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**Rules of**  
**Department of Health**  
**Division 30—Division of Health Standards**  
**and Licensure**  
**Chapter 40—Comprehensive Emergency Medical**  
**Services Systems Regulations**

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**Title 19—DEPARTMENT OF  
HEALTH**

**Division 30—Division of  
Health Standards and Licensure  
Chapter 40—Comprehensive  
Emergency Medical Services Systems  
Regulations**

**19 CSR 30-40.005 Abbreviations and  
Definitions Relating to Ambulance Regula-  
tions**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.005. Original rule filed March 13, 1979, effective June 11, 1979. Amended: Filed Jan. 13, 1990, effective April 26, 1990. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.010 Staffing of Ambulances**  
(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.010. Original rule filed Aug. 22, 1974, effective Feb. 23, 1975. Amended: Filed Jan. 13, 1990, effective April 26, 1990. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.020 Ambulance Vehicle  
Configuration and Equipment Require-  
ments for Licensure**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.115, RSMo 1986 and 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.020. Original rule filed Aug. 22, 1974, effective Feb. 23, 1975. Amended: Filed Oct. 7, 1983, effective Jan. 13, 1984. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.025 Ambulance Markings**  
(Rescinded February 28, 1999)

*AUTHORITY: sections 190.115.1(4), RSMo 1986 and 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.025. Original rule filed Oct. 7, 1983, effective Jan. 13, 1984. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.030 Insurance Requirements  
for Ambulance Licensure**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.120, RSMo 1986, 190.185, RSMo Supp. 1993 and 537.610, RSMo Supp. 1989. This rule was previously filed as 13 CSR 50-40.030. Original rule filed Aug. 22, 1974, effective Feb. 23, 1975. Amended: Filed Oct. 7, 1983, effective Jan. 13, 1984. Amended: Filed Nov. 14, 1989, effective Jan. 26, 1990. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.035 Reporting Fire and  
Motor Vehicle Accidents Involving Am-  
bulances**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. Original rule filed Jan. 18, 1990, effective April 26, 1990. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.040 Patient Care Equipment**  
(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.040. Original rule filed Aug. 22, 1974, effective Feb. 23, 1975. Amended: Filed Oct. 7, 1983, effective Jan. 13, 1984. Amended: Filed Jan. 13, 1990, effective April 26, 1990. Amended: Filed Aug. 26, 1993, effective April 9, 1994. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.045 Communicable Disease  
Policy**

(Rescinded: February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. Original rule filed Jan. 18, 1990, effective April 26, 1990. Amended: Filed Aug. 14, 1992, effective Feb. 26, 1993. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.047 Mandatory Notice to  
Emergency Response Personnel of Possible  
Exposure to Communicable Diseases**

*PURPOSE: This rule establishes an inquiry and notice procedure to be followed by receiving medical facility personnel concerning the possibility of exposure to communicable diseases by emergency response personnel and good samaritans.*

(1) The following definitions shall be used in the interpretation of this rule:

(A) Aerosols mean tiny invisible particles or droplet nuclei usually less than ten (10) micrometers in diameter, which float on air currents and are capable of being suspended in air for a considerable period of time and are not to be confused with droplet as defined in subsection (1)(F) of this rule;

(B) Airborne transmission means person-to-person transmission of infectious organisms through the air by means of droplet nuclei;

(C) Bloodborne transmission means person-to-person transmission of an infectious agent through contact with an infected person's blood or other body fluids;

(D) Communicable disease means an infectious disease transmitted by a significant exposure as defined in subsections (2)(A)—(E) of this rule, and examples of likely communicable diseases for investigation for possible significant exposures are—

1. Airborne diseases—pulmonary tuberculosis (*Mycobacterium tuberculosis*) and measles;

2. Bloodborne diseases—Hepatitis B and C and human immunodeficiency virus (HIV) infection including acquired immunodeficiency syndrome (AIDS);

3. Droplet spread diseases—rubella, *Corynebacterium diphtheriae*, and *Neisseria meningitidis*; and

4. Uncommon or rare diseases—hemorrhagic fevers including Lassa, Marburg, Ebola and Congo-Crimean; plague (*Yersinia pestis*); and rabies;

(E) Designated officer means a city or county health department officer, or his/her designee, appointed by the director of the Department of Health or his/her designee. The designated officer's designee may be, at local option, a person associated with an ambulance service, fire department or other enforcement agency; the designated officer may appoint multiple designees as needed;

(F) Droplets mean large particles of moisture that rapidly settle out on horizontal surfaces and originate from talking, sneezing or coughing;

(G) Droplet spread means brief passage of an infectious agent through the air, usually within three feet (3') of the source;

(H) Emergency means a sudden or unforeseen situation or occurrence that requires immediate action to save life or to prevent suffering or disability; the determination of the existence of the emergency can be made either by the patient/victim or by any emergency response personnel (ERP) or good samaritan on the scene;

(I) Emergency response personnel (ERP) means firefighters, law enforcement officers, paramedics, emergency medical technicians,

first responders and other persons including employees of legally organized and recognized volunteer organizations—regardless of whether the individuals receive compensation—who, in the course of professional duties, respond to emergencies;

(J) Exposure or significant exposure means an ERP or good samaritan has experienced a possible risk of becoming infected with a communicable disease(s) including those identified in paragraphs (1)(D)1.-4. of this rule by a means identified in subsections (2)(A)–(E) of this rule;

(K) Good samaritans mean individuals that are not ERPs that provide emergency medical assistance or aid until ERPs arrive;

(L) Medical facility means a health care facility licensed under Chapter 197, RSMo or a state medical facility;

(M) Pathogen means any disease-producing microorganism;

(N) Patient means the victim of an emergency who has been aided by an ERP or good samaritan;

(O) Potentially life-threatening communicable disease means an infectious disease which can cause death in a susceptible host; and

(P) Universal precautions means an approach to infection prevention and control that requires all human blood and certain human body fluids to be treated as if infectious for HIV, hepatitis B virus (HBV), and other bloodborne pathogens.

(2) Means of transmission of communicable diseases are—

(A) Any person-to-person contact in which a commingling of respiratory secretions (saliva and sputum) between the patient and ERP or good samaritan may have taken place;

(B) Transmittal of the blood or bloody fluids of the patient onto the mucous membranes (mouth, nose or eyes) of the ERP or good samaritan or into breaks in the skin of the ERP or good samaritan;

(C) Transmittal of other body fluids (semen, vaginal secretions, amniotic fluids, feces, wound drainage or cerebral spinal fluid) onto the mucous membranes or breaks in the skin of the ERP or good samaritan;

(D) Any nonbarrier unprotected contact of the ERP or good samaritan with mucous membranes or nonintact skin of the patient; or

(E) Sharing of airspace by an ERP or a good samaritan with a patient who has been determined by the treating facility to have an infectious disease caused by airborne pathogens.

(3) The designated officer shall have the following duties:

(A) Collecting, upon request, facts surrounding possible exposure of an ERP or good samaritan to a communicable disease or infection;

(B) Contacting facilities that received patients who potentially exposed ERPs or good samaritans to ascertain if a determination has been made as to whether the patient has a communicable disease or infection and to ascertain the results of that determination;

(C) Notifying the ERP or good samaritan as to whether s/he has been exposed within forty-eight (48) hours of receiving the patient's diagnosis report, medical information or necessary test results and providing information regarding the exposure, importance of appropriate medical follow-up and confidentiality; and

(D) Upon request of the receiving medical facility or coroner/medical examiner's office, notifying the ERP or good samaritan of potential exposure to a communicable disease.

(4) The receiving medical facility personnel shall notify the ERP or good samaritan or the appropriate designated officer as soon as there has been a determination that there may have been a significant exposure—as defined in subsection (1)(J), of this rule—to communicable diseases including those identified in paragraphs (1)(D)1.-4. of this rule, by those means identified in subsections (2)(A)–(E) of this rule, thereby creating a risk of infection from a patient transported or assisted during the possible time of communicability of the particular disease. Information provided shall include to the extent known the type of disease in question; date, time and place of possible exposure; and recommendations regarding appropriate followup. The receiving medical facility or coroner/medical examiner's office shall make a commitment to faithfully implement the procedures provided for by section (4) of this rule, to assign appropriate personnel to investigate cases that appear to have involved a significant exposure as defined in subsection (1)(J) of this rule to an ERP or good samaritan and to provide the notification to the ERP or good samaritan or designated officer. If the receiving medical facility has determined that contacting the appropriate designated officer was better than notifying the ERP or good samaritan directly, then the designated officer shall employ previously developed policies and procedures governing the dissemination of information to the ERP or good samaritan and shall direct them to seek appropriate medical care. Nothing in this section shall be construed to imply

that a medical facility has absolute knowledge as to the communicable disease status of all its patients at all times. Neither shall this section be construed as eliminating or reducing any preexisting duty under the common law or sections 2681–2690 of the Public Health Service Act (PHS) in 42 U.S.C.A. 300ff-81–300ff-90 to determine the communicable disease status of any patient.

(5) An ERP or good samaritan may submit a request for a determination whether s/he has had a significant exposure to a communicable disease, preferably within twenty-four (24) hours but as soon as possible.

(A) Upon receipt of a request from a designated officer, an ERP or good samaritan, the medical facility or coroner/medical examiner's office shall evaluate the facts and determine if the ERP or good samaritan may have had a significant exposure to a communicable disease.

(B) If a determination is made of a possibly significant exposure—as defined in subsection (1)(J) of this rule—to a communicable disease(s) including those identified in paragraphs (1)(D)1.-4. of this rule, by a means identified in subsections (2)(A)–(E) of this rule, the ERP or good samaritan shall be notified as soon as possible, but not later than forty-eight (48) hours after receiving the patient's diagnosis report.

(C) If the information provided by the ERP, good samaritan or designated officer is insufficient to make a determination, the ERP, good samaritan or designated officer shall be notified in writing, by telephone, or by electronic transmission as soon as possible but not later than forty-eight (48) hours after receiving the initial request.

(D) If the ERP, good samaritan or designated officer receives notice that insufficient information was provided, the ERP or good samaritan may request the designated officer to evaluate the request and the medical facility's or coroner/medical examiner's office response. The designated officer shall then evaluate the request and the medical facility's or coroner/medical examiner's response and report his/her findings to the ERP or good samaritan as soon as possible but not later than forty-eight (48) hours after receiving the request.

1. If the designated officer finds the information provided is sufficient to make a determination of exposure, s/he shall submit the report to the medical facility or coroner/medical examiner's office.

2. If the designated officer finds the information provided was insufficient to make a determination of exposure, s/he shall contact the ERP or good samaritan to gather

the additional needed information, contact the medical facility or coroner/medical examiner's office, or both, to collect any additional available relevant information. If sufficient facts are then collected by the medical facility or coroner/medical examiner's office, the ERP or good samaritan shall be notified of any change in status.

3. If there was not a significant exposure, the medical facility, coroner/medical examiner's office or designated officer shall notify the ERP or good samaritan, or designated officer (who shall notify the ERP or good samaritan) within forty-eight (48) hours.

(6) If the ERP, good samaritan, designated officer and medical facility or coroner/medical examiner's office are unable to achieve satisfactory resolution to questions or issues under the procedures in subsections (5)(A)–(D) of this rule, a request may be made to the Department of Health, through its director or the director's designee, to resolve the issues or questions, preferably within seventy-two (72) hours, but as soon as possible.

(7) The Department of Health's Communicable Disease Exposure Report (form MO 580-1825, 4/94) shall be used by ERPs or good samaritans to notify medical facilities or coroners/medical examiner's office or designated officer regarding suspected exposure. The ERP or good samaritan shall retain a copy of the form and shall send one (1) copy to the designated officer and one (1) copy to the receiving medical facility or coroner/medical examiner's office.

(8) The designated officer and the local health department shall assure that an adequate supply of reporting forms is provided to all receiving medical facilities or coroner/medical examiner's offices within the geographic area served.

(9) The notification process established by the receiving medical facility or coroner/medical examiner's office to deal with reported exposures to ERPs or good samaritans shall be as comprehensive as that for employees of the medical facility or coroner/medical examiner's office.

(10) Receiving medical facilities or coroner/medical examiner's offices and designated officers with information regarding the significant exposure—as defined in subsection (1)(J) of this rule—of an ERP or good samaritan to a communicable disease(s) including those identified in paragraphs

(1)(D)1.–4. of this rule by a means identified in subsections (2)(A)–(E) of this rule, shall provide information directly to the affected ERP. In the case of a good samaritan the designated officer or his/her designee shall provide the information directly to the good samaritan. All information shall be in a manner that protects the identity and confidentiality of the possibly infected individual and the ERP or good samaritan.

(11) A sending medical facility in advance of the transfer of a patient to another medical facility or back to the patient's residence shall notify the ambulance personnel of the existence and nature of any communicable disease(s) including those identified in paragraphs (1)(D)1.–4. of this rule by those means identified in subsections (2)(A)–(E) of this rule and appropriate precautions and procedures to follow. If the information supplied by the sending medical facility is unclear to the ambulance personnel, the ambulance personnel may make a specific inquiry as to whether there are any known communicable disease(s) involving a possible significant exposure that might occur during the transport of the patient. Nothing in this section shall be construed to imply that a medical facility has absolute knowledge as to the communicable disease status of all its patients at all times, but neither shall this section be construed to imply that a medical facility has absolute knowledge as to the communicable disease status of all its patients at all times, but neither shall this section be construed as eliminating or reducing any preexisting duty under the common law or sections 2681–2690 of the PHS Act in 42 U.S.C.A. 300ff-81–300ff-90 to determine the communicable disease status of any patient.

*AUTHORITY: sections 192.020, RSMo 1986 and 192.806.1, RSMo Supp. 1993.\* Original rule filed Feb. 2, 1994, effective Aug. 28, 1994.*

*\*Original authority: 192.020, RSMo 1939, amended 1945, 1951 and 192.806, RSMo 1992, amended 1993.*



**TO BE COMPLETED BY MEDICAL FACILITY OR CORONER/MEDICAL EXAMINER'S OFFICE**

<input type="checkbox"/>	<b>NO SIGNIFICANT EXPOSURE</b> There was no significant exposure to the emergency response personnel or good samaritan.
<input type="checkbox"/>	<b>SIGNIFICANT EXPOSURE</b> The following disease/test results were identified in the patient:  _____ Date <u>  </u> / <u>  </u> / <u>  </u>  _____ Date <u>  </u> / <u>  </u> / <u>  </u>  _____ Date <u>  </u> / <u>  </u> / <u>  </u>
<input type="checkbox"/>	Final receiving facility _____ whose address is _____ Form forwarded on _____
<b>Emergency Response Personnel or Good Samaritan or Designated Officer Notified:</b> Name: _____ Date <u>  </u> / <u>  </u> / <u>  </u> Time _____ am pm	
Comments: _____  _____	
<b>Completed by:</b>  Name (print) _____  Title _____  Medical Facility _____  Signature _____  Date _____	



## COMMUNICABLE DISEASE EXPOSURE REPORT INSTRUCTIONS

### INFORMATION FOR EMERGENCY RESPONSE PERSONNEL AND GOOD SAMARITANS

Missouri Department of Health regulations contain detailed information concerning this form and the obligations of both the medical facility or coroner/medical examiner's office and the emergency response personnel and/or good samaritan.

### WHO SHOULD FILE THIS FORM?

Any Missouri prehospital emergency response personnel (ERP) {EMS agency, law enforcement officer, firefighter, first responder, or good samaritan} who has sustained a significant exposure should file this form either directly with the receiving medical facility or coroner/medical examiner's office or the service's designated officer who will determine whether to file the form with the medical facility to which the patient was initially taken. A significant exposure is defined by the Centers for Disease Control and Prevention as:

- A. Any person-to-person contact in which a co-mingling of respiratory secretions (saliva and sputum) of the patient and ERP or good samaritan may have taken place;
- B. Transmittal of the blood or bloody body fluids of the patient onto the mucous membranes (mouth, nose, eyes) of the ERP or good samaritan and/or into breaks of the skin of the ERP or good samaritan;
- C. Transmittal of other body fluids (semen, vaginal secretions, amniotic fluids, feces, wound drainage, or cerebral spinal fluid) onto the mucous membranes or breaks in the skin of the ERP or good samaritan;
- D. Any non-barrier unprotected contact of the ERP or good samaritan with mucous membranes or non-intact skin of the patient.

### WHAT WILL HAPPEN WHEN THIS FORM IS FILED?

If appropriate personnel determine that the patient involved in the significant exposure has one of the specified diseases listed below and that the exposure described could transmit any of these diseases, you will be notified within 48 hours or as soon as possible after receipt of the patient's diagnosis report. You will also be advised by either the designated officer or by the receiving medical facility's personnel depending on who directly contacted the ERP or good samaritan on what are the appropriate medical precautions and recommended followup. The specified diseases are: pulmonary tuberculosis, hepatitis B and C, human immunodeficiency virus infection including acquired immunodeficiency syndrome (AIDS), rubella, measles, *Corynebacterium diphtheriae*, *Neisseria meningitidis*, hemorrhagic fevers including Lassa, Marburg, Ebola, Congo-Crimean, and others yet to be identified; plague (*Yersinia pestis*); and rabies.

### NOTIFICATION

You will be notified within forty-eight hours or as soon as possible of the patient's diagnosis report. The filing of this report does not mandate testing of the patient.

04/94

WHAT ARE THE OBLIGATIONS OF THE MEDICAL FACILITY OR CORONER/MEDICAL EXAMINER'S OFFICE?

The medical facility or coroner/medical examiner's office is required to:

- A. Have a significant supply of blank copies of the Communicable Disease Report Form for use by ERPs or good samaritans or their designated officers.
- B. Forward one copy of the form to the final receiving facility if the patient is transferred (to a trauma center or specialty care facility).
- C. If the medical facility or coroner/medical examiner's office determines the patient has one of the specified communicable diseases and that the exposure described could transmit the communicable disease, the medical facility or coroner/medical examiner's office shall notify the ERP or good samaritan within 48 hours or as soon as possible after determination of the disease to which they have been exposed and advise the ERP or good samaritan concerning appropriate medical followup.
- D. Maintain a record of all communicable disease exposure forms received which shall contain at least the following information:
  1. Name of patient.
  2. Missouri uniform ambulance reporting form number.
  3. Name of ERP or good samaritan.
  4. Date and time the form was received.
  5. Whether the patient had one of the designated communicable diseases.
  6. If a communicable disease was determined, the date the ERP or good samaritan was notified.
  7. Other medical facilities or coroner/medical examiner's offices, if any, to which the form was transferred.

CONFIDENTIAL INFORMATION

Missouri Department of Health regulations require that the names of both the person who has suffered the communicable disease exposure and the person determined as having a communicable disease be kept confidential. A person who violates this confidentiality is guilty of a misdemeanor and is subject to fine or jail term.

ADDITIONAL INFORMATION

For additional information regarding this form, the laws or regulations, please contact the Missouri Department of Health, Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, Missouri 65102 (314) 751-6369.

04/94

**19 CSR 30-40.048 Training for Emergency Response Personnel and Good Samaritans on the Communicable Disease Reporting Regulation**

(Rescinded February 28, 1999)

*AUTHORITY: sections 192.020, RSMo 1986 and 192.806.1, RSMo Supp. 1993. Original rule filed Feb. 2, 1994, effective Aug. 28, 1994. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.050 Mobile Emergency Medical Technicians**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.050. Original rule filed Aug. 22, 1974, effective Feb. 23, 1975. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.060 Emergency Medical Service Personnel Application**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo 1994. Original rule filed Sept. 1, 1995, effective April 30, 1996. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.070 Public Convenience and Necessity Hearings**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.125 and 190.185, RSMo 1994. This rule was previously filed as 13 CSR 50-40.070. Original rule filed Aug. 22, 1974, effective Feb. 23, 1975. Rescinded and readopted: Filed Nov. 16, 1987, effective Jan. 29, 1988. Amended: Filed April 14, 1992, effective Jan. 15, 1993. Emergency amendment filed May 2, 1994, effective May 14, 1994, expired Sept. 10, 1994. Amended: Filed May 2, 1994, effective Oct. 30, 1994. Amended: Filed Nov. 15, 1994, effective May 28, 1995. Amended: Filed March 20, 1996, effective Sept. 30, 1996. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.080 Records and Forms**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.080. Original rule filed Aug. 22, 1974, effective Feb. 23, 1975. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.090 Examination Procedures**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.090. Original rule filed March 13, 1979, effective June 11, 1979. Amended: Filed April 14, 1992, effective Jan. 15, 1993. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.100 Relicensure Procedures**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.100. Original rule filed March 13, 1979, effective June 11, 1979. Amended: Filed June 4, 1990, effective Oct. 31, 1990. Amended: Filed Nov. 9, 1993, effective July 10, 1994. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.110 Procedures for EMS Course Approvals**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.110. Original rule filed March 13, 1979, effective June 11, 1979. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.115 Requirements for Mobile Emergency Medical Technician (MENT) Continuing Education/Quality Improvement (CE/QI) Programs**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. Original rule filed Nov. 9, 1993, effective July 10, 1994. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.120 Instructor Qualifications for EMT Courses**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.120. Original rule filed March 13, 1979, effective June 11, 1979. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.130 Use of Obturators by EMTs**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.130. Original rule filed March 13, 1979, effective June 11, 1979. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.140 Criteria for Revocation, Suspension, Probation and/or Denial of Initial or Renewal Application for Ambulance Attendant, Attendant/Driver and Mobile Emergency Medical Technician Licenses**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo 1994. This rule was previously filed as 13 CSR 50-40.140. Original rule filed Oct. 7, 1983, effective Jan. 13, 1984. Amended: Filed Sept. 1, 1995, effective April 30, 1996. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.150 Restriction on Licensure Actions Without Thorough Investigation and Administrative Review**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.165, RSMo 1986 and 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.150. Original rule filed Oct. 7, 1983, effective Jan. 13, 1984. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.152 Criminal Background Checks by Department of Health for Licensure and Renewal Applications**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo 1994. Original rule filed Sept. 1, 1995, effective April 30, 1996. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.160 Physician Medical Advisor Required for All Ambulance Services**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.160. Original rule filed Oct. 7, 1983, effective Jan. 13, 1984. Amended: Filed Jan. 13, 1990, effective April 26, 1990. Amended: Filed Aug. 15, 1994, effective Feb. 26, 1995. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*



**19 CSR 30-40.170 Misrepresenting the Level of Ambulance Service or Training, a Violation of Law**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.185 RSMo Supp. 1993 and 570.160, RSMo 1986. This rule was previously filed as 13 CSR 50-40.170. Original rule filed Oct. 7, 1983, effective Jan. 13, 1984. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.175 Minimum Training Level of Personnel Using Emergency Medical Equipment**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. Original rule filed Jan. 18, 1990, effective April 26, 1990. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.180 Use of Pneumatic Counter Pressure Device by EMTs**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.180. Original rule filed Oct. 7, 1983, effective Jan. 13, 1984. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.190 Exceptions to the Requirement for Maintenance of Voice Contact or Telemetry in Regard to Mobile Emergency Medical Technician Advanced Life-Support Procedures**

(Rescinded February 28, 1999)

*AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.190. Original rule filed Oct. 7, 1983, effective Jan. 13, 1984. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.195 Emergency Medical Service (EMS) Personnel Within the Hospital Emergency Department**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.140, RSMo Supp. 1987 and 190.185, RSMo. Supp. 1993. Original rule filed April 14, 1992, effective Jan. 15, 1993. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.200 Definitions Relating to Air Ambulance Services**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.125, RSMo 1986 and 190.185, RSMo Supp. 1993. Original rule filed Jan. 5, 1988, effective March 25, 1988. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.210 Air Ambulance Regulations for Helicopter**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.100(1) and 190.185, RSMo Supp. 1993. Original rule filed Jan. 5, 1988, effective March 25, 1988. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.220 Air Ambulance Regulations for Fixed-Wing Aircraft**

(Rescinded February 28, 1999)

*AUTHORITY: sections 190.100(1) and 190.185, RSMo Supp. 1993. Original rule filed Jan. 5, 1988, effective March 25, 1988. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.*

**19 CSR 30-40.302 Emergency Medical Services Regions and Committees**

*PURPOSE: This rule identifies the counties that are included in each of the six (6) emergency medical services regions and establishes the requirements for the appointment of members to each of the six (6) regional committees.*

(1) The following identifies the counties that shall be included in each of the six (6) emergency medical services (EMS) regions.

(A) The Central EMS region shall include the counties of Adair, Audrain, Benton, Boone, Callaway, Camden, Chariton, Clark, Cole, Cooper, Dent, Gasconade, Howard, Knox, Lewis, Linn, Macon, Maries, Marion, Miller, Moniteau, Monroe, Montgomery, Morgan, Osage, Pettis, Phelps, Pulaski, Putnam, Ralls, Randolph, Saline, Schuyler, Scotland, Shelby, and Sullivan.

(B) The Kansas City EMS region shall include the counties of Bates, Caldwell, Carroll, Cass, Clay, Clinton, Henry, Jackson, Johnson, Lafayette, Platte, and Ray.

(C) The Northwest EMS region shall include the counties of Andrew, Atchison, Buchanan, Davies, DeKalb, Gentry, Grundy,

Harrison, Holt, Livingston, Mercer, Nodaway, and Worth.

(D) The St. Louis EMS region shall include the counties of Franklin, Jefferson, Lincoln, Pike, St. Charles, St. Louis, Warren, and St. Louis City.

(E) The Southeast EMS region shall include the counties of Bollinger, Butler, Cape Girardeau, Carter, Crawford, Dunklin, Iron, Madison, Mississippi, New Madrid, Pemiscot, Perry, Reynolds, Ripley, Saint Francois, Sainte Genevieve, Scott, Stoddard, Washington, and Wayne.

(F) The Southwest EMS region shall include the counties of Barry, Barton, Cedar, Christian, Dade, Dallas, Douglas, Greene, Hickory, Howell, Jasper, Laclede, Lawrence, McDonald, Newton, Oregon, Ozark, Polk, St. Clair, Shannon, Stone, Taney, Texas, Vernon, Webster, and Wright.

(2) Each of the six (6) EMS regional committees shall consist of no more than fifteen (15) members, appointed by the director of the Department of Health.

(3) The committees should include representation from emergency medical technicians-basic, emergency medical technicians-paramedic, registered nurses with expertise in emergency medicine, firefighter/emergency medical technicians, trauma surgeons, physicians with expertise in emergency medicine, trauma nurse coordinators from designated trauma centers, emergency medical response agencies, ground ambulance service managers, EMS training entities, pediatric hospitals or physicians/registered nurses with expertise in pediatric care, emergency medical dispatchers, air ambulance services, physicians with expertise in EMS medical direction, local health departments, hospital administrators, medical examiners or coroners, and EMS consumers.

*AUTHORITY: sections 190.102 and 190.185, RSMo 2000.\* Original rule filed Dec. 1, 2000, effective May 30, 2001.*

*\*Original authority: 190.102, RSMo 1998; 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

**19 CSR 30-40.303 Medical Director Required for All: Ambulance Services and Emergency Medical Response Agencies That Provide Advanced Life Support Services, Basic Life Support Services Utilizing Medications or Providing Assistance With Patients' Medications, or Basic Life Support Services Performing Invasive Procedures Including Invasive Airway Procedures; Dispatch Agencies Providing**

**Pre-arrival Medical Instructions; and Training Entities**

*PURPOSE: This rule describes the qualifications and requirements related to medical directors of ambulance services, emergency medical response agencies, dispatch agencies, and training entities.*

(1) As used in this rule, the following terms shall have the meanings specified:

- (A) ACLS—advanced cardiac life support;
- (B) ALS—advanced life support;
- (C) ATLS—advanced trauma life support;
- (D) BCLS—basic cardiac life support;
- (E) BLS—basic life support;
- (F) Board eligibility—a physician who has applied to a specialty board and has received a ruling that s/he has fulfilled the requirements to take the board examination and the board certification must be obtained within five (5) years of the first appointment;
- (G) EMS—emergency medical services;
- (H) EMT-Basic—emergency medical technician-basic;
- (I) EMT-Paramedic—emergency medical technician-paramedic;
- (J) PALS—pediatric advanced life support; and
- (K) Primary care specialty—family/general practice, internal medicine, or pediatrics.

(2) Ambulance services that provide advanced life support services, basic life support services utilizing medications (medications include, but are not limited to, activated charcoal, oral glucose and/or oxygen) or providing assistance with patients' medications (patient medications include, but are not limited, to a prescribed inhaler, nitroglycerin and/or epinephrine), or basic life support services performing invasive procedures including invasive airway procedures (invasive airway procedures include, but are not limited to, esophageal or endotracheal intubation) shall comply with this section of the regulation.

(A) Each licensed ambulance service which provides ALS care shall have a medical director who is licensed as a doctor of medicine or a doctor of osteopathy by the Missouri State Board of Registration for the Healing Arts and who has—

- 1. Board certification in emergency medicine; or
- 2. Board certification or board eligibility in a primary care specialty or surgery and has actively practiced emergency medicine during the past year and can demonstrate current course completion or certification in ACLS, ATLS and PALS (certification in ACLS, ATLS and PALS must be obtained no

later than one (1) year after initial ambulance service licensure), or documentation of equivalent education in cardiac care, trauma care and pediatric care within the past five (5) years; or

3. An active practice in the community, with current course completion or certification in ACLS and PALS (certifications shall be obtained no later than one (1) year after initial ambulance service licensure), or documented equivalent education in cardiac care and pediatric care within the past five (5) years who develops a written agreement with a physician who meets the requirements stated in (2)(A)1. or (2)(A)2. to review and approve the processes required in (2)(C), (2)(D), and (2)(E) in order to facilitate the medical direction of the ambulance service.

(B) Each licensed ambulance service which provides only BLS care shall have a medical director who is licensed as a doctor of medicine or a doctor of osteopathy by the Missouri State Board of Registration for the Healing Arts and can demonstrate current course completion or certification in ACLS and PALS (certifications must be obtained no later than one (1) year after initial ambulance service licensure), or can document equivalent education in cardiac care and pediatric care within the past five (5) years.

(C) The medical director, in cooperation with the ambulance service administrator, shall develop, implement and annually review the following:

- 1. Medical and treatment protocols for medical, trauma and pediatric patients;
- 2. Triage and transport protocols;
- 3. Protocols for do-not-resuscitate requests;
- 4. Air ambulance utilization; and
- 5. Medications and medical equipment to be utilized.

(D) The medical director, in cooperation with the ambulance service administrator, shall ensure that all licensed service personnel meet the education and skill competencies required for their level of license and patient care environment. The medical director shall have the authority to require additional education and training for any licensed service personnel who fail to meet this requirement and limit the patient care activities of personnel who deviate from established standards.

(E) The medical director, in cooperation with the ambulance service administrator, shall develop, implement and annually review the following:

- 1. Prolonged ambulance scene, response or transport times;
- 2. Incomplete run documentation;
- 3. Ambulances that are diverted from their original destinations;

4. Compliance with adult and pediatric triage, treatment and transport protocols (or sample thereof);

5. Skills performance (or sample thereof); and

6. Any other activities that the administrator or medical director deem necessary.

(3) Emergency medical response agencies that provide advanced life support services, basic life support services utilizing medications (medications include, but are not limited to, activated charcoal, oral glucose and/or oxygen) or providing assistance with patients' medications (patient medications include, but are not limited to, a prescribed inhaler, nitroglycerin and/or epinephrine), or basic life support services performing invasive procedures including invasive airway procedures (invasive airway procedures include, but are not limited to, esophageal or endotracheal intubation) shall comply with this section of the regulation.

(A) Each emergency medical response agency which provides ALS care shall have a medical director who is licensed as a doctor of medicine or a doctor of osteopathy by the Missouri State Board of Registration for the Healing Arts and who has—

1. Board certification in emergency medicine; or

2. Board certification or board eligibility in a primary care specialty or surgery and has actively practiced emergency medicine during the past year and can demonstrate current course completion or certification in ACLS, ATLS and PALS (certification in ACLS, ATLS and PALS must be obtained no later than one (1) year after initial emergency medical response agency licensure), or documentation of equivalent education in cardiac care, trauma care and pediatric care within the past five (5) years; or

3. An active practice in the community, with current course completion or certification in ACLS and PALS (certifications shall be obtained no later than one (1) year after initial emergency medical response agency licensure), or documented equivalent education in cardiac care and pediatric care within the past five (5) years who develops a written agreement with a physician who meets the requirements stated in (3)(A)1. or (3)(A)2. to review and approve the processes required in (3)(C), (3)(D), and (3)(E) in order to facilitate the medical direction of the emergency medical response agency.

(B) Each emergency medical response agency which provides only BLS care shall have a medical director who is licensed as a doctor of medicine or a doctor of osteopathy by the Missouri State Board of Registration

for the Healing Arts and can demonstrate current course completion or certification in ACLS and PALS, or can document equivalent education in cardiac care and pediatric care within the past five (5) years.

(C) The medical director, in cooperation with the emergency medical response agency administrator, shall develop, implement and annually review the following:

1. Medical and treatment protocols for medical, trauma and pediatric patients;
2. Triage protocols;
3. Protocols for do-not-resuscitate requests;
4. Air ambulance utilization; and
5. Medications and medical equipment to be utilized.

(D) The medical director, in cooperation with the emergency medical response agency administrator, shall ensure that all licensed agency personnel meet the education and skill competencies required for their level of license and patient care environment. The medical director shall have the authority to require additional education and training for any licensed agency personnel who fail to meet this requirement and limit the patient care activities of personnel who deviate from established standards.

(E) The medical director, in cooperation with the emergency medical response agency administrator, shall develop, implement and annually review the following:

1. Prolonged emergency medical response agency response times;
2. Incomplete run documentation;
3. Compliance with adult and pediatric triage and treatment protocols (or sample thereof);
4. Skills performance (or sample thereof); and
5. Any other activities that the administrator or medical director deem necessary.

(4) All dispatch agencies which provide pre-arrival medical instructions shall comply with this section of the regulation.

(A) Each dispatch agency shall have a medical director who is licensed as a doctor of medicine or a doctor of osteopathy by the Missouri State Board of Registration for the Healing Arts who can demonstrate current course completion or certification in ACLS, or can document equivalent education in cardiac care within the past five (5) years.

(B) The medical director, in cooperation with the dispatch agency administrator, shall develop, implement and annually review the following:

1. Medical pre-arrival instruction protocols; and

2. Standards related to the administration of those protocols.

(C) The medical director, in cooperation with the dispatch agency administrator, shall ensure that all dispatch personnel giving medical pre-arrival instructions meet the education and skill competencies required for their patient care environment. The medical director shall have the authority to require additional education and training for any personnel who fail to meet this requirement and limit the activities related to giving medical pre-arrival instructions of personnel who deviate from established standards.

(D) The medical director, in cooperation with the dispatch agency administrator, shall develop, implement and annually review the following:

1. Prolonged ambulance or emergency medical response agency dispatch times;
2. Compliance with medical pre-arrival instruction protocols (or sample thereof); and
3. Any other activities that the administrator or medical director deem necessary.

(5) Training entities shall comply with this section of the regulation.

(A) Each EMT-Paramedic training entity shall have a medical director who is licensed as a doctor of medicine or a doctor of osteopathy by the Missouri State Board of Registration for the Healing Arts and who has—

1. Board certification in emergency medicine; or
2. Board certification or board eligibility in a primary care specialty or surgery and has actively practiced emergency medicine during the past year and can demonstrate current course completion or certification in ACLS, ATLS and PALS (certification in ACLS, ATLS and PALS must be obtained no later than one (1) year after initial training entity accreditation), or documented equivalent education in cardiac care, trauma care and pediatric care within the past five (5) years; or

(B) Each EMT-Basic, continuing education, first responder or emergency medical dispatch training entity shall have a medical director who is licensed as a doctor of medicine or a doctor of osteopathy by the Missouri State Board of Registration for the Healing Arts and can demonstrate current course completion or certification in ACLS and PALS (certifications must be obtained no later than one (1) year after initial training entity accreditation), or can document equivalent education in cardiac care and pediatric care within the past five (5) years.

(C) Each EMS training entity medical director shall be responsible for ensuring an

accurate and thorough presentation of the medical content of the education and training program. Ensure that the student has met the education and skill competencies based on current national standards and scope of practice for each level of licensure and/or certification.

*AUTHORITY: sections 190.103, 190.108, 190.109, 190.131, 190.133, 190.134 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Emergency rescission and rule filed July 30, 1999, effective Aug. 9, 1999, expired Feb. 3, 2000. Rescinded and readopted: Filed: July 30, 1999, effective Jan. 30, 2000.*

*\*Original authority: 190.103, RSMo 1998; 190.108, RSMo 1998; 190.109, RSMo 1998; 190.131, RSMo 1998; 190.133, RSMo 1998; 190.134, RSMo 1998; and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

#### **19 CSR 30-40.308 Application and Licensure Requirements Standards for the Licensure and Relicensure of Air Ambulance Services**

*PURPOSE: This rule provides the requirement and standards related to the licensure and relicensure of air ambulance services.*

(1) Application Requirements for Air Ambulance Service Licensure.

(A) Each applicant for ownership of an air ambulance service license or relicensure shall submit an application for licensure to the Bureau of Emergency Medical Services (EMS) no less than thirty (30) days or no more than one hundred and twenty (120) days prior to their desired date of licensure or relicensure.

(B) An application shall include the following information: type of license applied for (rotary wing or fixed wing); trade name of air ambulance service; location of aircraft; number of aircraft to be used as an air ambulance(s); name, address, telephone numbers and e-mail address (if applicable) of operator of air ambulance service; name of manager; name, address, whether a medical doctor or doctor of osteopathy, telephone numbers, e-mail address (if applicable), and signature of medical director and date signed; certification by the medical director that they are aware of the qualification requirements and the responsibilities of an air ambulance service medical director and agree to serve as medical director; name, address, telephone numbers and e-mail address (if applicable) of proposed licensee of air ambulance service;

name of licensee's chief executive officer; all ambulance service licensure and related administrative licensure actions taken against the ambulance service or owner by any state agency in any state; and certification by the applicant that the application contains no misrepresentations or falsifications and that the information given by them is true and complete to the best of their knowledge, and that the ambulance service has both the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Service Systems Act, Chapter 190, RSMo Supp. 1998.

(C) Each air ambulance service that meets the requirements and standards of the statute and regulations shall be licensed and relicensed for a period of five (5) years. Air ambulances based inside or outside Missouri that do intra-Missouri transports shall be licensed in the state of Missouri and shall be held to the same standards.

(D) Air ambulance services which are currently accredited by the Commission on Accreditation of Medical Transportation Services (CAMTS) and have the required liability insurance coverage shall be considered to be compliant with the rules for air ambulance services. Accredited air ambulance services shall attach to their application evidence of accreditation and proof of their liability insurance coverage. The Bureau of EMS shall conduct periodic site reviews and inspections of applicable records and medical equipment as necessary to verify compliance.

(E) Fixed wing air ambulances shall meet the requirements stated in this regulation except (2)(E), (4)(A)1., (4)(A)2., (8)(D), (8)(E), and (11).

(2) Air ambulance services shall meet the following operation and maintenance standards:

(A) Air ambulance services shall possess or contract for a valid Federal Aviation Administration Title 14 CFR part 135 Certificate and if a rotary air ambulance be authorized to conduct helicopter air ambulance operations in accordance with Federal Aviation Regulation part 135 and this operations specification;

(B) The air ambulance service shall ensure prompt response to all requests to that service for emergency care twenty-four (24) hours per day, each and every day of the year, and shall provide patients with medically necessary care and transportation in accordance with that air ambulance service's protocols;

(C) Each air ambulance program shall have established information that is made available to each emergency service in the area in which they operate to include the following:

- 1. Aircraft capabilities;

2. Appropriate utilization of air ambulances;

3. Education and skills of the crew; and

4. Safety considerations;

(D) Public liability insurance or proof of self-insurance, condition to pay losses and damage caused by or resulting from the negligent operation, maintenance, or use of ambulance services under the service's operating authority or for loss or damage to property or others. Documents submitted as proof of insurance shall specify the limits of coverage and include the ambulance service license number. Public liability coverage for air ambulance services which transport patients shall meet or exceed:

1. Two hundred fifty thousand dollars (\$250,000) for bodily injury to, or death of, one (1) person;

2. Five hundred thousand dollars (\$500,000) for bodily injury to, or death of, all persons injured or killed in any one (1) accident, subject to a minimum of two hundred fifty thousand dollars (\$250,000) per person; and

3. One hundred thousand dollars (\$100,000) for loss or damage to property of others in one (1) accident, excluding cargo; and

(E) The aviation crew of an air ambulance shall meet all requirements of the Federal Aviation Administration Title 14 CFR part 135.

(3) Each aircraft, when operated as an air ambulance, shall meet the following equipment requirements:

(A) Documentation that each aircraft is equipped with pediatric and adult medical supplies and equipment as required by the air ambulance service medical director for the various advanced life support procedures or protocols for the patient care activities in the out-of-hospital setting to which it will respond. Each service shall be able to produce these records for inspection during normal business hours;

(B) The aircraft will be equipped with all equipment to allow reliable communication, flight following and emergency locator transmitter; and

(C) The air ambulance service shall have a policy and provide for the effective maintenance, storage, usage and replacement of its medical equipment, devices and medications.

(4) Each aircraft operated as an ambulance shall meet the following staffing requirements:

(A) Air medical staff mix shall be selected by each air ambulance program in accordance with the medical director's best judgment as

to what is best for patients transported by the service, and—

1. On scene flights there shall be at least two (2) air medical crew members. The primary crew member shall be a registered nurse or physician and the secondary crew member shall be an EMT-Paramedic, registered nurse or physician; and

2. On all transports other than scenes, there shall be at least two (2) air medical crew members, one (1) of whom will be a registered nurse or physician, and a secondary crew member who is approved by the medical director to provide critical care; and

(B) The medical flight crew members will receive training designed by the medical director and clinical registered nurse supervisor to provide knowledge and skills needed to carry out advanced life support procedures and written protocols. The unique flight and pre-hospital environment will be addressed during training.

(5) Each air ambulance service shall maintain accurate records and forms that include the following:

(A) An air ambulance report to record information on each air ambulance request;

(B) Air ambulance service license;

(C) Medical director protocol and policy authorization;

(D) Equipment maintenance records; and

(E) Continuing education records.

(6) Each air ambulance service shall have medical control policies, procedures and standing orders that have been approved by their medical director and clinical registered nurse supervisor—

(A) The protocols will include authorization for standing orders;

(B) The written protocols will be provided to the Bureau of EMS upon request; and

(C) The medical director will ensure the air medical personnel are provided appropriate training to meet standards established by the program.

(7) Each air ambulance service shall have a designated medical director, working under an agreement, who is trained and meets the requirements for a medical director in accordance with 19 CSR 30-40.303(1).

(A) Medical directors for flight programs shall also demonstrate expertise in advanced trauma life support, advanced cardiac life support, and in-flight conditions unique to the air transport of patients.

(B) Medical directors for flight programs must have a current and valid license to practice medicine in the state of Missouri and shall also maintain staff privileges at a



Missouri licensed hospital that regularly receives patients from the air ambulance program.

(C) An air ambulance used for transport of trauma patients must have a medical advisor who is a trauma surgeon on the staff of a designated trauma center that regularly receives patients from the air ambulance program and who will provide expertise in cooperation with the medical director in the development of policies, procedures and quality improvement for all trauma related air ambulance activities.

(8) Each aircraft operated as an ambulance shall have the capability to communicate by voice with local hospital(s), trauma centers, and the service's own dispatching agency.

(A) Communication specialists shall have the training commensurate to the scope of responsibility in the communication center.

(B) Training shall be provided in aircraft capabilities, operational limitations, navigation and map coordination.

(C) Information pertinent to each call shall be logged in order to retrieve complete activity review reports.

(D) Communication specialists shall be responsible for flight following based on requirements of the program and Federal Aviation Administration Title 14 CFR part 135.

(E) A system shall be in place to assure emergency requests are answered, the phone calls and radio traffic are recorded and a back-up power source is available. The system shall include means to provide the crew the ability to communicate by voice with local hospitals, trauma centers, police, sheriff and fire dispatching agencies.

(F) The hospital emergency ambulance radio system shall not be used for flight following.

(9) There shall be an ongoing quality improvement program designed to objectively and systematically monitor, review and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems. A safety committee shall be established and shall meet regularly to assess and evaluate the safety aspects of the operation.

(10) Each air ambulance service shall maintain policies and procedures that include the following:

(A) Safety program, including infection control program;

(B) Communications procedures;

(C) Ambulance operations procedures;

(D) Standards of clinical care (medical protocols);

(E) Equipment maintenance;

(F) Disaster/multiple casualty protocols; and

(G) Quality improvement program.

(11) Helicopter visual flight rule programs will adhere to the ceiling and visibility standards of the Federal Aviation Administration as authorized when conducting helicopter air ambulance operations in accordance with Federal Aviation Regulation part 135. These operations specifications will be available for inspection by the Bureau of EMS during normal business hours.

(12) Each ambulance service shall display a copy of their ambulance service license in the patient care compartment of each ambulance aircraft operated by the ambulance service.

*AUTHORITY: sections 190.103, 190.108, 190.120, 190.160, 190.165, 190.175, 190.176 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

*\*Original authority: 190.103, 190.108, RSMo, 1998; 190.120, RSMo 1973, amended 1980, 1998; 190.160, RSMo 1973, amended 1998; 190.165, RSMo 1973, amended 1978, 1998; 190.175, RSMo 1973, amended 1998; 190.176, RSMo 1998; and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

### **19 CSR 30-40.309 Application and Licensure Requirements Standards for the Licensure and Relicensure of Ground Ambulance Services**

*PURPOSE: This rule provides the requirement and standards related to the licensure and relicensure of ground ambulance services.*

(1) Application Requirements for Ground Ambulance Service Licensure.

(A) Each applicant for ownership of an ambulance service license or relicensure shall submit an application for licensure to the Bureau of Emergency Medical Services (EMS) no less than thirty (30) days or no more than one hundred and twenty (120) days prior to their desired date of licensure or relicensure.

(B) An application shall include the following information: trade name of the ambulance service; location of vehicles; number of vehicles to be operated by the ambulance service; name, address, telephone numbers and e-mail address (if applicable) of operator

of the ambulance service; name of manager; name, address, whether a medical doctor or doctor of osteopathy, telephone numbers, e-mail address (if applicable), and signature of medical director and date signed; certification by the medical director that they are aware of the qualification requirements and the responsibilities of an ambulance service medical director and agree to serve as medical director; name, address, telephone numbers and e-mail address (if applicable) of proposed licensee of the ambulance service; name of licensee's chief executive officer; all ambulance service licensure and related administrative licensure actions taken against the ambulance service or owner by any state agency in any state; and certification by the applicant that the application contains no misrepresentations or falsifications and that the information given by them is true and complete to the best of their knowledge, and that the ambulance service has both the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Service Systems Act, Chapter 190, RSMo Supp. 1998.

(C) Each ambulance service that meets the requirements and standards of the statute and regulations shall be licensed and relicensed for a period of five (5) years.

(D) Ambulance services which are currently accredited by the Commission on Accreditation of Ambulance Services (CAAS) or the Commission on Accreditation of Medical Transportation Services (CAMTS) and have the required liability insurance coverage shall be considered to be compliant with the rules for ambulance services. Accredited ambulance services shall attach to their application evidence of accreditation and proof of their liability insurance coverage. The Bureau of EMS may conduct periodic site reviews as necessary to verify compliance.

(2) Each vehicle operated as an ambulance shall meet the following vehicle design, specification, operation and maintenance standards:

(A) Vehicle Design and Specification Standards. In providing the transportation of patients, ambulance services shall utilize only vehicles specifically designed, manufactured and equipped for use as an ambulance and which meet current (at date of vehicle manufacture) U.S. Department of Transportation KKK-A-1822 specifications with exceptions of the following:

1. Image elements (such as paint) may be altered to the agency's preference;

2. Variation of warning lights is allowed for: type and color of lens, strobe lights in



lieu of halogen lights, additional warning lights beyond the U.S. Department of Transportation KKK-A-1822 specifications;

3. Power supply and equipment in the patient compartment may be altered to the agency's preference; and

4. Other variations may be allowed by the Bureau of EMS;

(B) Operational Standards.

1. Ambulance services shall provide the quantity of ambulance vehicles, medical supplies and personnel to meet the emergency call volume which can be reasonably anticipated for their ambulance service area.

2. Ambulance services which are the 911 provider or the recognized emergency provider shall ensure prompt response to all requests to that service for emergency care originating from their ambulance service area twenty-four (24) hours per day, each and every day of the year, and shall provide patients with medically necessary care and transportation in accordance with that ambulance service's protocols.

3. Public liability insurance or proof of self-insurance, conditioned to pay losses and damage caused by or resulting from the negligent operation, maintenance, or use of ambulance services under the service's operating authority or for loss or damage to property of others. Documents submitted as proof of insurance shall specify the limits of coverage and include the ambulance service license number. Public liability coverage for ambulance services which transport patients in the patient compartment of a vehicle shall meet or exceed—

A. Two hundred fifty thousand dollars (\$250,000) for bodily injury to, or death of, one (1) person;

B. Five hundred thousand dollars (\$500,000) for bodily injury to, or death of, all persons injured or killed in any one (1) accident, subject to a minimum of two hundred fifty thousand dollars (\$250,000) per person; and

C. One hundred thousand dollars (\$100,000) for loss or damage to property of others in one (1) accident, excluding cargo; and

(C) Maintenance Standards. The ambulance service shall have a policy to provide for the effective maintenance of all its ambulances and maintain records that demonstrate compliance with such policy.

(3) Each vehicle operated as an ambulance shall meet the following equipment requirements:

(A) Documentation that each vehicle is equipped with pediatric and adult medical supplies and equipment as required by the

ambulance service medical director for the various patient care activities in the out-of-hospital setting to which it will respond. Each service shall be able to produce these records for inspection during normal business hours; and

(B) The ambulance service shall have a policy and provide for the effective maintenance, storage, usage and replacement of its medical equipment, devices and medications.

(4) Each vehicle operated as an ambulance shall meet the following staffing requirements:

(A) When transporting a patient, at least one (1) licensed EMT, registered nurse, or physician shall be in attendance with the patient in the patient compartment at all times; and

(B) When an ambulance service provides advanced life support care under its protocols, the patient shall be attended by an EMT-Paramedic, registered nurse or physician.

(5) Each ambulance service shall maintain accurate records and forms on the following:

(A) An ambulance report to record information on each emergency request for service and each ambulance run;

(B) Ground ambulance service license;

(C) Medical director protocol and policy authorization;

(D) Vehicle maintenance records;

(E) Vehicle driver education records;

(F) Equipment maintenance records; and

(G) Records required by other regulatory agencies.

(6) Each ambulance service shall have a medical control plan that has been approved by their medical director and service manager. The medical control plan is that portion of the medical protocols which specifically address the transfer of patient care between agencies.

(7) Each ambulance service that provides advanced life support services, basic life support services utilizing medications (medications include activated charcoal, oral glucose and/or oxygen) or providing assistance with patients' medications (patient medications include a prescribed inhaler, nitroglycerin and/or epinephrine), or basic life support services performing invasive procedures including invasive airway procedures (invasive airway procedures include esophageal or endotracheal intubation) shall have a designated medical director, working under an agreement, who is trained and meets the requirements for a medical director in accordance with 19 CSR 30-40.303.

(8) Each vehicle operated as an ambulance shall have the capability to communicate by voice with local hospital(s), trauma centers, and the service's own dispatching agency.

(9) There shall be an ongoing quality improvement program designed to objectively and systematically monitor, review and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems.

(10) Each ambulance service shall maintain policies and procedures that include the following:

(A) Safety program, including infection control program;

(B) Vehicle operations and driving procedures;

(C) Communications procedures;

(D) Ambulance operations procedures;

(E) Standards for clinical care (medical protocols);

(F) Vehicle and equipment maintenance;

(G) Disaster/multiple casualty protocols; and

(H) Quality improvement program.

(11) Each ambulance service shall display a copy of their ambulance service license in the patient care compartment of each ambulance vehicle operated by the ambulance service.

(12) Each ambulance service that held a valid ambulance vehicle license on August 28, 1998, and meets all the legislative and regulatory requirements for licensure shall be issued an initial license for a period of one to five (1-5) years. The Bureau of EMS will determine the initial licensure period for each ambulance service by randomly selecting an equal number of ambulance services for each of the five (5) periods of licensure based on the date the application is received by the Bureau of EMS.

*AUTHORITY: sections 190.103, 190.105, 190.107, 190.109, 190.120, 190.160, 190.165, 190.175, 190.176, 190.185 and 190.190, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

*\*Original authority: 190.103, RSMo 1998; 190.105, RSMo 1973, amended 1998; 190.107, 190.109, RSMo, 1998; 190.120, RSMo 1973, amended 1980, 1998; 190.160, RSMo, 1973, amended 1998; 190.165, RSMo 1973, amended 1978, 1998; 190.175, RSMo 1973, amended 1998; 190.176, RSMo 1998; 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998; and 190.190, RSMo 1973, amended 1998.*

**19 CSR 30-40.331 Application and Accreditation or Certification Requirements for Training Entities that Conduct Training for First Responders, Emergency Medical Dispatchers, Emergency Medical Technicians-Basic and Emergency Medical Technicians-Paramedic**

*PURPOSE: This rule provides the requirements for the application and accreditation or certification of training entities that conduct EMS-related training programs.*

(1) General Requirements for Certification of Emergency Medical Technician-Basic (EMT-B) Training Entities, Emergency Medical Technician-Paramedic (EMT-P) Training Entities, EMT-B Continuing Education Training Entities, and EMT-P Continuing Education Training Entities.

(A) Each applicant for certification as an emergency medical services (EMS) training entity shall make application to the Bureau of EMS and undergo a review by Bureau of EMS staff to determine compliance with these rules. An application shall include: trade name of the training entity; training entity business address; daytime telephone number of the training entity; type of accreditation applied for; name, address, telephone number and signature of the program director; name, address, telephone number and signature of the medical director; and certification by the applicant that the application contains no misrepresentations or falsifications and that the information given by them is true and complete to the best of their knowledge, and that the training entity has both the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Service Systems Act, Chapter 190, RSMo Supp. 1998.

(B) Only certified EMS training entities shall be authorized to conduct EMS training programs. Upon receipt of an application for EMS training entity certification, the Bureau of EMS shall cause an inspection of the applicant to determine compliance with these rules, and such subsequent inspection as is necessary or desirable to assure compliance with these rules. Such inspections shall occur not less than once every five (5) years.

(C) Each EMS training entity shall demonstrate an organizational structure that assures responsibility for the organization, administration, periodic review, continued development and effectiveness of all educational programs conducted by the EMS training entity. The EMS training entity shall have an organizational chart and job descriptions for relevant positions within the training entity and

make this available to Bureau of EMS personnel on request.

(D) Each EMS training entity shall demonstrate adequate resources for the continued operation of all educational programs conducted. This shall be available to Bureau of EMS personnel on request.

(E) Each EMS training entity shall have a medical director who reviews and approves the educational content of the program and quality of medical instruction. The medical director for EMS training entities shall meet the requirements set forth in 19 CSR 30-40.303.

(F) Each EMS training entity shall demonstrate a methodology to evaluate the need for training and to assure availability of effective training programs.

(G) Faculty Requirements.

1. Each EMS training entity shall have a qualified faculty. Credentials of faculty shall be available for review by the Bureau of EMS.

A. Primary faculty (those who teach twenty percent (20%) or more of classroom sessions) shall meet Bureau of EMS requirements for EMS instructors.

B. The training entity shall describe qualifications and training for laboratory instructors, where lab instructors are used.

C. The training entity shall describe qualifications and training for clinical instructors and field preceptors, where clinical instructors and field preceptors are used.

2. Qualifications for any adjunct instructors such as physicians, registered nurses, paramedics, clinical specialists or expert lecturers shall be documented and available for review by Bureau of EMS.

(H) Physical Facilities.

1. Classrooms and laboratories shall have sufficient space to accommodate the maximum planned number of students and shall be environmentally conducive to providing a quality learning environment. The Bureau of EMS may inspect classroom and laboratory facilities to determine compliance.

2. Equipment and supplies used in the provision of instruction shall be available and consistent with the requirements of the curriculum and adequate for the volume of students enrolled.

A. The Bureau of EMS may periodically inspect such equipment and supplies to determine compliance with this requirement.

B. The EMS training entity shall describe how they will meet this requirement to the Bureau of EMS.

C. The EMS training entity shall assure that the equipment used in its training programs is in proper working order and appropriately cleaned.

3. Training entities that conduct initial courses of instruction shall make available to all students clearly defined and published policies and procedures. Such policies and procedures shall include the following:

- A. Admission criteria;
- B. Student withdrawal and refund of tuition and/or fees policies;
- C. Attendance policy;
- D. Grading and academic criteria;
- E. Class cancellation policy;
- F. Appeal and grievance procedures;
- G. Examination policies;
- H. Health and safety procedures; and
- I. Certification requirements of the National Standard of Emergency Medical Technicians.

(I) Program Self-Evaluation.

1. Each EMS training entity shall demonstrate that the programs conducted under its authority conduct program self-evaluation. Such evaluation shall include:

A. Evaluation of students shall be conducted and documented on a recurring basis and with sufficient frequency to provide both the student and program faculty with valid and timely indicators of each student's progress toward and achievement of the competencies and objectives stated in the curriculum;

B. Test instruments and evaluation methods shall undergo periodic reviews by appropriate training entity staff and medical director; and

C. Evaluation of the program by the students shall be documented and reviewed by the appropriate training entity staff and medical director.

(J) Record Keeping and Reporting.

1. Records shall be maintained for each student that demonstrate all attendance, clinical, practical and written examination records.

2. Records shall be maintained for each class session that document name of instructor, title of session, beginning and ending time of each session, and attendance at the session.

3. Records shall be maintained for each initial course of instruction that document location of course, primary instructor, beginning enrollment, drop-out rate, course fail rate and number of students successfully completing the course.

4. Lesson plans shall be maintained for each course offered.

5. All records shall be available for review by Bureau of EMS and kept on file for at least five (5) years.

6. Each EMS training entity shall submit to the Bureau of EMS an annual report indicating the number, type and location of

courses offered, the pass/fail rate for each course, and the numbers of students completing training. Each annual report shall contain an affidavit that the principal officers and medical director of the training entity remain the same as the original application, or shall indicate any change.

7. Certificates of completion shall be issued by the training entity to students, at the request of the student, after successful completion of the appropriate criteria.

(K) EMS training entities may cooperate and develop satellite programs under their approval. In these cases, the EMS training entity remains responsible for assuring quality EMS education and compliance with Bureau of EMS rules.

(L) Upon EMS training entity approval by the Bureau of EMS, the Bureau of EMS shall assign an accreditation number to each EMS training entity. The EMS training entity shall reference this accreditation number on each course completion letter or certificate issued by the EMS training entity.

**(2) Specific Requirements for EMS Training Entities Offering Initial EMT-P Courses.**

(A) Only EMS training entities certified by the Bureau of EMS to conduct initial EMT-P courses shall offer initial EMT-P courses.

(B) EMT-P students are only authorized to perform the skills and practice in accordance with the national standard curriculum for EMT-P and approved by the training entity medical director. The skills and practice performed by the student must be under the direct supervision of a clinical preceptor and cannot be performed while being employed as an EMT-B.

(C) EMS training entities offering initial EMT-P courses shall also be certified to conduct EMT-B, and/or first responder and/or emergency medical dispatcher, and/or EMS continuing education programs. If the training entity conducts these programs, the training entity shall also be responsible for assuring compliance with the rules set forth for those programs.

(D) Each EMT-P training entity shall have a formal affiliation with an appropriately accredited university, senior college, community college, vocational school, technical school or an appropriately accredited medical institution with dedication to educational endeavors. This affiliation shall include the following:

1. Ability for the EMT-P training program to require prerequisite post-secondary educational courses;
2. Responsibility by the accredited post-secondary educational institution and/or medical institution over the educational

methodologies used by the EMT-P training program; and

3. Access by the EMT-P training program into remedial education as may be necessary for the EMT-P training program.

(E) Each EMT-P training program shall have a designated program director. Each EMT-P course shall have a designated lead instructor.

(F) Each EMT-P training program shall demonstrate and document that the EMT-P courses taught under its authority meet or exceed the requirements of the national standard curriculum for EMT-P training.

(G) Training entities that provide EMT-P programs shall regularly assess the effectiveness of the training program.

**(H) Clinical Requirements.**

1. Each EMS training entity that provides EMT-P programs shall document and demonstrate a supervised clinical experience for all students.

2. Clinical affiliations shall be established and confirmed in current written affiliation agreements with institutions and agencies that provide clinical experience under appropriate medical direction and clinical supervision.

3. Students shall be assigned in clinical settings where experiences are clinically and educationally effective in achieving the program's objectives.

4. When participating in clinicals, students will be clearly identified by name and student status using nameplate, uniform, or other apparent means to distinguish them from other personnel.

5. Field internship shall occur only in association with an Advanced Life Support ambulance service which demonstrates medical accountability and employs preceptors who meet the training entity requirements.

6. The Bureau of EMS will establish minimum standards for clinical experiences in accordance with current clinical recommendations of the national standard curriculum for EMT-P training.

**(I) Examination Requirements.**

1. Each EMT-P training entity shall ensure that graduating students meet entry level competence through the use of a final written and practical examination administered by that training entity.

2. Exam scores for all students shall be maintained and be made available for review by the Bureau of EMS staff.

3. The Bureau of EMS may review the overall pass rates for these examinations to pass rates for examination for licensure (the appropriate National Registry examination). Repeated and disparate differences in these rates from state averages may be ground for

review, recommendation or action by the Bureau of EMS on the training entity accreditation.

(J) Training entities which are currently accredited by the Commission on Accreditation of Allied Health Education Programs (CAAHEP) shall be considered to be compliant with the rules for training entities that conduct EMT-Paramedic programs. Joint Review Committee accredited programs shall attach to their application evidence of accreditation. The Bureau of EMS may conduct periodic site reviews as necessary to verify compliance.

**(3) Specific Requirements for EMS Training Entities Offering Initial EMT-B Courses.**

(A) Only EMS training entities certified by the Bureau of EMS to conduct initial EMT-B courses shall offer initial EMT-B courses.

(B) EMS training entities offering initial EMT-B courses shall also be certified to conduct first responder, emergency medical dispatcher, and EMS continuing education programs. If the training entity conducts these programs, the training entity shall also be responsible for assuring compliance with the rules set forth for those programs.

(C) Each EMT-B training program shall have a designated program director. Each EMT-B course shall have a designated lead instructor.

(D) Each EMT-B training program shall demonstrate and document that the EMT-B courses taught under its authority meet or exceed the requirements of the national standard curriculum for EMT-B training, except for endotracheal intubation which shall not be taught.

**(E) Clinical Requirements.**

1. Each EMS training entity that provides EMT-B programs shall document and demonstrate a supervised clinical experience for all students.

2. Clinical affiliations shall be established and confirmed in current written affiliation agreements with institutions and agencies that provide clinical experience under appropriate medical direction and clinical supervision.

3. Students shall be assigned in clinical settings where experiences are clinically and educationally effective in achieving the program's objectives.

4. When participating in clinicals, students will be clearly identified by name and student status using nameplate, uniform, or other apparent means to distinguish them from other personnel.

5. The Bureau of EMS will establish minimum standards for clinical experiences



in accordance with current clinical recommendations of the national standard curriculum for EMT-B training.

(F) Examination Requirements.

1. Each EMT-B training entity shall ensure that graduating students meet entry level competence through the use of a final written and practical examination administered by that training entity.

2. Exam scores for all students shall be maintained and be made available for review by the Bureau of EMS staff.

3. The Bureau of EMS may review the overall pass rate for these examinations to pass rates for examination for licensure (the appropriate National Registry examination). Repeated and disparate differences in these rates from state averages may be grounds for review, recommendation or action by the Bureau of EMS on the training entity accreditation.

(4) Specific Requirements for EMS Training Entities Offering EMS Continuing Education for EMT-B and EMT-P.

(A) EMS training entities offering EMS continuing education shall be certified to conduct EMT continuing education and/or first responder and/or emergency medical dispatcher training. If the training entity conducts these programs, the training entity shall also be responsible for assuring compliance to the rules set forth for those programs.

(B) Each EMS continuing education training entity shall have a designated program director.

(C) In order for EMS training entities to assign continuing education unit credit for a program, the topic must be related to the appropriate national standard curriculum. Improper assignment of continuing education units may be grounds for action upon the training entity accreditation.

(D) EMS training entities that provide continuing education shall assign continuing education units according to the formula of fifty (50) minutes training time equals one (1) continuing education unit.

(E) When possible, programs shall be awarded continuing education units according to recommendations of the National Registry of EMTs or the Continuing Education Coordinating Board for Emergency Medical Services (CECBEMS).

(F) EMS training entities that provide continuing education may assign continuing education units for instruction of EMS programs according to the formula of fifty (50) minutes training time equals one (1) continuing education unit for programs taught at the provider's level of licensure or higher.

(G) Accreditation of continuing education by appropriate recognized national accrediting bodies shall constitute approval under Bureau of EMS rules.

(5) Specific Requirements for EMS Training Entities Offering Emergency Medical Dispatcher Training.

(A) Each training entity offering emergency medical dispatcher training shall demonstrate and document that the emergency medical dispatcher courses taught under its authority meet or exceed the requirements of a national standard curriculum for emergency medical dispatcher training.

(B) Each training entity shall comply with subsections (1)(A) and (1)(B).

(C) Each training entity shall ensure that graduating students meet entry level competence through the use of a final written examination administered by that training entity.

(6) Specific Requirements for EMS Training Entities Offering First Responder Training.

(A) Each training entity offering first responder training shall demonstrate and document that the first responder courses taught under its authority meet or exceed the requirements of a national standard curriculum for first responder training.

(B) Each training entity shall comply with subsections (1)(A) and (1)(B).

(C) Each training entity shall ensure that graduating students meet entry level competence through the use of a final written and practical examination administered by that training entity.

(7) EMT-B and EMT-P Core Continuing Education Requirements.

(A) EMS training entities may offer EMT-B and/or EMT-P core continuing education programs by offering a stand-alone program, by attending appropriate sessions of an initial training program or through a continuing education format.

(B) EMT-B and/or EMT-P core continuing education programs shall include a final or modular evaluation.

(C) The Bureau of EMS will promulgate standards for offering EMT-B core continuing education programs through a continuing education format.

(D) The Bureau of EMS will promulgate standards for offering EMT-P core continuing education programs through a continuing education format.

(8) Primary Instructor Qualifications.

(A) The Bureau of EMS may authorize as primary instructors for EMS training pro-

grams those who can document the following:

1. Clinical expertise which meets the following:

A. Current licensure and at least two (2) years clinical experience in the level of certification instructed or higher; or

B. Credentials as a subject matter expert as approved by the training entity's medical director;

2. Instructor training which meets the following:

A. Successful completion of an instructor training program that meets or exceeds the United States Department of Transportation EMS instructor curriculum; or

B. Current certification as a Missouri Fire Service Instructor I; or

C. Successful completion of a course from an appropriately accredited post-secondary educational institution that is at least three (3) credit hours on educational methodology;

3. EMS instructional experience which meets the following:

A. Experience as an Advanced Cardiac Life Support, Basic Cardiac Life Support, Basic Trauma Life Support, Pre-Hospital Trauma Life Support, or Pediatric Advanced Life Support instructor; or

B. Experience as a laboratory or guest instructor with an EMS training entity;

4. Continuing education in instructional topics of at least twenty (20) hours over the past five (5) years; and

5. Competent in adult education theory and clinical competency consistent with the level of curricula that they intend to teach.

*AUTHORITY: sections 190.103, 190.131 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

*\*Original authority: 190.103 and 190.131, RSMo 1998 and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

**19 CSR 30-40.333 Application and Licensure Requirements for the Licensure and Relicensure of Emergency Medical Response Agencies That Provide Advanced Life Support**

*PURPOSE: This rule provides the requirement and standards related to the licensure and relicensure of emergency medical response agencies.*

(1) Application Requirements for Emergency Medical Response Agency Licensure.

(A) Each applicant for an emergency medical response agency license or relicense shall submit an application for licensure to the Bureau of Emergency Medical Services (EMS) no less than thirty (30) days or no more than one hundred twenty (120) days prior to their desired date of licensure or relicensure.

(B) An application shall include the following information: trade name of the emergency medical response agency; location of vehicles; name, address, telephone numbers and e-mail address (if applicable) of operator of the emergency medical response agency; name of manager; name, address, whether a medical doctor or doctor of osteopathy, telephone numbers, e-mail address (if applicable), and signature of medical director and date signed; certification by the medical director that they are aware of the qualification requirements and the responsibilities of an emergency medical response agency medical director and agree to serve as medical director; name, address, telephone numbers and e-mail address (if applicable) of proposed licensee of the emergency medical response agency; name of licensee's chief executive officer; all emergency medical response agency licensure and related administrative licensure actions taken against the emergency medical response agency or owner by any state agency in any state; and certification by the applicant that the application contains no misrepresentations or falsifications and that the information given by them is true and complete to the best of their knowledge, and that the emergency medical response agency has both the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Service Systems Act, Chapter 190, RSMo Supp. 1998.

(C) Each emergency medical response agency that meets the requirements and standards of the statute and regulations shall be licensed and relicensed for a period of five (5) years.

(D) A political subdivision or corporation that is licensed as an ambulance service cannot be licensed as an emergency medical response agency.

(2) Operational Standards.

(A) Emergency medical response agencies shall ensure prompt response to all requests to that service for emergency care originating from their service area, in accordance with a memorandum of understanding with the local ambulance services.

(B) In accordance with the memorandum of understanding with local ambulance services, emergency medical response agencies shall provide services, personnel and supplies to meet the emergency call volume which can be reasonably anticipated.

(C) The emergency medical response agency shall have a policy and provide for the effective maintenance, storage, usage and replacement of its medical equipment, devices and medications.

(3) Each emergency medical response agency shall maintain accurate records and forms that include the following:

- (A) A report to record information on each emergency medical call;
- (B) Medical director protocol and policy authorization;
- (C) Equipment maintenance records; and
- (D) Records required by other regulatory agencies.

(4) Each emergency medical response agency shall have a medical control plan that has been approved by their medical director and agency manager. The medical control plan is that portion of the medical protocols which specifically addresses the transfer of patient care between agencies.

(5) Each emergency medical response agency that provides advanced life support shall have a designated medical director, working under an agreement, who is trained and meets the requirements for a medical director in accordance with 19 CSR 30-40.303.

(6) Each emergency medical response agency shall have the capability to communicate by voice with the agency's own dispatching agency and when possible, local hospital(s), trauma centers, and local ambulance services.

(7) Each emergency medical response agency shall have a memorandum of understanding with each ambulance service that is a 911 provider or recognized emergency provider in areas not covered by 911 ambulance services in the agency's jurisdictional boundaries and will include the following:

- (A) Triage protocols;
- (B) Do-not-resuscitate requests;
- (C) Air utilization requests;
- (D) Medical and trauma treatment protocols;
- (E) Quality assurance and improvement program; and
- (F) Response capabilities of the emergency medical response agency.

(8) There shall be an ongoing quality improvement program designed to objectively and systematically monitor, review and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems.

(9) Each emergency medical response agency shall maintain policies and procedures that include the following:

- (A) Safety program, including infection control program;
- (B) Communications procedures;
- (C) Standards of clinical care (medical protocols);
- (D) Equipment maintenance;
- (E) Disaster/multiple casualty protocols; and
- (F) Quality improvement program.

*AUTHORITY: sections 190.103, 190.133, 190.160, 190.165, 190.175, 190.176 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

*\*Original authority: 190.103 and 190.133, RSMo 1998; 190.160, RSMo 1973, amended 1998; 190.165, RSMo 1973, amended 1978, 1998; 190.175, RSMo 1973, amended 1998, 190.176, RSMo 1998; and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

**19 CSR 30-40.340 Initial Emergency Medical Technician Licensure of Mobile Emergency Medical Technicians, Ambulance Attendants and Ambulance Attendant-Drivers Who Have a License with an Expiration Date of August 28, 1998 or Later**

*PURPOSE: This rule provides the requirements related to the initial emergency medical technician licensure of mobile emergency medical technicians, ambulance attendants and ambulance attendant-drivers who have a license with an expiration date of August 28, 1998 or later.*

(1) Any person who has a valid mobile emergency medical technician, ambulance attendant or ambulance attendant-driver license with an expiration date of August 28, 1998, or later shall be considered as holding a valid initial license as an emergency medical technician in accordance with section 190.142, RSMo Supp. 1998, after August 28, 1998.

(2) Mobile emergency technicians shall be considered as Emergency Medical Technician-Paramedics and ambulance attendants

and ambulance attendant-drivers shall be considered as Emergency Medical Technician-Basics in accordance with section 190.142, RSMo Supp. 1998 after August 28, 1998.

(3) A licensee who has a valid mobile emergency medical technician, ambulance attendant or ambulance attendant-driver license with an expiration date of August 28, 1998 or later shall be issued upon application a replacement license with an expiration date two (2) years from the date of expiration shown on that license.

(4) Each application for an emergency medical technician (EMT) replacement license and two (2)-year extension shall include the following: current Missouri Emergency Medical Services (EMS) license number and expiration date; applicant's name, address, date of birth, sex, daytime telephone number, e-mail address (if applicable), and Social Security number; applicant's signature; and a photocopy of the applicant's current license.

*AUTHORITY: sections 190.142 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

*\*Original authority: 190.142, RSMo 1998 and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

### 19 CSR 30-40.342 Application and Licensure Requirements for the Initial Licensure and Relicensure of Emergency Medical Technician-Basics and Emergency Medical Technician-Paramedics

*PURPOSE: This rule provides the requirements related to the initial licensure and relicensure of EMT-Basics and EMT-Paramedics.*

(1) Application Requirements for Emergency Medical Technician (EMT) Licensure.

(A) Each applicant for licensure or relicensure as an EMT-Basic or EMT-Paramedic shall submit an application for licensure to the Bureau of Emergency Medical Services (EMS). An applicant for relicensure must submit their application no less than thirty (30) days or no more than one hundred twenty (120) days prior to the expiration date of their current license.

(B) An application shall include the following information: whether an initial licensure or relicensure application; if previously licensed, their license number and expiration date; type of license applied for (EMT-Basic or EMT-Paramedic); type of certification or education used for licensure or relicensure;

applicant's name, signature, address, date of birth, sex, daytime telephone number, e-mail address (if applicable), and Social Security number; if applicable, type of present primary EMS affiliation; prior administrative licensure actions taken against their EMT license in Missouri or any other state; whether they have been, during the past five (5) years, 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 they received a suspended imposition of sentence for any criminal offense; if the answer is yes to the preceding statement they must attach to their application a certified copy of all charging documents (such as complaints, informations or indictments), judgements and sentencing information and any other information they wish considered; certification by the applicant that they have the ability to speak, read and write the English language; certification by the applicant that they do not have a physical or mental impairment which would substantially limit their ability to perform the essential functions of an emergency medical technician position with or without a reasonable accommodation; certification by the applicant that if relicensing using continuing education that they have successfully completed the required continuing education in accordance with state regulations, have attached a list of these continuing education units, and are in possession of documents of the required continuing education, and will make all records available to the Bureau of EMS upon request under penalty of license action up to and including revocation; certification by the applicant that the application contains no misrepresentations or falsifications and that the information given by them is true and complete to the best of their knowledge; certification by the applicant that they have the intention and the ability to comply with the regulations promulgated under the Comprehensive Emergency Medical Services Systems Act, Chapter 190, RSMo Supp. 1998; and certification by the applicant that they have been a resident of Missouri for five (5) consecutive years prior to the date on their application or have attached to the application at least two (2) completed fingerprint cards supplied by the Bureau of EMS.

(C) All applicants shall provide their Social Security number on their application so the Bureau of EMS can perform criminal history checks to determine the recency and relatedness of any criminal convictions prior to the licensure or relicensure of the applicant. Criminal history checks that the Bureau of EMS finds not to be relevant to the licen-

sure or relicensure of an EMT will not be maintained in the applicant's file.

(D) All applicants shall attach to the application a list of the qualifying continuing education used for relicensure, as applicable. This list shall include verification by the applicant's training officer or medical director that all core requirements have been met. Receipt of this list does not constitute approval of continuing education by the Bureau of EMS.

(E) An applicant shall provide all information and certification required on the Bureau of EMS application for EMT licensure. Incomplete or inaccurate information on an application shall be cause to deny or take action upon a license.

(2) EMT-Basic (EMT-B) Licensure and Relicensure Requirements.

(A) EMT-Basic (Initial Licensure). Initial licensure requirements apply to any person who was not licensed in Missouri prior to August 28, 1998, as an attendant or attendant-driver by the Bureau of EMS or whose Missouri license has expired for more than two (2) years. The applicant for initial licensure shall submit with their license application to the Bureau of EMS evidence of current certification with the National Registry of EMTs as an EMT-B, EMT-Intermediate or EMT-Paramedic (EMT-P).

(B) EMT-Basic (Relicensure or Step Down from EMT-P).

1. The applicant for relicensure shall submit with their license application to the Bureau of EMS evidence of current certification with the National Registry of EMTs as an EMT-Basic, EMT-Intermediate or EMT-Paramedic; or

2. An applicant shall certify to the Bureau of EMS:

A. That they have successfully completed one hundred (100) hours of continuing education which meet Bureau of EMS approval criteria under 19 CSR 30-40.331, forty-eight (48) hours of which cover all elements of the EMT-B core continuing education curriculum and fifty-two (52) hours of which may be elective topics from the EMT-B or EMT-P curriculum;

B. That they are able to produce documentation of the required continuing education, and will make all records available to the Bureau of EMS upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure. Failure to obtain and retain complete and accurate documentation shall be cause for taking action upon a license; and

C. That they have current basic cardiac life support training (does not count



towards core continuing education curriculum).

(3) EMT-Paramedic Licensure and Relicensure Requirements.

(A) EMT-Paramedic (Initial Licensure). Initial licensure requirements apply to any person who was not licensed in Missouri prior to August 28, 1998 as a mobile emergency medical technician by the Bureau of EMS or whose Missouri license has expired for more than two (2) years. The applicant for initial licensure shall submit with their license application to the Bureau of EMS evidence of current certification with the National Registry of EMTs as an EMT-P.

(B) EMT-Paramedic (Relicensure).

1. The applicant for relicensure shall submit with their license application to the Bureau of EMS evidence of current certification with the National Registry of EMTs as an EMT-P; or

2. An applicant shall certify to the Bureau of EMS:

A. That they have successfully completed one hundred and forty-four (144) hours of continuing education which meet Bureau of EMS approval criteria under 19 CSR 30-40.331, forty-eight (48) hours of which may be elective topics and the remaining ninety-six (96) hours covering all elements of the EMT-P core continuing education curriculum;

B. That they are able to produce documentation of the required continuing education, and will make all records available to the Bureau of EMS upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure. Failure to obtain and retain complete and accurate documentation shall be cause for taking action upon a license; and

C. That they have current advanced cardiac life support training (can be counted towards the refresher requirement).

(4) The Bureau of EMS may select one (1) or more qualified providers to administer the practical licensure examination for EMT-Bs and EMT-Ps. The provider shall—

(A) Meet all the requirements of the National Registry of EMTs;

(B) Make application to the Bureau of EMS that—

1. Demonstrates necessary expertise, experience and resources needed in administering EMT practical examinations; and

2. Demonstrates evidence of practical examiner training and credentialing;

(C) Operate all tests in accordance with the policies and procedures of the National Registry of EMTs and the Bureau of EMS.

*AUTHORITY: sections 190.142, 190.160, 190.165 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

*\*Original authority: 190.142, RSMo 1998; 190.160, RSMo 1973, amended 1998; 190.165, RSMo 1973, amended 1998; and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

**19 CSR 30-40.365 Reasons and Methods the Department Can Use to Take Administrative Licensure Actions**

*PURPOSE: This rule provides the reasons and methods the state can use to take administrative licensure actions.*

(1) The department may refuse to issue or may deny renewal of any certificate, permit or license required pursuant to the comprehensive emergency medical services systems act for failure to comply with the provisions of the comprehensive emergency medical services systems act or for any cause listed in section (2) below. The department shall notify the applicant in writing of the reasons for the refusal or denial and shall advise the applicant of his or her right to file a complaint with the Administrative Hearing Commission as provided by Chapter 621, RSMo.

(2) The department may cause a complaint to be filed with the Administrative Hearing Commission as provided by Chapter 621, RSMo, against any holder of any certificate, permit or license required by the comprehensive emergency medical services systems act or any person who has failed to renew or has surrendered his or her certificate, permit or license for failure to comply with the provisions of the comprehensive emergency medical services systems act or for any of the following reasons:

(A) Use or unlawful possession of any controlled substance, as defined in Chapter 195, RSMo, or alcoholic beverage to an extent that such use impairs a person's ability to perform the work of any activity licensed or regulated by the comprehensive emergency medical services systems act;

(B) Being finally adjudicated and found guilty, or having entered a plea of guilty or *nolo contendere*, in a criminal prosecution under the laws of any state or of the United States, for any offense reasonably related to the qualifications, functions or duties of any activity licensed or regulated pursuant to the comprehensive emergency medical services systems act, for any offense an essential element of which is fraud, dishonesty or an act

of violence, or for any offense involving moral turpitude, whether or not sentence is imposed;

(C) Use of fraud, deception, misrepresentation or bribery in securing any certificate, permit or license issued pursuant to the comprehensive emergency medical services systems act or in obtaining permission to take any examination given or required pursuant to the comprehensive emergency medical services systems act;

(D) Obtaining or attempting to obtain any fee, charge, tuition or other compensation by fraud, deception or misrepresentation;

(E) Incompetency, misconduct, gross negligence, fraud, misrepresentation or dishonesty in the performance of the functions or duties of any activity licensed or regulated by the comprehensive emergency medical services systems act;

(F) Violation of, or assisting or enabling any person to violate, any provision of the comprehensive emergency medical services systems act, or of any lawful rule or regulation adopted by the department pursuant to the comprehensive emergency medical services systems act;

(G) Impersonation of any person holding a certificate, permit or license or allowing any person to use his or her certificate, permit, license or diploma from any school;

(H) Disciplinary action against the holder of a license or other right to practice any activity regulated by the comprehensive emergency medical services systems act granted by another state, territory, federal agency or country upon grounds for which revocation or suspension is authorized in this state;

(I) Being finally adjudged insane or incompetent by a court of competent jurisdiction;

(J) Assisting or enabling any person to practice or offer to practice any activity licensed or regulated by the comprehensive emergency medical services systems act who is not licensed and currently eligible to practice pursuant to the comprehensive emergency medical services systems act;

(K) Issuance of a certificate, permit or license based upon a material mistake of fact;

(L) Violation of any professional trust or confidence;

(M) Use of any advertisement or solicitation which is false, misleading or deceptive to the general public or persons to whom the advertisement or solicitation is primarily directed; and

(N) Violation of the drug laws or rules and regulations of this state, any other state or the federal government.

(3) The Department of Health may suspend any certificate, permit or license required pursuant to the comprehensive emergency medical services systems act simultaneously with the filing of the complaint with the Administrative Hearing Commission, if the department finds that there is an imminent threat to the public health. The notice of suspension shall include the basis of the suspension and notice of the right to appeal such suspension. The licensee may appeal the decision to suspend the license, certificate or permit to the department. The appeal shall be filed within ten (10) days from the date of the filing of the complaint. A hearing shall be conducted by the department within ten (10) days from the date the appeal is filed. The suspension shall continue in effect until the conclusion of the proceedings, including review thereof, unless sooner withdrawn by the department, dissolved by a court of competent jurisdiction or stayed by the Administrative Hearing Commission.

*AUTHORITY: sections 190.165 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Jan. 14, 1999, effective Jan. 24, 1999, expired July 22, 1999. Original rule filed Jan. 14, 1999, effective June 30, 1999.*

*\*Original authority: 190.165, RSMo 1973, amended 1978, 1998 and 190.185, RSMo 1973, amended 1984, 1993, 1995, 1998.*

### 19 CSR 30-40.375 Uniform Data Collection System and Ambulance Reporting Requirements for Ambulance Services

*PURPOSE: This rule provides the requirements for an ambulance service to report certain information on each ambulance run and to submit certain data to the department.*

(1) An ambulance report or an electronic ambulance reporting system shall be used by an ambulance service to record information on each ambulance run and shall be subject to approval by the department.

(2) A copy of all emergency life threatening runs as described in section (4) shall be sent to the department at least quarterly no later than thirty (30) days after the end of each quarter.

(3) Each ambulance service shall report to the department the total number of emergency life threatening runs, emergency urgent runs, emergency dry runs, non-emergency life threatening runs, non-emergency urgent, and non-emergency dry runs no later than

thirty (30) days after the end of each calendar year.

(4) Each ambulance report shall include, but not be limited to, the following information: run report number; date of run; ambulance service number, vehicle identification number; state of pickup; county of pickup; type of run to scene; type of run from scene; times dispatched, enroute, arrive scene, depart scene, and arrive destination; place of incident; patient destination; personnel license numbers; systolic blood pressure; respiratory rate; glasgow coma score; protective equipment used; factors affecting emergency medical services (EMS); treatment authorization; trauma assessments; cause of injury; illness assessment; destination determination; patient name, address, date of birth, race, and sex; and treatment administered. The ambulance service shall keep a copy of this information for at least five (5) years.

*AUTHORITY: sections 190.175 and 190.185, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

*\*Original authority: 190.175, RSMo 1973; amended 1998 and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998.*

### 19 CSR 30-40.410 Definitions and Abbreviations Relating to Trauma Centers

*PURPOSE: This rule defines terminology related to trauma centers.*

(1) The following definitions and abbreviations shall be used in the interpretation of the rules in 19 CSR 30-40.400 to 19 CSR 30-40.450:

(A) Advanced cardiac life support (ACLS) certified means that an individual has successfully completed a course of training in advanced cardiac life-support techniques certified by the American Heart Association and that certification is maintained;

(B) ATLS course means the advanced trauma life support course approved by the American College of Surgeons when required, certification shall be maintained;

(C) Bureau of EMS means the Missouri Department of Health's Bureau of Emergency Medical Services;

(D) Board-admissible means that a physician has applied to a specialty board and has received a ruling that s/he has fulfilled the requirements to take the examinations. Board certification must be obtained within five (5) years of the first appointment;

(E) Board-certified means that a physician has fulfilled all requirements, has satisfactorily completed the written and oral examinations, and has been awarded a board diploma in a specialty field;

(F) Certified registered nurse anesthetist (CRNA) means a registered nurse who has graduated from a school of nurse anesthesia accredited by the Council on Accreditation of Educational Programs of Nurse Anesthesia or its predecessor and who has been certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists;

(G) CME means continuing medical education and refers to the highest level of continuing education approved by the Missouri State Medical Association, the Missouri Association of Osteopathic Physicians and Surgeons, The American Osteopathic Association or the Accreditation Council for Continuing Medical Education;

(H) Continuing nursing education means education approved or recognized by a national nurses' organization and/or trauma medical director;

(I) Credentialed or credentialing is a hospital-specific system of documenting and recognizing the qualifications of medical staff and nurses and authorizing the performance of certain procedures in the hospital setting;

(J) Glasgow coma scale is a scoring system for assessing a patient's level of consciousness utilizing a point system which measures eye opening, verbal response and motor response. The higher the total score, the better the patient's neurological status;

(K) Immediately available (IA) means being present at the time of the patient's arrival at the hospital when prior notification is possible and no more than twenty (20) minutes from the hospital under normal driving and weather conditions;

(L) In-house (IH) means being on the hospital premises twenty-four (24) hours a day;

(M) Major pediatric trauma case means a patient fifteen (15) years of age or under with a revised trauma score of 11 or less;

(N) Major trauma case is a patient with an injury severity score of more than fifteen (15), using the scoring method described in the article "The Injury Severity Score," pages 187-196 of *The Journal of Trauma*, Vol. 14, No. 3, 1974;

(O) Major trauma patient means a trauma patient with cardiopulmonary arrest, unstable blunt or penetrating chest or abdominal injury, airway compromise, systolic blood pressure less than ninety (90) millimeters of mercury, pulse less than sixty (60) or greater than one hundred (100) per minute with clinical signs of shock, severe neurological



injuries or signs of deteriorating neurological status, or prolonged loss of consciousness;

(P) Missouri trauma registry is a statewide data collection system to compile and maintain statistics on mortality and morbidity of trauma victims, using a reporting form provided by the Missouri Department of Health;

(Q) Multidisciplinary trauma conference means a meeting of members of the trauma team and other appropriate hospital personnel to review the care of trauma patients at the hospital;

(R) PALS means pediatric advanced life support, a course of training available through the American Heart Association when required, certification shall be maintained;

(S) Physician advisory group is two (2) or more physicians who collectively assume the role of a medical advisor;

(T) Promptly available (PA) means arrival at the hospital within thirty (30) minutes after notification of a patient's arrival at the hospital;

(U) R is a symbol to indicate that a standard is a requirement for trauma center designation at a particular level;

(V) Revised trauma score (RTS) is a numerical methodology for categorizing the physiological status of trauma patients;

(W) Review is the inspection of hospitals to determine compliance with the rules of this chapter. There are four (4) types of reviews: the initial review of hospitals never before designated as trauma centers or hospitals never before reviewed for compliance with the rules of this chapter or hospitals applying for a new level of trauma center designation; the verification review to evaluate the correction of any deficiencies noted in a previous review; and the validation review, which shall occur every five (5) years to assure continued compliance with the rules of this chapter, and a focus review to allow review of substantial deficiencies by a review team;

(X) Senior resident is a physician in at least the third post-graduate year of study;

(Y) Severely injured patient is an injured patient with a glasgow coma score less than thirteen (13) or a systolic blood pressure less than ninety (90) millimeters of mercury or respirations less than ten (10) per minute or more than twenty-nine (29) per minute;

(Z) Surgical trauma call roster is a hospital-specific list of surgeons assigned to trauma care, including date(s) of coverage and back-up surgeons;

(AA) Trauma center is a hospital that has been designated in accordance with the rules in this chapter to provide systematized medical and nursing care to trauma patients. Level I is the highest level of designation, usually

representing a large urban hospital with a university affiliation. Level II is the next highest level of designation and is usually a large community hospital dealing with large volumes of serious trauma in a geographic area lacking a hospital with resources of level I. Level III is the next level and usually represents a small rural hospital with a commitment to trauma care that is commensurate with limited resources;

(BB) Trauma medical director is a surgeon designated by the hospital who is responsible for the trauma service and quality assurance programs related to trauma care;

(CC) Trauma nurse coordinator is a registered nurse designated by the hospital with responsibility for monitoring and evaluating the nursing care of trauma patients and the coordination of quality assurance programs for the trauma center;

(DD) Trauma nursing course is an education program in nursing care of trauma patients;

(EE) Trauma service is an organizational component of the hospital specializing in the care of injured patients;

(FF) Trauma team is a team consisting of the emergency physician, physicians on the surgical trauma call roster, appropriate anesthesiology staff, nursing and other support staff as needed;

(GG) Trauma team activation protocol is a hospital document outlining the criteria used to identify major trauma patients and the procedures for notification of trauma team members and indicating surgical and non-surgical specialty response times acceptable for treating major trauma patients; and

(HH) Trauma triage is an estimation of injury severity at the scene of an accident.

*AUTHORITY: sections 190.185 and 190.241, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

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

### **19 CSR 30-40.420 Trauma Center Designation Requirements**

*PURPOSE: This rule establishes the requirements for participation in Missouri's trauma center program.*

(1) Participation in Missouri's trauma center program is voluntary and no hospital shall be required to participate. No hospital shall in any way indicate to the public that it is a trauma

center unless that hospital has been designated as such by the Bureau of Emergency Medical Services (EMS). Hospitals desiring trauma center designation shall apply to the Bureau of EMS. Only those hospitals found by review to be in compliance with the requirements of the rules in this chapter shall be designated by Bureau of EMS as trauma centers.

(2) The application required for trauma center designation shall be made upon forms prepared or prescribed by the Bureau of EMS and shall contain information the Bureau of EMS deems necessary to make a fair determination of eligibility for review and designation in accordance with the rules of this chapter.

(A) An application shall include the following information: designation level requested; name, address and telephone number of hospital; name of chief executive officer, chairman/president of board of trustees, surgeon in charge of trauma care, trauma nurse coordinator, director of emergency medicine, and director of trauma intensive care; number of emergency department trauma caseload, trauma team activations, computerized tomography scan capability, magnetic resonance imaging capability, operating rooms, intensive care unit/critical care unit beds, burn beds, rehabilitation beds, trauma surgeons, neurosurgeons, orthopedists, emergency department physicians, anesthesiologists, certified registered nurse anesthetists, pediatricians, and pediatric surgeons; date of application; and signatures of the chairman/president of board of trustees, hospital chief executive officer, surgeon in charge of trauma, and director of emergency medicine.

(B) The Bureau of EMS shall notify the hospital of any apparent omissions or errors in the completion of the application and shall contact the hospital to arrange a date for the review.

(C) Failure of a hospital to cooperate in arranging for a mutually suitable date for review shall constitute forfeiture of application when a hospital's initial review is pending or suspension of designation when a hospital's verification or validation review is pending.

(D) Hospitals designated as trauma centers under the previous designation system shall maintain their designation until a review is conducted using the rules of this chapter.

(3) The review of hospitals for trauma center designation shall include interviews with designated hospital staff, a review of the physical plant and equipment, and a review of records and documents as deemed necessary

to assure compliance with the requirements of the rules of this chapter. The cost of any and all site reviews shall be paid by each applicant hospital or renewing trauma center unless adequate funding is available to Bureau of EMS to pay for reviews.

(A) For the purpose of reviewing trauma centers and hospitals applying for trauma center designation, the Bureau of EMS shall use review teams consisting of two (2) surgeons, one (1) emergency physician and one (1) registered nurse who are experts in trauma care, experienced in trauma center review and disinterested politically and financially in the hospitals to be reviewed. Out-of-state review teams shall conduct levels I and II reviews. In-state reviewers may conduct level III reviews.

(B) Any substantial deficiencies cited in the initial review or the validation review regarding patient care issues, especially those related to delivery of timely surgical intervention, shall require a focused review to be conducted. When deficiencies involve documentation or policy or equipment, the hospital's plan of correction shall be submitted to Bureau of EMS and verified by Bureau of EMS personnel.

(C) The verification review shall be conducted in the same manner and detail as initial and validation reviews. A review of the physical plant will not be necessary unless a deficiency was cited in the physical plant in the preceding initial or validation review. If deficiencies relate only to a limited number of areas of hospital operations, a focused review shall be conducted. The review team for a focused review shall be comprised of review team members with the required expertise to evaluate corrections in the specified deficiency area.

(D) Validation reviews shall occur every five (5) years. Level I and II trauma centers undergoing American College of Surgeons reverification review at shorter intervals may incorporate Bureau of EMS personnel in these reviews and, if they successfully pass reverification and meet all requirements herein, submit that review for Bureau EMS reverification.

(E) Upon completion of a review, the reviewers shall submit a report of their findings to the Bureau of EMS. If this is also an American College of Surgeons (ACS) verification or reverification, the hospital shall request a copy of the report be sent directly to the Bureau of EMS from the ACS verification committee. The report shall state whether the specific standards for trauma center designation have or have not been met; if not met, in what way they were not met. The report shall include the patient chart

audits and a narrative summary to include pre-hospital, hospital, trauma service, emergency department, operating room, recovery room, clinical lab, intensive care unit, blood bank, rehabilitation, quality improvement, education, outreach, research, chart review, and interviews. The Bureau of EMS has final authority to determine compliance with the rules of this chapter.

(F) Within thirty (30) days after receiving a review report, the Bureau of EMS shall return a copy of the report in whole to the chief executive officer of the hospital reviewed. Included with the report shall be notification indicating that the hospital has met the criteria for trauma center designation or has failed to meet the criteria for the designation level for which it applied and options the hospital may pursue.

(G) If a verification review is required, the hospital shall be allowed a period of up to eight (8) months to correct deficiencies. A plan of correction form shall be provided by the Bureau of EMS and shall be completed by the hospital and returned to the Bureau of EMS within sixty (60) days after notification of review findings.

(H) Once a review is completed, a final report shall be prepared by the Bureau of EMS. The final report shall be public record and shall disclose the standards by which the reviews were conducted and whether the standards were met. The reports filed by the reviewers shall be held confidential and shall be disclosed only to the hospital's chief executive officer or an authorized representative.

(4) The Bureau of EMS shall have the authority to put on probation, suspend, revoke or deny trauma center designation if there is reasonable cause to believe that there has been a substantial failure to comply with the requirements of the rules in this chapter. Once designated as a trauma center, a hospital may voluntarily surrender the designation at any time without giving cause, by contacting the Bureau of EMS. In these cases, the application and review process shall be completed again before the designation may be reinstated.

(A) Trauma center designation shall be valid for a period of five (5) years from the date the trauma center is designated. Expiration of the designation shall occur unless the trauma center applies for validation review within this five (5)-year period.

(B) The Bureau of EMS shall investigate complaints against trauma centers. Failure of the hospital to cooperate in providing documentation and interviews with appropriate staff may result in revocation of trauma center designation. Any hospital which takes adverse action toward an employee for coop-

erating with the Bureau of EMS regarding a complaint is subject to revocation of trauma center designation.

*AUTHORITY: sections 190.185 and 190.241, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

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

### 19 CSR 30-40.430 Standards for Trauma Center Designation

*PURPOSE: This rule establishes standards for level I, II and III trauma center designation.*

*PUBLISHER'S NOTE: I-R, II-R or III-R after a standard indicates a requirement for level I, II or III trauma centers respectively. I-IH, II-IH or III-IH after a standard indicates an in-house requirement for level I, II or III trauma centers respectively. I-IA, II-IA or III-IA indicates an immediately available requirement for level I, II or III trauma centers respectively. I-PA, II-PA or III-PA indicates a promptly available requirement for level I, II or III trauma centers respectively.*

#### (1) General Standards for Trauma Center Designation.

(A) The hospital board of directors, administration, medical staff and nursing staff shall demonstrate a commitment to quality trauma 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 trauma center; assure that all trauma 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 trauma program; and establish a priority admission for the trauma patient to the full services of the institution. (I-R, II-R, III-R)

(B) Trauma centers shall agree to accept all trauma victims 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)

(C) The hospital shall demonstrate evidence of a trauma program that provides the trauma team with appropriate experience to maintain skill and proficiency in the care of trauma patients. Such evidence shall include,

meeting of continuing education unit requirements by all professional staff, documented regular attendance at trauma quality improvement meetings, documentation of continued experience in management of sufficient numbers of severe trauma patients to maintain skill levels, and outcome data on quality of patient care.

(D) There shall be a lighted designated helicopter landing area at the trauma center to accommodate incoming medical helicopters. (I-R, II-R, III-R)

1. The landing area shall serve solely as the receiving and take-off area for medical helicopters and shall be cordoned off at all times from the general public to assure its continual availability and safe operation. (I-R, II-R, III-R)

2. The landing area shall be on the hospital premises no more than three (3) minutes from the emergency room. (I-R, II-R, III-R)

(E) The hospital shall appoint a board-certified surgeon to serve as the trauma medical director. (I-R, II-R, III-R)

1. There shall be a job description and organization chart depicting the relationship between the trauma medical director and other services. (I-R, II-R, III-R)

2. The trauma medical director shall be a member of the surgical trauma call roster. (I-R, II-R, III-R)

3. The trauma medical director shall be responsible for the education and training of the medical and nursing staff in trauma care. (I-R, II-R, III-R)

4. The trauma medical director shall document a minimum average of sixteen (16) hours of continuing medical education (CME) in trauma care every year. (I-R, II-R, III-R)

5. The trauma medical director shall participate in the trauma center's research and publication projects. (I-R)

(F) There shall be a trauma nurse coordinator. (I-R, II-R, III-R)

1. There shall be a job description and organization chart depicting the relationship between the trauma nurse coordinator and other services. (I-R, II-R, III-R)

2. The trauma nurse coordinator shall document a minimum average of twenty-four (24) hours of continuing nursing education in trauma care every year. (I-R, II-R, III-R)

(G) By the time of the initial review, all members of the surgical trauma call roster shall have successfully completed or be registered for a provider Advanced Trauma Life Support (ATLS) course. (I-R, II-R, III-R)

(H) All members of the surgical trauma call roster and anesthesiology, neurosurgery and orthopedic surgery shall document a minimum average of eight (8) hours of CME

in trauma care every year. In hospitals designated as adult/pediatric trauma centers, an additional six (6) hours per year of pediatric trauma education must be maintained by trauma surgeons caring for pediatric patients. (I-R, II-R, III-R)

(I) The hospital shall demonstrate that there is adequate post-discharge follow-up on trauma patients, including rehabilitation results where applicable. This shall include identification of members of the rehabilitation team, discharge summary of trauma care to the patient's private physician and documentation in the patient's medical record of the post-discharge plan. (I-R, II-R, III-R)

(J) A Missouri trauma registry shall be completed on each of the following trauma patients: any patient who is admitted and has a length of stay of twenty-four (24) hours or more; any patient who is transferred to or admitted from another acute care hospital; any patient who dies in the hospital; and any patient who is admitted to the intensive care unit (ICU) at any time during the hospital stay. The registry form shall include the following items: hospital identification number and hospital medical record number; patient name and address, Social Security number, date of birth, sex and race; if minor (under eighteen (18) years) name of parent or guardian; date of injury; time of injury; external cause of injury (E code); scene of injury; place of injury; protective equipment used; mode of arrival; ambulance service number; ambulance report number; ambulance times; if transfer in, name of sending hospital, city located, date and time patient arrived at sending hospital; date and time of arrival in emergency department; glasgow coma score, systolic blood pressure and respiratory rate at arrival in the emergency department; time sent to computerized tomography (ct); time of call and arrival in emergency department of the trauma surgeon and neurosurgeon; time of discharge from emergency department; blood alcohol concentration (mg/dl); drugs detected as result of toxicology test; admitting service; emergency department disposition; if transferred out, name and location of receiving hospital; date and time of arrival in operating room; operating room procedures ranked by apparent severity; final diagnoses ranked by apparent severity; date and time admitted; date and time discharged; total ICU days; disposition at discharge; degree of disability and disability related to; billed hospital charges; and expected main source of payment. The registry forms for patients discharged during any one (1) month shall be completed and sent to the Department of Health by the last day of the following month. The registry may be

submitted electronically in a format defined by the Department of Health. Electronic data shall be submitted quarterly, ninety (90) days after the quarter ends. The trauma registry must be current and complete. A patient log with admission date, patient name, and injuries must be available for use during the site review process. Information provided by hospitals on the trauma registry shall be subject to the same confidentiality requirements and procedures contained in section 192.067, RSMo. (I-R, II-R, III-R)

(K) The hospital shall have a trauma team activation protocol that establishes the criteria used to rank trauma patients according to the severity and type of injury and identifies the persons authorized to notify trauma team members when a major trauma patient is en route or has arrived at the trauma center. (I-R, II-R, III-R)

1. The trauma team activation protocol shall provide for immediate notification and rapid response requirements for trauma team members when a major trauma patient is en route to the trauma center. (I-R, II-R, III-R)

(L) The hospital shall have a plan to notify an organ or tissue procurement organization and cooperate in the procurement of anatomical gifts in accordance with the provisions in section 194.233, RSMo. (I-R, II-R, III-R)

(M) There shall be no level III trauma centers designated within fifteen (15) miles of any Missouri level I or II trauma center. Hospitals which have continually been level III trauma centers since January 1, 1989, and which are within fifteen (15) miles of a Missouri level I or II trauma center may continue as level III trauma centers, provided they continue to meet standards for level III trauma centers.

(2) Hospital Organization Standards for Trauma Center Designation.

(A) There shall be a delineation of privileges for the trauma service staff made by the medical staff credentialing committee. (I-R, II-R, III-R)

(B) All members of the surgical trauma call roster shall comply with the availability and response requirements in subsection (2)(D) of this rule. If not on the hospital premises, trauma team members who are immediately available shall carry electronic paging devices at all times to permit contact by the hospital and shall respond immediately to a contact by the hospital. (I-R, II-R, III-R)

(C) Physicians who are board-certified or board-admissible in the following specialties and who are credentialed by the hospital for trauma care shall be on the trauma center staff:

1. Cardiac surgery—I-R;
2. General surgery—I-R, II-R, III-R;
3. Neurologic surgery—I-R, II-R;
4. Obstetric-gynecologic surgery—I-R, II-R;
5. Ophthalmic surgery—I-R, II-R;
6. Dental surgery—I-R;
7. Orthopedic surgery—I-R, II-R;
8. Otorhinolaryngologic surgery—I-R, II-R;
9. Pediatric surgery—I-R;
10. Plastic, oral and maxillofacial surgery—I-R, II-R;
11. Thoracic surgery—I-R, II-R; and
12. Urologic surgery—I-R, II-R.

(D) The following specialists who are credentialed by the hospital for trauma care shall be available to the patient as indicated:

1. General surgery—I-IH, II-IA, III-PA.

A. The general surgery staffing requirement may be fulfilled by senior residents credentialed in general surgery, including trauma care, and capable of assessing emergent situations in general surgery.

B. The trauma surgeon shall be immediately available and be in attendance with the patient when a senior surgical resident is fulfilling availability requirements;

2. Neurologic surgery—I-IH, II-IA.

A. The neurologic surgery staffing requirement may be fulfilled by a surgeon who has been approved by the chief of neurosurgery for care of patients with neural trauma.

B. The surgeon shall be capable of initiating measures toward stabilizing the patient and performing diagnostic procedures.

3. Cardiac surgery—I-PA;
4. Obstetric-gynecologic surgery—I-PA, II-PA;
5. Ophthalmic surgery—I-PA, II-PA;
6. Orthopedic surgery—I-PA, II-PA;
7. Otorhinolaryngologic surgery—I-PA, II-PA;
8. Pediatric surgery—I-PA;
9. Plastic and maxillofacial surgery—I-PA, II-PA;
10. Thoracic surgery—I-PA, II-PA;
11. Urologic surgery—I-PA, II-PA;
12. Emergency medicine—I-IH, II-IH, III-IH;
13. Anesthesiology—I-IH, II-IA, III-PA.

A. In a level I or II trauma center, anesthesiology staffing requirements may be fulfilled by anesthesiology residents capable of assessing emergent situations in trauma patients and of providing any indicated treatment. When anesthesiology residents are used to fulfill availability requirements, the staff anesthesiologist on call will be advised and promptly available.

B. In a level II trauma center, anesthesiology staffing requirements may be fulfilled when the staff anesthesiologist is promptly available and an in-house certified registered nurse anesthetist (CRNA) capable of assessing emergent situations in trauma patients and of initiating and providing any indicated treatment is available.

C. In a level III trauma center, anesthesiology requirements may be fulfilled by a CRNA with physician supervision;

14. Cardiology—I-PA, II-PA;
15. Chest medicine—I-PA;
16. Gastroenterology—I-PA;
17. Hematology—I-PA, II-PA;
18. Infectious diseases—I-PA;
19. Internal medicine—I-PA, II-PA, III-PA;
20. Nephrology—I-PA, II-PA;
21. Pathology—I-PA, II-PA;
22. Pediatrics—I-PA, II-PA;
23. Psychiatry—I-PA, II-PA; and
24. Radiology—I-PA, II-PA.

(3) Standards for Special Facilities/Resources/Capabilities for Trauma Center Designation.

(A) The hospital shall meet emergency department standards for trauma center designation.

1. The emergency department staffing shall ensure immediate and appropriate care of the trauma patient. (I-R, II-R, III-R)

A. The physician director of the emergency department shall be board-certified or board-admissible in emergency medicine. (I-R, II-R)

B. There shall be a physician competent in the care of the critically injured in the emergency department twenty-four (24) hours a day. (I-R, II-R, III-R)

(I) All emergency department physicians shall be currently certified in ATLS and advanced cardiac life support (ACLS). (I-R, II-R, III-R)

(II) The emergency department physician shall be a designated member of the trauma team, and shall document a minimum average of sixteen (16) hours of trauma education per year. (I-R, II-R, III-R)

C. There shall be written protocols defining the relationship of the emergency department physicians to other physician members of the trauma team. (I-R, II-R, III-R)

D. The emergency department shall employ a trauma utilization assessment system which predicts the number of registered nurses needed to provide adequate care and resuscitation of trauma patients. There shall be no fewer than one (1) registered nurse per shift credentialed in trauma nursing on duty

in the emergency department. (I-R, II-R, III-R)

E. All registered nurses regularly assigned to the emergency department shall be credentialed in trauma nursing by the hospital within one (1) year of assignment. (I-R, II-R, III-R)

(I) Registered nurses credentialed in trauma nursing shall document a minimum of eight (8) hours of trauma-related continuing nursing education per year. (I-R, II-R, III-R)

(II) By the time of the initial review, all registered nurses assigned to the emergency department shall have successfully completed or be registered for a provider ACLS course. (I-R, II-R, III-R)

2. Equipment for resuscitation and life support for the critically or seriously injured shall include the following:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, sources of oxygen and mechanical ventilator, including pediatric sizes—I-R, II-R, III-R;

B. Suction devices, including pediatric sizes—I-R, II-R, III-R;

C. Electrocardiograph, oscilloscope and defibrillator, including pediatric capability—I-R, II-R, III-R;

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

E. All standard intravenous fluids and administration devices and intravenous catheters, including pediatric sizes—I-R, II-R, III-R;

F. Sterile surgical sets for procedures standard for the emergency department, including pediatric sizes—I-R, II-R, III-R;

G. Gastric lavage equipment, including pediatric sizes—I-R, II-R, III-R;

H. Drugs and supplies necessary for emergency care, including pediatric dosages—I-R, II-R, III-R;

I. Two-way radio linked with emergency medical service (EMS) vehicles—I-R, II-R, III-R;

J. End-tidal carbon dioxide monitor—I-R, II-R, III-R and mechanical ventilators, including pediatric capability—I-R, II-R;

K. Skeletal tongs—I-R, II-R, III-R;

L. Temperature control devices for patient, parenteral fluids and blood—I-R, II-R, III-R; and

M. Rapid infusion system for parenteral infusion—I-R, II-R, III-R.

3. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

4. There shall be a designated trauma resuscitation area in the emergency department. (I-R, II-R)

5. There shall be X-ray capability with twenty-four (24)-hour coverage by technicians. (I-IH, II-IH, III-IA)

6. Nursing documentation for the trauma patient shall be on a trauma flow sheet. (I-R, II-R, III-R)

(B) The hospital shall meet intensive care unit (ICU) standards for trauma center designation.

1. There shall be a designated surgeon medical director for the ICU. (I-R, II-R, III-R)

2. A physician who is not the emergency department physician shall be on duty in the ICU or available in-house twenty-four (24) hours a day in a level I trauma center and shall be on call and available within twenty (20) minutes in a level II trauma center.

3. The ICU shall utilize a patient classification system which defines the severity of injury and indicates the number of registered nurses needed to staff the unit. The minimum registered nurse/trauma patient ratio used shall be one to two (1:2). (I-R, II-R, III-R)

4. Registered nurses shall be credentialed in trauma care within one (1) year of assignment, documenting a minimum of eight (8) hours of trauma-related continuing nursing education per year. (I-R, II-R, III-R)

5. Nursing care documentation shall be on a twenty-four (24)-hour patient flow sheet. (I-R, II-R, III-R)

6. At the time of the initial review, nurses assigned to ICU shall have successfully completed or be registered for a provider ACLS course. (I-R, II-R, III-R)

7. There shall be beds for trauma patients or comparable care provided until space is available in ICU. (I-R, II-R, III-R)

8. Equipment for resuscitation and to provide life support for the critically or seriously injured shall include, but not be limited to:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes, bag-mask resuscitator, and a mechanical ventilator, including pediatric sizes—I-R, II-R, III-R;

B. Oxygen source with concentration controls—I-R, II-R, III-R;

C. Cardiac emergency cart, including pediatric cardiac equipment and medications—I-R, II-R, III-R;

D. Temporary transvenous pacemakers, including pediatric sizes—I-R, II-R, III-R;

E. Electrocardiograph, oscilloscope and defibrillator, including pediatric sizes—I-R, II-R, III-R;

F. Cardiac output monitoring—I-R, II-R;

G. Electronic pressure monitoring and pulse oximetry—I-R, II-R;

H. End tidal carbon dioxide monitor and mechanical ventilators, including pediatric capability—I-R, II-R, III-R;

I. Patient weighing devices, including pediatric scales—I-R, II-R, III-R;

J. Pulmonary function measuring devices, including pediatric capability—I-R, II-R, III-R;

K. Temperature control devices for adult and pediatric patients—I-R, II-R, III-R;

L. Drugs, intravenous fluids and supplies for adult and pediatric patients—I-R, II-R, III-R; and

M. Intracranial pressure monitoring devices—I-R, II-R.

9. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-R)

10. There shall be separate pediatric and adult ICUs or a combined ICU with nurses trained in pediatric intensive care. (I-R)

(C) The hospital shall meet post-anesthesia recovery room (PAR) standards for trauma center designation.

1. Registered nurses and other essential personnel who are not on duty shall be on call and available within twenty (20) minutes. (I-R, II-R, III-R)

2. Equipment for resuscitation and to provide life support for the critically or seriously injured shall include, but not be limited to:

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, III-R;

B. Suction devices—I-R, II-R, III-R;

C. Electrocardiograph, oscilloscope and defibrillator—I-R, II-R, III-R;

D. Apparatus to establish central venous pressure monitoring—I-R, II-R;

E. All standard intravenous fluids and administration devices, including intravenous catheters—I-R, II-R, III-R;

F. Sterile surgical set for emergency procedures—I-R, II-R, III-R;

G. Drugs and supplies necessary for emergency care—I-R, II-R, III-R;

H. Temperature control devices for the patient, for parenteral fluids and for blood—I-R, II-R, III-R;

I. Intracranial pressure monitoring devices—I-R, II-R;

J. Temporary pacemaker—I-R, II-R, III-R;

K. Electronic pressure monitoring—I-R, II-R; and

L. Pulmonary function measuring devices—I-R, II-R, III-R.

(D) The hospital shall have acute hemodialysis capability or a written transfer agreement. (I-R, II-R, III-R)

(E) The hospital shall have a physician-directed burn unit or a written transfer agreement. (I-R, II-R, III-R)

(F) The hospital shall have injury rehabilitation and spinal cord injury rehabilitation capability or a written transfer agreement. (I-R, II-R, III-R)

(G) The hospital shall have pediatric trauma management capability or a written transfer agreement. (I-R, II-R, III-R)

(H) Radiological capabilities for trauma center designation shall include:

1. Angiography of all types—I-R, II-R;

2. Sonography available twenty-four (24) hours a day with a thirty (30)-minute maximum response time—I-R;

3. Nuclear scanning available twenty-four (24) hours a day with a thirty (30)-minute maximum response time—I-R;

4. Resuscitation equipment available to the radiology department—I-R, II-R, III-R;

5. Adequate physician and nursing personnel present with monitoring equipment to fully support the trauma 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;

6. In-house computerized tomography (Mobile computerized tomography services, contracts for those services with other institutions or computerized tomography in remote areas of a hospital requiring transportation from the main hospital building shall not be considered in-house.)—I-R, II-R; and

7. Computerized tomography technician—I-IH, II-IA.

(I) There shall be documentation of adequate support services in assisting the patient's family from the time of entry into the facility to the time of discharge. (I-R, II-R, III-R)

(J) Medical surgical floors of a designated trauma center shall have the following personnel and equipment:

1. Registered nurses and other essential personnel on duty twenty-four (24) hours a day—I-R, II-R, III-R;

2. Equipment for resuscitation and to provide support for the injured patient including, but not limited to:

A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes of all sizes, bag-mask resuscitator and sources of oxygen—I-R, II-R, III-R;

B. Suction devices—I-R, II-R, III-R;

C. Electrocardiograph, oscilloscope and defibrillator—I-R, II-R, III-R;

D. All standard intravenous fluids and administration devices and intravenous catheters—I-R, II-R, III-R; and

E. Drugs and supplies necessary for emergency care—I-R, II-R, III-R; and

3. Documentation that all equipment is checked according to the hospital preventive maintenance schedule—I-R, II-R, III-R.

(K) The operating room personnel, equipment and procedures of a trauma center shall include, but not be limited to:

1. An operating room adequately staffed in-house twenty-four (24) hours a day—I-R, II-R;

2. Equipment for resuscitation and to provide life support for the critically or seriously injured, including, but not limited to:

A. Cardiopulmonary bypass capability—I-R;

B. Operating microscope—I-R;

C. Thermal control equipment for patient, parenteral fluids and blood—I-R, II-R, III-R;

D. X-ray capability—I-R, II-R, III-R;

E. Endoscopes, all varieties—I-R, II-R, III-R;

F. Instruments necessary to perform an open craniotomy—I-R, II-R; and

G. Monitoring equipment—I-R, II-R, III-R;

3. Documentation that all equipment is checked according to the hospital preventive maintenance schedule—I-R, II-R, III-R; and

4. Documentation that any certified registered nurse anesthetist (CRNA) participating in care of trauma patients completes a minimum average of eight (8) hours of trauma-related continuing nursing education every year—I-R, II-R, III-R;

(L) The following clinical laboratory services shall be available twenty-four (24) hours a day:

1. Standard analyses of blood, urine and other body fluids—I-R, II-R, III-R;

2. Blood typing and cross-matching—I-R, II-R, III-R;

3. Coagulation studies—I-R, II-R, III-R;

4. Comprehensive blood bank or access to a community central blood bank and adequate hospital blood storage facilities—I-R, II-R, III-R;

5. Blood gases and pH determinations—I-R, II-R, III-R;

6. Serum and urine osmolality—I-R, II-R;

7. Microbiology—I-R, II-R, III-R;

8. Drug and alcohol screening—I-R, II-R, III-R; and

9. A written protocol that the trauma patient receives priority—I-R, II-R, III-R.

(4) Standards for Programs in Quality Assurance, Outreach, Public Education and Training for Trauma Center Designation.

(A) There shall be an ongoing quality assurance program designed to objectively and systematically monitor, review and evaluate the quality and appropriateness of patient care, pursue opportunities to improve patient care and resolve identified problems. (I-R, II-R, III-R)

(B) The following additional quality assurance measures shall be required:

1. Regular reviews of all trauma-related deaths that are within seven (7) days of admission to the trauma center—I-R, II-R, III-R;

2. A regular morbidity and mortality review—I-R, II-R, III-R;

3. A regular multidisciplinary trauma conference that includes all members of the trauma team, with minutes of the conferences to include attendance, individual cases reviewed and findings—I-R, II-R, III-R;

4. Regular medical nursing audits, utilization reviews and tissue reviews—I-R, II-R, III-R;

5. Regular reviews of the reports generated by the Department of Health from the Missouri trauma registry and the head and spinal cord injury registry—I-R, II-R, III-R;

6. Regular reviews of pre-hospital and regional systems of trauma care—I-R, II-R, III-R; and

7. In trauma centers using CRNAs to fulfill any part of the anesthesiology staffing requirements, a separate quality assurance program to assure ongoing review by the physician(s) responsible for the anesthesiology service.

(C) An outreach program shall be established to assure twenty-four (24)-hour availability of telephone consultation with physicians in the outlying region. (I-R)

(D) A public education program shall be established to promote injury prevention and standard first aid and to resolve problems confronting the public, medical profession and hospitals regarding optimal care for the injured. (I-R, II-R)

(E) The hospital shall document existing or planned programs to increase public awareness of trauma prevention. These programs may be collectively presented with other hospitals and organizations. (I-R, II-R)

(F) The hospital shall be actively involved in local and regional emergency medical services systems by providing training and clinical resources. (I-R, II-R, III-R)

(G) There shall be a hospital-approved procedure for credentialing nurses in trauma care. (I-R, II-R, III-R)

1. All nurses regularly assigned to the emergency department or ICU shall complete a minimum of sixteen (16) hours of trauma nursing courses to become credentialed in trauma care. (I-R, II-R, III-R)

2. The content and format of any trauma nursing courses developed and offered by a hospital shall be developed in cooperation with the trauma medical director. A copy of the course curriculum used shall be filed with the Bureau of EMS. (I-R, II-R, III-R)

3. Trauma nursing courses offered by institutions of higher education in Missouri or the Trauma Nurse Core curriculum offered by the Emergency Nurses' Association may be used to fulfill this requirement. To receive credit for this course, a nurse shall obtain advance approval for the course from the trauma medical director and trauma nurse coordinator and shall present evidence of satisfactory completion of the course. (I-R, II-R, III-R)

(H) Hospital diversion information must be maintained to include date, length of time and reason for diversion. This must be monitored as a part of the quality improvement process and available when the hospital is site reviewed.

(5) Standards for the Programs in Trauma Research for Trauma Center Designation.

(A) The hospital and its staff shall document a research program in trauma. (I-R)

(B) The hospital shall agree to cooperate and participate with the Bureau of EMS in conducting epidemiological studies and individual case studies for the purpose of developing injury control and prevention programs. (I-R, II-R, III-R)

*AUTHORITY: sections 190.185 and 190.241, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

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

#### **19 CSR 30-40.440 Standards for Pediatric Trauma Center Designation**

*PURPOSE: This rule establishes standards for pediatric trauma center designation.*

(1) General Standards for Pediatric Trauma Center Designation.

(A) The pediatric trauma center shall be located in a children's hospital or in a level I trauma center.

(B) The hospital board of directors, administration, medical staff and nursing staff shall demonstrate a commitment to quality pediatric trauma care and shall treat any pediatric trauma patient presented to the facility for care. Methods of demonstrating the commitment shall include, but not be limited to, a board resolution that the hospital governing body agrees to establish policies and procedures for the maintenance of the services essential to a pediatric trauma center; assure that all pediatric trauma patients will receive medical care that meets the standards of this rule; commit the institution's financial, human and physical resources as needed for the trauma program; and establish a priority for the pediatric trauma patient to the full services of the institution.

(C) The hospital shall demonstrate evidence of a pediatric trauma program that provides the trauma team with appropriate experience to maintain skill and proficiency in the care of pediatric trauma patients.

(D) The hospital shall have a pediatric trauma team activation protocol that establishes the criteria used to rank trauma victims according to the severity and type of injury and identifies the persons authorized to notify trauma team members when a major pediatric trauma patient is en route or has arrived at the pediatric trauma center. That protocol shall provide for immediate notification and rapid response requirements for trauma team members.

(E) There shall be a lighted helipad on the hospital premises no more than three (3) minutes from the emergency department.

(F) The hospital shall appoint a board-certified pediatric surgeon to serve as pediatric trauma medical director.

1. The pediatric trauma medical director shall document a minimum average of sixteen (16) hours of trauma-related continuing medical education (CME) every year.

2. There shall be a job description and organizational chart depicting the relationship between the pediatric trauma program director and other services.

(G) A registered nurse shall be appointed to serve as the pediatric trauma nurse coordinator.

1. The pediatric trauma nurse coordinator shall document a minimum average of twenty-four (24) hours of trauma-related continuing nursing education every year.

2. There shall be a job description and organization chart depicting the relationship

between the pediatric trauma nurse coordinator and other services.

(H) By the time of the initial review, pediatric surgeons who comprise the pediatric surgical trauma call roster shall have successfully completed or be registered for a provider advanced trauma life support (ATLS) course.

(I) All members of the pediatric surgical trauma call roster, including anesthesiology, shall document a minimum average of eight (8) hours of trauma-related CME every year.

(J) The hospital shall be able to document active involvement in local and regional emergency medical services (EMS) systems. The hospital can demonstrate involvement in the local and regional EMS programs by participating in EMS training programs and joint educational programs regarding the pediatric patient; providing appropriate clinical experience and EMS system quality assessment and quality assurance mechanisms; and assisting in the development of regional policies and procedures.

(K) The hospital shall have a plan to notify an organ or tissue procurement organization and cooperate in the procurement of anatomical gifts in accordance with the provisions in section 194.233, RSMo.

(L) All pediatric trauma centers shall support and fully participate in the Missouri trauma registry and shall belong to the Missouri poison control network.

(2) Hospital Organization Standards for Pediatric Trauma Center Designation.

(A) Pediatric specialists representing the following specialties shall be on staff at the center and shall be board-certified or board-admissible and credentialed in trauma care: cardiac surgery, neurologic surgery, ophthalmic surgery, oral surgery-dental, orthopedic surgery, otorhinolaryngologic surgery, pediatric surgery; plastic and maxillofacial surgery, thoracic surgery and urologic surgery. Obstetric and gynecologic surgeons shall be available on a consultant basis.

(B) The emergency department staffing shall ensure immediate and appropriate care of the pediatric trauma patient. The emergency department pediatrician shall be board-certified/eligible in pediatric medicine and shall function as a designated member of the pediatric trauma team. All emergency department physicians shall have successfully completed and be current in ATLS and pediatric advanced life support (PALS) course prior to the initial review and shall document a minimum average of sixteen (16) hours of CME in trauma care every year. There shall be written protocols to clearly establish responsibilities and define the relationship between the

emergency department pediatricians and other physician members of the pediatric trauma team.

(C) The pediatric trauma surgeon on call shall be physically present in-house twenty-four (24) hours a day and shall meet all major trauma patients in the emergency department at the time of the patient's arrival. This requirement may be fulfilled by senior residents in general surgery who are ATLS-certified and able to deliver surgical treatment immediately and provide control and leadership for care of the pediatric trauma patient. When senior residents are used to fulfill availability requirements, the pediatric trauma surgeon shall be immediately available.

(D) A neurosurgeon shall be available in-house and dedicated to the hospital's pediatric trauma service. The neurosurgeon requirement may be fulfilled by a surgeon experienced in the care of pediatric patients with neural trauma and able to deliver surgical treatment immediately and provide control and leadership for the care of the pediatric patient with neural trauma.

(E) Pediatric specialists representing the following specialties shall be on call and promptly available: cardiac surgery, microsurgery, hand surgery, ophthalmic surgery, oral surgery-dental, orthopedic surgery, otorhinolaryngologic surgery, pediatric surgery, plastic and maxillofacial surgery, thoracic surgery and urologic surgery.

(F) A board-certified or board-admissible pediatrician credentialed in emergency care shall be available in the emergency department twenty-four (24) hours a day. This requirement may be fulfilled by a physician who is board-certified or board-admissible in emergency medicine who demonstrates commitment by engaging in the exclusive practice of pediatric emergency medicine a minimum of one hundred (100) hours per month or has an additional year of training in pediatric emergency medicine.

(G) A board-certified or board-admissible anesthesiologist credentialed in pediatric care shall be available in-house twenty-four (24) hours a day. Senior anesthesiology residents or anesthesiologists not credentialed in pediatric care may fulfill the in-house requirement if the credentialed pediatric anesthesiologist is on call and promptly available.

(H) A pediatric radiologist shall be promptly available twenty-four (24) hours a day.

(I) Pediatric specialists representing the following non-surgical specialties shall be on call and available: cardiology, chest medicine, gastroenterology, hematology,

infectious diseases, nephrology, neurology, pathology, psychiatry and neonatology.

(3) Standards for Special Facilities/Resources/Capabilities for Pediatric Trauma Center Designation.

(A) Hospitals shall meet emergency department standards for pediatric trauma center designation.

1. There shall be a minimum of two (2) registered nurses per shift specializing in pediatric trauma care assigned to the emergency department.

A. All registered nurses regularly assigned to pediatric care in the emergency department shall document a minimum of eight (8) hours per year of continuing nursing education on care of the pediatric trauma patient.

B. All registered nurses regularly assigned to pediatric care in the emergency department shall be PALS certified within one (1) year of assignment to the unit and shall maintain a current PALS certification.

2. Respiratory therapy technicians who work with pediatric trauma patients in the emergency department shall be experienced in pediatric respiratory therapy techniques.

3. There shall be a designated trauma resuscitation area in the emergency department equipped for pediatric patients. Equipment to be immediately accessible for resuscitation and to provide life support for the seriously injured pediatric patient shall include, but not be limited to:

A. Airway control and ventilation equipment for all size patients, including laryngoscopes, assorted blades, airways, endotracheal tubes and bag-mask resuscitator;

B. Oxygen, air and suction devices;

C. Electrocardiograph, monitor and defibrillator to include internal and external pediatric paddles;

D. Apparatus to establish central venous pressure monitoring and arterial monitoring;

E. All standard intravenous fluids and administration devices, including intravenous catheters designed for delivering IV fluids and medications at rates and in amounts appropriate for pediatric patients;

F. Sterile surgical sets for standard procedures for the emergency department;

G. Gastric lavage equipment;

H. Drugs and supplies necessary for emergency care;

I. Two-way radio linked with EMS vehicles;

J. Equipment for spinal stabilization for all age groups;

K. Temperature control devices for patients, parenteral fluids and blood;

L. Blood pressure cuffs, chest tubes, nasogastric tubes and urinary drainage apparatus for the pediatric patient; and

M. Patient weighing devices.

(B) The hospital shall meet radiological capabilities for pediatric trauma center designation.

1. There shall be X-ray capability with twenty-four (24)-hour coverage by in-house technicians.

2. There shall be radiological capabilities promptly available, including general, peripheral and cerebrovascular angiography, sonography and nuclear scanning.

3. Adequate physician and nursing personnel shall be present with monitoring equipment to fully support the trauma patient and provide documentation of care during the time that the patient is physically present in the radiology department and during transportation to and from the radiology department.

4. There shall be in-house computerized tomography with a technician available in-house twenty-four (24) hours a day. Mobile computerized tomography services, contracts for those services with other institutions or computerized tomography in remote areas of a hospital requiring transportation from the main hospital building shall not be considered in-house.

5. The pediatric trauma surgeon, neurosurgeon and emergency pediatrician shall each have the authority to initiate computerized tomography.

6. There shall be a continuing review of the availability of computerized tomography services for the pediatric trauma patient.

7. There shall be adequate resuscitation equipment available to the radiology department.

(C) The hospital shall meet pediatric intensive care unit standards for trauma center designation.

1. The medical director for the pediatric intensive care unit (PICU) shall be board-certified or board-eligible in pediatric critical care.

2. There shall be a pediatrician or senior pediatric resident on duty in the PICU twenty-four (24) hours a day or available from inside the hospital. This physician shall maintain a current PALS certification. The physician on duty in the PICU shall not be the emergency department pediatrician or the on-call trauma surgeon.

3. The PICU patient shall have nursing care by a registered nurse who is regularly assigned to pediatric intensive care.

4. The PICU shall utilize a patient classification system which defines the severity of injury and indicates the number of registered nurses needed to staff the unit. The minimum registered nurse/trauma patient ratio used shall be one to two (1:2).

5. All registered nurses regularly assigned to the PICU shall document a minimum of eight (8) hours per year of continuing nursing education on care of the pediatric trauma patient.

6. Within one (1) year of assignment, all registered nurses regularly assigned to PICU shall be PALS-certified. Registered nurses in pediatric trauma centers designated before January 1, 1989 shall have successfully completed or be registered for a PALS course by January 1, 1991.

7. There shall be immediate access to clinical laboratory services.

8. Equipment to be immediately accessible for resuscitation and life support for seriously injured pediatric patients shall include, but not be limited to:

A. Airway control and ventilation equipment for all size patients including laryngoscopes, assorted blades, endotracheal tubes, bag-mask resuscitator and mechanical ventilator;

B. Oxygen and suction devices;

C. Electrocardiograph, monitor and defibrillator, including internal and external pediatric paddles;

D. Apparatus to establish invasive hemodynamic monitoring, end tidal carbon dioxide monitoring and pulse oximetry;

E. All standard intravenous fluids and administration devices, including intravenous catheters designed for delivering IV fluids and medications at rates and in amounts appropriate for pediatric patients;

F. Gastric lavage equipment;

G. Drugs and supplies necessary for emergency care;

H. Temporary transvenous pacemaker;

I. Patient weighing devices;

J. Cardiac output monitoring devices;

K. Pulmonary function measuring devices;

L. Temperature control devices for the patient, parenteral fluids and blood;

M. Intracranial pressure monitoring devices;

N. Appropriate emergency surgical trays; and

O. Blood pressure cuffs, chest tubes, nasogastric tubes and urinary drainage apparatus for the pediatric patient.

(D) The hospital shall meet post-anesthesia recovery room (PAR) standards for pediatric



trauma center designation. Unless the hospital uses PICU to recover pediatric trauma patients, the following PAR standards apply:

1. The post-anesthesia recovery room shall be staffed with registered nurses regularly assigned to pediatric care and other essential personnel on call and available twenty-four (24) hours a day; and

2. Equipment to be accessible for resuscitation and life support for the seriously injured pediatric patient shall include, but not be limited to:

A. Airway control and ventilation equipment for all size patients including laryngoscopes, assorted blades, airways, endotracheal tubes and bag-mask resuscitator;

B. Oxygen and suction devices;

C. Electrocardiograph, monitor and defibrillator, including internal and external pediatric paddles;

D. Apparatus to establish and maintain hemodynamic monitoring;

E. All standard intravenous fluids and administration devices, including intravenous catheters designed for delivering IV fluids and medications at rates and in amounts appropriate for pediatric patients;

F. Sterile surgical sets for emergency procedures;

G. Drugs and supplies necessary for emergency care;

H. Temperature control devices for the patient, parenteral fluids and blood;

I. Temporary transvenous pacemaker; and

J. Electronic pressure monitoring.

(E) The pediatric trauma center shall have hemodialysis capability.

(F) The pediatric trauma center shall have organized burn care or a written transfer agreement.

(G) The pediatric trauma center shall have spinal cord injury management capability or a written transfer agreement.

(H) There shall be documentation of adequate support services in assisting the patient's family from the time of entry into the facility to the time of discharge.

(I) There shall be an operating room adequately staffed in-house and available twenty-four (24) hours a day with a back-up operating room staff on call and promptly available. Equipment for resuscitation and to provide life support for the critically or seriously injured pediatric patient shall include, but not be limited to:

1. Cardiopulmonary bypass capability;

2. Operating microscope;

3. Thermal control equipment for patient, parenteral fluids and blood;

4. Endoscopes, all varieties;

5. Instruments necessary to perform an open craniotomy;

6. Invasive and noninvasive monitoring equipment;

7. Pediatric anesthesia equipment;

8. Cardiac output equipment;

9. Defibrillator and monitor, including internal and external pediatric paddles; and

10. Blood pressure cuffs, chest tubes, nasogastric tubes and urinary drainage apparatus for the pediatric patient.

(J) Clinical laboratory services shall be available twenty-four (24) hours a day. There shall be a comprehensive blood bank and access to a community central blood bank and adequate hospital storage facilities. There shall be provisions to provide and receive the following laboratory test results twenty-four (24) hours a day:

1. Microbiology;

2. Standard analyses of blood, urine and other body fluids;

3. Blood typing and cross-matching;

4. Coagulation studies;

5. Blood gases and pH determinations;

6. Serum and urine osmolality; and

7. Drug and alcohol screening.

(4) Standards for Programs in Quality Assurance, Outreach, Public Education and Training for Pediatric Trauma Center Designation.

(A) There shall be a special audit of all trauma-related deaths. There shall be a mechanism in place to review all deaths and identify primary admitted patients versus transferred patients. Transferred patients shall be further identified as transferred after stabilizing treatment or direct admission after prolonged treatment.

(B) There shall be a morbidity and mortality review.

(C) There shall be a regular multidisciplinary trauma conference that includes all members of the trauma team. Minutes of the conference shall include attendance, individual cases reviewed and findings.

(D) There shall be a medical and nursing quality assessment program and utilization reviews and tissue reviews on a regular basis. Documentation of quality assurance shall include problem identification, analysis, action plan, documentation and location of action, implementation and reevaluation.

(E) There shall be twenty-four (24)-hour availability of telephone consultation with physicians in the outlying areas.

(F) The hospital shall demonstrate leadership in injury prevention in infants and children.

(G) The hospital and its staff shall document a research program in pediatric trauma.

(H) There shall be formal continuing education programs in pediatric trauma and rehabilitation provided by the hospital for staff physicians and nurses.

(I) The hospital shall provide programs in continuing education for the area physicians, registered nurses and emergency medical service providers concerning the treatment of the pediatric trauma patient.

(5) Standards for the Programs in Trauma Rehabilitation for Pediatric Trauma Center Designation.

(A) The hospital shall have a rehabilitation facility or a written transfer agreement with a rehabilitation center which is specifically equipped for the care of children.

(B) The pediatric trauma rehabilitation team shall develop and implement a procedure for discharge planning for the pediatric trauma patient.

(C) The pediatric trauma rehabilitation plan developed for the pediatric trauma patient shall be under the direction of a physiatrist or a physician with experience in pediatric trauma rehabilitation.

(D) The hospital shall develop a plan to document that there is adequate post-discharge follow-up on pediatric trauma patients, including rehabilitation results where applicable. This shall include identification of members of the rehabilitation team, discharge summary of trauma care to the patient's private physician and documentation in the patient's medical record of the post-discharge plan.

*AUTHORITY: sections 190.185 and 190.241, RSMo Supp. 1998.\* Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999.*

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