

**WEST VIRGINIA
SECRETARY OF STATE
NATALIE E. TENNANT
ADMINISTRATIVE LAW DIVISION**

Form #3

Do Not Mark In This Box

2010 JUL 30 PM 4:11

SECRETARY OF STATE
STATE OF WEST VIRGINIA

**NOTICE OF AGENCY APPROVAL OF A PROPOSED RULE
AND
FILING WITH THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE**

AGENCY: DHHR - Bureau for Public Health TITLE NUMBER: 64

CITE AUTHORITY: WV Code §§16-1-4, 16-4C-6, 16-4C-14 and 16-4C-23.

AMENDMENT TO AN EXISTING RULE: YES NO

IF YES, SERIES NUMBER OF RULE BEING AMENDED: 48

TITLE OF RULE BEING AMENDED: EMERGENCY MEDICAL SERVICES

IF NO, SERIES NUMBER OF RULE BEING PROPOSED: _____

TITLE OF RULE BEING PROPOSED: _____

THE ABOVE PROPOSED LEGISLATIVE RULE HAVING GONE TO A PUBLIC HEARING OR A PUBLIC COMMENT PERIOD IS HEREBY APPROVED BY THE PROMULGATING AGENCY FOR FILING WITH THE SECRETARY OF STATE AND THE LEGISLATIVE RULE-MAKING REVIEW COMMITTEE FOR THEIR REVIEW.

Patricia A. Hensley
Authorized Signature

3. Explanation of above estimates (including long-range effect):

Please include any increase or decrease in fees in your estimated total revenues.

WV OEMS is estimating 1,207 certifications and 3,205 re-certifications per year. Approximately 816 of those will be for miner EMS personnel that were not previously charged. Personal services will increase in order to collect fees, process background checks, and applications. An HHR Specialist (\$46,807 annual salary and benefits) will be needed in 2011, and an additional HHR Associate will be needed upon full implementation (\$42,582 annual salary and benefits). Total Personnel expense in 2011 and upon full implementation is \$89,389.

Equipment: Electronic credential card equipment (\$25,000) and Exam administration software (\$5,000) will be required for the electronic testing and certification of Emergency Medical Service Personnel. Total Equipment \$30,000.

Current Expense: A written test will be given the first year, while the electronic testing is being established. WVOEMS will need to purchase electronic card supplies (\$6,000 on-going), exam production supplies (\$2,500 on-going). In-state travel; which includes lodging and meals to administer EMS exam within the state is estimated at \$7,000; in-state travel for EMS Agency Inspections is estimated at \$8,000. The cost of current expenses upon full implementation is \$23,500.

Other: WVOEMS estimates administering 70 exams in 2011 and 85 exams in subsequent years. WV OEMS will work with the Atlantic Council for exam development, their share of the exam cost \$9,750 per year; in state exam writing meetings will cost \$5,250 upon full implementation.

Revenues: WV OEMS estimates that 806 certifications and 1,076 re-certifications for non-miner EMS personnel could be issued each year. Certifications and re-certifications for miner EMS personnel are estimated to be 4,887. Revenue from EMS certifications and re-certifications is \$27,150 in 2011 and \$86,825 upon implementation. Vehicle license fees will be \$200, this fee was previously \$100. EMS personnel estimates that 892 vehicles will be licensed, totaling \$89,200 in additional revenue. New Agency license fees are a onetime fee of \$500; this fee was previously \$300. EMS estimates that 12 new agencies will be certified per year totaling \$3,600 in additional revenue. Agency license renewal fee is \$300; this fee was previously \$200. This fee is paid every two years and not all agencies renew at the same time, therefore half the increase in revenue was used for the calculation. EMS estimates that this will generate \$10,850 in additional revenue.

Memorandum

Please identify any areas of vagueness, technical defects, reasons the proposed rule **would not** have a fiscal impact, and/or any special issues **not** captured elsewhere on this form.

Revenue: Fees for certification of EMS personnel have been revised as a result of public comments. The fees in the original proposed rule and fiscal note were as follows: certification from \$75 to \$50; recertification from \$50 to \$25; and all miners will be certified and recertified for \$25.

Increases in vehicle and agency licensure fee were included in the proposed rule but were not included in the original fiscal note.

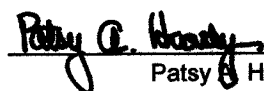
The cost of vehicle inspection has been included in this fiscal note. The activity has been paid for using general revenue funds in prior fiscal year. The Department will be charging inspection activity to the fee account thus allowing the general revenue funds to support other EMS activity.

Date

Agency

Authorized Representative

Department of Health and Human Resources



Patsy C. Hardy
Cabinet Secretary

Legislative Rule, 64CSR48
Emergency Medical Services
Department of Health and Human Resources
Bureau for Public Health
State Trauma and Emergency Medical Services

BRIEF SUMMARY

The proposed rule is a major revision of the existing EMS rule to comply with the requirements of HB 4143, passed in the 2010 legislative session. The bill re-wrote significant portions of Article 4C in the Public Health Chapter 16 governing all aspects of Emergency Medical Services code. The bill gave very specific direction about what the contents of the revised rule must include. The rule is reorganized and through the promulgation of this rule, the Bureau is also seeking the repeal of two legislative rules that will be superseded by the enactment of this rule. Those two rules are: 64CSR29, Specialized Multipatient Medical Transport and 64CSR44, Fire Department Rapid Respond Services Licensure. The amended rule for all Emergency Medical services and vehicles will cover the entirety of the subject of the two rules.

STATEMENT OF CIRCUMSTANCES

The West Virginia legislature has addressed concerns about the state Emergency Medical Services code by enacting a substantial revision of that article in 2010. This rule has been written in response to the statutory changes.

QUESTIONNAIRE

(Please include a copy of this form with each filing of your rule: Notice of Public Hearing or Comment Period; Proposed Rule, and if needed, Emergency and Modified Rule.)

DATE: July 30, 2010

TO: LEGISLATIVE RULE-MAKING REVIEW COMMITTEE

FROM: (Agency Name, Address & Phone No.) DHHR - Bureau for Public Health
350 Capitol Street, Room 702
Charleston, WV 25301
304 558-2971

LEGISLATIVE RULE TITLE: _____
EMERGENCY MEDICAL SERVICES 64CSR48

1. Authorizing statute(s) citation _____
WV Code §§ 16-1-4, 16-4C-6, 16-4C-14 and 16-4C-23.

2. a. Date filed in State Register with Notice of Hearing or Public Comment Period:
June 29, 2010

b. What other notice, including advertising, did you give of the hearing?

c. Date of ~~Public Hearing(s)~~ or Public Comment Period ended:
July 29, 2010

d. Attach list of persons who appeared at hearing, comments received, amendments, reasons for amendments.

Attached X No comments received _____

e. Date you filed in State Register the agency approved proposed Legislative Rule following public hearing: (be exact)

f. **Name, title, address and phone/fax/e-mail numbers** of agency person(s) to receive all written correspondence regarding this rule: (Please type)

Ann Goldberg, Director
Public Health Regulations
Bureau for Public Health
350 Capitol Street, Rm 702
Charleston, WV 25301
304 558-2971 phone
304 558-1035 fax
ann.a.goldberg@wv.gov

g. **IF DIFFERENT FROM ITEM 'f', please give Name, title, address and phone number(s)** of agency person(s) who wrote and/or has responsibility for the contents of this rule: (Please type)

Drema Mace, Office Director
State Trauma and Emergency Medical Services System
Bureau for Public Health
350 Capitol Street, 4th Floor
Charleston, WV 25301
304 558 7120 phone
304 558-8379 fax
drema.g.mace@wv.gov

3. If the statute under which you promulgated the submitted rules requires certain findings and determinations to be made as a condition precedent to their promulgation:

a. Give the date upon which you filed in the State Register a notice of the time and place of a hearing for the taking of evidence and a general description of the issues to be decided.

n/a

b. Date of hearing or comment period:

From June 29th to July 29th 2010 .

c. On what date did you file in the State Register the findings and determinations required together with the reasons therefor?

n/a

d. Attach findings and determinations and reasons:

Attached n/a

**PUBLIC COMMENTS AND DEPARTMENT RESPONSES
LEGISLATIVE RULE, 64 CSR 48
EMERGENCY MEDICAL SERVICES**

A public comment period on the proposed rule, Division of Health Legislative Rule, 64 CSR 48, was held beginning June, 2010 and ending July, 2010. There were multiple comments, which are summarized below, and the Department's responses are detailed. Some changes and revisions to this rule were necessitated by these comments.

Comment: Section 3.2.c. I understand the need for a PCR to an emergency room when delivering a patient so as to document pre-hospital care of a patient. Please explain the value of a completed detailed report with 72 hours. What other information, other than billing, mileage, and ambulance vehicle identification would be on this detailed report that is not already on the PCR? How are we intended to submit these full reports to hospitals?

Response: The patient handoff report, provided to the facility at the time of service is to ensure continuity of care. Per section 3.2.c. of the proposed rule, the electronic record is the "official record of the EMS incident." Several methods of providing electronic patient care reports to hospitals are being piloted within the EMS Data System. A broader initiative of electronic patient record sharing between all types of medical providers, including EMS, is being established statewide.

Comment: 4.1 – EMS agencies will be evaluated according to this rule. Does this mean this will become part of the licensure process?

Response: This is the same requirement as in the current rule. This statement simply refers to the fact that pertinent sections of the rule, specifically section 4, describe the licensure process.

Comment: 4.4 – display of license at each agency station.

Response: There appears to be no suggested changes to the proposed rule contained in this comment. However the intent of the proposed rule is to have a copy of the agency license at each station.

Comment: 4.4.i.1 – What is the intent here to single out fire departments from EMS units? I don't understand.

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Response: This section includes the existing fire department EMS rapid response rule, 64CSR44, within the overall proposed rule rather than leaving it as a free-standing rule.

Comment: 4.6.b. – EMS agencies seeking to make changes must do so prior to making the change.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 4.6.c – changes to management, medical director, or training officer of EMS agencies must submit a revised application within 10 days. Does this also mean another \$100 fee?

Response: Section 4.37.d. of the proposed rule provides that “changes of principal official, medical director, training officer, postal address or other contact information shall be exempt” from the \$100.00 fee.

Comment: 4.10.f – station identification – What method will be acceptable in identifying different stations?

Response: The proposed rule does not specify a method. This will be addressed in policy if the rule is approved.

Comment: 4.12. – records must be maintained for 7 years. Following this time period can I assume we can shred records?

Response: The proposed rule places a lower limit on records retention for regulatory purposes. Following the mandatory seven (7) year period the decision to eliminate records and the manner of disposal rests with the individual agency.

Comment: 4.20. – breakdown of licensure points. Is this a change to current licensure points?

Response: Yes, the standards and point values are different in this section

Comment: 4.22.a. – rapid response – is this like our current squad members who are EMT's that first respond to calls or does it mean something different?

Response: Per the proposed rule, "This may be provided by the EMS agency or by written agreement with licensed Rapid Response agencies." It can be your own personnel or those of a separate agency.

Comment: 4.28.b.1 – A full financial audit as compared to (4.28.b.2) a financial review. Does this mean if we only have a review and not an actual audit, we would lose points on our licensure? In long ago years when we have had a CPA firm conduct a "review" instead of when the state auditor's office conducts an audit, explain please.

Response: The proposed rule does have a different point value for a full financial audit or quarterly articulated financial statements provided by an independent accounting firm, ten (10) points as opposed to a financial review conducted by an independent entity five (5) points.

Comment: 4.29.a & b. – is this new? If not, how do we obtain our points from this section now?

Response: These are essentially the same requirements as in the current EMS rule. The proposed rule includes a higher degree of specificity and the point values are increased from three (3) to five (5).

Comment: 4.34.a. – does this mean the state is doing away with the "superior" rating and the 2 year, no test required for paramedics, issue if the agency scores in a "superior" rating? Please explain!

Response: The proposed rule replaces the current "Superior" rating with an "A" rating. Section 6.6 for the proposed rule changes all personnel certification periods to two (2) years regardless of agency rating.

Comment: 5.1.k.1 thru 5.1.k.4. – Does this only apply to all new vehicles purchased on or after 01/01/2012?

Response: Yes, section 5.1.k.1. states that marking requirements apply to "all ground ambulances purchased on or after January 1, 2012."

Comment: 6.3.f. – does this mean we have to begin having federal and state criminal background checks, etc. on all of our personnel even to recertify?

Response: Yes.

Comment: 6.4. – will this section now require even EVOC drivers to recertify and pay a recertification fee?

Response: Yes. Section 6.7 of the proposed rule establishes standards for a new level of certification, Emergency Medical Vehicle Operator, as directed by the legislature in H.B. 4143 passed March 13, 2010.

Comment: 6.6. – does this mean that all certifications, including EVOC drivers, will now be certified for only 2 years?

Response: Yes.

Comment: 6.7. – Is this new criteria for EVOC drivers that includes CPR, first aide, background checks?

Response: Yes, section 6.7 of the proposed rule establishes standards for a new level of certification, Emergency Medical Vehicle Operator, as directed by the legislature in H.B. 4143 passed March 13, 2010.

Comment: 6.9. – this section deals with all fees attached to various EMS positions, EXECPT, general paramedics. Is this an oversight?

Response: This is a typographical error. Section 6.9, line 3 is missing a comma between Paramedic and Mobile Critical Care Paramedic. This will be corrected in the final proposed rule. Paramedics are included in the fee schedule.

Comment: 2.44: The rule states that STEMS is an office in the Bureau of which OEMS is a component part.

I feel this is reversed. OEMS should be the governing body of which STEMS and all other aspects of EMS are a component part.

Response: The Bureau for Public Health has chosen the STEMS organizational structure to meet internal management needs.

Comment: 3.1.a.2 Establishes the minimum level of service required within the service area and ensures the established level of care is available to all citizens within that service area 24 hours per day and 365 days per year.

3.1.a.3.A. Dispatch, coordination and oversight of all agencies and personnel operating within the local EMS System

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The County Commission is responsible for ensuring that there is EMS and I would think they should ensure that it is available and adequate.

Response: The proposed rule does just what this comment suggests.

Comment: 3.1.c.1. Affiliation shall be evidenced by a contract, franchise agreement or other written documentation.

Any entity in the County should be bound by a contract to be recognized and accountable.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 3.1.d. Local EMS Systems shall designate an official contact person which shall be the primary contact for OEMS in all matters relating to the local EMS System.

Why would you not provide OEMS with a specific contact person?

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 3.2.b. EMS agencies shall collect, maintain and report accurate patient data for all EMS incidents. Agencies shall complete a patient care report (PCR) for all EMS incidents. PCRs shall be complete and submitted to the West Virginia Prehospital Information System (PreMIS) following the conclusion of providing EMS services to a patient, provided that within two (2) years of the effective date of this rule, such submission shall be completed within twenty-four (24) hours with ninety-five percent (95%) reliability.

This rule is unrealistic to large and small companies. In a large company there are too many calls to QA/QI in 24 hours, in a small company there is not enough manpower to QA/QI in 24 hours and many lack the ability to have internet access in a timely manner.

Response: It is understood that this requirement presents challenges to EMS agencies. The date of implementation of this section is delayed for two (2) years so that we may evaluate progress toward this goal.

Comment: 3.2.c. When an ambulance transports a patient to a medical facility's emergency room or department, a minimum written patient handoff report, as specified

by OEMS, shall be provided to the facility prior to departing. Within seventy-two (72) hours of the conclusion of providing EMS services to a patient, the EMS agency shall make a copy of the complete PCR available to the receiving facility, either electronically or written, which shall serve as the official record of the EMS incident.

Our goal is paperless. The medical facility should be responsible for accepting a wireless electronic transmission if they so desire prior to departure. A handwritten handoff may result in incomplete data between the initial report and final report. I suggest omission of the highlighted section and the addition of "per request".

Response: Section 3.2.b. of the proposed rule sets the goal of electronic submission of EMS patient records as the rule rather than the exception. The requirement for a patient handoff report is insure that minimal patient information is provided by EMS prior to departing. The exchange of electronic information, which is written, is not precluded. The proposed rule does not require a "handwritten" document. There was no change in the final proposed rule based on this comment.

Comment: 4.28.a. Budget - EMS agency has an approved, written operating and capital expenditures budget which includes projected income and expenses, actual income expenses, and an accounting of budget variances. Budget reports are provided quarterly, at a minimum, to the agency governing body or ownership, management personnel and other significant stakeholders. Five (5) points.

I think we need to continue to require financial stability of all agencies, private or public.

Response: This section of the proposed rule strengthens the ability of OEMS to determine financial stability through more specific, financially appropriate documentation.

Comment: 4.9.a. Fire department rapid response agency inspection:

4.9.a.1. The Official Representative of the agency, as indicated on the application, shall verify the applicant's compliance with the requirements of this rule and sign and attest to compliance before a notary public.

4.9.a.2. The commissioner may make inspections of all places of operation of an existing or proposed fire department rapid response service for compliance with this rule. The inspections shall be in addition to other federal, state, or local inspections required by law.

4.9.a.2.A. The commissioner may inspect all places of operations of an EMS agency or proposed EMS agency, at any time, for compliance with this rule. Such inspections shall be in addition to other federal, state or local inspections required by law. Inspections

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shall include all places of operations and all records of the EMS agency or proposed EMS agency. The commissioner may inspect, but not copy or maintain, records of a protected status.

4.9.a.2.B. Inspections shall be conducted at no cost to the applicant.

I have major concerns with requiring "Volunteer" Fire Departments to maintain a status comparative to a license EMS/Fire agency. They volunteer to assist and are already low on manpower and funds. I feel that adding additional requirements will result in loss of their services due to a lack manpower and lack of funds. In the rural setting they may be the only person the patient has contact with for an extended period of time. I think we should reward their efforts not by decreasing the standard of care expected, but by limiting the cost of providing that care as much as possible.

Response: The referenced sections are from current legislative rule 64 CSR 44, which, rather than standing alone, have been incorporated in the proposed rule. The proposed rule mirrors existing fire department EMS rapid response requirements, thus no negative impact is anticipated.

Comment: 4.10.f. Station Identification – All stations shall be identified by a sign in front of the station displaying the name of the agency, business telephone number and emergency telephone number.

Omission of the highlighted section. Adding the business number for that station may result in a lapse of time for patient care. A patient may call the business line prior to calling 911. As we know, minutes matter. We went to a unified number "9-1-1" to decrease confusion. This would be regression in my opinion.

Response: The suggested change was made in the final proposed rule.

Comment: 4.21.a.1. The medical director has a written contract with the EMS agency outlining duties and responsibilities and is actively involved with the agency through direct participation in activities, included, but not limited to: oversight of the training, skills maintenance and recertification; equipment selection; clinical performance evaluation and the performance improvement process as evidenced by documented attendance at quarterly, or more frequent, meetings with the agency officials and personnel. Ten (10) points.

I think this is an aspect of individual agency accountability. To decrease it to "medical, ethical and moral standard oversight and regular reviews", as suggested by the Advisory Council draft, is lowering our expectation of care and accountability. We should utilize the medical director for medical direction.

Response: The proposed rule establishes greater accountability for agency medical directors through more as compared to the current rule.

Comment: 4.22. Rapid Response.

4.22.a. The EMS Agency has a formal rapid response program which routinely places trained and equipped personnel on scene of potential life-threatening emergencies prior to the arrival of an ambulance. This may be provided by the EMS agency or by written agreement with licensed Rapid Response agencies. Five (5) points; or

4.22.b. The EMS agency has formalized rapid response capabilities provided irregularly, or not available in all parts of the service area. Two (2) points.

Definitely an omit. Many Fire Departments are not able to provide rapid response and the EMS agency should not be evaluated on their ability. I believe we will see more VFD's gracefully bowing out as we add additional restrictions to them as well.

Response: The proposed rule is less restrictive than the current rule regarding who or how rapid response services may be delivered; thus, no negative impact is anticipated.

Comment: 4.28.c. Financial Responsibility – The EMS agency has formally designated individual(s) with financial responsibility. Individual(s) with financial responsibility shall be appropriately insured or bonded. Five (5) points.

Insured or bonded should be a must. There have been too many financial issues through the years with many different agencies of variant sizes to reduce this expectation. My agency nearly dissolved because they did not carry this with prior administration.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 4.37.c. Yearly EMS vehicle permit, two hundred dollars (\$200.00) per vehicle provided that non-transporting vehicles shall be exempt.

I think the increase in cost should be absorbed by the agency rather than individuals. Increasing the cost per vehicle will increase revenue needed by OEMS and we should decrease the certification to \$50.00 for initial and \$25.00 for recertification because many EMS providers still do this as volunteers and those fees are not covered for them.

Response: Section 4.37.c. of the proposed rule applies only to licensed EMS transport vehicles, i.e.: ambulances, vans, helicopters, etc. These vehicles are owned by EMS agencies and not individuals. The vehicle permit fee does not apply to personal or agency-owned non-transporting vehicles.

A portion of this comment concerns individual certification and recertification fees. The referenced fees were established by the legislature two sessions ago. Fees include background checks, examination management and administrative expenses. A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 5.1.i. through 5.1.k.1.E.

We should follow current NIOSH, OSHA and other federal mandates.

Response: The science of rear ambulance passenger restraint is a work in progress and no functional standard exists. The science of emergency vehicle safety markings is a work in progress. The proposed rule combines the most current recommendations from various sources related to improved vehicle safety markings. The standard applies only vehicles purchased on or after January 1, 2012. There was no change in the final proposed rule based on this comment.

Comment: 5.1.k.3. An EMS vehicle may only be lettered with the terms "Paramedic", "Advanced Life Support", "Critical Care Transport" or similar service-level designations when the vehicle is both equipped and staffed by appropriately certified EMS personnel.

Agreed. I too will need to correct some lettering but I think otherwise we are sending a false message.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 5.3.b. Staffing requirements are dependent upon the level of service being provided on a particular EMS incident as specified in the Medical Direction system policy, protocols and scope of practice and shall be onboard at all times during patient treatment and transport:

5.3.b.1. Basic life support – at a minimum a certified EMVO and EMT;

5.3.b.2. Advanced life support – at a minimum a certified EMVO and ACT or Paramedic, provided that individual protocols may specify alternative staffing as specified by the OEMS Medical Direction System.

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I think we should add: may only be "scheduled" with and EMVO etc. During emergencies requiring assistance or in situations such as a second out call when no trucks are available, firefighters often drive for ambulance. I defiantly think this is better than no ambulance at all. All the random firefighters that assist EMS are not going to be certified as an EMVO, thus this would leave EMS unable to have a second crew at times or unable to obtain assistance when needed. I think this definitely would negatively impact patient care.

Response: The proposed rule sets a minimum standard crew compliment required for the provision of patient care at specific levels. It does not preclude the addition of personnel to the minimum crew compliment if a specific patient's condition warrants; thus, no negative impact is anticipated.

Comment: 6.2.c. EMS personnel shall not be impaired by legal or illegal drugs or intoxicating substances while on duty, when responding to or operating at EMS incidents, and when engaged in any patient care activities.

The debate seems to be over the word "legal" but I believe the important word is "impaired". Yes, you may take legal drugs as long as they are appropriately prescribed and you are not "impaired". I do not believe you are legally allowed to drive a car if you are "impaired" via legal or illegal drugs.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 6.2.g. EMS personnel shall not alter or change the appearance or wording of any license, permit, certificate, endorsement, designation, patient care record, or other official documents for the purpose of fraud, deceit, forgery or other deliberate misrepresentation or falsification of information.

I have no understand why they want to remove "patient care record". My interpretation is that you may make corrections but you cannot falsify. I would concur with this rule.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 6.4.g. Complete refresher and continuing medical education as prescribed by the commissioner appropriate for the level of certification;

6.4.h. Demonstrate continued competency via one of the following methods:

6.4.h.1. Maintain continuous National Registry certification if applicable, or

6.4.h.2. Successfully complete any state cognitive and skills examinations prescribed by the commissioner appropriate for the level of certification.

6.4.i. Meet other requirements as may be established by the commissioner.

The ongoing recertification process is redundant compared to other medical fields. We should determine what hours we want to see each year and proof of those hours and the fee should be submitted for recertification. Competency should be based upon the squad – if they are rated as an A or B squad, no competency testing because their training department would have proven their efficiency in training.

Response: The proposed rule does not use agency licensing rating in any way to determine EMS personnel recertification methodology. The intent is to allow for a variety of methods based upon individual or agency needs. Section 6.4.h.2. allows examinations as necessary but does not require “written and practical exams” as in the current rule.

Comment: 6.7.a.10. Shall not have been convicted of driving under the influence of alcohol or drugs, reckless driving or other vehicular violation causing bodily injury or death within the two (2) years prior to submitting an application;

I believe speeding can qualify as “reckless driving”, I’m not sure we need to specify that.

Response: West Virginia Code Section 17C-5-3 defines the term “reckless driving” as “willful or wanton disregard for the safety of persons or property” in West Virginia Code Section 17C-5-3. “Speeding” is exceeding any posted speed limit by any amount. It is the intent of the proposed rule to protect the public from EMS vehicle drivers who have demonstrated willful and wanton behavior as opposed most of the public who may commit minor traffic violations.

Comment: 6.9.b. Initial certification via stat examination, if available, includes fingerprint processing: \$75.00;

6.9d. Recertification via state only process: \$50.00

I agree with certification fees but I think we should decrease them to initial \$50 and recert \$25. The additional funds needed should come from the agency by increasing the ambulance rate to \$200. For most people \$25 isn’t much but to many people it is a lot, especially when they are not being paid for the service they are providing.

Response: The referenced fees were established by the legislature two sessions ago. Fees are all inclusive of background checks, examination management and

administrative expenses. A revised fee schedule addressing the spirit of the comment was incorporated in the final proposed rule.

Comment: 7.2.g. Failure to report to OEMS, within ten (10) days any arrest, misdemeanor or felony conviction, or revocation, suspension or other disciplinary sanction of a certificate or other authorization to practice any health care profession or occupation in any state for all EMS personnel affiliated with any agency.

I think misdemeanor with the addition of "other than a traffic violation".

Response: The intent of this section is to require reporting of any criminal offense, whether or not it would lead to action being taken against the individual by the state. There are a variety of misdemeanor offenses, beside traffic violations, which also do not pose a threat to the public. It is beyond the scope of the proposed rule to address every conceivable exemption to the reporting requirement.

Comment: 8.2.c.2. Program Director – The program director shall have a Bachelors Degree in a related field and at least three (3) years of experience in education administration and three (3) years of experience in ALS patient care. Responsibilities of the program director include:

I would like to see Associate's Degree instead of Bachelors. Bachelors is great but I think associates opens the door to more people.

Response: There is no Section 8.2.c.2. in the proposed rule.

Comment: 9.1.e.2.C. Grant, restrict or deny privileges for EMS personnel practice within the agency/county;

9.1.e.3. Authority – The Agency Medical Director may resist or deny privileges of EMS personnel affiliated with the agency/county at any time in order to assure quality patient care. This restriction of privileges shall be according to guidelines established by OEMS.

Combine the two by adding deny under Authority.

Response: Section 9.1.e.2.C. of the proposed rule describes the general responsibilities of agency medical directors. Section 9.1.e.3. specifically grants legislative authority to the medical director for emergent restriction of practice.

Comment: 7-15-4 Duty of county commissions to provide emergency ambulance service.

I am in agreement to add "or through private enterprise" as suggested by the Advisory Council, however, I am adamantly opposed to no contracting. The reality is that as a private business owner you could potentially put a station in the busiest area of a county and take some of those calls, thus reducing the funds to the county agency. The county agencies depend on the revenue from their busy area to compensate for the areas that need service but have low call volume. As a private for profit agency it is thought that the primary concern is not coverage for all of the patients, but company profit. Contracting will require coverage to all patients regardless of revenue. This is our goal in EMS.

Response: There is no Section "7-15-4" in the proposed rule.

Comment: I do agree with the removal of STEMS throughout the use of the Medical Direction System. STEMS is a branch from my understanding, not the governing body.

Response: The Bureau for Public Health has chosen the STEMS organizational structure to meet internal needs.

Comment: I concur that we should consider removing regional MCC's and possibly regional medical directors. With local, regional and state medical directors we are increasing the layers and causing repetition that I feel is not necessary with the statewide protocols. We need to simplify and refine our EMS system.

Response: If "MCC" is in reference to regional MPCCs, these will be removed from the final proposed rule. Regional medical directors will be retained in the final proposed rule; however, their responsibilities have been revised to reflect current and future needs and will be less duplicative of state or agency medical directors than in the current rule.

Comment: On the Fiscal Note for Proposed Rules in your summary you indicate that this would generate revenues of \$250,775 per year upon full implementation. This is a best guess estimate but I feel that you will find this amount to be less because in our county, which is still a volunteer organization just barely operating due to your recent changes in the past two years, we can't get new people who would like to certify as an EMT; and, we can't keep our trained people because of the electronic run sheets and the amount of time that it has added to each run that is made by each squad. Each hospital run is 50 miles+ and where it used to take 3 hours, we are not spending a

minimum of 4 hours. There are less people that are willing to donate their precious time filling out paper work. Our recent numbers are declining quickly.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: Under the explanation of the "above estimate of costs" you plan to add two positions (an office assistant II and an additional office assistant I) just to enable you to keep up with the proposals that are being submitted. If these changes aren't made, would it not be possible to save on Personnel expenses by \$31,857 for 2011.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 4.13 Insurance – Each EMS agency shall have in effect, maintain and furnish proof of errors and omissions insurance as required by WV Code 16-4C-16, and current insurance policies for all EMS vehicles operated by the agency. This will take lots of investigation to establish what that code is and if our insurance meets the specifications of that code.

Response: This is the same requirement as in the current rule. The agency currently meets this standard. There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: Non-Discrimination – EMS agencies shall maintain a written policy to prohibit the refusal of emergency response, treatment and transportation of patients to the nearest appropriate facility on EMS incidents and potentially critical illness or injury, regardless of the patient's age, sex, ethnicity or ability to pay for services. Our SOG's address this matter and again our squad is to provide services to all and all are invited to take the EMT classes and examinations.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: I notice that all levels of service are given a point value, so I assume that by adding this, it will help justify adding your positions to your office. What is wrong with the paper work that is submitted by each training officer to the state office? Why are point values now to be added because it seems as though you are trying to add work to what is already being done?

Response: Point values are in the current rule for various levels of service. There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: On 4.26.c. Personnel Screening – The EMS agency screens and selects applicants with a formal, documented, objective process. This is ridiculous!! There are not any people standing in line to become an EMT because of all the requirements. We do a door-to-door canvas of interested people; we allow people into the class that hold a current driver's license, have been finger printed, and have had no past convictions. We really don't have any type of people to discriminate against.

Response: This is essentially the same requirement as in the current EMS rule. There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: Agency fees under 4.37.a.b.c.d are as follows: original agency license application \$500; then a renewal fee for each agency licensing period of \$300; yearly EMS vehicle permit of \$200; and an agency license modification which would include a plan of improvement of \$100 which would include several changes per year. Why more cost – don't we pay enough?

Response: Since the inception of the agency licensing process, fees have been unchanged. The proposed increases partially cover the costs of inspection.

Comment: Now, under general requirements 5.1, and 5.1.a. the ground ambulances will meet applicable US Government Services Agency KKK-A-1822 specifications at the time of vehicle manufacture. Is the state going to give funds to this project because our county purchases a new ground ambulance a year? How many options will our county have to make a decision or is the state making those decisions for us now? This would need monitoring from the feds to make sure that state employees are getting any time of kick-back.

Response: This is the same requirement as in the current rule. The agency currently meets this standard. There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: I think it is wonderful that the Commissioner may initiate investigation under his or her own motion, and shall, upon the written complaint of any person, cause investigations to be conducted to determine if disciplinary action is called for and ... 16-4C-9 {7.1}, however, this is being done at the county level by representatives from each

participating rescue squad. It is good that there is some direction higher than our executive committee and the medical director.

Response: This is essentially the same requirement as in the current EMS rule. There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: The BLS Training Institutes (8.2) could be a concern for our county rescue squad depending on what the state is wanting. It seems that they would like to have the BLS/ALS training affiliated with a college or university and this is not practical for us. The closest branch college is 60 miles away; and, at the current time we use people who have been trained as an instructor and this is taken care of through RESA VIII. Grants are given in our community to independent organizations to get computers into fire departments and rescue squads. This is too late, since we had to purchase our computers, etc., to comply with new state regulations on electronic run sheets as of February, 2010. This certainly wasn't to help our agency but plans were made to use our building. That was money that could have been given directly to the fire and rescue departments to help insure their services would continue. Are you also going to look at the training rooms, because we have built a training/meeting room that has white boards, view master projector, TV, VCR for CD's and tapes, tables, air conditions, and isn't used at any other time when classes are given? Again, the control is taken from the county.

Response: This is essentially the same requirement as in the current EMS rule. There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: What is the Administrative Director in 8.2.b.2? This sounds like another job for your agency at the state level, whereas, our county training person has been setting up all class scheduling and assignment of instructors, providing and maintaining the required training equipment. The same can be said about the Lead Instructor, Visiting Instructor, and/or BLS Practical Skills Evaluator. It would mean adding additional people for positions that have been effectively done by other volunteers. Let's get real, is there anyone that does anything for free anymore? It is inevitable that there will be changes, but not everything needs to be changed, and not all changes are good.

Response: This is the same requirement as in the current rule. The Administrative Director in this section is at a BLS training institution (i.e. RESA) position, not an Office of EMS position. There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 5.4. Air Ambulance. – There shall be two (2) categories, one (1) for rotary wing aircraft and one (1) for fixed wing aircraft. Both categories of aircraft shall be licensed by the Federal Aviation Administration and comply with appropriate Federal Aviation Regulations (FAR). Any EMS agency engaging in air ambulance service under these regulations shall be a certified air carrier under appropriate FARs.

(5.4.) Air Evac would recommend including the language: “shall be a Federal Aviation Administration Part 135 Air Carrier Certificate holder”. Replacing “be a certified air carrier under appropriate FARs”.

Response: The suggested change will be made in the final proposed rule.

Comment: 5.4.a. Rotary Winged Aircraft.

5.4.a.1. An EMS rotary winged aircraft is primarily intended for response to the location of an EMS incident and for transportation of patients.

(5.4.a.) Air Evac would recommend removing the word “primarily”.

Response: The suggested change will be made in the final proposed rule.

Comment: 5.4.a.2. The aircraft patient compartment shall provide sufficient space to accommodate at least two (2) medical crew members and at least one (1) stretcher patient and have adequate room for medical equipment and supplies.

5.4.a.3. The cockpit shall accommodate safe operation of the aircraft by the pilot-in-command.

5.4.a.4. Door openings shall permit safe loading and unloading of a patient occupying a stretcher.

5.4.a.5. The patient compartment shall be large enough to allow access to the patient while in flight by at least two (2) medical crew members,

5.4.a.6. A visible warning device may be installed on the underside of the aircraft to provide adequate day and night emergency warning. An audible warning device may be installed to provide adequate emergency warning and external voice communications.

(5.4.a.6.) This section is clearly within the FAA’s regulatory requirements concerning aircraft warning markings under the FARs. An audible warning device, while an

excellent suggestion, is not a FAA requirement under aircraft equipment and should not be included.

Response: Section 5.4.a.6. of the proposed rule does not *require* either a visible or audible warning device. This section only allows the use of a “red light and siren” if the agency desires.

Comment: 5.4.a.7. The aircraft shall be equipped with a remote-controlled search light.

5.4.a.8. Patient area lighting shall not interfere with the safe operation of the aircraft.

5.4.a.9. The aircraft shall be equipped with a light that illuminates the tail rotor area. The device may be a Tel-Tailor equivalent.

(5.4.a.9.) Air Evac has no objection; however, we do not recommend using references to specific devices.

Response: Sections 5.4.a.7. and 5.4.a.9. will be removed from the final proposed rule.

Comment: 5.4.a.10. The aircraft shall have communications equipment which provides voice communications between the aircraft and its base of operation, between the aircraft and other EMS aircraft of the same EMS agency for which this requirement applies and between the aircraft and a WV Medical Command Center. The communications equipment shall be operational and compatible with the EMS communications system and comply with state and federal rules, regulations, policies and protocols.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Air Evac would recommend revisions to Section 5.5.

Comment: 5.5. An EMS Agency may use EMS rotary winged aircraft for the delivery of basic or advanced life support or critical care transport. The equipment supplies, and staffing required are dependent upon the level of service being provided on a particular EMS incident as specified by the Medical Direction System policy, protocols, guidelines and scope of practice.

(5.5.) Air Evac would recommend that all rotary winged aircraft must be licensed at the critical care transport level. Varying levels of licensure complicates and slows down the

dispatch process in determining the closest appropriate aircraft. Maintaining all aircraft to the critical care transport standard in licensure will ensure consistency of the quality of patient care.

Response: The suggested change will be made in the final proposed rule.

Comment: 5.5.a. Staffing requirements are determined by the level of service being provided on a particular EMS incident as specified by the Medical Direction System policy, protocols and scope of practice. The following shall be onboard at all times during patient treatment and transport:

(5.5.a.) Air Evac recommends that all rotary winged aircraft be required to obtain and maintain licensure at the critical care transport level, and then here, the language would need to reflect the change.

Response: The suggested change will be made in the final proposed rule.

Comment: 5.5.a.1. Advanced life support – minimum of a pilot-in-command and a Paramedic, provided that individual protocols may specify alternate staffing as specified by the OEMS Medical Direction System;

(5.5.a.1.) Air Evac recommends that all rotary winged aircraft be required to obtain and maintain licensure at the critical care transport level, therefore, we recommend deleting 5.5.a.1.

Response: The suggested change will be made in the final proposed rule.

Comment: 5.5.a.2. Critical care transport – a minimum of a pilot-in-command and one (1) MCCP and one (1) MCCN;

(5.5.a.2.) Air Evac agrees with this rule, however, availability of critical care transport courses must improve in order for air ambulance providers to meet and maintain this requirement.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: 5.5.a.3. The minimum equipment and supplies as defined by the OEMS policy is determined by the level of service being provided on a particular EMS incident and shall be onboard at the time of response and during patient treatment and transport.

(5.5.a.3) We recommend updates to the minimum equipment and supplies list, but agree that a statement should remain in rule referencing this topic as determined by OEMS policy.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

Comment: Sections 5.3.b.3 and 5.5.a.2: Expanding minimum staffing to include two MCCN approved care providers would allow for flexibility in staffing by permitting two critical care transport registered nurses to conduct rotor wing and/or ground patient transports. This is presently permitted, but would not be permitted under the proposed revision. It is my position that critical care transport agencies should be given the flexibility to primarily staff vehicles with either a nurse/paramedic or nurse/nurse team, providing that both primary clinicians are trained to West Virginia critical care transport provider standards. This change would not preclude paramedic/paramedic teams from conducting class two critical care transports as permitted in the existing and revised rule.

Response: The proposal sets the minimum standard crew compliment required for the provision of patient care at the class 1 CCT level. It does not preclude a crew compliment of two (2) MCCNs.

Comment: Sections 5.3.b.3 and 5.5.a.2: Many of Cabell Huntington Hospital's critical care rotor wing and ground transports are for interfacility neonatal, pediatric or high-risk obstetric intensive care patients. Staffing for these transports presently consists of one MCCN or MCCP and one specifically trained transport nurse from neonatal, pediatric or high-risk obstetric intensive care units. Under present critical care transport standards, these transports are conducted under the class zero category. This does not appear to be possible under the revised rule. Removing the ability to maintain our present crew configuration would impede the use of critical care rotor wing and ground transport resources from the continuum of care for the vulnerable pediatric and high-risk obstetric patient population. I believe that each of you would agree that is problematic at best.

Response: The suggested change to address specialty medical personnel in addition to one MCCP or MCCN will be made in the final proposed rule.

Comment: 2.4. Agency/County Medical Director

This section needs a technical correction. The role of an agency medical director is established in subsection 9.1.e not 9.1.c as drafted.

Response: The correction was made in the final proposed rule.

Comment: 2.5 Basic Life Support (BLS)

The West Virginia EMS Coalition is extremely concerned with the inclusion of the word "invasive" within the definition of Basic Life Support. The Centers for Medicare and Medicaid Services (CMS) has established stringent guidelines which include the invasive skill of establishment of IV access as a BLS skill. However, as it stands currently in the State of West Virginia, only advanced practice EMT-I and Paramedics may perform this skill. Our concern is that by adding the work invasive to the BLS definition, it could cloud the previous opinion of CMS and reduce payments to the state squads. This reduction would be approximately \$44.72 per occurrence. This would only be exacerbated by the increase cost of performing an IV start on such calls.

We would strongly encourage revising the definition of Basic Life Support to more closely reflect the definition contained in the current rule while making any necessary updates to the levels of personnel.

A basic level of out-of-hospital and interfacility emergency medical services provided when a patient requires BLS services or continual medical supervision. Basic life support can be performed by ALS personnel as well as an EMT, EMR or as stated in this rule.

Response: A revised definition of BLS, incorporating the concepts of the comment, was made in the final proposed rule.

Comment: 2.8. Communications Center

The definition of a communications center should be amended to include an EMS agency dispatch center. The revised section should read:

A facility that receives calls for emergency assistance and dispatches the appropriate responders to EMS incidents for a particular geographic area. These facilities include, but are not limited to; 911 centers, an EMS agency dispatch center, stand alone dispatch centers and other public safety answering points.

Response: The term "stand alone dispatch center" includes those operated by and EMS agency.

Comment: 2.29. Medical Policy and Care Committee (MPCC)

Department of Health and Human Resources
Bureau for Public Health, STEMS
Emergency Medical Services
64CSR48

We have previously recommended removing the regional MPCC. The regional MPCC do not exist in most regions of the state as they no longer serve a critical function with the adoption of statewide protocols. Even without a regional EMPCC, there is nothing to prevent the Regional Medical Director from consulting with agency/county medical directors on medical issues without the formal recognition of a regional MPCC.

This version of the rule supports this recommendation by removing the regional MPCC from the definition of Medical Policy and Care Committee. However, the regional MPCC is still contained in the rule in 9.1.d. The rule should be made consistent either by including regional MPCC in the definition section or removing regional EMPCCs from all sections of the rule.

Response: All references to regional MPCCs was struck from the final proposed rule.

Comment: 2.34.On-Line Medical Direction

On-line medical direction is given based on both OEMS guidelines and protocols. The definition should be amended to reflect the inclusion of protocols.

The medical direction given by an approved Medical Command Center to EMS personnel at the time of an EMS incident, by voice or other means, as established by OEMS protocol or guidelines.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 2.40. Protocol

The word "emergency" has been removed from the MPCC in other section of the code and should be deleted here for consistency. The definition of a protocol should recognize the scope of practice of the caregiver. The section should be amended to read;

A document developed and approved by the ~~Emergency~~ Medical Policy and Care Committee that describes the diagnostic procedures, treatment procedures, medication administration and patient care related practices that shall be completed by EMS personnel based upon the assessment of a patient and the scope of practice of the primary patient caregiver.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 3.1. Local EMS Systems

This section should include recognition of size, geography, population density and structure of the EMS delivery system in a particular county and require counties to consult with providers when standards are developed in a county.

3.1.a.3.c. Establishing, monitoring and reporting system response time standards in conjunction with the designated providers within the local EMS system with consideration given to the population density and funding availability within the geographical service area.

Response: It is the intent to allow county commissions or other legally responsible entities latitude in determining their EMS needs. The proposed rule will not be modified to define or restrict the parameters they decide to consider or with whom they consult.

Subsection 3.1.c. exempts non-public response agencies from the local EMS system. The rule does not clearly define a non-public response agency and it is unclear as to the purpose of exempting these entities.

Would a squad that doesn't respond to 911 dispatches but has contracts with nursing homes or insurance companies for non-emergency transportation qualify as a non-public response agency?

Or is it the intention of drafters to exempt industrial based squads? If so, shouldn't the industrial based squads be included within the local EMS system for purposes of the all-hazards disaster response plan as established by 3.1.a.3.D.

The West Virginia EMS Coalition feels this exemption should be removed. However if for a practical reason agencies are to be exempt from the local EMS system then the definition of a non-public response agency should included in the definition section of the rule in order to avoid unintended consequences.

3.1.c. County Commissions, statutory ambulance authorities or other legislatively established entities charged with the responsibility for providing such service shall designate those transporting and non-transporting EMS agencies which are affiliated with the local EMS system. Aeromedical agencies and ~~non-public response agencies~~ shall be exempt from this requirement.

Response: It is the intent of the proposed rule to exempt industrial-type entities from the requirements of this section because they do not provide service to the

public. A definition of non-public EMS entities, suggested by the comment, was placed in the final proposed rule.

Comment: 3.2.b EMS Data System

The 24 hour requirement for submission of PCR to PreMIS is not currently practical or achievable. Large squads participating in dozens of EMS incidents per day simply can't process the volume within this short time frame. Smaller squads often do not have the manpower necessary to meet this standard. Meeting this standard would also require some squads to work office staff on weekends and holidays. And adding manpower to process data faster simply isn't practical under the current reimbursement environment where Medicaid has not increased rates in over 10 years.

Establishing unachievable standards for data entry is particularly concerning considering the new administrative penalties including substantial fines created by this rule. A more appropriate standard would be:

3.2.b. EMS agencies shall collect, maintain and report accurate patient data for all EMS incidents. Agencies shall complete a patient care report (PCR) for all EMS incidents. EMS agencies shall make a good faith effort to ~~PCRs shall be complete~~ and submitted PCRs to the West Virginia Prehospital Information System (PreMIS) following the conclusion of providing EMS services to a patient, provided that within two (2) years of the effective date of this rule, such submission shall be completed within ~~twenty-four (24)~~ seventy-two (72) hours with ninety-five percent (95%) reliability.

Response: It is understood that this requirement presents challenges to EMS agencies. The date of implementation of this section is delayed for two (2) years so that we may evaluate progress toward this goal.

Comment: 3.2.c. EMS Data System

There remain concerns related to mandating a written patient handoff report. Written handoff reports run counter to current efforts to develop a paperless electronic records system. It also creates concerns about consistency of information if two separate documents are created at two separate times. Additionally, some squads have been instructed by some emergency departments not to supply the reports.

If written patient handoff reports are required, OEMS should establish the minimum data sets required for the reports but not prescribe the exact written patient handoff report

form to be used. This will allow agencies to provide reports that are compatible with their own electronic records systems.

~~When an ambulance transports a patient to a medical facility's emergency room or department, a minimum written patient handoff report, as specified by OEMS, shall be provided to the facility prior to departing. Within seventy-two (72) hours of the conclusion of providing EMS services to a patient, the EMS agency shall make a copy of the complete PCR available to the receiving facility, either electronically or written if requested, which shall serve as the official record of the EMS incident.~~

Response: Section 3.2.b. of the proposed rule sets the goal of electronic submission of EMS patient records as the rule rather than the exception. The requirement for a patient handoff report is to ensure that EMS provides minimal patient information prior to departing. The exchange of electronic information is not precluded by the proposed rule.

Comment: 4.4. Display of License.

Many EMS stations are not "public" places. Many sub-stations do not accommodate or provide access to the general public. As in the past Rule, the EMS License should be displayed in the headquarters of the agency.

~~The license shall be publicly displayed in all stations of the EMS agency with the original being displayed in the headquarters of the agency.~~

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.4.i.3 Exemption

The exemption found in this section from licensure should be expanded to include the provision of CPR and AED services. Consideration should be given to the fact that an AED can be accessed in the Mall or most high schools and the AED training is part of CPR training.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.5. Advertising.

While the intent of this section is appropriate, it should be further clarified so as not to prevent agencies from advertising for new employees or in support of community activities such as a charitable walk.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.10.f. Station Identification.

EMS Station signage should not have to display "911" or 'business numbers'; most EMS stations are simply locations for staging of ambulances, not independent office or business sites or places to bring patients for evaluation, i.e. med-express centers. Particularly concerning is the requirement to display a business telephone number. This appears to run counter to the stated purpose of the section as described at the EMS Advisory Council meeting. Adding the business number for a station or agency may result in a lapse of time for emergency patient care. A patient may call the business line prior to calling 911. As we know, minutes matter and promoting a business number may increase confusion and run counter to the purpose of a unified emergency "9-1-1" number.

Additionally, this section conflicts with instruction squads received from Homeland Security following 9/11. At that time, Homeland Security told squads not to discuss station location or where or how many vehicles were located at any place.

~~All stations shall be identified by a sign in front of the station displaying the name of the agency, business telephone number and emergency telephone number.~~

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.20. Level of Service.

The use of the word "all" is too restrictive and unduly punishes squads that meet this standard of care for the majority of calls. The following would be a more equitable application of the standard while maintaining the spirit of the requirement:

4.20.a. ALS staffed and equipped EMS vehicles are ~~dispatched on all~~ routinely available to respond to emergency requests for service, or; a tiered response dispatch system is dispatched based on criteria from an OEM recognized EMD program. Fifteen (15) points.

4.20.b. ALS services are available only on a part-time basis. Ten (10) points.

4.20.c. BLS services only are available. Five (5) points.

Response: The intent of Section 4.20.a. of the proposed rule is to recognize those agencies that perform at the highest level. "Routinely" cannot be readily evaluated or interpreted accurately across varying EMS agencies.

Comment: 4.21.a. Off-Line Medical Direction.

The intention of this section is to ensure the medical director is actively involved with agency. However, as drafted, this section can be interpreted to provide agency medical directors with the ability to dictate aspects of recertification, selection of equipment, etc. This would conflict with statewide protocols and guidelines established by OEMS and MPCC.

Additionally, the use of the word "attendance" may be too restrictive as agencies embrace technology and the use of teleconferencing and other electronic forms of communications.

Finally, the section should refer to medical director or directors in recognition of the use by certain squads of a physician group to provide medical direction.

4.21.a.1. The medical director(s) has a written contract with the EMS agency outlining duties and responsibilities and is actively involved with the agency through direct participation in activities, included, but not limited to; oversight of training, skills maintenance and recertification as established by OEMS and the MPCC; ~~equipment selection;~~ clinical performance evaluation—and the performance improvement process as evidenced by documented ~~attendance at~~ participation in quarterly, or more frequent, ~~meetings~~ reviews with agency officials and personnel. Ten (10) points; or

4.21.a.2. The medical director(s) has a written contract with the EMS agency outlining duties and responsibilities with minimal evidence of active involvement with the agency. Five (5) points.

Response: Portions of the suggested change were incorporated in the proposed final rule.

Comment: 4.22. Rapid Response.

Many EMS agencies find it more and more difficult to coordinate a meaningful Rapid Response program. This is primarily a service provided by volunteer fire departments. EMS agencies should not be held responsible during the licensure process if the

volunteer fire departments within their service area elect not to provide rapid response services.

~~4.22.a. The EMS agency has a formal rapid response program which routinely places trained and equipped personnel on scene of potential life-threatening emergencies prior to the arrival of an ambulance. This may be provided by the EMS agency or by written agreement with licensed Rapid Response agencies. Five (5) points; or~~

~~4.22.b. The EMS agency has formalized rapid response capabilities provided irregularly, or are not available in all parts of the service area. Two (2) points.~~

Response: Rapid response is a nationally recognized component of EMS. The intent of Section 4.22 of the proposed rule is to recognize those agencies which perform at the highest level, including assuring the provision of rapid response.

Comment: 4.27.a. Personnel Education

Smaller agencies that utilize RESA, colleges, TSN offices etc. for training and continuing education should not be penalized for offering their educational opportunities out of house.

If the agency meets the training institute policies in this rule they should receive 'credit'.

~~4.27.a.2. The EMS agency provides in-house or makes available training activities meeting all minimum recertification requirements for all EMS personnel levels within the agency. Ten (10) points; or~~

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 4.27.b. Training Officer's Program

Why is it an absolute necessity to offer training each quarter, typically summer is a difficult time to ensure student participation? As long as regular training sessions are provided that should suffice.

Squads have expressed a desire to add additional persons who are recognized by the state as STO so that we are not requiring a single training officer to be the signature for all employees. The current practice unduly stresses the system and doesn't allow any efficiency to be realized from the investment of the training course.

Smaller squads with training coordinators that make continuing education programs available "out of house" should receive some recognition. The current program is 10 points or 0 points.

4.27.b.1. The EMS agency participates fully in the state approved training officers' program with a qualified designated agency training officer or officers and completes in-house continuing education programs on a regular basis quarterly, ~~or more frequently~~. Ten (10) points.

4.27.b.2. The EMS agency participates in the state approved training officers' program with a qualified designated agency training coordinator and makes continuing education programs available to EMS personnel. Five (5) points.

Response: A revision incorporating a portion of the suggested change was incorporated in the proposed final rule.

Comment: 4.28.c. Financial Responsibility

While recognizing it's value, it is becoming increasingly difficult to find companies willing to issue the type of insurance or bonds prescribed by this section. We believe documentation of an accounting practices review or a review of internal controls by an outside CPA/accounting firm should provide an alternative method of ensuring appropriate financial controls.

4.28.c. Financial Responsibility – The EMS agency has formally designated individual(s) with financial responsibility. Individual(s) with financial responsibility shall be appropriately insured, ~~or bonded~~, or have documentation of accounting practices review or a review of internal controls by an outside CPA/accounting firm. Five (5) points.

Response: The intent of Section 4.28 of the proposed rule is to recognize those agencies which address their need for financial protection for their staff and company.

Comment: 4.32

A procedure should be formalized to allow the agency to respond to the findings of the licensure inspection and appeal those findings to the Director of OEMS or the Commissioner prior to issuing the license or the agency entering into a plan of correction. Entering into a plan of correction implies the squad acknowledges an error or problem exists which may not be the case. A disputed finding may simply be a difference in interpretation of rule between the squad and licensure inspector which could be resolved by the Director of OEMS or Commissioner prior to a plan of correction

One approach to this may be the following:

4.32. The Commissioner shall notify the EMS agency in writing of the preliminary findings of the licensure inspection and, if approved, issue an EMS agency license within sixty (60) days of receipt of application and completion of agency and vehicle inspections.

4.3 - The EMS agency shall have fifteen (15) days after receipt of the preliminary inspection findings to appeal in writing any disputed findings to the Commissioner.

4.3 - The Commissioner will review the additional information and make a final determination of EMS licensure status and, if approved, issue an EMS agency license within fifteen (15) days.

Response: A section incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 4.37.c. Yearly EMS vehicle permit.

The fiscal note submitted with this rule anticipates the total ongoing of costs to be \$190,067 annually and the revenue from personnel certifications and recertification to total over \$250,000 annually. This will result in the rule generating net surplus of over \$60,000 annually for the agency. The revenue section of the fiscal note does not include

the 100% increase in the annual vehicle permit fee from \$100 to \$200 contain in this section.

Given increased equipment and supply costs imposed on agencies over the past two years and the surplus being generated by the certification portion of this rule. We do not feel a doubling of the vehicle permit fees is justified at this time. A single agency anticipates their costs to increase by over \$9,000 annually if this increase were implemented.

Response: The referenced fees have been in effect since the inception of the agency licensing process. The proposed increases partially cover the costs of inspections.

Comment: 5.1.i. Safety belts

Safety standards regularly change and should not be prescribed by OEMS rule. We believe that current NIOSH and OSHA safety standards should dictate safety belt availability, operation and positioning.

5.1.i. Safety belts shall be available and operational for all seat positions in EMS vehicles and meet current NIOSH and OSHA safety standards. ~~no shoulder harness type restraints shall be allowed on side facing seat positions.~~

Response: The science of rear ambulance passenger restraint is a work in progress and no functional standard exists. However, there is irrefutable evidence that a shoulder harness on side-facing seating is considerably more dangerous to EMS personnel than a simple lap belt. There was no change in the final proposed rule based on this comment.

Comment: 5.1.j. Lockable Storage Compartment

This section requires all EMS vehicles to have lockable storage compartment for a medication kit and its supplies. We are unsure of the need for this section as the entire ambulance is essentially a lockable storage compartment for medication and supplies. It seems the goals of this section would be achieved by simply requiring all ambulances to have functioning locks on all doors.

Response: There was no change in the final proposed rule based on this comment.

Comment: 5.1.k. Exterior Vehicle Marking Requirements

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Exterior vehicle markings are largely dictated by the manufacturer and the ability to vary these markings is significantly influenced by national standards. Overly prescriptive state requirements add additional costs to a vehicle and equate to an unfunded mandate for squads. Additionally, exterior vehicle markings provide squads with a unique identity and a source of marketing. Provided that minimum safety standards are met, squads should have flexibility in the arrangement and composition of exterior vehicle markings. We would suggest the following:

5.1.k.1. Retro reflective vehicle markings shall be required as follows, at a minimum, on all ground ambulances purchased on or after January 1, 2012:

5.1.k.1.A. ~~Four inch (4") wide stripe~~ Reflective striping running the length of the sides of the vehicle at or below the level of the bottom of the windshield;

5.1.k.1.B. ~~Fifty percent (50%) of rear facing vertical surfaces have a forty five (45) degree down and away chevron pattern of contrasting color 6" stripes;~~ Reflective striping running across the back of the vehicle at or below the level of the bottom of the rear windows.

5.1.k.1.C. ~~Twenty five percent (25%) of the width of~~ The front of the vehicle will have reflective striping level the level of the windshield ~~a four inch (4") wide stripe;~~

5.1.k.1.D. ~~Two inch (2") wide vehicle side and rear boundary contour or edge markings; and~~

5.1.k.1.E. ~~Twelve inch (12")~~ "Star of Life" emblems on both sides and rear of the vehicle.

Response: The science of emergency vehicle safety markings is a work in progress. The proposed rule combines the most current recommendations from various sources related to improved vehicle safety markings. The standard applies only to vehicles purchased on or after January 1, 2012. There was no change in the final proposed rule based on this comment.

Comment: 5.1.k.3.

This language should be clarified to achieve its intended purpose. A strict interpretation of this requirement would prevent a CCT ambulance from being fueled or serviced without appropriately certified EMS personnel on the vehicle or would require the removal of "Critical Care Transport" from the vehicle prior to service.

5.1.k.3. An EMS vehicle may only be lettered with the terms "Paramedic", "Advanced Life Support", "Critical Care Transport" or similar service-level designations when the vehicle is licensed by the OEMS office for that level of service. ~~both equipped and staffed by appropriately certified EMS personnel.~~

Response: The intent of the proposed rule is to accurately portray the type of service the vehicle is staffed and equipped to provide. There was no change in the final proposed rule based on this comment.

Comment: 5.1.k.4

The inclusion of 911 or an alternative number on an EMS vehicle is an unnecessary mandate and should be deleted from rule. If the rule maintains this requirement then a grandfathering clause similar to that contained in 5.1.k.1 should be added to this section so that squads do not have to incur the expense of add the numbers to existing vehicles.

~~5.1.k.4. The public access emergency telephone number 9-1-1 shall be displayed on the ambulance. Specialized Multi-Patient Medical Transport (SMPMT) and non-public access EMS vehicles may display a different number.~~

Response: There was no change in the final proposed rule based on this comment.

Comment: 5.3.b

5.3.b establishes staffing requirements for levels of service. The WV EMS Coalition strongly encourages the inclusion of C3-IFT in this subsection in order to ensure that the state is meeting the requirements of service payors. The addition of the C3-IFT criteria is important for billing purposes, but beyond that C3-IFT has their own protocols, education requirements and secure exam. It should be outlined in the Rule.

C3-IFT – at a minimum a paramedic certified as a C3-IFT and an EMVO.

Response: C3-IFT was established as a scope of practice extension. There is no intent to establish it as a level of certification. There was no change in the final proposed rule based on this comment.

Comment: 5.3.b.4.

This section is one of many within the rule that created confusion by assigning

responsibility to STEMS or another division under the Commissioner which is either not recognized within 16-4C or where responsibility is assigned to another section or division with the rule and code. As an example;

In 5.3.b.4 **STEMS** dictates the equipment and level of service.

In 5.2.a **Medical Direction System** dictates the equip. & level of service

In 5.5.a.2 **OEMS Med Dir System** dictates equipment and level of service.

In 2.4, 2.18, 2.24, 2.31, 3.1.d, 4.6.a etc **OEMS** dictates functioning of EMS

In 6.2.a. EMS personnel shall comply with all applicable rules, policies and procedures implemented by the **State Emergency Medical System**

This is very confusing and has the potential to impact quality and create conflict within the Bureau. There needs to be a matrix outlining the differences in authority or simplify revert back to previous rule's drafting which assigned responsibility to either OEMS or Commissioner. These updates were drafted to help designate the EMS System's span of control.

Response: The Bureau for Public Health has chosen the **STEMS** organizational structure to meet management needs. There was no change in the final proposed rule based on this comment.

Comment: 6.2.k medical information

This section should properly reflect the HIPAA permitted uses of medical information including training.

6.2.k. EMS personnel shall abide by current HIPAA policy in regards to not disclosing medical information regarding any patient without that patient's consent, except that information required for continuation of treatment, for payment purposes or operations, including quality reviews and investigations, training, or by mandate of a legally issued subpoena or lawful court order.

Response: A revision incorporating a portion of the suggested change was incorporated in the proposed final rule.

Comment: 6.2.m

It appears the intent of this section is to require EMS personnel to have identification that reflects their certification while on duty and providing patient care. This section should be expanded to allow for EMS personnel to meet this requirement either by possessing state issue certification credentials or an agency issued identification card which includes the individuals certification credentials.

It was also discussed that the WV nurses, Ohio medics etc. all verify authorization to practice and certification by online verification. It is hoped a variant of this process can be implemented here.

EMS personnel shall possess either state issued certification credentials or an agency issued identification card which includes the individual's level of certification while on duty, when responding to or operating at EMS incidents, and when engaged in any patient care activities. Absent state or agency issued credentials or identification EMS personnel shall have a 24 hour credential verification process in place, i.e. medical command center and/or CIS verification

Response: The intent of the proposed rule is to identify certified EMS personnel to patients, the public, and other healthcare providers. An agency issued identification card does not suffice to meet the intent and neither does a remote verification process. There was no change in the final proposed rule based on this comment.

Comment: 6.2.n

The information this section requires to be reported to OEMS should also be reported to any agency with which the EMS Personnel is affiliated. Indictments should also be reported. Additionally, EMS personnel should be required to report if they have been excluded from any federal payor such as being listed on the excluded list by the Office of Inspector General.

6.2.n. EMS personnel shall report to OEMS, their agency medical director and their affiliated EMS agency(s), within ten (10) days any; arrest; indictment, misdemeanor or felony conviction, or revocation, suspension or other disciplinary sanction of a certificate or other privilege to practice any health care profession or occupation in any state or any exclusion from federal payors.

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

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Comment: 6.3.c

The word "continuously" should be removed from this section.

Response: There was no change in the final proposed rule based on this comment.

Comment: 6.3.d

This section requires technical clean-up. The last three words "in any state" should be replaced with West Virginia as the Commissioner is not responsible for issuing certification in other states.

Response: The correction was made in the final proposed rule.

Comment: 6.5 Credential Transfer Requirements

It is felt that the possibility exists that qualified MCCPs and MCCNs could seek reciprocity in the future and the ability to accommodate them is important.

6.5. Credential Transfer Requirements. -- The Commissioner may grant certification to individuals certified as an Emergency Medical Dispatcher, Emergency Medical Responder, Emergency Medical Technician, Advanced Care Technician, Paramedic, Mobile Critical Care Paramedic or Mobile Critical Care Nurse, or equivalent levels, in another U. S. state or territory provided that the individual:

Response: West Virginia has a state-specific CCT curriculum and certification process. There is no universally accepted equivalent in most states or territories. Until such time that CCT education and certification is more standardized, the suggested change will not be considered.

Comment: 6.9 Fees

6.9.d sets the fees for various types of certification and recertification. These fees as proposed are excessive and will generate an annual surplus of \$60,000 for the Office of EMS based upon the fiscal note accompanying the proposed rule. A similar licensing authority, the Board of Nursing, only charges \$25.00 for license renewal.

The West Virginia EMS Coalition is strongly opposed to the fees as currently proposed. The services being provided by OEMS are not substantially different from those

delivered at no cost prior to the code changes permitting the collection of certification and recertification fees. EMTs and paramedics should not be responsible for paying the full cost of services that were previously fully underwritten by the state.

Additionally, a significant effort has been underway within the state to boost recruitment and retention within EMS. Imposing significant new fees on EMS personnel appears to run counter to the progress made in these areas.

If these fees are implemented as proposed, squads and EMS personnel should receive assurances that the certification and recertification will be streamlined and expedited in return for the more than \$250,000 annually that will be invested in the office. And these processes should be outlined in rule. Despite the requirements established in West Virginia Code 16-4C-8(f) with the passage of HB 4143, the West Virginia EMS Coalition is told that EMS personnel are still waiting more than 15 days permitted for the issuance of their cards. As referenced above, the nursing board offers a more streamlined, expedited, on-line renewal for half the cost of the fees proposed in this rule.

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 6.12 Card or certificate replacement

This section establishes a \$25.00 fee for card or certificate replacement. Again, this fee is excessive compared to other government agencies. The board of nursing charges \$5.00 for license replacement. The Division of Natural Resources replaces lost licenses for free. The Department of Motor Vehicles charges \$5.00 for a duplicate license.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 7.2.g

Agencies should only be responsible for reporting any known arrest, misdemeanor, or felony convictions, etc. As written, an agency could be fined for not reporting these activities even if they were unaware they occurred.

7.2.g. Failure to report to OEMS, within ten (10) days any known arrest; misdemeanor or felony conviction, or revocation, suspension or other disciplinary sanction of a certificate or other authorization to practice any health care profession or occupation in any state for all EMS personnel affiliated with the agency.

Response: The suggested change was incorporated in the proposed final rule.

Comment: §64-48-8. Education. 8.1.g

OEMS recognizes CECBEMS courses for continuing education purposes. CECBEMS courses should be deemed as approved courses without a separate submission and approval from OEMS.

OEMS should allow unlimited training via the asynchronous format. Currently, CECBEMS hours are limited to ten defeating the CECBEMS approach. It shouldn't matter where a person receives the CME hours from as long as they are within the correct discipline. Improve accessibility to CME courses through asynchronous formats would greatly add to efforts to improve retention for smaller, rural squads.

8.1.g. Continuing education programs shall be submitted and approved in a manner and time frame specified by OEMS. CECBEMS (continuing education coordinating board for emergency medical services) distributive education programs shall be deemed approved without submission to OEMS. OEMS shall not limit the number of qualified hour of continuing education received through a CECBEMS distributive education program;

Response: There are multiple providers of medical continuing education approval. CECBEMS is recognized by OEMS via policy. The agency believes that mentioning a specific private entity in legislative rule is inappropriate.

Comment: Visiting Instructors

Sections 8.2.b.4, 8.3.c.6 and 8.4.c.5 need technical correction in drafting. These section could be incorrectly interpreted as stating that a visiting instructor cannot be certified in EMS or have EMS experience. An improved drafting of this section may be:

"Such faculty shall have expertise in a particular area and ~~may not be~~ are not required to be certified EMS personnel or have specific EMS experience. A visiting instructor is not eligible to be lead instructor.

Response: The suggested change was incorporated in the proposed final rule.

Comment: Facilities and Equipment

Sections 8.2.c, 8.3.d and 8.4.d should be amended to reflect non-traditional educational

course offerings.

“The institute shall maintain, or by agreement have available, facilities necessary for the provision of BLS training courses to include the asynchronous delivery of educational content.”

Response: The intent of the referenced sections of the proposed rule is to set minimum standards for training institutions. While the agency strongly encourages institutions to provide alternative educational opportunities, it is beyond the scope of the rule to require institutions that may not have the capability to do so.

Comment: 8.5 Renewal/Suspension/Revocation of Endorsement of 8.5.a.1.

While the establishment of standards for both class frequency and size is important in order to maintain quality standards, this section appears to be both difficult to achieve and vague. Would it be a requirement to offer 10 CCT classes or 10 Paramedic courses in 5 years? What is a “sufficient number of students” 10, 5, 3?

8.5.a.1. The sponsor has completed, within the five (5) year endorsement period, at least;

8.5.a.1.A ~~Ten (10)~~ Three (3) approved educational courses ~~with a sufficient number of students~~ for providers of continuing education; or

8.5.a.1.B ~~Five (5)~~ Three (3) approved educational courses ~~with a sufficient number of students~~ for providers of original certification education;

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 9.1.b. State Medical Policy and Care Committee

Subsection 9.1.b.1 outlines the duties and responsibilities of the State Medical Policy and Care Committee. These duties include the development of protocols, medical policies, scope of practice and determination of medications and procedures utilized by EMS personnel and agencies.

Changes in these protocols, policies, scope of practice, medications and procedures can have a significant financial and operational impact on squads. The West Virginia EMS Coalition strongly believes that any proposed changes to these areas of

responsibility for the SMPCC should be subject to a 30 day comment period prior to implementation. This will allow squads the opportunity to evaluate the proposed changes and provide SMPCC and STEMS with comments on the affect the change will have on patient care and agency finances.

9.1.b.2 Any changes in protocols, medication and procedures, scope of practice or policy and procedure as authorized in 9.1.b.1 shall be subject to a thirty (30) day public comment period prior to their effective date.

Response: It appears the intent of this suggestion is to allow input into changes that significantly impact EMS agencies. Merely providing a public comment period prior to implementation may not achieve the desired result. The intent of this comment is perhaps better addressed by policy rather than rule.

Comment: 9.1.c.2.N.

This section assigns the regional medical director with the responsibility to review regional plans, procedures, and processes for compliance with current standards of emergency care. With the adoption of statewide protocols and guidelines, what are regional plans and procedures? This section is antiquated.

9.1.c.2.N. Review regional plans, procedures, and processes within the region for compliance with current standards of emergency care; and

Response: The suggested change was incorporated in the proposed final rule.

Comment: 9.1.d. Regional Medical Policy and Care Committee (EMPCC).

As previously noted in a prior section, Regional EMPCCs do not exist in most regions of the state and have largely become obsolete with the adoption of statewide protocols. The rule should reflect current practice and delete the regional EMPCCs. Even without this section, nothing would prevent regional medical directors from consulting with agency/county medical directors in their region about issues of importance. If the Regional EMPCCs are not deleted then the definition should be restored in the definitions section of the rule.

~~The regional EMPCC serves as the primary advisory committee to the Regional Medical Director on all medical issues involving the regional EMS system.~~

~~9.1.d.1. Composition. The committee is composed, at a minimum, of all the agency/county medical directors in that region. At the discretion of the regional~~

~~medical director, and with approval of the EMS Medical Director, other persons may serve on this committee.~~

~~9.1.d.2. Organization. — The committee shall meet at least annually and more frequently as required to carry out its functions.~~

~~9.1.d.3. Responsibilities. — The Regional EMPCC shall:~~

~~9.1.d.3.A. Develop and review medical protocols, medications, and procedures for consideration by the State EMPCC;~~

~~9.1.d.3.B. Advise the Regional Medical Director on medical issues within the region; and~~

~~9.1.d.3.C. Perform other duties as assigned by the regional or EMS Medical~~

~~Director, or the Commissioner.~~

~~9.1.d.4. Authority — The regional EMPCC may implement procedures necessary to carry out the duties outlined in paragraph 9.1.d.3 of this rule.~~

Response: The suggested change was incorporated in the proposed final rule.

Comment: 9.1.e Agency Medical Director

This section refers to oversight by a medical director of the local EMS system. Are counties responsible for designating a local EMS system medical director? And if so, what is their role in the delivery of EMS within the local EMS system? Do they supersede the agency medical director?

9.1.e. Agency Medical Director -- The agency or ~~county~~ medical director, by written agreement with the agency, and concurrence of the regional EMS Medical Director and state EMS Medical Director, oversees medical aspects of an EMS agency or ~~local EMS system~~ and extends or restricts the privilege to practice to EMS personnel associated with the agency under the guidelines established by the Medical Direction System. or ~~local EMS system.~~

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 9.2. On-line Medical Direction.

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This section should be modified to provide future flexibility in operating the state's medical direction system. In the future, regional medical command centers may or may exist and the rule should reflect that possibility.

9.2.a. ~~Regional Medical Command Centers are centers designated by the EMS Medical Director under Medical Direction System guidelines State EMPCC, and STEMS, with advice of the respective Regional EMS Board of Directors, to serve as the regional medical command center for all on-line medical control advice and direction of to EMS personnel operating within the Medical Direction System. in a particular region. Where available Medical Command Centers within a specific region of the state will provide primary medical direction to the EMS personnel within that region.~~

9.2.a.1.A. Be equipped with appropriate communication equipment, as specified by ~~STEMS~~ the Medical Direction System, to communicate with EMS vehicles and personnel and interface with the state-wide ~~STEMS~~ communications system;

9.2.a.3.A. Serve as the authoritative medical command center facility for its primary region designated area but with the possibility of an expanded coverage area in the event of a disaster and/or the inoperability of other medical command centers;

Response: A revision incorporating a portion of the suggested change was incorporated in the proposed final rule.

Comment: 9.2.a.5. Alternative Facilities.

Again, the rule should contemplate the possibility of a medical direction system that is not regionally based. Additionally, this remains an important section of the rule for its ability to give guidance to EMS personnel when faced with abnormal situations. The authority to operate by protocol needs to be recognized by this section.

9.2.a.5. Alternative Facilities. -- ~~Regions~~ The Medical Direction System may ~~elect to have designate~~ alternate command facilities medical command centers in the event of equipment malfunction or when the primary center cannot be contacted for any reason. These backup ~~facilities~~ centers shall be approved by the EMS Medical Director and included in the ~~regional~~ Medical Direction System communication plan. In the event none of the ~~command facilities~~ medical command centers can be reached, then the receiving hospital may provide medical command direction as needed to EMS personnel for those procedures not covered by protocol or other guidelines.

Response: There was no change in the final proposed rule based on this comment.

Comment: §64-48-10. EMS Personnel in Emergency Departments.

10.1. *This section should be amended to clarify the intended purpose of the law to allow EMS personnel employed by a hospital to act in this capacity.*

EMS personnel employed by a hospital may, in the event of a life threatening emergency, perform their full scope of practice as outlined by the EMPCC, within a hospital emergency room under the direct supervision of the attending physician.

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 2.4 Agency Medical Director. The Agency Medical Director is defined in 9.1.e. not 9.1.c. as listed.

Response: The correction was made in the final proposed rule.

Comment: 2.5 Basic Life Support. EMT's should not be defined by the word "invasive." This could confuse some payers and possible reduce reimbursements fro ALS services.

Response: A revised definition of BLS, incorporating the concepts of the comment, was made in the final proposed rule.

Comment: 2.6. Communication Center. EMS agency dispatch center should be added as an acceptable facility.

Response: The term "stand alone dispatch center" includes those operated by and EMS agency.

Comment: 2.18. EMS Medical Director. We feel that "Board certified in emergency medicine" is unnecessary. It could be listed as "preferred" but should not be mandatory.

Response: The medical community strongly supports this requirement for the state EMS Medical Director; therefore the proposed rule will not be modified as suggested.

Comment: 2.29. Medical Policy and Care Committee. The MPCC should be the "primary medical policy making body. Not just the policy making body."

Response: Further on, the definition continues "... concerning medical issues involving..." This is sufficient to indicate that it is a medical policy making body.

Comment: On Line Medical Direction. The addition of "protocols" would be clearer than guidelines.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 2.40. Protocols. Protocols should recognize the scope of practice of the care provider.

Response: The suggested change was incorporated in the proposed final rule.

Comment: Regional EMS Medical Director. It is our opinion that with the creation of State Wide Protocols there is little if any need in the regional EMS concept. The Regional EMS Medical Directors have no authority over local squads and are not employed by them. The Regional concept should be eliminated and concentrate on the State and Squad Medical Director.

Response: Regional medical directors were retained in the final proposed rule, with a change in responsibilities. The changes make the role less duplicative of either the state or agency medical director.

Comment: 3.1.c. this subsection exempts "non public response agencies." This is not clear as to the intent. Also, "non-public" agencies are not defined in this rule.

Response: It is the intent of the proposed rule to exempt industrial-type entities from the requirements of this section because they do not provide service to the public. A definition of non-public EMS entities, suggested by the comment, was placed in the final proposed rule.

Comment: 3.2.b. The 24 hour requirement is not very practical. Large squads have too much volume to process and small squads do not have the manpower to comply. 72 hours is more appropriate and more obtainable.

Response: It is understood that this requirement presents challenges to EMS agencies. The date of implementation of this section is delayed for two (2) years so that we may evaluate progress toward this goal.

Comment: 3.2.c. Written handoff reports should not be required. There are consistency issues between left reports and final reports. This could cause legal issues.

Response: Section 3.2.b. of the proposed rule sets the goal of electronic submission of EMS patient records as the rule rather than the exception. The requirement for a patient handoff report is insure that minimal patient information is provided by EMS prior to departing. The exchange of electronic information is not precluded by the proposed rule.

Comment: 4.4. Display of License. Many EMS stations are not public places. Why post a copy of the license there? It would be more important to just display the original at the Headquarters of the operation.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.4.i.3. Addition of "CPR and AED" for fire departments. These are skills taught to lay rescuers and AED's are in lots of public places.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.5. Advertising. Clearer definition as to not prevent advertising to support community functions.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.10.b. Supplies. Supplies do not need to be at each station, rather made available for each class of vehicle.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 4.10.f. Station Identification. 911 or business phone number should not be posted at each station. This can cause confusion and delay the patient from calling the correct number for service.

Response: Section 4.10.f was completely struck from the final proposed rule.

Comment: 4.20.a. Delete the word "all" from this requirement and add "routinely available to respond."

Response: The intent of Section 4.20.a. of the proposed rule is to recognize those agencies which perform at the highest level. "Routinely" cannot be readily evaluated or interpreted accurately across varying EMS agencies.

Comment: 4.22.a. Rapid Response. The EMS agency should not be penalized if the local Fire Departments elect to not participate in a rapid response program.

Response: Rapid response is a nationally recognized component of EMS. The intent of Section 4.22 of the proposed rule is to recognize those agencies which perform at the highest level, including assuring the provision of rapid response.

Comment: 4.27.a. Personnel Education. EMS agencies should provide or "make available" training to its personnel.

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 4.27.b.1. Why is training each quarter required? As long as regular training occurs it should suffice.

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 4.37.c. Increasing the vehicle fees 100% is not justified. Given the increase in all operating expenses and the decrease in reimbursement this fee increase would be extremely taxing to EMS agencies.

Response: The referenced fees have been in effect since the inception of the agency licensing process. The proposed increases partially cover the costs of inspections.

Comment: 5.1.i. The use of or non use of should not be in the EMS rule. Current OSHA and NIOSH should dictate the use of these systems.

Response: The science of rear ambulance passenger restraint is a work in progress and no functional standard exists. However, there is irrefutable evidence that shoulder harness on side-facing seating is considerably more dangerous to EMS personnel than a simple lap belt. There was no change in the final proposed rule based on this comment.

Comment: 5.1.k. Exterior Markings. Markings are driven by Nation Standards. This should continue and not be decided by EMS rule. Minimum safety standards should be set and further vehicle markings as required by Federal Mandate.

Response: The science of emergency vehicle safety markings is a work in progress. The proposed rule combines the most current recommendations from various sources related to improved vehicle safety markings. The standard applies only vehicles purchased on or after January 1, 2012. There was no change in the final proposed rule based on this comment.

Comment: 5.3.b. C3-IFT needs to be added to this section under staffing requirement.

Response: The intent of the proposed rule is to accurately portray the type of service the vehicle is staffed and equipped to provide. There was no change in the final proposed rule based on this comment.

Comment: 5.3.b.3. Critical Care Transport. The current configuration does not allow for level "0" or specialty transports such as PICU, NICU, etc. These types of CCT transports do not require 2 MCCP's or MCCN. It should be added to allow for an EMVO, 1 MCCP and a specialty nurse in that specific discipline.

Response: The suggested change to address specialty medical personnel in addition to one MCCP or MCCN will be made in the final proposed rule.

Comment: 6.2.k. This section should reflect HIPAA and not be too specific.

Response: There was no change in the final proposed rule based on this comment.

Comment: 6.2.m. Why is it a must to carry EMS credentials? With the ability to verify state issued credentials on line this should be eliminated.

Response: The intent of the proposed rule is to identify certified EMS personnel to their patients, the public, and other healthcare providers. A remote verification process does not suffice to meet the intent. There was no change in the final proposed rule based on this comment.

Comment: 6.9. Fees. Although we do support some fees for certification and recertification please review and adjust the fees to a manageable amount. Based on other professions, the proposed EMS fees are extreme.

Response: A revision incorporating the intent of the suggested change was incorporated in the proposed final rule.

Comment: 6.12. The proposed card replacement fee is too extreme. Please review and make reasonable accommodations.

Response: The suggested change was incorporated in the proposed final rule.

Comment: 7.2.g. EMS agencies should only be punished if they do not report "known" offenses or violations of this rule. How can they report if they do not know?

Response: The suggested change was incorporated in the proposed final rule.

Comment: 8.3.c.2. ALS Program Director. We don't feel the Bachelors Degree requirement is a must. It would be appropriate if the ALS program director held an Associate Degree or higher.

Response: ALS education is provided at a college level in West Virginia. A bachelor's degree is the generally accepted minimum qualification for college-level program managers. There was no change in the final proposed rule based on this comment.

Comment: 9.1.c. Regional Medical Directors. As stated before, with the State Wide Protocols there is no need to continue to support a regional system. This includes regional medical directors. They are not employed by the EMS agencies and have no oversight in their operation.

Response: Regional medical directors were retained in the final proposed rule with a change in responsibilities. The changes make their role less duplicative of either the state or agency medical director.

Comment: 9.1.e. Agency Medical Director. They are an agent of the EMS agency therefore if the regional medical directors still exist they have no authority over the appointment of the agency medical director.

Response: The proposed rule only allows regional medical directors to "review the appointments of all agency medical directors", not to approve or disapprove of them.

Comment: 64-48-10. EMS Personnel in the Emergency Department.

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This sections needs clarification as to the intent. We can not make recommendations until that intent is understood.

Response: There appears to be no suggested changes to the proposed rule contained in this comment.

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TITLE 64

LEGISLATIVE RULE

**DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH**

SERIES 48

EMERGENCY MEDICAL SERVICES

- §64-48-1. General.**
- §64-48-2. Definitions.**
- §64-48-3. Systems/ Operations.**
- §64-48-4. Agencies.**
- §64-48-5. Vehicles.**
- §64-48-6. Personnel.**
- §64-48-7. Investigative/Disciplinary Actions.**
- §64-48-8. Education.**
- §64-48-9. Medical Direction.**
- §64-48-10. EMS Personnel in Emergency Departments.**
- §64-48-11. Administrative Due Process.**

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Emergency Medical Services
Department of Health and Human Resources
Bureau for Public Health
State Trauma and Emergency Medical Services

BRIEF SUMMARY

The proposed rule is a major revision of the existing EMS rule to comply with the requirements of HB 4143, passed in the 2010 legislative session. The bill re-wrote significant portions of Article 4C in the Public Health Chapter 16 governing all aspects of Emergency Medical Services code. The bill gave very specific direction about what the contents of the revised rule must include. The rule is reorganized and through the promulgation of this rule, the Bureau is also seeking the repeal of two legislative rules that will be superseded by the enactment of this rule. Those two rules are: 64CSR29, Specialized Multipatient Medical Transport and 64CSR44, Fire Department Rapid Respond Services Licensure. The amended rule for all Emergency Medical services and vehicles will cover the entirety of the subject of the two rules.

STATEMENT OF CIRCUMSTANCES

The West Virginia legislature has addressed concerns about the state Emergency Medical Services code by enacting a substantial revision of that article in 2010. This rule has been written in response to the statutory changes.

TITLE 64

LEGISLATIVE RULE

2010 JUL 30 PM 4:12

DEPARTMENT OF HEALTH AND HUMAN RESOURCES
BUREAU FOR PUBLIC HEALTH

SERIES 48

EMERGENCY MEDICAL SERVICES

§64-48-1. General.

1.1. Scope -- This rule is intended to ensure adequate provision of emergency medical services to the citizens of West Virginia and to meet the purposes set out in WV Code §16-4C-2; to provide clear direction to emergency medical services (EMS) personnel and agencies in West Virginia.

1.2. Authority -- WV Code §§16-1-4, 16-4C-6, 16-4C-14 and 16-4C-23.

1.3. Filing Date --

1.4. Effective Date --

1.5. Repeal and Replacement of Former Rules -- This legislative rule repeals and replaces Bureau for Public Health rule, Emergency Medical Services, 64CSR48. Additionally, this rule repeals and supersedes two existing Legislative rules filed as: Division of Health rule, Specialized Multipatient Medical Transport, 64CSR29; and Division of Health rule, Fire Department Rapid Response Services Licensure, 64CSR44. All statutorily required elements of those rules are included in and addressed by this rule.

1.6. Applicability -- The provisions of this rule are not intended to limit the scope of practice of any person who is a duly licensed health care provider under other pertinent provisions of this code and who is acting within the scope of his or her license. This rule applies to all persons or entities defined in WV Code §§16-4C-14 and 16-4C-3 and to all other persons or entities engaging in the provision of emergency medical services in West Virginia; included, but not limited to; the following:

- 1.6.a. Emergency medical services agencies;
- 1.6.b. Emergency medical services personnel;
- 1.6.c. Emergency medical services providers;
- 1.6.d. Emergency medical services line officers;
- 1.6.e. Medical command; and

1.6.f. Small emergency medical services providers.

1.7. Enforcement -- This rule is enforced by the Commissioner of the Bureau for Public Health.

§64-48-2. Definitions.

2.1. ACT -- A person certified as an Advanced Care Technician

2.2. Advanced Life Support (ALS) -- A level of emergency medical services which includes, but is not limited to; the assessment, treatment and transportation of the sick and injured, invasive and non-invasive medical procedures, the administration of medications and basic life support procedures as approved for the appropriate level of certification by the OEMS Medical Direction System.

2.3. Air Ambulance -- An aircraft configured and medically equipped to transport patients by air. The patient care compartment of air medical ambulances shall be staffed by a certified medical crew meeting the requirements of this rule.

2.4. Agency Medical Director -- A West Virginia licensed physician who meets the requirements of subdivision 9.1.e. of this rule, and accepts responsibility for providing medical oversight, medical performance review and extending privilege to practice to a licensed EMS agency and its personnel under the guidelines established by OEMS.

2.5. Basic Life Support (BLS) -- A level of emergency medical services which includes, but is not limited to, assessment, treatment and transportation of the sick and injured; including medical procedures, the administration of limited medications, basic life saving procedures and continuous medical supervision as approved for the appropriate level of certification by the OEMS Medical Direction System.

2.6. Certification -- The process by which a person acquires a certificate as an emergency medical services personnel for a level in which he or she is not currently certified in this state.

2.7. Certification Transfer -- The issuance of certification through reciprocity, legal recognition, challenge, or equivalency based on prior training, certification or licensure in another state, commonwealth, territory or the United States military.

2.8. Communications Center -- A facility that receives calls for emergency assistance and dispatches the appropriate responders to EMS incidents for a particular geographic area. These facilities include, but are not limited to; 911 centers, stand alone dispatch centers and other public safety answering points.

2.9. Credentialing -- The total process of becoming certified and authorized to practice EMS in West Virginia.

2.10. Critical Care Transport -- A level of sophisticated, specialized medical care and transportation requiring specifically trained, skilled and equipped personnel operating under guidelines established by the OEMS Medical Direction System.

2.11. Disaster -- A natural or man-made occurrence which creates need for the provision of EMS which exceeds the capacity of prompt provision of care or transportation by the EMS providers in the immediate area of the occurrence.

2.12. Driver -- A person who possesses appropriate qualifications, as specified by the commissioner pursuant to this rule, that is responsible for the operation of a ground EMS vehicle.

2.13. Emergency Medical Services Vehicle (EMS vehicle) -- EMS transportation vehicles including: ambulances, air ambulances and other patient transportation vehicles; and non-transporting, medically equipped vehicles operated by licensed EMS agencies as described in this rule. EMS vehicles include any private or publicly owned vehicle or craft intended to provide on-scene emergency medical services or patient transportation.

2.14. EMD -- A person certified as an Emergency Medical Dispatcher.

2.15. EMR -- A person certified as an Emergency Medical Responder.

2.16. EMS Data System -- An electronic system designated by OEMS for the collection, storage, and retrieval of all information relating to the provision of EMS including, but not limited to electronic patient care records, credentialing information system (CIS), state medical asset resource tracking tool (SMARTT), EMS toolkits, medical command data, and other specialized data collections.

2.17. EMS Incident -- An event which generates a request to provide emergency medical services assessment, treatment or transportation by EMS agencies and personnel. EMS incidents include, but are not limited to 911 response, non-emergency transportation, inter-facility transport, patient refusals of care, no care needed or provided and standby in support of other emergency responses or emergency events.

2.18. EMS Medical Director -- A West Virginia licensed physician, board certified in emergency medicine, with substantial experience in emergency medicine, appointed by the Commissioner, to oversee all medical aspects of the WV State Trauma and Emergency Medical Services (STEMS) System.

2.19. EMT -- A person certified as an Emergency Medical Technician.

2.20. EMT-M -- A person certified as an Emergency Medical Technician – Miner.

2.21. EMVO -- A person certified as an Emergency Medical Vehicle Operator.

2.22. Inspector -- A person authorized by OEMS to inspect EMS agencies, vehicles, training

institutions, or other facilities as necessary.

2.23. Investigator -- A person authorized by OEMS to conduct investigations on behalf of the Commissioner.

2.24. Local EMS System -- A coordinated arrangement of resources organized to provide emergency ambulance service within a defined geographical area. Such systems are provided under the authority of either a county commission, statutory ambulance authority or other legislatively-established entity charged with the responsibility for providing such service.

2.25. Medical Command Center -- A designated facility staffed by paramedic communications specialists, operating under medical supervision, which provides on-line advice and direction to EMS personnel for specific EMS incidents regarding treatment, triage and destination decisions under the guidelines of the EMS Medical Direction System.

2.26. Medical Command Physician (MCP) -- A West Virginia licensed physician operating as part of a medical command center who provides on-line medical direction to EMS personnel utilizing patient care treatment, triage and transportation protocols and guidelines approved by the Office of EMS. The MCP has ultimate authority and responsibility for patient care activities provided on a specific EMS incident.

2.27. Medical Direction System -- The aggregate medical resources responsible for the establishment of policies and procedures governing all aspects of the operation of the on-line and off-line medical direction for all EMS activities in West Virginia.

2.28. Medical Facility -- Any hospital, medical clinic, physician's office, or other similar facility, licensed or certified by the appropriate State agency, at which medical care and treatment is available.

2.29. Medical Policy and Care Committee (MPCC) -- The MPCC is composed of each regional medical director and may include physicians representing specialty areas such as pediatrics, trauma cardiology and others as necessary. The committee serves as the primary policy making body and advisory body to the state EMS Medical Director concerning medical issues involving the STEMS system. The committee shall meet at least bi-annually, or more frequently as necessary.

2.30. Mobile Critical Care Nurse (MCCN) -- A person possessing a valid, unrestricted Registered Nurse license in West Virginia who meets OEMS requirements for paramedic certification and who has completed additional state-approved education and meets other requirements to provide Critical Care Transport.

2.31. Mobile Critical Care Paramedic (MCCP) -- A person certified as a paramedic who has completed additional state-approved education and meets other requirements to provide Critical Care Transport.

2.32. Non-Public EMS Response Entity – A licensed EMS agency which provides EMS to a specific population and geographic area, including, but not limited to industrial sites and military operations. Such service is not accessible by or available to the general public.

2.33. OEMS -- The Office of Emergency Medical Services under the Commissioner of the Bureau for Public Health as created by statute in WV Code §16-4C-4.

2.34. Official Representative – An individual assigned by the licensed EMS agency with signature authority to represent the licensed EMS agency.

2.35. Off-Line Medical Direction -- The component of medical oversight provided to EMS personnel and agencies including, but not limited to; medical treatment protocols and guidelines, triage protocols, destination protocols, policies and procedures, determination of EMS personnel scopes of practice, privilege to practice, medical command center operation, and other issues of a medical nature.

2.36. On-Line Medical Direction -- The medical direction given by an approved Medical Command Center to EMS personnel at the time of an EMS incident, by voice or other means, as established by OEMS protocol and guidelines.

2.37. Paramedic -- A person certified as a Paramedic.

2.38. Patient Transportation -- Movement or transfer of a patient from any location to another by an EMS vehicle licensed by OEMS.

2.39. Pilot-in-Command -- A person who possesses appropriate Federal Aviation Administration credentials and who, pursuant to this rule, is responsible for the operation of an air ambulance

2.40. Primary Patient Caregiver -- A person certified pursuant to this rule that has primary authority and responsibility for the care of patients with respect to the provision of emergency medical services on a particular EMS incident.

2.41. Privilege to Practice – Authority to perform those skills and procedures defined within the scope of practice established by the OEMS Medical Direction System for a particular level of certification granted by the agency medical director with concurrence of the State EMS Medical Director.

2.42. Protocol -- A document developed and approved by the Medical Policy and Care Committee that describes the diagnostic procedures, treatment procedures, medication administration and patient care practices that shall be completed by EMS personnel within their scope of practice based upon the assessment of a patient, and the scope of practice of the primary patient caregiver.

2.43. Rapid Response -- A form of EMS designed to provide an initial response service to improve EMS incident response time and patient outcome. Rapid response services shall be

coordinated as part of a local EMS system or licensed EMS agency. Rapid response EMS personnel operating under the OEMS Medical Direction System, provide on-scene assessment, intervention and treatment without patient transportation.

2.44. Recertification -- The process by which EMS personnel renew an EMS certificate for which they are or were certified in this State.

2.45. Regional EMS Medical Director – A West Virginia licensed physician, recommended by a regional EMS Board of Directors and by the EMS Medical Director, appointed by the Commissioner to oversee medical aspects of EMS within a particular geographic region of the state.

2.46. STEMS – The State Trauma and Emergency Medical System, an Office in the Bureau for Public Health.

§64-48-3. Systems/Operations.

3.1. Local EMS Systems -- WV Code §7-15-1, et seq., establishes the duty of county commissions to provide emergency ambulance service. That service may be provided directly, through private enterprise, by its designees, by contracting, by creation of an ambulance authority or other legislatively-established entity charged with the responsibility for providing such service.

3.1.a. County commissions shall establish local EMS systems which meet the following requirements:

3.1.a.1. Defines a geographical service area, the minimum size of which shall be one (1) county.

3.1.a.2. Establishes the minimum level of service required within the service area and ensures the established level of care is available to all citizens within that service area 24 hours per day and 365 days per year.

3.1.a.3. Each county shall develop an EMS plan describing how the local EMS system will address the following:

3.1.a.3.A. Dispatch, coordination and oversight of all agencies and personnel operating within the local EMS system;

3.1.a.3.B. Sufficient numbers of permitted and staffed ambulances to provide emergency ambulance coverage to the service area 24 hours per day;

3.1.a.3.C. Establishing, monitoring and reporting system response time standards;

3.1.a.3.D. Integrating EMS with other county emergency management entities in the county's all-hazard disaster plan; and

3.1.a.3.E. An EMS communication system that provides for:

3.1.a.3.E.1. Public access using the telephone number 9-1-1 within the public telephone network as the primary method to request EMS assistance;

3.1.a.3.E.2. An emergency communications system operated by public safety telecommunicators with training in the management of calls for emergency medical assistance available 24 hours per day;

3.1.a.3.E.3. Dispatch of the most appropriate EMS agency or EMS vehicle to any request for assistance in accordance with a written plan for management and deployment of EMS resources, including requests for mutual aid; and

3.1.a.3.E.4. Two-way voice communications from within the defined service area to the emergency communications center or Public Safety Answering Point (PSAP).

3.1.b. A local EMS system may utilize one (1) or more licensed EMS agencies within the established service area.

3.1.c. County Commissions, statutory ambulance authorities or other legislatively-established entities charged with the responsibility for providing such service shall designate those transporting and non-transporting EMS agencies which are affiliated with the local EMS system. Air ambulance agencies and non-public response agencies shall be exempt from this requirement.

3.1.c.1. Affiliation shall be evidenced by a contract, franchise agreement or other written documentation.

3.1.d. Local EMS Systems shall designate an official contact person which shall be the primary contact for OEMS in all matters relating to the local EMS System.

3.2. EMS Data System

3.2.a. OEMS shall participate in the National EMS Information System (NEMSIS) electronic data collection project. OEMS shall establish and publish a minimum EMS data set required for collection on all EMS incidents. An EMS data dictionary shall be established describing the definitions of each data element. All data collection systems shall be certified NEMSIS compliant for all state required data elements. OEMS shall maintain a list of collection programs approved for use in the state. Additionally, state approved collection programs shall be certified NEMSIS compliant for each EMS agency.

3.2.b. EMS agencies shall collect, maintain and report accurate patient data for all EMS incidents. Agencies shall complete a patient care report (PCR) for all EMS incidents. PCRs shall be complete and submitted to the West Virginia Prehospital Information System (PreMIS) following the conclusion of providing EMS services to a patient, provided that within two (2)

years of the effective date of this rule, such submission shall be completed within twenty-four (24) hours with ninety-five percent (95%) reliability.

3.2.c. When an ambulance transports a patient to a medical facility's emergency room or department, a minimum written patient handoff report, as specified by OEMS, shall be provided to the facility prior to departing. Within seventy-two (72) hours of the conclusion of providing EMS services to a patient, the EMS agency shall make a copy of the complete PCR available to the receiving facility, either electronically or written, which shall serve as the official record of the EMS incident.

§64-48-4. Agencies.

4.1. The Commissioner shall evaluate EMS agencies according to this rule.

4.2. Responsibility. -- EMS agencies are responsible for ensuring that vehicles operated and maintained by the agency and personnel associated with the agency comply with this rule at all times.

4.3. License Required. -- No person or entity shall establish or operate and maintain or advertise any service or organization as an EMS agency without a valid OEMS license.

4.4. Display of License. -- The license shall be displayed publicly in the headquarters of the agency.

4.5. Licensed Service Types. -- EMS licenses shall be issued for one or more of the following EMS services:

4.5.a. Rapid response. -- basic life support;

4.5.b. Rapid response. -- advanced life support;

4.5.c. Basic life support;

4.5.d. Advanced life support;

4.5.e. Critical care transport;

4.5.f. Rotary wing transport;

4.5.g. Fixed wing transport; and

4.5.h. Specialized multi-patient medical transport; provided that this type of service cannot be licensed unless the agency provides at least basic life support service.

4.5.i. Fire Department Rapid Response Agency -- This section applies only to fire departments certified by the State Fire Commission.

4.5.i.1. A fire department rapid response service that charges a fee for its medical services or transports patients is subject to all licensure requirements and applicable standards of this rule, including payment of fees.

4.5.i.2. A fire department rapid response service that does not charge a fee for its medical services or transport of patients shall obtain one of the following:

4.5.i.2.A. License subject to all requirements and applicable standards of this rule, including full inspection and payment of fees, or;

4.5.i.2.B. License subject to requirements and applicable standards of this rule as outlined in subdivision 4.9.a. of this rule.

4.5.i.3. A certified fire department is not subject to licensure as described in this rule if it only provides CPR and AED services, manpower or other non-medical assistance on EMS incidents.

4.6. Advertising. -- EMS agencies shall not advertise, in print, electronic or other media for public consumption, any service for which they are not licensed. Aeromedical agencies shall not solicit direct flight requests for service from the general public. This rule shall not preclude agencies from advertising for personnel or other community-oriented activities.

4.7. Application.

4.7.a. The EMS agency shall submit an application to OEMS for a license, in a format specified by the Commissioner, prior to agency inspection.

4.7.b. Any EMS agency seeking to make changes in the level of service, service area, station locations or number of vehicles shall submit an application in a format specified by the Commissioner, prior to making the change.

4.7.c. Management of an EMS agency includes those serving as Official Representative, Medical Director or Training Officer. Any changes to Management require a revised application to be submitted within ten (10) days of the change.

4.8. Verification. -- The Commissioner may use any lawful investigatory means necessary to verify information contained in an application.

4.9. License Issuance. -- The Commissioner shall determine whether an applicant shall be issued a license based upon: the applicant's previous record of performance in the provision of similar service; the resources available to the applicant for the provision of service(s); an objective measurement of the applicant's compliance with requirements and standards of this rule; and evidence of the applicant's current compliance with all state, local and federal obligations, included, but not limited to; taxes and worker's compensation obligations.

4.10. Inspection. -- The Commissioner may inspect all places of operation of an EMS agency or proposed EMS agency, at any time, for compliance with this rule. Such inspection(s) shall be in addition to other federal, state or local inspections required by law. Inspection(s) shall include all places of operations and all records of the EMS agency or proposed EMS agency. The Commissioner may inspect, but not copy or maintain, records of a protected status.

4.10.a. Fire department rapid response agency inspection:

4.10.a.1. The Official Representative of the agency, as indicated on the application, shall verify the applicant's compliance with the requirements of this rule and sign and attest to compliance before a notary public.

4.10.a.2. The Commissioner may make inspections of all places of operation of an existing or proposed fire department rapid response service for compliance with this rule. The inspections shall be in addition to other federal, state, or local inspections required by law. The Commissioner may inspect, but not copy or maintain, records of a protected status.

4.10.a.2.A. The Commissioner may inspect all places of operation of an EMS agency or proposed EMS agency, at any time, for compliance with this rule. Such inspections shall be in addition to other federal, state or local inspections required by law. Inspections shall include all places of operations and all records of the EMS agency or proposed EMS agency. The Commissioner may inspect, but not copy or maintain, records of a protected status.

4.10.a.2.B. Inspections shall be conducted at no cost to the applicant.

4.11. Place of Operations. -- EMS agencies shall comply with the following requirements pertaining to all places of operations:

4.11.a. Storage. -- The EMS agency shall provide adequate and clean storage spaces in an enclosed area for equipment and supplies. These storage spaces shall be constructed to permit thorough cleaning;

4.11.b. Supplies. -- The EMS agency shall maintain medical supplies required for the all classes of vehicles operated by the agency;

4.11.c. Sanitary Requirements. -- All areas used for storage of equipment and supplies shall be kept neat, clean and sanitary. Plastic bags or enclosed containers shall be provided for soiled supplies;

4.11.d. Living Quarters. -- If crews are required to work twenty-four (24) hour or greater length shifts, appropriate quarters shall be provided. These quarters shall meet standards established by WV Code §21-3-1 as amended, Safety and Welfare of Employees, and others as may be established by the Commissioner.

4.11.e. Medical Waste. -- All forms of medical waste shall be stored and disposed of according to WV Code §20-5J-1, et seq. and Division of Health Legislative Rule, Infectious Medical Waste, 64CSR56.

4.12. Operational Policies and Procedures. -- EMS agencies shall maintain current written operational policies and procedures which shall be subject to and available for inspection by the Commissioner. Required policies and procedures include, but are not limited to: operation and maintenance of services, equipment and facilities management, health and safety practices for EMS personnel, patient safety, a medication management plan compliant with federal and state requirements, infection control practices, anti-harassment, vehicle operations, and personnel management. Additional aeromedical agency requirements include: a contemporaneous flight following plan utilized in all phases of flight operations; a notification policy for requesting agencies and facilities which includes estimated time of arrival, any changes in time or flight status; a routinely drilled post accident/incident plan; a policy to reduce "helicopter shopping" including appropriate pre-flight screening and cooperation with other aeromedical providers; and a customer education program addressing patient preparation, landing zone management, and customer safety around the aircraft & equipment.

4.13. Records. -- EMS agencies are responsible for the preparation and maintenance of records. All records shall be subject to and available for inspection by the Commissioner. Records shall be stored in a manner as to provide reasonable safety from water and fire damage and from disclosure to persons other than those authorized by law. Secure storage shall be provided for all medical records. The EMS agency shall prepare and maintain for a period of not less than seven (7) years the following records:

4.13.a. Personnel records for EMS personnel and other staff documenting training, qualifications and certifications for position(s) held;

4.13.b. Records for each EMS vehicle including vehicle registration records, records of safety inspections, repair and crash incident reports as specified by the Commissioner;

4.13.c. EMS agencies shall comply with data collection and reporting requirements in subsection 3.2. of this rule.

4.14. Insurance. -- Each EMS agency shall have in effect, maintain and furnish proof of errors and omissions insurance as required by WV Code §16-4C-16, and current insurance policies for all EMS vehicles operated by the agency.

4.15. Non-Discrimination. -- EMS agencies shall maintain a written policy to prohibit the refusal of emergency response, treatment and transportation of patients to the nearest appropriate facility on EMS incidents with potentially critical illness or injury, regardless of the patient's age, sex, ethnicity or ability to pay for services.

4.16. Public Access. -- An EMS agency shall provide a publicly listed telephone number to receive requests for service from the general public within its regular operating area.

4.16.a. The primary emergency number shall be 911.

4.16.b. Secondary telephone numbers may be provided for the provision of non-emergency services.

4.16.c. An EMS agency that, according to written policy, does not respond to calls from the general public and responds only to calls from a defined, closed population, such as the population of an institution, an industrial plant, facility or a university, is not required to provide a publicly listed telephone number. These agencies shall provide a telephone number that is known to the defined population served and is answered during all periods when that population may require service.

4.17. Availability -- EMS agencies shall ensure that service for which they are licensed is available to the public or population served within their regular operating area on a twenty-four (24) hour continuous basis either by providing the service themselves or by written agreement with another licensed EMS agency.

4.18. Communications -- EMS communication systems shall comply with state and federal rules, regulations, policies and protocols.

4.19. Performance Improvement -- EMS agencies shall comply with the minimum performance improvement program established by the Commissioner.

4.20. Standards -- In addition to the requirements set forth in this rule, the Commissioner shall score the EMS agency or proposed EMS agency according to the following standards:

4.20.a. Applicability of Standards. -- Certain standards, as determined by the Commissioner, may not apply to an EMS agency depending on the type of service provided or population served.

4.21. Level of Service.

4.21.a. ALS staffed and equipped EMS vehicles are dispatched on all emergency requests for service, or; a tiered response is dispatched based on criteria from an OEMS recognized Emergency Medical Dispatch program. Fifteen (15) points.

4.21.b. ALS services are available only on a part-time basis. Ten (10) points.

4.21.c. BLS services only are available. Five (5) points.

4.22. Medical Accountability.

4.22.a. Off-Line Medical Direction.

4.22.a.1. The medical director has a written contract with the EMS agency outlining duties and responsibilities and is actively involved with the agency through direct participation in

activities, included, but not limited to; oversight of training, skills maintenance and recertification; equipment selection; clinical performance evaluation and the performance improvement process as evidenced by documented participation in quarterly, or more frequent, meetings with agency officials and personnel. Ten (10) points; or

4.22.a.2. The medical director has a written contract with the EMS agency outlining duties and responsibilities with minimal evidence of active involvement with the agency. Five (5) points.

4.22.b. Performance Improvement – EMS agency demonstrates superior commitment to performance improvement as evidenced by activities substantially exceeding state minimum requirement described in subsection 4.18. of this rule. Fifteen (15) points.

4.23. Rapid Response.

4.23.a. The EMS agency has a formal rapid response program which routinely places trained and equipped personnel on scene of potential life-threatening emergencies prior to the arrival of an ambulance. This may be provided by the EMS agency or by written agreement with licensed Rapid Response agencies. Five (5) points; or

4.23.b. The EMS agency has formalized rapid response capabilities provided irregularly, or are not available in all parts of the service area. Two (2) points.

4.24. Public Education and Information

4.24.a. The EMS agency has community presence which is documented through provision of EMS public education and community service programs for the covered population. The EMS agency offers such activities quarterly, or more often and actively participates with outside organizations and groups. Five (5) points; or

4.24.b. The EMS agency provides limited or intermittent education or service programs within the community. One (1) point.

4.25. Disaster Capability

4.25.a. Disaster Plan.

4.25.a.1. The EMS agency has a current, written all-hazards plan for disaster response which is integrated with adjacent providers and emergency management officials. The plan is compliant with current federal and state emergency planning and operational standards. Five (5) points.

4.25.b. Disaster Drills

4.25.b.1. The EMS agency conducts, or participates in, disaster drills with adjacent EMS agencies, other emergency response entities and county emergency management agencies at least annually. Five (5) points.

4.26. Mutual Aid

4.26.a. The EMS agency maintains current written mutual aid agreements addressing all aspects of reciprocal service provision with all adjacent EMS agencies, or operates under written mutual aid guidelines established by the local EMS system. Five (5) points.

4.26.b. The EMS agency has limited-scope mutual aid agreements or does not have them with all adjacent EMS agencies. One (1) point.

4.27. Personnel

4.27.a. Job Descriptions – The EMS agency maintains current written job descriptions for all positions within the agency. Three (3) points.

4.27.b. Recruitment – The EMS agency utilizes a formal, documented recruitment program to actively recruit new personnel. Three (3) points.

4.27.c. Personnel Screening – The EMS agency screens and selects applicants with a formal, documented, objective process. Three (3) points.

4.27.d. Orientation – The EMS agency uses a formal orientation process with documented completion of specific stated objectives. Documentation of completion is maintained in each personnel file. Three (3) points.

4.27.e. Retention – The EMS agency utilizes a formal, documented retention program to aid in retention of qualified personnel. Three (3) points.

4.28. Education and Training

4.28.a. Personnel Education

4.28.a.1. The EMS agency provides EMS education for all EMS personnel levels within the agency. Educational offerings exceed minimum recertification requirements and include at least one program leading to original certification. Fifteen (15) points; or

4.28.a.2. The EMS agency provides, or makes available, in-house training activities meeting all minimum recertification requirements for all EMS personnel levels within the agency. Ten (10) points; or

4.28.a.3. The EMS agency provides some in-house training activities meeting some recertification requirements for EMS personnel. Five (5) points.

4.28.b. Training Officer's Program

4.28.b.1. The EMS agency participates fully in the state approved training officers' program with a qualified designated agency training officer and offers in-house continuing education programs a minimum of two (2) time per year. Ten (10) points.

4.29. Financial – the following shall be prepared according to generally accepted accounting practices:

4.29.a. Budget – EMS agency has an approved, written operating and capital expenditures budget which includes projected income and expenses, actual income and expenses, and an accounting of budget variances. Budget reports are provided quarterly, at a minimum, to the agency governing body or ownership, management personnel and other significant stakeholders. Five (5) points.

4.29.b. Financial Stability – The EMS agency is financially viable as evidenced by:

4.29.b.1. A full financial audit or quarterly articulated financial statements provided by an independent accounting firm during the license period. Ten(10) points, or:

4.29.b.2. A financial review conducted by an independent entity within the license period. Five (5) points, or;

4.29.b.3. Interim articulated financial statements. Two (2) points.

4.29.c. Financial Responsibility – The EMS agency has formally designated individual(s) with financial responsibility. Individual(s) with financial responsibility shall be appropriately insured or bonded. Five (5) points.

4.30. Facilities and Equipment

4.30.a. Facilities Maintenance Program -- The EMS agency uses a documented, comprehensive program of routine inspection and preventive maintenance for all agency facilities. Five (5) points.

4.30.b. Vehicle Maintenance Program – The EMS agency uses a documented, comprehensive program of routine inspection and preventive maintenance performed by qualified personnel for all EMS vehicles. Five (5) points.

4.30.c. Medical Equipment – The EMS agency uses a documented, comprehensive program of routine inspection and preventive maintenance performed by qualified personnel for all EMS medical equipment. Five (5) points.

4.31. Accountability and Stability

4.31.a. Government Support and Recognition:

4.31.a.1. The responsible county commission statutory ambulance authority or other legislatively-established entity charged with the responsibility for providing such service formally recognizes the agency as part of the local EMS system and provides sufficient resources to support of agency operations. Five (5) points; or

4.31.a.2. The agency is formally recognized by the responsible county commission, statutory ambulance authority or other legislatively-established entity charged with the responsibility for providing such service as part of the local EMS system but receives minimal support. One (2) points;

4.31.b. Organization and Management:

4.31.b.1. The agency is formally and legally organized with clear lines of managerial authority and responsibility as evidenced by agency charter or articles of incorporation, current written by-laws, current registration with the secretary of state, current organizational charts, policies, etc. Five (5) points.

4.31.b.2. Management Education – EMS agency management personnel have documented education in EMS management practices and procedures. Continuing education in management practice is required and participation of current management personnel is documented. Five (5) points.

4.32. The Commissioner may issue a license according to WV Code §16-4C-4a, provided the information contained in the application is complete and correct, and the applicant is determined by the Commissioner to be entitled to such in accordance with this rule.

4.33. The Commissioner shall notify the EMS agency in writing of the findings of the inspection and, if approved, issue an EMS agency license within sixty (60) days of receipt of application and completion of agency and vehicle inspections.

4.34. An EMS agency license shall include the following information:

4.34.a. The name and address of the EMS agency;

4.34.b. The name of the official representative of the EMS agency;

4.34.c. All levels of service for which the agency is licensed; and

4.34.d. The issue and expiration dates of the license.

4.35. The standards ratings and renewal periods are determined as follows:

4.35.a. "A" rating – a score of ninety percent (90%) or higher of applicable points. A four (4) year license shall be issued.

4.35.b. "B" rating – a score of between eighty percent (80%) and eighty-nine percent (89%) of applicable points. A three (3) year license may be issued.

4.35.c. "C" rating – a score of between seventy percent (70%) and seventy-nine percent (79%) of applicable points. A two (2) year license may be issued.

4.35.d. "F" rating – a score of less than seventy percent (70%) of applicable points. No license shall be issued.

4.35.e. "Provisional" rating – a score of greater than seventy percent (70%) of applicable points earned by a new agency. Six (6) months license may be issued.

4.35.f. Extension of license – The Commissioner may extend, as necessary, an agency license for a period of not greater than six (6) months from the date of expiration.

4.36 Review of Preliminary Agency Inspection Findings.

4.36.a. When a preliminary inspection report is completed, the OEMS inspector and the agency official representative will meet to discuss the findings.

4.36.a.1. The agency official representative will either concur with the findings or present documentation or facts disputing any portion thereof.

4.36.2. In the case of disputed findings the OEMS inspector may concur with the information provided and revise the findings appropriately, or refer the preliminary report, along with all documentation presented by the official representative to the Director of OEMS for review.

4.36.2.a. The Director may either uphold the inspector's findings or modify the findings based on the facts presented.

4.36.2.b. The Director shall communicate his action the agency principal official within ten (10) days of receiving the preliminary report and associated documentation.

4.37. Plan of Improvement.

4.37.a. An EMS Agency may submit a plan of improvement to improve the rating upon receipt of a final license inspection report.

4.37.b. A plan of improvement shall only be applicable to the standards section of a final license inspection report.

4.37.c. The agency has ten (10) working days from receipt of the final license inspection report to notify OEMS of intent to submit a plan of improvement.

4.37.d. The proposed plan of improvement shall be submitted within fifteen (15) days of initial notification.

4.37.e. Plans of improvement shall include:

4.37.e.1. Standards to be addressed;

4.37.e.2. Specific improvement strategies to be implemented;

4.37.e.3. Desired outcome of the proposed improvements; and

4.37.e.4. A proposed implementation period.

4.37.f. The Commissioner has ten (10) working days to approve or reject the plan.

4.37.g. Rejection shall specify the areas rejected.

4.37.h. In event of plan rejection, the agency may submit a revised plan within ten (10) working days of receipt of notice of rejection.

4.37.i. Once an improvement plan is approved, the agency is required to complete the proposed improvements within the agency specified implementation period.

4.37.j. Upon completion of the improvement period, OEMS shall re-inspect the specific standards proposed for improvement.

4.37.k. If, as a result of re-inspection, standards ratings improve, the Commissioner shall issue a new license reflecting the change.

4.37.l. If, as a result of re-inspection, there is no improvement, the original license rating stands without opportunity for further review until the next inspection period.

4.38. Alternative Licensing Method.

4.38.a. In lieu of the requirements set forth in this section, the Commissioner may recognize agency evaluation by a nationally recognized EMS agency accrediting body as meeting state licensing requirements. Provided that the agency shall meet or exceed State requirements, as determined by the Commissioner, and;

4.38.b. An OEMS inspector shall accompany accreditation officials during the site visit to the EMS agency, and;

4.38.c. The accrediting body shall provide a copy of the findings of the accreditation site visit directly to OEMS, and;

4.38.d. Agencies seeking alternative licensing are subject to the fees set forth in subsection 4.39. of this rule.

4.39. Agency Fees– Non-refundable fees for agency license and vehicle permits shall be due upon receipt of the invoice. Fees are:

4.39.a. Original agency license application, five hundred dollars (\$500.00).

4.39.b. Renewal fee for each agency licensing period, three hundred dollars (\$300.00), except that no additional fee shall be charged to provisional licensees.

4.39.c. Yearly EMS vehicle permit, two hundred dollars (\$200.00) per vehicle, provided that non-transporting vehicles shall be exempt.

4.39.d. Agency license modification, including revision based upon a plan of improvement, one hundred dollars (\$100.00), provided that changes of official representative, medical director, training officer, postal address or other contact information shall be exempt.

4.39.e. Fees shall be paid to the West Virginia Bureau for Public Health in a manner specified by the Commissioner.

§64-48-5.Vehicles.

5.1. General Requirements.

5.1.a. Ground ambulances shall meet applicable US Government Services Agency KKK-A-1822 specifications at the time of vehicle manufacture.

5.1.b. Each EMS vehicle shall be maintained in good repair and operating condition and shall have a current state inspection if required by the state issuing the vehicle license.

5.1.c. EMS vehicles shall not be maintained or operated except by a licensed EMS agency. Unites States government EMS vehicles are exempt from this requirement.

5.1.d. The EMS agency may exercise emergency operating privileges, including the use of audible and visible emergency warning devices, only during response to the location of an emergency call, while at the location, and during transportation of a patient. Operation of these devices shall be in compliance with the WV Code §17C-2-5.

5.1.e. All drivers of ground EMS vehicles shall meet the requirements of paragraphs

6.7.a.9., 6.7.a.10. and 6.7.a.11. of this rule, in addition to minimum standards established for the individual's level of certification.

5.1.f. Sanitation. -- The following requirements for sanitary conditions apply to all EMS vehicles:

5.1.f.1. The interior of EMS vehicles, including all storage areas, linens, equipment, and supplies shall be clean and sanitary;

5.1.f.2. Freshly laundered linen or disposable sheets and pillow cases shall be used during the transporting of patients and shall be changed after each use;

5.1.f.3. Pillows and mattresses used in EMS vehicles shall be clean and in good repair;

5.1.f.4. Plastic bags, covered containers or compartments shall be used for the storage of soiled supplies and used disposable items. Biohazard bags clearly marked with the biohazard symbol shall be used for infectious waste;

5.1.f.5. Exterior surfaces shall be clean;

5.1.f.6. Blankets used in EMS vehicles shall be clean and replaced after use;

5.1.f.7. Single use devices or supplies shall be stored in a sterile manner and appropriately disposed of after use. Reusable items shall be sterilized in accordance with current medical practices;

5.1.f.8. Waterless antibacterial hand cleaner shall be available on each EMS vehicle;

5.1.f.9. A bleach or disinfectant solution, approved by the United States Centers for Disease Control, shall be available on EMS vehicles for cleaning purposes;

5.1.f.10. A disposal container for used sharp items shall be available on each EMS vehicle; and

5.1.f.11. The EMS agency shall ensure that, when EMS vehicles are used to transport a patient with an infectious disease, all interior contact surfaces shall be cleaned and disinfected prior to being occupied by another patient.

5.1.g. Equipment and Supplies. -- The EMS agency shall ensure that each EMS vehicle has all required equipment and supplies necessary for the level of service being provided while en route to an EMS incident, at the scene and during transport of a patient.

5.1.g.1. The EMS agency shall ensure that vehicle equipment is maintained in good working operation at all times;

5.1.g.2. The EMS agency shall ensure that supplies are restocked as necessary to maintain the minimum requirements during each response.

5.1.h. The operator's compartment shall accommodate safe operation of the EMS vehicle.

5.1.i. Safety belts shall be available and operational for all seat positions in EMS vehicles, no shoulder harness-type restraints shall be allowed on side - facing seat positions.

5.1.j. All EMS vehicles shall have a lockable storage compartment for a medication kit and its supplies.

5.1.k. Exterior Vehicle Marking Requirements:

5.1.k.1. Retro reflective vehicle markings shall be required as follows, at a minimum, on all ground ambulances purchased on or after January 1, 2012:

5.1.k.1.A. Four inch (4") wide stripe running the length of the sides of the vehicle at or below the level of the bottom of the windshield;

5.1.k.1.B. Fifty percent (50%) of rear facing vertical surfaces have a forty-five (45) degree down-and-away chevron pattern of contrasting-color 6" stripes;

5.1.k.1.C. Twenty-five percent (25%) of the width of the front of the vehicle have a four inch (4") wide stripe;

5.1.k.1.D. Two inch (2") wide vehicle side and rear boundary contour or edge markings; and

5.1.k.1.E. Twelve inch (12") "Star of Life" emblems on both sides and rear of the vehicle.

5.1.k.2. The name of the agency shall appear on both sides and back of the vehicle in four inch (4") minimum height letters. Clearly readable logos or emblems are acceptable.

5.1.k.3. An EMS vehicle may only be lettered with the terms "Paramedic", "Advanced Life Support", "Critical Care Transport" or similar service-level designations when the vehicle is both equipped and staffed by appropriately certified EMS personnel.

5.1.k.4. The public access emergency telephone number 9-1-1 shall be displayed on the ambulance. Specialized Multi Patient Medical Transport (SMPMT) and non-public access EMS vehicles may display a different number.

5.1.k.5. Emergency warning lights shall be visible from all four sides of the vehicle in accordance with applicable US Government Services Agency KKK-A-1822 specifications at the time of vehicle manufacture.

5.1.k.6. One (1) or more audible warning devices shall be installed to provide adequate audible warning.

5.1.k.7. All EMS vehicles shall have communications equipment which provides voice communication between the vehicle and its dispatch center, other EMS vehicles of the same EMS agency, and medical command. Communication equipment shall be operational and compatible with the EMS communication system and comply with state and federal rules, regulations, policies and protocols.

5.1.l. Inspection. -- All EMS vehicles shall be subject to, and available for, inspection by the Commissioner for compliance with this rule at any time and without prior notification. This inspection shall be in addition to other inspections required for EMS vehicles by Federal, State, or local law, rules, and regulations.

5.2. Non-Transporting EMS Vehicles.

5.2.a. The EMS Agency may use non-transporting EMS vehicles intended for the immediate movement of EMS personnel and equipment to the location of an EMS incident. Personally Owned Vehicles (POVs) may be used for similar purposes and are exempt from this rule, provided that they are authorized by the official representative of the licensed EMS agency. POVs and their operators are subject to requirements of the Division of Motor Vehicles and OEMS Emergency Vehicle Permit program.

5.2.b. Non-transporting EMS vehicles shall not be used for the transportation of patients except in the case of a disaster.

5.3. Transporting EMS Vehicles, excluding Specialized Multi Patient Medical Transport vehicles, shall meet the following requirements:

5.3.a. Transporting EMS vehicles are used for the delivery of basic or advanced life support or critical care transport. The equipment, supplies, and staffing required are dependent upon the level of service being provided on a particular EMS incident as specified in Medical Direction System policy, protocols and scope of practice.

5.3.b. Staffing requirements are dependent upon the level of service being provided on a particular EMS incident as specified in the Medical Direction system policy, protocols and scope of practice and shall be onboard at all times during patient treatment and transport:

5.3.b.1. Basic life support – at a minimum a certified EMVO and EMT;

5.3.b.2. Advanced life support – at a minimum a certified EMVO and ACT or Paramedic, provided that individual protocols may specify alternative staffing as specified by the OEMS Medical Direction System.

5.3.b.3. Critical care transport – at a minimum a certified EMVO and two (2) MCCPs, or one (1) MCCP and one (1) MCCN as required by treatment guidelines and policies

specific to the individual patient's care requirements as specified by the OEMS Medical Direction System. Hospital-based specialty medical personnel may replace one of the certified EMS personnel for the purpose of providing a higher level of care required by a particular patient.

5.3.b.4. The minimum equipment and supplies required are dependent upon the level of service being provided on a particular EMS incident as specified in OEMS policy, protocols and scope of practice and shall be onboard at the time of response and during patient treatment and transport.

5.4. Air Ambulance. -- There shall be two (2) categories, one (1) for rotary wing aircraft and one (1) for fixed wing aircraft. All EMS agencies engaging in air ambulance service under this rule shall be a Federal Aviation Administration (FAA) Part 135 air carrier certificate holder.

5.4.a. Rotary Winged Aircraft.

5.4.a.1. An EMS rotary winged aircraft is intended for response to the location of an EMS incident or for interfacility transportation of patients.

5.4.a.2. The aircraft patient compartment shall accommodate at least two (2) medical personnel which shall have access to the patient's head and upper body from a seat-belted position while in flight and at least one (1) stretcher patient, and:

5.4.a.2.A. Provide necessary space to insure that the patient's airway is maintained and to provide adequate ventilator support from a secured, seat-belted position of medical personnel, and;

5.4.a.2.B. Be configured to allow medical personnel to have full-body patient view and access, and access to equipment and supplies to initiate basic, advanced, and critical care life support emergency procedures while in flight.

5.4.a.3. The cockpit shall be configured so that flight controls and pilot communications equipment are protected from intended or accidental interference by the patient or medical equipment and supplies.

5.4.a.4. Door openings shall accommodate the loading of a stretcher without compromising the stability of the patient or the functioning of monitoring systems, intravenous lines, and manual or mechanical ventilation.

5.4.a.5. A visible warning device may be installed on the underside of the aircraft to provide adequate day and night emergency warning. An audible warning device may be installed to provide adequate emergency warning and external voice communications.

5.4.a.6. Patient area lighting shall not interfere with the safe operation of the aircraft.

5.4.a.7. The aircraft shall have communications equipment which provides voice

communications between the aircraft and its base of operation, between the aircraft and other EMS aircraft of the same EMS agency for which this requirement applies and between the aircraft and a WV Medical Command Center. The communications equipment shall be operational and compatible with the EMS communications system and comply with state and federal rules, regulations, policies and protocols.

5.5. An EMS Agency may use EMS rotary winged aircraft for the delivery of critical care transport. The equipment, supplies, and staffing required are dependent upon the level of service being provided on a particular EMS incident as specified in the Medical Direction System policy, protocols, guidelines and scope of practice.

5.5.a. Staffing requirements are determined by the level of service being provided on a particular EMS incident as specified in the Medical Direction System policy, protocols and scope of practice. The following shall be onboard at all times during patient treatment and transport:

5.5.a.1. Critical care transport – a minimum of a pilot-in-command and one (1) MCCP and one (1) MCCN. Hospital-based specialty medical personnel may replace one of the certified EMS personnel for the purposes of providing a higher level of care required by a particular patient;

5.5.a.2. The minimum equipment and supplies as defined by OEMS policy is determined by the level of service being provided on a particular EMS incident and shall be onboard at the time of response and during patient treatment and transport.

5.5.b. Fixed Wing Aircraft.

5.5.b.1. An EMS fixed wing aircraft is primarily intended for extended air transport between medical facilities within the state or across state boundaries.

5.5.b.2. The aircraft patient compartment shall accommodate at least two (2) medical personnel which shall have access to the patient's head and upper body from a seat-belted position while in flight and at least one (1) stretcher patient and:

5.5.a.2.A. Provide necessary space to insure that the patient's airway is maintained and to provide adequate ventilator support from a secured, seat-belted position of medical personnel.

5.5.a.2.B. Be configured to allow medical personnel to have full-body patient view and access, and access to equipment and supplies to initiate basic, advanced, and critical care life support emergency procedures.

5.5.b.3. The cockpit shall be configured so that flight controls and pilot communications equipment are protected from intended or accidental interference by the patient or medical equipment and supplies.

5.5.b.4. Door openings shall accommodate the loading of a stretcher without

compromising the stability of the patient or the functioning of monitoring systems, intravenous lines, and manual or mechanical ventilation.

5.5.b.5. Patient area lighting shall not interfere with the safe operation of the aircraft.

5.5.b.6. All EMS aircraft shall have communications equipment which provides voice communications between the aircraft and its base of operation and voice communications between the aircraft and other EMS aircraft of the same EMS agency for which this requirement applies and between the aircraft and its Medical Command Center. The communications equipment shall be operational and compatible with the EMS communications system and comply with state and federal rules, regulations, policies and protocols.

5.5.b.7. Staffing requirements are determined by the level of service being provided on a particular EMS incident as specified by Medical Direction System policy, protocols and scope of practice and shall be onboard at all times during patient treatment and transport:

5.5.b.7.A. Basic life support – a minimum of a pilot-in-command and EMT;

5.5.b.7.B. Advanced life support – at a minimum of a pilot-in-command and Paramedic, provided that individual protocols may specify alternative staffing as specified by the OEMS Medical Direction System.

5.5.b.7.C. Critical care transport – a minimum of a pilot-in-command and two (2) MCCPs, or one (1) MCCP and one (1) MCCN based on treatment guidelines and policies as specified by the OEMS Medical Direction System. Hospital-based specialty medical personnel may replace one of the certified EMS personnel for the purpose of providing a higher level of care required by a particular patient.

5.5.b.7.D. The minimum equipment and supplies as defined by OEMS policy is determined by the level of service being provided on a particular EMS incident and shall be onboard at the time of response and during patient treatment and transport.

5.6 Specialized Multi Patient Medical Transport (SMPMT) vehicles:

5.6.a. A specialized multi patient medical transport (SMPMT) vehicle is used to transport patients, with a medical history and no apparent immediate need for any level of medical supervision, to and from scheduled medical appointments.

5.6.b. SMPMT vehicles shall be maintained in good repair and operating condition and shall have a current state inspection if required by the state issuing the vehicle license.

5.6.c. The interior of SMPMT vehicles, including all storage areas, equipment, and supplies shall be clean and sanitary;

5.6.d. Safety belts shall be available and operational for all seat positions in SMPMT vehicles.

5.6.e. SMPMT vehicles shall not be equipped with any form of stretcher.

5.6.f. An EMS agency may not use SMPMT vehicle for delivery of basic or advanced life support, except in case of disaster.

5.6.g. SMPMT vehicle specifications include the following:

5.6.g.1. The vehicle may be a commercial passenger van or specially modified passenger van. Passenger sedans, limousines, recreational vehicles and sport utility vehicles with less than three (3) passenger doors and a wheelbase of less than one hundred (100) inches are not permitted.

5.6.g.2. The name of the agency shall appear on both sides and back of the vehicle in four inch (4") minimum height letters. Clearly readable logos or emblems are acceptable.

5.6.g.3. A contact phone number, other than 911, may appear on the vehicle

5.6.g.4. Neither the word ambulance nor other EMS emergency designation shall appear on the vehicle, provided that such appearing as part of the name of the agency shall be exempt.

5.6.g.5. No Star of Life shall be permitted on the vehicle.

5.6.h. Equipment and supplies for SMPMT vehicles include:

5.6.h.1. Communications equipment which provides voice communications between the vehicle and its dispatch center

5.6.h.2. The minimum equipment and supplies required are as specified in OEMS policy.

5.6.i. All SMPMT vehicles shall be inspected by OEMS.

5.6.j. SMPMT vehicles shall be staffed with one (1) EMS personnel who shall be certified, at a minimum, as an Emergency Medical Vehicle Operator pursuant to subsection 6.7. of this rule.

§64-48-6. Personnel.

6.1. Minimum Eligibility Requirements. – Applicants for certification as EMS personnel, and certificate holders, shall meet and maintain compliance with the following:

6.1.a. Be at least eighteen (18) years of age, provided that Emergency Medical Responder and Emergency Medical Technician minimum shall be sixteen (16) years of age, and further provided that persons under eighteen (18) years of age shall not serve as primary patient care attendant or driver of any EMS vehicle.

6.1.b. Be neat and clean in appearance.

6.1.c. Possess the ability to speak, hear, read and write the English language.

6.1.d. Possess physical and mental abilities to independently perform all relevant EMS skills including, but not limited to: performing physical assessments, providing appropriate patient care, calculating medication dosages, communicating effectively, and documenting patient care activities.

6.1.e. Possess manual dexterity and fine motor skills required to perform all patient care functions.

6.1.f. Possess ability to bend, stoop, crawl, and walk on uneven surfaces.

6.1.g. Meet minimum vision requirements to operate a motor vehicle in the state.

6.2. Standards of Conduct

6.2.a. EMS personnel shall comply with all applicable rules, policies and procedures implemented by the State Emergency Medical System.

6.2.b. EMS personnel shall comply with all federal, state, and local laws.

6.2.c. EMS personnel shall not be impaired by legal or illegal drugs or intoxicating substances while on duty, when responding to or operating at EMS incidents, and when engaged in any patient care activities.

6.2.d. EMS personnel shall not misrepresent themselves as authorized to perform a level of care for which they are not currently certified or authorized nor provide such care. Except that students currently enrolled in an approved EMS education program when properly authorized and supervised may provide care for which they are trained.

6.2.e. EMS personnel shall not obtain, aid or encourage another person or entity to obtain agency licensure, vehicle permits, certification, endorsement or designation through fraud, deceit, forgery or other misrepresentation or falsification of information.

6.2.f. EMS personnel shall not make false statements, misrepresentations, file false credentials or conceal or omit information from OEMS regarding application for agency licensure, vehicle permitting, certification, endorsement or investigation.

6.2.g. EMS personnel shall not alter or change the appearance or wording of any license, permit, certificate, endorsement, designation, patient care record, or other official documents for the purpose of fraud, deceit, forgery or other deliberate misrepresentation or falsification of information.

6.2.h. EMS personnel shall not possess, remove, use or administer any controlled substances, medications, medication delivery devices, or other regulated medical devices from any EMS agency, EMS vehicle, healthcare facility, academic institution or other location without documented authorization.

6.2.i. EMS personnel shall not discriminate in the provision of emergency medical services based on race, gender, religion, age, national origin, medical condition or any other reason prohibited by law.

6.2.j. EMS personnel shall not engage in illegal harassment of patients or coworkers.

6.2.k. EMS personnel shall not disclose medical information regarding any patient without that patient's consent, except that information required for continuation of treatment, for payment purposes or operations, including quality review investigations and training, or by mandate of a legally issued subpoena or lawful court order.

6.2.l. EMS personnel shall disclose illegal, unethical acts and/or conduct of EMS personnel or agencies to OEMS.

6.2.m. EMS personnel shall possess state issued certification credentials while on duty, when responding to or operating at EMS incidents, and when engaged in any patient care activities.

6.2.n. EMS personnel shall report to OEMS and to their affiliated EMS agencies within ten (10) days any arrest, indictment, misdemeanor or felony conviction, or revocation, suspension or other disciplinary sanction of a certificate or other privilege to practice any health care profession or occupation in any state or exclusion from federal reimbursement programs.

6.3. Certification Requirements. In addition to the requirements of subsection 6.1. of this rule, all applicants for Emergency Medical Vehicle Operator, Emergency Medical Dispatcher, Emergency Medical Responder, Emergency Medical Technician, Advanced Care Technician, Paramedic, Mobile Critical Care Paramedic or Mobile Critical Care Nurse certification shall meet the following requirements:

6.3.a. Apply in a format prescribed by the Commissioner.

6.3.b. Submit appropriate fees as described in subsection 6.9. of this rule.

6.3.c. Continuously meets all requirements for EMS personnel as described in this rule.

6.3.d. Disclose any limitations or exclusions by an EMS agency, EMS Medical Director or any other healthcare profession certification or licensing authority in any state. Such limitations or exclusions may be considered by the Commissioner prior to issuance of certification in West Virginia.

6.3.e. Possess valid CPR certification prescribed by the Commissioner.

6.3.f. Apply for and be cleared by background checks as specified by the Commissioner, including, but not limited to; federal and state criminal background checks, child support status check, sexual offender registry, federal and state medical practice exclusions or restrictions.

6.3.f.1. Shall not have demonstrated an inability or unwillingness to comply with state laws, rules, procedures, etc.

6.3.f.2. Shall not pose a threat to public safety, health or welfare.

6.3.g. Successfully completes an education program appropriate for the level of certification as prescribed by the Commissioner.

6.3.h. Successfully complete cognitive and skills examinations appropriate for the level of certification as prescribed by the Commissioner.

6.3.i. Meet other requirements as may be established by the Commissioner.

6.4. Recertification Requirements. All applicants for Emergency Medical Vehicle Operator, Emergency Medical Dispatcher, Emergency Medical Responder, Emergency Medical Technician, Advanced Care Technician, Paramedic, Mobile Critical Care Paramedic or Mobile Critical Care Nurse recertification shall meet the following:

6.4.a. Apply for recertification during the last year of his or her certification period, but no later than ninety (90) days prior to the end of the applicant's certification period;

6.4.b. Apply in a format prescribed by the Commissioner;

6.4.c. Submit appropriate fees as described in subsection 6.9. of this rule;

6.4.d. Continuously meets all requirements for EMS personnel as described in this rule;

6.4.e. Shall disclose any limitations or exclusions by an EMS agency, EMS Medical Director or any other healthcare profession certification or licensing authority in any state. Such limitations or exclusions may be considered by the Commissioner prior to issuance of recertification in West Virginia;

6.4.f. Possess valid CPR certification prescribed by the Commissioner;

6.4.g. Complete refresher and continuing medical education as prescribed by the Commissioner appropriate for the level of certification;

6.4. h. Demonstrate continued competency via one of the following methods:

6.4.h.1. Maintain continuous National Registry certification, if applicable, or

6.4. h.2. Successfully complete any state cognitive and skills examinations prescribed by the Commissioner appropriate for the level of certification.

6.4.i. Meet other requirements as may be established by the Commissioner.

6.5. Credential Transfer Requirements. -- The Commissioner may grant certification to individuals certified as an Emergency Medical Dispatcher, Emergency Medical Responder, Emergency Medical Technician, Advanced Care Technician, Paramedic, or equivalent levels, in another U. S. state or territory provided that the individual:

6.5.a. Meets all requirements for the EMS certification level for which he or she is applying as described in this rule;

6.5.b. Demonstrates current equivalent education and certification in another US state or territory, the US military or federal agency;

6.5.c. Applies for and is cleared by background checks as specified by the Commissioner, including, but not limited to federal and state criminal background checks, child support status check, federal and state medical practice exclusions or restrictions;

6.5.d. Demonstrates competency via one of the following methods:

6.5.d.1. Possesses current National Registry certification at the appropriate level; or

6.5.d.2. Previous National Registry certification at the appropriate level with continuous, current, state certification with one (1) year or more remaining; or

6.5.d.3. Possesses a valid state certification with one (1) year or more remaining, provided that such applicants may be required to successfully complete state cognitive and skills examinations as prescribed by the Commissioner.

6.5.e. Completes training and education in West Virginia protocols and scope of practice at the appropriate level as prescribed by the Commissioner;

6.5.f. Meets other requirements as may be established by the Commissioner.

6.5.g. Shall disclose any limitations or exclusions by an EMS agency, EMS Medical Director or any other healthcare profession certification or licensing authority in any state. Such limitations or exclusions may be considered by the Director or Commissioner prior to issuance of certification in any state.

6.6. Certification Period. -- Certification as an Emergency Medical Dispatcher, Emergency Medical Vehicle Operator, Emergency Medical Responder, Emergency Medical Technician, Advanced Care Technician, Paramedic, Mobile Critical Care Paramedic or Mobile Critical Care Nurse is valid for a period of two (2) years with expiration dates determined by the Commissioner.

6.7. Emergency Medical Vehicle Operator.

6.7.a. Certification Requirements:

6.7. a.1. Apply in a format prescribed by the Commissioner;

6.7. a.2. Submit appropriate fees as described in subsection 6.9. of this rule;

6.7.a.3. Be 18 years of age;

6.7.a.4. Possess valid CPR certification as prescribed by the Commissioner;

6.7.a.5. Successfully complete hazardous materials awareness training meeting Department of Labor, Occupational Safety and Health Administration (OSHA) 1910.120 requirements or greater;

6.7.a.6. Successfully complete first aid training meeting United States Department of Labor, OSHA 1910.266, appendix B, requirements or greater;

6.7.a.7. Apply for and be cleared by background checks as specified by the Commissioner, including, but not limited to federal and state criminal background checks, child support status check, sexual offender registry, federal and state medical practice exclusions or restrictions;

6.7.a.8. Shall disclose any limitations or exclusions by an EMS agency, EMS Medical Director or any other healthcare profession certification or licensing authority in any state. Such limitations or exclusions may be considered by the Commissioner prior to issuance of certification credentials;

6.7.a.9. Possess and maintain a valid driver's license;

6.7.a.10. Shall not have been convicted of driving under the influence of alcohol or drugs, reckless driving or other vehicular violation causing bodily injury or death within the two (2) years prior to submitting an application; and

6.7.a.11. Successful completion of an emergency vehicle operator course as approved by the Commissioner.

6.7.b. Recertification requirements:

6.7.b.1. Apply in a format prescribed by the Commissioner;

6.7. b.2. Submit appropriate fees as described in subsection 6.9. of this rule;

6.7.b.3. Possess valid CPR certification as prescribed by the Commissioner;

6.7.b.4. Successfully complete hazardous materials awareness training meeting US Department of Labor OSHA 1910.120 requirements or greater;

6.7.b.5. Possess valid first aid certification meeting US Department of Labor OSHA 1910.266, appendix B requirements or greater;

6.7.b.6. Possess and maintain a valid driver's license.

6.8. EMT-Miner. This certification is established in accordance with WV Code §22A-10-1, et seq.

6.8.a. Certification Requirements:

6.8.a.1 Apply in a format prescribed by the Commissioner;

6.8. a.2. Submit appropriate fees as described in subsection 6.10. of this rule;

6.8.a.3. Be 18 years of age;

6.8.a.4. Possess valid CPR certification prescribed by the Commissioner;

6.8.a.5. Successfully complete an education program, as prescribed by the Commissioner;

6.8.a.6. Successfully complete cognitive and skills examinations as prescribed by the Commissioner; and

6.8.a.7. Certification shall be valid for a period of three (3) years.

6.8.b. Recertification requirements:

6.8.b.1. Apply in a format prescribed by the Commissioner;

6.8.b.2. Submit appropriate fees as described in subsection 6.10. of this rule;

6.8.b.3. Successful completion of a thirty-two (32) hour recertification course for three (3) year certification, or

6.8.b.4. Successful completion of eight (8) hours of specific training each year for one (1) year certification; and

6.8.b.5. Successfully complete cognitive and skills examinations as prescribed by the Commissioner for the appropriate recertification method.

6.8.c. Practice as a certified EMT-Miner shall only be authorized during the certificate holder's active employment on mine property.

6.9. Fees. Non-refundable certification fees for Emergency Medical Vehicle Operator, Emergency Medical Responder, Emergency Medical Technician, Advanced Care Technician, Paramedic, Mobile Critical Care Paramedic or Mobile Critical Care Nurse applicants, to be deposited in the Emergency Medical Services Agency Licensure Fund, establish by the provisions of WV Code §16-4C-6b, shall be paid as follows:

6.9.a. Initial certification via National Registry or state examination, includes fingerprint processing: \$50.00;

6.9.b. Recertification via National Registry maintenance or state process: \$25.00;

6.9.c. Legal recognition: \$100.00;

6.9.d. Reinstatement:

6.9.d.1. If expired beyond two (2) years, includes fingerprint processing: \$100.00;

6.9.d.2. Certification suspended or otherwise expired as a result of actions taken per subsection 7.5. of this rule: \$100.00.

6.10. Fees for EMT-Miner and Emergency Medical Dispatcher applicants:

6.10.a. Initial certification: \$25.00;

6.10.b. Recertification: \$25.00.

6.11. Fee for certification modification: \$5.00.

6.12. Card or certificate replacement: \$5.00.

6.13. Late (within 90 days of expiration date) recertification application, additional \$25.00.

§64-48-7. Investigative/Disciplinary.

7.1. The Commissioner may initiate investigations on his or her own motion, and shall, upon the written complaint of any person, cause investigations to be conducted to determine if disciplinary action is called for and impose the sanctions upon EMS personnel as described in WV Code §16-4C-9. Reasons for such actions include, but are not limited to:

7.1.a. Failure to comply with any requirements of subsections 6.1. or 6.2. of this rule;

7.1.b. Incompetent practice while providing emergency medical services;

7.1.c. Abuse or abandonment of a patient;

7.1.d. Willful preparation or filing of false medical reports or records, or the inducement of others to do so;

7.1.e. Destruction of medical records required to be maintained;

7.1.f. Failure to comply with patient care reporting requirements as established by the Commissioner;

7.1.g. A willful or consistent pattern of failure to complete details on a patient's medical record;

7.1.h. Having a license, certification or other authorization to practice a health care profession or occupation revoked, suspended or subjected to disciplinary sanction;

7.1.i. Improper disclosure of confidential patient information;

7.1.j. Violating a duty imposed by the EMS act, this rule or an order of the Commissioner previously entered in a disciplinary proceeding; or

7.1.k. Other reasons as determined by the Commissioner which may pose a threat to the health and safety of the public or exposes the public to risk or loss.

7.2. The Commissioner may initiate complaints, investigations and impose the sanctions upon EMS agencies as described in WV Code §16-4C-9. Reasons for such actions include, but are not limited to:

7.2.a. Failure to comply with any requirements of section 4 of this rule;

7.2.b. Operating EMS vehicles which fail to comply with section 5 of this rule;

7.2.c. Failure to comply with all applicable rules, policies and procedures of the OEMS;

7.2.d. Disclosure of medical or other information if prohibited by Federal or State law;

7.2.e. Preparation or filing of false medical reports or records, or the inducement of others to do so;

7.2.f. Failure to disclose illegal, unethical acts and/or conduct of EMS personnel or agencies to OEMS.

7.2.g. Failure to report to OEMS, within ten (10) days any known arrest, indictment, misdemeanor or felony conviction, or revocation, suspension or other disciplinary sanction of a certificate or other authorization to practice any health care profession or occupation in any state for all EMS personnel affiliated with the agency.

7.2.h. Destruction of medical records required to be maintained;

7.2.i. Refusal to render emergency medical care because of a patient's race, sex, creed, national origin, age, handicap, medical problem or financial inability to pay;

7.2.j. Violating a duty imposed by the act, this rule or an order of the Commissioner previously entered in a disciplinary proceeding; or

7.2.k. Other reasons as determined by the Commissioner which may pose a threat to the health and safety of the public or exposes the public to risk or loss.

7.3. Investigation. -- Investigations shall be conducted with the intent to obtain appropriate resolution of complaints.

7.3.a. OEMS may conduct investigations in conjunction with licensed agencies or law enforcement personnel as well as conduct separate and distinct investigations themselves.

7.3.b. OEMS shall investigate any and all matters within its jurisdiction, in accordance with established investigative protocols.

7.3.c. If it is determined that OEMS does not have jurisdiction over an investigative matter, OEMS may refer the complaint to another agency or organization having jurisdiction.

7.3.d. Initiation of an OEMS investigation does not release an EMS agency or other responsible entity from performing an internal investigation or imposing sanctions.

7.4. Filing of false or slanderous allegations against EMS personnel may result in penalties for civil as well as criminal false reporting.

7.5. Disciplinary and Corrective Action -- The Commissioner may impose disciplinary or corrective measures in this rule upon EMS Agencies and EMS personnel for non compliance with this rule. Disciplinary options may include, but are not limited to one or more of the following:

7.5.a. Administrative fines of up to \$5,000 per violation;

7.5.b. Denial of certification;

7.5.c. Written reprimand;

7.5.d. Limitation on certificate holder's authorization to practice;

7.5.e. Limitation of licensee's provision of service;

7.5.f. Required refresher courses or other education at the individual's expense;

7.5.g. Consent agreement;

7.5.h. Probation;

7.5.i. Suspension;

7.5.j Revocation; and

7.5.k. Mandatory participation in a detoxification/rehabilitation program at the individual's expense.

7.5.1. The factors which may be considered by the Commissioner when determining the appropriate disciplinary action include, but are not limited to:

7.5.1.1. Nature and severity of the actions under consideration;

7.5.1.2. Actual or potential harm to the public or public trust;

7.5.1.3. Actual or potential harm to a patient;

7.5.1.4. Prior disciplinary record;

7.5.1.5. Prior remediation;

7.5.1.6. Number or variety of the actions under consideration;

7.5.1.7. Aggravating evidence;

7.5.1.8. Mitigating evidence;

7.5.1.9. Discipline imposed by the EMS agency or EMS Medical Director, if any, for the same occurrence;

7.5.1.10. In cases of criminal conviction, compliance with the terms of the sentence or court ordered conditions;

7.5.1.10.A. The period of time elapsed since the act leading to conviction occurred.

7.6. Administrative Fines -- OEMS may impose an administrative fine of up to five thousand dollars (\$5,000.00) per violation on any licensee or certificate holder found by the preponderance of the evidence to have committed any of the infractions described by this rule.

7.6.a. In assessing fines, OEMS shall give due consideration to the appropriateness of the fine with respect to factors that include the gravity of the violation, the good faith of the licensee or certificate holder, the history of previous violations, and the totality of the discipline to be imposed.

7.6.b. Fines shall be paid in a manner prescribed by the Commissioner within sixty (60) days of receipt of notice of a fine.

7.7. Procedures for hearing, right of appeal, judicial review shall apply as described in WV Code §16-4C-10.

7.7.a. It is the intention of this rule to safeguard the citizens of West Virginia by preventing any person who may be unfit or unqualified from practicing in EMS and to safeguard the interests of EMS personnel by affording them due process of law and an opportunity for fair notice and a meaningful hearing.

7.7.b. Those persons adversely affected by the enforcement of this rule desiring a contested case hearing to determine any rights, duties, interests or privileges shall do so in a manner prescribed in the West Virginia Bureau for Public Health rule, 64CSR01, Rules of Procedure for Contested Case Hearings and Declaratory Rulings, and the provisions of this rule.

7.8. Confidentiality of Proceedings.

7.8.a. It is the intention of this rule that any action taken by the Commissioner prior to the completion of administrative remedies and procedures established by WV Code §16-4C-10 and §29-5-1 et seq. shall remain confidential to the greatest extent consistent with the public good and State law.

7.8.b. The Commissioner shall communicate proposed action prior to the completion of the administrative remedies and procedures only to the affected individual, his or her EMS agency, the agency medical director and the regional medical director of the region affected.

7.9. Filing Papers.

7.9.a. Written communications concerning proceedings under this rule shall be filed with the Commissioner by mailing the communications to the OEMS and the Commissioner shall consider the postmark on the communications to be the filing date of the communications.

7.9.b. Copies of the written communications shall be furnished to the affected individual, his or her EMS agency(s) official representative, the agency's medical director and the regional medical director for the region affected, and a notation shall be endorsed on all these communications showing that all of these persons have been furnished copies.

7.10. Emergency Suspension. -- The Commissioner or Director may issue an emergency suspension order to any licensee or certificate holder if there is probable cause that the conduct or continued service or practice of any licensee or certificate holder may create danger to public health or safety.

7.10.a. An emergency suspension is effective immediately without a hearing or prior notice to the license holder or certificate holder. Notice to the license holder shall be presumed

established on the date that a copy of the signed emergency suspension order is sent to the licensee or certificate holder via US certified mail, return receipt requested, at the address shown in the current records of OEMS or via personal service;

7.10.b. A copy of the emergency suspension order shall be sent to the licensee's or certificate holder's EMS agency(s) official representative and medical director and may be sent to other parties whose legitimate interests may be at risk;

7.10.c. Written request for a hearing shall be received within ten (10) days of the notification of suspension order. Such written request shall specify the grounds for the appeal;

7.10.d. Upon receipt of the written request, OEMS shall respond to the request for a hearing within ten (10) days;

7.10.e. Hearing appeals shall be governed by WV Code §29-A-5.

§64-48-8. Education.

8.1. Endorsement of Sponsors of Continuing Education. – The Commissioner may grant endorsement to an applicant as a continuing education sponsor provided that the following requirements are met:

8.1.a. Entities and institutions shall apply in a format prescribed by the Commissioner;

8.1.b. Continuing education programs shall contribute directly to the professional competence, skills, and education of EMS personnel;

8.1.c. Lead instructors shall possess the necessary practical and academic skills to conduct the courses effectively and meet all standards specified by OEMS;

8.1.d. Visiting instructors shall possess the necessary practical and academic skills to present specific content effectively.

8.1.e. Continuing education program materials shall be written and distributed to attendees at or before the time offered whenever practical;

8.1.f. Continuing education programs shall be presented in a suitable setting, including on-line or other distributive education methods, appropriate to the educational purpose of the specific course;

8.1.g. Continuing education programs shall be submitted and approved in a manner and time frame specified by OEMS;

8.1.h. If the continuing education sponsor is a licensed EMS agency, the agency shall be in compliance with the OEMS standards for Agency Training Officer Programs. The Agency Training Officer Program shall have at a minimum:

8.1.h.1. An Agency Training Coordinator – This individual shall meet the standards and policies as set forth by OEMS, or;

8.1.h.2. An Agency Training Officer – This individual shall meet the standards and policies as set forth by OEMS

8.1.i. Endorsement of the continuing education sponsor shall be effective for five (5) calendar years, provided that revocation of program endorsement may occur per subsection 8.5. of this rule.

8.2. BLS Training Institutes. -- A BLS training institute shall be a secondary or post-secondary institution, or a consortium of secondary or post-secondary institutions or other entities determined by OEMS to be qualified to deliver EMS education. To qualify for endorsement as a BLS training institute, the entity shall comply with the following:

8.2.a. Criteria. -- The institute shall demonstrate the ability to conduct one (1) or more of the following training programs:

8.2.a.1. Emergency Medical Technician original course compliant with Department of Transportation (DOT) National EMS Education Standards or standards approved by OEMS;

8.2.a.2. Emergency Medical Technician Refresher compliant with DOT National EMS Education Standards or standards approved by OEMS;

8.2.a.3. Emergency Medical Responder compliant with DOT National EMS Education Standards or standards approved by OEMS;

8.2.a.4. Emergency Medical Responder refresher compliant with DOT National EMS Education Standards or standards approved by OEMS.

8.2.a.5. Emergency Medical Dispatcher compliant with DOT National Education Standards or standards approved by OEMS.

8.2.a.6. Emergency Medical Technician-Miner compliant with standards approved by OEMS.

8.2.a.7. Emergency Medical Technician-Miner refresher compliant with standards approved by OEMS.

8.2.b. Personnel.

8.2.b.1. Medical Director. – The institute shall have a medical director who is a physician licensed in the State of West Virginia. The medical director shall be experienced in emergency medical care and shall assist with:

8.2.b.1.A. Practical skills development and testing;

8.2.b.1.B. Recruitment, selection and orientation of training institute faculty; and

8.2.b.1.C. Providing medical advice and assistance to training institute faculty and students;

8.2.b.1.D. Provide medical oversight for student clinical practice.

8.2.b.2. Administrative Director. -- A BLS training institute shall have an administrative director who has experience in educational administration. Responsibilities of the administrative director include:

8.2.b.2.A. Application processing and oversight of the student selection process;

8.2.b.2.B. Class scheduling and assignment of instructors;

8.2.b.2.C. Provision and maintenance of required training equipment;

8.2.b.2.D. Request written and practical examinations;

8.2.b.2.E. Maintenance and submission of student records in a manner specified by OEMS;

8.2.b.2.F. Select and supervise qualified instructors and skills evaluators;

8.2.b.2.G. Manage EMS budget for the institute; and

8.2.b.2.H. Administer grievance procedure as outlined in paragraph 8.2.d.3. of this rule.

8.2.b.3. Lead Instructor. -- BLS training institutes shall designate a lead instructor for each educational program conducted by the training institute. Lead instructors shall possess the necessary practical and academic skills to conduct programs effectively and comply with all instructor standards specified by OEMS. The lead instructor is responsible for the management and supervision of specific BLS educational programs offered by the training institute.

8.2.b.4. Visiting Instructor. -- BLS training institutes may use the services of adjunct faculty for specific portions of an educational program. Such faculty shall have expertise in a particular area and are not required to be certified EMS personnel or have specific EMS experience. A visiting instructor is not eligible to be lead instructor.

8.2.b.5. BLS Practical Skills Evaluator. -- This individual shall meet the standards and policies as set forth by OEMS.

8.2.c. Facilities and Equipment. -- The institute shall maintain, or by agreement have

available, facilities necessary for the provision of BLS training courses. The facilities shall include classrooms and space for equipment storage, and shall be a suitable setting devoted to the educational purpose of the course. The institute shall provide and maintain the essential equipment and supplies to provide all approved programs of instruction as determined by OEMS.

8.2.d. Operating Procedures.

8.2.d.1. The institute shall develop and implement an anti-discrimination policy with respect to student selection and faculty recruitment.

8.2.d.2. Records shall be maintained on each enrolled student including class performance, practical and written examination results, and reports made concerning the progress of the student during the training program.

8.2.d.3. The institute shall provide a mechanism by which students may appeal decisions made by the institute regarding dismissal or other disciplinary action.

8.2.d.4. Students shall be provided with a clear description of the program and its content including learning goals, course objectives, and competencies to be attained.

8.2.d.5. The institute shall submit documentation of all educational programs in a manner specified by OEMS.

8.2.e. Liability - The institute shall provide evidence of professional liability and errors and omissions insurance in the amount of one million dollars (\$1,000,000) for all training programs offered by the institute.

8.2.f. Endorsement of the BLS Training Institute shall be effective for five (5) calendar years, provided that revocation of program endorsement may occur per subsection 8.5. of this rule.

8.3. ALS Training Institutes. -- An ALS training institute shall be a post-secondary institution, or a consortium of a post-secondary institution and other entity determined by OEMS to be qualified to deliver EMS education. To qualify for endorsement as an ALS training institute, the entity shall comply with the following:

8.3.a. Training Programs. -- The institute shall evidence the ability to conduct one (1) or more of the following training programs:

8.3.a.1. Paramedic course compliant with DOT National EMS Education Standards or standards approved by OEMS;

8.3.a.2. Paramedic refresher course compliant with DOT National EMS Education Standards or standards approved by OEMS;

8.3.a.3. Advanced Care Technician (ACT) course, compliant with DOT National

EMS Education Standards or standards approved by OEMS; or

8.3.a.4. Advanced Care Technician (ACT) refresher course, compliant with DOT National EMS Education Standards or standards approved by OEMS.

8.3.b. The ALS training institute shall maintain appropriate clinical agreements with hospitals and ALS prehospital care agencies for the provision of student clinical experiences.

8.3.c. Personnel.

8.3.c.1. Medical Director. -- An institute shall have a medical director who is a physician licensed in the State of West Virginia. The medical director shall be experienced in emergency medical care and shall assist with:

8.3.c.1.A. Practical skills development and testing;

8.3.c.1.B. Recruitment, selection and orientation of training institute faculty; and

8.3.c.1.C. Providing medical advice and assistance to training institute faculty and students.

8.3.c.1.D. Provide medical oversight for student clinical practice;

8.3.c.1.E. Identify and approve facilities and ALS services where students can fulfill clinical and field internship requirements;

8.3.c.1.F. Identify and approve individuals to serve as field and clinical preceptors for supervising and evaluating student performance when fulfilling clinical and field internship requirements.

8.3.c.2. Program Director. -- The program director shall have a Bachelors Degree in a related field and at least three (3) years of experience in education administration and three (3) years of experience in ALS patient care. Responsibilities of the program director include:

8.3.c.2.A. Application processing and oversight of the student selection process;

8.3.c.2.B. Class scheduling and assignment of instructors;

8.3.c.2.C. Provision and maintenance of required training equipment;

8.3.c.2.D. Request written and practical examinations;

8.3.c.2.E. Maintenance and submission of student records in a manner specified by OEMS; and

8.3.c.2.F. Select and supervise qualified course coordinators, instructors and

skills evaluators.

8.3.c.2.G. Manage EMS education budget for the institute.

8.3.c.2.H. Administer grievance procedure as outlined in paragraph 8.2.d.3.

8.3.c.3. Lead Instructor. -- The ALS training institute shall designate a lead instructor for each course of instruction conducted by the training institute. Lead instructors shall possess the necessary practical and academic skills to conduct programs effectively and comply with all instructor standards specified by OEMS. Specific duties of the lead instructor also include:

8.3.c.3.A. Scheduling and supervising course instructors;

8.3.c.3.B. Scheduling and supervising student clinical activities and field internships;

8.3.c.3.C. Maintenance and submission of student records in a manner specified by OEMS;

8.3.c.3.D. Providing counseling services for students; and

8.3.c.3.E. Development of course syllabi and instructional resources.

8.3.c.4. Clinical Preceptors. -- The ALS training institute shall ensure the availability of qualified clinical preceptors for each clinical rotation. The clinical preceptor is responsible for the supervision and evaluation of students while fulfilling clinical requirements in an approved facility.

8.3.c.5. Field Preceptors. -- The ALS training institute shall ensure the availability of qualified field preceptors for each student. The field preceptor is responsible for supervision and evaluation of students while fulfilling field internships with an approved ALS service.

8.3.c.6. Visiting Instructor. -- ALS training institutes may use adjunct faculty for specific portions of an educational program. Such faculty shall have expertise in a particular area and are not required to be certified EMS personnel or have specific EMS experience. A visiting instructor is not eligible to be lead instructor.

8.3.c.7. ALS Practical Skills Evaluator. -- This individual shall meet the standards and policies as set forth by OEMS.

8.3.d. Facilities and Equipment. -- The institute shall maintain, or by agreement have available, facilities necessary for the provision of ALS training courses. The facilities shall include classrooms and space for equipment storage, and shall be a suitable setting devoted to the educational purpose of the course. The institute shall provide and maintain the essential equipment and supplies to provide all approved programs of instruction as determined by OEMS

8.3.e. Operating Procedures.

8.3.e.1. The institute shall develop and implement an anti-discrimination policy with respect to student selection and faculty recruitment.

8.3.e.2. Records shall be maintained on each enrolled student including class performance, practical and written examination results, and reports made concerning the progress of the student during the training program.

8.3.e.3. The institute shall provide a mechanism by which students may appeal decisions made by the institute regarding dismissal or other disciplinary action.

8.3.e.4. Students shall be provided with a clear description of the program and its content, including learning goals, course objectives, and competencies to be attained.

8.3.e.5. The institute shall submit documentation of all education programs in a manner specified by OEMS.

8.3.f. Liability - The institute shall provide evidence of professional liability and errors and omissions insurance in the amount of one million dollars (\$1,000,000) for all training programs offered by the institute.

8.3.g. Endorsement of the ALS Training Institute shall be effective for five (5) calendar years, provided that revocation of program endorsement may occur per subsection 8.5. of this rule.

8.3.h. Alternative Recognition Method.

8.3.h.1. In lieu of the standards described thus far in this section, OEMS may endorse any institute that is accredited by a nationally recognized accrediting agency for EMS educational programs, provided that the standards used by that agency meet or exceed state endorsement standards. In addition, the following conditions apply:

8.3.h.1.A An OEMS official shall accompany national accrediting agency officials during site visits to the ALS Training Institute.

8.3.h.1.B . The accrediting agency shall forward a copy of the findings of the site visit directly to OEMS.

8.4. CCT Training Institutes. -- A CCT training institute shall be a post-secondary institution, or a consortium of a post-secondary institution and other entity determined to be qualified by OEMS to deliver EMS education. To qualify for endorsement as a CCT training institute, the entity shall comply with the following:

8.4.a. Training Programs. -- The institute shall demonstrate the ability to conduct the following training programs approved by the Commissioner:

8.4.a.1. Critical Care Transport (CCT) course compliant with STEMS Standards;

8.4.a.2. Critical Care Transport (CCT) refresher content compliant with STEMS Standards;

8.4.b. The CCT training institute shall maintain appropriate clinical agreements with hospitals and ALS prehospital care agencies for the provision of student clinical experiences.

8.4.c. Personnel.

8.4.c.1. Medical Director. -- An institute shall have a medical director who is a physician licensed in the State of West Virginia. The medical director shall be experienced in critical care medicine. The responsibilities of the medical director include:

8.4.c.1.A. Assuring that the course content is in compliance with standards set by STEMS;

8.4.c.1.B. Assisting with the recruitment, selection, and orientation of training institute faculty;

8.4.c.1.C. Providing technical advice and assistance to training institute faculty and students;

8.4.c.1.D. Approving the content of written and practical skills and participate in the final skills evaluation;

8.4.c.1.E. Identifying and approving facilities and CCT services where students can fulfill clinical and field internship requirements;

8.4.c.1.F. Identifying and approving individuals to serve as qualified field and clinical preceptors.

8.4.c.2. Lead Instructor. -- The CCT training institute shall designate a lead instructor for each educational program conducted by the training institute. Lead instructors shall possess the necessary practical and academic skills to conduct programs effectively and comply with all instructor standards specified by OEMS. The lead instructor is responsible for the management and supervision of specific CCT educational programs offered by the training institute. Duties of the lead instructor include:

8.4.c.2.A. Application processing and oversight of the student selection process;

8.4.c.2.B. Class scheduling and assignment of instructors;

8.4.c.2.C. Provision and maintenance of required training equipment;

8.4.c.2.D. Request written and practical examinations;

8.4.c.2.E. Maintenance and submission of student records in a manner specified by STEMS; and

8.4.c.2.F. Select and supervise qualified instructors and skills evaluators.

8.4.c.3. Clinical Preceptors. -- The CCT training institute shall ensure the availability of qualified clinical preceptors for each clinical rotation. The clinical preceptor is responsible for the supervision and evaluation of students while fulfilling clinical requirements in an approved facility.

8.4.c.4. Field Preceptors. -- The CCT training institute shall ensure the availability of qualified field preceptors for each student. The field preceptor is responsible for supervision and evaluation of students while fulfilling field internships with an approved CCT service.

8.4.c.5. Visiting Instructor. -- CCT training institutes may use adjunct faculty for specific portions of an educational program. Such faculty will have expertise in a particular area and are not required to be certified EMS personnel or have specific EMS experience. A visiting instructor is not eligible to be lead instructor.

8.4.c.6. CCT Practical Skills Evaluator. -- This individual shall meet the standards and policies as set forth by STEMS.

8.4.d. Facilities and Equipment. -- The institute shall maintain, or by agreement have available, facilities necessary for the provision of CCT training courses. The facilities shall include classrooms and space for equipment storage, and shall be a suitable setting devoted to the educational purpose of the course. The institute shall provide and maintain the essential equipment and supplies to provide all approved programs of instruction as determined by OEMS.

8.4.e. Operating Procedures.

8.4.e.1. The institute shall develop and implement an anti-discrimination policy with respect to student selection and faculty recruitment.

8.4.e.2. Records shall be maintained on each enrolled student including class performance, practical and written examination results, and reports made concerning the progress of the student during the training program.

8.4.e.3. The institute shall provide a mechanism by which students may appeal decisions made by the institute regarding dismissal or other disciplinary action.

8.4.e.4. Students shall be provided with a clear description of the program and its content, including learning goals, course objectives, and competencies to be attained.

8.4.e.5. The institute shall submit documentation of all educational programs in a

manner specified by STEMS.

8.4.f. Liability - The institute shall provide evidence of professional liability and errors and omissions insurance in the amount of one million dollars (\$1,000,000) for all training programs offered by the institute.

8.4.g. Endorsement of the CCT Training Institute shall be effective for five (5) calendar years, provided that revocation of program endorsement may occur per subsection 8.5. of this rule.

8.5. Renewal/Suspension/Revocation of Endorsement.

8.5.a. Renewal: At least ninety (90) days prior to the program endorsement expiration, the institute shall reapply in a format prescribed by the Commissioner. The Commissioner may renew the sponsor's endorsement if the sponsor meets the following requirements:

8.5.a.1. The sponsor has offered, within the five (5) year endorsement period, at least:

8.5.a.1.A. Sponsors of Continuing Education - Ten (10) approved educational courses; or

8.5.a.1.B. Providers of Original Certification Education (BLS, ALS & CCT) – Three (3) approved educational courses with a cumulative sixty percent (60%) completion rate for initially enrolled students; and,

8.5.a.2. The program has maintained continual compliance with all requirements of this rule appropriate for the educational programs it provides.

8.5.b. The Commissioner may suspend or revoke the endorsement of a training institute for one (1) or more of the following:

8.5.b.1. Failure to maintain compliance with all criteria, standards and policies set forth by STEMS;

8.5.b.2. Absence of completed programs or student enrollment in programs for two (2) consecutive years shall result in automatic revocation of program endorsement;

8.5.b.3. Failure to meet performance measures as established by STEMS:

8.5.b.4. Evidence of falsification of any program activity or student record:

8.5.b.5. Loss of independent program accreditation status, if applicable:

8.5.b.6. Other reasons as determined by the Commissioner which may pose a threat to the health and safety of the public or exposes the public to risk or loss.

8.5.c. The Commissioner shall give written notice to the institute's administrative director thirty (30) days prior to withdrawing endorsement. The notice shall identify specific reasons for withdrawal of endorsement.

8.5.d. The institute shall have fifteen (15) days to respond to the notice. The Commissioner shall determine whether the withdrawal stands or is reconsidered.

§64-48-9. Medical Direction.

9.1. Off-Line Medical Direction.

9.1.a. EMS Medical Director. -- The EMS Medical Director shall be a physician appointed by the Commissioner to be in charge of overseeing the medical aspects of the West Virginia EMS System.

9.1.a.1. The EMS Medical Director shall have the following qualifications:

9.1.a.1.A. A valid, unrestricted license to practice medicine in the State of West Virginia;

9.1.a.1.B. Experience in emergency management of acutely ill or injured patients;

9.1.a.1.C. Experience in on-line medical direction of EMS personnel;

9.1.a.1.D. Experience in the education of EMS personnel;

9.1.a.1.E. Experience in the medical audit, review, and critique of EMS personnel and agencies;

9.1.a.1.F. Board certification in emergency medicine; and

9.1.a.1.G. Experience in medical administration and management.

9.1.a.2. The EMS Medical Director shall perform the following duties:

9.1.a.2.A. Act as the primary medical authority on all medical issues pertaining to the statewide EMS system;

9.1.a.2.B. Chair the Medical Policy and Care Committee (MPCC);

9.1.a.2.C. Review and recommend to the Commissioner the appointment of all regional EMS Medical Directors;

9.1.a.2.D. Establish and review all system-wide medical protocols and policies in consultation with the state Emergency Medical Policy and Care Committee;

9.1.a.2.E. Designate all regional medical command centers;

9.1.a.2.F. Consult with the Commissioner, as requested, concerning revocations of EMS personnel certification;

9.1.a.2.G. Assist OEMS in establishing certification, recertification, and continuing education requirements for EMS personnel;

9.1.a.2.H. Review and recommend the designation of specialty care centers to the Commissioner;

9.1.a.2.I. Maintain liaison with the members of the legislature on medical issues related to EMS;

9.1.a.2.J. Review state procedures, plans, and processes for compliance with current standards of emergency medical care;

9.1.a.2.K. May appoint physician specialists and other appropriate medical personnel to the MPCC;

9.1.a.2.L. Delegate portions of their authority to other qualified physicians; and

9.1.a.2.M. Perform other duties as assigned by the Commissioner.

9.1.a.3. The EMS Medical Director has the following authority:

9.1.a.3.A. Final decision on all matters of a medical nature related to STEMS;

9.1.a.3.B. To restrict privileges of EMS personnel at any time in order to assure quality patient care;

9.1.a.3.C. To establish medical policies and procedures to carry out the activities outlined in this rule; and

9.1.a.3.D. Other authority as designated by the Commissioner.

9.1.b. Medical Policy and Care Committee (MPCC). -- The MPCC is composed of each regional medical director and may include physicians representing specialty areas such as pediatrics, trauma, cardiology and others as necessary. The committee serves as the primary policy making body and advisory body to the EMS Medical Director concerning medical issues involving the EMS system. The committee shall meet at least annually, or more frequently as necessary.

9.1.b.1. The MPCC has the following duties and authority:

9.1.b.1.A. Create, review, and approve treatment, triage and transportation protocols utilized within the state EMS system;

9.1.b.1.B. Determine medications and procedures utilized within STEMS;

9.1.b.1.C. Establish scopes of practice for all certified EMS personnel;

9.1.b.1.D. Act on and/or advise the EMS Medical Director on emergency health related issues;

9.1.b.1.E. Establish policies and procedures governing categorization of individual facility medical capabilities in order to determine the appropriateness of EMS transport to that facility.;

9.1.b.1.F. Implement procedures necessary to carry out its duties; and

9.1.b.1.G. Perform other duties as assigned by the EMS Medical Director or Commissioner.

9.1.c. Regional Medical Director. -- The regional medical director shall be a physician, recommended by the regional board of directors, and appointed by the Commissioner in consultation with the EMS Medical Director to oversee medical aspects of a regional EMS system.

9.1.c.1. The regional medical director shall have the following qualifications:

9.1.c.1.A. A valid, unrestricted license to practice medicine in the State of West Virginia;

9.1.c.1.B. Experience in emergency management of acutely ill or injured patients;

9.1.c.1.C. Experience in on-line medical direction of EMS personnel;

9.1.c.1.D. Experience in the education of EMS personnel;

9.1.c.1.E. Experience in the medical audit, review, and critique of EMS personnel and agencies;

9.1.c.1.F. Board certification in emergency medicine is preferred, however, this requirement may be waived in the discretion of the EMS Medical Director.

9.1.c.2. The regional EMS Medical Director shall perform the following duties:

9.1.c.2.A. Serve as the medical liaison with the EMS Medical Director;

9.1.c.2.B. Serve as a member of the MPCC;

9.1.c.2.C. Serve as the primary medical authority on medical issues of the regional EMS system;

9.1.c.2.D. Review the appointments of all Agency Medical Directors;

9.1.c.2.E. Implement and monitor a regional performance improvement program;

9.1.c.2.F. Educate, train and monitor the medical command physicians who operate in the regional command centers;

9.1.c.2.G. May serve as medical director of the regional medical command center;

9.1.c.2.H. Establish and review protocols in conjunction with the MPCC;

9.1.c.2.I. Serve as medical liaison to the regional EMS board of directors;

9.1.c.2.J. Assist STEMS in ensuring that personnel in the regional EMS system comply with certification, recertification, credentialing and continuing education requirements established by OEMS;

9.1.c.2.K. Recommend to OEMS disciplinary actions involving EMS personnel;

9.1.c.2.L. Delegate portions of their authority to other qualified physicians as needed;

9.1.c.2.M. Review plans, procedures, and processes within the region for compliance with current standards of emergency care; and

9.1.c.2.N. Meet with the Agency Medical Directors within the region, at least annually, or as necessary to disseminate information regarding activities of the STEMS system.

9.1.c.3. Authority. -- The regional EMS Medical Director may restrict privileges of any prehospital personnel within the region at any time in order to assure quality patient care. This may be accomplished in conjunction with the Agency Medical Director. This restriction of privileges shall be according to guidelines established by STEMS.

9.1.d. Agency Medical Director -- The agency medical director, by written agreement with the Agency, and concurrence of the regional EMS Medical Director and State EMS Medical Director, oversees medical aspects of an EMS agency or local EMS system and extends or restricts the privilege to practice to EMS personnel associated with the agency.

9.1.d.1. Qualifications. -- The Agency Medical Director shall possess:

9.1.d.1.A. A valid, unrestricted license to practice medicine in the State of West

Virginia;

9.1.d.1.B. Experience in prehospital and emergency department management of acutely ill or injured patients;

9.1.d.1.C. The following qualifications are desirable but may be waived by the Regional Medical Director:

9.1.d.1.C.1 Experience in on-line medical direction of EMS personnel;

9.1.d.1.C.2. Experience in the education of EMS personnel;

9.1.d.1.C.3. Experience in the medical audit, review, and critique of EMS personnel and agencies; and

9.1.d.1.C.4. Board certification in emergency medicine.

9.1.d.2. Responsibilities. -- The Agency Medical Director shall:

9.1.d.2.A. Provide advice and guidance of all aspects of the medical care provided by the agency/county;

9.1.d.2.B. Be the physician on whose authority all medical care is administered by agency/county EMS personnel;

9.1.d.2.C. Grant, restrict or deny privileges for EMS personnel practice within the agency/county;

9.1.d.2.D. Oversee the medical review of patient care provided by the agency/county;

9.1.d.2.E. Serve as a member of the regional MPCC; and

9.1.d.2.F. Perform other duties as assigned by the regional or EMS Medical Directors or the Commissioner.

9.1.d.3. Authority. -- The Agency Medical Director may restrict privileges of EMS personnel affiliated with the agency/county at any time in order to assure quality patient care. This restriction of privileges shall be according to guidelines established by OEMS.

9.2. On-line Medical Direction.

9.2.a. Regional Medical Command Centers are centers designated by the MPCC, and STEMS, with advice of the respective Regional EMS Board of Directors, to serve as the regional medical command center for all on-line medical control of EMS personnel operating in a particular region.

9.2.a.1. Requirements/ Designation. -- Regional medical command centers shall meet the following requirements:

9.2.a.1.A. Be equipped with appropriate communication equipment, as specified by STEMS, to communicate with EMS vehicles and personnel and interface with the STEMS communications system;

9.2.a.1.B. Meet all requirements listed in this rule;

9.2.a.1.C. Agree to abide by all policies and procedures contained in the state/regional communications systems plan as established by STEMS; and

9.2.a.1.D. Agree to abide by medical treatment protocols or guidelines, triage and destination protocols or guidelines, and other policies and procedures as approved by the STEMS Medical Direction System.

9.2.a.2. Staffing. -- The Regional Command Center shall be staffed twenty-four (24) hours per day, three hundred sixty-five (365) days per year by paramedic communication specialists and shall have ready access to medical command physicians at all times.

9.2.a.3. Responsibilities. -- The regional medical command facility shall:

9.2.a.3.A. Serve as the authoritative medical command center for its primary designated area, but with the possibility of an expanded coverage area in the event of a disaster and/or the inoperability of other medical command centers;

9.2.a.3.B. Control and facilitate all communications of a medical nature for the EMS agencies and personnel operating in its region including ground and aeromedical EMS vehicles;

9.2.a.3.C. Serve as the final decision maker regarding the provision of patient care for all prehospital EMS incidents within the region, including, but not limited to interpretation/authorization of patient treatment, facility destination or diversion protocols and guidelines;

9.2.a.3.D. Assist EMS agencies and personnel with medical direction for interfacility transfer patient care, as needed;

9.2.a.3.E. Follow all procedures and guidelines governing delivery of medical command and direction of units as established by STEMS including, but not limited to, data collection and quality assurance;

9.2.a.3.F. Maintain a record keeping system as outlined by STEMS guidelines and make those records available to state or regional EMS Medical Directors, or STEMS investigators, for review as requested;

9.2.a.3.G. Perform other duties as assigned by regional or EMS Medical

Directors ; and

9.2.a.3.H. Provide on-line medical command to EMS personnel passing through the region who require medical direction.

9.2.a.4. Authority. -- The regional medical command center has the authority to implement procedures necessary to carry out its duties outlined in this rule and STEMS guidelines.

9.2.a.5. Alternative Facilities. -- Regions may elect to have alternate command facilities in the event of equipment malfunction or when the primary center cannot be contacted for any reason. These backup facilities shall be approved by the EMS Medical Director and included in the regional communication plan. In the event none of the command facilities can be reached, then the receiving hospital may provide medical command as needed to EMS personnel.

§64-48-10. EMS Personnel in Emergency Departments.

10.1. EMS personnel employed by the hospital may, in the event of a life threatening emergency, perform their full scope of practice as outlined by the MPCC, within the hospital under the direct supervision of the attending physician.

10.2. In all other situations EMS personnel may only perform those services outlined in the written policy and procedures established by the local facility as outlined in subsection 10.3. of this section.

10.3. Any hospital using and/or employing EMS personnel to provide services within the hospital emergency room or department shall develop and implement written policies and procedures governing these activities. These policies and procedures shall:

10.3.a. Include the roles, responsibilities, and specific tasks or procedures which may be performed by EMS personnel;

10.3.b. Be developed jointly by the director of nursing of the emergency room and the medical director of the emergency room or department;

10.3.c. Allow for the direct supervision of the EMS personnel by a registered professional nurse and comply with all supervision guidelines established by the Board of Registered Professional Nurses;

10.3.d. Comply with the training requirements established by STEMS;

10.3.e. Contain specific procedures governing medical review and quality improvement of services provided by EMS personnel in the hospital setting and shall include the mechanisms for identification, correction, training, and disciplinary functions associated with these activities; and

10.3.f. Be approved by the Joint Care Committee as established in subsection 10.7. of this rule.

10.4. EMS personnel shall not exceed the scope of practice established by the MPCC for the individual's certification level.

10.5. EMS personnel shall maintain active EMS certification and meet all requirements for contained in section 6 of this rule.

10.6. The medical facility shall maintain training records and in-service records of the EMS personnel in their employment and make such available for inspection by STEMS and/or the Board of Examiners for Registered Professional Nurses.

10.7. The EMS Medical Director or designee and the President of the Board of Examiners for Registered Professional Nurses or designee shall establish a Joint Care Committee for the purpose of establishing minimum guidelines for the policies and procedures to be used by the local facilities concerning the functioning of EMS personnel in the emergency room setting. These guidelines may include a list of specific procedures and activities performed by EMS personnel in the emergency room setting and shall also contain the definition of a life threatening emergency.

§64-48-11. Administrative Due Process.

Any person adversely affected by the enforcement of this rule desiring a contested case hearing to determine any rights, duties, interests or privileges shall do so in a manner prescribed in the Bureau for Public Health rule, Rules of Procedure for Contested Case Hearings and Declaratory Rulings, 64CSR01.