



RULES OF

Department of Health and Senior Services

Division 30—Division of Regulation and Licensure

Chapter 40—Comprehensive Emergency Medical Services Systems Regulations

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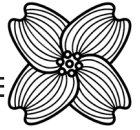
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**TITLE 19 – DEPARTMENT OF HEALTH AND
SENIOR SERVICES**

**Division 30 – Division of Regulation and Licensure
Chapter 40 – Comprehensive Emergency Medical
Services Systems Regulations**

**19 CSR 30-40.005 Abbreviations and Definitions Relating to
Ambulance Regulations**
(Rescinded February 28, 1999)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Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.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(Rescinded February 28, 1999)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 CS. 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 Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.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 Requirements 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(Rescinded February 28, 1999)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 Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.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(Rescinded February 28, 1999)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 Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.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(Rescinded February 28, 1999)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 Ambulances**
(Rescinded February 28, 1999)

AUTHORITY: section 190.185, RSM. 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, RSM. 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);

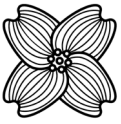
3. Droplet spread diseases – rubella, *Corynebacterium diphtheriae*, and *Neisseria meningitidis*; and

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.

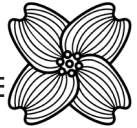
(5) An ERP or good samaritan may submit a request for a determination whether s/he has had a significant exposure to a communicable disease, preferably within twenty-four (24) hours but as soon as possible.

(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.

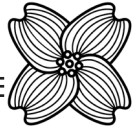
(8) The designated officer and the local health department shall assure that an adequate supply of reporting forms is provided to all receiving medical facilities or coroner/medical examiner's offices within the geographic area served.

(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.



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

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

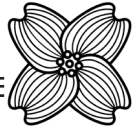
WHAT WILL HAPPEN WHEN THIS FORM IS FILED?

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.

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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:

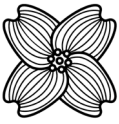
- A. Have a significant supply of blank copies of the Communicable Disease Report Form for use by ERPs or good samaritans or their designated officers.
- B. Forward one copy of the form to the final receiving facility if the patient is transferred (to a trauma center or specialty care facility).
- C. 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.



*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.*

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, RSM. 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 (MEMT) 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 CS. 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)

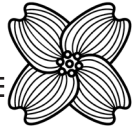
AUTHORITY: section 190.185, RSMo Supp. 1993. This rule was previously filed as 13 CSR 50-40.130. Original rule filed March 13, 1979, effective June 11, 1979. Rescinded: Filed Aug. 28, 1998, effective Feb. 28, 1999.

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 CS. 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 Con-act 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.

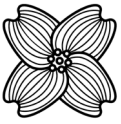
(C) The Northwest EMS region shall include the counties of Andrew, Atchison, Buchanan, Davies, DeKalb, Gentry, Grundy, Harrison, Holt, Livingston, Mercer, Nodaway, and Worth.

(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.

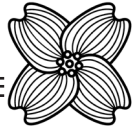
(C) The medical director, in cooperation with the ambulance service administrator, shall develop, implement and annually review the following:

- 1. Medical and treatment protocols for medical, trauma and pediatric patients;
- 2. Triage and transport protocols;
- 3. Protocols for do-not-resuscitate re-quests;
- 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.

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

(1) Application Requirements for Air Ambulance Service Licensure.

(A) Each applicant for an air ambulance service license or relicense shall submit an application for licensure to the Emergency Medical Services (EMS) Bureau 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: 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 email address (if applicable) of operator of air ambulance service; name, address, telephone numbers, and email address (if applicable) of manager; name, address, whether a medical doctor or doctor of osteopathy, telephone numbers, email 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 email 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.

(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 EMS Bureau 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 (8)(D), (8)(F), and (12).

(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 comply with 14 CFR section 119, a regulation from the Federal Aviation Administration and 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, scope of care, and capabilities.

1. If a scene request for emergency services is made to an air ambulance service which is not the recognized emergency provider, then the 911 provider or the recognized emergency provider shall be notified immediately by the air ambulance service receiving the request; and

2. Emergency transports shall not require a guarantee of payment prior to transport;

(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:

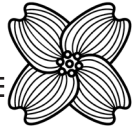
1. Aircraft capabilities;
2. Appropriate utilization of air ambulances;
3. Education and skills of the crew; and
4. Safety considerations;

(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, and the medical crew responding to scenes shall be able to demonstrate successful completion and maintenance of the following:

1. Education–

A. Basic Cardiac Life Support (BCLS) which is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions;

B. Advanced Cardiac Life Support (ACLS) or national equivalent. ACLS is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions;

C. Pediatric Advanced Life Support (PALS) or national equivalent. PALS is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions; and

D. Trauma Nurse Core Course (TNCC) or a trauma course approved by the medical director. TNCC is incorporated by reference in this rule as published by the Emergency Nurses Association in 2007 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. Examples of equivalent courses are, but not limited to: Pediatric Education for Pre-Hospital Professionals (PEPP); Emergency Nurse Pediatric Course (ENPC); International Trauma Life Support (ITLS); Pre-Hospital Trauma Life Support (PHTLS); and Transport Nurse Advanced Trauma Course (TNATC). PEPP is incorporated by reference in this rule as published by the American Academy of Pediatrics in 2006 and is available at the American Academy of Pediatrics, 141 Northwest Point Boulevard, Elk Grove, IL 60007. This rule does not incorporate any subsequent amendments or additions. ENPC is incorporated by reference in this rule as published by the Emergency Nurses Association in 2004 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. ITLS is incorporated by reference in this rule as published by ITLS International in 2007 and is available at ITLS International, 1 S. 280 Summit Ave., Court B-2, Oakbrook Terrace, IL 60181. This rule does not incorporate any subsequent amendments or additions. PHTLS is incorporated by reference in this rule as published by the National Association of Emergency Medical Technicians in 2006 and is available at the National Association of Emergency Medical Technicians, PO Box 1400, Clinton, MS 39060. This rule does not incorporate any subsequent amendments or additions. TNATC is incorporated by reference in this rule as published by the Air and Surface Transport Nurse's Association in 2006 and is available at the Air and Surface Transport Nurse's Association, 7995 East Prentice Avenue, Suite 100, Greenwood Village, CO 80111. This rule does not incorporate any subsequent amendments or additions; an.

2. Licensure/certification–

A. Each medical crew member must hold a current and valid Missouri license as required for their level of practice.

(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/or 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 and flight following;

(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;

(D) All medical equipment, except disposable items, shall be so designed, constructed, and of such material that under normal conditions and operations, it is durable and capable of withstanding repeated cleaning and being stored in a secure and protected manner; and

(E) The service shall:

1. Comply with Occupational Safety and Health Administration (OSHA) standard 29 CFR 1910.1030 and section 191.694, RSMo; and

2. Monitor and direct the use, control, and security of drugs.

(4) Each aircraft operated as an ambulance shall be staffed by personnel selected by each air ambulance program to meet the mission and scope of that program, and at a minimum –

(A) 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

(B) 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;

(C) A minimum of sixteen (16) hours of continuing education is required annually for each crew member to include safety, crew resource management, survival, and flight physiology; and

(D) 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) Records and forms, policies and procedures–each air ambulance service shall maintain accurate records and forms that include the following:

(A) An air ambulance report form approved by the EMS Bureau to record information on each patient transport;

(B) Disaster/multiple casualty protocols;

(C) Medical equipment maintenance records;

(D) Air ambulance service license;

(E) Licensed service personnel records;

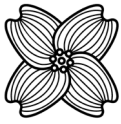
(F) Medical director qualifications and authorized physician-ordered treatment protocols and policies;

(G) Patient care records;

(H) Quality improvement program;

(I) Records required by other regulatory agencies including the Missouri Department of Health and Senior Services, Bureau of Narcotics and Dangerous Drugs (BNDD), and the Federal Drug Enforcement Administration (DEA);

(J) Safety program to include a safety committee and infection control policy as required by OSHA standard 29 CFR 1910.1030 and section 191.694, RSMo;



- (K) Continuing education records; and
- (L) Flight response 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 EMS Bureau 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.

(D) The medical director of the flight program shall have access to consulting physicians with expertise in specialties to include, but is not limited to:

1. Pediatrics;
2. Neonatology;
3. Burns;
4. Cardiology;
5. Trauma; and
6. Neurology/Neurosurgery.

(E) In the event of a resignation or other occurrence, and there is no medical director for the air ambulance service, the service is only authorized to operate under strict radio communications or direct written and/or verbal orders by a physician for a period not to exceed ten (10) days before appointing a new or replacement medical director.

(F) Each air ambulance service shall notify the EMS Bureau in writing of any change in medical director within five (5) days.

(8) Communication Centers and Communication Specialists.

(A) Training shall be provided in aircraft capabilities, operational limitations, navigation, and map coordination to the communication specialists.

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

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

(D) 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 hospitals and emergency agencies.

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

(F) Each aircraft operated as an ambulance shall have the capability to communicate by voice with hospitals and the service's own communication center.

(G) The communication center shall:

1. Have a least one (1) dedicated telephone line for the purpose of receiving requests and the coordination of the air ambulance service;

2. Have a system for recording all incoming and outgoing telephone and radio transmissions with time recording and playback capabilities. Recordings shall be kept for a minimum of thirty (30) days;

3. Have the capability to immediately contact the aviation staff, medical crew, and online medical direction (through page, radio, or telephone, etc.);

4. Maintain all equipment in full operating condition and in good repair;

5. Have a back-up emergency power source for communications or a policy delineating methods for maintaining communications during power outages and in disaster situations; and

6. Have a communications policy and procedures manual to include:

A. A pre-arranged emergency plan to cover situations in which the aircraft is overdue, communications cannot be established, or an aircraft location cannot be verified.

(H) All helicopter air ambulance services shall have flights coordinated by designated communication specialists assigned and available twenty-four (24) hours per day to receive and coordinate the request for an air ambulance.

1. The communication specialists must advise the requesting caller of an accurate estimated time of arrival of the responding aircraft for all flight requests.

2. The communication specialists shall have training commensurate with the scope of responsibility of the communications center personnel and it shall include:

A. Federal Communications Commission regulations and appropriate provisions of the certificate holder's operations specifications and operations manual;

B. General safety rules, emergency procedures, and flight following procedures;

C. Map reading, aeronautical chart interpretation, basic navigation, and flight planning;

D. Weather terminology and procedures for flight service weather advisories;

E. Types of radio frequency bands used; and

F. Annual training that includes at least a review of the program's Post-Accident/Incident Plan (PAIP) and competency in the areas included in subsections (8)(A)–(G).

(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) A safety committee shall be established and shall meet regularly to assess and evaluate the safety aspects of the operation.

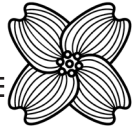
(11) Each air ambulance service shall maintain policies and procedures that include the following:

(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.

(12) 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 EMS Bureau during normal business hours.

(13) 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: section 190.103, RSMo 2000, sections 190.108, 190.120, 190.160, 190.165, and 190.185, RSMo Supp. 2007 and section 190.176, HB 1790, 94th General Assembly, Second Regular Session, 2008. * Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008, effective Jan. 30, 2009. ***

**Original authority: 190.103, RSMo 1998; 190.120, RSMo 1973, amended 1980, 1998, 2002; 190.160, RSMo 1973, amended 1998, 2002; 190.165, RSMo 1973, amended 1978, 1998, 2002; 190.175, RSMo 1973, amended 1998, 2002; 190.176, RSMo 1998, 2008; 190.180, RSMo 1998, amended 2002; and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002.*

***Pursuant to Executive Orders 20-04 and 20-10, 19 CSR 30-40.308, subsections (1)(A) and (1)(C) was suspended from April 29, 2020 through June 15, 2020.*

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.

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

(1) Application Requirements for Ground Ambulance Service Licensure.

(A) Each applicant for ownership of an ambulance service 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 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) standards/specifications set forth by the U.S. Department of Transportation KKK-A-1822, the Commission on Accreditation of Ambulance Services *Ground Vehicle Standard for Ambulances* v.1.0 edition or the National Fire Protection Association *1917 Standard for Automotive Ambulances* 2016 Edition. The Commission on Accreditation of Ambulance Services *Ground Vehicle Standard for Ambulances* v.1.0 edition is incorporated by reference in this rule as published in 2016 and is available at the Ground Vehicle Standard, 1926 Waukegan Road Suite 300, Glenview IL 60025-1770. This rule does not incorporate any subsequent amendments or additions. The National Fire Protection Association *1917 Standard for Automotive Ambulances* 2016 Edition is incorporated by reference in this rule as published in 2016 and is available at the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169-7471. This rule does not incorporate any subsequent amendments or additions. Exceptions to these standards/specifications may include 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, National Fire Protection Association *1917 Standard for Automotive Ambulances* 2016 edition or the Commission on Accreditation of Ambulance Services *Ground Vehicle Standard for Ambulances* v.1.0 edition 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 addresses 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.

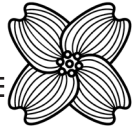
(12) Each ambulance service that held a valid ambulance vehicle license on August 28, 1998, and meets all the legislative and regulatory requirements for licensure shall be issued an initial license for a period of one to five (1-5) years. The Bureau of EMS will determine the initial licensure period 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.

(13) An existing ambulance service licensee may apply for and be granted by Bureau of EMS a reduction in their primary service area if they meet the following requirements:

(A) Submit a completed application for licensure, requesting a reduction of their ambulance service area and include a detailed description of the affected area that will no longer be included in their primary service area; and

(B) Provide written documentation of an agreement with another licensed ambulance service, stating the service has agreed to provide ambulance service to the vacated service area through an expansion of their services, by either contract or mutual aid agreement or provide public notice to residents of the affected area.

1. Public notice to residents of the affected area includes:



A. Publishing notice in a newspaper of the largest general circulation, that is published in the county in the area affected by the decision to withdraw ambulance coverage, a minimum of one (1) year in advance of the proposed date of discontinuation of ambulance services. A completed affidavit of publication and an original clipping of published notice must accompany the application for licensure; and

B. Providing written notice to the county commission of any county that as a whole or in part, will be affected by the discontinuation of services, a minimum of one (1) year in advance of the proposed date of discontinuation of ambulance services.

AUTHORITY: sections 190.109, 190.176, 190.185, and 190.190, RSMo 2016. 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 amendment filed March 31, 2003, effective April 14, 2003, expired Oct. 11, 2003. Amended: Filed March 31, 2003, effective Sept. 30, 2003. Emergency amendment filed March 16, 2017, effective March 26, 2017, expired Jan. 3, 2018. Amended: Filed March 16, 2017, effective Nov. 30, 2017. ***

**Original authority: 190.109, RSMo 1998, amended 2001, 2002; 190.176, RSMo 1998, amended 2008, 2011; 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002; and 190.190, RSMo 1973, amended 1998.*

***Pursuant to Executive Orders 20-04 and 20-10, 19 CSR 30-40.309, subsection (2) (B) and section 190.243.4, RSMo was suspended from March 19, 2020 through June 15, 2020 and subsections (1)(A), (1)(C), and (1)(D) was suspended from April 29, 2020 through June 15, 2020.*

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, Emergency Medical Technicians-Intermediate, 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.

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

(1) General Requirements for Certification of Emergency Medical Technician-Basic (EMT-B) Training Entities, Emergency Medical Technician-Paramedic (EMT-P) Training Entities, Emergency Medical Technician-Intermediate (EMT-I) 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 EMS Bureau and undergo a review by the EMS Bureau staff to determine compliance with these rules. An application shall include, but not be limited to, the following: 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. The training entity accreditation application form, included herein, is available at the EMS Bureau office or by mailing a written request to the Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.

(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 EMS Bureau shall cause an inspection of the applicant to determine compliance with these rules, and such subsequent inspection as is necessary or desirable to ensure compliance with these rules. Such inspections shall occur not less than once every five (5) years.

1. Training entities shall be certified to conduct the following programs:

A. EMT-P training entities shall be certified to conduct initial EMT-P; EMT-P refresher to include remedial training and National Registry bridge programs; EMT-P continuing education; initial EMT-I programs; EMT-I refresher to include remedial training; EMT-I continuing education; initial EMT-B; EMT-B refresher to include remedial training and National Registry bridge programs; EMT-B continuing education; initial first responder; first responder refresher; and emergency medical dispatcher (EMD) courses;

B. EMT-P continuing education training entities shall be certified to conduct EMT-P continuing education courses, EMT-I continuing education courses, and EMT-B continuing education courses;

C. EMT-B training entities shall be certified to conduct initial EMT-B; EMT-B refresher to include remedial training and National Registry bridge programs; EMT-B continuing education; initial first responder; first responder refresher; and emergency medical dispatcher courses;

D. EMT-B continuing education training entities shall be certified to conduct EMT-B continuing education programs;

E. First responder training entities shall be certified to conduct only initial first responder and first responder refresher courses; and

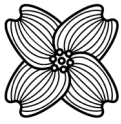
F. EMD training entities shall be certified to conduct only EMD courses.

(C) Each EMS training entity shall demonstrate an organizational structure that ensures 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 the EMS Bureau 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 the EMS Bureau 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 ensure availability of effective training programs. The tools used to develop the



methodology shall be made available for review by the EMS Bureau.

(G) Faculty Requirements.

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

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

(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 EMS Bureau 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 EMS Bureau 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 EMS Bureau.

C. The EMS training entity shall ensure 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;

I. Certification requirements of the National Registry of Emergency Medical Technicians and licensing requirements for the state of Missouri; and

J. Recent statutes and regulations of the state of Missouri that pertain to EMS which can be obtained from the EMS Bureau. This can either be in an electronic or paper format.

(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 the EMS Bureau and kept on file for at least five (5) years.

6. Each EMS training entity shall submit to the EMS Bureau 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 ensuring quality EMS education and compliance with the EMS Bureau rules.

(L) Upon EMS training entity approval by the EMS Bureau, the EMS Bureau 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.

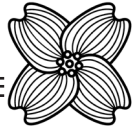
(2) Specific Requirements for EMS Training Entities Offering Initial EMT-P Courses and EMT-I Courses.

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

(B) EMT-P and EMT-I students are only authorized to perform the skills and practice in accordance with the national standard curriculum for EMT-P and EMT-I 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 during scheduled clinicals at an approved site with a current clinical agreement and cannot be performed while on duty.

(C) EMS training entities offering initial EMT-P and EMT-I courses shall also be certified to conduct EMT-I, 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 ensuring 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 instructor(s) and the educational methodologies used by the EMT-P training program;
3. Access by the EMT-P training program into remedial education as may be necessary for the EMT-P training program; and
4. Access by the students to financial assistance such as, but not limited to, grants and Veteran's Benefits.

(E) Each EMT-P training program shall have a designated program director. Each EMT-P course shall have a designated primary 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 current 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. Each training entity shall approve or disapprove clinical preceptors.

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 shall be clearly identified by name and student status using nameplate, uniform, or other apparent means to distinguish them from other personnel.

5. Clinical experience 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. Each training entity shall approve or disapprove services to be used as clinic experience sites.

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

7. All EMT-I students shall be currently licensed as an EMT-B.

8. All EMT-P students shall be currently licensed as an EMT-B or an EMT-I.

(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 EMS Bureau staff.

3. The EMS Bureau shall review the first attempt computer adaptive test examinations results (pass rates) from each EMT-P training entity. The computer adaptive test licensure examination pass rate for first attempt candidates from each EMT-P training entity shall be no less than the national pass rate, as documented by the National Registry of EMTs for each calendar year. The EMT-P training entity with a pass rate

below the national pass rate shall:

- A. First year – provide the EMS Bureau with a report analyzing all aspects of the education program and identifying areas contributing to the unacceptable pass rate and a plan of action to resolve low pass rates;

- B. Second consecutive year – the program manager shall be required to appear before and present to the EMS Bureau an analysis of measures taken the first year, problems identified, and plan of correction; and

- C. The training entity must appear before the EMS Bureau and provide the information outlined in (2)(I)3.B. until they have two (2) consecutive years of pass rates on the first attempt at the national pass rate.

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

- (K) An EMT-P primary instructor must be present in at least eighty percent (80%) of all class sessions to ensure program continuity and to be able to identify that the students have cognitive, affective, and psychomotor skills necessary to function as an EMT-P. This primary instructor shall have attended a workshop that reviews the format, philosophy, and skills of the curriculum.

- (L) Minimum EMT-P course requirements: one thousand (1,000) hours of instruction to include:

1. Two hundred fifty (250) hours of clinical experience in a clinical setting with a Missouri licensed ambulance service;

2. Five hundred (500) hours of classroom/practical lab;

3. Two hundred fifty (250) hours of clinical hours in a health care facility; and

4. Clinical skills as outlined in the most current *EMT-P National Standard Curriculum* and the *National Scope of Practice for EMT-P* shall be the established minimums. The *EMT-P National Standard Curriculum* is incorporated by reference in this rule as published in 1998 and the refresher course in 2001 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The *National Scope of Practice* is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

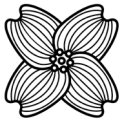
- (M) Minimum EMT-I course requirements: three hundred (300) hours of instruction to include:

1. Seventy-five (75) hours of clinical experience in a clinical setting with a Missouri licensed ambulance service;

2. One hundred seventy-five (175) hours of classroom/practical lab;

3. Fifty (50) hours of clinical hours in a health care facility; and

4. Clinical skills as outlined in the most current *EMT-I National Standard Curriculum* and the *National Scope of Practice for EMT-I* shall be the established minimums. The *EMT-I National Standard Curriculum* is incorporated by reference in this rule as published in 1999 and the refresher course in 2001 by the U.S. Department of Transportation and is



available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The *National Scope of Practice* is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

(N) United States Armed Forces Including National Guard and Reserves Option for EMT-I and EMT-P course requirements.

1. An EMT-B licensee that was issued a license by the EMS Bureau pursuant to 19 CSR 30-40.342(2)(A) and section (3) indicating the licensee is a current or past member of the United States Armed Forces including National Guard and Reserves and has met the EMS Bureau's requirements for this license may present this license to a training entity certified by the EMS Bureau within two (2) years of the date of their honorable discharge if the licensee is a past member of the United States Armed Forces including National Guard and Reserves or at any time that the licensee is a current member of the United States Armed Forces including National Guard and Reserves.

2. The EMT-B licensee may request the training entity for the EMT-P or EMT-I programs evaluate their military training for advanced placement credit to determine which competencies have been met through their military training. The training entity shall allow the EMT-B licensee's military training to be assessed for competencies through advanced placement if the EMT-B licensee presents an EMT-B United States Armed Forces license from the EMS Bureau indicating the licensee is a current or past member of the United States Armed Forces including National Guard and Reserves and has met the requirements in 19 CSR 30-40.342(2)(A) and section (3). Advanced placement is any process where a program formally recognizes prior learning of a student and applies that recognition toward meeting the program requirements. Advanced placement shall be applied on a case-by-case basis and allows a student to "place out" of specified program didactic, laboratory, clinical, or field requirements. This may shorten the time for completion of the program and is often thought of as an alternative pathway to program completion and eligibility for the National Registry of Emergency Medical Technicians or state examination at the paramedic level. The EMT-P and EMT-I training entities shall use the minimum training requirements for the appropriate licensure level in subsection (2)(L) above for the EMT-P program and subsection (2)(M) above for the EMT-I program to determine what the EMT-B licensee will place out of following the advanced placement review of the EMT-B licensee's military training. The EMT-B licensee shall complete all of the minimum training requirements for the appropriate licensure level in subsection (2)(L) above for the EMT-P program and subsection (2)(M) above for the EMT-I program that the EMT-B licensee is not awarded credit for through the advanced placement assessment of the EMT-B licensee's military training.

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

(A) Only EMS training entities certified by the EMS Bureau to conduct initial EMT-B courses shall offer 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 ensuring 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 primary 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. Clinical supervision shall be conducted by a preceptor.

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 shall be clearly identified by name and student status using nameplate, uniform, or other apparent means to distinguish them from other personnel.

5. The EMS Bureau shall establish minimum standards for clinical experiences in accordance with current clinical recommendations of the current 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. The practical examination shall include all skills designated in the National Standard Curriculum, except endotracheal intubation.

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

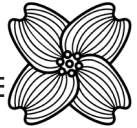
3. The EMS Bureau shall review the first attempt computer adaptive test examinations results (pass rates) from each EMT-B training entity. The computer adaptive test licensure examination pass rate for first attempt candidates from each EMT-B training entity shall be no less than the national pass rate, as documented by the National Registry of EMTs for each calendar year. The EMT-B training entity with a pass rate below the national pass rate shall:

A. First year—provide the EMS Bureau with a report analyzing all aspects of the education program and identifying areas contributing to the unacceptable pass rate and a plan of action to resolve low pass rates;

B. Second consecutive year – the program manager shall be required to appear before and present to the EMS Bureau an analysis of measures taken the first year, problems identified, and plan of correction; and

C. The training entity must appear before the EMS Bureau to provide the information outlined in (3)(F)3.B. until they have two (2) consecutive years of pass rates on the first attempt at the national pass rate.

(G) An EMT-B primary instructor must be present in at least eighty percent (80%) of all class sessions to ensure program continuity and to be able to identify that the students have cognitive, affective, and psychomotor skills necessary to function as an EMT-B. The primary instructor is responsible



for the teaching of a specific lesson of the EMT-B course. The primary instructor shall have attended a workshop that reviews the format, philosophy, and skills of the new curriculum. The course shall use the following minimums:

1. Minimum of one hundred ten (110) hours of instruction; and
2. Minimum of five (5) patient contacts in a clinical setting.

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

(A) EMT-P continuing education training entities shall be certified to conduct EMT-P, EMT-I, and EMT-B continuing education. Continuing education training entities shall not conduct refresher courses, National Registry bridge programs, or remedial education. EMT-B continuing education training entities shall be certified to conduct only EMT-B continuing education courses.

(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 Co-ordinating 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 and other state EMS agencies shall constitute approval under the EMS Bureau 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 standards set forth by the National Academy of Emergency Medical Dispatch.

(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. The first responder in Missouri shall be taught

and permitted to perform all skills including spinal motion restriction in the current *First Responder National Standard Curriculum* and the *National Scope of Practice for First Responder* shall be the established minimums. *First Responder National Standard Curriculum* is incorporated by reference in this rule as published in 1995 and the refresher course in 1996 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The National Scope of Practice is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

(7) EMT-B, EMT-I, 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 written evaluation and, if applicable, a practical evaluation.

(C) Continuing education training entities must have a current copy of the most recent statutes and regulations of the state of Missouri that pertain to EMS which can be obtained from the EMS Bureau. These copies shall be available at all times for reference by the student and/or the training entity.

(8) Primary Instructor Qualifications.

(A) The EMS Bureau may authorize as primary instructors for EMS training programs those who can document the following:

1. EMT-B Instructor:

A. Current Missouri licensure, National Registry, or other state license or certification as a paramedic and at least two (2) years clinical experience as an EMT-P, EMT-B, or licensure as a registered nurse or physician with at least two (2) years clinical experience;

B. Successful completion of an instructor-training program that meets or exceeds the United States Department of Transportation EMS Instructor Curriculum which is incorporated by reference in this rule as published in 2002 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions;

C. EMS instructional experience, which meets the following:

(I) Documentation of instructor status as an *Advanced Cardiac Life Support*, *Basic Cardiac Life Support*, *International Trauma Life Support*, or *Pre-Hospital Trauma Life Support*. *Advanced Cardiac Life Support* is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Green-ville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. *International Trauma Life Support* is incorporated by reference in this rule as published by ITLS International in 2007 and is available at ITLS International, 1 S. 280 Summit Ave., Court B-2, Oakbrook Terrace, IL 60181. This rule does not incorporate any subsequent amendments or additions. *Pre-Hospital Trauma Life*



Support is incorporated by reference in this rule as published by the National Association of EMTs in 2006 and is available at the National Association of EMTs, PO Box 1400, Clinton, MS 39060-1400. This rule does not incorporate any subsequent amendments or additions; or

(II) Experience as a laboratory or guest instructor with an EMS training entity;

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

E. Competent in adult education theory and clinical skills consistent with the current *EMT-B National Standard Curriculum* which is incorporated by reference in this rule as published in 1994 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions;

2. EMT-P and EMT-I Instructor:

A. Current Missouri licensure, National Registry, or other state license or certification as a paramedic and at least two (2) years clinical experience as an EMT-P, or licensure as a registered nurse or physician with at least two (2) years clinical experience;

B. Successful completion of an instructor training program that meets or exceeds the *United States Department of Transportation EMS Instructor Curriculum*. The *United States Department of Transportation EMS Instructor Curriculum* is incorporated by reference in this rule as published in 2002 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions;

C. EMS instructional experience, which meets the following:

(I) Documentation of instructor experience in *Advanced Cardiac Life Support*, *International Trauma Life Support*, *PreHospital Trauma Life Support*, *Pediatric Advanced Life Support*, or *Pediatric Education for Pre-Hospital Professionals (PEPP)*. *Advanced Cardiac Life Support (ACLS)* is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Green-ville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. *International Trauma Life Support (ITLS)* is incorporated by reference in this rule as published by ITLS International in 2007 and is available at ITLS International, 1 S. 280 Summit Avenue, Court B-2, Oakbrook Terrace, IL 60181. This rule does not incorporate any subsequent amendments or additions. *Pre-Hospital Trauma Life Support (PHTLS)* is incorporated by reference in this rule as published by the National Association of Emergency Medical Technicians in 2006 and is available at the National Association of Emergency Medical Technicians, PO Box 1400, Clinton, MS 39060-1400. This rule does not incorporate any subsequent amendments or additions. *Pediatric Advanced Life Support (PALS)* is incorporated by reference in this rule as published by the American Heart Association in 2005 and is available at the American Heart Association, 7272 Green-ville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent amendments or additions. PEPP is incorporated by reference in this rule as published by the American Academy of Pediatrics in 2006 and is available at the American Academy of Pediatrics, 141 Northwest Point Blvd., Elk Grove Village, IL 60007. This rule does not incorporate any subsequent amendments or additions; and

(II) Experience as a laboratory or guest lecturer;

D. Continuing education in instructional topics of at

least twenty (20) hours over the past five (5) years;

E. Competent in adult education theory and clinical skills consistent with the most current EMT-P National Standard Curriculum and the National Scope of Practice for EMT-P shall be the established minimums. The *EMT-P National Standard Curriculum* is incorporated by reference in this rule as published in 1998 and the refresher course in 2001 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions. The *National Scope of Practice* is also incorporated by reference in this rule as published by the U.S. Department of Transportation in 2007 and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions; and

F. As of July 1, 2012, all newly employed primary instructors of initial EMT-P training entities shall possess a minimum of sixty (60) credit hours from an accredited post secondary educational institution;

3. First Responder Instructor:

A. The primary instructor must be a first responder, licensed EMT-B, EMT-I, EMT-P, registered nurse, or physician;

B. The primary instructor must be knowledgeable in all aspects of out-of-hospital emergency medical care, in the techniques and methods of adult education, and in managing resources and personnel;

C. The primary instructor shall have attended and successfully completed a program in EMS instruction methodology;

D. The primary instructor must be present in at least eighty percent (80%) of all class sessions to ensure program continuity and to be able to identify that the students have cognitive, affective, and psychomotor skills necessary to function as a first responder. The primary instructor is responsible for the teaching of a specific lesson of the first responder course. The primary instructor shall have attended a workshop that reviews the format, philosophy, and skills of the new curriculum.

(9) Initial licensure examination for EMT-B, EMT-Intermediate, and EMT-Paramedic.

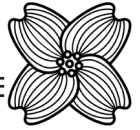
(A) The EMS Bureau shall use the National Registry of EMTs examination process as the basis for initial licensure examinations for all levels of EMTs. The EMT-Basic exam conducted in Missouri is considered "the state approved practical examination" by the National Registry of Emergency Medical Technicians. It shall serve as the state of Missouri's examination used for National Registry of EMT's certification as an EMT-Basic.

1. Any student of an accredited Missouri EMT-Basic program shall complete the EMT-B practical examination in Missouri.

2. If a student from a Missouri accredited EMT-B program attempts a state approved exam outside the state of Missouri, that student shall complete all practical testing in that state and shall be ineligible from completing the Missouri EMT-B practical examination.

3. EMT-I and EMT-P candidates shall complete the National Registry of EMTs practical exam in Missouri or at an approved National Registry of EMTs' Advanced Level exam site in another state.

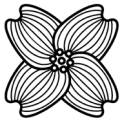
(B) The EMS Bureau shall select providers of the practical licensure examination in the state of Missouri. The providers



shall, with the EMS Bureau approval, operate all test sites and dates in accordance with the policies and procedures of the National Registry of EMTs and the EMS Bureau.

1. The EMS Bureau shall have oversight and review authority of all EMT-B, EMT-I, and EMT-P practical and written examinations administered in the state of Missouri used to obtain licensure.

2. Out-of-state applicants for EMT-B practical testing shall have their practical skills reviewed by a Missouri accredited EMT-B or EMT-P training entity. The training entity shall provide documentation to the EMS Bureau that verifies that the student is competent in all the skills listed in the National Standard Curriculum for EMT-B, except endotracheal intubation. The *EMT-B National Standard Curriculum* is incorporated by reference in this rule as published in 1994 by the U.S. Department of Transportation and is available at the U.S. Department of Transportation, Office of Emergency Medical Services, West Building W44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.



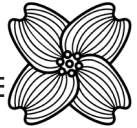
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
UNIT OF EMERGENCY MEDICAL SERVICES
TRAINING ENTITY ACCREDITATION APPLICATION

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

<input type="checkbox"/> INITIAL ACCREDITATION	TRAINING ENTITY ACCRED NO. <input type="text"/>	DATE PASSED REVIEW <input type="text"/>
<input type="checkbox"/> REACCREDITATION	DATE APPLICATION REC'D <input type="text"/>	ISSUE DATE <input type="text"/>
INSPECTOR ASSIGNED _____	DATE INSPECTOR ASSIGNED <input type="text"/>	EXPIRATION DATE <input type="text"/>
	DATE OF FIRST INSPECTION <input type="text"/>	

APPLICANT MUST COMPLETE INFORMATION BELOW TYPE OR PRINT

1. TRADE NAME OF TRAINING ENTITY		DAYTIME TELEPHONE NO.	
		()	
TRAINING ENTITY BUSINESS ADDRESS (STREET, ROUTE, CITY, STATE, ZIP)			
2. TYPE OF ACCREDITATION APPLIED FOR (check all that apply)			
<input type="checkbox"/> EMT-P	<input type="checkbox"/> EMT-B	<input type="checkbox"/> CEUS	<input type="checkbox"/> FIRST RESPONDER
		<input type="checkbox"/> EMERGENCY MEDICAL DISPATCH	
3. PROGRAM DIRECTOR			
NAME (LAST, FIRST, MI)		TELEPHONE NUMBER	
		()	
MAILING BUSINESS ADDRESS (STREET, ROUTE, ETC.)		FAX NUMBER	
		()	
CITY	STATE	ZIP CODE	E-MAIL
4. MEDICAL DIRECTOR			
NAME (LAST, FIRST, MI)		<input type="checkbox"/> M.D. <input type="checkbox"/> D.O.	
MAILING ADDRESS (STREET, ROUTE, ETC.)		OFFICE TELEPHONE NUMBER	
		()	
CITY	STATE	ZIP CODE	E-MAIL
		FAX NUMBER	
		()	
I HEREBY CERTIFY that I am aware of the qualification requirements and the responsibilities of an accredited training entity medical director and I agree to serve as medical director.			
SIGNATURE OF MEDICAL DIRECTOR		DATE	
I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Training Entity has both the intention and the ability to comply with the regulations promulgated under Chapter 190, RSMo. I have attached all training entity licensure and related administrative licensure actions taken against this training entity or owner by any state agency in any state.			
SIGNATURE OF AUTHORIZED REPRESENTATIVE OF TRAINING ENTITY LICENSEE		DATE	
<i>WARNING: In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. §575.060. RSMo</i>			
Mail Application to: Unit of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102			



AUTHORITY: sections 190.131 and 190.185, RSMo Supp. 2013. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Amended: Filed March 11, 2016, effective Oct. 30, 2016. ***

**Original authority: 190.131, RSMo 1998, amended 2002 and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002.*

***Pursuant to Executive Orders 20-04 and 20-10, 19 CSR 30-40.331, subsections (1)(A) and (1)(B) was suspended from April 29, 2020 through June 15, 2020. Pursuant to Executive Order 21-07, 19 CSR 30-40.331, paragraphs (2)(L)1. and (2)(L)3. was suspended from August 6, 2020 through August 31, 2021.*

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) Record. 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.*

***Pursuant to Executive Orders 20-04 and 20-10, 19 CSR 30-40.333, subsections (1)(A) and (1)(C) was suspended from April 29, 2020 through June 15, 2020.*

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, Emergency Medical Technician-Intermediate, and Emergency Medical Technician-Paramedics

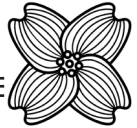
PURPOSE: This rule provides the requirements related to the initial licensure and relicensure of EMT-Basics and EMT-Para-medics.

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

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

(A) Each applicant for licensure or relicensure as an EMT-Basic, EMT-Intermediate, or EMT-Paramedic shall submit an application for licensure to the Emergency Medical Services (EMS) Bureau. 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, but is not limited to, the following information: whether an initial licensure or relicensure application; if previously licensed, their license number and expiration date; type of licensure applied for (EMT-Basic (EMT-B), EMT-Intermediate (EMT-I), or EMT-Paramedic (EMT-P)); type of certification or education used for licensure or relicensure; applicant's name, signature, address, date of birth, sex, daytime telephone number, email address (if applicable), and Social Security number; if applicable, whether or not the applicant is a past member of the United States Armed Forces including National Guard and Reserves who has been honorably discharged within the past two (2) years who requests an EMT-B United States Armed Forces license and, if applicable, attach to the application a copy of the applicant's certificate of release or discharge from active duty (DD form 214) or an NGB-22 which verifies the applicant's honorable discharge and discharge date; whether or not the applicant is a current member of the United States Armed Forces including National Guard and Reserves who requests an EMT-B United States Armed Forces license and, if applicable, attach to the application a copy of the applicant's common access card; type of present primary EMS affiliation. prior administrative licensure actions taken against any license or certification in Missouri or any other state; whether they have been finally adjudicated and found guilty, or entered a plea of guilty or *nolo contendere*, in a criminal prosecution under the laws of any state or of the United States, whether or not 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), judgments and sentencing information, plea agreements and probation terms, 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 EMS Bureau upon request under penalty of license action up to and including revocation; certification by the applicant that the application contains no misrepresentation 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; 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.

(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 EMS Bureau finds not to be relevant to the licensure 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 EMS Bureau.

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

(F) An applicant shall disclose if they have ever been subject to limitation, suspension, or termination of their right to practice in a health care occupation and/or voluntarily surrendered a health care license or certification in any state.

(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 EMS Bureau 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 EMS Bureau evidence of current certification with the National Registry of EMTs as an EMT-B, EMT-I, or EMT-P. Any applicant for initial licensure as an EMT-B who is a past member of the United States Armed Forces including National Guard and Reserves who has been honorably discharged from the United States Armed Forces including National Guard and Reserves within the past two (2) years may request an EMT-B United States Armed Forces license with the EMS Bureau. The applicant shall submit to the EMS Bureau a copy of the applicant's certificate of release or discharge from active duty (a DD form 214) or NGB-22 which verifies the applicant's honorable discharge and discharge date in order to receive an EMT-B United States Armed Forces license from the EMS Bureau that will provide the licensee's date of honorable military discharge. Any applicant for initial licensure as an EMT-B who is a current member of the United States Armed Forces including National Guard and Reserves may request an EMT-B United States Armed Forces license with the EMS Bureau. The applicant shall submit to the EMS Bureau a copy of the applicant's common access card in order to receive an EMT-B United States Armed Forces license from the EMS Bureau that will provide that the applicant is currently in the United States Armed Forces including National Guard and Reserves.

(B) The EMT-B in Missouri may be permitted to perform blood glucose analysis, twelve (12) lead EKG acquisition and transmission, non-invasive airway devices not intended to be placed in the trachea, and all skills in the *National Scope of Practice for Emergency Medical Technicians* which is

incorporated by reference in this rule as published in 2007 by the U.S. Department of Transportation and is available at U.S. Department of Transportation, Office of Emergency Medical Services, West Building W 44-314, 1200 New Jersey Ave. SE, NTI 140, Washington, DC 20590. This rule does not incorporate any subsequent amendments or additions.

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

1. The applicant for relicensure shall submit with their license application to the EMS Bureau 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 EMS Bureau:

A. That they have successfully completed one hundred (100) hours of continuing education which meet the EMS Bureau's 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, EMT-I, 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 EMS Bureau 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) Any applicant for relicensure as an EMT-B who has been honorably discharged from the United States Armed Forces including National Guard and Reserves within the past two (2) years may request an EMT-B United States Armed Forces license with the EMS Bureau. The applicant shall submit to the EMS Bureau a copy of the applicant's certificate of release or discharge from active duty (a DD form 214) or an NGB-22 which verifies the applicant's honorable discharge and discharge date in order to receive an EMT-B United States Armed Forces license from the EMS Bureau that will provide the licensee's date of honorable military discharge. Any applicant for relicensure as an EMT-B who is a current member of the United States Armed Forces including National Guard and Reserves may request an EMT-B United States Armed Forces license with the EMS Bureau. The applicant shall submit to the EMS Bureau a copy of the applicant's common access card in order to receive an EMT-B United States Armed Forces license from the EMS Bureau that will provide that the applicant is currently in the United States Armed Forces including National Guard and Reserves.

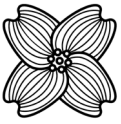
(4) EMT-Paramedic Licensure and Relicensure Requirements.

(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 EMS Bureau 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 EMS Bureau 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 EMS Bureau evidence of current certification with the National Registry of EMTs as an EMT-P; or

2. An applicant shall certify to the EMS Bureau—



A. That they have successfully completed one hundred forty-four (144) hours of continuing education which meet the EMS Bureau's 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 EMS Bureau 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).

B. That they are able to produce documentation of the required continuing education and shall make all records available to the EMS Bureau upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure; and

C. Applicants shall also have current basic cardiac life support training. This does not count towards core continuing education curriculum.

(5) EMT-Intermediate (EMT-I) Licensure and Relicensure Requirements.

(A) EMT-I (Initial Licensure). Initial licensure requirements apply to any person applying for licensure in Missouri. The applicant for initial licensure shall submit with their license application to the EMS Bureau evidence of current certification with the National Registry of Emergency Medical Technicians as an EMT-I. The EMT-I in Missouri may perform all the skills except intraosseous infusions in the *National EMS Scope of Practice Model for Advanced EMT* which is incorporated by reference in this rule as published in 2007 by the U.S. Department of Transportation and is available at U.S. Department of Transportation, Office of Emergency Medical Services, West Building W 44-314, 1200 New Jersey Ave. SE, NTI 140, Washington DC 20590. This rule does not incorporate any subsequent amendments or additions.

(B) EMT-Intermediate (EMT-I) Relicensure.

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

2. An applicant shall certify to the EMS Bureau—

A. That they have successfully completed one hundred forty-four (144) hours of continuing education which meet the EMS Bureau's approval criteria under 19 CSR 30-40.331, seventy-two (72) hours of which cover all elements of the EMT-I core continuing education curriculum and seventy-two (72) hours of which may be elective topics from the EMT-B, EMT-I, or EMT-P curriculum;

B. That they are able to produce documentation of the required continuing education and shall make all records available to the EMS Bureau upon request. Licensees shall maintain such records for a period of five (5) years after the date of relicensure; and

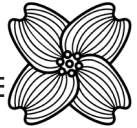
C. Applicants shall produce a copy of the front and back of a basic cardiac life support training card which confirms that the applicant has successfully completed a basic life support training course within the past two (2) years.

(C) EMT-B Step Down from EMT-P or EMT-I.

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

2. An applicant shall certify to the EMS Bureau—

A. That they have successfully completed one hundred (100) hours of continuing education which meet the EMS Bureau's 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, EMT-I, or EMT-P curriculum;



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
EMS PERSONNEL LICENSE APPLICATION

UEMS USE ONLY

EMT LICENSE NO. □□□□□□	APPROVED BY/DATE _____	DATE LICENSED □□□□□□
DATE APP. REC'D. □□□□□□		EXPIRATION DATE □□□□□□

APPLICANT MUST COMPLETE INFORMATION BELOW *TYPE OR PRINT*

1. <input type="checkbox"/> INITIAL LICENSE APP.	CURRENT MO EMS LIC NO. _____	EXPIRATION DATE _____
2. <input type="checkbox"/> RELICENSURE APP.	IF APPLICABLE □□□□□□	AND □□□□□□

3. TYPE OF LICENSE APPLIED FOR (Check One) EMT-Basic EMT-Intermediate EMT-Paramedic

4. CERTIFICATION/EDUCATION USED FOR INITIAL LICENSURE OR RELICENSURE: *(PLEASE CHECK ONLY ONE)*

<input type="checkbox"/> EMT-B NATIONAL REGISTRY <i>(Attach copy of card)</i>	<input type="checkbox"/> EMT-I NATIONAL REGISTRY <i>(Attach copy of card)</i>	<input type="checkbox"/> EMT-P NATIONAL REGISTRY <i>(Attach copy of card)</i>	<input type="checkbox"/> EMT-B CONTINUING EDUCATION	<input type="checkbox"/> EMT-I CONTINUING EDUCATION	<input type="checkbox"/> EMT-P CONTINUING EDUCATION
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5. NAME (LAST, FIRST, MIDDLE INITIAL) _____

SOCIAL SECURITY NUMBER _____	DATE OF BIRTH MO ___ DAY ___ YR ___	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DAYTIME PHONE NUMBER _____
MAILING ADDRESS (STREET) _____			

CITY _____	STATE _____	ZIP CODE _____	COUNTY _____
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6. Are you a past member of the United States Armed Forces including National Guard and Reserves that has been honorably discharged within the past two (2) years who requests an EMT-B United States Armed Forces license? Yes No If yes, please attach a copy of your certificate of release or discharge from active duty (DD form 214) or an NGB-22 which verifies your honorable discharge and discharge date with your application.

7. Are you a current member of the United States Armed Forces including National Guard and Reserves who requests an EMT-B United States Armed Forces license? Yes No If yes, please attach a copy of your common access card with your application.

8. NAME OF THE EMS AGENCY YOU ARE CURRENTLY WORKING FOR. (If applicable) _____

9. TYPE OF PRESENT PRIMARY EMS AFFILIATION *(IF APPLICABLE)*

<input type="checkbox"/> AMBULANCE SERVICE	<input type="checkbox"/> UNLICENSED FIRST RESPONDER AGENCY	<input type="checkbox"/> POLICE DEPARTMENT
<input type="checkbox"/> LICENSED EMRA	<input type="checkbox"/> FIRE SERVICE	<input type="checkbox"/> OTHER

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

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

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

13. HAVE YOU EVER BEEN FINALLY ADJUDICATED AND FOUND GUILTY, OR ENTERED A PLEA OF GUILTY OR NOLO CONTENDERE IN A CRIMINAL PROSECUTION UNDER THE LAWS OF ANY STATE OR OF THE UNITED STATES, WHETHER OR NOT YOU RECEIVED A SUSPENDED IMPOSITION OF SENTENCE FOR ANY CRIMINAL OFFENSE? Yes No

IF YOU HAVE ANSWERED YES TO THE ABOVE QUESTION YOU MUST ATTACH TO YOUR APPLICATION A CERTIFIED COPY OF ALL CHARGING DOCUMENTS (SUCH AS COMPLAINTS, INFORMATIONS OR INDICTMENTS), JUDGMENTS AND SENTENCING INFORMATION, PLEA AGREEMENTS AND PROBATION TERMS AND ANY OTHER INFORMATION YOU WISH CONSIDERED.

14. I HEREBY CERTIFY THAT:

A. I am able to speak, read and write the English language.

B. I do not have a physical or mental impairment which would substantially limit my ability to perform the essential functions of an emergency medical technician with or without a reasonable accommodation.

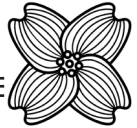
C. This application contains no misrepresentations or falsifications and the information given by me is true and complete to the best of my knowledge. I further certify that I have both the intention and the ability to comply with the regulations promulgated under Chapter 190 RSMo.

D. I have been a resident of Missouri for five (5) consecutive years prior to the date on the application or I have attached to the application at least two (2) completed fingerprint cards.

IF RELICENSING USING CONTINUING EDUCATION, PLEASE COMPLETE THE REVERSE SIDE OF THIS FORM.

Applicant's Signature _____	Date _____
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WARNING: In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor pursuant to section 575.06 RSMo.



AUTHORITY: sections 190.142, 190.160, 190.165, and 190.185, RSMo Supp. 2013. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Aug. 27, 2009, effective April 30, 2010. Amended: Filed March 11, 2016, effective Oct. 30, 2016. ***

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

***Pursuant to Executive Order 21-09, 19 CSR 30-40.342, subsection (2)(B) was suspended from October 9, 2020 through December 31, 2021. Pursuant to Executive Order 21-09, 19 CSR 30-40.342, subsection (2)(B) was suspended from March 3, 2021 through December 31, 2021.*

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, confidence, or legally protected privacy rights of a patient by means of an unauthorized or unlawful disclosure;

(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;

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

(O) Refusal of any applicant or licensee to respond to reasonable department requests for necessary information to process an application or to determine license status or license eligibility.

(P) Any conduct or practice which is or might be harmful or dangerous to the mental or physical health or safety of a patient or the public; and

(Q) Repeated acts of negligence or recklessness in the performance of the functions or duties of any activity licensed or regulated by sections 190.100 to 190.245, RSMo.

(3) The Department of Health and Senior Services 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 2016. Emergency rule filed Jan. 14, 1999, effective Jan. 24, 1999, expired July 22, 1999. Original rule filed Jan. 14, 1999, effective June 30, 1999. Amended: Filed March 1, 2012, effective Sept. 30, 2012. Amended: Filed Aug. 7, 2017, effective March 30, 2018.*



**Original authority: 190.165, RSMo 1973, amended 1978, 1998, 2002, 2016 and 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002.*

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) Anesthesiologist assistant (AA) means a person who meets each of the following conditions:
 1. Has graduated from an anesthesiologist assistant

program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency;

2. Has passed the certifying examination administered by the National Commission on Certification of Anesthesiologist Assistants;

3. Has active certification by the National Commission on Certification of Anesthesiologist Assistants;

4. Is currently licensed as an anesthesiologist assistant in the state of Missouri; and

5. Provides health care services delegated by a licensed anesthesiologist. For the purposes of subsection (1)(B), the licensed anesthesiologist shall be "immediately available" as this term is defined in section 334.400, RSMo;

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

(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 and/or state professional organization and/or trauma medical director;

(I) Core surgeon is a member of the trauma team listed on the trauma call schedule ten percent (10%) of the time or greater;

(J) 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 and establishing clinical privileges in the hospital setting;

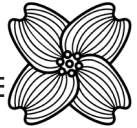
(K) EMS Bureau means the Missouri Department of Health and Senior Services Emergency Medical Services Bureau;

(L) 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;

(M) Immediately available (IA) means being present at bedside 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;

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

(O) Liaison means one (1) physician representative from each of the following areas: Emergency Medicine, Neurosurgery, Orthopedics, and Anesthesia who is selected to attend the Performance Improvement and Patient Safety Committee and to disseminate information to the other physicians within his/



her specialty taking trauma call;

(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 method provided by the Missouri Department of Health and Senior Services;

(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) Non-core surgeon is a member of the trauma call team listed on the trauma call schedule less than ten percent (10%) of the time;

(S) PALS means pediatric advanced life support, ENPC means Emergency Nurses Pediatric Course, and APLS means Advanced Pediatrics Life Support; when required, certification shall be maintained;

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

(U) Promptly available (PA) means arrival at the patient's bedside within thirty (30) minutes after notification of a patient's arrival at the hospital under normal driving and weather conditions;

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

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

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

(Z) Severely injured adult patient is an injured patient with a glasgow coma score (GCS) less than fourteen (14) 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.

(AA) Severely injured child is defined as a patient fourteen (14) years of age or less having a GCS less than fourteen (14), shock following injury, pediatric trauma score less than eight (8), or with any of the following conditions: unable to establish or maintain an airway; ineffective respiratory effort; penetrating injury to head, neck, chest, abdomen, or extremity proximal to elbow or knee; burns greater than ten percent (10%) of the body surface area or involving inhalation injury; two (2) or more proximal long bone fractures or pelvic fracture; open or depressed skull fracture; suspected spinal cord injury and/or paralysis; amputation proximal to wrist or ankle; facial or tracheal injury with airway compromise; pre-existing medical conditions; or respiratory or cardiopulmonary arrest after injury;

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

(CC) 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 and functions as a resource center for the hospitals within that region. Level

II is the next highest level of designation dealing with large volumes of serious trauma. Level III is the next level with limited resources;

(DD) Trauma medical director is a surgeon designated by the hospital who is responsible for the trauma service and performance improvement and patient safety programs related to trauma care;

(EE) Trauma nurse coordinator/trauma program manager is a registered nurse designated by the hospital with responsibility for monitoring and evaluating the care of trauma patients and the coordination of performance improvement and patient safety programs for the trauma center in conjunction with the trauma medical director;

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

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

(HH) 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;

(II) Trauma team activation protocol is a hospital document outlining the criteria used to identify severely injured 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;

(JJ) Trauma triage is an estimation of injury severity at the scene of an accident; and

(KK) Virtual review means a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.

AUTHORITY: section 190.185, RSMo 2016, and section 190.241, RSMo Supp. 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Jan. 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022, effective June 30, 2023.*

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

19 CSR 30-40.420 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 Department of Health and Senior Services (the department). Hospitals desiring trauma center designation shall apply to the department either through the option outlined in section (2) or section (3). Only those hospitals found to be in compliance with the requirements of the rules in this chapter shall be designated by the department as trauma centers.

(2) Hospitals requesting to be reviewed and designated as a trauma center by the department shall meet the following requirements:

(A) The application required for trauma center designation shall be made upon forms prepared or prescribed by the



department and shall contain information the department deems necessary to make a fair determination of eligibility for review and designation in accordance with the rules of this chapter;

(B) 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/program manager, 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. The trauma center review and designation application form, included herein, is available at the Health Standards and Licensure (HSL) office or may be obtained by mailing a written request to Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570;

(C) The department 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;

(D) 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;

(E) 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;

(F) 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 department may conduct an on-site review, a virtual review, or a combination thereof on the hospitals/trauma centers. For announced reviews that are scheduled with the hospitals/trauma centers, the department will make the hospitals/trauma centers aware at least ninety (90) days prior to the scheduled review whether the department intends that the review will be conducted on-site and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted on-site and/or virtually less than ninety (90) days before the announced review. The department will contact the hospitals/trauma centers to make the hospitals/trauma centers aware of any changes about how the review will be conducted, either on-site and/or virtually, and/or when the review will be conducted with as much advance notice as possible prior to the date of the announced review. 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 the department to pay for reviews. Hospitals/trauma centers shall be responsible for paying expenses related to the cost of the qualified contractors to review their respective hospitals/trauma centers during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/trauma center include—

1. An honorarium shall be paid to each qualified

contractor of the review team whether the review occurs on-site or virtually. Qualified contractors of the review team for levels I and II trauma center reviews shall be paid one thousand four hundred fifty dollars (\$1,450) per reviewer. Qualified contractors of the review team for levels III and IV trauma center reviews shall be paid one thousand dollars (\$1,000) per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins if on-site or prior to the beginning of the review if the review is conducted virtually.

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, unless the review is conducted virtually. The hospital/trauma center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred fifty dollars (\$250) and may include the following:

- A. Airport parking;
- B. Checking bag charges;
- C. Meals during the review; and

D. Mileage to and from the review if no airfare was charged by the reviewer. If the reviewer solely participated virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid. Mileage shall be paid at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website www.irs.gov;

(G) For the purpose of reviewing trauma centers and hospitals applying for trauma center designation, the department shall use review teams consisting of two (2) surgeons and one (1) emergency physician who are experts in trauma care and one (1) trauma nurse coordinator/trauma program manager experienced in trauma center review. The team shall be 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. In the event that out-of-state reviewers are unavailable, level II reviews may be conducted by in-state reviewers from emergency medical services (EMS) regions other than the region being reviewed with approval of the director of the Department of Health and Senior Services or his/her designee. When utilizing in-state review teams, the level II trauma center shall have the right to refuse one (1) review team.

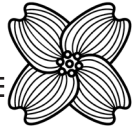
1. Any individual interested in becoming a qualified contractor to conduct reviews shall—

A. Send the department a curriculum vitae (CV) or résumé that includes his or her experience and expertise in trauma care and whether an individual is in good standing with his or her licensing boards. A qualified contractor shall be in good standing with his or her respective licensing boards.

B. Provide the department evidence of his or her previous site survey experience (state and/or national designation survey process); an.

C. Submit a list to the department that details any ownership he or she may have in a Missouri hospital(s), whether he or she has been terminated from any Missouri hospital(s), any lawsuits he or she has currently or had in the past with any Missouri hospital(s), and any Missouri hospital(s) for which his or her hospital privileges have been revoked.

2. Qualified contractors for the department shall enter into a written agreement with the department indicating that, among other things, they agree to abide by Chapter 190, RSMo, and the rules in this chapter, during the review process;



(H) 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 the department and verified by department personnel;

(I) 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;

(J) Validation reviews shall occur every three (3) years;

(K) Hospitals/Trauma centers being reviewed through a virtual survey shall do the following:

1. Provide a videoconferencing platform to be used for the hospital/trauma center virtual review;
2. Provide a live tour of the hospital;
3. Ensure the videoconferencing platform used during the review is compliant with state and federal laws for protected health information;
4. Assign an on-site visit coordinator for the review. The on-site visit coordinator role cannot be fulfilled by the trauma program manager. This on-site visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:
 - A. Scheduling the videoconferencing meetings;
 - B. Sending out calendar invitations;
 - C. Providing electronic medical record (EMR) access to designated individuals;
 - D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and
 - E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors and the department;
5. Assign one staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the trauma program manager, the trauma program medical director, the trauma program registrar, or the on-site visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR.
6. Provide the department with requested patient care report information for the review no later than thirty (30) days prior to the virtual review;
7. Provide the department with requested medical records, PIPS documentation, registry report and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;
8. Schedule a pre-review call with the qualified contractors, the department, the trauma program medical director, the trauma program manager, the staff navigators, and the on-site visit coordinator approximately one (1) week prior to the virtual review;
9. Test the functionality of the videoconferencing platform for the live tour of the hospital prior to the pre-review call; and
10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review. Any changes that occur to this list may be

communicated to the department during the review meeting or before the virtual review;

(L) The department may conduct an on-site review of the hospital prior to the virtual review to ensure that the hospital meets the requirements for trauma designation;

(M) Upon completion of a review, the reviewers shall submit a report of their findings to the department. 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, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department has final authority to determine compliance with the rules of this chapter;

(N) Within thirty (30) days after receiving a review report, the department 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;

(O) If a verification review is required, the hospital shall be allowed a period of six (6) months to correct deficiencies. A plan of correction form shall be provided to the department and shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings;

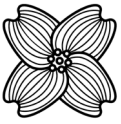
(P) Once a review is completed, a final report shall be prepared by the department. The final report shall be public record and shall disclose the standards by which the reviews were conducted and whether the standards were met. The reports filed by the reviewers shall be held confidential and shall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

(Q) The department shall have the authority to put on probation, suspend, revoke, or deny trauma center designation if the department has determined 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 department. In these cases, the application and review process shall be completed again before the designation may be reinstated;

(R) Trauma center designation shall be valid for a period of three (3) 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 three- (3-) year period. Trauma center designation shall be site specific and not transferable when a trauma center changes location;

(S) The department 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 cooperating with the department regarding a complaint is subject to revocation of trauma center designation; and

(T) Failure of a hospital/trauma center to provide all medical records and quality improvement documentation necessary for the department to conduct a trauma review in order to determine if the requirements of 19 CSR 30-40.430 have been met shall result in the revocation of the hospital/trauma center's designation as a trauma center.



(3) Hospitals seeking trauma center designation by the department based on their current verification as a trauma center by the American College of Surgeons shall meet the following requirements:

(A) An application for trauma center designation by the department for hospitals that have been verified as a trauma center by the American College of Surgeons shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a determination of eligibility for review and designation in accordance with the rules of this chapter. The application for trauma verified hospital designation form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at www.health.mo.gov, or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for trauma center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation or expiration of the current designation;

(B) The application for trauma verified hospital designation form, included herein, shall be complete before the department designates a hospital/trauma center. The department shall notify the hospital/trauma center of any apparent omissions or errors in the completion of the application for trauma verified hospital designation form. Upon receipt of a completed and approved application, the department shall designate such hospital as follows:

1. The department shall designate a hospital as a level I trauma center if such hospital has been verified as a level I trauma center (adult and pediatric) by the American College of Surgeons;

2. The department shall designate a hospital as a level II trauma center if such hospital has been verified as a level II trauma center (adult and pediatric) by the American College of Surgeons;

3. The department shall designate a hospital as a level III trauma center if such hospital has been verified as a level III trauma center (adult and pediatric) by the American College of Surgeons;

4. The department shall designate a hospital as a level IV trauma center if such hospital has been verified as a level IV trauma center (adult and pediatric) by the American College of Surgeons;

5. The department shall designate a hospital as a level I pediatric trauma center if such hospital has been verified as a level I pediatric trauma center (only treats children) by the American College of Surgeons;

6. The department shall designate a hospital as a level II pediatric trauma center if such hospital has been verified as a level II pediatric trauma center (only treats children) by the American College of Surgeons;

7. The department shall designate a hospital as a level I trauma center if such hospital has been verified as a level I trauma center (only treats adults) by the American College of Surgeons; and

8. The department shall designate a hospital as a level II trauma center if such hospital has been verified as a level II trauma center (only treats adults) by the American College of Surgeons.

(C) Within thirty (30) days of any changes or receipt of a verification, the hospital shall submit to the department proof of verification as a trauma center by the American College of Surgeons and the names and contact information of the medical director of the trauma center and the program

manager of the trauma center. Verification as a trauma center by the American College of Surgeons shall accompany the application for trauma verified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is verified as a trauma center by the American College of Surgeons for which the hospital used to receive its corresponding designation with the department as a trauma center, whether because the hospital voluntarily surrendered this verification or because the hospital's verification was suspended or revoked by the American College of Surgeons or expired;

(D) Participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes;

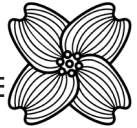
(E) The designation of a hospital as a trauma center pursuant to section (3) shall continue if such hospital retains verification as a trauma center by the American College of Surgeons; and

(F) The department may remove a hospital's designation as a trauma center if requested by the hospital or if the department determines that the verification by the American College of Surgeons has been suspended or revoked. The department may also remove a hospital's designation as a trauma center if the department determines the hospital's verification with the American College of Surgeons has expired. Any decision made by the department to withdraw the designation of a trauma center that is based on the revocation or suspension of a verification by the American College of Surgeons shall not be subject to judicial review.

(4) Hospitals that choose to apply to the department under sections (2) and (3) above and maintain a trauma designation with both the department and the American College of Surgeons may request either of the following two (2) options:

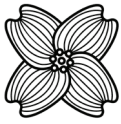
(A) Hospitals may choose to apply to the department under section (2) above and meet the requirements in section (2) above and 19 CSR 30-40.410 and 19 CSR 30-40.430. Hospitals may request a separate review by only the department pursuant to section (2). Hospitals may choose to apply to the department under section (3) above and meet the requirements set by the American College of Surgeons. Hospitals may request a separate review by only the American College of Surgeons; or

(B) Hospitals may choose to apply to the department under section (2) above and meet the requirements in section (2) above and 19 CSR 30-40.410 and 19 CSR 30-40.430. Hospitals may choose to apply to the department under section (3) above and meet the requirements set by the American College of Surgeons. Hospitals may request a joint review by both the American College of Surgeons and the department. In a joint review, department personnel shall be incorporated into these reviews upon the consent of the American College of Surgeons. During these joint reviews, the trauma review team chosen by the American College of Surgeons shall also include at least one (1) emergency department physician and at least one (1) trauma program manager (nurse). All costs for the review and review team shall be paid by the hospitals. If a hospital successfully passes the joint review by the department and the American College of Surgeons, then the hospital will be designated by the department as a trauma center under both sections (2) and (3) above.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
APPLICATION FOR TRAUMA CENTER REVIEW AND DESIGNATION

In accordance with the requirements of Chapter 190, RSMo and the applicable regulations, this application is hereby submitted for trauma center review and designation.		Designation Level Requested <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III	
HOSPITAL INFORMATION			
Name Of Hospital (Name To Appear On Designation Certificate)		Telephone Number	
Address (Street And Number)		(City)	(Zip)
PROFESSIONAL INFORMATION			
Chief Executive Officer		Chairman/President Of Board Of Trustees	
Surgeon In Charge Of Trauma Care		Trauma Nurse Coordinator/Program Manager	
Director Of Emergency Medicine		Director Of Trauma Intensive Care	
RESOURCE INFORMATION			
E.D. Trauma Caseload	Trauma Team Activations	C.T. Scan Capability	M.R.I. Capability
Operating Rooms	ICU/CCU Beds	Burn Beds	Rehab. Beds
Trauma Surgeons	Neurosurgeons	Orthopaedists	E.D. Physicians
Anesthesiologists	C.R.N.A.s	Pediatricians	Pediatric Surgeons
CERTIFICATION			
<p>WE, the undersigned, hereby certify that the information provided in this application for trauma center review and designation is true and accurate and give assurance of the intent and ability of the hospital to comply with the regulations promulgated under Chapter 190, RSMo. We further certify that the hospital will comply with all recommendations for improvement contained in the trauma center site review reports prepared by the Missouri Department of Health and Senior Services. We further certify that we have attached additional documentation for trauma center review and designation as listed in Section B of the attached instruction document.</p> <p>Date of application _____</p> <p>Signed _____ Chairman/President of Board of Trustees, Owner, or one Partner of Partnership</p> <p>Signed _____ Surgeon In Charge Of Trauma Care</p> <p>Signed _____ Hospital Chief Executive Officer</p> <p>Signed _____ Director of Emergency Medicine</p>			

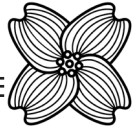


MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE

APPLICATION FOR TRAUMA VERIFIED HOSPITAL DESIGNATION

In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a trauma center. Please complete all information.		ORGANIZATION'S TRAUMA IDENTIFICATION NUMBER	
CURRENT TRAUMA VERIFICATION ORGANIZATION AND LEVEL			
<p style="text-align: center;">ADULT AND PEDIATRIC (TREATS ADULTS AND CHILDREN)</p> <p><input type="checkbox"/> Level I Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level II Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level III Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level IV Trauma Center by the American College of Surgeons</p>	<p style="text-align: center;">PEDIATRIC (TREATS CHILDREN ONLY)</p> <p><input type="checkbox"/> Level I Pediatric Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level II Pediatric Trauma Center by the American College of Surgeons</p>	<p style="text-align: center;">ADULTS (TREATS ADULTS ONLY)</p> <p><input type="checkbox"/> Level I Trauma Center by the American College of Surgeons</p> <p><input type="checkbox"/> Level II Trauma Center by the American College of Surgeons</p>	
HOSPITAL INFORMATION			
NAME OF HOSPITAL (NAME TO APPEAR ON DESIGNATION CERTIFICATE)			TELEPHONE NUMBER
ADDRESS (STREET AND NUMBER)	CITY	ZIP CODE	
PROFESSIONAL INFORMATION			
CHIEF EXECUTIVE OFFICER		CHAIRMAN/PRESIDENT OF BOARD TRUSTEES	
TRAUMA MEDICAL DIRECTOR (NAME, EMAIL, AND CONTACT PHONE NUMBER)		TRAUMA PROGRAM MANAGER (NAME, EMAIL, AND CONTACT PHONE NUMBER)	
The following should be submitted to the department as indicated			
Proof of trauma verification with the American College of Surgeons with the expiration date of the verification.			
RESOURCE INFORMATION			
E.D. TRAUMA CASELOAD	TRAUMA TEAM ACTIVATIONS	C.T. SCAN CAPABILITY	M.R.I. CAPABILITY
OPERATING ROOMS	ICU/CCU BEDS	BURN BEDS	REHAB. BEDS
TRAUMA SURGEONS	NEUROSURGEONS	ORTHOPEAEDISTS	E.D. PHYSICIANS
ANESTHESIOLOGISTS	C.R.N.A.s	PEDIATRICIANS	PEDIATRIC SURGEONS
CERTIFICATION			
We, the undersigned hereby certify that:			
A. Within thirty (30) days of any changes or receipt of a verification, we will submit to the department proof of trauma verification with the American College of Surgeons.			
B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of our trauma center.			
C. Within thirty (30) days of the date that our hospital is no longer verified by the American College of Surgeons, whether because we voluntarily surrendered our verification or because our verification has been suspended or revoked by the American College of Surgeons or has expired, we will report this change in writing to the department.			
D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes.			
E. We understand that our designation as a trauma center by the department shall continue only if our hospital remains verified as a trauma center by the American College of Surgeons.			
DATE OF APPLICATION			
SIGNED (CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP)			
SIGNED (HOSPITAL CHIEF EXECUTIVE OFFICER)			
SIGNED (TRAUMA MEDICAL DIRECTOR)			
SIGNED (DIRECTOR OF EMERGENCY MEDICINE)			

MO 580-3238 (10-2022)



AUTHORITY: sections 190.176 and 190.185, RSMo 2016, and section 190.241, RSMo Supp. 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Feb. 2, 2018, effective Feb. 12, 2018, expired Aug. 10, 2018. Amended: Filed Feb. 2, 2018, effective Aug. 30, 2018.** Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expired June 4, 2023. Amended: Nov. 21, 2022, effective June 30, 2023.*

**Original authority: 190.176, RSMo 1998, amended 2008, 2011; 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002; and 190.241, RSMo 1987, amended 1998, 2008, 2016, 2017, 2022.*

***Pursuant to Executive Order 21-07, 19 CSR 30-40.420, subsection (2)(A) and section (3) was suspended from April 2, 2020 through May 1, 2021. Pursuant to Executive Order 21-09, 19 CSR 30-40.420, subsections (2)(G) and (2)(I) and section 190.241.3, RSMo was suspended from April 2, 2020 through December 31, 2021.*

19 CSR 30-40.430 Standards for Trauma Center Designation

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

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

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

(1) 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 by all core trauma surgeons and liaison representation from neurosurgeons, orthopedic surgeons, emergency medicine physicians, and anesthesiologists at

trauma program performance improvement and patient safety program meetings, documentation of continued experience as defined by the trauma medical director in management of sufficient numbers of severely injured patients to maintain skill levels, and outcome data on quality of patient care as defined by regional emergency medical service committees. Regular attendance shall be defined by each trauma service, but shall be not less than fifty percent (50%) of all meetings. The trauma medical director must ensure and document dissemination of information and findings from the peer review meetings to the non-core surgeons on the trauma call roster.

(D) The trauma center shall have a helicopter landing area. (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 oversight of 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 thirty-six (36) hours of continuing medical education (CME) in trauma care every three (3) years. (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/trauma program manager. (I-R, II-R, III-R)

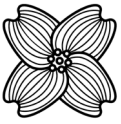
1. There shall be a job description and organization chart depicting the relationship between the trauma nurse coordinator/trauma program manager and other services. (I-R, II-R, III-R)

2. The trauma nurse coordinator/trauma program manager shall document thirty-six (36) hours of continuing nursing education in trauma care every three (3) years. (I-R, II-R, III-R)

(G) By the time of the initial review, all general surgeon members of the surgical trauma call roster shall have successfully completed or be registered for a provider Advanced Trauma Life Support (ATLS) course. Current certification must then be maintained by each general surgeon on the trauma call roster. (I-R, II-R, III-R)

(H) The hospital shall demonstrate that there is a plan for adequate post-discharge follow-up on trauma patients, including rehabilitation. (I-R, II-R, III-R)

(I) A trauma registry shall be completed on each patient who sustains a traumatic injury and meets the following criteria: Includes at least one (1) code within the range of the following injury diagnostic codes as defined in the *International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9)-(CM) 800-959.9*, which is incorporated by reference in this rule as published by the Centers for Disease Control and Prevention in 2006 and is available at National Center for Health Statistics, 1600 Clifton Road, Atlanta, GA 30333. This rule does not incorporate any subsequent amendments or additions. Excludes all diagnostic codes within the following code ranges: 905-909.9 (late effects of injury), 910-924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites), 930-939.9 (foreign bodies), and must include one (1) of the following criteria: hospital admission, patient transfer out of facility, or death resulting from the traumatic injury (independent of hospital admission or hospital transfer status). Trauma centers shall enter trauma care data elements for each patient who meets these criteria. The trauma care data



elements shall be those identified and defined by the National Trauma Data Standard, which is incorporated by reference in this rule as published by the American College of Surgeons in 2022 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R).

1. Trauma centers shall enter trauma care data elements for each patient who meets the criteria above into the following:

A. Trauma centers shall submit data into the department's Missouri trauma registry. The data required in subsection (1) (I) above shall be submitted electronically into the Missouri trauma registry via the department's website at www.health.mo.gov; or (I-R, II-R, III-R)

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

2. Electronic data shall be submitted quarterly, ninety (90) days after the quarter ends. The trauma registry must be current and complete. (I-R, II-R, III-R)

3. 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)

(J) A patient log of those patients entered into the trauma registry with admission date, patient name, and injuries must be available for use during the site review process. (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 severely injured 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 response requirements for trauma team members when a severely injured 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 communication 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) Surgeons who are board-certified or board-admissible or complete an alternate pathway as documented and defined by the trauma medical director using the criteria established by the American College of Surgeons (ACS) in the current Resource for Optimal Care Document in the following specialties and who are credentialed by the hospital for trauma care shall be on the trauma center staff and/or be available to the patient as indicated. The Resource for Optimal Care Document is incorporated by reference in this rule as published by the American College of Surgeons in 2006 and is available at the American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions.

1. General surgery—I-R, II-I/A, III-P/A.

A. The general surgery staffing requirement may be fulfilled by a senior surgery resident credentialed in general surgery, including trauma care, and Advanced Trauma Life Support (ATLS) certification and capable of assessing emergency situations in general surgery.

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

C. In a level I or II center, call rosters providing back-up coverage will be maintained for general trauma surgeons. In a level III center, call rosters providing for back-up coverage for general trauma surgeons will be maintained or a written transfer agreement to a level I or II trauma center provided.

D. Surgeons who are board-certified or board-admissible and who are credentialed by the hospital for trauma care shall be on the trauma center staff.

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/Thoracic surgery—I-R/PA, II-R/PA.

4. Obstetric-gynecologic surgery—I-R/PA, II-R/PA.

5. Ophthalmic surgery—I-R/PA, II-R/PA.

6. Orthopedic surgery—I-R/PA, II-R/PA.

7. Maxillofacial trauma surgery—I-R/PA, II-R/PA.

8. Otorhinolaryngologic surgery—I-R/PA, II-R/PA.

9. Pediatric surgery/trauma surgeon credentialed and privileged in pediatric trauma care—I-R/IA, II-R/PA; this requirement will be waived in centers that provide evaluation and care to adults only.

10. Plastic surgery—I-R/PA, II-R/PA.

11. Urologic surgery—I-R/PA, II-R/PA.

12. Emergency medicine—I-R/IH, II-R/IH, III-R/IH.

13. Cardiology—I-R/PA, II-R/PA.

14. Chest pulmonary medicine—I-R/PA, II-R/PA.

15. Gastroenterology—I-R/PA, II-R/PA.

16. Hematology—I-R/PA, II-R/PA.

17. Infectious diseases—I-R/PA, II-R/PA.

18. Internal medicine—I-R/PA, II-R/PA, III-R/PA.

19. Nephrology—I-R/PA, II-R/PA.

20. Pathology—I-R/PA, II-R/PA.

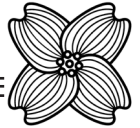
21. Pediatrics—I-R/PA, II-R/PA.

22. Psychiatry—I-R/PA, II-R/PA.

23. Radiology—I-R/PA, II-R/PA.

24. Anesthesiology—I-R/IH, II-R/IA, III-R/PA.

A. In a level I or II trauma center, anesthesiology staffing requirements may be fulfilled by anesthesiology residents or certified registered nurse anesthetists (CRNA) capable of assessing emergent situations in trauma patients and of



providing any indicated treatment including induction of anesthesia or may be fulfilled by anesthesiologist assistants with anesthesiologist supervision in accordance with sections 334.400 to 334.430, RSMo.

B. In a level III trauma center, anesthesiology requirements may be fulfilled by a CRNA with physician supervision, or an anesthesiologist assistant with anesthesiology supervision.

(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 trained in the care of the critically injured as evidenced by credentialing in ATLS in the emergency department twenty-four (24) hours a day. ATLS is incorporated by reference in this rule as published by the American College of Surgeons in 2003 and is available at American College of Surgeons, 633 N. St. Clair St., Chicago, IL 60611. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)

C. All emergency department physicians shall be certified in ATLS at least once. Physicians who are certified by boards other than emergency medicine who treat trauma patients in the emergency department are required to have current ATLS status. (I-R, II-R, III-R)

D. 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)

E. All registered nurses 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 care shall maintain current provider status in the Trauma Care After Resuscitation (TCAR), Trauma Nurse Core Curriculum (TNCC), or Advanced Trauma Care for Nurses (ATCN) and either Pediatric Care After Resuscitation (PCAR), Pediatric Advanced Life Support (PALS), Advanced Pediatric Life Support (APLS), or Emergency Nursing Pediatric Course (ENPC) within one (1) year of employment in the emergency department. The requirement for Pediatric Care After Resuscitation, Pediatric Advanced Life Support, Advanced Pediatric Life Support, or Emergency Nursing Pediatric Course may be waived in centers where policy exists diverting injured children to a pediatric trauma center and where a pediatric trauma center is adjacent and a performance improvement filter reviewing any children seen is maintained. The *Trauma Nurse Core Curriculum* is incorporated by reference in this rule as published in 2007 by the Emergency Nurses Association and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. *Advanced Trauma Care for Nurses* is incorporated by reference in this rule as published in 2003 by the Society of Trauma Nurses and is available at the Society of Trauma Nurses, 1926 Waukegan Road, Suite 100, Glenview, IL 60025. This rule does not incorporate any subsequent amendments or additions. *Pediatric Advanced Life Support* is incorporated by reference in this rule as published in 2005 by the American Heart Association and is available at the American Heart Association, 7272 Greenville Avenue, Dallas, TX 75231. This rule does not incorporate any subsequent

amendments or additions. The Emergency Nursing Pediatric Course is incorporated by reference in this rule as published by the Emergency Nurses Association in 2004 and is available at the Emergency Nurses Association, 915 Lee Street, Des Plaines, IL 60016-9659. This rule does not incorporate any subsequent amendments or additions. Trauma Care After Resuscitation and Pediatric Care After Resuscitation are incorporated by reference in this rule as published in 2022 by TCAR Education Programs and are available at TCAR Education Programs, 33456 Havlik Drive, Scappoose, Oregon 97056. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R)

2. Equipment for resuscitation and life support with age appropriate sizes 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 – I-R, II-R, III-R;

B. Suction devices – I-R, II-R, III-R;

C. Electrocardiograph, cardiac monitor, and defibrillator – 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 including intravenous catheters – I-R, II-R, III-R;

F. Sterile surgical sets for procedures standard for the emergency department – I-R, II-R, III-R;

G. Gastric lavage equipment – I-R, II-R, III-R;

H. Drugs and supplies necessary for emergency care – 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 – I-R, II-R;

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

L. 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 approved by the trauma medical director and trauma nurse coordinator/trauma program manager. (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 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. (I-R, II-R, III-R)

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

6. Nurses assigned to the ICU shall maintain current provider status in Advanced Cardiac Life Support (ACLS) or Advanced Life Support (ALS). ACLS is incorporated by reference



in this rule as published in 2021 by the American Heart Association and is available for purchase at the American Heart Association, 7272 Greenville Ave., Dallas, TX 75231 or online at www.cpr.heart.org. This rule does not incorporate any subsequent amendments or additions. ALS is incorporated by reference in this rule as published in 2022 by the American Red Cross and is available for purchase at the American Red Cross, National Headquarters, 430 17th St. NW, Washington DC 20006 or online at www.redcross.org. This rule does not incorporate any subsequent amendments or additions. At the time of the initial review, nurses assigned to ICU shall have successfully completed or be registered for a provider ACLS or ALS course. The requirement for ACLS or ALS may be waived in pediatric centers where policy exists diverting injured adults to an adult trauma center and where an adult trauma center is adjacent to the affected pediatric facilities, and a performance improvement filter reviewing any adult trauma patients seen is maintained. (I-R, II-R, III-R)

7. There shall be separate pediatric and adult ICUs or a combined ICU with nurses trained in pediatric intensive care. In ICUs providing care to children, registered nurses shall maintain credentialing in PALS, APLS, or ENPC. (I-R, II-R)

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

9. Equipment for resuscitation and to provide life support for the critically or seriously injured shall be available for the intensive care unit. In ICUs providing care for the pediatric patient, equipment with age appropriate sizes shall also be available. This equipment shall include but not be limited to –

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

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

C. Cardiac emergency cart, including medications – I-R, II-R, III-R;

D. Temporary transvenous pacemakers – I-R, II-R, III-R;

E. Electrocardiograph, cardiac monitor, and defibrillator – 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 – I-R, II-R, III-R;

I. Patient weighing devices – I-R, II-R, III-R;

J. Temperature control devices – I-R, II-R, III-R;

K. Drugs, intravenous fluids, and supplies – I-R, II-R, III-R; and

L. Intracranial pressure monitoring devices – I-R, II-R.

10. There shall be documentation that all equipment is checked according to the hospital preventive maintenance schedule. (I-R, II-R, III-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 sixty (60) 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, and III-R;

C. Electrocardiograph, cardiac monitor, 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, and 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. Temporary pacemaker – I-R, II-R, III-R;

J. Electronic pressure monitoring – I-R, II-R; and

K. 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 possess pediatric trauma management capability or maintain written transfer agreements. (I-R, II-R, III-R)

(H) Radiological capabilities for trauma center designation including a mechanism for timely interpretation to aid in patient management shall include:

1. Angiography with interventional capability available twenty-four (24) hours a day with a one- (1-) hour maximum response time from time of notification – I-R, II-R;

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

3. Resuscitation equipment available to the radiology department – I-R, II-R, III-R;

4. 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. Nurses providing care for the trauma patients that are not accompanied by a trauma nurse while in the radiology department during initial evaluation and resuscitation shall maintain the same credentialing required of emergency department nursing personnel – I-R, II-R, III-R;

5. In-house computerized tomography – I-R, II-R; and

6. 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:

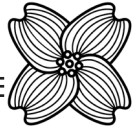
A. Airway control and ventilation equipment including laryngoscopes, endotracheal tubes of all sizes, bag-mask resuscitator, and sources of oxygen – I-R, II-R, III-R;

B. Suction devices – I-R, II-R, III-R;

C. Electrocardiograph, cardiac monitor, 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 including, but not limited to:

A. Operating microscope— I-R. .

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

C. X-ray capability— I-R, II-R, III-R;

D. Endoscopic capabilities, all varieties— I-R, II-R, III-R;

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

F. Monitoring equipment— 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;

(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 Performance Improvement and Improvement Patient Safety Program, Outreach, Public Education, and Training for Trauma Center Designation.

(A) There shall be an ongoing performance improvement and patient safety 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 performance improvement and patient safety measures shall be required:

1. Regular reviews of all trauma-related deaths— I-R, II-R, III-R;

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

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

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

5. Regular reviews of pre-hospital trauma care including inter-facility transfers and all adult patients seen in pediatric centers— I-R, II-R, III-R;

6. Participation in reviews of regional systems of trauma care as established by the Department of Health and Senior Services— I-R, II-R, III-R; and

7. Trauma patients remaining greater than six (6) hours prior to transfer will be reviewed as a part of the performance improvement and patient safety program— I-R, II-R, III-R.

(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 trauma care and to resolve problems confronting the public, medical profession, and hospitals regarding optimal care for the injured. These must address major trauma issues as identified in that program's performance improvement and patient safety process. (I-R, II-R)

(E) 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)

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

1. All nurses providing care to severely injured patients and assigned to the emergency department or ICU shall complete a trauma nursing course in order 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 department's time critical diagnosis unit. (I-R, II-R, III-R)

3. Trauma nursing courses offered by institutions of higher education in Missouri such as the Advanced Trauma Care for Nurses, Emergency Nursing Pediatric Course, Trauma Care After Resuscitation, Pediatric Care After Resuscitation, or the Trauma Nurse Core Curriculum 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/trauma program manager and shall present evidence of satisfactory completion of the course. (I-R, II-R, III-R)

(G) 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 Performance Improvement and Patient Safety program, and available when the hospital is site reviewed.

(H) Each trauma center shall have a disaster plan. A copy of this disaster plan must be maintained within the trauma center policies and procedures and should document the trauma services role in planning and response.

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

(A) The hospital and its staff shall support a research program in trauma as evidenced by any of the following:

1. Publications in peer reviewed journals— I-R;

2. Reports of findings presented at regional or national meetings— I-R;

3. Receipt of grants for study of trauma care— I-R; and

4. Production of evidence-based reviews— I-R.

(B) The hospital shall agree to cooperate and participate with the EMS Bureau 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: section 190.185, RSMo 2016, and section 190.241, RSMo Supp. 2022. Emergency rule filed Aug. 28, 1998, effective Sept. 7, 1998, expired March 5, 1999. Original rule filed Sept. 1, 1998, effective Feb. 28, 1999. Amended: Filed Jan. 16, 2007, effective Aug. 30, 2007. Amended: Filed May 19, 2008, effective Jan. 30, 2009. Emergency amendment filed Nov. 21, 2022, effective Dec. 7,*



2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022, effective June 30, 2023.

**Original authority: 190.185, RSMo 1973, amended 1989, 1993, 1995, 1998, 2002, and 90.241, RSMo 1987, amended 1998, 2008, 2016, 2017, 2022.*

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.

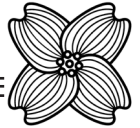
(B) The emergency department staffing shall ensure immediate and appropriate care of the pediatric trauma patient. The emergency department pediatrician shall be board certified/eligible in pediatric medicine and shall function as a designated member of the pediatric trauma team. All emergency department 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/Re-sources/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.

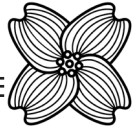
(I) The hospital shall provide programs in continuing education for the area physicians, registered nurses and emergency medical service providers concerning the treatment of the pediatric trauma patient.

(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.*

**19 CSR 30-40.528 Application and Licensure Requirements;
Standards for the Licensure and Relicensure of Stretcher
Van Services**

*PURPOSE: This rule provides the requirements and standards
related to the licensure and relicensure of stretcher van services.*

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

(1) Application requirements for stretcher van service
licensure –

(A) Each applicant for a stretcher van service license shall submit an application for licensure to the Emergency Medical Service. (EMS) Bureau 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, but is not limited to, the following information: trade name of the stretcher van service; location of vehicles; number of vehicles to be operated by the stretcher van service; name, address, telephone numbers, and email address (if applicable) of manager; name, address, telephone numbers, and email address (if applicable) of proposed licensee of the stretcher van service; name, address, telephone numbers, and email address (if applicable) of licensee's chief executive officer; all stretcher van service licensure and related administrative licensure actions taken against the stretcher van service or owner by any state agency in any state; and certification by the applicant that the application contains no misrepresentation or falsifications and that the information given by them is true and complete to the best of their knowledge and that the stretcher van service has both the intention and the ability to comply with the regulations promulgated under Chapter 190, RSMo. The stretcher van application form, included herein, is available at the EMS Bureau office or by mailing a written request to the Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.

(C) Each stretcher van service that meets the requirements and standards of the statutes and regulations shall be licensed for a period of five (5) years.

(2) Passengers may be transported in a stretcher van provided the passenger –

(A) Needs no medical equipment (except self-administered medications, including oxygen);

(B) Needs no medical monitoring; and

(C) Needs routine transportation to or from a medical appointment or service if that passenger(s) is convalescent or otherwise non-ambulatory and does not require medical monitoring, aid, care, or treatment during transport.

(3) Stretcher van services shall not transport patients currently admitted to a hospital or patients being transported to a hospital for admission or emergency treatment. A stretcher van shall not transport a patient or passenger whom –

(A) Is acutely ill, wounded, or medically unstable;

(B) Is experiencing an emergency medical condition as defined in section 190.100, RSMo, an acute medical condition, an exacerbation of a chronic medical condition, or a sudden illness or injury; and

(C) Was administered a medication that might prevent the person from caring for him/herself.

(4) Vehicle design and specifications for stretcher vans –

(A) Delivery of each stretcher van vehicle will include documentation that the vehicle's design and construction will afford safety, comfort, and avoid aggravation of the passenger's(s') present condition. The vehicle shall be complete and furnished with such modifications and attachments as may be necessary to enable the vehicle to function reliably and efficiently in sustained operation. All vehicles shall be constructed by a qualified vehicle manufacturer, designed and built to meet or exceed (at date of vehicle manufacture) Federal Motor Vehicle Safety Standards (FMVSS) and regulations included in 49 CFR 571.1 through 571.500. Federal regulations 49 CFR 571.1 through 571.500 revised October 1, 2007, are incorporated by reference in this rule as published in the *Code of Federal Regulations* and are available at the United States Government Printing Office, 732 North Capitol Street NW, Washington, DC 20401, contact center via telephone at 1-866-512-1800 or online at www.gpoaccess.gov. This rule does not incorporate any subsequent amendments or additions.

(B) Stretchers and mounting must meet or exceed KKK-A-1822 specifications or Ambulance Manufacturers Division (AMD) Standards 004 – litter retention system. The KKK-A-1822 specifications are incorporated by reference in this rule as published in 2007 by the General Services Administration and are available at Chief, Automotive Engineering & Commodity Management Branch (QMDAA), Office of Motor Vehicle Management, General Services Administration, 2200 Crystal Drive, Suite 1006, Arlington, VA 22202. This rule does not incorporate any subsequent amendments or additions. The Ambulance Manufacturers Division Standards are incorporated by reference in this rule as published in 2007 by the Ambulance Manufacturers Division and are available at Ambulance Manufacturers Division, 37400 Hills Tech Drive, Farmington Hills, MI 48331-3414. This rule does not incorporate any subsequent amendments or additions. The operation of the stretcher shall follow manufacturer's specifications and guidelines;

(C) No emergency warning lights are allowed on vehicle;

(D) No "ambulance" lettering or "Star of Life" may be displayed on vehicle;

(E) Store or secure all equipment, including passengers' own oxygen delivery system, in a readily accessible and protected manner to limit its movement during a crash; and

(F) To facilitate cleaning and disinfecting, the stretcher



compartment shall be impervious to soap and water, disinfectants, mildew, fire resistant, and comply with FMVSS 302; be easily cleaned/disinfected (carpeting, cloth, and fabrics are not acceptable); and all exposed surfaces shall be free of vent devices that would permit the entrapment of biological contaminants.

(5) Vehicle and equipment operation and maintenance standards –

(A) Each service shall ensure that all vehicle drivers possess a valid Class E, Missouri chauffeurs driver license;

(B) Each service shall ensure that all vehicle drivers complete a driver safety education program or vehicle operations course and be able to provide documentation of completion. These records shall be available for inspection by the EMS Bureau during normal business hours;

(C) Each vehicle shall maintain a current motor vehicle safety inspection from a certified inspector mechanic;

(D) Each service shall establish a preventive maintenance program for their vehicles, and each vehicle shall receive periodic maintenance as recommended by the qualified vehicle manufacturer. The records shall be available for inspection by the EMS Bureau during normal business hours; and

(E) Each service shall comply with the stretcher manufacturer's guidelines for maintenance of the stretchers.

(6) Vehicle staffing requirements –

(A) Each vehicle shall be staffed with a minimum of two (2) persons when transporting a passenger(s).

(B) At a minimum, stretcher van personnel shall have completed a nationally recognized course in cardiopulmonary resuscitation (CPR) and be certified at the community and workplace level.

(7) Vehicle communications requirements – Each service shall establish a policy for notification of 911 in an emergency and each vehicle shall be equipped to allow stretcher van personnel to communicate by voice with the service's own dispatching agency or 911 operator.

(8) On-board equipment standards – Each vehicle shall be equipped with body substance isolation (BSI) supplies in accordance with section 191.694, RSMo.

(9) Each service shall maintain accurate records and reports on the following –

(A) A passenger transport report to record information on each request for service and transportation;

(B) Stretcher van service license;

(C) Vehicle maintenance records;

(D) Vehicle driver education records;

(E) Equipment maintenance records;

(F) Records required by other regulatory agencies; and

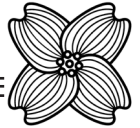
(G) Each service shall be able to produce these records for inspection during normal business hours.

(10) Each service shall have 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 stretcher van 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 stretcher van service license number. Liability coverage for stretcher van services 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 (\$100,000.00) for loss or damage to property of others in one (1) accident, excluding cargo.



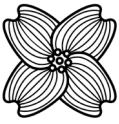
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
STRETCHER VAN APPLICATION

FOR DHSS OFFICE USE ONLY - DO NOT WRITE IN THIS SPACE			
<input type="checkbox"/> INITIAL LICENSURE <input type="checkbox"/> RELICENSURE INSPECTOR ASSIGNED _____	STRETCHER VAN LIC. # <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DATE APPLICATION RECEIVED <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DATE INSPECTOR ASSIGNED <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DATE OF FIRST INSPECTION <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	DATE PASSED INSPECTION <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> DATE LICENSED <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> EXPIRATION DATE <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	

APPLICANT MUST COMPLETE INFORMATION BELOW TYPE OR PRINT

1. TRADE NAME OF STRETCHER VAN SERVICE (Name on vehicle)				NUMBER OF VEHICLES	
LOCATION OF VEHICLES (STREET, ROUTE, CITY, STATE, ZIP)					
2. OPERATOR OF STRETCHER VAN SERVICE					
NAME OF OPERATOR		NAME OF MANAGER (LAST, FIRST, MI)		TELEPHONE NUMBER-BUSINESS ()	
OPERATOR MAILING ADDRESS (STREET, ROUTE, ETC.)				TELEPHONE NUMBER-EMERGENCY CONTACT ()	
CITY	STATE	ZIP CODE	E-MAIL	FAX NUMBER ()	
3. STRETCHER VAN SERVICE LICENSEE					
NAME OF CORPORATION		NAME OF CEO		TELEPHONE NUMBER-BUSINESS ()	
BUSINESS MAILING ADDRESS (STREET, ROUTE, ETC.)				TELEPHONE NUMBER-EMERGENCY CONTACT ()	
CITY	STATE	ZIP CODE	E-MAIL	FAX NUMBER ()	
I HEREBY CERTIFY that this application contains no misrepresentations or falsifications and that the information given by me is true and complete to the best of my knowledge. I further certify that the above named Stretcher Van Service has both the intention and the ability to comply with the regulations promulgated under Chapter 190, RSMo.					
I have attached all Stretcher Van Service licensure and related administrative licensure actions taken against this stretcher van service or owner by any state agency in any state.					
SIGNATURE OF AUTHORIZED REPRESENTATIVE OF STRETCHER VAN SERVICE LICENSEE				DATE	
WARNING; In addition to licensure action, anyone who knowingly makes a false statement in writing with the intent to mislead a public servant in the performance of his official duty may be guilty of a class B misdemeanor. §575.060.RSMo					

Mail Application to: Bureau of Emergency Medical Services, P.O. Box 570, Jefferson City, MO 65102



AUTHORITY: sections 190.528 and 190.537, RSMo Supp. 2007.
Original rule filed May 19, 2008, effective Jan. 30, 2009. ***

**Original authority: 190.528, RSMo 2002 and 190.537, RSMo 2002.*

***Pursuant to Executive Orders 20-04 and 20-10, 19 CSR 30-40.528, subsections (1)(A) and (1)(C) was suspended from April 29, 2020 through June 15, 2020.*

19 CSR 30-40.600 Outside the Hospital Do-Not-Resuscitate (OHDNR)

PURPOSE: This rule establishes a procedure to be followed by personnel to comply with the outside the hospital do-not-resuscitate protocol when presented with an outside the hospital do-not-resuscitate identification or an outside the hospital do-not-resuscitate order.

(1) As used in this rule, the following terms shall mean:

(A) "Attending physician" –

1. A physician licensed under Chapter 334, RSMo, selected by or assigned to a patient who has primary responsibility for treatment and care of the patient; or

2. If more than one (1) physician shares responsibility for the treatment and care of a patient, one (1) such physician who has been designated the attending physician by the patient or the patient's representative shall serve as the attending physician;

(B) "Cardiopulmonary resuscitation" or "CPR," emergency medical treatment administered to a patient in the event of the patient's cardiac or respiratory arrest and shall include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures;

(C) "Department," the Department of Health and Senior Services;

(D) "Emergency medical services personnel," paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency service personnel acting within the ordinary course and scope of their professions, but excluding physicians;

(E) "Health care facility," any institution, building, or agency or portion thereof, private or public, excluding federal facilities and hospitals, whether organized for profit or not, used, operated, or designed to provide health services, medical treatment, or nursing, rehabilitative, or preventive care to any person or persons. Health care facility includes, but is not limited to, ambulatory surgical facilities, health maintenance organizations, home health agencies, hospices, infirmaries, renal dialysis centers, long-term care facilities licensed under sections 198.003 to 198.186, RSMo, medical assistance facilities, mental health centers, outpatient facilities, public health centers, rehabilitation facilities, and residential treatment facilities;

(F) "Hospital," a place devoted primarily to the maintenance and operation of facilities for the diagnosis, treatment, or care for not less than twenty-four (24) consecutive hours in any week of three (3) or more nonrelated individuals suffering from illness, disease, injury, deformity, or other abnormal physical conditions; or a place devoted primarily to provide for not less than twenty-four (24) consecutive hours in any week medical or nursing care for three (3) or more nonrelated individuals. Hospital does not include any long-term care facility licensed under sections 198.003 to 198.186, RSMo;

(G) "Outside the hospital do-not-resuscitate (OHDNR) identification" or "outside the hospital DNR identification," a standardized identification card, bracelet, or necklace of a single color,

form, and design that signifies that the patient's attending physician has issued an outside the hospital do-not-resuscitate order for the patient and has documented the grounds for the order in the patient's medical file;

(H) "Outside the hospital do-not-resuscitate (OHDNR) order" or "outside the hospital DNR order," a written physician's order signed by the patient and the attending physician, or the patient's representative and the attending physician, which authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest;

(I) "Outside the hospital do-not-resuscitate (OHDNR) protocol" or "outside the hospital DNR protocol," a standardized method or procedure for the withholding or withdrawal of cardiopulmonary resuscitation by emergency medical services personnel from a patient in the event of cardiac or respiratory arrest;

(J) "Patient," a person eighteen (18) years of age or older who is not incapacitated, as defined in section 475.010, RSMo, and who is otherwise competent to give informed consent to an outside the hospital do-not-resuscitate order at the time such order is issued, and who, with his or her attending physician, has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621, RSMo. A person who has a patient's representative shall also be a patient for the purposes of sections 190.600 to 190.621, RSMo, if the person or the person's patient's representative has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621, RSMo; and

(K) "Patient's representative" –

1. An attorney-in-fact designated in a durable power of attorney for health care for a patient determined to be incapacitated under sections 404.800 to 404.872, RSMo; or

2. A guardian or limited guardian appointed under Chapter 475, RSMo, to have responsibility for an incapacitated patient.

(2) A properly executed OHDNR order –

(A) Shall be completed on an OHDNR order form with an optional instruction form. The OHDNR order form and instruction form are included herein and available at the Emergency Medical Services Bureau office, online at www.dhss.mo.gov/EMS, or obtained by mailing a written request to the Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570. The instruction form may be photocopied on the back side of the OHDNR order form or attached as a separate page to the OHDNR order form;

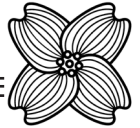
(B) Shall only be effective when the patient has not been admitted to or is not being treated within a hospital or has not yet come to the emergency department as defined in the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. section 1395dd, and the regulation 42 C.F.R. section 489.24(a) and referenced in the Centers for Medicare and Medicaid Services State Operations Manual Appendix V – Interpretive Guideline – Responsibilities of Medicare Participating Hospitals in Emergency Cases (Rev. 1, 05-21-04);

(C) Shall be maintained as the first page of a patient's medical record in a health care facility unless otherwise specified in the health care facility's policies and procedures;

(D) Shall be transferred with the patient when the patient is transferred from one health care facility to another health care facility;

(E) Shall be provided to any other facility, person, or agency responsible for the medical care of the patient or to the patient or patient's representative if the patient is transferred outside of a hospital;

(F) Shall be signed and dated by the patient or the patient's



legal representative and the patient's attending physician;

(G) Shall be printed on eight and one half inch by eleven inch (8.5" x 11") card stock that is purple in color;

(H) May be photocopied or faxed, and this photocopy or other complete facsimile of the original OHDNR order may be used for any purpose for which the original OHDNR order may be used;

(I) May be revoked at anytime. A patient or a patient's representative may revoke an OHDNR order by:

1. Signing in the box on the OHDNR order form labeled revocation provision. The revocation provision box shall remain unsigned in order for the OHDNR order to remain in effect;

2. Expressing to emergency medical services personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated; or

3. Destroying a patient's original OHDNR order form and any applicable OHDNR identification such as an identification card, bracelet, or necklace; and

(J) Shall be valid and effective whether or not an instruction form is included on the back side of the OHDNR form or attached as a separate page to the OHDNR order form.

(3) Emergency medical services personnel are authorized to comply with the OHDNR protocol when presented with OHDNR identification or an OHDNR order. The outside the hospital do-not-resuscitate (OHDNR) protocol includes the following standardized methods or procedures:

(A) An OHDNR order shall only be effective when the patient has not been admitted to or is not being treated within a hospital or has not yet come to the emergency department as defined in the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. section 1395dd, and the regulation 42 C.F.R. section 489.24(a) and referenced in the Centers for Medicare and Medicaid Services State Operations Manual Appendix V – Interpretive Guideline – Responsibilities of Medicare Participating hospitals in Emergency Cases (Rev. 1, 05-21-04);

(B) Emergency medical services personnel shall not comply with an OHDNR order or the OHDNR protocol when the patient or patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated;

(C) An OHDNR order shall not be effective during such time as the patient is pregnant;

(D) A properly executed OHDNR order authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest. Emergency medical services personnel shall not withhold or withdraw other medical interventions, such as intravenous fluids, oxygen, or therapies other than cardiopulmonary resuscitation such as those to provide comfort care or alleviate pain. Nothing in this regulation shall prejudice any other lawful directives concerning such medical interventions and therapies;

(E) If any doubt exists about the validity of the OHDNR identification or an OHDNR order, resuscitation shall be initiated and medical control shall be contacted;

(F) If the OHDNR order or OHDNR identification is presented after basic or advanced life support procedures have started, the emergency medical services personnel shall honor the form and withhold or withdraw cardiopulmonary resuscitation from a patient who is suffering cardiac or respiratory arrest;

(G) After noting the properly executed OHDNR order or OHDNR identification, no cardiac monitoring is necessary and no medical control contact is necessary; and

(H) Emergency medical services personnel shall document

review of the OHDNR order and/or OHDNR identification in the patient care record.

(4) Single Color, Form, and Design for Additional/Optional OHDNR Identification.

(A) The OHDNR identification card –

1. Shall be signed and dated by the patient or the patient's legal representative and the patient's attending physician;

2. Shall be printed on card stock that is purple in color; and

3. Shall be three and seven sixteenth by four and one eighth (3 7/16 x 4 1/8) inches in size and may be folded and/or laminated.

(B) The OHDNR bracelet –

1. Shall contain a representation of the geographical shape of Missouri with the word "STOP" etched in purple, imposed over the geographical shape of Missouri on the face of the bracelet; and

2. Shall contain the inscription "MO OHDNR order" on the back of the bracelet.

(C) The OHDNR necklace –

1. Shall include a medallion containing a representation of the geographical shape of Missouri with the word "STOP" etched in purple, imposed over the geographical shape of Missouri on the face of the medallion; and

2. Shall contain the inscription "MO OHDNR order" on the back of the medallion.

(D) OHDNR bracelet and necklace vendors shall obtain approval from the department prior to manufacturing and distributing an initial OHDNR bracelet and necklace for a Missouri resident. To obtain approval from the department, OHDNR bracelet and necklace vendors shall submit to the department –

1. A document expressing an interest in manufacturing and distributing OHDNR bracelets and necklaces for Missouri residents;

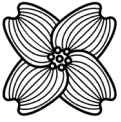
2. A document stating that the OHDNR vendor understands and agrees to manufacture and distribute the OHDNR bracelet and necklace for each patient only after being shown an OHDNR order issued by the patient's attending physician for the patient requesting the OHDNR bracelet or necklace. This OHDNR order must be executed by the patient or patient's representative and the patient's attending physician and on the form created by the department, included herein;

3. A document stating that the OHDNR vendor understands and agrees to send with the OHDNR bracelet or necklace a statement with the words, "Pursuant to sections 190.600–190.621, RSMo, this OHDNR identification shall only be worn by a person who has executed an effective OHDNR order"; and

4. A prototype of the necklace and/or bracelet that meets the specifications as described herein in subsection (4)(B) or (4)(C).

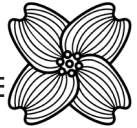
(E) After review of the required documentation and prototype from an OHDNR vendor, the department may approve the OHDNR vendor to manufacture and distribute OHDNR bracelets and necklaces. A list of approved OHDNR bracelet or necklace vendors is available at the EMS Bureau office, online at www.dhss.mo.gov/EMS or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, EMS Bureau, PO Box 570, Jefferson City, MO 65102-0570.

(F) Department-approved OHDNR vendors shall be shown, for each patient requesting an OHDNR bracelet or necklace, an effective OHDNR order issued by the patient's attending physician for the patient requesting the OHDNR bracelet or



necklace. To be effective, this OHDNR order must be executed by the patient or patient’s representative and the patient’s attending physician and on the form created by the department, included herein.

(G) Department-approved OHDNR vendors shall send with each OHDNR necklace or bracelet manufactured and distributed to a Missouri resident a statement with the words, “Pursuant to sections 190.600–190.621, RSMo, this OHDNR identification shall only be worn by a person who has executed an effective OHDNR order.”



OUTSIDE THE HOSPITAL DO-NOT-RESUSCITATE (OHDNR) ORDER

I, _____, authorize emergency medical services personnel to
(name)
withhold or withdraw cardiopulmonary resuscitation from me in the event I suffer cardiac or respiratory arrest. Cardiac arrest means my heart stops beating and respiratory arrest means I stop breathing.

I understand that in the event that I suffer cardiac or respiratory arrest, this OHDNR order will take effect and no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care and medical interventions, such as intravenous fluids, oxygen or therapies other than cardiopulmonary resuscitation such as those deemed necessary to provide comfort care or to alleviate pain by any health care provider (e.g. paramedics) and/or medical care directed by a physician prior to my death.

I understand I may revoke this order at any time.

I give permission for this OHDNR order to be given to outside the hospital care providers (e.g. paramedics), doctors, nurses, or other health care personnel as necessary to implement this order.

I hereby agree to the "Outside The Hospital Do-Not-Resuscitate" (OHDNR) Order.

Patient – Printed or Typed Name	Date
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Patient's Signature or Patient Representative's Signature	Date
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REVOCATION PROVISION	
I hereby revoke the above declaration.	

Patient's Signature or Patient Representative's Signature	Date
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**I AUTHORIZE EMERGENCY MEDICAL SERVICES PERSONNEL TO WITHHOLD OR WITHDRAW
CARDIOPULMONARY RESUSCITATION FROM THE PATIENT IN THE EVENT OF CARDIAC OR
RESPIRATORY ARREST.**

I affirm this order is the expressed wish of the patient/patient's representative, medically appropriate and documented in the patient's permanent medical record.

Attending Physician's Signature (Mandatory)	Date
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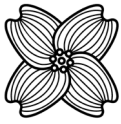
Attending Physician – Printed or Typed Name	Attending Physician's License No.	Attending Physician's Telephone No.
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Address – Printed or Typed	Facility or Agency Name
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**THIS OHDNR ORDER SHALL REMAIN WITH THE PATIENT WHEN TRANSFERRED OUTSIDE THE
HEALTH CARE FACILITY.**

Emergency Medical Services personnel shall not comply with an outside the hospital do-not-resuscitate order when the patient or the patient's representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated or if the patient is or is believed to be pregnant.

Statutory citation 190.600-190.621 RSMo
9/07



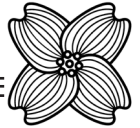
**DEFINITIONS OF KEY TERMS FOR THE OUTSIDE THE HOSPITAL
DO-NOT-RESUSCITATE (OHDNR) ORDER**

Attending physician	(1) A physician licensed under Chapter 334, RSMo, selected by or assigned to a patient who has primary responsibility for treatment and care of the patient; or (2) If more than one physician shares responsibility for the treatment and care of a patient, one such physician who has been designated the attending physician by the patient or the patient’s representative shall serve as the attending physician.
Cardiopulmonary resuscitation (CPR)	Emergency medical treatment administered to a patient in the event of the patient’s cardiac or respiratory arrest, and shall include cardiac compression, endotracheal intubation and other advanced airway management, artificial ventilation, defibrillation, administration of cardiac resuscitation medications, and related procedures.
Emergency medical services personnel	Paid or volunteer firefighters, law enforcement officers, first responders, emergency medical technicians, or other emergency service personnel acting within the ordinary course and scope of their professions, but excluding physicians.
Outside the hospital do-not-resuscitate identification	A standardized identification card, bracelet, or necklace of a single color, form and design as set forth in 19 CSR 30-40.600 that signifies that the patient’s attending physician has issued an outside the hospital do-not-resuscitate order for the patient and has documented the grounds for the order in the patient’s medical file.
Outside the hospital do-not-resuscitate order	A written physician’s order signed by the patient and the attending physician, or the patient’s representative and the attending physician, which authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest.
Patient	A person eighteen years of age or older who is not incapacitated, as defined in section 475.010, RSMo, and who is otherwise competent to give informed consent to an outside the hospital do-not-resuscitate order at the time such order is issued, and who, with his or her attending physician, has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621, RSMo. A person who has a patient’s representative shall also be a patient for the purposes of sections 190.600 to 190.621, RSMo, if the person or the person’s representative has executed an outside the hospital do-not-resuscitate order under sections 190.600 to 190.621, RSMo.
Patient’s representative	(1) An attorney in fact designated in a durable power of attorney for health care for a patient determined to be incapacitated under sections 404.800 to 404.872, RSMo; or (2) A guardian or limited guardian appointed under Chapter 475, RSMo, to have responsibility for an incapacitated patient.

OUTSIDE THE HOSPITAL DO-NOT- RESUSCITATE (OHDNR) PROTOCOL

Emergency medical services personnel are authorized to comply with the OHDNR protocol when presented with OHDNR identification or an OHDNR order. The Outside the Hospital Do Not Resuscitate (OHDNR) protocol includes the following standardized methods or procedures:

- (1) An OHDNR order shall only be effective when the patient has not been admitted to or is not being treated within a hospital or has not yet come to the emergency department as defined in the Emergency Medical Treatment and Active Labor Act (EMTALA), 42 U.S.C. 1395dd, and the regulation 42 C.F.R. 489.24(a) and referenced in the Centers for Medicare and Medicaid Services State Operations Manual Appendix V – Interpretive Guideline – Responsibilities of Medicare Participating hospitals in Emergency Cases (Rev. 1, 05-21-04);
- (2) Emergency medical services personnel shall not comply with an OHDNR order or the OHDNR protocol when the patient or patient’s representative expresses to such personnel in any manner, before or after the onset of a cardiac or respiratory arrest, the desire to be resuscitated;
- (3) An OHDNR order shall not be effective during such time as the patient is pregnant;



- (4) A properly executed OHDNR order authorizes emergency medical services personnel to withhold or withdraw cardiopulmonary resuscitation from the patient in the event of cardiac or respiratory arrest. Emergency medical services personnel shall not withhold or withdraw other medical interventions, such as intravenous fluids, oxygen, or therapies other than cardiopulmonary resuscitation such as those to provide comfort care or alleviate pain. Nothing in this regulation shall prejudice any other lawful directives concerning such medical interventions and therapies;
- (5) If any doubt exists about the validity of the OHDNR identification or an OHDNR order, resuscitation shall be initiated and medical control shall be contacted;
- (6) If the OHDNR order or OHDNR identification is presented after Basic or Advanced Life Support procedures have started, the emergency medical services personnel shall honor the form and withhold or withdraw cardiopulmonary resuscitation from a patient who is suffering cardiac or respiratory arrest;
- (7) After noting the properly executed OHDNR order or OHDNR identification, no cardiac monitoring is necessary and no medical control contact is necessary; and
- (8) Emergency medical services personnel shall document review of the OHDNR order and/or OHDNR identification in the patient care record.



**Outside the Hospital Do- Not- Resuscitate
Identification Card**

Patient's Full Name _____

I affirm that I have authorized an Outside the Hospital Do- Not -
Resuscitate Order for this patient and have documented the
grounds for the order in this patient's medical file.

Attending Physician Signature _____

Attending Physician (print) _____

Address _____ **Phone** _____

Date _____

I, _____
(name)

authorize emergency medical services personnel to withhold or
withdraw cardiopulmonary resuscitation from me in the event I
suffer cardiac or respiratory arrest.

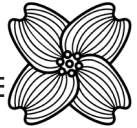
I understand this means that if my heart stops beating or I stop
breathing, no medical procedure to restart heart function or
breathing will be instituted.

I understand that I may revoke this order at anytime.

Patient or Patient's Representative

Signature _____

Date _____



*AUTHORITY: section 190.618, RSMo Supp. 2008. * Original rule filed Jan. 9, 2009, effective Aug. 30, 2009.*

**Original authority: 190.618, RSMo 2007.*

19 CSR 30-40.710 Definitions and Abbreviations Relating to Stroke Centers

PURPOSE: This rule defines terminology related to stroke centers.

(1) As used in 19 CSR 30-40.720 and 19 CSR 30-40.730, the following terms shall mean –

(A) Acute – an injury or illness that happens or appears quickly and can be serious or life threatening;

(B) Anesthesiologist assistant (AA) – a person who –

1. Has graduated from an anesthesiologist assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency;

2. Has passed the certifying examination administered by the National Commission on Certification of Anesthesiologist Assistants;

3. Has active certification by the National Commission on Certification of Anesthesiologist Assistants;

4. Is currently licensed as an anesthesiologist assistant in the state of Missouri; and

5. Provides health care services delegated by a licensed anesthesiologist;

(C) Board-admissible/board-eligible – a physician who is eligible to apply or has applied to a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada and has received a ruling that he or she has fulfilled the requirements to take the examinations. Board certification is generally obtained within five (5) years of the first appointment;

(D) Board-certified – a physician who has fulfilled all requirements, has satisfactorily completed the written and oral examinations, and has been awarded a board diploma in a specialty field by the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada;

(E) Catchment area – the surrounding area served by the institution (the stroke center).

(F) Certified registered nurse anesthetist (CRNA) – a registered nurse who –

1. Has graduated from a school of nurse anesthesia accredited by the Council on Accreditation of Education Programs of Nurse Anesthesia or its predecessor;

2. Has been certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists; and

3. Has been licensed in Missouri pursuant to Chapter 335, RSMo;

(G) Clinical staff – an individual that has specific training and experience in the treatment and management of stroke patients. Examples include: physicians, registered nurses, advanced practice nurses, physician assistants, pharmacists, and technologists;

(H) Clinical team – a team of healthcare professionals involved in the care of the stroke patient and may include, but not be limited to, neurologists, neuro-interventionalists, neurosurgeons, anesthesiologists, emergency medicine, and other stroke center clinical staff. The clinical team is part of the hospital program's stroke team;

(I) Continuing education – education approved or recognized

by a national and/or state professional organization and/or stroke medical director;

(J) Continuing medical education (CME) – the highest level of continuing education for physicians that is approved or recognized by a national and/or state professional organization and/or stroke medical director;

(K) Core team – a subunit of the hospital stroke team consisting of a physician experienced in diagnosing and treating cerebrovascular disease (usually the stroke medical director) and at least one (1) other health care professional or qualified individual competent in stroke care as determined by the hospital (usually the stroke program manager/coordinator);

(L) Credentialed or credentialing – a hospital-specific system of documenting and recognizing the qualifications of medical staff and nurses and authorizing the performance of certain procedures and establishing clinical privileges in the hospital setting;

(M) Department – the Missouri Department of Health and Senior Services;

(N) Door-to-needle time – the time from arrival at the hospital door to initiation of lytic therapy to restore blood flow in an obstructed blood vessel;

(O) Emergency medical service regions – the six (6) regions in the state of Missouri that are defined in 19 CSR 30-40.302;

(P) Hospital – an establishment as defined by section 197.020.2, RSMo, or a hospital operated by the state;

(Q) Immediately available (IA) – being present at the bedside 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;

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

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

(T) Missouri stroke registry – a statewide data collection system comprised of key data elements as defined in 19 CSR 30-40.730 that are used to compile and trend statistics of stroke patients in both pre-hospital and hospital settings, using a coordinated electronic reporting method provided by the department;

(U) Multidisciplinary team – a team of appropriate representatives of hospital units involved in the care of the stroke patient. This team supports the care of the stroke patient with the stroke team;

(V) Neurologist – a licensed physician with the appropriate specialty training.

(W) Neuro-interventionalist – a licensed physician with the appropriate specialty training;

(X) Neuro-interventional team – a team of physicians, nurses, and other clinical staff, and technical support that perform the neuro-interventions and who are part of the stroke clinical team;

(Y) Neurology service – an organizational component of the hospital specializing in the care of patients who have had strokes or some other neurological condition or disorder;

(Z) Patient – an individual who is sick, injured, wounded, diseased, or otherwise incapacitated or helpless, or dead, excluding deceased individuals being transported from or between private or public institutions, homes, or cemeteries, and individuals declared dead prior to the time an ambulance is called for assistance;



(AA) Peer review system—the process the stroke center establishes for physicians to review stroke cases on patients who are admitted to the stroke center, transferred out of the stroke center, or die as a result of the stroke (independent of hospital admission or hospital transfer status);

(BB) Physician—a person licensed as a physician pursuant to Chapter 334, RSMo;

(CC) Promptly available (PA)—arrival at the hospital at the patient’s bedside within thirty (30) minutes after notification of a patient’s arrival at the hospital;

(DD) Protocol—a predetermined, written medical care guideline, which may include standing orders;

(EE) Qualified individual—a physician, registered nurse, advanced practice nurse, and/or physician assistant licensed in the state of Missouri who demonstrates administrative ability and shows evidence of educational and clinical experience in the care of cerebrovascular patients;

(FF) Regional outcome data—data used to assess the regional process for pre-hospital, hospital, and regional patient outcomes;

(GG) Repatriation—the process used to return a stroke patient to his or her home community from a level I or level II stroke center after his or her acute treatment for stroke has been completed. This allows the patient to be closer to home for continued hospitalization or rehabilitation and follow-up care as indicated by the patient’s condition;

(HH) Reperfusion—the process of restoring normal blood flow to an organ or tissue that has had its blood supply cut off, such as after an ischemic stroke or myocardial infarction;

(II) Requirement (R)—a symbol used to indicate that a standard is a requirement for stroke center designation at a particular level;

(JJ) Review—the inspection of a hospital to determine compliance with the rules of this chapter;

(KK) Stroke—a sudden brain dysfunction due to a disturbance of cerebral circulation. The resulting impairments include but are not limited to paralysis, slurred speech, and/or vision loss. Ischemic strokes are typically caused by the obstruction of a cerebral blood vessel. Hemorrhagic strokes are typically caused by rupture of a cerebral artery;

(LL) Stroke call roster—a schedule that provides twenty-four (24) hours a day, seven (7) days a week neurology service coverage. The call roster identifies the physicians or qualified individuals on the schedule that are available to manage and coordinate emergent, urgent, and routine assessment, diagnosis, and treatment of the stroke patients;

(MM) Stroke care—emergency transport, triage and acute intervention, and other acute care services for strokes that potentially require immediate medical or surgical intervention or treatment, and may include education, primary prevention, acute intervention, acute and sub-acute management, prevention of complications, secondary stroke prevention, and rehabilitative services;

(NN) Stroke center—a hospital that is currently designated as such by the department to care for patients with a stroke.

1. A level I stroke center is a receiving center staffed and equipped to provide total care for every aspect of stroke care, including care for those patients with complications, that also functions as a resource center for the hospitals within that region, and conducts research.

2. A level II stroke center is a receiving center staffed and equipped to provide care for a large number of stroke patients within the region.

3. A level III stroke center is a referral center staffed and equipped to initiate lytic therapy and initiate timely transfer to a higher level of care. The level III stroke center also provides

prompt assessment, indicated resuscitation, and appropriate emergency intervention for stroke patients. A level III stroke center may admit and monitor patients as in-patients if there are designated stroke beds and an established relationship exists with a level I or level II stroke center through which the level I or level II stroke center provides medical direction and oversight for those stroke patients kept at the level III stroke center under that relationship.

4. A level IV stroke center is a referral center in an area considered rural or where there are insufficient hospital resources to serve the patient population requiring stroke care. A level IV stroke center provides prompt assessment, indicated resuscitation, appropriate emergency intervention, and arranges and expedites transfer to a higher level stroke center as needed;

(OO) Stroke medical director—a physician designated by the hospital who is responsible for the stroke service and performance improvement and patient safety programs related to stroke care;

(PP) Stroke program—an organizational component of the hospital specializing in the care of stroke patients;

(QQ) Stroke program manager/coordinator—a qualified individual designated by the hospital with responsibility for monitoring and evaluating the care of stroke patients and the coordination of performance improvement and patient safety programs for the stroke center in conjunction with the stroke medical director;

(RR) Stroke team—a component of the hospital stroke program consisting of the core stroke team and the clinical stroke team;

(SS) Stroke unit—the functional division or facility of the hospital that provides care for stroke patients admitted to the stroke center;

(TT) Symptom onset-to-treatment time—the time from symptom onset to initiation of therapy to restore blood flow in an obstructed blood vessel;

(UU) Telemedicine—the use of medical information exchanged from one (1) site to another via electronic communications to improve patient’s health status. A neurology specialist will assist the physician in the center in rendering a diagnosis. This may involve a patient “seeing” a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to the specialist;

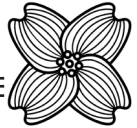
(VV) Thrombolytics—drugs, including recombinant tissue plasminogen activator, used to dissolve clots blocking flow in a blood vessel. These thrombolytic drugs are used in the treatment of acute ischemic stroke and acute myocardial infarction;

(WW) Transfer agreement—a document which sets forth the rights and responsibilities of two (2) hospitals regarding the inter-hospital transfer of patients; and

(XX) Virtual review—a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.

AUTHORITY: sections 192.006 and 190.185, RSMo 2016, and section 190.241, RSMo Supp. 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022, effective June 30, 2023..*

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



19 CSR 30-40.720 Stroke Center Designation Application and Review

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

(1) Participation in Missouri's stroke center program is voluntary and no hospital shall be required to participate. No hospital shall hold itself out to the public as a state-designated stroke center unless it is designated as such by the Department of Health and Senior Services (department). Hospitals desiring stroke center designation shall apply to the department either through the option outlined in section (2) or section (3). Only those hospitals found to be in compliance with the requirements of the rules of this chapter shall be designated by the department as stroke centers.

(2) Hospitals requesting to be reviewed and designated as a stroke center by the department shall meet the following requirements:

(A) An application for stroke center designation shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a fair determination of eligibility for review and designation in accordance with the rules of this chapter. The stroke center review and designation application form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at www.health.mo.gov, or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for stroke center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation or expiration of the current designation.

(B) Both sections A and B of the stroke center review and designation application form, included herein, shall be complete before the department will arrange a date for the review. The department shall notify the hospital/stroke center of any apparent omissions or errors in the completion of the stroke center review and designation application form. When the stroke center review and designation application form is complete, the department shall contact the hospital/stroke center to arrange a date for the review.

(C) The hospital/stroke center shall cooperate with the department in arranging for a mutually suitable date for any announced reviews;

(D) The department may conduct an on-site review, a virtual review, or a combination thereof on the hospitals/stroke centers. For announced reviews that are scheduled with the hospitals/stroke centers, the department will make the hospitals/stroke centers aware at least ninety (90) days prior to the scheduled review whether the department intends that the review will be conducted on-site and/or virtually. Due to unforeseen circumstances, the department may need to change whether the review is conducted onsite and/or virtually less than ninety (90) days before the announced review. The department will contact the hospitals/stroke centers to make the hospitals/stroke centers aware of any changes about how the review will be conducted, either on-site and/or virtually, and/or when the review will be conducted with as much advance notice as possible prior to the date of the announced review. The different types of reviews to be conducted on hospitals/stroke centers seeking stroke center designation by the department include –

1. An initial review shall occur on a hospital applying to be initially designated as a stroke center. An initial review 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. This review may occur on-site and/or virtually.

2. A validation review shall occur on a designated stroke center applying for renewal of its designation as a stroke center. Validation reviews shall occur no less than every three (3) years. A validation review shall include interviews with designated stroke center 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. This review may occur on-site and/or virtually; and

3. A focus review shall occur on a designated stroke center in which an initial or validation review was conducted and substantial deficiency(ies) were cited. A review of the physical plant will not be necessary unless a deficiency(ies) was cited in the physical plant in the preceding validation review. The focus review team shall be comprised of a representative from the department and may include a qualified contractor(s) with the required expertise to evaluate corrections in areas where deficiencies were cited. This review may occur on-site and/or virtually;

(E) Stroke center designation shall be valid for a period of three (3) years from the date the stroke center/hospital is designated. Expiration of the designation shall occur unless the stroke center applies for validation review within this three- (3-) year period and the department is unable to conduct a review before the designation expires.

1. Stroke center designation shall be site specific and non-transferable when a stroke center changes location.

2. Once designated as a stroke center, a stroke center may voluntarily surrender the designation at any time without giving cause, by contacting the department in writing. In these cases, the application and review process shall be completed again before the designation may be reinstated;

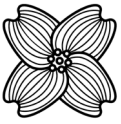
(F) For the purpose of reviewing previously designated stroke centers and hospitals applying for stroke center designation, the department shall use review teams consisting of qualified contractors. These review teams shall consist of one (1) stroke coordinator or stroke program manager who has experience in stroke care and one (1) emergency medicine physician also experienced in stroke care. The review team shall also consist of at least one (1) and no more than two (2) neurologist(s)/neuro-interventionalist(s) who are experts in stroke care. One (1) representative from the department will also be a participant of the review team. This representative shall coordinate the review with the hospital/stroke center and the other review team members.

1. Any individual interested in becoming a qualified contractor to conduct reviews shall –

A. Send the department a curriculum vitae (CV) or résumé that includes his or her experience and expertise in stroke care and whether an individual is in good standing with his or her licensing boards. A qualified contractor shall be in good standing with his or her respective licensing boards.

B. Provide the department evidence of his or her previous site survey experience (state and/or national designation survey process); and

C. Submit a list to the department that details any ownership he or she may have in a Missouri hospital(s), whether he or she has been terminated from any Missouri hospital(s), any lawsuits he or she has currently or had in the past with any Missouri hospital(s), and any Missouri hospital(s) for which his or her hospital privileges have been revoked.



2. Qualified contractors for the department shall enter into a written agreement with the department indicating, that among other things, they agree to abide by Chapter 190, RSMo, and the rules in this chapter, during the review process;

(G) Out-of-state review team members shall conduct levels I and II hospital/stroke center reviews. Review team members are considered out-of-state review team members if they work outside of the state of Missouri. In-state review team members may conduct levels III and IV hospital/stroke center reviews. Review team members are considered in-state review team members if they work in the state of Missouri. In the event that out-of-state reviewers are unavailable, levels I and II stroke center reviews may be conducted by in-state reviewers from Emergency Medical Services (EMS) regions as set forth in 19 CSR 30-40.302 other than the region being reviewed with the approval of the director of the department or his/her designee. When utilizing in-state review teams, levels I and II hospital/stroke centers shall have the right to refuse one (1) in-state review team or certain members from one (1) in-state review team.

(H) Hospitals/stroke centers shall be responsible for paying expenses related to the cost of the qualified contractors to review their respective hospitals/stroke centers during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/stroke center include –

1. An honorarium shall be paid to each qualified contractor of the review team whether the review occurs on-site or virtually. Qualified contractors of the review team for levels I and II stroke center reviews shall be paid one thousand four hundred fifty dollars (\$1,450) per reviewer. Qualified contractors of the review team for levels III and IV stroke center reviews shall be paid one thousand dollars (\$1,000) per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins if on-site or prior to the review beginning if the review is conducted virtually;

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, unless the review is conducted virtually. The hospital/stroke center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred fifty dollars (\$250) and may include the following:

- A. Airport parking;
- B. Checking bag charges;
- C. Meals during the review; and

D. Mileage to and from the review if no airfare was charged by the reviewer. If the reviewer solely participated virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid. Mileage shall be paid at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website www.irs.gov;

(I) Hospitals/stroke centers being reviewed through a virtual survey shall do the following:

1. Provide an audio and videoconferencing platform to be used for the hospital/stroke center virtual review;

2. Provide a live tour of the hospital;

3. Ensure the video and audio conferencing service used during the review is compliant with state and federal laws for protected health information;

4. Assign an on-site visit coordinator for the review.

The on-site visit coordinator role cannot be fulfilled by the stroke program manager. This on-site visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

A. Scheduling the videoconferencing meetings;

B. Sending out calendar invitations;

C. Providing electronic medical record (EMR) access to designated individuals;

D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors, and the department;

5. Assign one (1) staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the stroke program manager, the stroke program medical director, the stroke program registrar, or the on-site visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review through a method that is compliant with state and federal laws for protected health information no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report, and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

8. Schedule a pre-review call with the qualified contractors, the department, the stroke program medical director, the stroke program manager, the staff navigators, and the on-site visit coordinator approximately one (1) week prior to the virtual review;

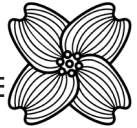
9. Test the functionality of the audio and videoconferencing service for the live tour of the hospital prior to the pre-review call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review;

(J) The department may conduct an on-site review of the hospital prior to the virtual review to ensure that the hospital meets the requirements for stroke designation;

(K) Upon completion of a review, the qualified contractors from the review team shall submit a report of their findings to the department. This report shall state whether the specific standards for stroke center designation have or have not been met and if not met, in what way they were not met. This report shall detail the hospital/stroke center's strengths, weaknesses, deficiencies, and recommendations for areas of improvement. This report shall also include findings from patient chart audits and a narrative summary of the following areas: prehospital, hospital, stroke service, emergency department, operating room, angiography suites, recovery room, clinical lab, intensive care unit, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department shall have the final authority to determine compliance with the rules of this chapter;

(L) The department shall return a copy of the report to the chief executive officer, the stroke medical director, and the stroke program manager/coordinator of the hospital/stroke center reviewed. Included within the report shall be



notification indicating whether the hospital/stroke center has met the criteria for stroke center designation or has failed to meet the criteria for the stroke center designation requested. Also, if a focus review of the stroke center is required, the time frame for this focus review will be shared with the chief executive officer, the stroke medical director, and the stroke program manager/coordinator of the stroke center reviewed;

(M) When the hospital/stroke center is found to have deficiencies, the hospital/stroke center shall submit a plan of correction to the department. The plan of correction shall include identified deficiencies, actions to be taken to correct deficiencies, time frame in which the deficiencies are expected to be resolved, and the person responsible for the actions to resolve the deficiencies. A plan of correction form shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings and designation. If a focus review is required, then the stroke center shall be allowed a minimum period of six (6) months to correct deficiencies;

(N) A stroke center shall make the department aware in writing within thirty (30) days if there are any changes in the stroke center's name, address, contact information, chief executive officer, stroke medical director, or stroke program manager/coordinator;

(O) Failure of a hospital/stroke center to provide all medical records and quality improvement documentation necessary for the department to conduct a stroke review in order to determine if the requirements of 19 CSR 30-40.730 have been met shall result in the revocation of the hospital/stroke center's designation as a stroke center;

(P) Any person aggrieved by an action of the Department of Health and Senior Services affecting the stroke center designation pursuant to Chapter 190, RSMo, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination thereon by the Administrative Hearing Commission under Chapter 621, RSMo. It shall not be a condition to such determination that the person aggrieved seek reconsideration, a rehearing, or exhaust any other procedure within the department; and

(Q) The department may deny, place on probation, suspend, or revoke such designation in any case in which it has determined that there has been a substantial failure to comply with the provisions of Chapter 190, RSMo, or any rules or regulations promulgated pursuant to this chapter. If the Department of Health and Senior Services has determined that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the hospital to verify compliance. If a stroke center fails two (2) consecutive on-site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245, RSMo, or rules adopted by the department pursuant to sections 190.001 to 190.245, RSMo, its center designation shall be revoked.

(3) Hospitals seeking stroke center designation by the department based on their current certification or verification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall meet the following requirements:

(A) An application for stroke center designation by the department for hospitals that have been certified or verified as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to

make a determination of eligibility for review and designation in accordance with the rules of this chapter. The application for stroke certified hospital designation form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at www.health.mo.gov, or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for stroke center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation;

(B) Both sections A and B of the application for stroke certified hospital designation form, included herein, shall be complete before the department designates a hospital/stroke center. The department shall notify the hospital/stroke center of any apparent omissions or errors in the completion of the application for stroke certified hospital designation form. Upon receipt of a completed and approved application, the department shall designate such hospital as follows:

1. The department shall designate a hospital a level I stroke center if such hospital has been certified as a comprehensive stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program;

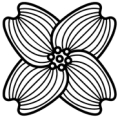
2. The department shall designate a hospital a level II stroke center if such hospital has been certified as a primary stroke center, thrombectomy-capable stroke center, thrombectomy ready stroke center, or primary plus stroke center by either the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program; or

3. The department shall designate a hospital a level III stroke center if such hospital has been certified as an acute stroke-ready center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program;

(C) Within thirty (30) days of any changes or receipt of a certificate or verification, the hospital shall submit to the department proof of certification or verification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program and the names and contact information of the medical director of the stroke center and the program manager of the stroke center. A certificate or verification as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall accompany the application for stroke certified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is certified or verified as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program for which the hospital used to receive its corresponding designation with the department as a stroke center, whether because the hospital voluntarily surrendered this certificate or verification or because the hospital's certificate or verification was suspended or revoked by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program or expired;

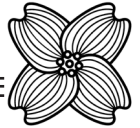
(D) Any hospital designated as a level III stroke center that is certified or verified by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program as an acute stroke-ready center shall have a formal agreement with a level I or level II stroke center designated by the department for physician consultative services for evaluation of stroke patients for thrombolytic therapy and the care of the patient post-thrombolytic therapy;

(E) Participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes;



(F) The designation of a hospital as a stroke center pursuant to section (3) shall continue if such hospital retains certification as a stroke center by the Joint Commission, DNV-GL Healthcare, or Healthcare Facilities Accreditation Program; and

(G) The department may remove a hospital's designation as a stroke center if requested by the hospital or the department determines that the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program certification or verification has been suspended or revoked. Any decision made by the department to withdraw the designation of a stroke center that is based on the revocation or suspension of a certification or revocation by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program shall not be subject to judicial review.



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

SECTION A			
In accordance with the requirements of the Chapter 190 RSMo and the applicable regulations, this application is hereby submitted for review and designation as a stroke center. Please complete all information applicable to the requested designation level.			Designation Level Requested <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV
Joint Commission Certification <input type="checkbox"/> Primary Stroke Center <input type="checkbox"/> Comprehensive Stroke Center			
HOSPITAL INFORMATION			
Name Of Hospital (Name To Appear On Designation Certificate)		Telephone Number	
Address (Street And Number)		City	Zip Code
PROFESSIONAL INFORMATION			
Chief Executive Officer		Chairman/President Of Board Of Trustees	
Stroke Medical Director		Stroke Program Manager	
Medical Director of Emergency Medicine		Medical Director of Intensive Care Unit	
RESOURCE INFORMATION			
Stroke Caseload	Stroke Team Activations	CT Scan Capability <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> NONE	MRI Capability <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> NONE
Neurosurgical Capability or Transfer Plan	ICU or NICU Beds	Stroke Unit Beds	Stroke Rehab <input type="checkbox"/> INPATIENT <input type="checkbox"/> OUTPATIENT
Neurologists	Neurosurgeons	Neuro-Interventionalists	Emergency Department (ED) Physicians
Anesthesiologists/ CRNAs & AAs	Angiography Suites	Avg number of patients who received neuro-intervention (not required for initial review)	Avg number of patients who received thrombolytics in the past 24 months (not required for initial review)
CERTIFICATION			
We, the undersigned, hereby certify that the information provided in this application for stroke center review and designation is true and accurate; and give assurance of the intent and ability of the hospital to comply with regulations promulgated under the Chapter 190, RSMo.			
We further certify that the hospital will comply with all recommendations for improvement contained in the stroke center site review reports prepared by the Missouri Department of Health and Senior Services.			
Date of application _____			
Signed _____ Chairman/President of Board of Trustees, Owner, or one Partner of Partnership		Signed _____ Hospital Chief Executive Officer	
Signed _____ Stroke Medical Director		Signed _____ Director of Emergency Medicine	

MO 580

EMS

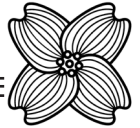


MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE
APPLICATION FOR STROKE CENTER REVIEW AND DESIGNATION

SECTION B

Please attach the following documentation to the application form. **Name of Hospital:**

- Hospital organizational chart depicting the relationship of the stroke services to other services and defining the organizational structure of the stroke service.
- Job descriptions and CV for the stroke medical director and stroke coordinator/program manager.
- A narrative description of the administrative commitment for the stroke center, including how stroke center designation relates to the overall mission of the hospital.
- A current board resolution supporting the stroke center.
- A narrative description of the catchment area for the stroke center.
- A narrative description of the prehospital system including the hospital's participation in medical control, quality assurance, and education of the emergency medicine personnel.
- Hospital diversion policy.
- List of the stroke medical director and stroke program coordinator or program manager (core stroke team) indicating the neuro-cerebrovascular related continuing education for each over the past three (3) years. (Do not send continuing education information about the clinical stroke team. This should be available at the time of the review.)
- Multidisciplinary team policy.
- List of all neurologists, neurosurgeons, neuro-interventionalists and emergency department physicians and indicate stroke-related CME for each over the past three (3) years.
- List of physicians and plan for supervised relationship between Level III and higher level stroke center where stroke patients are admitted for care in a Level III center if applicable (this list and plan are only required for Level III centers with a supervised relationship with a Level I or Level II center).
- Narrative description of the system for notifying/activating stroke team.
- One-call stroke team activation protocol.
- Copies of all transfer agreements pertaining to stroke.
- Policy for consultation for physical medicine and rehabilitation, physical therapy, occupational therapy and speech therapy.
- Protocols on post-discharge and post-transfer follow-up for stroke patients.
- A narrative description of the stroke quality improvement (QI) processes utilized by the hospital (Do not send copies of QI minutes or documents. These should be available at the time of review.)
- Examples of stroke-related educational, outreach, and research projects undertaken by the hospital.
- Summary of source of stroke information for Table 1 on next page. Table 1 is only required to be filled out by a stroke center which is applying for renewal of its designation prior to a validation review. Table 1 is not required to be filled out by a hospital requesting an initial review and designation.
- Verification of Primary or Comprehensive Joint Commission certified center (e.g. certificate).



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

Table 1. Ischemic Stroke Numbers for Past Two (2) Years				
Table 1 is only required to be filled out by a stroke center which is applying for renewal of its designation prior to a validation review.				
A	B	C	D	E
Indicate year ¹ Provide two years of data	Stroke cases ²	Stroke cases eligible for NI ⁴	Stroke cases eligible for Lytics ⁶	Stroke deaths ⁸
	Transfers ³	Received NI ⁵	Received lytics ⁷	
For example:	53	14	25	2
2011	22	8	12	
Total				
Average/Year				

¹ Include data for the last two (2) years of hospital data. Indicate time frame in months if it is other than January to December.

² Include all stroke patients, independent of hospital admission or hospital transfer status. To include walk-ins, transfers, EMS transports, admitted patients, and patients that die. Include all stroke patients that have ICD-9-principal diagnosis code of 433.01, 433.10, 433.11, 433.21, 433.31, 433.81, 433.91, 434.00, 434.01, 434.11, 434.91, 436.00, 430.00 and 431.00

³ Provide number of all stroke patients transferred to this hospital from another hospital.

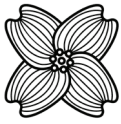
⁴ Provide number of stroke patients eligible for neuro-intervention (NI).

⁵ Provide number of stroke patients that received neuro-intervention (NI).

⁶ Provide number of stroke patients that are eligible for thrombolytics.

⁷ Provide number of stroke patients that received thrombolytics.

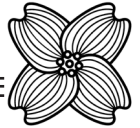
⁸ Include all deaths, ED and inpatient, independent of hospital admission or hospital transfer status.



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES SECTION OF HEALTH STANDARDS AND LICENSURE APPLICATION FOR STROKE CERTIFIED HOSPITAL DESIGNATION

SECTION A ORGANIZATION'S STROKE IDENTIFICATION NO. In accordance with the requirements of the Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a stroke center. Please complete all information. CURRENT STROKE CERTIFICATION ORGANIZATION [] The Joint Commission [] DNV-GL Healthcare [] Healthcare Facilities Accreditation Program CURRENT STROKE CERTIFICATION LEVEL [] Comprehensive Stroke Center [] Thrombectomy-Capable Stroke Center [] Thrombectomy-Ready Stroke Center [] Primary Plus Stroke Center [] Primary Stroke Center [] Acute Stroke-Ready Center HOSPITAL INFORMATION NAME OF HOSPITAL (NAME TO APPEAR ON DESIGNATION CERTIFICATE) TELEPHONE NUMBER ADDRESS (STREET AND NUMBER) CITY ZIP CODE PROFESSIONAL INFORMATION CHIEF EXECUTIVE OFFICER CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES STROKE MEDICAL DIRECTOR (NAME, EMAIL, AND CONTACT PHONE NUMBER) STROKE PROGRAM MANAGER (NAME, EMAIL, AND CONTACT PHONE NUMBER) SECTION B The following should be submitted to the department as indicated: [] Proof of stroke certification with the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program. If applying for Acute Stroke-Ready/Level III Stroke Center designation, the following should be submitted to the Department: [] Formal agreement with Level I or Level II stroke center for physician consultative services for evaluation of stroke patients for thrombolytic therapy and the care of the patients' post-thrombolytic therapy. CERTIFICATION We, the undersigned, hereby certify that: A. Within thirty (30) days of any changes or receipt of a certificate or verification, we will submit to the department proof of stroke certification with the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program. B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of our stroke center. C. Within thirty (30) days of the date that our hospital is no longer certified or verified by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program, whether because we voluntarily surrendered our certification or verification or because our certification or verification has been suspended or revoked by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program or expired, we will report this change in writing to the department. D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes. E. We understand that our designation as a stroke center by the department shall continue only if our hospital remains certified as a stroke center by the Joint Commission, DNV-GL Healthcare or Healthcare Facilities Accreditation Program. SIGNATURE OF CHAIRMAN/PRESIDENT OF BOARD OF TRUSTEES, OWNER, OR ONE PARTNER OF PARTNERSHIP SIGNATURE OF HOSPITAL CHIEF EXECUTIVE OFFICER SIGNATURE OF STROKE MEDICAL DIRECTOR SIGNATURE OF DIRECTOR OF EMERGENCY MEDICINE DATE

MO 580-3189 (10-2022)



*AUTHORITY: sections 190.185 and 192.006, RSMo 2016, and section 190.241, RSMo Supp. 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Aug. 7, 2017, effective Aug. 17, 2017, expired Feb. 22, 2018. Amended: Filed Aug. 7, 2017, effective March 30, 2018.** Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022 effective June 30, 2023.*

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

***Pursuant to Executive Order 21-07, 19 CSR 30-40.720, subsections (2)(A) and (2)(B) and section (3) was suspended from April 2, 2020 through May 1, 2021. Pursuant to Executive Order 21-09, 19 CSR 30-40.720, paragraph (2)(D)2. and subsections (2)(F) and (2)(G) was suspended from April 2, 2020 through December 31, 2021.*

19 CSR 30-40.730 Standards for Stroke Center Designation

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

AGENCY NOTE:

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

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

(1) General Standards for Stroke Center Designation.

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

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

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

1. The stroke center shall maintain a stroke team that at a minimum shall consist of—

A. A core team which provides administrative oversight and includes:

(I) A physician experienced in diagnosing and treating

cerebrovascular disease (usually the stroke medical director); and (I-R, II-R, III-R, IV-R)

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

B. A stroke call roster that provides twenty-four (24) hours a day, seven (7) days a week neurology service coverage. The call roster identifies the physicians or qualified individuals on the schedule that are available to manage and coordinate emergent, urgent, and routine assessment, diagnosis, and treatment of stroke patients. A level I stroke center call roster shall include but not be limited to the emergency department physician, neuro-interventionalist, neurologist, and others as appropriate. A level II stroke center call roster shall include, but not be limited to the emergency department physician, a physician with experience and expertise in diagnosing and treating patients with cerebrovascular disease, and others as appropriate. The level III stroke center call roster shall include but not be limited to the emergency department physician and others as appropriate. A level IV stroke center call roster shall include but not be limited to the emergency department physician and other qualified individuals as appropriate. (I-R, II-R, III-R, IV-R)

(I) This coverage shall be available from notification of stroke patients according to the response requirements as set out below—

(a) Level I and II stroke centers shall have this coverage available within fifteen (15) minutes of notification of a stroke patient; and (I-R, II-R)

(b) Level III and IV stroke centers shall have a regional networking agreement with a level I or level II stroke center for telephone consult or telemedicine consultation available within fifteen (15) minutes of notification of a stroke patient; and (III-R, IV-R)

C. A clinical team appropriate to the center level designation that may include but not be limited to members of the stroke call roster, neurologists, physicians with expertise caring for stroke patients, neuro-interventionalists, neurosurgeons, anesthesiologists, intensivists, emergency department physicians, and other stroke center clinical staff as applicable; (I-R, II-R, III-R, IV-R)

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

3. The stroke team members shall have appropriate experience to maintain skills and proficiencies to care for stroke patients. The stroke center shall maintain evidence that it meets the following requirements by documenting the following.

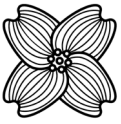
A. A list of all stroke team members; (I-R, II-R, III-R, IV-R)

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

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

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

E. Participation by stroke team members in at least half of the regular, ongoing stroke program performance improvement and patient safety meetings and documentation



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

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

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

H. Evidence of a written agreement between a level III stroke center and a level I or II stroke center when a level III stroke center has a supervised relationship with a physician affiliated with a level I or II stroke center. A level III stroke center which provides lytic therapy to stroke patients may have an established plan for admitting and caring for stroke patients under a supervised relationship with a physician affiliated with a level I or II stroke center. This supervised relationship shall consist of a formally established and pre-planned relationship between the centers in which a physician from a level I or level II center supervises a physician in a level III center in the evaluation of a stroke patient for lytic therapy and the care of the patient post-lytic therapy in certain circumstances where that level III center does not transfer the patient to a higher level stroke center. In this setting, management decisions, including but not limited to administration of lytic therapy, transfer or non-transfer of patient, and post-lytic therapy shall be made jointly between the supervising and supervised physicians. Care protocols and pathways for patients that fall into this category shall be established by both parties at the outset of the establishment of the relationship. This supervised relationship shall be established by written agreement and detail the supervision of patient care. This written agreement may also include but not be limited to observation of patient care, review of level III stroke center's patient encounters, review of level III center's outcomes, evaluation of the level III center's process pertaining to stroke patients, and lytic therapy and guidance on methods to improve process, performance, and outcomes; and

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

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

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

(D) A level I stroke center shall provide the services of a neuro-interventional laboratory staffed twenty-four (24) hours a day, seven (7) days a week.

1. The staff of the neuro-interventional laboratory, referred

to as the neuro-interventional laboratory team, shall consist of at least the following:

A. Neuro-interventional specialist(s); and (I-R/PA)

B. Other clinical staff as deemed necessary. (I-R/PA)

2. The stroke center neuro-interventional laboratory team shall maintain core competencies annually as required by the stroke center. (I-R/PA)

3. The hospital credentialing committee shall document that the neuro-interventional specialist(s) have completed appropriate training and conducted sufficient neuro-interventional procedures. (I-R/PA)

4. The stroke center neuro-interventional laboratory team shall remain up to date in their continuing education requirements which are set forth in section (4) of this rule. (I-R/PA)

5. Resuscitation equipment shall be available in the neuro-interventional lab. (I-R)

(E) It is recommended that a level I stroke center meet the volume for stroke patient cases that is required for eligibility by The Joint Commission in its Advanced Certification of Comprehensive Stroke Centers as posted on January 31, 2012, which is incorporated by reference in this rule and is available at The Joint Commission, One Renaissance Boulevard, Oakbrook Terrace, IL 60181 or on The Joint Commission's website at www.jointcommission.org. This rule does not incorporate any subsequent amendments or additions.

(F) The stroke center shall appoint a physician to serve as the stroke medical director. A stroke medical director shall be appointed at all times with no lapses. (I-R, II-R, III-R, IV-R)

1. A level I stroke medical director shall have appropriate qualifications, experience, and training. A board-certified or board-admissible neurologist or other neuro-specialty trained physician is recommended. If the stroke medical director is board-certified or board-admissible, then one (1) of the following additional qualifications shall be met and documented. If the stroke medical director is not board-certified, then two (2) of the following additional qualifications shall be met and documented:

A. Completion of a stroke fellowship; (I-R)

B. Participation (as an attendee or faculty) in one (1) national or international stroke course or conference each year or two (2) regional or state stroke courses or conferences each year; or (I-R)

C. Five (5) or more peer-reviewed publications on stroke. (I-R)

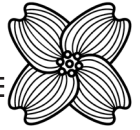
2. A level II stroke medical director shall have appropriate qualifications, experience, and training. A board-certified or board-admissible physician with training and expertise in cerebrovascular disease is recommended. If the stroke medical director is board-certified or board-admissible, then one (1) of the following additional qualifications shall be met. If the stroke medical director is not board-certified, then two (2) of the following additional qualifications shall be met and documented:

A. Completion of a stroke fellowship; (II-R)

B. Participation (as an attendee or faculty) in one (1) national or international stroke course or conference each year or two (2) regional or state stroke courses or conferences each year; or (II-R)

C. Five (5) or more peer-reviewed publications on stroke. (II-R)

3. A level III and IV stroke medical director shall have the appropriate qualifications, experience, and training. A board-certified or board-admissible physician is recommended. If the stroke medical director is not board-certified or board-admissible, then the following additional qualifications shall



be met and documented:

A. Complete a minimum of four (4) hours of continuing medical education (CME) in the area of cerebrovascular disease every year; and (III-R)

B. Attend one (1) national, regional, or state meeting every three (3) years in cerebrovascular disease. Continuing medical education hours earned at these meetings can count toward the four (4) required continuing medical education hours for level III stroke medical directors. (III-R)

4. The stroke medical director shall meet the department's continuing medical education requirements for stroke medical directors as set forth in section (4) of this rule. (I-R, II-R, III-R)

5. The stroke center shall have a job description and organizational chart depicting the relationship between the stroke medical director and the stroke center services. (I-R, II-R, III-R, IV-R)

6. The stroke medical director is encouraged to be a member of the stroke call roster. (I-R, II-R, III-R, IV-R)

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

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

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

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

2. The stroke program manager/coordinator shall—

A. Meet continuing education requirements as set forth in section (4) of this rule; and (I-R, II-R, III-R, IV-R)

B. Participate in the performance improvement and patient safety program. (I-R, II-R, III-R, IV-R)

(H) The stroke center shall have a specific and well-organized system to notify and rapidly activate the stroke team to evaluate patients presenting at the stroke center with symptoms suggestive of an acute stroke. (I-R, II-R, III-R, IV-R)

(I) The stroke center shall have a one- (1-) call stroke team activation protocol. This protocol shall establish the following:

1. The criteria used to triage stroke patients shall include but not be limited to the time of symptom onset; (I-R, II-R, III-R, IV-R)

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

3. The method for immediate notification and the response requirements for stroke team members when a suspected stroke patient is in route to the stroke center and/or when a suspected stroke patient has arrived at the stroke center; and (I-R/IA, II-R/IA, III-R/IA, IV-R/IA)

4. All members of the stroke call roster shall comply with the availability and response requirements per the stroke center's protocols and be in communication within fifteen (15) minutes of notification of the patient. If not on the stroke center's premises, stroke call roster members who are on call shall carry electronic communication devices at all times to permit contact by the hospital. It is recommended that one (1) member of the stroke team, per stroke center protocol, be at the patient's bedside within fifteen (15) minutes of notification

of the patient. (I-R, II-R, III-R, IV-R)

(J) The stroke center shall have a fibrinolysis protocol for cases when fibrinolysis is achievable. (I-R, II-R, III-R)

(K) The stroke center shall have transfer agreements between referring and receiving facilities that address the following:

1. A one- (1-) call transfer protocol that establishes the criteria used to triage stroke patients and identifies persons authorized to notify the designated stroke center; and (I-R, II-R, III-R, IV-R)

2. A rapid transfer process in place to transport a stroke patient to a higher level of stroke care when needed. (II-R, III-R, IV-R)

(L) The stroke center shall have rehabilitation services that are directed by a physician with board certification in physical medicine and rehabilitation or by other properly trained individuals (e.g., neurologist experienced in stroke rehabilitation). (I-R, II-R)

(M) The stroke center shall have consults for physical medicine and rehabilitation, physical therapy, occupational therapy, and speech therapy requested and completed when deemed medically necessary within forty-eight (48) hours of admission. (I-R, II-R)

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

(O) The stroke center shall maintain a stroke patient log. The log information shall be kept for a period of five (5) years and made available to the Department of Health and Senior Services (department) during reviews for all stroke patients which contains the following:

1. Response times; (I-R, II-R, III-R, IV-R)

2. Patient diagnosis; (I-R, II-R, III-R, IV-R)

3. Treatment/actions; (I-R, II-R, III-R, IV-R)

4. Outcomes; (I-R, II-R, III-R, IV-R)

5. Number of patients; and (I-R, II-R, III-R, IV-R)

6. Benchmark indicators. (I-R, II-R, III-R, IV-R)

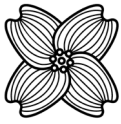
(P) The stroke center shall have a helicopter landing area. (I-R, II-R, III-R, IV-R)

(Q) Stroke centers shall enter data into a stroke registry as follows:

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

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

3. The data required in paragraphs (I)(Q)1. and 2. above shall be submitted electronically into the stroke registry on



at least a quarterly basis for that calendar year. Stroke centers have ninety (90) days after the quarter ends to submit the data electronically into the stroke registry; (I-R, II-R, III-R, IV-R)

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

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

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

(2) Medical Staffing Standards for Stroke Center Designation.

(A) The stroke center's medical staff credentialing committee shall provide a delineation of privileges for neurologists, neurosurgeons, and neuro-interventionalists, as applicable to the stroke center. (I-R, II-R)

(B) The stroke center shall credential and shall have the following types of physicians available as listed below.

1. A neurologist shall be available for consultation within fifteen (15) minutes of patient notification; (I-R)

2. A physician with experience and expertise in diagnosing and treating patients with cerebrovascular disease shall be available for consultation within fifteen (15) minutes of patient notification; (II-R)

3. A neurosurgeon as follows:

A. Neurosurgeon and back-up coverage on the call roster; (I-R/PA)

B. Neurosurgeon and back-up coverage on the call roster or available within two (2) hours by transfer agreement if not on staff; and (II-R/PA)

C. The neurosurgery staffing requirement may be fulfilled by a surgeon who has been approved by the chief of neurosurgery for care of stroke patients and shall be capable of initiating measures to stabilize the patient and perform diagnostic procedures; (I-R, II-R)

4. A neuro-interventional specialist; (I-R/PA)

5. An emergency department physician; (I-R/IH, II-R/IH, III-R/IH; IV-R/IA)

6. An internal medicine physician; (I-R/PA, II-R/PA, III-R/PA)

7. A diagnostic radiologist; and (I-R/IA, II-R/IA, III-R/IA)

8. An anesthesiologist. (I-R/PA, II-R/PA)

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

supervision of an anesthesiologist who is physically present or immediately available as this term is defined in section 334.400, RSMo. (I-R, II-R)

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

(A) The stroke center shall meet emergency department standards listed below. (I-R, II-R, III-R, IV-R)

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

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

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

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

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

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

F. The emergency department physician who provides coverage shall be current in continuing medical education in the area of cerebrovascular disease; (I-R)

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

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

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

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

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

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

A. Airway control and ventilation equipment including:

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

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

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

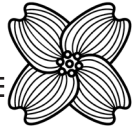
(IV) Sources of oxygen; and (I-R, II-R, III-R, IV-R)

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

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

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

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



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

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

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

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

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

4. The stroke center emergency department shall maintain equipment following the hospital's preventive maintenance schedule and document when this equipment is checked. (I-R, II-R, III-R, IV-R)

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

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

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

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

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

D. The stroke center intensive care unit shall have registered nurses in the intensive care unit who are current in continuing education requirements as set forth in section (4) of this rule. (I-R, II-R)

E. The stroke center intensive care unit shall have registered nurses in the intensive care unit who meet at least the following core credentials for care of stroke patients on a yearly basis:

(I) Care of patients after thrombolytic therapy; (I-R, II-R)

(II) Treatment of blood pressure abnormalities with parenteral vasoactive agents; (I-R, II-R)

(III) Management of intubated/ventilated patients; (I-R, II-R)

(IV) Detailed neurologic assessment and scales (e.g., National Institutes of Health Stroke Scale, Glasgow Coma Scale); (I-R, II-R)

(V) Care of patients with intracerebral hemorrhage and subarachnoid hemorrhage at all level I centers and all level II centers with neurosurgical capability; (I-R, II-R)

(VI) Function of ventriculostomy and external ventricular drainage apparatus in all level I centers and all level II centers with neurosurgical capability; and (I-R, II-R)

(VII) Treatment of increased intracranial pressure in all level I centers and all level II centers with neurosurgical capability. (I-R, II-R)

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

3. The stroke center intensive care unit shall have intensive care unit beds for stroke patients or, if space is not

available in the intensive care unit, the stroke center shall make arrangements to provide the comparable level of care until space is available in the intensive care unit. (I-R, II-R)

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

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

B. Oxygen source with concentration controls; (I-R, II-R)

C. Cardiac emergency cart, including medications; (I-R, II-R)

D. Telemetry, ECG capability, cardiac monitor, and defibrillator; (I-R, II-R)

E. Electronic pressure monitoring and pulse oximetry; (I-R, II-R)

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

G. Patient weighing devices; (I-R, II-R)

H. Drugs, intravenous fluids, and supplies; and (I-R, II-R)

I. Intracranial pressure monitoring devices. (I-R, II-R)

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

(C) Level I and level II stroke centers shall provide a stroke unit. A level III stroke center that has an established plan for admitting and caring for stroke patients under a supervised relationship with a level I or II stroke center pursuant to subparagraph (1)(C)3.H. above shall also provide a stroke unit. (I-R, II-R, III-R)

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

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

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

4. The stroke center stroke unit shall have registered nurses who are current in continuing education requirements as set forth in section (4) of this rule. (I-R, II-R, III-R)

5. The stroke center stroke unit shall annually credential registered nurses that work in the stroke unit. (I-R, II-R, III-R)

6. The stroke center stroke unit shall have written care protocols for identification and treatment of acute stroke patients (e.g., lytic and post-lytic management, hemorrhagic conversion according to current best evidence) which are available to stroke unit personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R)

7. The stroke center stroke unit shall have equipment to support the care and resuscitation of the stroke patient that includes at least the following:

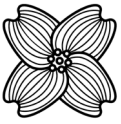
A. Airway control and ventilation equipment including:

(I) Laryngoscopes, endotracheal tubes of all sizes; (I-R, II-R, III-R)

(II) Bag-mask resuscitator and sources of oxygen; and (I-R, II-R, III-R)

(III) Suction devices; (I-R, II-R, III-R)

B. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R)



C. All standard intravenous fluids and administration devices and intravenous catheters; and (I-R, II-R, III-R)

D. Drugs and supplies necessary for emergency care. (I-R, II-R, III-R)

8. The stroke center stroke unit shall maintain equipment following the hospital preventive maintenance schedule and document when it is checked. (I-R, II-R, III-R)

(D) The stroke center shall provide radiological and diagnostic capabilities. (I-R, II-R, III-R)

1. The radiological and diagnostic capabilities shall include a documented mechanism for prioritization of stroke patients and timely interpretation to aid in patient management. (I-R, II-R, III-R)

2. The radiological and diagnostic capabilities shall include the following equipment and staffing capabilities:

A. Angiography with interventional capability available twenty-four (24) hours a day, seven (7) days a week; (I-R/PA)

B. Cerebroangiography technologist on call and available within thirty (30) minutes for emergent procedures, and on call and available within sixty (60) minutes for routine procedures, and available twenty-four (24) hours a day, seven (7) days a week; (I-R)

C. In-house computerized tomography; (I-R/IA, II-R/IA, III-R/IA)

D. Computerized tomography perfusion; (I-R/IA)

E. Computerized tomography angiography; (I-R/IA)

F. Computerized tomography technologist; (I-R/IH, II-R/IH, III-R/IA)

G. Magnetic resonance imaging; (I-R, II-R)

H. Magnetic resonance angiogram/magnetic resonance venography; (I-R, II-R)

I. Magnetic resonance imaging technologist on call and available within sixty (60) minutes, twenty-four (24) hours a day, seven (7) days a week; (I-R, II-R)

J. Extracranial ultrasound; (I-R, II-R)

K. Equipment and clinical staff to evaluate for vasospasm available within thirty (30) minutes for emergent evaluation, and available within sixty (60) minutes for routine evaluation, and available twenty-four (24) hours a day, seven (7) days a week; (I-R)

L. Transthoracic echo; (I-R, II-R)

M. Transesophageal echo; and (I-R, II-R)

N. Resuscitation equipment available to the radiology department. (I-R, II-R, III-R)

3. The radiological and diagnostic capabilities shall include adequate physician and nursing personnel available with monitoring equipment to fully support the acute stroke 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)

4. The radiological and diagnostic capabilities shall include the stroke center maintaining all radiology and diagnostic equipment according to the hospital preventive maintenance schedule and documenting when it is checked. (I-R, II-R, III-R)

(E) All level I stroke centers shall have operating room personnel, equipment, and procedures. Those level II stroke centers with neurosurgical capability shall also meet operating room personnel, equipment, and procedure requirements. (I-R, II-R)

1. Operating room staff shall be available twenty-four (24) hours a day, seven (7) days a week. (I-R/PA, II-R/PA)

2. Registered nurses shall annually maintain core competencies as required by the stroke center.

3. Operating rooms shall have at least the following

equipment:

A. Operating microscope; (I-R, II-R)

B. Thermal control equipment for patient and resuscitation fluids; (I-R, II-R)

C. X-ray capability; (I-R, II-R)

D. Instruments necessary to perform an open craniotomy; (I-R, II-R)

E. Monitoring equipment; and (I-R, II-R)

F. Resuscitation equipment available to the operating room. (I-R, II-R)

4. The operating room shall maintain all equipment according to the hospital preventive maintenance schedule and document when it is checked. (I-R, II-R)

(F) All level I stroke centers shall meet post-anesthesia recovery room (PAR) requirements listed below. Those level II stroke centers with neurosurgical capability shall also have a post-anesthesia recovery room and meet the requirements below –

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

2. The stroke center post-anesthesia recovery room's registered nurses shall annually maintain core competencies as required by the stroke center; (I-R, II-R)

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

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

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

C. Telemetry, ECG capability, cardiac monitor, and defibrillator; (I-R, II-R)

D. All standard intravenous fluids and administration devices, including intravenous catheters; and (I-R, II-R)

E. Drugs and supplies necessary for emergency care; and (I-R, II-R)

4. The stroke center post-anesthesia recovery room shall maintain all equipment according to the hospital preventive maintenance schedule and document when it is checked. (I-R, II-R)

(G) The stroke center shall have clinical laboratory services available twenty-four (24) hours a day, seven (7) days a week that meet the following requirements:

1. Written protocol to provide timely availability of results; (I-R, II-R, III-R, IV-R)

2. Standard analyses of blood, urine, and other body fluids; (I-R, II-R, III-R, IV-R)

3. Blood typing and cross-matching; (I-R, II-R, III-R)

4. Coagulation studies; (I-R, II-R, III-R, IV-R)

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

6. Blood bank or access to a community central blood bank and adequate hospital blood storage facilities; (IV-R)

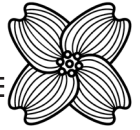
7. Blood gases and pH determinations; (I-R, II-R, III-R, IV-R)

8. Blood chemistries; and (I-R, II-R, III-R, IV-R)

9. Written protocol for prioritization of the stroke patient with other time critical patients. (I-R, II-R, III-R, IV-R)

(H) The stroke center shall have support services to assist the patient's family from the time of entry into the facility to the time of discharge and records to document that these services were provided. (I-R, II-R, III-R, IV-R)

(I) The stroke center shall have a stroke rehabilitation



program or a plan to refer those stroke patients that require rehabilitation to another facility or community agency that can provide necessary services. (I-R, II-R, III-R)

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

(A) The stroke center shall ensure that staff providing services to stroke patients receives required continuing medical education and continuing education and document this continuing medical education and continuing education for each staff member. The department shall allow up to one (1) year from the date of the hospital's initial stroke center designation for stroke center staff members to complete all of the required continuing medical education and continuing education if the stroke center staff complete and document that at least half of the required continuing medical education and/or continuing education hours have been completed for each stroke center staff member at the time of on-site initial application review. The stroke center shall submit documentation to the department within one (1) year of the initial designation date that all continuing medical education and continuing education requirements for stroke center staff members have been met in order to maintain the stroke center's designation. (I-R, II-R, III-R)

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

1. Level I core team members of the stroke call roster shall complete a minimum of eight (8) hours of continuing education in cerebrovascular disease every year, and it is recommended that a portion of those hours shall be on stroke care. All other members of the stroke call roster in level I stroke centers shall complete a minimum average of eight (8) hours of continuing education in cerebrovascular disease every year, except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department. This continuing education shall be reviewed for appropriateness to the practitioner's level of responsibility by the stroke medical director; and (I-R)

2. Level II core team members of the stroke call roster shall complete a minimum of eight (8) hours of continuing education in cerebrovascular disease every year, and it is recommended that a portion of those hours be in stroke care.

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

1. Level I and level II stroke medical directors shall complete a minimum of eight (8) hours of continuing medical education every year in the area of cerebrovascular disease; and (I-R, II-R)

2. Level III stroke medical directors shall complete a minimum of four (4) hours of continuing medical education every year in the area of cerebrovascular disease. (III-R)

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

1. Level I program managers/coordinators shall—

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

B. Attend one (1) national, regional, or state meeting every two (2) years focused on the area of cerebrovascular disease. If the national or regional meeting provides continuing education, then that continuing education may count toward

the annual requirement; (I-R)

2. Level II program managers/coordinators shall—

A. Complete a minimum average of eight (8) hours of continuing education every year in cerebrovascular disease. This continuing education shall be reviewed for appropriateness by the stroke medical director to the stroke program manager/coordinator's level of responsibility; and (II-R)

B. Attend one (1) national, regional, or state meeting every three (3) years focused on the area of cerebrovascular disease. If the national, regional, or state meeting provides continuing education, then that continuing education may count toward the annual requirement; and (II-R)

3. Level III center program managers/coordinators shall complete a minimum average of four (4) hours of continuing education in cerebrovascular disease every year. This continuing education shall be reviewed by the stroke medical director for appropriateness to the stroke program manager/coordinator's level of responsibility. (III-R)

(E) Emergency department personnel in stroke centers shall complete the following continuing education requirements:

1. Emergency department physicians in stroke centers shall complete—

A. Level I emergency department physicians providing stroke coverage shall complete a minimum of two (2) hours of continuing medical education in cerebrovascular disease every year, except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department; and (I-R)

2. Registered nurses assigned to the emergency departments in stroke centers shall complete—

A. Level I registered nurses shall complete a minimum of two (2) hours of cerebrovascular disease continuing education every year; and (I-R)

B. Registered nurses shall maintain core competencies in the care of the stroke patient annually as determined by the stroke center. Training to maintain these competencies may count toward continuing education requirements. (I-R, II-R, III-R, IV-R)

(F) Registered nurses assigned to the intensive care unit in the stroke centers who care for stroke patients shall complete the following continuing education requirements:

1. Level I intensive care unit registered nurses shall complete a minimum of eight (8) hours of cerebrovascular related continuing education every year; and (I-R)

2. The stroke medical director shall review the continuing education for appropriateness to the practitioner's level of responsibility. (I-R)

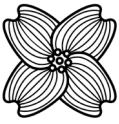
(G) Stroke unit registered nurses in the stroke centers shall complete the following continuing education requirements:

1. All level I stroke unit registered nurses shall complete a minimum of eight (8) hours of cerebrovascular disease continuing education every year; and (I-R)

2. The stroke medical director shall review the continuing education for appropriateness to the practitioner's level of responsibility. (I-R)

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

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



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

A. Door-to-needle time; (I-R, II-R, III-R)

B. Number of patients presenting within the treatment window; and (I-R, II-R, III-R)

C. Number of eligible patients treated with thrombolytics. (I-R, II-R, III-R)

2. The stroke center shall at least quarterly conduct a regular morbidity and mortality review meeting which shall be documented in the meeting minutes and/or the meeting attendance documents. (I-R, II-R, III-R, IV-R)

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

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

5. The stroke center shall participate in the emergency medical services regional system of stroke care in its respective emergency medical services region as defined in 19 CSR 30-40.302. (I-R, II-R, III-R, IV-R)

6. The stroke center shall document review of its cases of stroke patients who received U.S. Food and Drug Administration-approved thrombolytics and who remained at the referring hospital greater than ninety (90) minutes prior to transfer. (I-R, II-R, III-R)

7. The stroke center shall document its review of cases of stroke patients who did not receive U.S. Food and Drug Administration-approved thrombolytics and who remained greater than sixty (60) minutes at the referring hospital prior to transfer. (II-R, III-R, IV-R)

8. The stroke center shall review and monitor the core competencies of the physicians, practitioners, and nurses and document these core competencies have been met. (I-R, II-R, III-R, IV-R)

(B) The stroke center shall establish a patient and public education program to promote stroke prevention and stroke symptoms awareness. (I-R, II-R, III-R, IV-R)

(C) It is recommended that level I, II, and III stroke centers establish a professional education outreach program in catchment areas to provide training and other supports to improve care of stroke patients. (I-R, II-R, III-R)

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

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

2. A mechanism to assure that all nurses providing care to stroke patients complete a minimum of required continuing education as set forth in section (4) of this rule to become credentialed in stroke care; and (I-R, II-R, III-R, IV-R)

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

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

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

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

(A) Level I stroke centers shall support an ongoing stroke research program as evidenced by any of the following.

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

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

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

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

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

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

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

AUTHORITY: sections 192.006 and 190.185, RSMo 2016, and section 190.241, RSMo Supp. 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022, effective June 30, 2023.*

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

19 CSR 30-40.740 Definitions and Abbreviations Relating to ST-Segment Elevation Myocardial Infarction (STEMI) Centers

PURPOSE: This rule defines terminology related to STEMI centers.

(1) For the purposes of 19 CSR 30-40.750 and 19 CSR 30-40.760 the following terms shall mean –

(A) Acute – an injury or illness that happens or appears quickly and can be serious or life-threatening;

(B) Anesthesiologist assistant (AA) – a person who –

1. Has graduated from an anesthesiologist assistant program accredited by the American Medical Association's Committee on Allied Health Education and Accreditation or by its successor agency;

2. Has passed the certifying examination administered by the National Commission on Certification of Anesthesiologist Assistants;

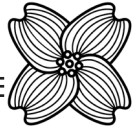
3. Has active certification by the National Commission on Certification of Anesthesiologist Assistants;

4. Is currently licensed as an anesthesiologist assistant in the state of Missouri; and

5. Provides health care services delegated by a licensed anesthesiologist;

(C) Board-admissible/board-eligible – a physician who has applied to a specialty board of the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada and has received a ruling that he or she has fulfilled the requirements to take the examinations. Board certification is generally obtained within five (5) years of the first appointment;

(D) Board-certified – a physician who has fulfilled all requirements, has satisfactorily completed the written and oral examinations, and has been awarded a board diploma in



a specialty field by the American Board of Medical Specialties, the American Osteopathic Association Board of Osteopathic Specialists, or the Royal College of Physicians and Surgeons of Canada;

(E) Cardiac catheterization laboratory – the setting within the hospital where percutaneous coronary interventions are done. Specialized staff, equipment, and protocol must be in place;

(F) Cardiac catheterization team – physicians and clinical staff who perform percutaneous coronary interventions and who are part of the clinical STEMI team;

(G) Cardiogenic shock – a life threatening condition in which the heart muscle does not pump enough blood to meet the body's needs;

(H) Cardiologist – a licensed physician with appropriate specialty training;

(I) Cardiology Service – an organizational component of the hospital specializing in the care of patients who have had STEMIs or some other cardiovascular condition or disorder;

(J) Catchment area – the surrounding area served by the institution (the STEMI center);

(K) Certified registered nurse anesthetist (CRNA) – a registered nurse who –

1. Has graduated from a school of nurse anesthesia accredited by the Council on Accreditation of Educational Programs of Nurse Anesthesia or its predecessor;

2. Has been certified as a nurse anesthetist by the Council on Certification of Nurse Anesthetists; and

3. Has been licensed in Missouri pursuant to Chapter 335, RSMo;

(L) Clinical staff – an individual that has specific training and experience in the treatment and management of STEMI patients. Examples include physicians, registered nurses, advanced practice nurses, physician assistants, pharmacists, and technologists;

(M) Clinical team – a team of health care professionals involved in the care of the STEMI patient and may include but not be limited to cardiologists, interventional cardiologists, cardiovascular surgeons, anesthesiologists, emergency medicine, and other STEMI center clinical staff. The clinical team is part of the hospital's STEMI team;

(N) Contiguous leads – the electrical cables that attach the electrodes on the patient to the electrocardiograph recorder and which are next to one another. They view the same general area of the heart;

(O) Continuing education – education approved or recognized by a national and/or state professional organization and/or STEMI medical director;

(P) Continuing medical education (CME) – the highest level of continuing education for physicians that is approved by a national and/or state professional organization and/or STEMI medical director;

(Q) Core team – a subunit of the hospital STEMI team which consists of a physician experienced in diagnosing and treating STEMI (usually the STEMI medical director) and at least one (1) other health care professional or qualified individual competent in STEMI care as determined by the hospital (usually the STEMI program manager/coordinator);

(R) Credentialed or credentialing – a hospital-specific system of documenting and recognizing the qualifications of medical staff and nurses and authorizing the performance of certain procedures and establishing clinical privileges in the hospital setting;

(S) Department – the Missouri Department of Health and Senior Services;

(T) Door-to-balloon-time – the time from arrival at the

hospital door to percutaneous coronary intervention balloon inflation for the purpose of restoring blood flow in an obstructed coronary artery in the cardiac catheterization lab. This term is commonly abbreviated as D2B;

(U) Door-to-device-time – the time from patient arrival at the hospital to the time the device is in the affected cardiac blood vessel;

(V) Door-to-needle-time – the time from arrival at the hospital door to initiation of lytic therapy to restore blood flow in an obstructed blood vessel;

(W) Electrocardiogram (ECG/EKG) – a recorded tracing of the electrical activity of the heart. The heart rate, heartbeat regularity, size and chamber position, presence of any prior heart attack, current injury, and the effects of drugs or devices (i.e., pacemaker can be determined). An abnormal ECG pattern is seen during a heart attack because damaged areas of the heart muscle do not conduct electricity properly;

(X) Emergency medical service regions – the six (6) regions in the state of Missouri which are defined in 19 CSR 30-40.302;

(Y) First medical contact – a patient's initial contact with a health-care provider either pre-hospital, which could be contact with emergency medical service personnel or another medical provider, or in the hospital;

(Z) First medical contact to balloon or device time – the time from a patient's first medical contact with a health-care provider to the time when the balloon is inflated or the device is in the affected cardiac blood vessel;

(AA) First medical contact to hospital door time – the time from a patient's first medical contact with a health-care provider to the time when the patient arrives at the hospital door;

(BB) Hospital – an establishment as defined by section 197.020.2, RSMo, or a hospital operated by the state;

(CC) Immediately available (IA) – being present at bedside 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;

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

(EE) Intermediate care unit – the functional division or facility of the hospital that provides care for STEMI patients admitted to the STEMI center;

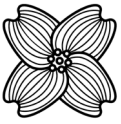
(FF) Interventional cardiologist – a licensed cardiologist with the appropriate specialty training;

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

(HH) Mentoring relationship – a relationship in which a high volume percutaneous coronary interventions operator, often described as performing one hundred fifty (150) or more procedures per year, serves as a mentor for an operator who performs less than eleven (11) primary percutaneous coronary interventions per year;

(II) Missouri STEMI registry – a statewide data collection system comprised of key data elements as identified by the Department of Health and Senior Services used to compile and trend statistics of STEMI patients both pre-hospital and hospital, using a coordinated electronic reporting method provided by the Missouri Department of Health and Senior Services;

(JJ) Multidisciplinary team – a team of appropriate representatives of hospital units involved in the care of the



STEMI patient. This team supports the care of the STEMI patient with the STEMI team;

(KK) Patient – an individual who is sick, injured, wounded, diseased, or otherwise incapacitated or helpless, or dead, excluding deceased individuals being transported from or between private or public institutions, homes, or cemeteries, and individuals declared dead prior to the time an ambulance is called for assistance;

(LL) Peer review system – is the process the STEMI center establishes for physicians to review STEMI cases on patients that are admitted to the STEMI center, transferred out of the STEMI center, or die as a result of the STEMI (independent of hospital admission or hospital transfer status);

(MM) Percutaneous coronary intervention (PCI) – is a procedure used to open or widen narrowed or blocked blood vessels to restore blood flow supplying the heart. A primary percutaneous coronary intervention is one that is generally done on an emergency basis for a ST-elevation myocardial infarction (STEMI). Treatment occurs while the blood clot is still forming – usually within twenty-four (24) hours of onset, but ideally within two (2) hours of symptoms onset. An elective percutaneous coronary intervention is one that is done on a non-urgent basis to reduce signs and symptoms of angina;

(NN) Percutaneous coronary intervention window – the time frame in which percutaneous coronary intervention is most advantageous and recommended;

(OO) Phase I cardiac rehabilitation – an inpatient program that provides an individualized exercise and education plan for patients with cardiac illnesses;

(PP) Physician – a person licensed as a physician pursuant to Chapter 334, RSMo;

(QQ) Promptly available (PA) – arrival at the hospital at the patient's bedside within thirty (30) minutes after notification of a patient's arrival at the hospital;

(RR) Protocol – a predetermined, written medical care guideline, which may include standing orders;

(SS) Qualified individual – a physician, registered nurse, advanced practice registered nurse, and/or physician assistant that demonstrates administrative ability and shows evidence of educational preparation and clinical experience in the care of STEMI patients and is licensed by the state of Missouri;

(TT) Regional outcome data – data used to assess the regional process for pre-hospital, hospital, and regional patient outcomes;

(UU) Repatriation – the process used to return a STEMI patient to his or her home community from a level I or level II STEMI designated hospital after his or her acute treatment for STEMI has been completed. This allows the patient to be closer to home for continued hospitalization or rehabilitation and follow-up care as indicated by the patient's condition;

(VV) Reperfusion – the process of restoring normal blood flow to an organ or tissue that has had its blood supply cut off, such as after an ischemic stroke or myocardial infarction;

(WW) Requirement (R) – a symbol to indicate that a standard is a requirement for STEMI center designation at a particular level;

(XX) Review – is the inspection of a hospital to determine compliance with the rules of this chapter;

(YY) ST-elevation myocardial infarction (STEMI) – a myocardial infarction for which the electrocardiogram shows ST-segment elevation, usually in association with an acutely blocked coronary artery. A STEMI is one type of heart attack that is a potentially lethal condition for which specific therapies, administered rapidly, reduce mortality and disability. The more time that passes before blood flow is restored, the more damage that is done to the heart muscle;

(ZZ) STEMI call roster – a schedule that provides twenty-four (24) hours a day, seven (7) days a week cardiology service coverage. The call roster identifies the physicians or qualified individuals on the schedule that are available to manage and coordinate emergent, urgent, and routine assessment, diagnosis, and treatment of the STEMI patients;

(AAA) STEMI care – education, prevention, emergency transport, triage, acute care, and rehabilitative services for STEMI that requires immediate medical or surgical intervention or treatment;

(BBB) STEMI center – a hospital that is currently designated as such by the department to care for patients with ST-segment elevation myocardial infarctions.

1. A level I STEMI center is a receiving center staffed and equipped to provide total care for every aspect of STEMI care, including care for those patients with complications. It functions as a resource center for the hospitals within that region and conducts research.

2. A level II STEMI center is a receiving center staffed and equipped to provide care for a large number of STEMI patients within the region.

3. A level III STEMI center is primarily a referral center that provides prompt assessment, indicated resuscitation, and appropriate emergency intervention for STEMI patients to stabilize and arrange timely transfer to a Level I or II STEMI center, as needed.

4. A level IV STEMI center is a referral center in an area considered rural or where there are insufficient hospital resources to serve the patient population requiring STEMI care. The level IV STEMI center provides prompt assessment, indicated resuscitation, appropriate emergency intervention, and arranges and expedites transfer to a higher level STEMI center as needed;

(CCC) STEMI identification – a diagnosis is made on a basis of symptoms, clinical examination, and electrocardiogram changes, specifically ST-segment elevation;

(DDD) STEMI medical director – a physician designated by the hospital who is responsible for the STEMI service and performance improvement and patient safety programs related to STEMI care;

(EEE) STEMI program – an organizational component of the hospital specializing in the care of STEMI patients;

(FFF) STEMI program manager – a qualified individual designated by the hospital with responsibility for monitoring and evaluating the care of STEMI patients and the coordination of performance improvement and patient safety programs for the STEMI center in conjunction with the physician in charge of STEMI care;

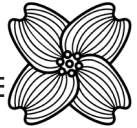
(GGG) STEMI team – a component of the hospital STEMI program which consists of the core team and the clinical team;

(HHH) Symptom onset-to-treatment time – the time from symptom onset to initiation of therapy to restore blood flow in an obstructed blood vessel;

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

(JJJ) Transfer agreement – a document which sets forth the rights and responsibilities of two (2) hospitals regarding the inter-hospital transfer of patients; and

(KKK) Virtual review – a type of review conducted through the use of secure virtual video and audio conferencing and secure file transfers in order to determine compliance with the rules of this chapter.



AUTHORITY: sections 192.006 and 190.185, RSMo 2016, and section 190.241, RSMo Supp. 2022. Original rule filed Nov. 15, 2012, effective June 30, 2013. Emergency amendment filed Nov. 21, 2022, effective Dec. 7, 2022, expires June 4, 2023. Amended: Filed Nov. 21, 2022, effective June 30, 2023.*

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

19 CSR 30-40.750 ST-Segment Elevation Myocardial Infarction (STEMI) Center Designation Application and Review

PURPOSE: This rule establishes the requirements for participation in Missouri’s STEMI center program.

(1) Participation in Missouri’s STEMI center program is voluntary and no hospital shall be required to participate. No hospital shall hold itself out to the public as a state-designated STEMI center unless it is designated as such by the Department of Health and Senior Services (department). Hospitals desiring STEMI center designation shall apply to the department either through the option outlined in section (2) or section (3). Only those hospitals found to be in compliance with the requirements of the rules of this chapter shall be designated by the department as STEMI centers.

(2) Hospitals requesting to be reviewed and designated as a STEMI center by the department shall meet the following requirements:

(A) An application for STEMI center designation shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a fair determination of eligibility for review and designation in accordance with the rules of this chapter. The STEMI center review and designation application form, included herein, is available at the Health Standards and Licensure (HSL) office, online at the department’s website at www.health.mo.gov, or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for STEMI center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation or expiration of the current designation;

(B) Both sections A and B of the STEMI center review and designation application form, included herein, shall be complete before the department will arrange a date for the review. The department shall notify the hospital/STEMI center of any apparent omissions or errors in the completion of the STEMI center review and designation application form. When the STEMI center review and designation application form is complete, the department shall contact the hospital/STEMI center to arrange a date for the review.

(C) The hospital/STEMI center shall cooperate with the department in arranging for a mutually suitable date for any announced reviews;

(D) The department may conduct an onsite review, a virtual review, or a combination thereof on the hospitals/STEMI centers. For announced reviews that are scheduled with the hospitals/STEMI centers, the department will make the hospitals/STEMI centers aware at least ninety (90) days prior to the scheduled review whether the department intends that the review will be conducted onsite and/or virtually. Due to unforeseen circumstances, the department may need to change whether

the review is conducted onsite and/or virtually less than ninety (90) days before the announced review. The department will contact the hospitals/STEMI centers to make the hospitals/STEMI centers aware of any changes about how the review will be conducted, either onsite and/or virtually, and/or when the review will be conducted with as much advance notice as possible prior to the date of the announced review. The different types of reviews to be conducted on hospitals/STEMI centers seeking STEMI center designation by the department include –

1. An initial review shall occur on a hospital applying to be initially designated as a STEMI center. An initial review 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. This review may occur onsite and/or virtually.

2. A validation review shall occur on a designated STEMI center applying for renewal of its designation as a STEMI center. Validation reviews shall occur no less than every three (3) years. A validation review shall include interviews with designated STEMI center 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. This review may occur on-site and/or virtually; and

3. A focus review shall occur on a designated STEMI center in which an initial or validation review was conducted and substantial deficiency(ies) were cited. A review of the physical plant will not be necessary unless a deficiency(ies) was cited in the physical plant in the preceding validation review. The focus review team shall be comprised of a representative from the department and may include a qualified contractor(s) with the required expertise to evaluate corrections in areas where deficiencies were cited. This review may occur on-site and/or virtually;

(E) STEMI center designation shall be valid for a period of three (3) years from the date the STEMI center/hospital is designated. Expiration of the designation shall occur unless the STEMI center applies for validation review within this three- (3-) year period and the department is unable to conduct a review before the designation expires.

1. STEMI center designation shall be site specific and non-transferable when a STEMI center changes location.

2. Once designated as a STEMI center, a STEMI center may voluntarily surrender the designation at any time without giving cause, by contacting the department in writing. In these cases, the application and review process shall be completed again before the designation may be reinstated;

(F) For the purpose of reviewing previously designated STEMI centers and hospitals applying for STEMI center designation, the department shall use review teams consisting of qualified contractors. These review teams shall consist of one (1) STEMI coordinator or STEMI program manager who has experience in STEMI care and one (1) emergency medicine physician experienced in STEMI care. The review team shall also consist of at least one (1) and no more than two (2) cardiologist(s)/ interventional cardiologist(s) who are experts in STEMI care. One (1) representative from the department will also be a participant of the review team. This representative shall coordinate the review with the hospital/STEMI center and the other review team members.

1. Any individual interested in becoming a qualified contractor to conduct reviews shall –

A. Send the department a curriculum vitae (CV) or résumé that includes his or her experience and expertise in



STEMI care and whether an individual is in good standing with his or her licensing boards. A qualified contractor shall be in good standing with his or her respective licensing boards;

B. Provide the department evidence of his or her previous site survey experience (state and/or national designation survey process); and

C. Submit a list to the department that details any ownership he or she may have in a Missouri hospital(s), whether he or she has been terminated from any Missouri hospital(s), any lawsuits he or she has currently or had in the past with any Missouri hospital(s), and any Missouri hospital(s) for which his or her hospital privileges have been revoked.

2. Qualified contractors for the department shall enter into a written agreement with the department indicating, that among other things, they agree to abide by Chapter 190, RSMo, and the rules in this chapter, during the review process;

(G) Out-of-state review team members shall conduct levels I and II hospital/STEMI center reviews. Review team members are considered out-of-state review team members if they work outside of the state of Missouri. In-state review team members may conduct levels III and IV hospital/STEMI center reviews. Review team members are considered in-state review team members if they work in the state of Missouri. In the event that out-of-state reviewers are unavailable, levels I and II STEMI center reviews may be conducted by in-state reviewers from Emergency Medical Services (EMS) regions as set forth in 19 CSR 30-40.302 other than the region being reviewed with the approval of the director of the department or his/her designee. When utilizing in-state review teams, levels I and II hospital/STEMI centers shall have the right to refuse one (1) in-state review team or certain members from one (1) in-state review team;

(H) Hospitals/STEMI centers shall be responsible for paying expenses related to the costs of the qualified contractors to review their respective hospitals/STEMI center during initial, validation, and focus reviews. The department shall be responsible for paying the expenses of its representative. Costs of the review to be paid by the hospital/STEMI center include –

1. An honorarium shall be paid to each qualified contractor of the review team whether the review occurs on-site or virtually. Qualified contractors of the review team for level I and II STEMI center reviews shall be paid one thousand four hundred fifty dollars (\$1,450) per reviewer. Qualified contractors of the review team for level III and IV STEMI center reviews shall be paid one thousand dollars (\$1,000) per reviewer. This honorarium shall be paid to each qualified contractor of the review team at the time the site survey begins if on-site or prior to the review beginning if the review is conducted virtually;

2. Airfare shall be paid for each qualified contractor of the review team, if applicable;

3. Lodging shall be paid for each qualified contractor of the review team, unless the review is conducted virtually. The hospital/STEMI center shall secure the appropriate number of hotel rooms for the qualified contractors and pay the hotel directly; and

4. Incidental expenses, if applicable, for each qualified contractor of the review team shall not exceed two hundred fifty dollars (\$250) and may include the following:

- A. Airport parking;
- B. Checking bag charges;
- C. Meals during the review; and

D. Mileage to and from the review if no airfare was charged by the reviewer. If the reviewer solely participated virtually in the review and did not travel by vehicle to the review, then no mileage shall be paid. Mileage shall be paid

at the federal mileage rate for business miles as set by the Internal Revenue Service (IRS). Federal mileage rates can be found at the website www.irs.gov;

(I) Hospitals/STEMI centers being reviewed through a virtual survey shall do the following:

1. Provide a videoconferencing platform to be used for the hospital/STEMI center virtual review;

2. Provide a live tour of the hospital;

3. Ensure the videoconferencing platform used during the review is compliant with state and federal laws for protected health information;

4. Assign an on-site visit coordinator for the review. The on-site visit coordinator role cannot be fulfilled by the STEMI program manager. This on-site visit coordinator will be responsible for the logistical aspects of the virtual review. Responsibilities include, at least, the following:

A. Scheduling the videoconferencing meetings;

B. Sending out calendar invitations;

C. Providing electronic medical record (EMR) access to designated individuals;

D. Ensuring all required participants are on the videoconferencing line for the various parts of the review; and

E. Sending separate calendar invitations for each section of the virtual review to hospital staff, qualified contractors, and the department;

5. Assign one (1) staff navigator per qualified contractor to help remotely navigate the EMR, the patient performance improvement patient safety (PIPS) documentation, and supporting documentation. The staff navigator role cannot be fulfilled by the STEMI program manager, the STEMI program medical director, the STEMI program registrar, or the on-site visit coordinator for the review. The individuals designated as the staff navigators shall be familiar with navigating through the EMR;

6. Provide the department with requested patient care report information for the review no later than thirty (30) days prior to the virtual review;

7. Provide the department with requested medical records, PIPS documentation, registry report, and all supporting documentation at least seven (7) days prior to the virtual visit through a method that is compliant with state and federal laws for protected health information;

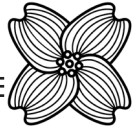
8. Schedule a pre-review call with the qualified contractors, the department, the STEMI program medical director, the STEMI program manager, the staff navigators and the on-site visit coordinator approximately one (1) week prior to the virtual review;

9. Test the functionality of the videoconferencing platform for the live tour of the hospital prior to the pre-review call; and

10. Provide a list of attendees for the review meeting and their roles to the review team and the department prior to the virtual review;

(J) The department may conduct an on-site review of the hospital prior to the virtual review process to ensure that the hospital meets the requirements for STEMI center designation;

(K) Upon completion of a review, the qualified contractors from the review team shall submit a report of their findings to the department. This report shall state whether the specific standards for STEMI center designation have or have not been met and if not met, in what way they were not met. This report shall detail the hospital/STEMI center's strengths, weaknesses, deficiencies, and recommendations for areas of improvement. This report shall also include findings from patient chart audits and a narrative summary of the following areas: prehospital, hospital, STEMI service, emergency department, operating room, angiography suites, recovery room, clinical lab,



intensive care unit, rehabilitation, performance improvement and patient safety programs, education, outreach, research, chart review, and interviews. The department shall have the final authority to determine compliance with the rules of this chapter;

(L) The department shall return a copy of the report to the chief executive officer, the STEMI medical director, and the STEMI program manager/coordinator of the hospital/STEMI center reviewed. Included within the report shall be notification indicating whether the hospital/STEMI center has met the criteria for STEMI center designation or has failed to meet the criteria for STEMI center designation as requested. Also, if a focus review of the STEMI center is required, the time frame for this focus review will be shared with the chief executive officer, the STEMI medical director, and the STEMI program manager/coordinator of the STEMI center reviewed;

(M) When the hospital/STEMI center is found to have deficiencies, the hospital/STEMI center shall submit a plan of correction to the department. The plan of correction shall include identified deficiencies, actions to be taken to correct deficiencies, time frame in which the deficiencies are expected to be resolved, and the person responsible for the actions to resolve the deficiencies. A plan of correction form shall be completed by the hospital and returned to the department within thirty (30) days after notification of review findings and designation. If a focus review is required, the STEMI center shall be allowed a minimum period of six (6) months to correct deficiencies;

(N) No hospital shall hold itself out as a STEMI center designated by the department until given written approval by the department. The department shall give written approval to the hospitals to begin holding themselves out as designated STEMI centers by the department after all initial STEMI reviews have been completed for those hospitals which applied for STEMI review and designation with the department during the first round of applications and the time for plans of corrections have expired;

(O) A STEMI center shall make the department aware in writing within thirty (30) days if there are any changes in the STEMI center's name, address, contact information, chief executive officer, STEMI medical director, or STEMI program manager/coordinator;

(P) Failure of a hospital/STEMI center to provide all medical records and quality improvement documentation necessary for the department to conduct a STEMI review in order to determine if the requirements of 19 CSR 30-40.760 have been met shall result in the revocation of the hospital/STEMI center's designation as a STEMI center;

(Q) Any person aggrieved by an action of the department affecting the STEMI center designation pursuant to Chapter 190, RSMo, including the revocation, the suspension, or the granting of, refusal to grant, or failure to renew a designation, may seek a determination by the Administrative Hearing Commission under Chapter 621, RSMo. It shall not be a condition to such determination that the person aggrieved seek reconsideration, a rehearing, or exhaust any other procedure within the department; and

(R) The department may deny, place on probation, suspend, or revoke such designation in any case in which it has determined that there has been a substantial failure to comply with the provisions of Chapter 190, RSMo, or any rules or regulations promulgated pursuant to this chapter. If the department has determined that a hospital is not in compliance with such provisions or regulations, it may conduct additional announced or unannounced site reviews of the hospital to verify compliance. If a STEMI center fails two (2) consecutive

on-site reviews because of substantial noncompliance with standards prescribed by sections 190.001 to 190.245, RSMo, or rules adopted by the department pursuant to sections 190.001 to 190.245, RSMo, its center designation shall be revoked.

(3) Hospitals seeking STEMI center designation by the department based on their current certification or verification as a STEMI center by the Joint Commission, American Heart Association, or American College of Cardiology shall meet the following requirements:

(A) An application for STEMI center designation by the department for hospitals that have been certified or verified as a STEMI/chest pain center by the Joint Commission, American Heart Association, or American College of Cardiology shall be made upon forms prepared or prescribed by the department and shall contain information the department deems necessary to make a determination of eligibility for review and designation in accordance with the rules of this chapter. The application for STEMI certified hospital designation form, included herein, is available at the Health Standards and Licensure (HSL) office, or online at the department's website at www.health.mo.gov, or may be obtained by mailing a written request to the Missouri Department of Health and Senior Services, HSL, PO Box 570, Jefferson City, MO 65102-0570. The application for STEMI center designation shall be submitted to the department no less than sixty (60) days and no more than one hundred twenty (120) days prior to the desired date of the initial designation or expiration of the current designation;

(B) Both sections A and B of the application for STEMI certified hospital designation form, included herein, shall be complete before the department designates a hospital/STEMI center. The department shall notify the hospital/STEMI center of any apparent omissions or errors in the completion of the application for STEMI certified hospital designation form. Upon receipt of a completed and approved application, the department shall designate such hospital as follows:

1. The department shall designate a hospital as a level I STEMI center if such hospital has been certified as a comprehensive cardiac center by the Joint Commission;

2. The department shall designate a hospital as a level II STEMI center if such hospital has been certified as any of the following:

A. Mission Lifeline Percutaneous Coronary Intervention (PCI)/STEMI receiving center by the American Heart Association;

B. Chest pain center with PCI center by the American College of Cardiology;

C. Chest pain with PCI and resuscitation center by the American College of Cardiology;

D. Primary Heart Attack Center by the Joint Commission;

or
E. Comprehensive Heart Attack Center by the Joint Commission;

3. The department shall designate a hospital as a level III STEMI center if such hospital has been certified as any of the following:

A. Mission Lifeline non/PCI STEMI referral center by the American Heart Association;

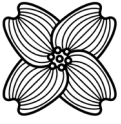
B. Chest pain center by the Joint Commission;

C. Acute Heart Attack Ready Center by the Joint Commission;

D. Primary Acute Myocardial Infarction (AMI) center by the Joint Commission; or

E. Chest pain center by the American College of Cardiology;

(C) No hospital shall hold itself out as a STEMI center designated by the department until given written approval by



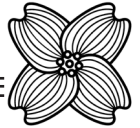
the department. The department shall give written approval to the hospitals to begin holding themselves out as designated STEMI centers by the department. This does not prohibit the hospitals from holding themselves out as certified STEMI/chest pain centers by the Joint Commission, the American Heart Association, or the American College of Cardiology;

(D) Within thirty (30) days of any changes or receipt of a certificate or verification, the hospital shall submit to the department proof of certification as a STEMI/chest pain center by the Joint Commission, the American Heart Association, or the American College of Cardiology and the names and contact information of the medical director of the STEMI/chest pain center and the program manager of the STEMI/chest pain center. A certificate or verification as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology shall accompany the application for STEMI certified hospital designation form. A hospital shall report to the department in writing within thirty (30) days of the date the hospital no longer is certified or verified as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology for which the hospital used to receive its corresponding designation by the department as a STEMI center, whether because the hospital voluntarily surrendered this certificate or verification, or because the hospital's certificate or verification was suspended or revoked by the Joint Commission, the American Heart Association, or the American College of Cardiology or expired.

(E) Participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes;

(F) The designation of a hospital as a STEMI center pursuant to section (3) shall continue if such hospital retains certification as a STEMI center by the Joint Commission, the American Heart Association, or the American College of Cardiology; and

(G) The department may remove a hospital's designation as a STEMI center if requested by the hospital or the department determines that the Joint Commission, the American Heart Association, or the American College of Cardiology certification or verification has been suspended or revoked. The department may also remove a hospital's designation as a STEMI center if the department determines the hospital's certification or verification with the Joint Commission, the American Heart Association, or the American College of Cardiology has expired. Any decision made by the department to withdraw the designation of a STEMI center that is based on the revocation or suspension of a certification or verification by the Joint Commission, the American Heart Association, or the American College of Cardiology shall not be subject to judicial review.

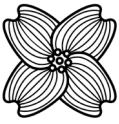


MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH SERVICES AND LICENSURE
APPLICATION FOR STEMI CENTER REVIEW AND DESIGNATION

SECTION A			
In accordance with the requirements of the Chapter 190 RSMo and the applicable regulations, this application is hereby submitted for review and designation as a STEMI center. Please complete all information applicable to the requested designation level.			Designation Level Requested <input type="checkbox"/> I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV
HOSPITAL INFORMATION			
Name Of Hospital (Name To Appear On Designation Certificate)		Telephone Number	
Address (Street And Number)		City	Zip
PROFESSIONAL INFORMATION			
Chief Executive Officer		Chairman/President of Board of Trustees	
STEMI Medical Director		STEMI Program Manager	
Medical Director of Emergency Medicine		Medical Director of Intensive Care/Cardiac Care Unit	
RESOURCE INFORMATION			
STEMI Caseload	STEMI Team Activations	Cardiac Cath Lab Team Activations for STEMI	CT Capability <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> NONE
MRI Capability <input type="checkbox"/> FULL <input type="checkbox"/> PARTIAL <input type="checkbox"/> NONE	Cardiothoracic Surgery Capability or Plan	ICU/CCU Beds	Cath Lab Suites
Cardiac Rehab <input type="checkbox"/> Phase I <input type="checkbox"/> Plan for Rehab	Cardiologists	Interventional Cardiologists	Cardiothoracic Surgeons
ED Physicians	Anesthesiologists/CRNAs & AAs	Avg Elective PCI/Primary PCIs over the last 3 years (not required for initial review)	Average STEMI cases lytics eligible/STEMI cases that receive lytics in the past 3 years (not required for initial review)
CERTIFICATION			
We, the undersigned, hereby certify that the information provided in this application for STEMI center review and designation is true and accurate; and give assurance of the intent and ability of the hospital to comply with regulations promulgated under Chapter 190 RSMo.			
We further certify that the hospital will comply with all recommendations for improvement contained in the STEMI center site review reports prepared by the Missouri Department of Health and Senior Services.			
Date of application _____			
Signed _____ Chairman/President of Board of Trustees, Owner, or one Partner of Partnership		Signed _____ Hospital Chief Executive Officer	
Signed _____ STEMI Medical Director		Signed _____ Director of Emergency Medicine	

MO 580

EMS



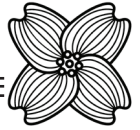
MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
SECTION OF HEALTH STANDARDS AND LICENSURE
APPLICATION FOR STEMI CENTER REVIEW AND DESIGNATION

SECTION B

Please attach the following documentation to the application form.

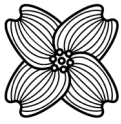
Name of Hospital:

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



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

SECTION A		
In accordance with the requirements of Chapter 190, RSMo, and the applicable regulations, this application is hereby submitted for designation as a STEMI center. Please complete all information.		Organization's STEMI Identification Number
Current STEMI Certification Organization and Level		
<p>LEVEL I</p> <input type="checkbox"/> Joint Commission, Comprehensive Cardiac Center	<p>LEVEL II</p> <input type="checkbox"/> American Heart Association, Mission Lifeline Percutaneous Coronary Intervention (PCI)/ STEMI Receiving Center <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI Center <input type="checkbox"/> American College of Cardiology, Chest Pain with PCI and Resuscitation Center <input type="checkbox"/> Joint Commission, Primary Heart Attack Center	<p>LEVEL III</p> <input type="checkbox"/> American Heart Association, Mission Lifeline Non/PCI STEMI Referral Center <input type="checkbox"/> Joint Commission, Chest Pain Center <input type="checkbox"/> Joint Commission, Primary Acute Myocardial Infarction (AMI) Center <input type="checkbox"/> American College of Cardiology, Chest Pain Center <input type="checkbox"/> Joint Commission, Acute Heart Attack Ready Center
HOSPITAL INFORMATION		
Name of Hospital (Name to Appear on Designation Certificate)		Telephone Number
Address (Street and Number)	City	Zip Code
PROFESSIONAL INFORMATION		
Chief Executive Officer	Chairman/President of Board of Trustees	
STEMI Medical Director (Name, email, and contact phone number)	STEMI Program Manager (Name, email, and contact phone number)	
Section B		
The following should be submitted to the department as indicated:		
<input type="checkbox"/> Proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology with the expiration date of the certification.		
CERTIFICATION		
We, the undersigned, hereby certify that: A. Within thirty (30) days of any changes or receipt of a certificate or verification, we will submit to the department proof of STEMI certification with the Joint Commission, American Heart Association or American College of Cardiology. B. Within thirty (30) days, we will submit to the department any changes in the names and/or contact information of our medical director and the program manager of the STEMI center. C. Within thirty (30) days that our hospital is no longer certified or verified with the Joint Commission, the American Heart Association or the American College of Cardiology, whether because we voluntarily surrendered our certification or verification or because our certification or verification has been suspended or revoked by the Joint Commission, the American Heart Association or American College of Cardiology or expired, we will report this change in writing to the department. D. We will participate in local and regional emergency medical services systems for purposes of providing training, sharing clinical educational resources, and collaborating on improving patient outcomes. E. We understand that our designation as a STEMI center by the department shall continue only if our hospital remains certified as a STEMI center by the Joint Commission, the American Heart Association or the American College of Cardiology.		
Date of application _____		
Signed _____ Chairman/President of Board of Trustees, Owner, or one Partner of Partnership	Signed _____ Hospital Chief Executive Officer	
Signed _____ STEMI Medical Director	Signed _____ Director of Emergency Medicine	



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

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

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

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

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

AGENCY NOTE:

I-R, II-R, III-R, or IV-R after a standard indicates a requirement for level I, II, III, or IV STEMI centers respectively.

I-IH, II-IH, III-IH, or IV-IH after a standard indicates an in-house requirement for level I, II, III, or IV STEMI centers respectively.

I-IA, II-IA, III-IA, or IV-IA indicates an immediately available requirement for level I, II, III, or IV STEMI centers respectively.

I-PA, II-PA, III-PA, or IV-PA indicates a promptly available requirement for level I, II, III, or IV STEMI centers respectively.

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

(1) General Standards for STEMI Center Designation.

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

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

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

1. The STEMI center shall maintain a STEMI team that at a

minimum consists of—

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

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

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

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

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

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

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

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

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

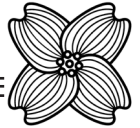
A. A list of all STEMI team members; (I-R, II-R, III-R, IV-R)

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

1. Option one –

A. It is recommended that the cardiac catheterization

laboratory perform –

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

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

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

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

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

B. If a STEMI center performs less than an annual recommended average of two hundred (200) elective percutaneous coronary interventions over three (3) consecutive preceding years, it is recommended that the STEMI center perform an annual average of thirty-six (36) primary percutaneous coronary interventions over three (3) consecutive preceding years, and it is recommended that all operators perform seventy-five (75) or more elective percutaneous coronary interventions and eleven (11) or more primary percutaneous coronary interventions per year or have a mentoring relationship defined by a written agreement with a highly experienced operator. This mentor may be a member of the same institution or belong to another institution.



This relationship, established by a written agreement, may include but not be limited to on-site supervision and observation of performance during primary and elective percutaneous coronary interventions, review of mentee's patient encounters, review of mentee's outcomes, evaluation of mentee and hospital's process pertaining to elective and primary percutaneous coronary interventions, and guidance on methods to improve process, performance, and outcomes; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

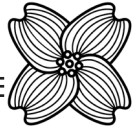
1. The criteria used to triage STEMI patients; (I-R, II-R, III-R, IV-R)

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

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

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

(M) The STEMI centers shall have a fibrinolysis protocol for instances when percutaneous coronary intervention is not achievable within an appropriate designated time frame and for when fibrinolysis is achievable within an appropriate designated time frame. It is recommended that the designated time frame follow nationally acceptable standards, for example as set forth in Appendix A number eight (8) entitled "Time to Fibrinolytic Therapy" included in the article entitled "ACC/AHA Clinical Performance Measures for Adults with ST-Elevation and Non-ST-Elevation Myocardial Infarction: A Report of the American College of Cardiology/American Heart Association Task Force on Performance Measures (Writing Committee to Develop Performance Measures on ST-Elevation and Non-ST-Elevation Myocardial Infarction)" as published by the Journal of the American College of Cardiology in 2006, volume 47, pages 236–265 which is incorporated by reference in this rule and is



available at the Journal of the American College of Cardiology, Reprint Department Elsevier Inc., 360 Park Avenue South, New York, NY 10010-1710 or on the Journal of the American College of Cardiology website at <http://content.onlinejacc.org>. This rule does not incorporate any subsequent amendments or additions. (I-R, II-R, III-R, IV-R)

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

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

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

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

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

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

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

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

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

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

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

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

electronically into the STEMI registry; (I-R, II-R, III-R, IV-R)

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

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

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

(2) Medical Staffing Standards for STEMI Center Designation.

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

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

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

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

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

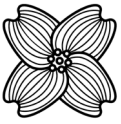
4. An emergency department physician; (I-R/IH, II-R/IH, III-R/IH, IV-R/IA)

5. An internal medicine physician; (I-R/PA, II-R/PA, III-R/PA)

6. A diagnostic radiologist; and (I-R/IA, II-R/IA, III-R/IA, IV-R/PA)

7. An anesthesiologist. (I-PA, II-PA)

A. Anesthesiology staffing requirements may be fulfilled by anesthesiology residents or certified registered nurse anesthetists (CRNA), or anesthesia assistants capable of assessing emergent situations in STEMI patients and of providing any indicated treatment including induction of anesthesia. When anesthesiology residents or CRNAs are used to fulfill availability requirements, the staff anesthesiologist on call will be advised and be promptly available and present for all operative interventions and emergency airway conditions. The CRNA may proceed with life preserving therapy while the anesthesiologist is in route under the direction of the cardiologist/cardiovascular surgeon, including induction of anesthesia. An anesthesiologist assistant shall practice only under the direct supervision of an anesthesiologist who is physically present or immediately available as this term is defined in section 334.400, RSMo. (I-PA, II-PA)



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

A. Airway control and ventilation equipment including:

- (I) Laryngoscopes; (I-R, II-R, III-R, IV-R)
- (II) Endotracheal tubes; (I-R, II-R, III-R, IV-R)
- (III) Bag-mask resuscitator; (I-R, II-R, III-R, IV-R)
- (IV) Sources of oxygen; and (I-R, II-R, III-R, IV-R)
- (V) Mechanical ventilator; (I-R, II-R, III-R)

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

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

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

E. All standard intravenous fluids and administration

devices including intravenous catheters and intraosseous devices; (I-R, II-R, III-R, IV-R)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

B. Oxygen source with concentration controls; (I-R, II-R)

C. Cardiac emergency cart, including medications:

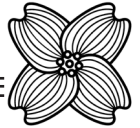
(I) External pacemaker; and (I-R, II-R)

(II) Transvenous pacemaker; (I-R, II-R)

D. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R)

E. Electronic pressure monitoring and pulse oximetry; (I-R, II-R)

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



- G. Patient weighing devices; and (I-R, II-R)
- H. Drugs, intravenous fluids, and supplies. (I-R, II-R)
- 5. The STEMI center intensive care unit shall check all equipment according to the hospital preventive maintenance schedule and document when it is checked. (I-R, II-R)
 - (C) The STEMI center shall have a cardiac catheterization lab. (I-R, II-R)
 - 1. The STEMI center cardiac catheterization lab shall have angiography with interventional capability available twenty-four (24) hours a day, seven (7) days a week. (I-R/PA, II-R/PA)
 - 2. All members of the STEMI center catheterization lab and team shall maintain core competencies annually as required by the STEMI center. (I-R, II-R)
 - 3. Resuscitation equipment shall be readily available in the STEMI center catheterization lab. (I-R, II-R)
 - 4. The following diagnostic equipment shall be readily available in the STEMI center cardiac catheterization lab:
 - A. Sheaths; (I-R, II-R)
 - B. Diagnostic wires; (I-R, II-R)
 - C. Diagnostic catheters; (I-R, II-R)
 - D. Manifold or contrast injector/delivery system; and (I-R, II-R)
 - E. Pressure tubing. (I-R, II-R)
 - 5. The following interventional equipment shall be readily available in the STEMI center cardiac catheterization lab:
 - A. Sheaths; (I-R, II-R)
 - B. Interventional guide wires; (I-R, II-R)
 - C. Interventional guide catheters; (I-R, II-R)
 - D. Balloon catheters –
 - (I) Compliant; and (I-R, II-R)
 - (II) Non-compliant; (I-R, II-R)
 - E. Stents –
 - (I) Bare metal stents; and (I-R, II-R)
 - (II) Drug eluting stents; (I-R, II-R)
 - F. Balloon pump catheters; and (I-R, II-R)
 - G. Thrombectomy aspiration catheters or mechanical thrombectomy device. (I-R, II-R)
 - 6. The following equipment shall be readily available to the STEMI center cardiac catheterization lab:
 - A. Balloon pump; (I-R, II-R)
 - B. The level I STEMI center cardiac catheterization labs shall have percutaneous or surgically implanted circulatory assist devices (i.e., left ventricular assistive device (LVAD)). It is also recommended that the level II STEMI center cardiac catheterization labs have left ventricular assistive devices; and (I-R)
 - C. Emboloic protection device. (I-R, II-R)
 - 7. The cardiac catheterization laboratory shall maintain equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is checked. (I-R, II-R)
 - (D) The STEMI center shall have an intermediate care unit (e.g., step down unit). (I-R, II-R, III-R)
 - 1. The STEMI center shall have a designated medical director for the STEMI center intermediate care unit who has access to a physician knowledgeable in STEMI care and who meets the STEMI call roster continuing medical education requirements as set forth in section (4) of this rule. (I-R, II-R, III-R)
 - 2. The STEMI center intermediate care unit shall have a physician on duty or available twenty-four (24) hours a day, seven (7) days a week who is not the emergency department physician. This physician shall have access to a physician on the STEMI call roster. (I-R/IA, II-R/IA, III-R/IA)
 - 3. The STEMI center intermediate care unit shall have registered nurses and other essential personnel on duty

- twenty-four (24) hours a day, seven (7) days a week. (I-R, II-R, III-R)
 - 4. The STEMI center intermediate care unit registered nurses shall remain current in continuing education requirements as set forth in section (4) of this rule. (I-R)
 - 5. The STEMI centers shall annually credential registered nurses that work in the intermediate care unit. (I-R, II-R, III-R)
 - 6. The STEMI center intermediate care unit shall have written care protocols for identification and treatment of STEMI patients which are available to the cardiac unit personnel, reviewed annually, and revised as needed. (I-R, II-R, III-R)
 - 7. The STEMI center intermediate care unit shall have equipment to support the care and resuscitation of the STEMI patient that includes at least the following:
 - A. Airway control and ventilation equipment including:
 - (I) Laryngoscopes, endotracheal tubes of all sizes; (I-R, II-R, III-R)
 - (II) Bag-mask resuscitator and sources of oxygen; and (I-R, II-R, III-R)
 - (III) Suction devices; and (I-R, II-R, III-R)
 - B. Telemetry, electrocardiograph, cardiac monitor, and defibrillator; (I-R, II-R, III-R)
 - C. All standard intravenous fluids and administration devices and intravenous catheters; (I-R, II-R, III-R)
 - D. Drugs and supplies necessary for emergency care. (I-R, II-R, III-R)
 - 8. The STEMI center intermediate care unit shall maintain equipment according to the STEMI center's preventive maintenance schedule and document when the equipment is checked. (I-R, II-R, III-R)
 - (E) The STEMI center shall have the following radiological and diagnostic capabilities:
 - 1. The STEMI center radiological and diagnostic capabilities shall include a mechanism for timely interpretation to aid in the management of STEMI patients; (I-R, II-R, III-R, IV-R)
 - 2. Resuscitation equipment shall be readily available in the radiology department; (I-R, II-R, III-R, IV-R)
 - 3. The STEMI center radiology department shall have adequate physician and nursing personnel available with monitoring equipment to fully support the STEMI patient and provide documentation of care during the time the patient is physically present in the radiology department and during transportation to and from the radiology department; (I-R, II-R, III-R, IV-R)
 - 4. The STEMI center radiology department shall have x-ray capability with twenty-four (24) hours a day, seven (7) days a week coverage; (I-R/IH, II-R/IH, III-R/IA, IV-R/PA)
 - 5. The STEMI center radiology department shall have a radiological technician; (I-R/IH, II-R/IH, III-R/IA, IV-R/PA)
 - 6. The STEMI center radiology department shall have in-house computerized tomography; (I-R, II-R)
 - 7. The STEMI center radiology department shall have a computerized tomography technician; and (I-R/IH, II-R/IA)
 - 8. The STEMI center shall maintain all radiology and diagnostic equipment according to the hospital's preventive maintenance schedule and document when the equipment is checked. (I-R, II-R, III-R, IV-R)
 - (F) All level I STEMI centers and level II STEMI centers with cardiothoracic surgery capability shall have operating room personnel, equipment, and procedures that meet the following requirements:
 - 1. The STEMI center operating room staff shall be available twenty-four (24) hours a day, seven (7) days a week; (I-R/PA, II-R/PA with cardiothoracic surgery capability)
 - 2. Registered nurses in the STEMI center operating room



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

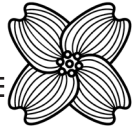
1. Level I and level II STEMI centers shall have Phase I cardiac rehabilitation on site. (I-R, II-R)

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

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

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

1. Core team members of the STEMI call roster in level I STEMI centers shall document a minimum of eight (8) hours every year of continuing education in the area of acute coronary syndrome. All other members of the STEMI call roster shall document a minimum of eight (8) hours every



year of continuing education in the area of cardiovascular disease, except for physicians who are emergency medicine board certified or board eligible through the American Board of Emergency Medicine (ABEM) or the American Osteopathic Board of Emergency Medicine (AOBEM) and who are practicing in the emergency department. This continuing education shall be reviewed by the STEMI center medical director for appropriateness to the practitioner's level of responsibility. (I-R)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

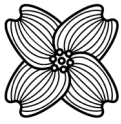
D. Number of eligible STEMI patients treated with percutaneous coronary intervention and/or thrombolytic administration; and (I-R, II-R, III-R, IV-R)

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

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

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

4. The STEMI center shall conduct a monthly review of its



pre-hospital STEMI care including inter-facility transfers. (I-R, II-R, III-R, IV-R)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

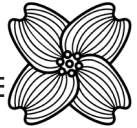
(B) Designate, and provide contact information for, an individual, plan's designee who will serve as the plan's point of contact throughout the plan's approval and administration process; and

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

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

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

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



may modify its plan according to the committee's reason(s) for non-recommendation and resubmit the plan within thirty (30) days directly to the committee.

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

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

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

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

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

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

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

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

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

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

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

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

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

(C) Lytics are thrombolytic drugs, including recombinant tissue plasminogen activator, used to dissolve clots blocking flow in a blood vessel. These lytic/thrombolytic drugs are used

in the treatment of acute ischemic stroke and acute myocardial infarction.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

2. If there are no life threatening conditions, go to step 2



below in subsection (1)(B); an.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

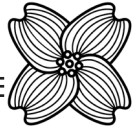
7. Communicate electrocardiogram findings to the hospital.

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

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

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

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



according to the patient's condition. Consider out-of-state transport based on local and regional process for bi-state regions.

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

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

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

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

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

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

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

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

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

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

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

2. If there are no life-threatening conditions, then assess the patient using the *2021 National Guideline for the Field Triage of Injured Patients*, which is incorporated by reference in this rule as published by the American College of Surgeons and available online at www.facs.org/quality-programs/trauma/

systems/field-triage-guidelines/ or from the American College of Surgeons, 633 N. Saint Clair St., Chicago, Illinois 60611-3295. This rule does not incorporate any subsequent amendments or additions.

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

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

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

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

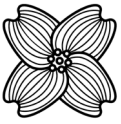
AUTHORITY: section 190.185, RSMo 2016, and sections 190.200 and 190.243, RSMo Supp. 2022. Original rule filed Nov. 21, 2022, effective June 30, 2023.*

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

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

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

PUBLISHER'S NOTE: The secretary of state has determined that the



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

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

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

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

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

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

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

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

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

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

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

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

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

B. The Social Determinants of Health Model;

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

D. Developing Cultural Competency; and

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

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

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

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

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

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

1. Name or type of course;

2. The division or module;

3. The number of hours of the course;

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

5. The date the applicant completed the course.

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

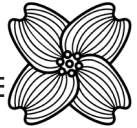
(E) An application for recertification as an EMT-CP, which is included herein, shall be submitted with the application for relicensure as an EMT-Paramedic. This application shall be submitted to the EMS Bureau either via mail to the Department of Health and Senior Services, Emergency Medical Services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

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

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

(5) Medical Director for Community Paramedic Programs.

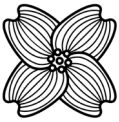
(A) In addition to the medical director duties set forth in 19 CSR 30-40.303, the medical director of an ambulance service which utilizes EMT-CPs shall approve the implementation of the community paramedic program for that ambulance service by following the requirements set forth in 19 CSR 30-40.303.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



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

(6) Community Paramedic Program.

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



MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF EMERGENCY MEDICAL SERVICES
EMT-COMMUNITY PARAMEDIC CERTIFICATION/RECERTIFICATION APPLICATION

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

EMT-P LICENSE NO. <input type="text"/>	DATE CERTIFIED OR RECERTIFIED AS EMT-COMMUNITY PARAMEDIC <input type="text"/>
EXPIRATION DATE OF EMT-P LICENSE <input type="text"/>	EMT-COMMUNITY PARAMEDIC CERTIFICATION NO. <input type="text"/>
DATE APP. REC'D. <input type="text"/>	

APPLICANT MUST COMPLETE INFORMATION BELOW TYPE OR PRINT

CURRENT MO EMT-PARAMEDIC LIC NO <input type="text"/>	CURRENT MO EMT-PARAMEDIC LICENSE NO. EXPIRATION DATE <input type="text"/>	<input type="checkbox"/> INITIAL CERTIFICATION APP. <input type="checkbox"/> RECERTIFICATION APP.
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NAME (LAST, FIRST, MIDDLE INITIAL)

SOCIAL SECURITY NUMBER	DATE OF BIRTH ____/____/____ mm dd yyyy	SEX <input type="checkbox"/> M <input type="checkbox"/> F	DAYTIME PHONE NUMBER
			E-MAIL ADDRESS

MAILING ADDRESS (STREET)

CITY	STATE	ZIP CODE	COUNTY
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NAME OF THE COLLEGE, UNIVERSITY OR EDUCATIONAL INSTITUTION WHERE YOU COMPLETED YOUR COMMUNITY PARAMEDIC CERTIFICATION PROGRAM

MAILING ADDRESS (STREET)

CITY	STATE	ZIP CODE	PHONE NUMBER
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NAME OF AMBULANCE SERVICE YOU WILL BE WORKING AS AN EMT-COMMUNITY PARAMEDIC

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

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

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

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

I HEREBY CERTIFY THAT:

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

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



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

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

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