-line (system) medical control system to provide a standardized approach to each commonly encountered patient problem. This provides a consistently defined level of pre-hospital care. When treatment is based on such protocols, the on-line physician assists the pre-hospital personnel in their interpretation of the patient's complaint, the findings of their evaluation, and the application of the appropriate treatment protocol. The process should be reviewed periodically in order to consider changing medical standards, new therapies, and data generated from audits of patient care.

In the realm of pre-hospital emergency medicine, there are a limited number of interventions to cover the myriad of problems that may be present. Although advanced life support may be skilled in many maneuvers, there are limitations on what they can accomplish in the pre-hospital setting. Basic life support personnel can do even less. The goal of pre-hospital care is to respond correctly and consistently.

Because the types of illnesses and inquiries commonly encountered in a given EMS system may be grouped into broad categories, protocols and standing orders may be established to help accomplish this goal. There are three major advantages to using protocols:

Pre-hospital personnel may be trained to respond to a given medical problem in a defined manner. Regardless of the weather, the hostility of the crowd, the immediate danger of any other outside stress, the pre-hospital personnel can consistently treat the problem in a defined manner with minimal chance of omission.

The EMS system will have a set standard by which care may be audited. The system and its successes or failures may be measured against consistent standards allowing for necessary change and improvement based on documented evidence, and not on the notion of this year's medical director or any other outside influence not based in fact and logic.

Protocols provide a standard of medical treatment for each patient problem so that individual variations necessary for non-routine patient problems may have a context to aid the on-line physician in a complex treatment regimen.

Protocol Development

The development of protocols may include the following steps:

List the common illnesses and injuries that are currently encountered by the local EMS system. A chart review on a random basis for all months of the preceding year should suffice. All months are important, for there may be significant seasonal variations with particular illnesses or injuries.

This list must also include any life-threatening problems that can be affected positively in the pre-hospital setting, but that are not seen routinely (e.g., anaphylaxis, snake bite).

This list may be divided into two general categories-pediatric problems and adult problems-even though there will be duplication within these two lists. Asthma, seizures, trauma, and other illnesses and injuries are common to both groups, but the physical interventions and medications are sufficiently different to justify this separation.

Similar problems (e.g., cardiopulmonary, trauma, poisons/overdose, etc.) may be combined into groups.

Some problems that will not fit easily into groupings (e.g., hypothermia) may be listed separately or included in a miscellaneous group called "other."

In each of these groups, there will be common parameters, such as the ABCs, vital signs, history of the current illness/injury, medical history, and medications, allergy history.

For each of the problems within the group, additional parameters or interventions may be added to further reduce the patient's morbidity or mortality.

Additional treatments for special cases may be added to create a more specifically detailed protocol.

For a given region, the level of training of the pre-hospital personnel involved, the capabilities of the EMS response system as a whole, the capabilities of the receiving hospital and the medical opinion in the region must be considered before applying protocols synthesized outside the EMS system.

Protocol Implementation

Protocols are the responsibility of the medical director, who often delegates their development to a committee consisting of emergency physicians and other appropriate physicians. This committee implements the protocols, which reflect the currently optimal method for pre-hospital treatment of the defined problems. All levels of controllers, the medical director, and off-line and on-line physicians, must be cognizant of the adopted protocols, and must agree to function "by the book."

Discrepancies of disagreements that evolve should be brought back to the committee for consideration.

Pre-hospital personnel are then trained in the use of the protocols and held accountable through the audit and review process. Variance from protocol must be clearly documented and justified.

Consistently occurring variances, whether or not justified and documented, should induce review of that protocol. Even when no problems emerge, the committee should review all protocols at least annually in light of past experience and new medical insight.

APPENDIX 3 – EMS DRIVER TRANING PROGRAMS

State Approval Process

Each EMS Driver Training Program must be formally approved by the Mississippi State Board of Health. The Mississippi EMS Advisory Council and the BEMS jointly reviews all proposals for BEMS training. Affirmative reviews are submitted as recommendations to the Board for adoption (state approval). All inquiries relative to EMS Driver Training and/or requests for state approval for the establishment of EMS Driver Training programs should be submitted in triplicate as follows:

Address

Mississippi State Department of Health

Bureau of Emergency Medical Services

P.O. Box 1700

Jackson, Mississippi 39215-1700

Format (application content)

As governed by state regulations, all applications for the establishment of Emergency Medical Services Driver Training Programs must demonstrate adherence to the Department of Transportation's Training Program for Operation of Emergency Vehicles as a minimum. The skid pad requirement is not required. The proposal for training must include as a minimum the following requirements:

Faculty profile - Provide names and resumes of all faculty (include instructor training obtained); indicate whether faculty are full-time, part-time, or consultants; and indicate those that are classroom vs. field preceptors.

Entry requirements - Taking all applicable state requirements into consideration, list all additional student selection criteria.

Class size - Indicate minimum and maximum numbers of students per class.

Facilities - Name and describe all facilities used for classroom and field training.

Course Implementation - Provide copies of all instructor lesson plans; provide testing and evaluation of student competencies and skills.

Budget - List sources of funds supporting the training program.

Equipment - Identify equipment and training materials available.

APPENDIX 4 – EMERGENCY TRANSPORT TO MEDICAL FACILITIES

Emergency Ambulance Transport To Medical Facilities

Patients who are transported under the direction of an emergency medical service system should be taken whenever possible to an in hospital facility that meets the Emergency Care Guidelines of the American College of Emergency Physicians.

The EMS Medical Control Authority should have the discretion to authorize transport to non-in hospital medical facilities that meet the Emergency Care Guidelines under that extraordinary circumstance when lack of timely availability of such an in hospital facility necessitates earlier patient stabilization.

If an area does not have a facility that meets the Emergency Care Guidelines, it may be necessary for the responsible EMS Medical Control Authority to designate some medical facility to receive patients by ambulance. The American College of Emergency Physicians strongly encourages the modification of such facilities to meet the Emergency Care Guidelines of the College, so that every area has a facility capable of providing emergency care.

APPENDIX 5 – RELATED OSHA REGULATIONS

General Industry

Part 1910 of title 29 of the Code of Federal Regulations is amended as follows:

PART 1910-[AMENDED]

Subpart Z-[Amended]

The general authority citation for subpart Z of 29 CFR part 1910 continues to read as follows and a new citation for 1910.1030 is added:

Authority: Sec. 6 and 8, Occupational Safety and Health Act, 29 U.S.C. 655.657. Secretary of Labor's Orders Nos. 12-71 (36 FR 8754). 8-76 (41 FR 25059), or 9-83 (48 FR 35736), as applicable; and 29 CFR part 1911.

Section 1910.1030 also issued under 29 U.S.C. 653.

Section 1910.1030 is added to read as follows:

1910.1030 Blood borne Pathogens.

Scope and Application. This section applies to all occupational exposure to blood or other potentially infectious materials as defined by paragraph (b) of this section.

Definitions. For purposes of this section, the following shall apply:

Assistant Secretary means the Assistant Secretary of Labor for Occupational Safety and Health, or designated representative.

Blood means human blood, human blood components, and products made from human blood.

Blood borne Pathogens means pathogenic microorganisms that are present in human blood and can cause disease in humans. These pathogens include, but are not limited to, hepatitis B virus (HBV) and human immunodeficiency virus (HIV).

Clinical Laboratory means a workplace where diagnostic or other screening procedures are performed on blood or other potentially infectious materials.

Contaminated means the presence or the reasonably anticipated presence of blood or other potentially infectious materials on an item or surface.

Contaminated Laundry means laundry which has been soiled with blood or other potentially infectious materials on an item or surface.

Contaminated Sharps means any contaminated object that can penetrate the skin including, but not limited to, needles, scalpels, broken glass, broken capillary tubes, and exposed ends of dental wires.

Decontamination means the use of physical or chemical means to removed, inactivate, or destroy blood borne pathogens on a surface or item to the point where they are no longer capable of transmitting infectious particles and the surface or item is rendered safe for handling, use, or disposal.

Director means the Director of the National Institute for Occupational Safety and Health, U.S. Department of Health and Human Services, or designated representative.

Engineering Controls means controls (e.g., sharps disposal containers, self-sheathing needles) that isolate or remove the blood borne pathogens hazard for the workplace.

Exposure Incident means a specific eye, mouth, other mucous membrane, non-intact skin, or parenteral contact with blood or other potentially infectious materials that result from the performance of an employee's duties.

Handwashing Facilities means a facility providing an adequate supply of running potable water soap and single use towels or hot air drying machines.

Licensed Healthcare Professional is a person whose legally permitted scope of practice allows him or her to independently perform the activities required by paragraph (f) Hepatitis B Vaccination and Post-exposure Evaluation and Follow-up.

HBV means hepatitis B virus.

HIV means human immunodeficiency virus.

Occupational Exposure means reasonably anticipated skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials that may result from the performance of an employee's duties.

Other Potentially Infectious Materials means

The following human blood fluids: semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids;

Any unfixed tissue or organ (other than intact skin) from a human (living or dead); and

HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV.

Parenteral means piercing mucous membranes or the skin barrier through such events as needlesticks, human bites cuts, and abrasions.

Personal Protective Equipment is specialized clothing or equipment worn by an employee for protection against a hazard. General work clothes (e.g., uniforms, pants, shirts, or blouses) not

intended to function as protection against a hazard is not considered to be personal protective equipment.

Production Facility means a facility engaged in industrial-scale, large-volume or high concentration production of HIV or HBV.

Regulated Waste means liquid or semi-liquid blood or other potentially infectious materials; contaminated items that would release blood or other potentially infectious materials in a liquid or semi-liquid state if compressed; items that are caked with dried blood or potentially infectious materials are capable of releasing these materials during handling; contaminated sharps; and pathological and microbiological wastes containing blood or other potentially infectious materials.

Research Laboratory means a laboratory producing or using research laboratory-scale amounts of HIV or HBV. Research laboratories may product high concentrations of HIV or HBV but not in the volume found in production facilities.

Source Individual means any individual living or dead, whose blood or other potentially infectious materials may be a source of occupational exposure to the employee. Examples include but are not limited to hospital and clinic patients; clients in institutions for the developmentally disabled; trauma victims; clients of drug and alcohol treatment facilities; residents of hospices and nursing homes; human remains; and individuals who donate or sell blood or blood components.

Sterilize means the use of a physical or chemical procedure to destroy all microbial life including highly resistant bacterial endospores.

Universal Precautions is an approach to infection control. According to the concept of Universal Precautions, all human blood and certain human body fluids are treated as if know to be infectious for HIV, HBV, and other blood borne pathogens.

Work Practice Controls means controls that reduce the likelihood of exposure by altering the manner in which a task is performed (e.g., prohibiting recapping of needles by a two-handed technique).

EXPOSURE CONTROL

Exposure Control Plan: Each employer having an employee(s), with occupational exposure as defined by paragraph (b) of this section shall establish a written Exposure Control Plan designed to eliminate or minimize employee exposure.

The Exposure Control Plan shall contain at least the following elements;

The exposure determination required by paragraph(c)(2).

The schedule and method of implementation for paragraphs (d) Methods of Compliance, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-

Exposure Evaluation and Follow-up, (g) Communication of Hazards to Employees, and (h) Recordkeeping, of this standard and

The procedure for the evaluation of circumstances surrounding exposure incidents as required by paragraph(f)(3)(i) of this standard.

Each employer shall ensure that a copy of the Exposure Control Plan is accessible to employees in accordance with 29 CFR 1910.20(e).

The Exposure Control Plan shall be reviewed and updated at least annually and whenever necessary to reflect new or modified tasks and procedures which effect occupational exposure and to reflect new or revised employee positions with occupational exposure.

The Exposure Control Plan shall be made available to the Assistant Secretary and the Director upon request for examination and copying.

Exposure determination.

Each employer who has an employee(s) with occupational exposure as defined by paragraph (b) of this section shall prepare an exposure determination. This exposure determination shall contain the following:

A list of all job classifications in which all employees in those job classifications have occupational exposure;

A list of job classifications in which some employees have occupational exposure, and

A list of all tasks and procedures or groups of closely related task and procedures in which occupational exposure occurs and that are performed by employees in job classifications listed in accordance with the provisions of paragraph(c)(2)(i)(B) of this standard.

This exposure determination shall be made without regard to the use of personal protective equipment.

METHODS OF COMPLIANCE

General-Universal precautions shall be observed to prevent contact with blood or other potentially infectious materials. Under circumstances in which differentiation between body fluid types is difficult or impossible, all body fluids shall be considered potentially infectious materials.

Engineering and work practice controls.

Engineering and work practice controls shall be used to eliminate or minimize employee exposure. Where occupational exposure remains after institution of these controls personal protective equipment shall also be used.

Engineering controls shall be examined and maintained or replaced on a regular schedule to ensure their effectiveness.

Employees shall provide handwashing facilities which are readily accessible to employees.

When provision of handwashing facilities is not feasible, the employer shall provide either an appropriate antiseptic hand cleanser in conjunction with clean cloth/paper towels or antiseptic towelettes. When antiseptic hand cleaners or towelettes are used, hands shall be washed with soap and running water as soon as feasible.

Employers shall ensure that employees wash their hands immediately or as soon as feasible after removal of gloves or other personal protective equipment.

Employers shall ensure that employees wash their hands and any other skin with soap and water, or flush mucous membranes with water immediately or as soon as feasible following contact of such body areas with blood or other potentially infectious materials.

Contaminated needles and other contaminated sharps shall not be net, recapped, or removed except as noted in paragraphs (d)(2)(vii)(A) and (d)(2)(vii)(B) below. Shearing or breaking of contaminated needles is prohibited.

Contaminated needles and other contaminated sharps shall not be recapped or removed unless the employer can demonstrate that no alternative is feasible or that such action is required by a specific medical procedure.

Such recapping or needle removal must be accomplished through the use of a mechanical device or a one-handed technique.

Immediately or as soon as possible after use, contaminated reusable sharps shall be placed in appropriate containers until properly processed. These containers shall be:

Puncture resistant;

Labeled or color-coded in accordance with this standard;

Leak proof on the sides and bottom; and

In accordance with the requirements set forth in paragraph (d)(4)(ii)(E) for reusable sharps.

Eating, drinking, smoking applying cosmetics or lip balm, and handling contact lenses are prohibited in work areas where there is a reasonable likelihood of occupational exposure.

Food and drink shall not be kept in refrigerators, freezers, shelves, cabinets or on countertops or bench tops where blood or other potentially infectious materials are present.

All procedures involving blood or other potentially infectious materials shall be performed in such a manner as to minimize splashing, spraying, spattering, and generation of droplets of these substances.

Mouth pipetting/suctioning of blood or other potentially infectious materials is prohibited.

Specimens of blood or other potentially infectious materials shall be placed in a container which prevents leakage during collection, handling, processing, storage, transport, or shipping.

The container for storage, transport, or shipping shall be labeled or color-coded according to paragraph(g)(1)(i) and closed prior to being stored, transported, or shipped. When a facility utilizes Universal Precautions in the handling of all specimens, the labeling/color-coding of specimens is not necessary provided containers are recognizable as containing specimens. This exemption only applies while such specimens/containers remain within the facility. Labeling or color-coding in accordance with paragraph(g)(1)(i) is required when such specimens/containers leave the facility.

If outside contaminations of the primary container occurs, the primary container which prevents leakage during handling, processing, storage, transport, or shipping and is labeled or color-coded according to the requirements of this standard.

If the specimen could puncture the primary container, the primary container shall be placed within a secondary container which is puncture-resistant in addition to the above characteristics.

Equipment which may become contaminated with blood or other potentially infectious materials shall be examined prior to servicing or shipping and shall be decontaminated as necessary, unless the employer can demonstrate that decontamination of such equipment is not feasible.

A readily observable label in accordance with paragraph (g)(1)(i)(H) shall be attached to the equipment stating which portions remain contaminated.

The employer shall ensure that this information is conveyed to all affected employees, the servicing representative, and/or the manufacturer, as appropriate prior to handling, servicing, or shipping so that appropriate precautions will be taken.

Personal protective equipment-

Provision. When there is occupational exposure, the employer shall provide, at no cost to the employee, appropriate personal protective equipment such as, but not limited to, gloves, gowns, laboratory coats, face shields or masks and eye protection, and mouthpieces, resuscitation bags, pocket masks, or other ventilation devices. Personal protective equipment will be considered "appropriate" only if it does not permit blood or other potentially infectious materials to pass through to or reach the employee's work clothes, street clothes, undergarments, skin, eyes, mouth, or other mucous membranes under normal conditions of use and for the duration of time which the protective equipment will be used.

Use. The employer shall ensure that the employee uses appropriate personal protective equipment unless the employer shows that the employee temporarily and briefly declined to use personal protective equipment when, under rare and extraordinary circumstances, it was the employee's professional judgment that in the specific instance its use would have prevented the delivery of health care or public safety services or would have posed an increased hazard to the safety of the worker or co-worker. When the employee makes this judgment, the circumstances

shall be investigated and documented in order to determine whether changes can be instituted to prevent such occurrences in the future.

Accessibility. The employer shall ensure that appropriate personal protective equipment in the appropriate sizes is readily accessible at the worksite or is issued to employees. Hypoallergenic gloves, glove liners, powderless gloves, or other similar alternatives shall be readily accessible to those employees who are allergic to the gloves normally provided.

Cleaning, Laundering, and Disposal. The employer shall clean, launder, and dispose of personal protective equipment required by paragraphs(d) and (e) of this standard, at not cost to the employee.

Repair and Replacement. The employer shall repair or replace personal protective equipment as needed to maintain its effectiveness, at no cost to the employee.

If a garment(s) is penetrated by blood or other potentially infectious materials, the garment(s) shall be removed immediately or as soon as feasible.

All personal protective equipment shall be removed prior to leaving the work area .

When personal protective equipment is removed prior to leaving the work site.

When personal protective equipment is removed it shall be placed in an appropriately designated area or container for storage or disposal.

Gloves. Gloves shall be worn when it can be reasonably anticipated that the employee may have hand contact with blood, other potentially infectious materials, mucous membranes, and on-intact skin; when performing vascular access procedures except as specified in paragraph(d)(3)(ix)(D); and when handling or touching contaminated items or surfaces.

Disposal (single use) gloves such as surgical or examination gloves, shall be replaced as soon as practical when contaminated or as soon as feasible if they are torn, punctured, or when their ability to function as a barrier is compromised.

Disposable (single use) gloves shall not be washed or decontaminated for re-use.

Utility gloves may be decontaminated for re-use if the integrity of the glove is not compromised. However, they must be discarded if they are cracked, peeling, torn, punctured, or exhibits other signs of deterioration or when their ability to function as a barrier is compromised.

If an employer in a volunteer blood donation center judges that routine gloving for all phlebotomies is not necessary then the employer shall:

Periodically reevaluate this policy;

Make gloves available to all employees who wish to use them for phlebotomy; and

Require that gloves be used for phlebotomy in the following circumstances:

When the employee has cuts, scratches, or other breaks in his or her skin;

When the employee judges that hand contamination with blood may occur, for example, when performing phlebotomy on an uncooperative source individual; and

When the employee is receiving training in phlebotomy.

Make, Eye Protection, and Face Shields. Masks in combination with eye protection devices, such as goggles or glasses with solid side shields, or chin length face shields, shall be worn whenever splashes, spray, spatter, or droplets of blood or other potentially infectious materials may be generated and eye, nose, or mouth contamination can be reasonably anticipated.

Gowns, Aprons, and Other Protective Body Clothing. Appropriate protective clothing such as, but not limited to, gowns, aprons, lab coats, clinic jackets, or similar outer garments shall be worn in occupational exposure situations. The type and characteristics will depend upon the task and degree of exposure anticipated.

Surgical caps or hoods and/or shoe covers or boots shall be worn in instances when gross contamination can reasonably be anticipated (e.g., autopsies, orthopedic surgery).

Housekeeping.

General. Employers shall ensure that the worksite is maintained in a clean and sanitary condition. The employer shall determine and implement an appropriate written schedule for cleaning and method of decontamination based upon the location within the facility, type of surface to be cleaned, type of soil present, and tasks or procedures being performed in the area.

All equipment and environmental and working surfaces shall be cleaned and decontaminated after contact with blood or other potentially infectious materials.

Contaminated work surfaces shall be decontaminated with an appropriate disinfectant after completion of procedures; immediately or as soon as feasible when surfaces are overtly contaminated or after any spill of blood or other potentially infectious materials; and at the end of the work shift if the surface may have become contaminated since the last cleaning.

Protective coverings, such as plastic wrap, aluminum foil, or imperviously-backed absorbent paper used to cover equipment and environmental surfaces, shall be removed and replaced as soon as feasible when they become overtly contaminated or at the end of the work shift if they may have become contaminated during the shift.

All bins, pails, cans, and similar receptacles intended for reuse which have a reasonable likelihood for becoming contaminated with blood or other potentially infectious materials shall be inspected and decontaminated on a regularly scheduled basis and cleaned and decontaminated immediately or as soon as feasible upon visible contamination.

Broken glassware which may be contaminated shall not be picked up directly with the hands. It shall be cleaned up using mechanical means, such as a brush and dust pan, tongs, or forceps.

Reusable sharps that are contaminated with blood or other potentially infectious materials shall not be stored or processed in a manner that requires employees to reach by hand into the containers where these sharps have been placed.

Regulated Waste.

Contaminated sharps shall be discarded immediately or as soon as feasible in containers that are:

Closable;

Puncture resistant;

Leakproof on sides and bottom; and

Labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard.

During use, containers for contaminated sharps shall be:

Easily accessible to personnel and located as close as is feasible to the immediate area where sharps are used or can be reasonably anticipated to be found (e.g., laundries);

Maintained upright throughout use; and

Replaced routinely and not be allowed to overfill.

When moving containers of contaminated sharps from the area of use, the containers shall be:

Closed immediately prior to removal or replacement to prevent spillage or protrusion of contents during handling, storage, transport, or shipping;

Placed in a secondary container if leakage is possible. The second container shall be:

Closable;

Constructed to contain all contents and prevent leakage during handling, storage, transport, or shipping; and

Labeled or color-coded according to paragraph(g)(1)(i) of this standard.

Reusable containers shall not be opened, emptied, or cleaned manually or in any other manner which would expose employees to the risk of percutaneous injury.

Regulated waste shall be placed in containers which are:

Closable;

Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

Labeled or color-coded in accordance with paragraph(g)(1)(i) this standard; and

Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

If outside contamination of the regulated waste container occurs, it shall be placed in a second container. The second container shall be:

Closable;

Constructed to contain all contents and prevent leakage of fluids during handling, storage, transport or shipping;

Labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard; and

Closed prior to removal to prevent spillage or protrusion of contents during handling, storage, transport, or shipping.

Disposal of all regulated waste shall be in accordance with applicable regulations of the United States, States and Territories, and political subdivisions of States and Territories.

Laundry.

Contaminated laundry shall be handled as little as possible with a minimum of agitation.

Contaminated laundry shall be bagged or containerized at the location where it was used and shall not be sorted or rinsed in the location of use.

Contaminated laundry shall be placed and transported in bags or containers labeled or color-coded in accordance with paragraph(g)(1)(i) of this standard. When a facility utilizes Universal Precautions in the handling of all soiled laundry, alternative labeling or color-coding is sufficient if it permits all employees to recognize the container as requiring compliance with Universal Precautions.

Whenever contaminated laundry is wet and presents a reasonable likelihood of soak-through of or leakage from the bag or container, the laundry shall be placed and transported in bags or containers which prevent soak-through and/or leakage of fluids to the exterior.

The employer shall ensure that employees who have contact with contaminated laundry wear protective gloves and other appropriate personal protective equipment.

When a facility ships contaminated laundry off-site to a second facility which does not utilize Universal Precautions in the handling of all laundry, the facility generating the contaminated laundry must place such laundry in bags or containers which are labeled or color-coded in accordance with paragraph(g)(1)(i).

HIV and HBV Research Laboratories and Production Facilities.

This paragraph applies to research laboratories and production facilities engaged in the culture, production, concentration, experimentation, and manipulation of HIV and HBV. It does not apply to clinical or diagnostic laboratories engaged solely in the analysis of blood, tissues, or organs. These requirements apply in addition to the other requirements of the standard.

Research laboratories and production facilities shall meet the following criteria:

Standard microbiological practices. All regulated waste shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy blood borne pathogens.

Special practices.

Laboratory doors shall be kept closed when work involving HIV or HBV is in progress.

Contaminated materials that are to be decontaminated at a site away from the work area shall be placed in a durable, leak proof, labeled or color-coded container that is closed before being removed from the work area.

Assess to the work area shall be limited to authorized persons. Written policies and procedures shall be established whereby only persons who have been advised of the potential biohazard, who meet any specific entry requirements, and who comply with all entry and exit procedures shall be allowed to enter the work areas and animal rooms.

When other potentially infectious materials or infected animals are present in the work area or containment module, a hazard warning sign incorporating the universal biohazard symbol shall be posted on all access doors. The hazard warning sign shall comply with paragraph(g)(1)(ii) of this standard.

All activities involving other potentially infectious materials shall be conducted in biological safety cabinets or other physical-containment devices within the containment module. No work with these other potentially infectious materials shall be conducted on the open bench.

Laboratory coats, gowns, smocks, uniforms, or other appropriate protective clothing shall be used in the work area and animal rooms. Protective clothing shall not be worn outside of the work area and shall be decontaminated before being laundered.

Special care shall be taken to avoid skin contact with other potentially infectious materials. Gloves shall be worn when handling infected animals and when making band contact with other potentially infectious materials is unavoidable.

Before disposal, all waste from work areas and from animal rooms shall either be incinerated or decontaminated by a method such as autoclaving known to effectively destroy blood borne pathogens.

Vacuum lines shall be protected with liquid disinfectant traps and high-efficiency particulate air (HEPA) filters or filters of equivalent or superior efficiency and which are checked routinely and maintained or replaced, as necessary.

Hypodermic needles and syringes shall be used only for parenteral injection and aspiration of fluids from laboratory animals and diaphragm bottles. Only needle-locking units (i.e., the needle is integral to the syringe) shall be used for the injection or aspiration of other potentially infectious materials. Extreme caution shall be used when handling needles and syringes. A needle shall not be bent, sheared, replaced in the sheath or guard, or removed from the syringe following use. The needle and syringe shall be promptly placed in a puncture-resistant container and autoclaved or decontaminated before reuse or disposal.

All spills shall be immediately contained and cleaned up by appropriate professional staff or others properly trained and equipped to work with potentially concentrated infectious materials.

A spill or accident that results in an exposure incident shall be immediately reported to the laboratory director or other responsible person.

A biosafety manual shall be prepared or adopted and periodically reviewed and updated at least annually or more often if necessary. Personnel shall be advised of potential hazards, shall be required to read instructions on practices and procedures, and shall be required to follow them.

Containment equipment.

Certified biological safety cabinets (Class I, II, or III) or other appropriate combinations of personal protection or physical containment devices, such as special protective clothing, respirators, centrifuge safety cups, sealed centrifuge rotors, and containment caging for animals, shall be used for all activities with other potentially infectious materials that pose a threat of exposure to droplets, splashes, spills, or aerosols.

Biological safety cabinets shall be certified when installed, whenever they are moved and at least annually.

HIV and HBV research laboratories shall meet the following criteria:

Each laboratory shall contain a facility for hand washing and an eye wash facility which is readily available within the work area.

An autoclave for decontamination of regulated waste shall be available.

HIV and HBV production facilities shall meet the following criteria:

The work areas shall be separated from areas that are open to unrestricted traffic flow within the building. Passage through two sets of doors shall be the basic requirement for entry into the work area from access corridors or other contiguous areas. Physical separation of the high-containment work area from access corridors or other areas or activities may also be provided by a double-doored clothes-change room (showers may be included), airlock, or other access facility that requires passing through two sets of doors before entering the work area.

The surfaces of doors, walls, floors, and ceilings in the work area shall be water resistant so that they can be easily cleaned. Penetrations in these surfaces shall be sealed or capable of being sealed to facilitate decontamination.

Each work area shall contain a sink for washing hands and a readily available eye wash facility. The sink shall be foot, elbow, or automatically operated and shall be located near the exit door of the work area.

Access doors to the work area or containment module shall be self-closing.

An autoclave for decontamination of regulated waste shall be available within or as near as possible to the work area.

A ducted exhaust-air ventilation system shall be provided. This system shall create directional airflow that draws air into the work area through the entry area. The exhaust air shall not be recirculated to any other area of the building, shall be discharged to the outside, and shall be dispersed away from occupied areas and air intakes. The proper direction of the airflow shall be verified (i.e., into the work area).

Training Requirements. Additional training requirements for employees in HIV and HBV research laboratories and HIV and HBV production facilities are specified in paragraph(g)(2)(ix).

Hepatitis B vaccination and post-exposure evaluation and follow-up-

General.

The employer shall make available the hepatitis B vaccine and vaccination series to all employees who have occupational exposure, and pot-exposure evaluation and follow-up to all employees who have had an exposure incident.

The employer shall ensure that all medical evaluations and procedures including the hepatitis B vaccine and vaccination series and post-exposure evaluation and follow-up, including prophylaxis are:

Made available at not cost to the employee;

Made available to the employee at a reasonable time and place;

Performed by or under the supervision of a licensed physician or by or under the supervision of another licensed healthcare professional; and

Provided according to recommendations of the U.S. Public Health Service current at the time these evaluations and procedures take place, except as specified by this paragraph(f).

The employers hall ensure that all laboratory at no cost to the employee.

Hepatitis B Vaccination

Hepatitis B vaccination shall be made available after the employee has received the training required in paragraph (g)(2)(vii)(I) and within 10 workings days of initial assignment to all employees who have occupational exposure unless the employee has previously received the

complete hepatitis B vaccination series, antibody testing has revealed that the employee is immune, or the vaccine is contraindicated for medical reasons.

The employee shall not make participation in a pre-screening program a prerequisite for receiving hepatitis B vaccination.

If the employee initially declines Hepatitis B vaccination but at a later date while still covered under the standard decides to accept the vaccination, the employer shall make available hepatitis B vaccination at that time.

The employer shall assure that employees who decline to accept hepatitis B vaccination offered by the employer sign the statement in appendix A.

If a routine booster dose(s) of hepatitis B vaccine is recommended by the U.S. Public Health Service at a future date, such booster dose(s) shall be made available in accordance with section(f)(1)(ii).

Post-exposure Evaluation and Follow-up. Following a report of an exposure incident, the employer shall make immediately available to the exposed employee a confidential medical evaluation and follow-up, including at least the following elements:

Documentation of the route(s) of exposure, and the circumstances under which the exposure incident occurred;

Identification and documentation of the source individual, unless the employer can establish that identification is infeasible or prohibited by state or local law;

The source individual's blood shall be tested as soon as feasible and after consent is obtained in order to determine HBV and HIV infectivity. If consent is not obtained, the employer shall establish that legally required consent cannot be obtained. When the source individual's consent is not required by law, the source individual's blood, if available, shall be tested and the results documented.

When the source individual is already known to be infected with HBV or HIV, testing for source individual's known HBV or HIV status need not be repeated.

Results of the source individual's testing shall be made available to the exposed employee, and the employee shall be informed of applicable laws and regulations concerning disclosure of the identity and infectious status of the source individual.

Collection and testing of blood for HBV and HIV serological status;

The exposed employee's blood shall be collected as soon as feasible and tested after consent is obtained.

If the employee consents to baseline blood collection, but does not give consent at that time for HIV serologic testing, the sample shall be preserved for at least 90 days. If within 90 days of the

exposure incident, the employee elects to have the baseline sample tested, such testing shall be done as soon as feasible.

Post-exposure prophylaxis, when medically indicated, as recommended by the U.S. Public Health Service;

Counseling; and

Evaluation of reported illnesses.

Information Provided to the Healthcare Professional.

The employer shall ensure that the healthcare professional responsible for the employee's Hepatitis B vaccination is provided a copy of this regulation.

The employer shall ensure that the healthcare professional evaluating an employee after an exposure incident is provided the following information:

A copy of this regulation;

A description of the exposed employee's duties as they relate to the exposure incident:

Documentation of the route(s) of exposure and circumstances under which exposure occurred;

Results of the source individual's blood testing, if available; and

All medical records relevant to the appropriate treatment of the employee including vaccination status which are the employer's responsibility to maintain.

Healthcare Professional's Written Opinion. The employer shall obtain and provide the employee with a copy of the evaluating healthcare professional's written opinion within 15 days of the completion of the evaluation.

The healthcare professional's written opinion for Hepatitis B vaccination shall be limited to whether Hepatitis B vaccination is indicated for an employee, and if the employee has received such vaccination.

The healthcare professional's written opinion for post-exposure evaluation and follow-up shall be limited to the following information:

That the employee has been informed of the results of the evaluation; and

That the employee has been told about any medical conditions resulting from exposure to blood or other potentially infectious materials which require further evaluation or treatment.

All other findings or diagnoses shall remain confidential and shall not be included in the written report.

Medical recordkeeping. Medical records required by this standard shall be maintain in accordance with paragraph(h)(1) of this section.

Communication of hazards to employees- Labels and signs.

Labels. Warning labels shall be affixed to containers of regulated waste, refrigerators and freezers containing blood or other potentially infectious material; and other containers used to store, transport or ship blood or other potentially infectious material; except as provided in paragraph(g)(1)(i)(E), (F) and (G).

Labels required by this section shall include the following legend: Biohazard

These labels shall be fluorescent orange or orange-red or predominantly so, with lettering or symbols in contrasting color.

Labels required by affixed as close as feasible to the container by string, wire, adhesive, or other method that prevents their loss or unintentional removal.

Red bags or red containers may be substituted for labels.

Containers of blood, blood components, or blood products that are labeled as to their contents and have been released for transfusion or other clinical use are exempted from the labeling requirements of paragraph (g).

Individual containers of blood or other potentially infectious materials that are placed in a labeled container during storage, transport, shipment, or disposal are exempted from the labeling requirement.

Labels required for contaminated equipment shall be in accordance with this paragraph and shall also state which portions of the equipment remain contaminated.

Regulated waste that has been decontaminated need not be labeled or color-coded.

Signs. The employer shall post signs at the entrance to work areas specified in paragraph(e), HIV and HBV Research Laboratory and Production Facilities, which shall bear the following legend:

Biohazard

(Name of the Infectious Agent)

(Special requirements for entering the area)

(Name, telephone number of the laboratory director or other responsible person).

These signs shall be fluorescent orange-red or predominantly so, with lettering or symbols in a contrasting color.

Information and Training. Employers shall ensure that all employees with occupational exposure participate in a training program which must be provided at no cost to the employee and during working hours.

Training shall be provided as follows:

At the time of initial assignment to tasks where occupational exposure may take place;

Within 90 days after the effective date of the standard; and

At least annually thereafter.

For employees who have received training on blood borne pathogens in the year preceding the effective date of the standard, only training with respect to the provisions of the standard which were not included need be provided.

Annual training for all employees shall be provided within one year of their previous training.

Employers shall provide additional training when changes such as modification of tasks or procedures or institution of new tasks or procedures affect the employee's occupational exposure. The additional training may be limited to addressing the new exposures created.

Material appropriate in content and vocabulary to educational level, literacy, and language of employees shall be used.

The training program shall contain at a minimum the following elements;

Inaccessible copy of the regulatory text of this standard and an explanation of its contents;

A general explanation of the epidemiology and symptoms of blood borne diseases;

An explanation of the modes of transmission of blood borne pathogens;

An explanation of the employer's exposure control plan and the means by which the employee can obtain a copy of the written plan;

An explanation of the appropriate methods for recognizing tasks and other activities that may involve exposure to blood and other potentially infectious materials;

An explanation of the use and limitations of methods that will prevent or reduce exposure including appropriate engineering controls, work practices and personal protective equipment;

Information on the types, proper use, location, removal, handling, decontamination and disposal of personal protective equipment;

An explanation of the basis for selection of personal protective equipment;

Information on the hepatitis B vaccine, including information on its efficacy, safety, method of administration, the benefits of being vaccinated, and that the vaccine and vaccination will be offered free of charge;

Information on the appropriate actions to take and persons to contact in an emergency involving blood or other potentially infectious materials;

An explanation of the procedure to follow if an exposure incident occurs, including the method of reporting the incident and the medical follow-up that will be made available;

Information on the post-exposure evaluation and follow-up that the employer is required to provide for the employee following and exposure incident;

An explanation of the signs and label and/or color coding required by paragraph(g)(1); and

An opportunity for interactive questions and answers with the person conducting the training session.

The person conducting the training shall be knowledgeable in the subject matter covered by the elements contained in the training program as it relates to the workplace that the training will address.

Additional Initial Training for Employees in HIV and HBV Laboratories and Production Facilities. Employees in HIV or HBV research laboratories and HIV or HBV production facilities shall receive the following initial training in addition to the above training requirements.

The employer shall assure that employees demonstrate proficiency in standard microbiological practices and techniques and in the practices and operations specific to the facility before being allowed to work with HIV or HBV.

The employer shall assure that employees have prior experience in the handling of human pathogens or tissue cultures before working with HIV or HBV.

The employer shall provide a training program to employees who have no prior experience in handling human pathogens. Initial work activities shall not include the handling of infectious agents. A progression of work activities shall be assigned as technique are learned and proficiency is developed. The employer shall assure that employees participate in work activities involving infectious agents only after proficiency has been demonstrated.

Recordkeeping-

Medical Records. The employer shall establish and maintain an accurate record for each employee with occupational exposure, in accordance with 29 CFR 1910.20. This record shall include:

The name and social security number of the employee;

A copy of the employee's hepatitis B vaccination status including the dates of all the hepatitis B vaccinations and any medical records relative to the employee's ability to receive vaccination as required by paragraph(f)(2);

A copy of all results of examinations, medical testing, and follow-up procedures as required by paragraph (f)(3);

The employer's copy of the healthcare professional's written opinion as required by paragraph (f)(5); and

A copy of the information provided to the healthcare professional as required by paragraphs (f)(4)(ii)(B)(C) and (D).

Confidentiality. The employer shall ensure that employee medical records required by paragraph (h)(1) are:

Kept confidential; and

Are not disclosed or reported without the employee's express written consent to any person within or outside the workplace except as required by this section or as may be required by law.

The employer shall maintain the records required by paragraph(h) for at least the duration of employment plus 30 years in accordance with 29 CFR 1910.20.

Training Records.

Training records shall include the following information: The dates of the training sessions; The contents or a summary of the training sessions; The names and qualifications of persons conducting the training; and The names and job titles of all persons attending the training sessions.

Training records shall be maintained for 3 years from the date on which the training occurred.

Availability.

The employer shall ensure that all records required to be maintained by this section shall be made available upon request to the Assistant Secretary and the Director for examination and copying.

Employee training records required by this paragraph shall be provided upon request for examination and copying to employees, to employee representatives, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

Employee medical records required by this paragraph shall be provided upon request for examination and copying to the subject employee, to anyone having written consent of the subject employee, to the Director, and to the Assistant Secretary in accordance with 29 CFR 1910.20.

Transfer of Records.

The employer shall comply with the requirements involving transfer of records set forth in 29 CFR 1910.20(h).

If the employer ceases to do business and there is no successor employer to receive and retain the records for the prescribed period, the employer shall notify the Director, at least three months prior to their disposal and transmit them to the Director, if required by the Director to do so, within that three month period.

Dates-

Effective Date. The standard shall become effective on March 6, 1992.

The Exposure Control Plan required by paragraph(c)(2) of this section shall be completed on or before May 5, 1992.

Paragraph (g)(2) Information and Training and (h) Recordkeeping shall take effect on or before June 4, 1992.

Paragraphs (d)(2) Engineering and Work Practice Controls, (d)(3) Housekeeping, (e) HIV and HBV Research Laboratories and Production Facilities, (f) Hepatitis B Vaccination and Post-Exposure Evaluation and Follow-up, and (g) (1) Labels and Signs, shall take effect July 6, 1992.

Appendix A to Section 1910.1030-Hepatitis B Vaccine Declination (Mandatory)

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV)a infection, I have been given the opportunity to be vaccinated with hepatitis B vaccine, at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

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APPENDIX 6 TRANSFERS: INTERHOSPITAL AND OTHER MEDICAL FACILITIES

Definitions - Inter-Hospital And Other Medical Facilities Appropriate Transfer - An appropriate transfer to a medical facility is a transfer in which the receiving facility:

a) has available space and qualified personnel for the treatment of the patient, and

b) has agreed to accept transfer of the patient and to provide appropriate medical treatment;

in which the transferring hospital provides the receiving facility with appropriate medical records of the examination and treatment effected at the transferring hospital;

In which the transfer is affected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer.

Medical Control During Interhospital Transfers

Once an emergency patient arrives for initial evaluation at a medical facility the patient becomes the responsibility of that facility, and its medical staff. This responsibility continues until the patient is appropriately discharged, or until the patient is transferred and the responsibility is assumed by personnel and a facility of equal or greater capability for the patient's existing condition.

Routine Interhospital Transfers

If a transfer is being made for the convenience of the patient or patient's physicians, and the patient is not receiving treatment, and is expecting to remain stable during transport, the transfer may be conducted by and appropriately trained medical provider (EMT-Basic or higher).

Emergency Interhospital Transfers

Conducted by the Transferring Facility If the patient is being transferred to another facility for other convenience, is receiving treatment, is medically unstable, or is potentially unstable, it is the responsibility of the transferring physician and hospital to provide medical records and assure that appropriately qualified personnel and transportation equipment are utilized. The transferring personnel will act as the agents of the transferring hospital and the physician approving the transfer, regardless of any other employer/employee relationship. The transferring physician must provide written orders to non-physician personnel for use during the interhospital transfer. If the patient experiences complications beyond situations addressed in these written orders, the provider should, if possible.

Contact the transferring hospital or the receiving facility for additional orders or, if necessary, contact a recognized communications resource for medical direction.

Emergency Interhospital Transfers Conducted by Receiving Facility (Transferring personnel are agents of the receiving hospital)

If the transferring personnel include a physician, the patient becomes the responsibility of the receiving facility as soon as the patient leaves the transferring facility. If the transferring team does not include a physician, the responsibility for the patient's well being may be shared between the receiving and transferring facility. The transferring facility retains the responsibility to assure that the transport agency has qualified personnel and transportation equipment.

Critical Care Transfers

If the patient is receiving treatment beyond the scope of practice of available transferring nonphysician providers or if the patient’s needs or reasonably perceived needs cannot be managed within the scope of practice of non-physician personnel, the transfer shall be managed by an appropriately trained physician.

APPENDIX 7 – RELATED COBRA REGULATIONS H.R. 3128-83 Subpart B- Miscellaneous Provisions Sec. 9121. Responsibilities of Medicare Hospitals in Emergency Cases.

Requirement of Medicare Hospital Provider Agreements.-Section 1866(a)(1) of the Social Security Act (42 USC 1395cc (a)(1) is amended-

by striking out "and" at the end of subparagraph (G),

by striking out the period at the end of subparagraph (H) and inserting in lieu thereof", and ", and

by inserting after subparagraph (H) the following new subparagraph: "(I) in the case of a hospital, to comply with the requirements of section 1867 to the extent applicable."

Requirements-Title XVIII of such Act is amended by inserting after section 1866 the following new section:

Examination and Treatment for Emergency Medical Conditions and Women in Active Labor: "Spec. 1867 (a) Medical Screening Requirement.-In the case of a hospital that has a hospital emergency department, if any individual (whether or not eligible for benefits under this title) comes to the emergency department and a request is made on the individual's behalf for examination or treatment for a medical condition, the hospital must provide for an appropriate medical screening examination within the capability of the hospital's emergency department to determine whether or not an emergency medical condition (within the meaning of subsection (3)(1) exists or to determine if the individual is in active labor (within the meaning of subsection (e)(2)).

Necessary Stabilizing Treatment for Emergency Medical Conditions and Active Labor.- In general.-If any individual (whether or not eligible for benefits under this title) comes to a hospital and the hospital determines that the individual has an emergency medical condition or is in active labor, the hospital must provide either-

within the staff and facilities available at the hospital, for such further medical examination and such treatment as may be required to stabilize the medical condition or to provide for treatment of the labor, or

for transfer of the individual to another medical facility in accordance with subsection (c).

Refusal to Consent to Treatment - A hospital is deemed to meet the requirement of paragraph (1)(A) with respect to an individual if the hospital offers the individual the further medical examination and treatment described in that paragraph but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the examination or treatment.

H.R.3128-84

Refusal to Consent to Transfer - A hospital is deemed to meet the requirement of paragraph (1) with respect to an individual if the hospital offers to transfer the individual to another medical facility in accordance with subsection (c) but the individual (or a legally responsible person acting on the individual's behalf) refuses to consent to the transfer.

Restricting Transfers Until Patient Stabilized -

Rule. - If a patient at a hospital has an emergency medical condition which has not been stabilized (with the meaning of subsection (e)(4)(B) or is in active labor, the hospital may transfer the patient unless-

(i) the patient (or a legally responsible person acting on the patient's behalf) requests that the transfer be effected, or

a physician (within the meaning of section 1861(r)(1), or other qualified medical personnel when a physician is not readily available in the emergency department, has signed a certification that, based upon the reasonable risks and benefits to the patient, and based upon the information available at the time, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual's medical condition from effecting the transfer; and

in which the transferring hospital provides the receiving facility with appropriate medical records (or copies thereof) of the examination and treatment effected at the transferring hospital;

in which the transfer is effected through qualified personnel and transportation equipment, as required including the use of necessary and medically appropriate life support measures during the transfer; and

which meets such other requirements as the Secretary may find necessary in the interest of the health and safety of patients transferred.

Enforcement-

As Requirement of Medicare Provider Agreement. - If a hospital knowingly and willfully, or negligently, fails to meet the requirements of this section, such hospital is subject to-

termination of its provider agreement under this title in accordance with section 1866(b), or

at the option of the Secretary, suspension of such agreement for such period of time as the Secretary determines to be appropriate, upon reasonable notice to the hospital and to the public.

Civil Monetary Penalties. - In addition to the other grounds for imposition of a civil money penalty under section 1128A(a), a participating hospital that knowingly violates a requirement of this section and the responsible physician in the hospital with respect to such a violation are each subject, under that section, to a civil money penalty of not more than $25,000 for each such violation. As used in the previous sentence, the term "responsible physician" means, with respect to a hospital's, a physician who-

is employed by, or under contract with, the participating hospital, and

acting as such an employee or under such a contract, has professional responsibility for the provision of examinations or treatments for the individual, or transfers of the individual, with respect to which the violation occurred.

Civil Enforcement-

Personal Harm.- Any individual who suffers personal harm as a direct result of a participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for personal injury under the law of the State in which the hospital is located, and such equitable relief as appropriate.

Financial Loss To Other Medical Facility.- Any medical facility that suffers a financial loss as a direct result of participating hospital's violation of a requirement of this section may, in a civil action against the participating hospital, obtain those damages available for financial loss, under the law of the State in which the hospital is located, and such equitable relief as is appropriate.

Limitations On Actions.- No action may be brought under this paragraph more than two years after the date of the violation with respect to which the action is brought.

Definitions.- In this section:

The term `emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part.

The term `participating hospital' means hospital that has entered into a provider agreement under section 1866 and has, under the agreement, obligated itself to comply with the requirements of this section.

(A) The term `to stabilize' means, with respect to an emergency medical condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from the transfer of the individual from a facility.

The term `stabilized' means with respect to an emergency medical condition, that no material deterioration of the condition is likely, within reasonable medical probability, to result from the transfer of the individual from a facility.

The term `transfer' means the movement (including the discharge) of a patient outside a hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the hospital, but does not include such movement of a patient who (A) has been declared dead, or (B) leaves the facility without the permission of any such person.

Preemption.- The provisions of this section do not preempt any State or local law requirement, except to the extent that the requirement directly conflicts with a requirement of this section.

Effective Date.- The amendments made by this section shall take effect on the first day of the first month that begins at least 90 days after the date of the enactment of this Act.

Report.- The Secretary of Health and Human Services shall, not later than 6 months after the effective date described in subsection (c), report to Congress on the methods to be used for monitoring and enforcing compliance with section 1867 of the Social Security Act.

Sec. 9122. Requirement For Medicare Hospitals for Participate In Champus and Champva Programs.

In General.- Section 1866(a)(1) of the Social Security Act (42 U.S.C. 1395cc(a)(1) is amended-

by striking out "and" at the end of subparagraph (H),

by striking out the period at the end of subparagraph (I) and inserting in lieu thereof", and", and

by inserting after subparagraph (I) the following new subparagraph:

in the case of hospitals which provide inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care under any health plan contracted for under section 1079 or 1086 of title 10, or under section 613 of title 38, United States Code, in accordance with admission practices, payment methodology, and amounts as prescribed under joint regulations issued by the Secretary and by the Secretaries of Defense and Transportation, in implementation of sections 1079 and 1086 of title 10, United States Code."

Effective Date.- The amendments made by subsection (a) shall apply to agreements entered into our renewed on or after the date of the enactment of this Act, but shall apply only to inpatient hospital services provided pursuant to admissions to hospitals occurring on or after January 1, 1987.

Reference to Study Required.- For a study of the use by Champus of the Medicare prospective payment system, see section 634 of the Department of Defense Authorization Act, 1985 (Public Law 98-525), the deadline for which is extended under section 2002 of this Act.

Report.- The Secretary of Health and Human Services shall report to Congress periodically on the number of hospitals that have terminated or failed to renew an agreement under section 1866 of the Social Security Act as a result of the additional conditions imposed under the amendments made by subsection(a).

APPENDIX 8 – DEATHS - PRONOUNCEMENTS/REPORTING/MOVING BODIES/PENALTIES FOR VIOLATIONS

When to resuscitate

The statute in no way attempts to define when resuscitation should be initiated or withheld. This always has been and still is a medical and not a legal decision. The American Heart Association has established guidelines on decision-making and CPR, and the National Registry of Emergency Medical Technicians recognizes these as acceptable standards. They are as follows:

Few reliable criteria exist by which death can be defined immediately.

Decapitation, rigor mortis, and evidence of tissue decomposition and dependent lividity are reliable criteria. In the absence of such findings, CPR generally should be initiated immediately unless there is an acceptable reason to withhold it. If the decision not to initiate CPR is made by medical professional functioning in his professional capacity, the basis of the decision should not be arbitrary. The reason to withhold CPR should be sufficiently firm so that, should it later be subject to question, a decision can be effectively supported. Contact Medical Control in any questionable decision.

Laws As They Relate To Emergency Medical Services

The source of the laws which pertain to death is the Medical Examiners Act of 1986 and its revisions. For the purpose of this appendix only the portions of the laws that directly effect EMS will be quoted.

It should be pointed out that in any case and under any circumstances, if it is felt by EMS personnel that the patient is resuscitable, neither the Medical Examiner nor Law Enforcement personnel can force the withholding of treatment.

APPENDIX 9 – GLOSSARY REPEALED Effective 07/01/2022

Consolidated Trauma Activation Criteria and Destination Guidelines

APPENDIX 10 – MISSISSIPPI GUIDELINES FOR FIELD TRIAGE OF INJURED PATIENTS

1

Measure vital signs and level of consciousness.

Glascow Coma Scale	≤13
Systolic blood pressure	(mmHg) <90 mmHg
Respiratory Rate	<10 or > 29 Breaths per minute or ventilatory support (<20 in infant aged <1 year.)

YES → **Transport to a LEVEL I, II, or III Trauma Center as appropriate for injuries.**

The following indicators warrant transport to the closest hospital:
- **Cardiac Arrest**
- **Unsecured/non-patent airway**
- **EMS Provider safety**

YES → **Consider use of air transport based on patient condition, weather, and availability of aircraft.**
PEDIATRICS: Transport to a TERTIARY or SECONDARY Pediatric Trauma Center as appropriate for injuries.

(Steps 1 and 2 attempt to identify the most seriously injured patients. These patients should be transported preferentially to the highest level of care within the defined trauma system.)

NOTIFY RECEIVING FACILITY AS EARLY AS POSSIBLE.

NO → **Assess anatomy of injury**

2

All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee.
Chest wall instability or deformity (e.g. flail chest)
Two or more proximal long-bone fractures
Crushed, degloved, mangled or pulseless extremity
Amputation proximal to wrist or ankle
Pelvic Fractures
Open or depressed skull fracture
Paralysis (Secondary to Trauma)

NO → **Assess mechanism of injury and evidence of high-energy impact**

3

Falls
- -Adults: >20 feet (one story = 10 feet)
- -Children: >10 feet or two or three times the height of the child.

High Risk Auto Crash
- -Intrusion (*interior*), including roof: >12 inches occupant site; >18 inches any site.
- -Ejection (partial or complete) from automobile
- -Death in same passenger compartment
- -Vehicle telemetry data consistent with high risk injury

Auto vs. Pedestrian/bicyclist thrown, run over, or w/significant (>20 mph) impact
Motorcycle crash >20 mph

YES → Transport to a LEVEL I, II, III, or IV Designated Trauma Center as appropriate for injuries, which need not be the highest level trauma center.

PEDIATRICS: Transport to a TERTIARY or SECONDARY Pediatric Trauma Center as appropriate for injuries.

NOTIFY RECEIVING FACILITY AS EARLY AS POSSIBLE.

NO → **Assess special patient or system considerations**

4

Older Adults
- -Risk of injury/death increases after 55 years
- -SPB <110 may represent shock after age 65
- -Low impact mechanisms (e.g. ground level falls) may result in severe injury.

Children are defined as < 16 years
Anticoagulants and bleeding disorders
- -Patients with head injury are at high risk for rapid deterioration.

Burns
- -With trauma mechanism: triage to trauma center.

Pregnancy >20 weeks
EMS Provider Judgement

YES → Transport to a trauma center or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control.

NO → **Transport according to protocol.**

CONTACT MEDICAL CONTROL.
If there is any question concerning appropriate patient destination, or if requested by the patient or other person to deviate from protocol

Chapter 11 AUTOMATED EXTERNAL DEFIBRILLATOR GRANT PROGRAM

Subchapter 1 Eligibility

Rule 11.1.1 Only Department of Education approved public and charter schools may apply for the Automated External Defibrillator (AED) Grant Program.

SOURCE: Miss. Code Ann. §41-60-34

Subchapter 2 Application Process

Rule 11.2.1 Applicants may access the application for the AED Grant Program online via the Department website or by contacting the Bureau of EMS. Applications must be submitted prior to December 15th by 5 p.m. Applications received after this date will not be processed as part of the current fiscal year.

SOURCE: Miss. Code Ann. §41-60-34

Rule 11.2.2 Applications must be signed by the superintendent, principal, or headmaster

SOURCE: Miss. Code Ann. §41-60-34

Subchapter 3 Eligible Uses of Grant Funds

Rule 11.3.1 AED Program Grant funds must be deposited into the school treasury account. Items purchased with grant funds must be purchased in the name of the school. The school must follow state procurement law and policies for the purchasing, inventory, and disposal of AEDs. A sticker which states "this equipment purchased by the citizens of the State of Mississippi" shall identify AEDs purchased with grant funds.

SOURCE: Miss. Code Ann. §41-60-34

Subchapter 4 Reports and Audits

Rule 11.4.1 Funds must be expended by the end of the state fiscal year in which the funds are disbursed. A detailed justification for all grant expenditures must be submitted to the Bureau of EMS by December 15th by 5 p.m. of the following fiscal year.

SOURCE: Miss. Code Ann. §41-60-34

Rule 11.4.2 AED Grant Program awards will be audited according to Department policies and procedures to ensure grantee compliance and confirm eligibility for future program awards.

SOURCE: Miss. Code Ann. §41-60-34

Subchapter 5 Appeal Process

Rule 11.5.1 Any school district whose application for AED Grant Program funding has been rejected shall have the right to appeal such decision, within thirty (30) days after receipt of said decision, to the Bureau of EMS, who may refer the matter to a hearing officer, and/or make a final recommendation to the State Health Officer.

SOURCE: Miss. Code Ann. §41-60-34