MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH SERVICES AND LICENSURE
APPLICATION FOR STEMI CENTER REVIEW AND DESIGNATION

SECTION A

In accordance with the requirements of the Chapter 190 RSMo and the applicable regulations, this application is hereby submitted for review and designation as a STEMI center. Please complete all information applicable to the requested designation level.

Designation Level Requested ☐ I ☐ II ☐ III ☐ IV

HOSPITAL INFORMATION

Name Of Hospital (Name To Appear On Designation Certificate) | Telephone Number

Address (Street And Number) | City | Zip

PROFESSIONAL INFORMATION

Chief Executive Officer	Chairman/President of Board of Trustees
STEMI Medical Director	STEMI Program Manager
Medical Director of Emergency Medicine	Medical Director of Intensive Care/Cardiac Care Unit

RESOURCE INFORMATION

STEMI Caseload	STEMI Team Activations	Cardiac Cath Lab Team Activations for STEMI	CT Capability ☐ FULL ☐ PARTIAL ☐ NONE
MRI Capability ☐ FULL ☐ PARTIAL ☐ NONE	Cardiothoracic Surgery Capability or Plan	ICU/CCU Beds	Cath Lab Suites
Cardiac Rehab ☐ Phase I ☐ Plan for Rehab	Cardiologists	Interventional Cardiologists	Cardiothoracic Surgeons
ED Physicians	Anesthesiologists/CRNAs & AAs	Avg Elective PCI/Primary PCIs over the last 3 years (not required for initial review)	Average STEMI cases lytics eligible/STEMI cases that receive lytics in the past 3 years (not required for initial review)

CERTIFICATION

We, the undersigned, hereby certify that the information provided in this application for STEMI center review and designation is true and accurate; and give assurance of the intent and ability of the hospital to comply with regulations promulgated under Chapter 190 RSMo.

We further certify that the hospital will comply with all recommendations for improvement contained in the STEMI center site review reports prepared by the Missouri Department of Health and Senior Services.

Date of application_____

Signed_____
Chairman/President of Board of Trustees, Owner, or one Partner of Partnership

Signed_____
Hospital Chief Executive Officer

Signed_____
STEMI Medical Director

Signed_____
Director of Emergency Medicine

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MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE
APPLICATION FOR STEMI CENTER REVIEW AND DESIGNATION

SECTION B:

Please attach the following documentation to the application form.

Name of Hospital:

- ☐ Hospital organizational chart depicting the relationship of the STEMI services to other services and defining the organizational structure of the STEMI service.
- ☐ Job descriptions and CV for the STEMI medical director and STEMI coordinator/program manager.
- ☐ A narrative description of the administrative commitment for the STEMI center, including how STEMI center designation relates to the overall mission of the hospital.
- ☐ A current board resolution supporting the STEMI center.
- ☐ A narrative description of the catchment area for the STEMI center.
- ☐ A narrative description of the prehospital system including the hospital's participation in medical control, quality assurance, and education of the emergency medicine personnel.
- ☐ Hospital diversion policy.
- ☐ List of the STEMI medical director and STEMI program coordinator or program manager (core STEMI team) indicating the cardiac related continuing education for each over the past three (3) years. (Do not send continuing education information about the clinical STEMI team. This should be available at the time of the review.)
- ☐ Multidisciplinary team policy.
- ☐ List of all cardiologists, cardiothoracic surgeons, interventional cardiologists and emergency department physicians indicating cardiac-related CME for each over the past three (3) years.
- ☐ List of mentors, if applicable, their relationship to the hospital and the mentor plan.
- ☐ Narrative description of the system for notifying/activating STEMI team
- ☐ Cardiac catheterization lab team activation protocol.
- ☐ One-call cardiac catheterization lab activation by EMS protocol and/or by ED protocol.
- ☐ Copies of all transfer agreements pertaining to STEMI.
- ☐ Policy for cardiac rehabilitation.
- ☐ Protocols on post-discharge and post-transfer follow-up for STEMI patients.
- ☐ A narrative description of the STEMI quality improvement (QI) processes utilized by the hospital (Do not send copies of QI minutes or documents. These should be available at the time of review.)
- ☐ Examples of STEMI-related educational, outreach, and research projects undertaken by the hospital.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE
APPLICATION FOR ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) CERTIFIED HOSPITAL DESIGNATION

SECTION A

In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a STEMI center. Please complete all information.	Organization's STEMI Identification Number

Current STEMI Certification Organization and Level

LEVEL I	LEVEL II	LEVEL III
☐ Joint Commission, Comprehensive Cardiac Center	☐ American Heart Association, Mission Lifeline Percutaneous Coronary Intervention (PCI)/ STEMI Receiving Center	☐ American Heart Association, Mission Lifeline Non/PCI STEMI Referral Center
	☐ American College of Cardiology, Chest Pain with PCI Center	☐ Joint Commission, Chest Pain Center
	☐ American College of Cardiology, Chest Pain with PCI and Resuscitation Center	☐ Joint Commission, Primary Acute Myocardial Infarction (AMI) Center
	☐ Joint Commission, Primary Heart Attack Center	☐ American College of Cardiology, Chest Pain Center
		☐ Joint Commission, Acute Heart Attack Ready Center

HOSPITAL INFORMATION

Name of Hospital (Name to Appear on Designation Certificate)		Telephone Number
Address (Street and Number)	City	Zip Code

PROFESSIONAL INFORMATION

Chief Executive Officer	Chairman/President of Board of Trustees
STEMI Medical Director (Name, email, and contact phone number)	STEMI Program Manager (Name, email, and contact phone number)

Section B

The following should be submitted to the department as indicated:

☐ Proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology with the expiration date of the certification.

CERTIFICATION

We, the undersigned, hereby certify that:
A. Within thirty (30) days of any changes or receipt of a certificate or verification, we will submit to the department proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology.
B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of the STEMI center.
C. Within thirty (30) days that our hospital is no longer certified or verified with the Joint Commission, the American Heart Association or the American College of Cardiology, whether because we voluntarily surrendered our certification or verification or because our certification or verification has been suspended or revoked by the Joint Commission, the American Heart Association or American College of Cardiology or expired, we will report this change in writing to the department.
D. We will participate in local and regional emergency medical services sytems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes.
E. We understand that our designation as a STEMI center by the department shall continue only if our hospital remains certified as a STEMI center by the Joint Commission, the American Heart Association or the American College of Cardiology.

Date of application _____

Signed_____
Chairman/President of Board of Trustees, Owner, or one Partner of Partnership

Signed _____
Hospital Chief Executive Officer

Signed_____
STEMI Medical Director

Signed _____
Director of Emergency Medicine

*AUTHORITY: sections 190.185 and 192.006, RSMo 2016, and section 190.241, RSMo Supp. 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Feb. 2, 2018, effective Feb. 12, 2018, expired Aug. 10, 2018. Amended: Filed Feb. 2, 2018, effective Aug. 30, 2018. Emergency amendment filed Aug. 28, 2019, effective Sept. 12, 2019, expired March 9, 2020. Amended: Filed Aug. 28, 2019, effective March 30, 2020.** Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022, effective June 30, 2023.*

**Original authority: 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002; 190.241, RSMo 1987, amended 1998, 2008, 2016, 2017, 2022; and 192.006, RSMo 1993, amended 1995.*

***Pursuant to Executive Order 21-07, 19 CSR 30-40.750, subsections (2)(A) and (2)(B) and section (3) was suspended from April 2, 2020 through May 1, 2021. Pursuant to Executive Order 21-09, 19 CSR 30-40.750, paragraph (2)(D)2. and subsections (2)(F) and (2)(G) was suspended from April 2, 2020 through December 31, 2021.*

19 CSR 30-40.760 Standards for ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation

PURPOSE. This rule establishes standards for level I, II, III, and IV STEMI center designation.

AGENCY NOTE:
I-R, II-R, III-R, or IV-R after a standard indicates a requirement for level I, II, III, or IV STEMI centers respectively.
I-IH, II-IH, III-IH, or IV-IH after a standard indicates an in-house requirement for level I, II, III, or IV STEMI centers respectively.
I-IA, II-IA, III-IA, or IV-IA indicates an immediately available requirement for level I, II, III, or IV STEMI centers respectively.
I-PA, II-PA, III-PA, or IV-PA indicates a promptly available requirement for level I, II, III, or IV STEMI centers respectively.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) General Standards for STEMI Center Designation.

(A) The STEMI center board of directors, administration, medical staff, and nursing staff shall demonstrate a commitment to quality STEMI care. Methods of demonstrating the commitment shall include but not be limited to a board resolution that the hospital governing body agrees to establish policy and procedures for the maintenance of services essential for a STEMI center; assure that all STEMI patients will receive medical care at the level of the hospital's designation; commit the institution's financial, human, and physical resources as needed for the STEMI program; and establish a priority admission for the STEMI patient to the full services of the institution. (I-R, II-R, III-R, IV-R)

(B) STEMI centers shall agree to accept all STEMI patients appropriate for the level of care provided at the hospital, regardless of race, sex, creed, or ability to pay. (I-R, II-R, III-R, IV-R)

(C) The STEMI center shall demonstrate evidence of a STEMI program. The STEMI program shall be available twenty-four (24) hours a day, seven (7) days a week to treat and evaluate STEMI patients. (I-R, II-R, III-R, IV-R)

1. The STEMI center shall maintain a STEMI team that at a minimum consists of –

A. A core team which provides administrative oversight and includes the following.

(I) A physician experienced in diagnosing and treating cardiovascular disease and STEMI (usually the STEMI medical director); and (I-R, II-R, III-R, IV-R)

(II) At least one (1) other health care professional or qualified individual credentialed in STEMI care (usually the STEMI program manager/coordinator); (I-R, II-R, III-R, IV-R)

B. A STEMI call roster that provides twenty-four (24) hours a day, seven (7) days a week cardiology service coverage. The call roster identifies the physicians or qualified individuals on the schedule that are available to manage and coordinate emergent, urgent, and routine assessment, diagnosis, and treatment of the STEMI patients. A level I and level II STEMI call roster shall include, but not be limited to, the emergency department physician, interventional cardiologist, and others as appropriate. The level III STEMI center call roster shall include but not be limited to the emergency department physician and others as appropriate. A level IV STEMI center call roster shall include but not be limited to the emergency department physician and other qualified individuals as appropriate. (I-R, II-R, III-R, IV-R)

(I) Level I and II STEMI centers shall have this coverage promptly available from notification of STEMI patients. (I-R, II-R)

(II) Level III and IV STEMI centers shall have a regional networking agreement with a level I or level II STEMI center for telephone consult or telemedicine consultation promptly available from notification of STEMI patients; and (I-R, II-R, III-R, IV-R)

C. A clinical team appropriate to the center level designation that may include but not be limited to cardiologists, interventional cardiologists, clinical perfusionists, members of the STEMI call roster, members of the cardiac catheterization team, cardiothoracic surgeons, anesthesiologists, emergency department physicians, intensivists, and other STEMI center clinical staff as applicable. (I-R, II-R, III-R, IV-R)

2. The STEMI center shall have a peer review system to review STEMI cases respective of the STEMI center's designation. (I-R, II-R, III-R, IV-R)

3. The STEMI team shall have appropriate experience to maintain skill and proficiency to care for STEMI patients. The STEMI center shall maintain evidence that it meets the following requirements by documenting the following:

A. A list of all STEMI team members; (I-R, II-R, III-R, IV-R)

B. Position qualifications and completion of continuing education requirements by STEMI team members as set forth in sections (1), (2), and (4) of this rule; (I-R, II-R, III-R, IV-R)

C. Management of sufficient numbers of STEMI patients by the STEMI team members in order to maintain their STEMI skills; (I-R, II-R, III-R, IV-R.

D. Participation by the core team and members of the STEMI call roster in at least half of the regular, ongoing STEMI program peer review system meetings as shown in meeting attendance documents. The STEMI medical director shall disseminate the information and findings from the peer review system meetings to the STEMI call roster members and the core team and document such dissemination; (I-R, II-R, III-R, IV-R)

E. Participation by STEMI team members in at least half of the regular ongoing STEMI program performance improvement and patient safety meetings and documentation of such attendance in the meeting minutes and/or meeting attendance documents. The STEMI medical director shall

disseminate the information and findings from the performance improvement and patient safety meetings to the STEMI team members and document such dissemination. If a STEMI team member is unable to attend a STEMI program performance improvement and patient safety meeting, then the STEMI team member shall send an appropriate representative in his/her place; (I-R, II-R, III-R, IV-R)

F. Maintenance of skill levels in the management of STEMI patients by the STEMI team members as required by the STEMI center and the STEMI medical director and documentation of such continued experience; and (I-R, II-R, III-R, IV-R)

G. Review of regional outcome data on the quality of patient care by STEMI team members as part of the STEMI center's performance improvement and patient safety process. (I-R, II-R, III-R, IV-R)

4. The STEMI center shall maintain a multidisciplinary team, in addition to the STEMI team, to support the care of STEMI patients. (I-R, II-R, III-R, IV-R)

A. The multidisciplinary team shall include a suitable representative from hospital units as appropriate for care of each STEMI patient. The units represented on the multidisciplinary team may include but not be limited to: administration, emergency medical services, intensive care unit, cardiac catheterization lab, pharmacy, laboratory, intermediate care unit, cardiac rehabilitation, and discharge planning. (I-R, II-R, III-R, IV-R)

B. The multidisciplinary team members or their representatives shall attend at least half of the STEMI program performance improvement and patient safety meetings which shall be documented in meeting minutes and/or meeting attendance documents. (I-R, II-R, III-R, IV-R)

(D) The STEMI center shall provide the services of a cardiac catheterization laboratory staffed twenty-four (24) hours a day, seven (7) days a week. The staff of the cardiac catheterization laboratory, referred to as the cardiac catheterization laboratory team, shall consist of at least the following:

1. An interventional cardiologist. The STEMI center credentialing committee shall document that the interventional cardiologist has completed appropriate training and conducted sufficient coronary interventional procedures. In addition, the interventional cardiologist shall annually conduct a sufficient number of percutaneous coronary interventions (PCIs). It is recommended that interventional cardiologist(s) perform seventy-five (75) or more elective percutaneous coronary interventions per interventional cardiologist per year and eleven (11) or more primary percutaneous coronary interventions per interventional cardiologist per year; and (I-R/PA, II-R/PA)

2. Other healthcare professionals as deemed necessary. (I-R/PA, II-R/PA)

(E) A level I STEMI center shall meet the following criteria:

1. It is recommended that the cardiac catheterization laboratory perform –

A. At least an average of four hundred (400) or more elective percutaneous coronary interventions per year over three (3) consecutive preceding years per STEMI center; and

B. At least an average of forty-nine (49) or more primary percutaneous coronary interventions per year over three (3) consecutive preceding years per STEMI center; and

2. On-site emergency cardiothoracic surgical services as needed twenty-four (24) hours a day, seven (7) days a week. (I-R/PA)

(F) A level II STEMI center shall meet one (1) of the two (2) options outlined below to qualify for a level II STEMI center designation –

1. Option one –

A. It is recommended that the cardiac catheterization laboratory perform –

(I) An average of two hundred (200) or more elective percutaneous coronary interventions per year over three (3) consecutive preceding years per STEMI center; and

(II) An average of thirty-six (36) or more primary percutaneous coronary interventions per year over three (3) consecutive preceding years per STEMI center; and

B. On-site emergency cardiothoracic surgical services or have a written plan that has been shown to be effective, a transfer agreement, and expedited transfer process for cardiothoracic surgery back-up in a nearby STEMI center with appropriate hemodynamic support capability for transfer. The written plan shall ensure that once a potential need for cardiothoracic intervention is identified, the STEMI patient can be evaluated by cardiothoracic surgery and in the operating room (OR) of the receiving hospital as expeditiously as possible; or (II-R)

2. Option two is a level II STEMI center that performs less than a recommended average of two hundred (200) elective percutaneous coronary interventions per year and a recommended average of thirty-six (36) or more primary percutaneous coronary interventions per year over three (3) consecutive preceding years or a recommended average of two hundred (200) elective percutaneous coronary interventions per year or more and less than a recommended average of thirty-six (36) primary percutaneous coronary interventions per year over three (3) consecutive preceding years. The following requirements for option two shall be met to qualify for a level II center designation:

A. If a STEMI center performs less than an annual recommended average of thirty-six (36) primary percutaneous coronary interventions over three (3) consecutive preceding years, it is recommended that the STEMI center perform an annual average of two hundred (200) or more elective percutaneous coronary interventions over three (3) consecutive preceding years, and it is recommended that all operators shall perform seventy-five (75) or more elective percutaneous coronary interventions and eleven (11) or more primary percutaneous coronary interventions per year. If an operator does not perform a recommended eleven (11) or more primary percutaneous coronary interventions per year, he or she shall have a mentoring relationship defined by written agreement with a highly experienced operator. This mentor may be a member of the same institution or belong to another institution. This relationship, established by a written agreement, may include but not be limited to on-site supervision and observation of performance during primary and elective percutaneous coronary interventions per year, review of mentee's patient encounters, review of mentee's outcomes, evaluation of mentee and hospital's process pertaining to elective and primary percutaneous coronary interventions, and guidance on methods to improve process, performance, and outcomes; or

B. If a STEMI center performs less than an annual recommended average of two hundred (200) elective percutaneous coronary interventions over three (3) consecutive preceding years, it is recommended that the STEMI center perform an annual average of thirty-six (36) primary percutaneous coronary interventions over three (3) consecutive preceding years, and it is recommended that all operators perform seventy-five (75) or more elective percutaneous coronary interventions and eleven (11) or more

primary percutaneous coronary interventions per year or have a mentoring relationship defined by a written agreement with a highly experienced operator. This mentor may be a member of the same institution or belong to another institution. This relationship, established by a written agreement, may include but not be limited to on-site supervision and observation of performance during primary and elective percutaneous coronary interventions, review of mentee's patient encounters, review of mentee's outcomes, evaluation of mentee and hospital's process pertaining to elective and primary percutaneous coronary interventions, and guidance on methods to improve process, performance, and outcomes; and

C. Be able to provide on-site emergency cardiothoracic surgical services or have a written plan that has been shown to be effective, a transfer agreement, and expedited transfer process for cardiothoracic surgery back-up in a nearby STEMI center with appropriate hemodynamic support capability for transfer. The written plan shall ensure that once a potential need for cardiothoracic intervention is identified, the STEMI patient can be evaluated by cardiothoracic surgery and in the operating room of the receiving hospital as expeditiously as possible; and (II-R)

D. Provide cardiac intensive care capability; and (II-R)

E. Provide evidence of a written plan shown to be effective, a transfer agreement, and expedited transfer process for STEMI patients to higher level care in a nearby STEMI center with appropriate hemodynamic support capability for transfer; and (II-R)

F. The STEMI center shall collect, document, maintain for at least five (5) years, and make available for review by the department the following:

(I) The STEMI center's average time from the STEMI center door to percutaneous coronary interventions device inflation time (i.e., door-to-balloon (D2B) times) is no more than ninety (90) minutes at least seventy-five percent (75%) of the time; and (II-R)

(II) The STEMI center tracks and compares the time from the first medical contact to balloon times; and (II-R)

G. The STEMI center shall document that it collects and trends its past and current risk-adjusted outcome and process measures. (II-R)

(G) The STEMI center shall appoint a physician to serve as the STEMI medical director with appropriate qualifications, experience, and training. A STEMI medical director shall be appointed at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. Level I and II STEMI center medical directors shall be cardiologists or interventional cardiologists. It is recommended that the cardiologist or interventional cardiologist be board-certified or board-admissible in interventional cardiology or cardiology. (I-R, II-R)

2. Level III and IV STEMI center medical directors shall be physicians. A board-certified or board-admissible physician is recommended. (III-R, IV-R)

3. The STEMI center shall have a job description and organization chart depicting the relationship between the STEMI medical director and other services. (I-R, II-R, III-R, IV-R)

4. Level I and II STEMI medical directors are recommended to be members of the catheterization lab team call roster. (I-R, II-R)

5. The STEMI medical director shall meet the continuing medical education (CME) requirements as described in section (4) of this rule. (I-R)

6. The STEMI medical director shall be responsible for oversight of the education and training of the medical and clinical staff in STEMI care. This includes a review of the appropriateness of the education and training for the practitioner's level of responsibility. (I-R, II-R, III-R, IV-R)

7. Level I STEMI medical directors shall participate in the STEMI center's research and publication projects. (I-R)

(H) The STEMI center shall have a STEMI program coordinator/manager who is a registered nurse, other clinical staff, or qualified individual. The STEMI center shall have a STEMI program coordinator/manager at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. The STEMI center shall have a job description and organization chart depicting the relationship between the STEMI program coordinator/manager and other services. (I-R, II-R, III-R, IV-R)

2. The STEMI coordinator/manager shall meet continuing education requirements as described in section (4) of this rule. (I-R)

3. The STEMI program coordinator/manager shall participate in the formal STEMI center performance improvement and patient safety program. (I-R, II-R, III-R, IV-R)

(I) The STEMI center shall document a plan for and utilization of a specific and well-organized system as appropriate to center level designation for the emergency department to rapidly notify and activate the STEMI team or STEMI/cardiac catheterization lab team at the time the emergency department identifies STEMI on electrocardiogram (ECG) or verifies emergency medical services (EMS) STEMI electrocardiogram identification. (I-R, II-R, III-R, IV-R)

(J) The STEMI center shall have a protocol detailing a one-(1-) call cardiac catheterization lab activation by emergency medical services at the time emergency medical services identifies a STEMI patient and as appropriate to the hospital's process. (I-R, II-R)

(K) The STEMI center shall have a one- (1-) call STEMI team activation protocol or a STEMI/cardiac catheterization lab team activation protocol as appropriate for center level designation that establishes the following:

1. The criteria used to triage STEMI patients; (I-R, II-R, III-R, IV-R)

2. The person authorized to notify STEMI team or STEMI team/cardiac catheterization lab team members when a suspected STEMI patient is in route or when a suspected STEMI patient has arrived at the STEMI center; and (I-R, II-R, III-R, IV-R)

3. The method for immediate notification and the response requirements for STEMI team or STEMI/cardiac catheterization lab team members when a suspected STEMI patient is in route to the STEMI center. (I-R, II-R, III-R, IV-R).

(L) All members of the STEMI team or STEMI/cardiac catheterization lab team call roster shall comply with the availability and response requirements. If not on STEMI center premises, then STEMI/cardiac catheterization lab team members who are on call shall carry electronic communication devices at all times to permit contact by the STEMI center and shall be promptly available. (I-R, II-R, III-R, IV-R)

(M) The STEMI centers shall have a fibrinolysis protocol for instances when percutaneous coronary intervention is not achievable within an appropriate designated time frame and for when fibrinolysis is achievable within an appropriate designated time frame. It is recommended that the designated time frame follow nationally acceptable standards, for example as set forth in Appendix A numbe. eight (8) entitled "Time to Fibrinolytic Therapy" included in the article entitled "ACC/AHA Clinical Performance Measures for Adults with ST-Elevation and Non-ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology/American Heart Association

Task Force on Performance Measures (Writing Committee to Develop Performance Measures on ST-Elevation and Non-ST-Elevation Myocardial Infarction)" as published by the Journal of the American College of Cardiology in 2006, volume 47, pages 236–265 which is incorporated by reference in this rule and is available at the Journal of the American College of Cardiology, Reprint Department Elsevier Inc., 360 Park Avenue South, New York, NY 10010-1710 or on the Journal of the American College of Cardiology website at http://content.onlineJACC.org. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R, IV-R)

(N) STEMI centers shall have transfer agreements between referring and receiving facilities. (II-R, III-R, IV-R)

1. The STEMI center shall have a one- (1-) call transfer protocol to a level I or level II designated STEMI center that establishes the criteria used to triage STEMI patients and identifies the persons authorized to notify the designated STEMI center. (II-R, III-R, IV-R)

2. The STEMI center shall have a rapid transfer process in place to transport a STEMI patient to a higher level of STEMI care when needed. (II-R, III-R, IV-R)

(O) STEMI centers shall have cardiac rehabilitation services directed by a physician experienced in cardiac rehabilitation. (I-R, II-R)

(P) The STEMI centers shall demonstrate that there is a plan for adequate post-discharge and post-transfer follow-up on STEMI patients, including cardiac rehabilitation and repatriation if indicated. (I-R, II-R, III-R, IV-R)

(Q) The STEMI center shall maintain a STEMI patient log, keep this log for a period of five (5) years, and make this log readily retrievable during a review by the department. This patient log shall include all STEMI patients and shall contain the following information:

1. Response times; (I-R, II-R, III-R, IV-R)
2. Patient diagnosis; (I-R, II-R, III-R, IV-R)
3. Treatment/actions; (I-R, II-R, III-R, IV-R)
4. Outcomes; (I-R, II-R, III-R, IV-R)
5. Number of patients; and (I-R, II-R, III-R, IV-R)
6. Benchmark indicators. (I-R, II-R, III-R, IV-R)

(R) The STEMI center shall have a helicopter landing area. (I-R, II-R, III-R, IV-R)

(S) STEMI centers shall enter data into a STEMI registry as follows:

1. STEMI centers shall submit data into the department's Missouri STEMI registry on each STEMI patient who is admitted to the STEMI center, transferred out of the STEMI center, or dies as a result of the STEMI (independent of hospital admission or hospital transfer status). The data required to be submitted into the Missouri STEMI registry by the STEMI centers is listed and explained in the document entitled "Time Critical Diagnosis ST-Segment Elevation Myocardial Infarction (STEMI) Center Registry Data Elements," dated March 1, 2012, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at www.health.mo.gov. This rule does not incorporate any subsequent amendments or additions. The data shall be submitted electronically into the Missouri STEMI registry via the department's website at www.health.mo.gov; or (I-R, II-R, III-R, IV-R)

2. STEMI centers shall submit data into a national data registry or data bank capable of being used by the STEMI center to perform its ongoing performance improvement and patient safety program requirements for its STEMI patients. STEMI centers shall submit data for each data element included in the national data registry or data bank's data system; (I-R, II-R, III-R, IV-R)

3. This data required in paragraphs (1)(S)1. and 2. above shall be submitted electronically into the STEMI registry on at least a quarterly basis for that calendar year. STEMI centers have ninety (90) days after the quarter ends to submit the data electronically into the STEMI registry; (I-R, II-R, III-R, IV-R)

4. The data submitted by the STEMI centers shall be complete and current; and (I-R, II-R, III-R, IV-R)

5. The data submitted by the STEMI centers shall be managed in compliance with the confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R, IV-R)

(T) A STEMI center shall maintain a diversion protocol for the STEMI center that is designed to allow best resource management within a given area. The STEMI center shall create criteria for diversion in this diversion protocol and shall detail a performance improvement and patient safety process in the diversion protocol to review and validate the criteria for diversion created by the STEMI center. The STEMI center shall also collect, document, and maintain diversion information that includes at least the date, length of time, and reason for diversion. This diversion information shall be readily retrievable by the STEMI center during a review by the department and shall be kept by the STEMI center for a period of five (5) years. (I-R, II-R, III-R, IV-R)

(2) Medical Staffing Standards for STEMI Center Designation.

(A) There shall be a delineation of privileges for the cardiologists, cardiothoracic surgeons, and interventional cardiologists made by the medical staff credentialing committee in each STEMI center. (I-R, II-R)

(B) The STEMI center shall credential and have different types of physicians available as listed below –

1. A cardiologist; (I-R/PA, II-R/PA)
2. An interventional cardiologist; (I-R/PA, II-R/PA)
3. A cardiothoracic surgeon as follows:

A. A cardiothoracic surgeon and back-up coverage shall be available for level I STEMI centers and for those level II STEMI centers which provide cardiothoracic surgery; or (I-R/PA, II-R/PA)

B. A cardiothoracic surgeon and back-up coverage arrangements with a level I STEMI center or a level II STEMI center which provides cardiothoracic surgery shall be available for those level II STEMI centers that do not provide cardiothoracic surgery to ensure that the STEMI patient is in the operating room of the receiving STEMI center as expeditiously as possible, recommended within sixty (60) minutes of the time surgery is determined needed. (II-R)

4. An emergency department physician; (I-R/IH, II-R/IH, III-R/IH, IV-R/IA)
5. An internal medicine physician; (I-R/PA, II-R/PA, III-R/PA)
6. A diagnostic radiologist; and (I-R/IA, II-R/IA, III-R/IA, IV-R/PA)
7. An anesthesiologist. (I-PA, II-PA)

A. Anesthesiology staffing requirements may be fulfilled by anesthesiology residents or certified registered nurse anesthetists (CRNA), or anesthesia assistants capable of assessing emergent situations in STEMI patients and of providing any indicated treatment including induction of anesthesia. When anesthesiology residents or CRNAs are used to fulfill availability requirements, the staff anesthesiologist on call will be advised and be promptly available and present for all operative interventions and emergency airway conditions. The CRNA may proceed with life preserving therapy while

the anesthesiologist is in route under the direction of the cardiologist/cardiovascular surgeon, including induction of anesthesia. An anesthesiologist assistant shall practice only under the direct supervision of an anesthesiologist who is physically present or immediately available as this term is defined in section 334.400, RSMo. (I-PA, II-PA)

(3) Standards for Hospital Resources and Capabilities for STEMI Center Designation.

(A) The STEMI center shall meet emergency department standards listed below.

1. The emergency department staffing shall meet the following requirements:

A. The emergency department in the STEMI center shall provide immediate and appropriate care of the STEMI patient; (I-R, II-R, III-R, IV-R)

B. A level I STEMI center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician in emergency medicine by the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada; (I-R)

C. A level II STEMI center shall have a medical director of the emergency department who shall be a board-certified or board-admissible physician; (II-R)

D. A level III and IV STEMI center shall have a medical director of the emergency department who is recommended to be a board-certified or board-admissible physician; (III-R, IV-R)

E. There shall be an emergency department physician credentialed for STEMI care covering the emergency department twenty-four (24) hours a day, seven (7) days a week; (I-R/IH, II-R/IH, III-R/IH, IV-R/IA)

F. The emergency department physician who provides coverage shall be current in continuing medical education (CME) in the area of cardiovascular disease as set forth in section (4) of this rule; (I-R)

G. There shall be a written policy defining the organizational relationship of the emergency department physicians to other physician members of the STEMI team; (I-R, II-R, III-R, IV-R)

H. Registered nurses in the emergency department shall be current in continuing education requirements as set forth in section (4) of this rule; (I-R)

I. At a minimum, all registered nurses assigned to the emergency department shall be determined to be credentialed in the care of the STEMI patient by the STEMI center within one (1) year of assignment in the emergency department, and these registered nurses shall remain current in continuing education requirements as set forth in section (4) of this rule; and (I-R, II-R, III-R, IV-R)

J. The emergency department in STEMI centers shall have written care protocols for identification, triage, and treatment of acute STEMI patients that are available to emergency department personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R, IV-R)

2. Nursing documentation for the STEMI patient shall be on a STEMI flow sheet approved by the STEMI medical director and the STEMI program manager/coordinator. (I-R, II-R, III-R, IV-R)

3. The emergency department shall have at least the following equipment for resuscitation and life support available to the unit:

A. Airway control and ventilation equipment including:

(I) Laryngoscopes; (I-R, II-R, III-R, IV-R)

(II) Endotracheal tubes; (I-R, II-R, III-R, IV-R)

(III) Bag-mask resuscitator; (I-R, II-R, III-R, IV-R)

(IV) Sources of oxygen; and (I-R, II-R, III-R, IV-R)

(V) Mechanical ventilator; (I-R, II-R, III-R)

B. Suction devices; (I-R, II-R, III-R, IV-R)

C. Electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R, IV-R)

D. Central line insertion equipment; (I-R, II-R, III-R)

E. All standard intravenous fluids and administration devices including intravenous catheters and intraosseous devices; (I-R, II-R, III-R, IV-R)

F. Drugs and supplies necessary for STEMI emergency care; (I-R, II-R, III-R, IV-R)

G. Two- (2-) way communication link with emergency medical service (EMS) vehicles; (I-R, II-R, III-R, IV-R)

H. Equipment necessary to communicate with emergency medical services regarding pre-hospital ECG STEMI findings; (I-R, II-R, III-R, IV-R)

I. End-tidal carbon dioxide monitor; (I-R, II-R, III-R, IV-R)

J. Temperature control devices for patient and resuscitation fluids; (I-R, II-R, III-R, IV-R)

K. External pacemaker; and (I-R, II-R, III-R, IV-R)

L. Transvenous pacemaker. (I-R/IA, II-R/IA, III-R/IA)

4. The STEMI center emergency department shall maintain all equipment according to the hospital preventive maintenance schedule and document when the equipment is checked. (I-R, II-R, III-R, IV-R)

(B) The STEMI center shall have a designated intensive care unit (ICU). (I-R, II-R)

1. The STEMI center intensive care unit shall ensure staffing to provide appropriate care of the STEMI patient. (I-R, II-R)

A. The STEMI center intensive care unit shall have a designated medical director who has twenty-four (24) hours a day, seven (7) days a week access to a physician knowledgeable in STEMI care who meets the STEMI call roster continuing education requirements as set forth in section four (4) of this rule. (I-R, II-R)

B. The STEMI center intensive care unit shall have a physician on duty or available twenty-four (24) hours a day, seven (7) days a week in the STEMI center who is not the emergency department physician. This physician shall have access to a physician on the STEMI call roster. (I-R, II-R)

C. The STEMI center intensive care unit shall have a one to one (1:1) or one to two (1:2) registered nurse/patient ratio used for critically ill patients requiring intensive care unit level care. (I-R, II-R)

D. Registered nurses in the STEMI center intensive care unit shall annually maintain core competencies in the care of the STEMI patient and remain current in continuing education requirements as set forth in section (4) of this rule. (I-R, II-R)

2. The STEMI center intensive care unit shall have written care protocols for identification and treatment of acute STEMI patients which are available to intensive care unit personnel, reviewed annually, and revised as needed. (I-R, II-R)

3. The STEMI center intensive care unit shall have intensive care unit beds for STEMI patients or, if space is not available in the intensive care unit, the STEMI center shall make arrangements to provide the comparable level of care until space is available in the intensive care unit. (I-R, II-R)

4. The STEMI center intensive care unit shall have equipment available for resuscitation and to provide life support for the STEMI patient. This equipment shall include at least the following:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, and a mechanical ventilator; (I-R, II-R)

B. Oxygen source with concentration controls; (I-R, II-R)
C. Cardiac emergency cart, including medications:
(I) External pacemaker; and (I-R, II-R)
(II) Transvenous pacemaker; (I-R, II-R)
D. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R)
E. Electronic pressure monitoring and pulse oximetry; (I-R, II-R)
F. End-tidal carbon dioxide monitor; (I-R, II-R)
G. Patient weighing devices; and (I-R, II-R)
H. Drugs, intravenous fluids, and supplies. (I-R, II-R)

5. The STEMI center intensive care unit shall check all equipment according to the hospital preventive maintenance schedule and document when it is checked. (I-R, II-R)

(C) The STEMI center shall have a cardiac catheterization lab. (I-R, II-R)

1. The STEMI center cardiac catheterization lab shall have angiography with interventional capability available twenty-four (24) hours a day, seven (7) days a week. (I-R/PA, II-R/PA)

2. All members of the STEMI center catheterization lab and team shall maintain core competencies annually as required by the STEMI center. (I-R, II-R)

3. Resuscitation equipment shall be readily available in the STEMI center catheterization lab. (I-R, II-R)

4. The following diagnostic equipment shall be readily available in the STEMI center cardiac catheterization lab:
A. Sheaths; (I-R, II-R)
B. Diagnostic wires; (I-R, II-R)
C. Diagnostic catheters; (I-R, II-R)
D. Manifold or contrast injector/delivery system; and (I-R, II-R)
E. Pressure tubing. (I-R, II-R)

5. The following interventional equipment shall be readily available in the STEMI center cardiac catheterization lab:
A. Sheaths; (I-R, II-R)
B. Interventional guide wires; (I-R, II-R)
C. Interventional guide catheters; (I-R, II-R)
D. Balloon catheters –
(I) Compliant; and (I-R, II-R)
(II) Non-compliant; (I-R, II-R)
E. Stents –
(I) Bare metal stents; and (I-R, II-R)
(II) Drug eluting stents; (I-R, II-R)
F. Balloon pump catheters; and (I-R, II-R)
G. Thrombectomy aspiration catheters or mechanical thrombectomy device. (I-R, II-R)

6. The following equipment shall be readily available to the STEMI center cardiac catheterization lab:
A. Balloon pump; (I-R, II-R)
B. The level I STEMI center cardiac catherization labs shall have percutaneous or surgically implanted circulatory assist devices (i.e., left ventricular assistive device (LVAD)). It is also recommended that the level II STEMI center cardiac catherization labs have left ventricular assistive devices; and (I-R)
C. Emboloic protection device. (I-R, II-R)

7. The cardiac catheterization laboratory shall maintain equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is checked. (I-R, II-R)

(D) The STEMI center shall have an intermediate care unit (e.g., step down unit). (I-R, II-R, III-R)

1. The STEMI center shall have a designated medical director for the STEMI center intermediate care unit who has access to a physician knowledgeable in STEMI care and who meets the STEMI call roster continuing medical education requirements as set forth in section (4) of this rule. (I-R, II-R, III-R)

2. The STEMI center intermediate care unit shall have a physician on duty or available twenty-four (24) hours a day, seven (7) days a week who is not the emergency department physician. This physician shall have access to a physician on the STEMI call roster. (I-R/IA, II-R/IA, III-R/IA)

3. The STEMI center intermediate care unit shall have registered nurses and other essential personnel on duty twenty-four (24) hours a day, seven (7) days a week. (I-R, II-R, III-R)

4. The STEMI center intermediate care unit registered nurses shall remain current in continuing education requirements as set forth in section (4) of this rule. (I-R)

5. The STEMI centers shall annually credential registered nurses that work in the intermediate care unit. (I-R, II-R, III-R)

6. The STEMI center intermediate care unit shall have written care protocols for identification and treatment of STEMI patients which are available to the cardiac unit personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R)

7. The STEMI center intermediate care unit shall have equipment to support the care and resuscitation of the STEMI patient that includes at least the following:
A. Airway control and ventilation equipment including:
(I) Laryngoscopes, endotracheal tubes of all sizes; (I-R, II-R, III-R)
(II) Bag-mask resuscitator and sources of oxygen; and (I-R, II-R, III-R)
(III) Suction devices; and (I-R, II-R, III-R)
B. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R)
C. All standard intravenous fluids and administration devices and intravenous catheters; (I-R, II-R, III-R)
D. Drugs and supplies necessary for emergency care. (I-R, II-R, III-R)

8. The STEMI center intermediate care unit shall maintain equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is checked. (I-R, II-R, III-R)

(E) The STEMI center shall have the following radiological and diagnostic capabilities:

1. The STEMI center radiological and diagnostic capabilities shall include a mechanism for timely interpretation to aid in the management of STEMI patients; (I-R, II-R, III-R, IV-R)

2. Resuscitation equipment shall be readily available in the radiology department; (I-R, II-R, III-R, IV-R)

3. The STEMI center radiology department shall have adequate physician and nursing personnel available with monitoring equipment to fully support the STEMI patient and provide documentation of care during the time the patient is physically present in the radiology department and during transportation to and from the radiology department; (I-R, II-R, III-R, IV-R)

4. The STEMI center radiology department shall have x-ray capability with twenty-four (24) hours a day, seven (7) days a week coverage; (I-R/IH, II-R/IH, III-R/IA, IV-R/PA)

5. The STEMI center radiology department shall have a radiological technician; (I-R/IH, II-R/IH, III-R/IA, IV-R/PA)

6. The STEMI center radiology department shall have in-house computerized tomography; (I-R, II-R)

7. The STEMI center radiology department shall have a computerized tomography technician; and (I-R/IH, II-R/IA)

8. The STEMI center shall maintain all radiology and diagnostic equipment according to the hospital's preventive maintenance schedule and document when the equipment is

checked. (I-R, II-R, III-R, IV-R)

(F) All level I STEMI centers and level II STEMI centers with cardiothoracic surgery capability shall have operating room personnel, equipment, and procedures that meet the following requirements:

1. The STEMI center operating room staff shall be available twenty-four (24) hours a day, seven (7) days a week; (I-R/PA, II-R/PA with cardiothoracic surgery capability.

2. Registered nurses in the STEMI center operating room shall maintain core competencies annually as required by the STEMI center; (I-R/PA, II-R/PA with cardiothoracic surgery capability.)

3. The STEMI center shall provide twenty-four (24) hours a day, seven (7) days a week heart team coverage. This heart team includes physicians, perfusionists, and qualified individuals on call and available to provide cardiothoracic surgery; (I-R/PA, II-R/PA with cardiothoracic surgery capability.)

4. The STEMI center operating rooms shall have at least the following equipment:

A. Thermal control equipment for patient and resuscitation fluids; (I-R/PA, II-R/PA with cardiothoracic surgery capability.)

B. X-ray capability; (I-R/PA, II-R/PA with cardiothoracic surgery capability.

C. Instruments and equipment necessary for cardiothoracic surgical services; (I-R/PA, II-R/PA with cardiothoracic surgery capability.)

D. Patient monitoring equipment; and (I-R/PA, II-R/PA with cardiothoracic surgery capability.)

E. Resuscitation equipment readily available to the operating room; and (I-R/PA, II-R/PA with cardiothoracic surgery capability)

5. The STEMI center operating room shall maintain all equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is checked. (I-R/PA, II-R/PA with cardiothoracic surgery capability)

(G) All level I STEMI centers shall meet post-anesthesia recovery room (PAR) requirements as set out below. Those level II STEMI centers with cardiothoracic surgery capability shall also have a post-anesthesia recovery room and meet the requirements as set out below. (I-R/PA, II-R/PA with cardiothoracic surgery capability)

1. The STEMI center post-anesthesia recovery rooms shall have registered nurses and other essential personnel on call and available within sixty (60) minutes twenty-four (24) hours a day, seven (7) days a week. (I-R, II-R with cardiothoracic surgery capability)

2. Registered nurses who work in the STEMI center post-anesthesia recovery room shall maintain core competencies annually as required by the STEMI center. (I-R, II-R with cardiothoracic surgery capability)

3. The STEMI center post-anesthesia recovery rooms shall have at least the following equipment for resuscitation and to provide life support for the STEMI patient:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes of all sizes, bag-mask resuscitator, sources of oxygen, and mechanical ventilator; (I-R, II-R with cardiothoracic surgery capability)

B. Suction devices; (I-R, II-R with cardiothoracic surgery capability)

C. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R with cardiothoracic surgery capability)

D. All standard intravenous fluids and administration devices, including intravenous catheters. (I-R, II-R with cardiothoracic surgery capability)

4. Drugs and supplies necessary for emergency care. (I-R/PA, II-R/PA with cardiothoracic surgery capability)

5. The STEMI center post-anesthesia recovery room shall maintain all equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is checked. (I-R, II-R with cardiothoracic surgery capability)

(H) The STEMI center shall have clinical laboratory services available twenty-four (24) hours a day, seven (7) days a week. (I-R, II-R, III-R, IV-R)

1. The STEMI center's clinical laboratory services shall have a written protocol to provide timely availability of results. (I-R, II-R, III-R, IV-R)

2. The STEMI center's clinical laboratory services shall be able to conduct standard analyses of blood, urine, and other body fluids. (I-R, II-R, III-R, IV-R)

3. The STEMI center's clinical laboratory services shall be able to conduct blood typing and cross-matching. (I-R, II-R, III-R)

4. The STEMI center's clinical laboratory services shall be able to conduct coagulation studies. (I-R, II-R, III-R, IV-R)

5. Clinical laboratory services at level I, II, and III STEMI centers shall include a comprehensive blood bank or access to a community central blood bank and adequate hospital blood storage facilities. (I-R, II-R, III-R)

6. Clinical laboratory services at level IV STEMI centers shall include a blood bank or access to a community central blood bank and adequate hospital blood storage facilities. (IV-R)

7. The STEMI center's clinical laboratory services shall be able to perform blood gases and pH determinations. (I-R, II-R, III-R, IV-R)

8. The STEMI center's clinical laboratory services shall be able to perform blood chemistries. (I-R, II-R, III-R, IV-R)

9. The STEMI center's clinical laboratory services shall have a written protocol for prioritization of the STEMI patient in comparison to other time critical patients. (I-R, II-R, III-R, IV-R)

(I) The STEMI center shall have support services to assist the STEMI patient's family from the time of entry into the facility to the time of discharge or transfer, and the support services that were provided shall be documented. (I-R, II-R, III-R, IV-R)

(J) The STEMI center shall have cardiac rehabilitation or a written network agreement for the provision of cardiac rehabilitation. (I-R, II-R, III-R)

1. Level I and level II STEMI centers shall have Phase I cardiac rehabilitation on site. (I-R, II-R)

(4) Continuing Medical Education (CME) and Continuing Education Standards for STEMI Center Designation.

(A) The STEMI center shall ensure that staff providing services to STEMI patients receive continued medical education and continuing education as set forth in section (4) of this rule and document this education for each staff member. The department shall allow up to one (1) year from the date of the STEMI center's initial STEMI center designation for STEMI center staff members to complete all of the required continuing medical education and/or continuing education requirements if the STEMI center staff documents that at least half of the required continuing medical education and continuing education hours have been completed for each STEMI center staff at the time of the on-site initial application review. The STEMI center shall submit documentation to the department within one (1) year of the initial designation date that all continued medical education and continuing education requirements for STEMI center staff members have

been met in order to maintain the STEMI center's designation. (I-R)

(B) The STEMI call roster members shall complete the following continuing education requirements:

1. Core team members of the STEMI call roster in level I STEMI centers shall document a minimum of eight (8) hours every year of continuing education in the area of acute coronary syndrome. All other members of the STEMI call roster shall document a minimum of eight (8) hours every year of continuing education in the area of cardiovascular disease, except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department. This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the practitioner's level of responsibility. (I-R)

(C) The STEMI center medical director shall complete the following continuing medical education requirements:

1. Level I STEMI medical directors shall document a minimum average of eight (8) hours every year in the area of acute coronary syndrome. (I-R)

(D) The STEMI center's STEMI program manager/coordinator shall complete the following continuing education requirements:

1. A level I STEMI program coordinator/manager shall complete and document the following:

A. A minimum average of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the STEMI program manager's/coordinator's level of responsibility; and (I-R)

B. Attend one (1) national, regional, or state meeting every two (2) years focused on cardiovascular disease. If the national, regional, or state meeting provides continuing education, that continuing education may count towards the annual requirement. (I-R)

(E) STEMI center emergency department personnel shall complete the continuing education requirements for STEMI centers that are detailed below.

1. The emergency department physician(s) shall be current in cardiovascular continuing medical education. (I-R)

A. Emergency department physicians in level I STEMI centers shall complete and document a minimum average of two (2) hours every year of continuing medical education in the area of cardiovascular disease, except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department. (I-R)

2. Registered nurses assigned to the emergency department shall complete the following requirements:

A. Registered nurses assigned to the emergency department at level I STEMI centers shall complete and document a minimum of two (2) hours of continuing education every year in the area of cardiovascular disease; and (I-R)

B. Registered nurses assigned to the emergency department at STEMI centers shall maintain core competencies in the care of the STEMI patient annually as determined by the STEMI center. Continuing education earned in training to maintain these competencies may count toward continuing education requirements. (I-R, II-R, III-R, IV-R)

(F) Registered nurses assigned to the intensive care unit who provide care to STEMI patients shall complete the following continuing education requirements:

1. Registered nurses in the intensive care unit shall complete and document a minimum of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (I-R)

(G) Registered nurses and clinical staff assigned to the cardiac catheterization lab shall complete the following continuing education requirements:

1. Registered nurses and clinical staff shall complete and document a minimum of eight (8) hours of continuing education every year in the area of acute coronary syndrome. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (I-R)

(H) Registered nurses assigned to the intermediate care unit shall complete the following continuing education requirements:

1. Intermediate care unit registered nurses in level I STEMI centers shall complete and document a minimum of eight (8) hours every year of continuing education in the area of cardiovascular disease. This continuing education shall be reviewed for appropriateness by the STEMI center medical director to the practitioner's level of responsibility. (I-R)

(5) Standards for Hospital Performance Improvement, Patient Safety, Outreach, Public Education, and Training Programs for STEMI Center Designation.

(A) The STEMI center shall maintain an ongoing performance improvement and patient safety program designed to objectively and systematically monitor, review, and evaluate the quality, timeliness, and appropriateness of patient care, to resolve problems, and to improve patient care. (I-R, II-R, III-R, IV-R)

1. The STEMI center shall collect, document, trend, maintain for at least five (5) years, and make available for review by the department at least the following data elements:

A. Any STEMI center that performs percutaneous coronary interventions shall report all percutaneous coronary intervention-related data, including the time from first medical contact or pre-hospital electrocardiogram STEMI identification to hospital door time and the time from first medical contact to balloon or device time. The percutaneous coronary intervention-related data is set forth and identified in the columns labeled "Level I & II STEMI Centers" and "Only for Level III STEMI Centers which are Performing Percutaneous Coronary Interventions (PCIs) (Only on Patients Receiving Percutaneous Coronary Interventions (PCIs))" in the document entitled "Time Critical Diagnosis ST-Segment Elevation Myocardial Infarction (STEMI) Center Registry Data Elements" dated March 1, 2012, which is incorporated by reference in this rule and is available at the Missouri Department of Health and Senior Services, PO Box 570, Jefferson City, MO 65102-0570 or on the department's website at www.health.mo.gov. This rule does not incorporate any subsequent amendments or additions; (I-R, II-R, III-R)

B. Thrombolytic administration time which is the time from first medical contact or pre-hospital electrocardiogram STEMI identification to hospital door time and the time from hospital door to needle time; (I-R, II-R, III-R, IV-R)

C. Number of STEMI patients presenting within the treatment window for percutaneous coronary interventions and/or thrombolytic administration; (I-R, II-R, III-R, IV-R)

D. Number of eligible STEMI patients treated with percutaneous coronary intervention and/or thrombolytic administration; and (I-R, II-R, III-R, IV-R)

E. Time from when STEMI patient presents at the receiving STEMI center to time STEMI patient is in the operating room at the receiving STEMI center. (I-R, II-R if cardiac surgical capability)

2. The STEMI center shall at least quarterly conduct a regular morbidity and mortality review. (I-R, II-R, III-R, IV-R)

3. The STEMI center shall conduct a review of the reports generated by the department from the Missouri STEMI registry. (I-R, II-R, III-R, IV-R)

4. The STEMI center shall conduct a monthly review of its pre-hospital STEMI care including inter-facility transfers. (I-R, II-R, III-R, IV-R)

5. The STEMI center shall participate in the emergency medical services regional system of STEMI care. (I-R, II-R, III-R, IV-R)

6. The STEMI center shall review cases of STEMI patients remaining greater than thirty (30) minutes at the referring hospital prior to transfer as a part of its performance improvement and patient safety program. (I-R, II-R, III-R, IV-R)

7. The STEMI center shall review and monitor the core competencies of its physicians, practitioners, and nurses. (I-R, II-R, III-R, IV-R)

(B) It is recommended that level I and II STEMI centers establish a cardiology outreach program that provides physicians in the outlying areas with telephone access to the cardiology program. (I-R, II-R)

(C) STEMI centers shall establish a patient and public education program to promote STEMI prevention and awareness of signs and symptoms. (I-R, II-R, III-R, IV-R)

(D) Level I, II, and III STEMI centers shall establish a professional education outreach program in catchment areas to provide training and other supports to improve care of STEMI patients. (I-R, II-R, III-R)

(E) Each STEMI center shall establish a training program on caring for STEMI patients for professionals in the STEMI center that includes at least the following:

1. A procedure for training nurses and clinical staff to be credentialed in STEMI care; (I-R, II-R, III-R, IV-R)

2. A mechanism to assure that all nurses providing care to STEMI patients complete a minimum of required continuing education to become credentialed in STEMI care; and (I-R, II-R, III-R, IV-R)

3. The content and format of any STEMI continuing education courses developed and offered by the STEMI center shall be developed with the oversight of the STEMI center medical director. (I-R, II-R, II-R, IV-R)

(F) STEMI centers shall provide and monitor timely feedback to the emergency medical services providers and referring hospital(s), if involved. This feedback shall include, at least, diagnosis, treatment, and referring hospital, if involved. It is recommended that the feedback be provided within seventy-two (72) hours of admission to the hospital. When emergency medical services does not provide patient care data on patient arrival or in a timely fashion (recommended within three (3) hours of patient delivery), this time frame shall not apply. (I-R, II-R, III-R, IV-R)

(G) The STEMI centers shall be actively involved in local and regional emergency medical services systems by providing training and clinical educational resources. (I-R, II-R, III-R, IV-R)

(6) Standards for the Programs in STEMI Research for STEMI Center Designation.

(A) The STEMI center and its staff shall support an ongoing research program in STEMI as evidenced by any of the following:

1. Production of evidence based reviews of the STEMI program's process and clinical outcomes; (I-R)

2. Publications in peer-reviewed journals; (I-R)

3. Reports of findings presented at regional or national meetings; (I-R)

4. Receipt of grants for study of STEMI care; (I-R)

5. Participation in multi-center studies; or (I-R)

6. Epidemiological studies and individual case studies. (I-R)

(B) The STEMI center shall agree to cooperate and participate with the department for the purpose of developing prevention programs. (I-R, II-R, III-R, IV-R)

AUTHORITY: section 190.185, RSMo 2016, and section 190.241, RSMo Supp. 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022, effective June 30, 2023.

**Original authority: 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002 and 190.241, RSMo 1987, amended 1998, 2008, 2016, 2017, 2022.*

19 CSR 30-40.770 Community-based or Regional Plan for Emergency Medical Services for Trauma, ST-Segment Elevation Myocardial Infarction (STEMI), or Stroke

PURPOSE: This rule establishes the procedures for the submission of a community-based or regional plan for the transportation of patients to stroke, STEMI, or trauma centers.

(1) A community or region developing its own transportation plan for stroke, STEMI, and trauma patients may submit a plan at any time and shall ensure that it complies with section 190.200.3, RSMo. Such a plan shall also –

(A) Identify the geographic boundaries of the area covered by the plan;

(B) Designate, and provide contact information for, an individual, plan's designee who will serve as the plan's point of contact throughout the plan's approval and administration process; and

(C) Identify individuals involved in the drafting, planning, and/or consultation of the plan, who shall collectively be known as the "planning committee."

(2) Upon completion of a community-based or regional plan, the plan shall be submitted to the chair of the regional emergency medical services advisory committee defined by section 190.102, RSMo, and the regional emergency medical services medical director defined by section 190.103, RSMo, for the geographic area covered by the plan. Upon receipt of a plan submitted pursuant to the provisions of section 190.200, RSMo, the chair and medical director shall forward the plan to the emergency medical services medical director's advisory committee (the committee) as defined by section 190.103, RSMo, for consideration. Within forty-five (45) days of receipt of a community-based or regional plan, the committee shall meet and complete its review of the plan. Upon a finding of good cause, the chair of the committee may grant the committee a reasonable extension of time for review of the plan.

(3) In reviewing a community-based or regional plan, the committee shall determine whether the plan meets the requirements of section 190.200.3, RSMo, and this rule.

(4) At the conclusion of its review, the committee shall vote on the question of whether to recommend or not recommend

the plan for approval. If a majority of the committee votes to recommend the plan for approval, said recommendation shall constitute *prima facie* evidence that the plan meets the requirements of section 190.200.3, RSMo, and should be approved. The committee shall attach such conditions (such as regular analysis and reporting of medical outcomes to the committee) to its recommendation for approval as it deems appropriate to ensure that the plan continues to meet the requirements of Chapter 190, RSMo. If a majority of the committee votes to not recommend the plan, that decision, with an explanation of the reason(s) for the decision, shall be provided in writing to the plan's designee. A community or region receiving a non-recommendation by the committee may modify its plan according to the committee's reason(s) for non-recommendation and resubmit the plan within thirty (30) days directly to the committee.

(5) Following recommendation of a community-based or regional plan, the committee shall forward the plan to the Director of the Department of Health and Senior Services (director) for approval. The director shall have thirty (30) days to review the plan for its compliance with section 190.200.3, RSMo. At the conclusion of the review, the director shall approve or disapprove the plan. If the director disapproves the plan, the reason(s) for disapproval shall be provided in writing to the plan's designee along with the right to appeal the director's decision. The director's decision shall be the final agency action. A community or region whose plan is not approved by the director may modify its plan according to the director's reason(s) for disapproval and resubmit the plan within thirty (30) days directly to the committee and follow the approval process as outlined herein.

(6) Once a plan is approved by the director, the planning committee shall —

(A) Notify all agencies impacted by the plan of the manner in which emergency medical care is modified within the region based on the plan.

(B) Monitor per the plan the related medical and system outcomes and regional resources and capacity;

(C) Revise the plan when indicated based on medical and system outcomes, emerging clinical research or guidelines, or when revision is indicated based on changes in capacity or other related issues and submit through the approval process as outlined herein; and

(D Notify the committee and department at least thirty (30) days before ceasing to use the plan.

AUTHORITY: section 192.006, RSMo 2000, and sections 190.185 and 190.241, RSMo Supp. 2012. Original rule filed Nov. 15, 2012, effective June 30, 2013.*

**Original authority: 192.006, RSMo 1993, amended 1995; 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002; and 190.241, RSMo 1987, amended 1998, 2008.*

19 CSR 30-40.780 Definitions and Abbreviations Relating to the Transport Protocol for Stroke and the Transport Protocol for ST-Segment Elevation Myocardial Infarction (STEMI) Patients

PURPOSE: This rule defines terminology related to the state transport protocol for stroke and the state transport protocol for STEMI.

(1) The following definitions and abbreviations shall be used in the interpretation of the rule in 19 CSR 30-40.790:

(A) Field is the specific area or location, outside of the hospital, where an injury, accident, or medical emergency occurs requiring immediate assistance of medical personnel for the purpose of treating or transporting the sick or injured to another location for treatment;

(B) Local and regional process is the process that has been established and agreed upon specifically pertaining to a local city, town, or small district, or a combination of localities forming a regional area. This is not the community-based or regional plan;

(C) Lytics are thrombolytic drugs, including recombinant tissue plasminogen activator, used to dissolve clots blocking flow in a blood vessel. These lytic/thrombolytic drugs are used in the treatment of acute ischemic stroke and acute myocardial infarction.

(D) Lytic/therapeutic window is the period of time during which lytics can be administered following the onset of symptoms in order to reduce brain or heart injury.

(E) Lytic therapy (fibrinolysis/thrombolysis) is drug therapy used to dissolve clots blocking flow in a blood vessel. It refers to drugs used for that purpose, including recombinant tissue plasminogen activator. This type of therapy can be used in the treatment of acute ischemic stroke and acute myocardial infarction;

(F) Lytic/thrombolytic ineligible patients are those patients identified as ineligible for lytic/thrombolytic therapy due to specific contraindications. An appropriate course of treatment will be utilized when lytic/thrombolytic therapy is contraindicated;

(G) Out of the lytic/therapeutic or potential therapeutic window is the period of time following the accepted time (lytic/therapeutic window and potential therapeutic window) frames for specific therapies for a patient suffering an ischemic stroke;

(H) Outside of the percutaneous coronary intervention (PCI) window is the period of time following the accepted time frame in which PCI is most advantageous and recommended.

(I) Percutaneous coronary intervention (PCI) is a procedure used to open or widen narrowed or blocked blood vessels to restore blood flow supplying the heart;

(J) Percutaneous coronary intervention (PCI) window is a time frame in which PCI is most advantageous and recommended;

(K) Potential therapeutic window is the period of time after the accepted window for lytic therapy has expired in which interventional therapy may be beneficial in restoring blood flow during an ischemic stroke; and

(L) Recombinant tissue plasminogen activator (t-PA also known as rt-PA) is a thrombolytic (clot-dissolving) agent, the goal of which is to destroy the thrombus (clot) within the blood vessel by stimulating fibrinolysis (clot breakdown) to allow restoration of blood flow.

AUTHORITY: sections 190.185 and 190.241, RSMo Supp. 2012. Original rule filed Nov. 15, 2012, effective June 30, 2013.*

**Original authority: 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002 and 190.241, RSMo 1987, amended 1998, 2008.*

19 CSR 30-40.790 Transport Protocol for Stroke and ST-Segment Elevation Myocardial Infarction (STEMI) Patients

PURPOSE: This rule establishes protocols for transporting suspected STEMI patients by severity and time of onset to the STEMI center where resources exist to provide appropriate care and suspected

stroke patients by severity and time of onset to the stroke center where resources exist to provide appropriate care.

(1) All ground and air ambulances shall use the following state transport protocol for suspected stroke patients except in those circumstances listed in sections (3), (4), and (5) of this rule.

(A) Step 1 – Assess for life threatening conditions (serious airway or respiratory compromise or immediate life threatening conditions that cannot be managed in the field).

1. If there are life threatening conditions, transport the patient to the nearest appropriate facility for stabilization prior to transport to a stroke center. Consider air/ground/facility options for timely and medically appropriate care (particularly in non-urban areas).

2. If there are no life threatening conditions, go to step 2 below in subsection (1)(B); an.

(B) Step 2 – Assess the duration of onset of symptoms (time last known well).

1. Group 1 – If the patient is within the lytic/therapeutic window then transport to a level I, II, or III stroke center according to local and regional process. Consider the time for transport, the patient's condition, air/ground/hospital options for timely and medically appropriate care (particularly in non-urban areas), and the treatment windows. Continue to reassess the patient. If the patient's condition changes, then start back with subsection (1)(A) and follow the state stroke protocol outlined in section (1) starting from subsection (1)(A) and on according to the patient's condition. Consider out-of-state transport based on local and regional process for bi-state regions.

2. Group 2 – If the patient is within the potential therapeutic window then transport to a level I stroke center or transport to a level I, II, or III stroke center according to local and regional process. Consider the time for transport, the patient's condition, air/ground/hospital options for timely and medically appropriate care (particularly in non-urban areas), and the treatment windows. Continue to reassess the patient. If the patient's condition changes then start back with subsection (1)(A) and follow the state stroke protocol outlined in section (1) starting from subsection (1)(A) and on according to the patient's condition. Consider out-of-state transport based on local and regional process for bi-state regions.

3. Group 3 – If the patient is out of the lytic/therapeutic and potential therapeutic windows, then transport to a level I, II, III, or IV stroke center according to local and regional process. Consider the time for transport, the patient's condition, air/ground/hospital options for timely and medically appropriate care (particularly in non-urban areas), and the treatment windows. Continue to reassess the patient. If the patient's condition changes, then start back with subsection (1)(A) and follow the state stroke protocol outlined in section (1) starting from subsection (1)(A) and on according to the patient's condition. Consider out-of-state transport based on local and regional process for bi-state regions.

(2) All ground and air ambulances shall use the following state transport protocol for suspected STEMI patients except in those circumstances listed in sections (3), (4), and (5) of this rule.

(A) Step 1 – Assess for life threatening conditions (serious airway or respiratory compromise or immediate life threatening conditions that cannot be managed in the field).

1. If there are life threatening conditions, then transport the patient to the nearest appropriate facility for stabilization prior to transport to a STEMI center. Consider air/ground/facility options for timely and medically appropriate care (particularly in non-urban areas).

2. If there are no life threatening conditions, then go on to step 2 below in subsection (2)(B) and assess vital signs and perform an electrocardiogram (ECG) if the ground or air ambulance has that capability. An electrocardiogram and electrocardiogram equipment are recommended.

(B) Step 2 – Determine if the patient's vital signs and the electrocardiogram identifies the following:

1. ST-elevation in two (2) contiguous leads or new or presumed new left bundle branch block; and

2. The patient has two (2) of the following three (3) signs of cardiogenic shock:

A. Hypotension where systolic blood pressure is less than ninety millimeters of mercury (90 mmHG);

B. Respiratory distress where respirations are less than ten (10) or greater than twenty-nine (29) per minute; or

C. Tachycardia where the heart rate is greater than one hundred beats per minute (100 BPM);

3. If the patient has an electrocardiogram with ST-elevation in two (2) contiguous leads or new or presumed new left bundle branch block and two (2) of the three (3) signs of cardiogenic shock then transport to a level I STEMI center according to local and regional process. Consider the time for transport, the patient's condition, and the air/ground/hospital options for timely and medically appropriate care (particularly in non-urban areas).

4. If initial transport from the scene to a level I STEMI center is prolonged, then consider transporting to the nearest appropriate facility for stabilization prior to transport to a level I STEMI center;

5. Continue to reassess the patient. If the patient's condition changes, then start back at subsection (2)(A) above and follow the state STEMI protocol outlined in section (2) starting from subsection (2)(A) and on according to the patient's condition;

6. Consider out-of-state transport based on local and regional process for the bi-state region;

7. Communicate electrocardiogram findings to the hospital.

8. If the patient has a positive electrocardiogram but is negative for signs of cardiogenic shock, then go to step 3 in subsection (2)(C) below; and

(C) Step 3 – Calculate the estimated time from STEMI identification with the patient to expected percutaneous coronary interventio. (PCI) with the patient in order to determine whether the patient is within the percutaneous cornary intervention window. Communicate electrocardiogram findings to the hospital. If no ST-elevation or new or presumed new left bundle branch block then consider a fifteen- (15-) lead electrocardiogram, if available.

1. Group 1 – If the patient is within the PCI window or the patient has had chest pain longer than twelve (12) hours or the patient is lytic/thrombolytic ineligible then transport to a level I or level II STEMI center according to local and regional process. Consider the time for transport, the air/ground/hospital options for timely and medically appropriate care (particularly in non-urban areas), the patient's condition, and all treatment windows. Consider the ischemic time and the potential role for lytics (within the lytic window) at an intervening STEMI center in route to the percutaneous coronary intervention center if approaching longer times within the percutaneous coronary intervention window. Continue to reassess the patient. If the patient's condition changes, then start back at subsection (2)(A) and follow the state STEMI protocol outlined in section (2) starting from subsection (2)(A) and on according to the patient's condition. Consider out-of-state transport based on local and

regional process for bi-state regions.

2. Group 2 — If the patient is outside the percutaneous coronary intervention window and within the lytic/therapeutic window, or outside both windows and the patient has no other known complications, then transport to the STEMI center (level I, II, III, or IV) according to local and regional process. Consider the time for transport, air/gro-und/hospital options for timely and medically appropriate care (particularly in non-urban areas), the patient's condition, and all the treatment windows. Consider the lytic window and the potential for STEMI center lytic administration when determining the destination(s). Continue to reassess the patient. If the patient's condition changes, then start back at subsection (2)(A) above and follow the state STEMI protocol outlined in section (2) starting from subsection (2)(A) and on according to the patient's condition. Consider out-of-state transport based on local and regional process for bi-state regions.

(3) When initial transport from the scene of illness or injury to a STEMI or stroke center would be prolonged, the STEMI or stroke patient may be transported to the nearest appropriate facility for stabilization prior to transport to a STEMI or stroke center.

(4) Nothing in this rule shall restrict an individual patient's right to refuse transport to a recommended destination. All ground and air ambulances shall have a written process in place to address patient competency and refusal of transport to the recommended destination.

(5) Ground and air ambulances are not required to use the state transport protocols in this rule when the ambulance is using a community-based or regional plan that has been approved by the department pursuant to section 190.200.3, RSMo, that waives the requirements of this rule. Copies of flow charts of an algorithm depicting the stroke and STEMI state transport protocols are available at the Health Standards and Licensure (HSL) office, online at the department's website www.health.mo.gov, or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570 or by calling (573) 751-6400.

AUTHORITY: sections 190.185 and 190.241, RSMo Supp. 2012. Original rule filed Nov. 15, 2012, effective June 30, 2013.*

**Original authority: 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002 and 190.241, RSMo 1987, amended 1998, 2008.*

19 CSR 30-40.792 Adult Trauma and Pediatric Field Triage and Transport Protocol

PURPOSE: This rule establishes protocols for transporting suspected trauma patients by severity and time of onset to the trauma centers where resources exist to provide appropriate care.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome or expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) All ground and air ambulances shall use the Adult and Pediatric Trauma Field Triage and Transport Protocol unless the department has waived the requirements of the rule pursuant to section 190.200.3, RSMo, and 19 CSR 30-40.790.

(A) Assess for life-threatening conditions (such as serious airway or respiratory compromise or immediate life-threatening conditions that cannot be managed in the field).

1. If there are life-threatening conditions, then transport patient to the closest trauma center or hospital emergency department capable of managing the condition.

2. If there are no life-threatening conditions, then assess the patient using the *2021 National Guideline for the Field Triage of Injured Patients*, which is incorporated by reference in this rule as published by the American College of Surgeons and available online at www.facs.org/quality-programs/trauma/systems/field-triage-guidelines/ or from the American College of Surgeons, 633 N. Saint Clair St., Chicago, Illinois 60611-3295. This rule does not incorporate any subsequent amendments or additions.

A. If the patient is fifteen (15) years of age or older and meets any one (1) of the listed red criteria, then transport the patient to a level I or II trauma center according to local and regional process. If the patient is younger than fifteen (15) years old, then transport to a level I or II pediatric trauma center or a level I or II pediatric capable trauma center according to local and regional process. A pediatric capable trauma center is an adult trauma center designated by the department that admits fewer than one hundred (100) injured children younger than fifteen (15) years of age. The local and regional process shall take into consideration time for transport, patient condition, and treatment window (within 60 minutes from time of injury to the appropriate trauma center) with the goal to secure the appropriate treatment for the patient as expeditiously as possible via ground and/or air. The local and regional process for bi-state regions accounts for out-of-state transport when appropriate.

B. If the patient is fifteen (15) years of age or older and meets any one (1) of the listed yellow criteria, then transport the patient to a Level I, II or III trauma center. If the patient is less than fifteen (15) years old, then transport to a level I, II, or III pediatric trauma center or a level I, II or III pediatric capable trauma center according to local and regional process. Local and regional process shall take into consideration time for transport, patient condition, and treatment window (within 60 minutes from time of injury to the appropriate trauma center) with the goal to secure the appropriate treatment for the patient as expeditiously as possible via ground and/or air. The local and regional process for bi-state regions accounts for out-of-state transport when appropriate.

(2) When initial transport from the scene of illness or injury to a trauma patient is prolonged, the trauma patient may be transported to the nearest appropriate facility for stabilization prior to transport to an appropriate trauma center.

(3) Nothing in this rule shall restrict an individual patient's right to refuse transport to a recommended destination. All ground and air ambulances shall have a written process in place to address patient competency and refusal of transport to the recommended destination.

AUTHORITY: section 190.185, RSMo 2016, and sections 190.200 and 190.243, RSMo Supp. 2022. Original rule filed Nov. 21, 2022, effective June 30, 2023.*

**Original authority: 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002; and 190.200, RSMo 1998, amended 2008, 2022; 190.243, RSMo 1987, amended 1998. 2008. 2022.*

19 CSR 30-40.800 EMT-Community Paramedic, Community Paramedic Program, and Medical Director for EMT-Community Paramedic Program

PURPOSE: This rule establishes the requirements for certification and recertification as an EMT-Community Paramedic, the scope of practice and authority to practice for an EMT-Community Paramedic, requirements for a medical director of an ambulance service which utilizes EMT-Community Paramedics and implements a community paramedic program, and requirements for a community paramedic program.

PUBLISHER'S NOTE: The secretary of state has determined that the publication of the entire text of the material which is incorporated by reference as a portion of this rule would be unduly cumbersome and expensive. This material as incorporated by reference in this rule shall be maintained by the agency at its headquarters and shall be made available to the public for inspection and copying at no more than the actual cost of reproduction. This note applies only to the reference material. The entire text of the rule is printed here.

(1) Application Requirements for Emergency Medical Technician Community Paramedic (EMT-CP) Certification.

(A) Each applicant for certification as an EMT-CP shall be currently licensed with the Emergency Medical Services (EMS) Bureau as an EMT-Paramedic in the state of Missouri. If the application is approved, the applicant's length of certification as an EMT-CP will begin on the issuance date of the certification as an EMT-CP by the department and end on the applicant's Missouri EMT-Paramedic license expiration date.

(B) Each applicant for certification as an EMT-CP shall submit an application approved by the EMS Bureau which is included herein. This application shall be submitted to the EMS Bureau either via mail to the Department of Health and Senior Services, Emergency Medical Services (EMS) Bureau, PO Box 570, Jefferson City, MO 65102-0570 or online at www.health.mo.gov.

1. Each applicant shall attach to the application a certified copy of his/her community paramedic certification program transcript.

2. Each applicant shall provide the necessary information on his/her application so the EMS Bureau can perform criminal history checks to determine the recency and relatedness of any criminal convictions prior to the certification of the applicant.

3. Each applicant shall truthfully and accurately provide all information and certification required on the EMS Bureau application for community paramedic certification. Incomplete or inaccurate information on an application shall be cause to deny a certification or take action upon a certification.

4. If, after submitting an application, the applicant identifies an error or if any contact information changes after the applicant is certified as an EMT-CP, then the applicant shall submit the correction in writing to the EMS Bureau at the Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.

(2) EMT-Community Paramedic (EMT-CP) Certification Requirements.

(A) The applicant for EMT-CP certification shall have successfully completed a community paramedic certification program from a college, university, or educational institution that meets the following requirements:

1. Is accredited by the Committee on Accreditation of Educational Programs for the Emergency Medical Services Professions (CoAEMSP) or prior to January 1, 2016, conducted a pilot program meeting or exceeding the requirements in paragraphs (2)(A)2. and (2)(A)3. below;

2. Provides a minimum of sixty (60) hours of didactic training and practical and lab skills covering at a minimum the following subjects:

A. The Community Paramedic's Role in the Health Care System which includes training on mental health illnesses and Alzheimer's disease;

B. The Social Determinants of Health Model;

C. The Role of the Community Paramedic in the Community;

D. Developing Cultural Competency; and

E. Personal Safety and Wellness of the Community Paramedic; and

3. Includes at least forty (40) hours of clinical experience in a clinical setting.

(3) EMT-Community Paramedic (EMT-CP) Recertification Requirements.

(A) An applicant for recertification as an EMT-CP shall be currently licensed with the EMS Bureau as an EMT-Paramedic in the state of Missouri.

(B) The applicant for recertification as an EMT-CP shall certify to the EMS Bureau that the applicant has successfully completed four (4) hours of continuing education annually which relate to the community paramedic topics outlined in subparagraphs (2)(A)2.A.–E. above. These annual four (4) hours will be in addition to the one-hundred forty-four (144) hours of continuing education required for relicensure as an EMT-Paramedic pursuant to 19 CSR 30-40.342(3)(B)2.A.

(C) The applicant for recertification as an EMT-CP shall list the following information about his/her continuing education on the applicant's application:

1. Name or type of course;

2. The division or module;

3. The number of hours of the course;

4. The training entity accreditation number, EMS Bureau approval number, or other accrediting agency which taught the course; and

5. The date the applicant completed the course.

(D) The applicant shall be able to produce documentation of the required continuing education and shall make all records available to the EMS Bureau upon request. EMT-CPs shall maintain such records for a period of five (5) years after the date of recertification. Failure to obtain and retain complete and accurate documentation shall be cause for taking action against an EMT-CP's certification.

(E) An application for recertification as an EMT-CP, which is included herein, shall be submitted with the application for relicensure as an EMT-Paramedic. This application shall be submitted to the EMS Bureau either via mail to the Department of Health and Senio. Services, Emergency Medical Services (EMS) Bureau, PO Box 570, Jefferson City, MO 65102-0570 or online at www.health.mo.gov. This application for recertification as an EMT-CP shall be submitted to the EMS Bureau no less than thirty (30) days and no more than one hundred twenty (120) days prior to the expiration date of the applicant's certification as an EMT-CP which corresponds with the expiration of the applicant's EMT-Paramedic license.

(4) EMT-Community Paramedic (EMT-CP) Scope of Practice and Authority to Practice.

(A) An EMT-CP shall perform only those skills consistent with section 190.142.4, RSMo, and 19 CSR 30-40.342(3).

(5) Medical Director for Community Paramedic Programs.

(A) In addition to the medical director duties set forth in 19 CSR 30-40.303, the medical director of an ambulance service which utilizes EMT-CPs shall approve the implementation of the community paramedic program for that ambulance service by following the requirements set forth in 19 CSR 30-40.303. The medical director of an ambulance service which utilizes EMT-CPs shall develop, implement, and annually review the community paramedic protocols. The medical director of the ambulance service may seek input from medical providers with knowledge of the ambulance service's community paramedic program in developing, implementing, and annually reviewing the community paramedic protocols.

(B) With guidance and approval from the medical director and the administrator of the ambulance service which utilizes EMT-CPs, an ambulance service which utilizes EMT-CPs shall assess the needs of the community to implement an evaluation component to the community paramedic program which shall improve patient outcomes, ensure patient satisfaction, and decrease adverse outcomes.

(6) Community Paramedic Program.

(A) The community paramedic program shall include a method for the EMT-CP to follow-up with the patient's medical provider who is identified in the health care plan to ensure the transition of care. When no health care plan has been established, the EMT-CP shall follow-up with the patient's medical provider designated by the patient to ensure the transition of care. This follow-up may include, at a minimum, patient assessment, patient treatment, and/or rendered services.

MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES

EMT-COMMUNITY PARAMEDIC CERTIFICATION/RECERTIFICATION APPLICATION

FOR DHSS OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE

EMT-P LICENSE NO. ☐☐☐☐☐☐	**DATE CERTIFIED OR RECERTIFIED AS EMT-COMMUNITY PARAMEDIC** ☐☐ ☐☐ ☐☐
EXPIRATION DATE OF EMT-P LICENSE ☐☐ ☐☐ ☐☐	**EMT-COMMUNITY PARAMEDIC CERTIFICATION NO.** ☐☐☐☐☐☐☐☐☐
DATE APP. REC'D. ☐☐ ☐☐ ☐☐	

APPLICANT MUST COMPLETE INFORMATION BELOW *TYPE OR PRINT*

CURRENT MO EMT-PARAMEDIC LIC NO ☐☐☐☐☐☐	CURRENT MO EMT-PARAMEDIC LICENSE NO. EXPIRATION DATE ☐☐ ☐☐ ☐☐	☐ INITIAL CERTIFICATION APP. ☐ RECERTIFICATION APP.

NAME *(LAST, FIRST, MIDDLE INITIAL)*

SOCIAL SECURITY NUMBER	DATE OF BIRTH __ __/__ __/__ __ __ __ mm dd yyyy	SEX ☐ M ☐ F	DAYTIME PHONE NUMBER E-MAIL ADDRESS

MAILING ADDRESS *(STREET)*

CITY	STATE	ZIP CODE	COUNTY

NAME OF THE COLLEGE, UNIVERSITY OR EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR COMMUNITY PARAMEDIC CERTIFICATION PROGRAM

MAILING ADDRESS (STREET)

CITY	STATE	ZIP CODE	PHONE NUMBER

NAME OF AMBULANCE SERVICE YOU WILL BE WORKING AS AN EMT-COMMUNITY PARAMEDIC

Have you ever had administrative licensure action taken against your EMT license in Missouri or any other state?
Yes ☐ No ☐ *IF YES, EXPLAIN ON ATTACHED SHEET*

Has your right to practice in a health care occupation ever been subject to limitations, suspension or termination?
Yes ☐ No ☐ Not Applicable ☐ *IF YES, EXPLAIN ON ATTACHED SHEET*

Have you ever voluntarily surrendered a health care license or certification in any state?
Yes ☐ No ☐ Not Applicable ☐ *IF YES, EXPLAIN ON ATTACHED SHEET*

HAVE YOU EVER BEEN FINALLY ADJUDICATED AND FOUND GUILTY, OR ENTERED A PLEA OF GUILTY OR NOLO CONTENDERE IN A CRIMINAL PROSECUTION UNDER THE LAWS OF ANY STATE OR OF THE UNITED STATES, WHETHER OR NOT YOU RECEIVED A SUSPENDED IMPOSITION OF SENTENCE FOR ANY CRIMINAL OFFENSE? Yes ☐ No ☐
If you have answered yes to this question, then you must attach to your application a certified copy of all charging documents (such as complaints, informations or indictments), judgment and sentencing information, probation terms and any other information you wish considered).

I HEREBY CERTIFY THAT:

A. I am able to speak, read and write the English language.
B. I do not have a physical or mental impairment which would substantially limit my ability to perform the essential functions of an emergency medical technician-community paramedic with or without a reasonable accommodation.
C. This application contains no misrepresentations or falsifications and the information given by me and the certified copy of my community paramedic certification transcript are true and complete to the best of my knowledge. I further certify that I have both the intention and the ability to comply with Chapter 190, RSMo, and the regulations promulgated under Chapter 190, RSMo.
D. I have been a resident of Missouri for five (5) consecutive years prior to the date of the application or if I have not been a resident of Missouri for five (5) consecutive years prior to the date of the application, then I have provided with this application at least two (2) completed applicant fingerprint cards (FBI for FD-258).
E. I HAVE ATTACHED A CERTIFIED COPY OF MY COMMUNITY PARAMEDIC CERTIFICATION PROGRAM TRANSCRIPT TO THIS APPLICATION. (required only for initial certification)

APPLICANT'S SIGNATURE	DATE

WARNING: In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor pursuant to section 575.060 RSMo.

DECLARATION OF CEUS

NAME OR TYPE OF COURSE	DIV OR MODULE	# OF HRS OF COURSE	TRAINING ENTITY ACCREDITATION #, CECBEMS APPROVAL #, OR OTHER ACCREDITING AGENCY (ACLS, PALS, BTLS, MONA, ACEP, ETC.)	DATE OF COURSE COMPLETION
TOTAL HOURS				

COPY THIS SHEET IF NECESSARY

I HEREBY CERTIFY THAT:

1. I have successfully completed the required continuing education in accordance with state regulations.
2. I have attached a list of these continuing education units.
3. I am in possession of documentation of the required continuing education and will make all records available to the Missouri Department of Health and Senior Services upon request under penalty of license action, up to and including revocation.

APPLICANT'S SIGNATURE	DATE

AUTHORITY: sections 190.098, 190.109, 190.160, and 190.185, RSMo Supp. 2013, and sections 190.142 and 190.165, RSMo Supp. 2016. Original rule filed May 10, 2016, effective Dec. 30, 2016. ***

**Original authority: 190.098, RSMo 2013; 190.109, RSMo 1998, amended 2001, 2002; 190.142, RSMo 1998, amended 1999, 2002, 2016; 190.160, RSMo 1973, amended 1998, 2002; 190.165, RSMo 1973, amended 1978, 1998, 2002, 2016; and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002.*

***Pursuant to Executive Order 21-07, 19 CSR 30-40.800, paragraph (2)(A)3. was suspended from August 6, 2020 through August 31, 2021.*

19 CSR 30-40.810 Ground Ambulance Transport of Patients to Locations That Are Not Hospitals

PURPOSE: This rule establishes training and transport requirements for ground ambulances to transport patients to Missouri Department of Mental Health designated Behavioral Health Crisis Centers and other locations for those patients who do not require transport to a hospital and whose health needs can be met by Behavioral Health Crisis Centers or these other locations where patients are transported.

(1) As used in this rule, the following terms and phrases shall mean –

(A) Advanced emergency medical technician (also known as Emergency Medical Technician-Intermediate) shall mean the mid-level of licensure of licensed emergency medical services personnel who meet the requirements of 19 CSR 30-40.342(5);

(B) Advanced life support shall mean an advanced level of care as provided to the adult and pediatric patient when a patient is in a more critical condition and a paramedic is required to assist in the treatment of the patient during transport by an ambulance;

(C) Basic life support shall mean a basic level of care, as provided to the adult and pediatric patient where only emergency medical technicians are on ambulances during transport;

(D) BHCC shall mean Behavioral Health Crisis Centers designated by the Missouri Department of Mental Health;

(E) Department shall mean the Missouri Department of Health and Senior Services;

(F) Emergency medical technician means the lowest level of licensure of licensed emergency medical services personnel who meet the requirements in 19 CSR 30-40.342(2);

(G) Ground ambulance services shall mean ambulance services licensed under 19 CSR 30-40.309;

(H) Hospital shall mean the definition of hospital in section 197.020, RSMo, or a hospital operated by the state of Missouri;

(I) Medical director shall mean the medical director of an ambulance service as required by 19 CSR 30-40.303; and

(J) Paramedic shall mean the highest level of licensure of licensed emergency medical services' personnel who meet the requirements in 19 CSR 30-40.342(4).

(2) Transport of patients to locations that are not hospitals, following a request for emergency care.

(A) Hospital-owned or operated ground ambulance services should communicate with their hospitals and legal counsel about their ability to transport to locations that are not hospitals based on the federal Emergency Medical Treatment and Labor Act (EMTALA) law. Hospital-owned or operated ground ambulance services are required to transport patients according to EMTALA laws. Ground ambulance services may transport patients to locations that are not hospitals, such as BHCCs in Missouri, following a request for emergency care:

1. Ground ambulance services shall have written transportation protocols that allow ground ambulance services to transport to locations that are not hospitals, such as BHCCs in Missouri; or

2. Licensed emergency medical services personnel for ground ambulance services shall receive physician orders for approval to transport patients to locations that are not hospitals, such as BHCCs in Missouri;

3. Ground ambulance services shall transport patients to hospitals if patients require a level of care that only the hospitals can provide. This includes transporting to hospitals behavioral health patients who present with a likelihood of serious harm to themselves or others as the term "likelihood of serious harm" is defined under section 632.005, RSMo, or who present as significantly incapacitated by alcohol or drugs;

4. Ground ambulance services shall have a working relationship with the BHCCs and other providers of locations that they transport patients to that are not hospitals. Ground ambulance services shall understand the care that BHCCs and these other providers are able to give to patients, so patients are transported to an appropriate location in which the provider can provide the care and services that the patients require;

5. Ground ambulance services shall not transport patients to freestanding emergency departments unlicensed by the department; and

6. Nothing in this regulation supersedes local or statewide transport protocols in 19 CSR 30-40.790 and 19 CSR 30-40.792 or approved community or regional emergency medical services (EMS) transport protocols as allowed in 19 CSR 30-40.770.

(B) When providing services to patients transported to locations that are not hospitals following a request for emergency care, licensed emergency medical services personnel for ground ambulance services shall follow written medical protocols, physician orders to provide medical care, or orders from qualified health care professionals who have collaborative practice arrangements with physicians and are allowed under Missouri law and their collaborative practice arrangement to dispense or prescribe drugs and provide treatment. Paramedics for the ground ambulance services evaluating patients do not have to be on the ambulance crew that transports patients. Paramedics for the ground ambulance services can arrive on the scene to evaluate the patient and the patient may be transported to the location, which is not a hospital, with a basic life support ambulance staffed by emergency medical technicians and/or advanced emergency medical technicians if the patient does not require advanced life support care. Patients shall be transported by advanced life support ambulances or basic life support ambulances based on the patients' care needs.

(C) Licensed ground ambulance service personnel who evaluate and transport patients to facilities providing mental health services that are not hospitals, such as BHCCs in Missouri, shall be trained by the ground ambulance service or other providers on evaluating and caring for patients with mental health concerns. This training may include ground ambulance service personnel attending and completing the Missouri Crisis Intervention Team forty- (40-) hour course discussed in section 190.147, RSMo.

(D) Written transportation and medical protocols set forth in subsections (2)(A) and (2)(B) shall be approved by the medical director of the service. Community or regional EMS transportation protocols for transport to a trauma, stroke, or STEMI center shall also be approved by the EMS medical director's advisory committee, and the director of the

department pursuant to 19 CSR 30-40.770.

(E) Ground ambulance services shall conduct training and activities with the services' personnel to ensure written transportation protocols and medical protocols set forth in subsections (2)(A) and (2)(B) are properly implemented and followed.

(F) Ground ambulance services shall evaluate the written transportation and medical protocols set forth in subsections (2)(A) and (2)(B) to ensure the protocols are being properly implemented and followed by the services' personnel during a review of these transports through the services' quality improvement program.

AUTHORITY: sections 190.109 and 190.185, RSMo 2016, and section 190.142, RSMo Supp. 2023. Original rule filed Feb. 26, 2024, effective Aug. 30, 2024.*

**Original authority: 190.109, RSMo 1998, amended 2001, 2002; 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002; and 190.142, RSMo 1998, amended 1999, 2002, 2016, 2018, 2023.*