

AGREEMENT

THIS AGREEMENT is made and entered into this 12th day of June, 2018, by and between the COUNTY OF FRESNO, a Political Subdivision of the State of California, hereinafter referred to as "COUNTY," and VALLEY CHILDREN'S HOSPITAL, a California non-profit public benefit corporation, whose address is 9300 Valley Children's Place, Madera, CA 93638-8762, hereinafter referred to as "CONTRACTOR" (collectively, "the Parties").

WITNESSETH:

WHEREAS, COUNTY's Department of Public Health's Emergency Medical Services (EMS) Division, is the designated Local EMS Agency (hereinafter referred to as the "EMS Agency") for the Counties of Fresno, Kings, Madera and Tulare, as provided in Health & Safety Code section 1797.200; and

WHEREAS, COUNTY and EMS Agency recognize a continuous need for a Level II Pediatric Trauma Center to serve pediatric trauma victims in Fresno, Kings, Madera and Tulare Counties; and

WHEREAS, CONTRACTOR desires that the local EMS Agency designate CONTRACTOR as a Level II Pediatric Trauma Center in accordance with Title 22, Division 9, Chapter 7 of the California Code of Regulations, entitled "Trauma Care Systems" (§§ 100236 et seq.; hereinafter referred to as the "Trauma Care Regulations"), and the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act (Health & Safety Code, §§ 1797 et seq.; hereinafter referred to as the "EMS Act"); and

WHEREAS, in order for CONTRACTOR to be designated by the EMS Agency as a Level II Pediatric Trauma Center, CONTRACTOR is required to have a written agreement with the EMS Agency for the provision of such services, as provided by Trauma Care Regulation, section 100255(g); and

WHEREAS, CONTRACTOR represents that it will maintain and operate a qualifying trauma center, in accordance with the Trauma Care Regulations and the EMS Act, and is agreeable to such designation by the EMS Agency subject to the terms and conditions provided herein; and

NOW, THEREFORE, in consideration of their mutual covenants and conditions, and other valuable consideration, the receipt and adequacy of which is hereby acknowledged, the parties hereto

1 agree as follows:

2 **1. THE EMS SYSTEM/DESIGNATION OF CONTRACTOR**

3 A. The parties acknowledge and agree that the EMS Agency has the authority to
4 plan, implement and evaluate an emergency medical services system in Fresno, Kings, Madera, and
5 Tulare Counties pursuant to Health and Safety Code sections 1797.200 and 1797.204.

6 B. The parties acknowledge and agree that the EMS Agency has the authority to
7 implement and update a trauma care system for the EMS System, including the authority to designate
8 a Level II Pediatric Trauma Center for the EMS System, pursuant to Health & Safety Code sections
9 1798.160 et seq. of the EMS Act, and the Trauma Care Regulations.

10 C. The parties acknowledge and agree that the EMS Agency Medical Director
11 (including his or her Assistant Medical Directors) of the EMS Agency has the authority of medical
12 control of the EMS System, including the trauma care system, and the authority to assure medical
13 accountability through the planning, implementation and evaluation of the EMS System, including the
14 trauma care system, set forth in Health and Safety Code section 1797.202.

15 D. The parties acknowledge and agree that the service area for the
16 CONTRACTOR's Level II Pediatric Trauma Center is Fresno, Kings, Madera, and Tulare Counties.

17 E. CONTRACTOR acknowledges and agrees that neither the COUNTY nor the
18 EMS Agency makes any representation, warranty or guarantee, and cannot and do not assure
19 CONTRACTOR that any minimum number of trauma patients will be delivered or referred to
20 CONTRACTOR's facilities.

21 F. CONTRACTOR acknowledges and agrees that the EMS Agency's designation of
22 CONTRACTOR as a Level II Pediatric Trauma Center for the EMS System is made on a non-
23 exclusive basis, and that the EMS Agency reserves the right to designate any other qualifying
24 hospitals, at any time, as a Level I, II, III or IV Trauma Center or Level I or II Pediatric Trauma Center
25 for the EMS System. CONTRACTOR acknowledges that the EMS Agency has previously designated
26 Community Regional Medical Center as a Level I Trauma Center and Kaweah Delta Medical Center,
27 in Visalia, as a Level III Trauma Center for the EMS System, as provided in the Regional Trauma Plan.

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1 **2. RESPONSIBILITIES OF CONTRACTOR**

2 CONTRACTOR shall, at its own expense, at all times during the term of this Agreement:

3 A. Operate and function as a Level II Pediatric Trauma Center for all patients
4 presenting at CONTRACTOR's facilities, regardless of their ability to pay.

5 B. Provide and maintain the following as required to provide trauma center services
6 as a Level II Pediatric Trauma Center under this Agreement:

7 1. All facilities and resources, including, but not limited to, all necessary utilities,
8 supplies, equipment and furniture; and

9 2. All physicians, nurse and other professional personnel, and such technical,
10 administrative, allied and supportive paramedical personnel and such other personnel.

11 In this regard, CONTRACTOR specifically covenants that it will at all times comply with,
12 Trauma Care Regulations sections 100261 (entitled, "Level I and Level II Pediatric Trauma Centers")
13 which is incorporated herein by reference.

14 C. Take all necessary action to maintain the designation as a Level II Pediatric
15 Trauma Center in accordance with the EMS Act, the Trauma Care Regulations, and the EMS Agency
16 Policies and Procedures now in effect, or which may hereafter come into effect, all of which are
17 incorporated herein by reference.

18 D. Provide trauma center services as a Level II Pediatric Trauma Center in
19 accordance with all Federal, State, and local laws, and regulations now in effect, or which may
20 hereafter come into effect (including, but not limited to, the EMS Act and Trauma Center Regulations),
21 all of which are incorporated herein by reference.

22 E. Comply with all EMS Agency Policies and Procedures now in effect, or which
23 may hereafter come into effect, including, but not limited to, those policies and procedures related to
24 trauma care (EMS Agency Policies #330 – Trauma System Overview, #331 – Trauma Facility
25 Designation, #332 – Trauma System Monitoring, #333 – Trauma Center Criteria, and #334 – Trauma
26 Registry Data Collection) and with the EMS System's continuous quality improvement process
27 requirements now in effect, or which may hereafter come into effect (EMS Agency Policies #703 and
28 #704 adopted pursuant Trauma Care Regulation, sec. 100265, entitled "Quality Improvement"), all of

1 which are attached hereto as Exhibit A and incorporated herein by reference.

2 F. Within twenty-four (24) months from the COUNTY's execution of this Agreement,
3 obtain and continuously maintain, without interruption, American College of Surgeons Committee on
4 Trauma (ACS-COT) verification as a Level II Pediatric Trauma Center.

5 G. Actively and cooperatively participate as a member of the Regional Trauma Audit
6 Committee and the Central Region Trauma Coordinating Committee.

7 H. Develop and/or conduct periodic instructional and educational programs for the
8 benefit of the hospitals and pre-hospital care personnel throughout the EMS System that are related to
9 pre-hospital and in-hospital trauma care for patients.

10 I. Provide and maintain radio and communications equipment in CONTRACTOR's
11 facilities for communications with pre-hospital ambulance providers and hospitals throughout the EMS
12 region.

13 J. Maintain all licenses, permits and certificates necessary to operate as an acute
14 care hospital, which, at minimum, includes basic or comprehensive emergency services available,
15 pursuant to the Trauma Care Regulation, section 100261(c), and to maintain accreditation by the Joint
16 Commission on Accreditation of Healthcare Organizations, pursuant to Trauma Care Regulation,
17 section 100248, entitled, "Trauma Care Regulation."

18 K. Provide all appropriate medical direction and control as a Base Hospital, when
19 necessary, to emergency medical services personnel in the field in accordance with EMS Agency
20 Policies and Procedures, now in effect, or which may hereafter come into effect, including but not
21 limited to EMS Policy #311 – Base Hospital Criteria, attached hereto as Exhibit B and incorporated
22 herein by this reference.

23 L. Take corrective action where there is a failure of CONTRACTOR to comply with
24 the Trauma Center Standards set forth in EMS Policy #333 (See Exhibit A). The minimum acceptable
25 period of time to correct a deviation from or deficiency in complying with the standard or standards
26 shall be determined by the EMS Agency's Director on a case-by-case basis applicable to the situation.
27 Notice of any deficiencies alleged against contractor, must be sent in writing for review prior to any
28 action taken. CONTRACTOR's failure to take such corrective action within the time specified by the

1 EMS Agency may, upon declaration thereof by COUNTY, result in breach of this Agreement.

2 L. Perform all other obligations of CONTRACTOR under this Agreement.

3 **3. RESPONSIBILITIES OF COUNTY**

4 COUNTY shall, at its own expense, at all times during the term of this Agreement cause
5 and/or request the EMS Agency to:

6 A. Develop, implement and monitor trauma care system policies and procedures.

7 B. Develop and implement triage procedures, which include injury severity
8 assessment and the determination of patient destination.

9 C. Provide appropriate information and data to CONTRACTOR on the Trauma Care
10 System.

11 D. Perform periodic announced or unannounced site visits to CONTRACTOR's
12 facilities for the purpose of monitoring CONTRACTOR's performance under and compliance with this
13 Agreement. Site visits shall not unnecessarily interrupt CONTRACTOR or CONTRACTOR's
14 personnel.

15 E. Develop and implement, with input from CONTRACTOR, a Trauma Registry
16 Program and Trauma Registry database for the purpose of data collection, monitoring of trauma
17 centers' compliance with the Trauma Center Standards in the Regional Trauma Plan and evaluation of
18 the trauma care system.

19 F. Perform all other obligations of COUNTY under this Agreement.

20 **4. TERM**

21 The term of this Agreement shall be for a period of three (3) years, commencing on July 1, 2018
22 through and including June 30, 2021. This Agreement may be extended for two (2) additional
23 consecutive (12) month periods upon written approval of both parties no later than thirty (30) days
24 prior to the first day of the next twelve (12) month extension period. The Director of the Department of
25 Public Health or his or her designee is authorized to execute such written approval on behalf of
26 COUNTY based on CONTRACTOR's satisfactory performance.

27 **5. TERMINATION**

28 A. Non-Allocation of Funds - The terms of this Agreement, and the services to be

1 provided thereunder, are contingent on the approval of funds by the appropriating government agency.
2 Should sufficient funds not be allocated, the services provided may be modified, or this Agreement
3 terminated at any time by giving CONTRACTOR thirty (30) days advance written notice.
4 Notwithstanding anything stated to the contrary in this Agreement, the provisions of this Section 5.A.
5 shall not be construed as imposing any obligations on COUNTY or the EMS Agency to compensate
6 CONTRACTOR for any service it may provide, or function or activity that it may perform or undertake
7 in connection with this Agreement.

8 B. Breach of Contract - The COUNTY may immediately suspend or terminate this
9 Agreement in whole or in part, where in the determination of the COUNTY there is:

- 10 1) A failure to comply with any term of this Agreement;
11 2) A substantially incorrect or incomplete report submitted to the COUNTY;
12 or
13 3) Improperly performed service.

14 However, the COUNTY shall provide written notice to CONTRACTOR of any noncompliance with this
15 Agreement. CONTRACTOR shall have a reasonable time from the time of receipt of notice to cure any
16 noncompliance with this Agreement.

17 C. Without Cause - Under circumstances other than those set forth above, this
18 Agreement may be terminated by either party upon the giving of thirty (30) days advance written notice
19 of an intention to terminate.

20
21 **6. NO MONETARY COMPENSATION**

22 CONTRACTOR's Level II Pediatric Trauma Center functions, services and activities
23 conducted pursuant to the terms and conditions of this Agreement shall be performed without the
24 payment of any monetary compensation by COUNTY to CONTRACTOR. COUNTY shall not be liable
25 for any costs or expenses incurred by CONTRACTOR to satisfy its obligations under this Agreement.

26 The parties acknowledge and agree that their respective covenants made to the other
27 party and benefits received from the other party under this Agreement shall form the basis of the
28 consideration exchanged between them under this Agreement.

7. INDEPENDENT CONTRACTOR

1 A. In order to establish that COUNTY is not a co-employer of CONTRACTOR's
2 officers, agents or employees, the parties agree to the provisions of this Section 7.

3 B. In performance of the work, duties, and obligations assumed by CONTRACTOR
4 under this Agreement, it is mutually understood and agreed that CONTRACTOR, including any and all
5 of CONTRACTOR's officers, agents, and employees, will at all times be acting and performing as an
6 independent contractor, and shall act in an independent capacity and not as an officer, agent, servant,
7 employee, joint venturer, partner, or associate of COUNTY. COUNTY shall retain the right to
8 administer this Agreement so as to verify that CONTRACTOR is performing its obligations in
9 accordance with the terms and conditions thereof. CONTRACTOR and COUNTY shall comply with all
10 applicable provisions of law and the rules and regulations, if any, of governmental authorities having
11 jurisdiction over matters which are directly or indirectly the subject of this Agreement.

12 C. Because of its status as an independent contractor, CONTRACTOR shall have
13 absolutely no right to employment rights and benefits available to COUNTY employees.
14 CONTRACTOR shall be solely liable and responsible for providing to, or on behalf of, its employees all
15 legally-required employee benefits. In addition, CONTRACTOR shall be solely responsible and save
16 COUNTY harmless from all matters relating to payment of CONTRACTOR's employees, including
17 compliance with Social Security, withholding, and all other regulations governing such matters. It is
18 acknowledged that during the term of this Agreement, CONTRACTOR may be providing services to
19 others unrelated to the COUNTY or to this Agreement.

20 **8. MODIFICATION**

21 Any matters of this Agreement may be modified from time to time by the written consent
22 of all the parties without, in any way, affecting the remainder.

23 **9. NON-ASSIGNMENT**

24 Neither party shall assign, transfer or sub-contract this Agreement nor their rights or
25 duties under this Agreement without the prior written consent of the other party.

26 **10. HOLD HARMLESS**

27 A. CONTRACTOR agrees to protect, defend, indemnify and hold harmless
28 COUNTY, its elective and appointive boards, officers, agents, employees, EMS Agency, and EMS

1 Agency Medical Director(s), from any and all claims, suits, liabilities, expenses, costs, damages, or
2 judgments of any nature, including attorney fees, for injury to, or death of, any person, and for injury to
3 any property, including consequential damages of any nature resulting therefrom, arising out of, or in
4 any way connected with any negligent or wrongful acts or omissions by, or on behalf of
5 CONTRACTOR, its officers, employees, agents or contractors in performing or failing to perform any
6 services or functions provided for or referred to or in any way connected with any work, services, or
7 functions to be performed by CONTRACTOR, its officers, employees, agents, or contractors under this
8 Agreement. The foregoing clause shall in no way obligate CONTRACTOR to provide such protection,
9 indemnification, or defense to the extent of acts or omissions by COUNTY, its officers, employees,
10 agents, or contractors.

11 B. COUNTY agrees to protect, defend, indemnify and hold harmless
12 CONTRACTOR, its elective and appointive boards, officers, agents and employees from any and all
13 claims, suits, liabilities, expenses, costs, damages, or judgments of any nature, including attorney's
14 fees, for injury to, or death of, any persons, or for injury to any property, including consequential
15 damages of any nature resulting therefrom, arising out of, or in any way connected with the negligent
16 or wrongful acts or omissions by, or on behalf of COUNTY, its officers, employees, agents or
17 contractors in performing or failing to perform any services or functions provided for or referred to or in
18 any way connected with any work, services, or functions to be performed by COUNTY, its officers,
19 employees, agents or contractors under this Agreement. The foregoing clause shall in no way
20 obligate COUNTY to provide such protection, indemnification, or defense to the extent of acts or
21 omissions by CONTRACTOR, its officers, employees, agents, or contractors.

22 C. The aforesaid indemnity and hold harmless clauses by CONTRACTOR and
23 COUNTY shall apply to all damages and claims for damages of every kind suffered, or alleged to have
24 been suffered by the party to be indemnified, including but not limited to attorney fees, by reason of
25 the aforesaid operations of the indemnifying party, regardless of whether or not the insurance policies
26 of the indemnifying party shall have been determined to be applicable to any such damages or claims
27 for damages.

28 In addition, each party agrees to indemnify the other party for Federal, State of California

1 and/or local audit exceptions resulting from non-compliance herein on the part of the indemnifying
2 party.

3 **11. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT**

4 COUNTY and CONTRACTOR each consider and represent themselves as covered
5 entities as defined by the U.S. Health Insurance Portability and Accountability Act of 1996, Public Law
6 104-191(HIPAA) and agree to use and disclose protected health information as required by law.

7 COUNTY and CONTRACTOR acknowledge that the exchange of protected health
8 information between them is only for treatment, payment, and health care operations.

9 COUNTY and CONTRACTOR intend to protect the privacy and provide for the security
10 of Protected Health Information (PHI) pursuant to the Agreement in compliance with HIPAA, the
11 Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (HITECH),
12 and regulations promulgated thereunder by the U.S. Department of Health and Human Services
13 (HIPAA Regulations) and other applicable laws.

14 As part of the HIPAA Regulations, the Privacy Rule and the Security Rule require
15 CONTRACTOR to enter into a contract containing specific requirements prior to the disclosure of PHI,
16 as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code
17 of Federal Regulations (CFR).

18 **12. INSURANCE**

19 Without limiting the right to obtain indemnification from either party, the parties agree, at
20 their sole expense, to maintain in full force and effect the following insurance policies or a program of
21 self-insurance, including but not limited to, an insurance pooling arrangement or Joint Powers
22 Agreement (JPA) throughout the term of this Agreement:

23 A. Commercial General Liability

24 Commercial General Liability Insurance with limits of not less than One Million
25 Dollars (\$1,000,000) per occurrence with an annual aggregate of Five Million
26 Dollars (\$5,000,000). This policy shall be issued on a per occurrence basis.
27 This policy shall include coverage for bodily injury, broad form property damage,
28 personal injury, products and completed operations, and blanket contractual
coverage including, but not limited to, liability assumed under the Indemnification
provisions of this Agreement

B. Automobile Liability

1 Comprehensive Automobile Liability Insurance with a combined single limit of not
2 less than One Million Dollars (\$1,000,000) per accident. Coverage should
include owned and non-owned vehicles used in connection with this Agreement.

3 C. Worker's Compensation

4 A policy of worker's compensation insurance as may be required by the
5 California Labor Code.

6 D. Professional Liability

7 If CONTRACTOR employs licensed professional staff (e.g., Ph.D., R.N.,
8 L.C.S.W., M.F.C.C.) in providing services Professional Liability Insurance with
9 limits of not less than One Million Dollars (\$1,000,000) per incident, Five Million
10 Dollars (\$5,000,000) annual aggregate; Contractor agrees that it shall maintain,
11 at its sole expense, in full force and effect for a period of three (3) years following
12 the termination of this Agreement, one or more policies of professional liability
insurance with limits of coverage as specified therein. Insurance shall provide
13 coverage for incidents including but not limited to, defense of a suit from
14 mandatory reporting to child protective services and defense for sexual conduct
15 and misconduct if alleged as part of an otherwise covered suit.

16 Such insurance policy for Commercial General Liability insurance shall name the other party , its
17 officers, agents, and employees, individually and collectively, as additional insured, but only insofar as
18 the operations under this Agreement are concerned. Such coverage for additional insured shall apply
19 as primary insurance and any other insurance, or self-insurance, maintained by each party, its officers,
20 agents and employees shall be excess only and not contributing with insurance provided under
21 CONTRACTOR's policies herein. This insurance shall not be cancelled without a minimum of thirty
22 (30) days advance written notice given to other party. Both parties shall obtain endorsements to the
Commercial General Liability insurance policy naming other party as an additional insured and
providing for an unrestricted thirty (30) day prior written notice of cancellation.

23 Prior to the commencement of performing its obligations under this Agreement, CONTRACTOR
24 shall provide certificates of insurance, formal endorsements, for the foregoing policies, as required
25 herein, to the County of Fresno, 1221 Fulton Street, Fresno, California, 93721, Attention: Contracts
26 Section, stating that such insurance coverages have been obtained and are in full force; that the
27 County of Fresno, its officers, agents and employees will not be responsible for any premiums on the
28 policies; that such Commercial General Liability insurance names the County of Fresno, its officers,
agents and employees, individually and collectively, as additional insured, but only insofar as the

1 operations under this Agreement are concerned; that such coverage for additional insured shall apply
2 as primary insurance and any other insurance, or self-insurance, maintained by both parties, its
3 officers, agents and employees, shall be excess only and not contributing with insurance provided
4 under policies
5 herein; and that this insurance shall not be cancelled without a minimum of thirty (30) days
6 advance written notice given to other party.

7 In the event either party fails to keep in effect at all times insurance coverage as herein
8 provided, other party may, in addition to other remedies it may have, suspend or terminate this
9 Agreement upon the occurrence of such event.

10 All policies shall be with admitted insurers licensed to do business in the State of California.
11 Insurance purchased shall be purchased from companies possessing a current A.M. Best, Inc. rating
12 of A FSC VII or better.

13 **13. CONFIDENTIALITY**

14 All services performed by CONTRACTOR under this Agreement shall be in strict conformance
15 with all applicable Federal, State of California and/or local laws and regulations relating to
16 confidentiality, now in effect, or which may hereafter come into effect.

17 **14. NON-DISCRIMINATION**

18 During the performance of this Agreement, both parties shall not unlawfully discriminate against
19 any employee or applicant for employment, or recipient of services, because of race, religious creed,
20 color, national origin, ancestry, physical disability, mental disability, medical condition, genetic
21 information, marital status, sex, gender, gender identity, gender expression, age, sexual orientation, or
22 military and veteran status, pursuant to all applicable State of California and Federal statutes and
23 regulations.

24 **15. DISCLOSURE OF SELF-DEALING TRANSACTIONS**

25 This provision is only applicable if the CONTRACTOR is operating as a corporation (a for-profit or
26 non-profit corporation) or if during the term of this Agreement, the CONTRACTOR changes its status
27 to operate as a corporation.

28 Members of the CONTRACTOR's Board of Directors shall disclose any self-dealing transactions

1 that they are a party to while CONTRACTOR is providing goods or performing services under this
2 agreement. A self-dealing transaction shall mean a transaction to which the CONTRACTOR is a party
3 and in which one or more of its directors has a material financial interest. Members of the Board of
4 Directors shall disclose any self-dealing transactions that they are a party to by completing and signing
5 a Self-Dealing Transaction Disclosure Form, attached hereto as Exhibit C and incorporated herein by
6 reference, and submitting it to the COUNTY prior to commencing with the self-dealing transaction or
7 immediately thereafter.

8 **16. RECORDS/REPORTS**

9 CONTRACTOR shall develop and maintain a Trauma Registry Program which is approved by
10 the EMS Agency. The Trauma Registry Program shall include all appropriate trauma patient
11 information and "hospital data" (as that term is defined in Trauma Regulation, section 100257(c))
12 concerning such patients as set forth in EMS Policy #332 – Trauma System Monitoring and the
13 Regional Trauma Plan (See Exhibit A). All such records shall be complete and accurate. The EMS
14 Agency shall have access to all such records upon request. CONTRACTOR shall provide trauma
15 registry data and/or reports to the EMS Agency upon request and/or on a regularly scheduled
16 timetable such as monthly, quarterly, or annually, which will be agreed upon between the EMS Agency
17 and CONTRACTOR. In the event that the EMS Agency develops the capability to directly access and
18 retrieve trauma registry records through computer technology, CONTRACTOR shall, at no cost to the
19 EMS Agency, assist the EMS Agency in achieving such access and retrieval of CONTRACTOR's
20 Trauma Registry Program through such means.

21 **17. LICENSES/CERTIFICATES**

22 CONTRACTOR shall, at its own cost, throughout the term of this Agreement, maintain all necessary
23 licenses, permits and certificates necessary for the provision of services hereunder and now or
24 hereafter required by Federal, State and local laws and regulations, the EMS Agency and any other
25 applicable government agencies. This shall include, but not be limited to: 1) being licensed as a
26 general acute care hospital, and 2) holding a special permit for basic or comprehensive emergency
27 services.

28 **18. AUDITS AND INSPECTIONS**

1 CONTRACTOR shall at any time during business hours, and as often as the County
2 may deem necessary, make available to the COUNTY for examination all of their records and data with
3 respect to the matters covered by this Agreement. CONTRACTOR shall, upon request by the
4 COUNTY, permit the COUNTY to audit and inspect all such records and data necessary to ensure
5 CONTRATOR's compliance with the terms of this Agreement.

6 If this agreement exceeds ten thousand dollars (\$10,000.00), CONTRACTOR shall be subject
7 to the examination and audit of the Auditor General for a period of three (3) years after final payment
8 under contract (Government Code Section 8546.7).

9 **19. NOTICES**

10 The persons having authority to give and receive notices under this Agreement and their
11 addresses include the following:

12 **COUNTY**

13 Director, Fresno County
14 Department of Public
15 Health
16 P. O. Box 11867
17 Fresno, CA 93775

12 **CONTRACTOR**

13 President and COO
14 Valley Children's Hospital
15 9300 Valley Children's Place
16 Madera, CA 93638-8762

17 Any and all notices between the COUNTY and the CONTRACTOR provided for or
18 permitted under this Agreement, or by law, shall be in writing and shall be deemed duly served when
19 personally delivered to one of the parties, or in lieu of such personal service, when deposited in the
20 United States Mail, postage prepaid, addressed to such party.

21 **20. GOVERNING LAW**

22 The parties agree that for the purposes of venue, performance under this Agreement is
23 to be in Fresno County, California.

24 The rights and obligations of the parties and all interpretation and performance of this
25 Agreement shall be governed in all respects by the laws of the State of California.

26 **21. THIRD PARTY BENEFICIARIES**

27 The parties hereto agree that the covenants made and benefits received between them
28 (and for the benefit of the EMS Agency under this Agreement) are only between them (and for the
benefit of the EMS Agency), and that there are no intended third party beneficiaries of this Agreement,

1 provided however, for purposes of this Section 12, the EMS Agency shall be deemed to be an intended
2 beneficiary of this Agreement.

3 **22. ENTIRE AGREEMENT**

4 This Agreement constitutes the entire agreement between the CONTRACTOR and
5 COUNTY with respect to the subject matter hereof and supersedes all previous agreement
6 negotiations, proposals, commitments, writings, advertisements, publications, and understandings of
7 any nature whatsoever unless expressly included in this Agreement.

8 **23. USE OF NAME**

9 COUNTY shall not make any written use of or reference to CONTRACTOR name for
10 any marketing, public relations, advertising, display or other business purpose or make any use of
11 CONTRACTOR facilities for any activity unrelated to the express business purposes and interests of
12 CONTRACTOR without the prior written consent of CONTRACTOR.

13 **24. EXCLUSIONS/SUSPENSIONS**

14 COUNTY confirms that it has not been excluded, debarred or suspended from
15 participation in any governmental program, including but not limited to Medicare, Medicaid, or Medi-Cal
16 payor programs, and is not the subject of any investigation regarding participation in such programs,
17 and has not been convicted of any crime relating to any governmental program. COUNTY agrees to
18 notify CONTRACTOR immediately if COUNTY becomes aware of any adverse action related to
19 COUNTY eligibility to participate in a governmental program. This Agreement shall immediately
20 terminate if COUNTY becomes ineligible.

1 IN WITNESS WHEREOF, the parties hereto have executed this Agreement as of the day and
2 year first hereinabove written.

3 **CONTRACTOR**

COUNTY OF FRESNO

4 Debra A. Flores
5 (Authorized Signature)

Sal Quintero
6 Sal Quintero, Chairperson of the Board of
7 Supervisors of the County of Fresno

8 Debra A. Flores, President
9 Print Name & Title COO Hospital

10 9300 Valley Children's Place
11 Madera, CA 93638-8762
12 Mailing Address

13 **ATTEST:**
14 Bernice E. Seidel
15 Clerk of the Board of Supervisors
16 County of Fresno, State of California

17 By: Lisei Cruz
18 Deputy

19 **FOR ACCOUNTING USE ONLY:**

20 **ORG No.: 56201695**
21 **Account No.: 7295**

CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES
A Division of the Fresno County Department of Public Health

Manual	Emergency Medical Services Administrative Policies and Procedures	Policy Number 330 Page 1 of 4
Subject	Trauma System Overview	
References	California Code of Regulations Title 22. Social Security Division 9. Prehospital Emergency Medical Services Chapter 7. Trauma Care Systems	Effective 11/01/2002

I. POLICY

The Central California Emergency Medical Services Trauma Services System shall operate in accordance with Health and Safety Code Division 2.5, and the California Code of Regulations Title 22, Division 9, Chapter 7 and shall be implemented, monitored and evaluated by the EMS Agency.

The Central California Emergency Medical Services Trauma System maintains a trauma plan and EMS policies and procedures required by Section 100255 of the California Code of Regulations. The intent of the Trauma Plan and EMS policies and procedures is to provide a clear understanding of the structure of the trauma system in a manner that effectively utilizes the systems resources.

The following is a list of the policies required by Section 100255 of the California Code of Regulations and includes brief description of the policy and a reference where further policy information can be located.

A. System Organization and Management

The EMS Division of the Fresno County Department of Public Health is the designated local EMS agency for Fresno, Kings, Madera and Tulare Counties. The EMS Division is responsible for monitoring the ongoing operation of the regional trauma care system. This is accomplished through the development of EMS policies and procedures and by participating in the various EMS committees, including the Regional Trauma Audit Committee. The EMS agency staff supervises the collection and analysis of trauma data, including ongoing development of the trauma patient registry.

A Level I Trauma Center, Community Regional Medical Center (RMC), is located in Fresno and directly receives prehospital trauma patients from within the region often bypassing other receiving hospitals.

A Level III Trauma Center, Kaweah Delta Medical Center (KDMC), is located in Visalia and receives prehospital trauma patients from within Tulare County and adjacent counties.

Approved By	DANIEL J. LYNCH (Signature on File at EMS Agency)	Revision
EMS Director		01/01/2015
	JIM ANDREWS, M.D. (Signature on File at EMS Agency)	
EMS Medical Director		

Subject Trauma System Overview	Policy Number 330
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B. Trauma Care Coordination Within the Trauma System

The prehospital care and treatment of trauma patients shall be in accordance with EMS policy and procedures to insure consistent application of trauma services through-out the EMS region. These policies include EMS Policy # 332 – Trauma System Monitoring, EMS Policy #510 - Basic Life Support Protocols, EMS Policy #530 - Paramedic Treatment Protocols, EMS Policy #547 – Patient Destination, and other EMS policies and procedures.

C. Trauma Care Coordination with Neighboring Jurisdictions

Coordination of Trauma Care with neighboring jurisdictions is addressed in the prehospital setting and also the hospital setting. EMS Policy # 406 – EMS Dispatch Policy - Out of County Responses, and EMS Policy #408 – Helicopter Dispatch Policy, address the coordination of trauma response in the neighboring jurisdictions outside of the Central California EMS region. Coordination of trauma care with neighboring jurisdictions in the hospital setting is addressed in EMS Policy #341 – Patient Transfers Between Acute Care Facilities, and EMS Policy #342 – Transfer Agreements Between Acute Care Hospitals.

D. Collection and Management of Data

The designated trauma centers and non-trauma centers are responsible for submitting all required data to the EMS Agency on a monthly basis or as determined by the EMS Agency. The minimum data set as defined in the State Trauma Regulation Section 100257, is required by all participating trauma hospitals. Collection and management of data for the Central California Emergency Medical Services Trauma System is outlined in EMS Policy #332, and Policy #334. The trauma nurse coordinators/managers provide trauma registry data, which is used by the Trauma Audit Committee and EMS Agency and is submitted to the State’s data system (CEMSIS/NEMSIS).

E. Trauma Center Fees for Designation/Redesignation/Evaluation

There are currently no fees for trauma center designation, redesignation, or trauma center evaluation in the Central California Emergency Medical Services region.

F. Establishment of Service Areas for Trauma Centers

Community Regional Medical Center is the designated Level I trauma center in the Central California EMS region. The service area encompasses the entirety of the Central California EMS region. In very specific circumstances, such as airway compromise, a trauma patient may be transported to a receiving hospital for stabilization before proceeding to the trauma center. Kaweah Delta Medical Center is a designated Level III Trauma Center and is the primary trauma destination for trauma patients in Tulare County.

G. Designation and Re-designation of a Trauma Center/including Agreements

The Local EMS Agency designates Trauma Centers within the EMS Region. Trauma center designation is based upon the need for local and regional trauma care services. Trauma facility designation is outlined in EMS Policy #331 – Trauma Facility Designation.

H. Triage to the Appropriate Facility

The prehospital triage and transport decision process is very similar to the Centers for Disease Control (CDC) field triage process and involves an assessment not only of the physiology and anatomy of the injury but also the mechanism of the injury and special patient considerations. Seriously and moderately injured patients are transported directly to RMC or KDMC. EMS Policy #547 – Patient Destination outlines the required patient destination procedure for both trauma and medical patients.

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I. Repatriation of Stable Trauma Service Health Plan Members

EMS Policy #547 – Patient Destination requires prehospital personnel to attempt to transport stable patients to the patient’s health plan’s participating facility. In 2008, The EMS Agency partnered with the Hospital Council of Northern California and hospitals within the 4-county EMS region to create a patient transfer committee. This committee meets regularly to discuss the issues and barriers with repatriation of patients. Recognized as a best practice, the Committee developed an agreement signed by all hospitals that agrees to criteria and conditions on repatriating patients in an effort to increase capacity at the Trauma Centers and keep local patients in the local areas.

J. Inter-trauma Center & Inter-facility Transfer of the Trauma Patient

The EMS policies and procedures strictly address the coordination and management of Inter-trauma center and inter-facility transfers of the trauma patient and are addressed in EMS Policy #341 – Patient Transfers Between Acute Care Facilities, EMS Policy #342 – Transfer Agreements Between Acute Care Hospitals, and EMS Policy #553 – ALS Interfacility Transfers.

K. Role of the Pediatric Trauma Center

Community Regional Medical Center is the Level I Trauma Center and is the designated destination for all pediatric trauma.

L. Resources for Trauma Team Response- Equipment & Staff

Trauma Centers are required by EMS Policy #333 – Trauma Center Criteria to have internal hospital policies and procedures governing “Trauma Center Medical and Physician Services”, which include the resources and staff required for a trauma team response.

M. Criteria for Activation of the Trauma Team

Trauma Centers are required by EMS Policy #333 – Trauma Center Criteria, to have internal hospital policies and procedures outlining the specific criteria for trauma team activation.

N. Availability of Trauma Specialists

Trauma Centers are required by EMS Policy #333 – Trauma Center Criteria to have internal hospital policies and procedures outlining the availability of trauma team personnel and specialists.

O. Quality Improvement and System Evaluation/ include Multidisciplinary Peer Review Committee

Quality Improvement is a combined effort of hospitals, providers, and the EMS Agency. EMS Policies #703 – Continuous Quality Improvement, and #704 – Quality Improvement Reporting address the access to the continuous quality improvement process. The trauma services system is monitored through the continuous quality improvement process and also through EMS policy #332 – Trauma System Monitoring. The trauma system is also monitored by a peer review committee, which is outlined in EMS Policy #703 – Continuous Quality Improvement.

P. Identification and Transportation of the Adult and Pediatric Trauma Center Candidate

Trauma center patients are identified by a decision process that is very similar to the Centers for Disease Control (CDC) field triage process and involves an assessment not only of the physiology and anatomy of the injury but also the mechanism of the injury and special patient considerations. Once the patient is

Subject	Trauma System Overview	Policy Number 330
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identified as a trauma center patient, the prehospital personnel transport the patient directly to the trauma center in accordance with EMS Policy #547 – Patient Destination.

Q. Trauma Triage Training of Prehospital Personnel

Prehospital Personnel and MICN’s are trained in trauma triage through continuing education courses available throughout the EMS System. Continuing education courses must be in accordance with EMS Policy #701 – Continuing Education.

R. Public Information and Education on Trauma Systems

All public information and education requirements and services relative to the design, implementation, and operational effectiveness of the trauma system will be coordinated through the EMS Agency. Public information and educational activities will encompass trauma system design, citizen access, trauma system capabilities, and mechanism for follow up and incident review as requested by the public and/or medical community. Additional requirements will include:

1. A commitment to the establishment of a trauma system that supports the promotion of injury prevention and safety education.
2. The facilitation of speakers to address public groups and serves as a resource for trauma information and education.
3. Provide assistance to community and professional groups in the development and dissemination of education to the public on such topics as injury prevention, safety education programs and access to the trauma care system.
4. Each designated facility must participate in the development of public awareness and education campaigns for their service area.

S. Provider Marketing and Advertising

California Health and Safety Code, Division 2.5, states in part, “no health care provider shall use the term “trauma facility,” “trauma hospital,” “trauma center,” “trauma care provider,” “trauma care vehicle,” or similar terminology in its signs or advertisements, or in printed materials and information it furnishes to the general public, unless its use has been authorized by the EMS Agency.

All marketing and promotional plans, with respect to trauma center designation, shall be submitted to the EMS Agency for review and approval, prior to implementation.

T. Collaborative Injury Prevention Efforts with the Public/Private Sector

Trauma Centers shall participate in injury prevention programs with public and private agencies. Trauma Centers may produce their own Injury Prevention Programs based upon data analysis of the trauma center review at their facility. Trauma Centers may utilize information developed by the EMS Agency as a result of system review to produce injury prevention programs for the public and private sector in their communities.

CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES
A Division of the Fresno County Department of Public Health

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Subject	Trauma Facility Designation	
References	California Code of Regulations, Title 22. Social Security Division 9. Prehospital Emergency Medical Services Chapter 7. Trauma Care Systems	Effective 11/01/86

I. POLICY

Trauma Centers for the Central California EMS Region are designated by the Local EMS Agency based upon the need for local and regional EMS trauma care services.

II. DESIGNATED TRAUMA CENTERS

The following hospitals have been designated as Trauma Centers:

Trauma Center	Level of Designation	Date of Original Designation
Community Regional Medical Center	Level I Trauma Center	June 19, 1984
Kaweah Delta Medical Center	Level III Trauma Center	January 26, 2010

III. PROCEDURE FOR DESIGNATION

- A. The EMS Agency shall develop and update a plan for the provision of trauma care within the four-county region. This plan shall minimally address the provision of trauma care services, triage mechanisms for patient routing, the number and type of trauma hospitals needed for local and/or regional trauma care needs, and the evaluation process for the trauma system.
- B. The Regional Trauma Audit Committee will formalize recommendations to the EMS Agency concerning all aspects of the trauma system, including the number and type of trauma hospitals needed for effective system operation.
- C. Any hospital wishing to gain a trauma designation shall notify the EMS Agency, in writing, of its intent to seek trauma center designation. This documentation shall include the hospital's justification, plan, proposed trauma patient volume, and anticipated timetable for implementation.

Approved By EMS Director	DANIEL J. LYNCH (Signature on File at EMS Agency)	Revision 01/01/2015
EMS Medical Director	JIM ANDREWS, M.D. (Signature on File at EMS Agency)	

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- D. Prior to designation as a trauma center, the hospital shall submit to the EMS Agency:
 - 1. The Application for Trauma Designation with required documents.
 - 2. A copy of the American College of Surgeons Committee on Trauma (ACS-COT) Consultative Visit if done prior to designation.
 - 3. Documentation that the Trauma Center Standards in Policy 333 have been met.
- E. Applications shall be reviewed for their compliance with the State of California, local regulations and their impact on the local trauma system. The Regional Trauma Audit Committee, Regional Medical Control Committee, and each Emergency Medical Care Committee from each county in the region will be consulted for its recommendation.
- F. If more than one hospital competes for a role in the local system that is deemed necessary by the regional Trauma Audit Committee and the EMS Agency, a Request for Proposal procedure may be necessary to determine the successful applicant.
- G. After review of the submitted application and documents, the EMS Agency will conduct a site review of the facility as outlined in the Application for Trauma Designation. The cost of the site review shall be the sole responsibility of the hospital applying for trauma destination.
- H. Upon the completion of a satisfactory site review, the EMS Agency will designate the hospital as a Level I, II, III, IV, or Pediatric I or II trauma center.
- I. In the event that the hospital fails to meet the criteria for designation, the EMS Agency may elect to issue a conditional designation that will be followed within six (6) to twelve (12) months by another evaluation of the deficient areas.
- J. Upon satisfactory completion of the second evaluation, the EMS Agency will authorize full designation of the Trauma Center.
- K. If the second evaluation is unsatisfactory, the EMS Agency may elect to continue the conditional designation upon correction of the areas of deficiency or deny designation.
- L. The hospital requesting designation and the EMS Agency will enter into a contract for designation of the trauma center.
- M. A designated trauma center shall obtain American College of Surgeons Committee on Trauma (ACS-COT) verification within 2 (two) years of their initial trauma center designation. The cost of the verification shall be the sole responsibility of the hospital requesting such verification.
- N. The EMS Agency shall determine a plan for Trauma Care Services.
- O. Any change in designation will become part of the revised trauma plan and will be approved by the Local EMS Agency prior to submission to the State EMS Authority.

IV PROCEDURE FOR RE-EVALUATION OF A TRAUMA CENTER'S STATUS

- A. The EMS Agency shall evaluate the designated Trauma Centers' Status every three years for contractual compliance and compliance with the California Code of Regulations, Title 22, Division 9, Chapter 7.

Subject: Trauma Facility Designation	Policy Number: 331
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- B. Designated Trauma Centers shall maintain verification with the ACS-COT. Trauma Centers shall submit to the EMS Agency a copy of the re-verification visit summary from the ACS-COT every three years.

V. PROCEDURE FOR DE-DESIGNATION

- A. Failure by a hospital to comply with applicable Local, State, and ACS-COT trauma requirements or applicable recommendations by site survey teams approved by the EMS Agency or ACS-COT, may result in forfeiture of their trauma designation.
- B. Failure by a hospital to provide an adequate quality of care, as identified through medical audit and quality audit procedures, may result in forfeiture of their trauma designation.

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EMERGENCY MEDICAL SERVICES
A Division of the Fresno County Department of Public Health

Manual	Emergency Medical Services Administrative Policies and Procedures	Policy Number 332 Page 1 of 4
Subject	Trauma System Monitoring	
References	California Code of Regulations, Title 22. Social Security Division 9. Prehospital Emergency Medical Services Chapter 7. Trauma Care Systems	Effective 11/01/88

I. POLICY

The trauma care administered to patients of the local trauma care system will be reviewed for appropriateness and patient outcome. This review will be conducted through the use of the Regional Trauma Audit Committee and Regional Medical Control Committee, both which are composed of health care and trauma care specialists.

II. PROCEDURE

A. TRAUMA REGISTRY

1. Definition

The Trauma Registry is a confidential database of patients who have sustained major injuries or complications within the regional trauma system. This database is utilized for statistical reporting on system activities and quality improvement review of patient outcome. Registry data includes information from prehospital, emergency department, operative and intensive care, and the patient's final disposition. Trauma centers and non-trauma centers will follow the criteria outlined in Policy #334 regarding trauma registry data collection.

B. INTERNAL HOSPITAL REVIEW

The medical records (including prehospital) of each registry patient at trauma centers will be reviewed by the Trauma Nurse Coordinator /Manager or designee for completeness, accuracy and presence of any delays in evaluation and treatment. The hospital's Trauma Surgery Director or designee will review the registry records for appropriateness of diagnostic procedures relative to the admitting diagnosis, timeliness of care, appropriateness of operative therapy relative to diagnosis, complications, morbidity, and length of stay relative to diagnosis.

The Trauma Surgery Director and Trauma Nurse Coordinator/Manager will present registry cases that meet the established criteria to the hospital's appropriate reviewing committee. Trauma centers will utilize a specific Trauma Review Committee whose membership shall minimally include:

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EMS Medical Director	JIM ANDREWS, M.D. (Signature on File at EMS Agency)	

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TRAUMA CENTER TRAUMA REVIEW COMMITTEE

Trauma Surgery Director	Neurosurgeon
Emergency Medicine Representative	Orthopedic Surgeon
Trauma Nurse Manager/Coordinator	Hospital Administration
Emergency Department Manager/Supervisor	Prehospital Liaison Nurse

In addition to the members listed above, the Trauma Center should also consider the following representatives:

- Anesthesiology
- General Surgeon
- Nurse Manager - OR
- Nurse Manager – ICU
- Radiology Representative
- Blood Bank Representative

Medical Records will be available to allow the committee to review all aspects of the patient's care and course of hospital stay. The hospital Trauma Review Committee is responsible for reviewing the patient's care, identifying problems, providing feedback to individuals involved in a specific patient's care, formulating recommendations for hospital trauma operational procedures, and classification of deaths as mortality without opportunity for improvement, anticipated mortality with opportunity for improvement, or unanticipated mortality with opportunity for improvement. The committee shall forward unusual or problem cases to the Regional Trauma Audit Committee and formulate recommendations on Trauma Care System and EMS System operation. The definitions for the classifications of death are in accordance with the American College of Surgeons criteria and are as follows:

1. Mortality without opportunity for improvement- An event or complication sequela of a procedure, disease, illness, or injury for which reasonable and appropriate preventable steps had been taken.
2. Anticipated mortality with opportunity for improvement – An event or complication that is a sequela of a procedure, disease, illness, or injury that has the potential to be prevented or substantially ameliorated.
3. Unanticipated mortality with opportunity for improvement – An event or complication that is an expected or unexpected sequela of a procedure, disease, illness, or injury that could have been prevented or substantially ameliorated.

C. REGIONAL TRAUMA AUDIT COMMITTEE

1. Membership

The Regional Trauma Audit Committee is an advisory committee to the EMS Agency on issues related to trauma care. The membership shall be broad-based and shall represent the participants in the Trauma System and the local medical community. The Trauma Audit Committee membership shall minimally include:

MEMBERSHIP OF THE REGIONAL TRAUMA AUDIT COMMITTEE (TAC)

Trauma Centers	Non-Trauma Hospitals
Trauma Surgery Director	Trauma Surgery Director
Emergency Department Physician	Emergency Department Physician
Trauma Nurse Coordinator/Manager	Trauma Nurse Coordinator/PLN

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EMS Agency	Local Medical Community
EMS Medical Director	Neurosurgeon (from Neurosurgical Society)
EMS Director	Physician from Rural Area (from Medical Society)
EMS Trauma Coordinator	

Each of the agencies listed above shall notify the EMS Medical Director, in writing, of the name of the person designated to represent the agency and exercise Committee voting privileges. There will be one vote per facility.

2. Chairperson/Vice Chairperson

The Committee shall elect a Chairman who shall serve a term of one year with new elections each January. The committee may elect to choose a co-chairperson. The EMS Medical Director will serve as Vice Chairman in the event of absence of the chairperson (and co-chairperson). Meeting Minutes will be recorded on topics not related to specific confidential patient care issues. The EMS Agency will provide staff support for the Regional Trauma Audit Committee.

3. Committee Responsibilities

The Regional Trauma Audit Committee is responsible for reviewing all aspects of the Trauma Care System and developing recommendations on system operation for the EMS Agency. This will include system operation, trauma care planning, data analysis, trauma policy development, hospital assessment and selection and specific patient base reviews.

The Committee's agenda shall include a review and approval of monthly Minutes, case presentations and specific educational case reviews (e.g. neurologic case review, review of EMS procedures related to the Trauma Care System). Agenda items may occur on a regular schedule including monthly (e.g. case presentations) or at the request of the Committee members. Items not included in the Committee's written agenda may be added at the beginning of the meeting at the discretion of the Chairman.

The Trauma Centers will present case presentations each month. Non trauma centers may present problems transfers or problem cases as needed. Criteria for case presentation to the Regional Trauma Audit Committee are included in Attachment A. Specific educational case reviews may be presented to illustrate new techniques, patient problems, or system operational issues related to a medical specialty such as neurosurgery, orthopedics or pediatrics. The EMS Agency will provide monthly reports to the committee on the regional trauma system. The Committee may provide feedback on system operation or quality improvement issues directly to the EMS Agency, health care facility or provider, and other trauma/EMS advisory groups.

D. EMS AGENCY

The local EMS Agency is responsible for monitoring the operation of the Trauma Care System. The EMS Agency may request an onsite review of any designated trauma hospital with repetitive problems to ensure the problems are being resolved. Additional agency involvement (e.g. State Department of Health Care Services) may be requested as appropriate.

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ATTACHMENT A
CASE PRESENTATION CRITERIA

- I. Case Presentations shall occur each month at the regional Trauma Audit Committee. The criteria for case presentation shall include:
- A. Any death classified as unanticipated mortality with opportunity for improvement or anticipated mortality with opportunity for improvement by the hospital Trauma Review Committee, including:
 - 1. All deaths with initial surgery (required for stabilization) >1 hour after arrival at a trauma hospital.
 - 2. All deaths with a delay in the arrival of the surgeon (>10 minutes).
 - 3. All deaths with unanticipated autopsy findings or autopsy findings inconsistent with the admitting diagnosis.
 - 4. All deaths with inappropriate prolonged prehospital time including on-scene times greater than 10 minutes without explanation, or a transport time greater than 30 minutes if air transport was available.
 - 5. All deaths where probability of survival (PS) > 50% based upon Trauma Score - Injury Severity Score (TRISS).
 - B. Major complications (e.g. Grade 2, 3, 4 in accordance with ACS Guidelines) which significantly increase inpatient hospital time or lead to premature death.
 - C. A comatose patient (Glasgow Coma Scale of less than 8) going to CT or, leaving the emergency department before a definitive airway (endotracheal tube or surgical airway) is established.
 - D. Patients with epidural or subdural brain hematoma receiving craniotomy more than 4 hours from arrival at emergency department to surgical start time, excluding those performed for intracranial pressure (ICP) monitoring.
 - E. Delay to surgery for laparotomy:
 - 1. Surgery start time >1 hour if hypotensive (systolic blood pressure <90mm Hg)
 - 2. Surgery start time >4 hours if stable
 - F. Problem Transfers - Any trauma patient transfer of greater than 6 hours from original time of arrival time at the sending hospital.
 - G. Any trauma team activation with a delay in the arrival of the surgeon of greater than 15 minutes.
 - H. Any trauma case where the trauma consultant does not respond in the specified time period.
 - I. Any case which demonstrates system operational problems.
 - J. Interesting or educational cases.

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EMERGENCY MEDICAL SERVICES
A Division of the Fresno County Department of Public Health

Manual	Emergency Medical Services Administrative Policies and Procedures	Policy Number 333 Page 1 of 2
Subject	Trauma Center Criteria	
References	California Code of Regulations Title 22. Social Security Division 9. Prehospital Emergency Medical Services Chapter 7. Trauma Care Systems	Effective 11/08/88

I. POLICY

A trauma center is a licensed hospital, accredited by the Joint Commission on Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, IV, or Pediatric Level I or II trauma center by the Local EMS Agency. Designated trauma centers for the Central California EMS Region shall adhere to the minimum standards set forth in the California Code of Regulations, Title 22, Division 9, Chapter 7, Trauma Care Services and EMS Agency policy and procedure.

II. PROCEDURE

- A. Trauma centers shall maintain, at all times, the standards required of its designation as a Level I, II, III, IV, or Pediatric Level I or II trauma center in accordance the California Code of Regulations, the Central California EMS Policies and Procedures, and the American College of Surgeons Committee on Trauma (ACS-COT) once verified
- B. All designated trauma centers shall achieve and maintain ACS-COT verification within two (2) years of their initial designation as a trauma center. Copies of consultative visits or verification visits by the ACS-COT shall be submitted to the EMS Agency. Designated trauma centers at the time of this policy shall achieve their ACS-COT verification by January 1, 2016.
- C. In addition to the requirements listed in the Trauma Center Standards, a designated trauma center for the CCEMSA EMS Region shall meet and maintain the following additional requirements:
 - 1. Designated trauma centers shall designate a Trauma Program Medical Director, Trauma Nurse Coordinator/Manager, and an emergency department physician who shall regularly attend the EMS Agency’s Regional Trauma Audit Committee. They each shall attend at least nine (9) of the Regional Trauma Audit Committee meetings each calendar year. The emergency department physician representative shall be a board certified in emergency medicine or maintain current certification in Advanced Trauma Life Support (ATLS) and be a certified base hospital physician.
 - 2. Trauma centers shall be designated Base Hospitals and shall meet all requirements outlined in EMS Policy and Procedure.

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EMS Medical Director	JIM ANDREWS, M.D. (Signature on File at EMS Agency)	

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3. Trauma centers are expected to provide a full activation of their team resources for patients that meet the triage criteria for major trauma patients. Patients that are hemodynamically stable, without major anatomic injury may be considered for a reduced trauma team response. If a trauma center chooses to implement a tiered trauma team response, a quality assessment and improvement process must be in place to monitor the effectiveness of the care delivery. A copy of the Trauma Centers written procedure on trauma team response, including the process to monitor its effectiveness, must be on file at the EMS Agency.
 4. Designated trauma centers shall implement and maintain an EMS Agency approved trauma registry data collection program and provide registry data to the EMS agency on a monthly basis. The trauma registry program used in the CCEMSA is Trauma One by Lancet Technology.
 5. Designated trauma centers shall have a written agreement with the Local EMS Agency
 6. Designated trauma centers shall have a written transfer agreement with all affiliated trauma care hospitals and appropriate specialty care facilities. A copy of the written agreement shall be on file with the EMS Agency.
- D. Immediately Available
- Immediately available implies the physical presence of the surgeon in a stated location at the time of need by the trauma patient within 15 minutes 80% of the time, otherwise upon patient arrival with sufficient advanced notice.
- E. Promptly Available
- Promptly available is defined in this policy as the return of a notification call within 20 minutes and available to the Trauma Center within 30 minutes 80% of the time when requested by the trauma team leader.

**CCEMSA TRAUMA CENTER STANDARDS
SUMMARY OF CALIFORNIA CODE OF REGULATIONS, TITLE 22, CHAPTER 7**

CRITERIA	Level I	Level II	Level PEDS **	Level III	Level IV
<p>E = essential E*= CCEMSA D = desirable Level Peds** is requirements for Level II Pediatric TC E# = essential for Level I Pediatric TC in addition to Level II requirements</p>					
Institutions/Organization					
JACAHO Accreditation	E	E	E	E	E
Proof of licensure as a general acute care hospital in the State of California	E	E	E	E	E
Basic or comprehensive emergency services with special permits	E	E	E	E*	D
Shall have equipment and resources needed for initial stabilization and personnel knowledgeable in the treatment of adult and pediatric trauma (Pediatric TC – pediatric trauma)	E	E	E	E	E
A trauma center must demonstrate substantial medical, administrative, and financial commitment for the level of designation requested. Commitment must be demonstrated and include documentation from the hospitals: Administration Medical Staff Nursing	E*	E*	E*	E*	E*
Level I shall have one of the following patient volumes annually; A minimum of 1200 trauma program hospital admissions or A minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is >15, or An average of 35 trauma patients (ISS >15) per trauma program surgeon per year	E				
A trauma research program	E		E#		
An ACGME approved surgical residency program	E		E#		
Requirements for Trauma Centers					
Pediatric trauma centers must have qualified pediatric personnel and pediatric specific resources for all areas					
Trauma Program Medical Director	E	E	E	E	E
Qualifications					
Board Certified Surgeon or Fellow of ACSE *	E E*	E E*	E E*	D	
Board Certified Pediatric Surgeon for Pediatric Trauma Center			E#		
A qualified surgical specialist				E	
A qualified non-surgical specialist					E
Responsibilities include but not limited to:					
Recommending trauma team physician privileges	E	E	E	E	E

**CCEMSA TRAUMA CENTER STANDARDS
SUMMARY OF CALIFORNIA CODE OF REGULATIONS, TITLE 22, CHAPTER 7**

CRITERIA	Level I	Level II	Level PEDS **	Level III	Level IV
E = essential E*= CCEMSA D = desirable Level Peds** is requirements for Level II Pediatric TC E# = essential for Level I Pediatric TC in addition to Level II requirements					
Working with nursing & administration to support needs of trauma patients	E	E	E	E	E
Developing trauma treatment protocol	E	E	E	E	E
Determining appropriate equipment and supplies	E	E	E	E*	E*
Ensuring development of policies/procedures for domestic violence, elder/child abuse/neglect	E	E	E	E*	E*
Having authority & accountability for QI peer review process	E	E	E	E	E
Correct deficiencies in trauma care/exclude team members that don't meet standards	E	E	E	E	E
Coordinating pediatric trauma care with other hospitals/professional services	E	E	E	E*	E*
Coordinating with local and State EMS agencies	E	E	E	E*	E*
Assisting with the coordination of budgetary processes for trauma program	E	E	E	E	E
Identifying representatives from neurosurgery, orthopedic surgery, emergency medicine, pediatrics, and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma team	E	E	E	E*	E*
Trauma Nurse Coordinator/Manager	E	E	E	E	E
Qualifications:					
Registered nurse	E	E	E	E	E
Provide evidence of educational preparation, clinical experience in care of adult and pediatric trauma patients, and administrative responsibilities	E	E	E	E	E
Responsibilities include but not limited to:					
organizing services and systems necessary for multidisciplinary care of the injured patient	E	E	E	E	E
coordinating day-to-day clinical process & performance improvement of nursing and ancillary personnel	E	E	E	E	E
collaborating with trauma program medical director to carry out educational, clinical, research, administrative and outreach activities of the trauma program	E	E	E	E	E
Trauma Service	E	E	E	E	E
Pediatric TC must provide Pediatric Specialist/Services					
Implement requirements of Title 22 and Local policy & coordinate with the EMS agency	E	E	E	E	E

**CCEMSA TRAUMA CENTER STANDARDS
SUMMARY OF CALIFORNIA CODE OF REGULATIONS, TITLE 22, CHAPTER 7**

CRITERIA	Level I	Level II	Level PEDS **	Level III	Level IV
E = essential E*= CCEMSA D = desirable Level Peds** is requirements for Level II Pediatric TC E# = essential for Level I Pediatric TC in addition to Level II requirements					
Capable of providing immediate initial resuscitation and management of the trauma patient	E	E	E		
Capable of providing prompt assessment and stabilization of the trauma patient				E	E
Ability to provide treatment or arrange for transportation to a higher level trauma center				E	E
Trauma Team	E	E	E	E	E
A multidisciplinary team responsible for the initial resuscitation and management of the trauma patient.	E	E	E	E	E
Pediatric trauma center – the pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director, and Remainder of team shall include physician, nursing and support personnel in sufficient numbers to evaluate, treat, stabilize pediatric patients			E		
SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTION(S): Includes at least the following surgical specialties & staffed by qualified specialists: Pediatric TC must provide Pediatric Specialist					
General Surgery	E	E		E	
Neurologic May be provided through a written transfer agreement for Level III	E	E	E	E	
Obstetric/Gynecologic May be provided through written transfer agreement for Pediatric TC	E	E	E		
Ophthalmologic	E	E	E		
Oral/maxillofacial or head and neck	E	E	E		
Orthopedic	E	E	E	E	
Pediatrics	D	D	E		
Plastic	E	E	E		
Urologic	E	E	E		
Microsurgery/re-implantation (may be through transfer agreement with a hospital that has a department, division, service that provides this service			E		

**CCEMSA TRAUMA CENTER STANDARDS
SUMMARY OF CALIFORNIA CODE OF REGULATIONS, TITLE 22, CHAPTER 7**

CRITERIA	Level I	Level II	Level PEDS **	Level III	Level IV
E = essential E*= CCEMSA D = desirable Level Peds** is requirements for Level II Pediatric TC E# = essential for Level I Pediatric TC in addition to Level II requirements					
NON-SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTION(S): Which includes at least the following non-surgical specialties & staffed by qualified specialists: Pediatric TC must provide Pediatric Specialist					
Anesthesiology	E	E	E	E	
Internal Medicine	E	E			
Cardiology			E		
Critical Care			E		
Emergency medicine			E		
Gastroenterology			E		
General Pediatrics			E		
Hematology/Oncology			E		
Infectious Disease			E		
Neonatology			E		
Nephrology			E		
Neurology			E		
Pathology	E	E	E		
Psychiatry	E	E	E		
Pulmonology			E		
Rehabilitation/physical medicine, can be provided by written agreement			E	E	
Radiology	E	E	E		
Emergency Department with qualified specialist in emergency medicine, immediately available	E	E	E		
Emergency Department staffed, trauma patients are assured of immediate and appropriate initial care				E	E
QUALIFIED SURGICAL SPECIALIST(S): Pediatric TC must have Pediatric specialists in all areas					
General Surgeon capable of evaluating & treating adult and pediatric trauma patients, Board Certified, Immediately available In-house* at all times for trauma team activation and promptly available for consultation	E	E	E	D	

**CCEMSA TRAUMA CENTER STANDARDS
SUMMARY OF CALIFORNIA CODE OF REGULATIONS, TITLE 22, CHAPTER 7**

CRITERIA	Level I	Level II	Level PEDS **	Level III	Level IV
E = essential E*= CCEMSA D = desirable Level Peds** is requirements for Level II Pediatric TC E# = essential for Level I Pediatric TC in addition to Level II requirements					
Pediatric TC may be fulfilled by: A staff pediatric surgeon with experience in pediatric trauma, or A staff trauma surgeon with experience in pediatric trauma, or A senior surgical resident, who has completed 3 clinical years of surgical residency (See resident coverage below)			E		
General Surgeon capable of evaluating & treating adult and pediatric trauma patients, promptly available at all times				E	
Published on-call schedule	E*	E*	E*	E*	
Published back up schedule	E*	E*	E*	E*	
Surgical specialists' requirements may be fulfilled by supervised senior residents as defined in Section 100245 of Title 22 at the Level I, II, or pediatric trauma center.	E	E	E		
Residency coverage: (Pediatric TC must have pediatric specialist) Senior resident must be capable of assessing emergent situations in their respective specialty, and Shall be able to provide overall control and surgical leadership including surgical care if needed, and A supervising, staff trauma surgeon/surgeon with experience in trauma care shall be on-call and promptly available, and A supervising, staff trauma surgeon shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the ED for all major resuscitations and in the OR for a all trauma operative procedures	E	E	E		
Qualified Surgical Specialist On-Call and promptly available Pediatric TC must have Pediatric specialists in all areas					
Neurologic, Dedicated to one hospital or back up call *	E	E	E		
Level III may be provided through a written transfer agreement				E	
Obstetric/Gynecologic Pediatric TC available by Transfer agreement	E	E	E	D	
Ophthalmologic	E	E	E	D	
Oral/maxillofacial or head and neck	E	E	E	D	
Orthopedic, Dedicated to one hospital or back up call *	E	E	E	E	
Plastic	E	E	E	D	

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Reimplantation/microsurgery capability. May be provided through transfer agreement	E	E	E		
Urologic	E	E	E	D	
Cardiothoracic	E		E#	D	
Pediatrics	E				
Pediatric neurologic			E#		
Pediatric ophthalmologic			E#		
Pediatric oral or maxillofacial or head and neck			E#		
Pediatric orthopaedic			E#		
Surgical service- available for consultation or by transfer agreements					
Burns	E	E	E	E	
Cardiothoracic		E	E	D	
Pediatrics		E		E	
Re-implantation/Microsurgery	E	E	E		
Spinal cord injury	E	E	E	D	
QUALIFIED NON-SURGICAL SPECIALIST(S):					
Emergency Medicine					
Board Certified, in-house , immediately available at all times	E	E	E	E	
Emergency medicine physicians, board certified in emergency medicine shall not be required to complete ATLS.	E	E	E		
Current ATLS is required for all emergency medicine physicians who are qualified specialist in a specialty other than emergency medicine	E	E	E	D	
Residency coverage					
Maybe be fulfilled by supervised senior residents as defined in Section 100245 or Title 22, in emergency medicine, who are assigned to ED and serving in the same capacity.	E	E			
The senior resident shall be capable of assessing emergency situation in trauma patients and providing initial resuscitation.	E	E	E		
Pediatric trauma center:					
May be fulfilled by a qualified specialist in pediatric emergency medicine; or			E		
A qualified specialist in emergency medicine with pediatric experience; or			E		

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A subspecialty resident in pediatric emergency medicine who has completed at least one year of subspecialty residency in pediatric emergency medicine, and			E		
A supervising qualified specialist in pediatric emergency medicine, or emergency medicine with pediatric experience shall be promptly available,			E		
A supervising qualified specialist on-call shall be notified of all patients requiring resuscitation, operative surgical intervention or ICU admission.			E		
Anesthesiology Immediately available at all times, may be fulfilled by senior residents or CRNAs capable of assessing emergent situations, providing treatment, and supervised by staff anesthesiologist. The staff anesthesiologist on-call shall be promptly available at all times and present for all operations.	E	D	E# D	D	
Promptly available and must be in operating room when patient arrives, may be fulfilled by senior residents or CRNAs capable of assessing emergent situations, providing treatment, and supervised by staff anesthesiologist. The staff anesthesiologist on-call shall be promptly available at all times and present for all operations.		E	E	D	
On-call and promptly available and must be in operating room when patient arrives, may be fulfilled by senior residents or CRNAs capable of assessing emergent situations, providing treatment, and supervised by staff anesthesiologist. The staff anesthesiologist on-call shall be promptly available at all times and present for all operations.				E	
Radiology, promptly available	E	E	E	E	
Qualified non-surgical specialists available for consultation. Pediatric trauma centers must have qualified specialists with pediatric experience; pediatric TC - may be provided through transfer agreement					
Cardiology	E	E			
Gastroenterology	E	E			
Hematology	E	E		D	
Infectious Diseases	E	E		D	

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Internal medicine	E	E		D	
Nephrology	E	E		D	
Neurology	E	E		D	
Pathology	E	E		D	
Pulmonary Medicine	E	E		D	
Adolescent medicine			E		
Child development			E		
Genetics/dysmorphology			E		
Neuroradiology			E		
Obstetrics			E		
Pediatric allergy and immunology			E		
Pediatric dentistry			E		
Pediatric endocrinology			E		
Pediatric pulmonology			E		
Rehabilitation/physical medicine			E		
<p>Pediatric Critical Care - in-house, immediately available, fulfilled by: Qualified specialist in pediatric critical care medicine, or Qualified specialist in anesthesiology with experience in pediatric critical care; or Qualified surgeon with expertise in pediatric critical care, or A physician who has completed at least 2 years of residency in pediatrics. When a senior resident is responsible for critical patient care, there shall be a qualified specialist in pediatric critical care or qualified specialist in pediatric anesthesiology on-call and promptly available, and, is advised of all patients requiring admission to the PICU and participate in all major decisions and interventions.</p>			E		
<p>The qualified pediatric PICU specialist shall be immediately available, advised of all admitted patients to the PICU, and shall participate in all major therapeutic decisions and interventions</p>			E#		
<p>Pediatric trauma centers – qualified specialists with pediatric experience shall be on hospital staff and available for consultation, and Level I Pediatric Trauma Center, qualified pediatric non-</p>					

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surgical specialist or specialty availability on call and promptly available:					
General pediatrics			E		
Mental health			E		
Neonatology			E		
Nephrology			E		
Pathology			E		
Pediatric anesthesiology			E#		
Pediatric cardiology			E		
Pediatric emergency medicine			E#		
Pediatric gastroenterology			E E#		
Pediatric hematology/oncology			E		
Pediatric infectious disease			E E#		
Pediatric nephrology			E#		
Pediatric neurology			E E#		
Pediatric pulmonology			E#		
Pediatric radiology			E E#		
SERVICE CAPABILITIES:					
Radiological Service					
Radiologist technician immediately available in-house*, capable of performing plain film and computed tomography imaging.	E	E	E	D	
Promptly available - angiography and ultrasound	E	E	E		
Radiological technician promptly available				E	E
Clinical laboratory Service					
Immediately available at all times, Promptly available for Level III and IV, and	E	E	E	D E	E
Comprehensive blood bank or access to a community central blood bank	E	E	E	E	E
Type & cross, coagulation studies, micro-sampling	E*	E*	E*		
Surgical Service					
Operating suite available for trauma patient or being utilized for	E	E	E	E	

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trauma patients					
Operating staff - with trauma education*, Immediately available unless operating on trauma patients and backup personnel promptly available	E		E#		
Operating staff promptly available unless operating on trauma patients and backup staff who are promptly available		E	E		
Operating staff who are promptly available				E	
Appropriate surgical equipment/supplies as determined by trauma program medical director or EMS Agency for Level III	E	E	E	E	
Cardiopulmonary bypass	E		E#		
Operating microscope	E		E#		
Nursing Services – staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children			E		
Basic Emergency Services per Chapter 1, Division 5 of Title 22:					
Physician in-house, immediately at all times	E	E	E	E	
Designate emergency physician to be member of trauma team, and	E	E	E	E*	
Provide emergency medical services to adult and pediatric (pediatric patients for Pediatric TC) patients, and	E	E	E	E	
Trauma trained nursing personnel to provide continual monitoring, and	E*	E*	E*	E*	
Equipment and supplies appropriate for adult and pediatric patients as approved by the director of emergency medicine in collaboration with the trauma program director	E	E	E	E*	
Emergency department staffed so that trauma patients are assured of immediate and appropriate initial care	E	E	E	E	E
Communication with EMS vehicles	E	E	E	E	E
SUPPLEMENTAL SERVICES					
Pediatric trauma centers shall have Pediatric specialists in all areas					
Intensive Care Service , special permit licensing ICU services, Chapter 1, Division 5, of Title 22	E	E		E	
Appropriate equipment and supplies determined by physician responsible for intensive care service and the trauma program	E	E		E	

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medical director					
Qualified specialist, in-house, immediately available for trauma patients in ICU	E	D		D	
ICU specialist promptly available		E		E	
Qualified specialist may be a resident with 2 years of training, supervised by the staff intensivist or attending surgeon who participates in all critical decision making	E	E		E	
The qualified specialist shall be a member of the trauma team	E	E		E	
Registered Nurses with trauma education 24/7	E*	E*	E*	E*	
Burn Center					
In house or through written transfer agreement with a Burn Center	E	E	E	E	
Physical Therapy Service					
To include personnel trained in physical therapy and equipped for acute care of the critically injured patient	E	E	E		
Rehabilitation Center					
Services to include personnel trained in rehabilitation care and equipped for acute care of the critically injured patients. May be provided through a written transfer agreement with rehabilitation center	E	E	E	E	
Respiratory Care Service					
Services to include personnel trained in respiratory therapy and equipped for acute care of the critically injured patient	E	E	E	E*	
Acute Hemodialysis Capability	E	E	E		
Occupational Therapy Service					
To include personnel trained in occupational therapy and equipped for acute care of the critically injured patient	E	E	E		
Speech Therapy Service					
To include personnel trained in speech therapy and equipped for acute care of the critically injured patient	E	E	E		
Social Service	E	E	E	D	
Services or Programs (Special license or permit not required)					
Pediatric Service – Adult TC who provides in-house pediatric					

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services, in addition to Chapter 1, Division 5 of Title 22 shall have the following:	E	E			
Pediatric Intensive Care Unit (PICU), Shall be approved by California State Department of Health Services' California Children Services (CCS)	E	E	E		
Adult hospitals without a PICU shall establish written criteria for consultation and transfer of pediatric patients needing ICU care	E	E			
Have appropriate equipment/supplies approved by the pediatric intensive care specialist and pediatric trauma program medical director			E		
Pediatric intensive care specialist shall be promptly available for trauma patients in the PICU			E		
Qualified specialist shall be a member of the trauma team			E		
Have a multidisciplinary team to manage child abuse and neglect	E	E			
Pharmacy In house, 24 hour availability with pharmacist on call	E*	E*	E*	D	
Shall be in-house within 30 minutes of call				E*	
Acute Spinal Cord Management Capability In-house or by transfer agreement	E	E	E		
Organ Donor Protocol as described in Div. 7, Chapter 3.5, Cal. HS Code	E	E	E	E*	
Outreach Program , to include Capability to provide both telephone and on-site consultations with physicians in the community and outlying areas, and	E	E	E	E	
Trauma prevention to the general public	E	E	E	E*	
Public education and illness/injury prevention education	E*	E*	E	E*	
Continuing Education Continuing education in trauma care shall be provided for: Staff physicians Staff nurses Staff allied health personnel EMS personnel	E	E	E	E	E
Community physicians and health care personnel	E	E	E	E	E
Trauma physicians (CME, 50% must be extramural)	E*	E*	E*	E*	E*
General Trauma Surgeon, ATLS completion	E*	E*	E*	E*	

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Orthopedic Surgeons	E*	E*	E*	E*	
Neurosurgeons	E*	E*	E*	E*	
Emergency Medicine	E*	E*	E*	E*	E*
Pediatric Trauma Centers – In addition to special permit licensing services shall have:					
Outreach and injury prevention programs specifically related to pediatric trauma and injury prevention;			E		
A suspected child abuse and neglect team (SCAN)			E		
An aeromedical transport plan with designated landing site; and			E		
Child Life program			E		
Written Interfacility Transfer Agreements	E	E	E		
Transfer agreements with referring and specialty hospitals					
Written transfer agreements with Level I or II trauma centers, Level I or II pediatric trauma centers or specialty care centers for the immediate transfer of those patients whose medical care need additional resources				E	
Written transfer agreements with Level I, II, or III trauma centers, Level I or II pediatric trauma centers or specialty care centers for the immediate transfer of those patients whose medical care need additional resources					E
Trauma Quality Improvement Program					
Trauma centers of all levels shall have a quality improvement process to include structure, process, and outcome evaluations, identify root causes of problems, intervene to reduce or eliminate root causes and take appropriate steps to correct the process	E	E	E	E	E
Process shall include:					
Detailed audit of all trauma-related deaths, major complications, and transfers (including interfacility transfers);	E	E	E	E	E
A multidisciplinary trauma peer review committee that includes all members of the trauma team; (CCEMSA* 50% attendance by reps of Surg, Ortho, Neuro, EM, Anesthesia)	E	E	E	E	E
Participate in the trauma system data management system;	E	E	E	E	E
Participate in the local EMS agency trauma evaluation committee;	E	E	E	E	E

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Have a written system in place for patient, parents of minor children who are patients, legal guardian(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child;	E	E	E	E	E
Follow applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality	E	E	E	E	E
Appropriately licensed helicopter landing site	E*	E*	E*	D	
<p>Interfacility Transfer of Trauma Patients Patients may be transferred between and from trauma centers providing: Any transfer shall as determined by the trauma center surgeon of record, be medically prudent; Be in accordance with local EMS agency interfacility transfer policies.</p>	E	E	E	E	E
Hospitals shall have written transfer agreements with trauma centers and develop written criteria for consultation and transfer of patients needing a higher level of care.	E	E	E	E	E
Hospitals which have repatriated trauma patients from a designated trauma center shall provide the information required by the system trauma registry, as specified by local EMS agency policies.	E	E	E	E	E
Hospitals receiving trauma patients shall participate in system and trauma center quality improvement activities for those trauma patients who have been transferred.	E	E	E	E	E

**CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES**

A Division of the Fresno County Department of Public Health

Manual	Emergency Medical Services Administrative Policies and Procedures	Policy Number 334
Subject	Trauma Registry Data Collection	Page 1 of 3
References	California Code of Regulations, Title 22. Social Security Division 9. Prehospital Emergency Medical Services Chapter 7. Trauma Care Systems	Effective 12/15/2014

I. POLICY

The EMS Agency is responsible for monitoring the Central California EMS Region’s Trauma System. Data collection and management are critical components to monitoring the system, and essential to performance improvement and patient safety programs. This policy defines the means of collection of data for Quality Improvement of the Trauma System.

II. PROCEDURE

A. EMS AGENCY

1. The EMS Agency shall maintain a Trauma Registry and Trauma Information System. The data submitted by the hospitals shall be utilized for trauma system monitoring, evaluation, and research. Data will be used for periodic reports to the Regional Trauma Audit Committee.
2. The Trauma Registry will be utilized for quality improvement purposes and will be protected from disclosure per the California Evidence Code, Section 1157.7. The data base is not subject to the mandated patient authorization procedures of HIPPA.
3. Data from the Trauma Registry shall be integrated into the State EMS Authority data management system as required.

B. TRAUMA CENTERS

1. Trauma Centers shall use the Trauma Registry Program approved by the EMS Agency.
2. Trauma Registry Data will be completed by all trauma centers for all patients who meet the inclusion criteria for the trauma registry as outlined in Attachment A. Trauma Nurse Coordinators /Managers or Trauma Registrars at the trauma centers will be responsible for completing the documentation of registry patients.
3. Trauma registries should be concurrent. At a minimum, 80 percent of cases must be entered within 60 days of discharge.

Approved By EMS Director	DANIEL J. LYNCH (Signature on File at EMS Agency)	Revision
EMS Medical Director	JIM ANDREWS, M.D. (Signature on File at EMS Agency)	

Subject	Trauma Registry Data Collection	Policy Number 334
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4. The completed registry data will be forwarded to the EMS Agency electronically on a monthly basis. If a trauma registry record is updated at the trauma center, the revised record will be submitted to the EMS Agency.

C. NON-TRAUMA HOSPITALS

1. Non-trauma hospitals will complete a Non-Trauma Hospital Patient Registry Form (Attachment B) on the following critical trauma patients who present at a non-trauma hospital:
 - a. Trauma patients meeting any of the trauma triage criteria/destination criteria to a designated trauma center.
 - b. Trauma patients with a final disposition to a Trauma Center.
 - c. Trauma transfers from other facilities.
 - d. All traumatic arrests, trauma related deaths in the ED or after hospital admission.
2. Completed registry forms will be emailed to the EMS Agency within 60 days of patient discharge, transfer or death.
3. The registry form is to be completed by designated personnel from the non-trauma hospital. The names of designated personnel will be forwarded to the EMS Agency.

D. INSTRUCTIONS FOR COMPLETION OF THE NON-TRAUMA HOSPITAL PATIENT REGISTRY FORM

1. Section 1 – Identification
 - a. EMS Number
 - b. Incident Location: Enter the original location of the incident
 - c. Hospital: Enter the name of the non-trauma hospital completing the form.
 - d. Patient: Enter the name of the patient.
 - e. Date of birth
 - f. Age: Enter the patient’s age.
 - g. Sex: Check male or female.
2. Section 2 – Emergency Department Admission Data
 - a. Date of Arrival: Enter month, date, year admitted to the ED.
 - b. Time of Arrival: Enter time of arrival to the ED.
 - c. Method of Arrival: Check applicable; if “Other”, describe.
 - d. Mechanism of Injury: Check one; if “Other”, describe.

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- e. Vital Signs Upon Arrival: Enter initial GCS and vital signs taken in the ED.
 - f. Procedures: Check any applicable procedure and enter time; if “Other”, describe.
 - i. Blood products: Enter time of first unit and the total number of units given, if any products were given.
 - g. Injuries: Check applicable.
 - i. All trauma related hospital admits with at least one injury ICD-9 diagnosis code between 800.0-959.9.
3. Section 3 – Emergency Department Disposition
- a. Admitted: Check if applicable, enter time, and specify hospital unit under comments.
 - b. OR: Check if applicable, enter time, and specify procedure(s) if known under comments.
 - c. OR Disposition: Check if applicable, enter time, and specify hospital unit under comments.
 - d. Discharged: Check if applicable, and enter time.
 - e. Transfer to a Trauma Center ED: Check if applicable, enter time, and specify destination under comments.
 - f. Interfacility Transfer (Patient transferred to inpatient unit): Check if applicable, enter time, and specify destination under comments.
 - g. Ground Transport: Check if applicable, and enter time.
 - h. Air Transport: Check if applicable, and enter time.
 - i. Other: Check if applicable, enter time, and include explanation under comments.
4. Section 4 - Comments:
- a. Include anything pertinent, explanatory, or interesting information.
 - b. Include any transfer questions or problems.

ATTACHMENT A
TRAUMA REGISTRY – TRAUMA CENTER SELECTION CRITERIA

Reference: Current Version of the National Trauma Data Bank (NTDB) Data Dictionary and the State of California Data Dictionary.

1. All trauma related hospital admits with at least one injury ICD-9 diagnosis code between 800.0 – 959.9
 - A. Fractures (all)
 - B. Dislocations (all)
 - C. Intracranial injuries (all—includes concussion)
 - D. Internal injuries of chest, abdomen, and pelvis
 - E. Open wounds
 - F. Injuries to blood vessels
 - G. Crushing injuries
 - H. Burns (burn registry)
 - I. Injuries to optic nerves
 - J. Spinal cord injuries
 - K. Certain traumatic complications
 1. Air/fat embolism
 2. Secondary and recurrent hemorrhage
 3. Post traumatic wound infection
 4. Traumatic shock
 5. Subcutaneous emphysema
 - L. Excludes:
 1. 905-909 (late effects of injury—defined as “those things that occur at any time after an acute injury)
 2. 910-924 (blisters, contusions, abrasions, insect bites)
 3. 930-939 (foreign bodies)
 4. Isolated sprains/strains/contusions
2. All injury-related deaths in ED or after admission
3. All trauma transfers from other facilities

ATTACHMENT B
CENTRAL CALIFORNIA EMS AGENCY
NON-TRAUMA HOSPITAL PATIENT REGISTRY FORM

1. IDENTIFICATION

EMS Number _____

Incident Location _____

Hospital _____

Patient _____

DOB _____

Age _____ Male Female

2. EMERGENCY DEPARTMENT ADMISSION DATA

Date of Arrival _____

Time of Arrival _____

Method of Arrival:

Walk-in BLS Ambulance

ALS Ambulance Air Ambulance

Other If other, describe:

Mechanism of Injury:

Motor Vehicle Crash Motorcycle Bicycle

Pedestrian Assault Stabbing Gun Shot

Ground Level Fall Fall from Height Sports

Industrial Farming

Other If other, describe:

Vital Signs Upon Arrival:

Eyes: _____ Verbal: _____ Motor: _____

GCS: _____

HR: _____ RR: _____ BP: _____

Procedures:

Intubation _____ Time _____ Blood Products _____ Time _____

CT Scan _____ # of Units Given _____

Chest Tube _____

Other _____ If other, describe:

Injuries: (ICD -9-CM 800-959.9)

Fractures:

Skull Neck/Spine Limbs

Dislocations Intracranial Injury Sprains/Strains

Open wounds Burns Foreign Body

Internal Injury to: Chest Abdomen Pelvis

Injuries involving: Blood Vessels Crushing

Optic nerves Spinal Cord

3. EMERGENCY DEPARTMENT DISPOSITION

Time

Time

Admit _____ Transfer to Trauma Center ED _____

OR _____ Interfacility Transfer _____

OR Disposition : Ground Transport _____

Admit _____ Air Transport _____

Transfer _____ Other _____

Discharged Home _____

Please include comments concerning difficulties with the interfacility transfer arrangements, procedures, patient care, etc.

4. COMMENTS

Submitted by: _____

Within 30 days of patient discharge, transfer or death, email the completed form to Daniel Brown at dbrown@co.fresno.ca.us

CENTRAL CALIFORNIA EMERGENCY MEDICAL SERVICES

Manual: Emergency Medical Services Administrative Policies and Procedures	Policy Number: 703 Page: 1 of 7
Subject: Continuous Quality Improvement	
References: Division 2.5 of the California Health and Safety Code Title 22, Division 9 of the California Code of Regulations Section 1157.7 of Evidence Code	Effective: 08/07/00

I. POLICY

This policy describes the roles and responsibilities of all Central California EMS System participants in the provision of Continuous Quality Improvement (CQI). All EMS provider agencies shall meet the requirements of this policy.

II. PURPOSE

“Continuous Quality Improvement” or “CQI” means methods of evaluation that are composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process.

III. PROCEDURE

The EMS Agency is responsible for the oversight and supervision of the entire CQI process and communicating with all involved participants.

A. EMS Agency CQI Medical Director/Coordinator responsibilities include:

1. Implement, monitor and evaluate the CQI System, including CQI requirements as described in Appendix B.
2. Provide oversight of the CQI Committee.
3. Provide regular CQI reports to Medical Control Committee, Base Hospital Committee, EMSOC, CQI Committee and EMS Staff meetings.
4. Review individual QI Reports and take necessary action.
5. Provide an access point for Internal/External Customers as identified in Section III.F.
6. Create an Investigative Review Panel (IRP), as needed, to provide a grievance process for EMS personnel in accordance with State guidelines and requirements (Refer to Section III.G.).
7. Monitor quality indicators via database analysis as identified in Appendix A.

Approved By: EMS Division Manager	Signatures on File at EMS Agency	Revision: 3/3/2008
EMS Medical Director	Signatures on File at EMS Agency	

Subject:	Continuous Quality Improvement	Policy Number: 703
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8. Review and participate in research generated by the CQI process.
9. Forward CQI Committee recommendations to EMS Training Division.
10. Manage EMS database to assure quality and completeness of databases.

B. CQI Committee responsibilities include:

NOTE: All proceedings are confidential and protected under Section 1157.7 of Evidence Code: “The prohibition relating to discovery or testimony provided in Section 1157 shall be applicable to proceedings and records of any committee established by a local governmental agency to monitor, evaluate, and report on the necessity, quality, and level of specialty health services including, but not limited to trauma care services, provided by a general acute care hospital which has been designated or organized by that governmental agency as qualified to render specialty health care services.”

1. Review/Monitor Data from EMS System (III.C).
2. Select quality indicators, items for review and monitoring, create action plans, and monitor performance (i.e., time, patient satisfaction, workforce satisfaction, protocol compliance, outcome data). (See Appendix A.)
3. After review by EMS Agency, serve as a forum to discuss issues/concerns brought to the attention of the EMS Agency by internal and external customers (III. F.).
4. Propose, review, and participate in EMS research.
5. Promote CQI training throughout the EMS System.
6. Policy/Protocol Review – Selected policies reviewed with prenotification sent out to allow participant feedback. Initial review by CQI Coordinator/Medical Director and proposed revisions discussed at CQI Committee.
7. Provide recommendations to Training Division, including:
 - a. Orientation

Paramedic eight-hour introduction to Central California EMS policies, procedures and local scope of practice.
 - b. Primary Training
 - 1) Local EMS Paramedic Training Course
 - 2) Local EMT Courses (Fire Department/Schools/Provider Agencies)
 - 3) AED (AED Provider Agencies)
 - 4) Emergency Medical Dispatcher Training
 - 5) Mobile Intensive Care Nursing Training
 - 6) Base Hospital Physician Course

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- c. Continuing Education
 - 1) Case Review/Tape Review
 - 2) Provider Agency C.E.
 - 3) EMS C.E. – Topics Based on CQI identified deficiencies.

8. CQI Committee Members

- a. CQI Medical Director
- b. CQI Coordinator
- c. Base Hospital Physician (chosen by Medical Control Committee)
- d. PLN – (chosen by Base Hospital Committee)
- e. PLO – (Three – preferably one from each County)
- f. EMS Dispatcher
- g. Fire First Responder (chosen by Fire Chiefs Association)

9. CQI Committee Ex-Officio Members

- a. EMS Medical Director
- b. EMS Division Manager

10. CQI Committee Guests

CQI Medical Director or CQI Coordinator may approve the attendance of guests.

C. Data/System Review

Various databases currently exist which contain data relevant to Continuous Quality Improvement (CQI) in EMS (see list below). These databases must be searched to:

- 1. Prospectively identify areas of potential improvement.
- 2. Answer questions about the EMS System.
- 3. Monitor changes once improvement plans are implemented.
- 4. Provide accurate information enabling data driven decisions.
- 5. Monitor individual performance within the EMS System.
- 6. Support research that will improve our system and potentially broaden EMS knowledge through publication.
- 7. The involved databases include:
 - a. Dispatch Database
 - b. First Responder Database
 - c. EMT-D Database
 - d. PCR Databases
 - e. Hospital Databases

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- f. QI Database
- g. Trauma Registry
- h. County Coroner's Reports

D. Individual Quality Improvement Reports

Individual quality improvement reports are generated by anyone in the EMS System and are reviewed at the Base Hospital Physician level as well as by the EMS Agency.

E. EMS Research

Any parties interested in EMS research may participate. Leadership is expected from EMS Medical Directors and Senior EMS Specialists with EMS Division Manager and Medical Control Committee approval.

F. Internal/External Customers

Various entities interact with the EMS System. In order to allow input from these sources, the CQI process may be accessed via the EMS Agency who will determine if the issue raised will be put on the CQI Committee Agenda.

- 1. Internal Customers
 - Paramedics/EMT-IIIs/EMT-Is/First Responders
 - MICNs/Flight Nurses
 - Dispatch Personnel
 - EMS Students
 - Ambulance Providers
 - EMS Committees
 - Hospitals
 - State/Regional EMS Personnel
 - UCSF Residency Personnel
 - Base Hospital Physicians
- 2. External Customers
 - Patients
 - Patients' Families
 - Community/Public
 - Third Party Payors (Insurance Companies, HMOs)
 - Government Agencies (Public Health Department, Police, etc.)
 - Nursing Homes
 - Private Physicians

G. Investigative Review Panel

- 1. Created on an as needed basis as outlined in Title 22, Division 9.
- 2. Purpose - An impartial advisory body, the members of which are knowledgeable in the provision of prehospital emergency medical care and local EMS System policies and procedures, which may be convened to review allegations against the holder of an EMS prehospital emergency medical care certificate, assist in establishing facts of the matter, and provide its findings to the EMS Medical Director.

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APPENDIX A

Quality Indicators

The following quality indicators are monitored on a routine and continuous basis and reported to the appropriate EMS committees:

Initial System Review Items:

1. Trauma Scene Times (<10 minutes)
2. Medical Scene Times (<20 minutes)
3. Cardiac Arrest Survival Rates
4. Trauma Survival Rates
5. Percentage of Unrecognized Esophageal Intubation

Other Review Items:

1. AMA/RAS/RMCT Ratios (at each Base Hospital)
2. Codes (compliance with times in protocol)
3. Nature of Incident Frequency on QA Reports
4. Pediatric Survival Rates
5. Prehospital Violence
6. 90% Successful IV after Three Attempts
7. 95% Successful ET Placement after Three Attempts

Data to Determine Performance Excellence:

1. Are EMS services timely?
2. Do providers adhere to prescribed protocols?
3. What is the level of patient/stakeholder satisfaction?
4. How does performance compare with similar systems?
5. Are data and information used in planning and operation?
6. Do all workforce members understand and use available data?
7. Have CQI efforts been successful at improving performance?
8. Are changes in one critical performance indicator affecting other areas?
9. Are QI resolutions communicated to all involved parties?

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APPENDIX B

CQI Skills Retainment Requirements

EMT-II/EMT-PARAMEDIC

A. Patient Contact Requirement

The Central California EMS Agency maintains a standard of care that provides a high quality, consistent, and dependable skill level and knowledge base for its Emergency Medical Services personnel. To assure that EMT-II's or EMT-Paramedics maintain adequate patient assessment and other ALS skills, the EMS Agency acknowledges the importance of minimum patient contacts to assure the proficiency of skills, problem recognition, and knowledge.

Each EMT-II or EMT-Paramedic accredited in the Central California EMS System shall document an average of at least 20 patient contacts per month (240 per year) while working on an approved Central California County ALS unit. A written statement from the employer shall be submitted to the Central California EMS Agency by March 20th of each year.

A patient contact is defined as a patient who is completely assessed by an on-duty EMT-II or EMT-Paramedic during the course of an EMS response and a prehospital care report is completed as a result of the patient assessment. The EMS Agency shall audit records to verify compliance on a random basis.

In the event that an EMT-II or EMT-Paramedic does not achieve the 240 patient contacts (or prorated amount authorized by the Central California EMS Agency) in the twelve month period, the individual shall complete five (5) ALS field evaluations within a sixty (60) day period beginning March 21st. An EMS Training Officer approved by the Central California EMS Agency must continuously supervise this field evaluation. An ALS response includes a patient contact involving the use of one or more ALS skills excluding cardiac monitoring and basic CPR. The EMS Agency, in the event of an unsatisfactory evaluation, may prescribe additional education or evaluation.

B. Paramedic Field Evaluation Requirement

Document satisfactory field evaluations performed by an approved Central California EMS Training Officer. EMT-II's or EMT-Paramedics that have been certified/accredited less than two (2) years within the Central California EMS Region must be evaluated by a designated EMS Training Officer, each six (6) months (Deadline-September 20th and March 20th). EMT-II's or EMT-Paramedics that have been certified/accredited greater than two (2) years within the Central California EMS Region will not be required to do a field evaluation.

A field evaluation will consist of an EMS Training Officer observing an EMT-II or EMT-Paramedic conducting three (3) patient assessments. The EMS Training Officer will evaluate the EMT-II or EMT-Paramedic based upon criteria utilized for field internships as developed by the Central California EMS Agency. An evaluation is documented utilizing a field evaluation form (as utilized for field internships) and shall be submitted to the Central California EMS Agency within fifteen days of the completion of the field evaluation.

The agency's liaison officer and the EMS Agency will review unsatisfactory evaluations with the EMT-II or EMT-Paramedic. Possible actions by the Central California EMS Agency in the case of an unsatisfactory evaluation include reevaluation, additional training, or initiation of the formal investigation.

C. ACLS Requirement

Within two (2) years of initial accreditation, the EMT-Paramedic shall demonstrate proof of current certification and continued certification as an Advanced Cardiac Life Support (ACLS) provider according to the standards of the American Heart Association. Fulfillment of this requirement may be utilized for completing a portion of the on-going continuing education requirements.

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D. BTLS/PHTLS Requirement

Within two (2) years of initial accreditation, the EMT-Paramedic shall demonstrate proof of satisfactory completion of a Basic Trauma Life Support (BTLS) course according to the standards of the American College of Emergency Physicians, or Prehospital Trauma Life Support (PHTLS). Fulfillment of this requirement may be utilized for completing a portion of the on-going continuing education requirements. Refresher training in these courses may be assigned to individuals by the EMS Medical Director for remedial education as a condition of accreditation.

AED SERVICE PROVIDERS

A. Skills Proficiency

AED service providers shall assure that all AED authorized personnel have proven AED skills proficiency at least once every six (6) months. AED service providers shall maintain documentation of such skill proficiency exams and provide copies to the AED Base Hospital and EMS Agency upon request.

B. Case Review

AED service providers shall provide AED authorized personnel with no less than four (4) hours of AED case review every two (2) years. Attendance documentation shall be forwarded to the AED Base Hospital. AED case review information and data shall be provided by the designated AED Base Hospital in each county. The four (4) hours of case review may be used towards the 24 hours of continuing education required for EMT-I recertification.

C. AED Refresher Course

AED Service provider personnel shall complete a two (2) hour AED refresher course, which can be included in an EMT-I refresher course and/or required EMT-I continuing education. The refresher course shall include the successful completion of an AED written and skill examination approved by the Central California EMS Agency. This should be completed at a minimum every 2 years in conjunction with EMT-I recertification or refresher training for First Aid.

**CENTRAL CALIFORNIA
EMERGENCY MEDICAL SERVICES**

COUNTY INVOLVED:

FRESNO KINGS MADERA TULARE
 OTHER _____

Exhibit A
OFFICIAL USE ONLY

CQI # _____

DATE RCVD: _____

Emergent Non-Emergent

CONFIDENTIAL

(In Accordance with California Civil Code Section 56, et seq, California Evidence Code Section 1040 and Section 1157, et seq, and California Code of Regulations, Title 22, Division 9)

**QUALITY IMPROVEMENT
REPORT**

(Information for Attorneys representing the Central California EMS Agency)

Incident Logistics

Call Location: _____ EMS Disp. #: _____

Date: _____ Time: _____ Location: On Scene Enroute
 At Hospital Other

Patient Name: _____ Med. Record # or DOB: _____

PCR/BHRR # (Attach Copy): _____

Personnel Involved

Agency

Discussed with Individual

Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No
 Yes No

Primary Tracking

Date & Time On-Duty Supervisor /PLN/PLO Notified: _____

Name & Title of Individual Contacted: _____

Author Information

Signature: _____

Date: _____

Print Name: _____

Cert. #: _____

Agency/Facility: _____

Date Submitted to PLO/PLN: _____

CENTRAL CALIFORNIA EMERGENCY MEDICAL SERVICES

Manual	Emergency Medical Services Administrative Policies and Procedures	Policy Number 311 Page 1 of 4
Subject	Base Hospital Criteria	
References	Title 22, Division 9, Chapter 4, Article 7	Effective 01/01/82

I. POLICY

Base Hospitals for the medical control of EMS Personnel shall be selected by the EMS Agency based upon appropriate criteria and the needs of the EMS System.

II. PROCEDURE

A. BASE HOSPITAL MUST:

1. Be licensed by the State Department of Health as a general acute care hospital.
2. Be accredited by the Joint Commission on Accreditation of Hospitals.
3. Have a special permit for basic or comprehensive emergency medical service pursuant to the provisions of Title 22, Division 5.
4. Have the approval and support of hospital administration, medical staff and Emergency Department staff to participate as a Base Hospital.
5. Agree to provide care to all emergency patients regardless of ability to pay.
6. Demonstrate an on-call system that assures a promptly available specialist and admitting physician and commitment for care of all critically ill patients regardless of ability to pay.
7. Agree to abide by the letter and intent of the Health and Safety Code, Division 2.5.
8. Comply with all County regulations and policies regarding Base Hospitals.

B. BASE HOSPITAL OPERATIONAL REQUIREMENTS

Base Hospitals designated as such and under contract with the EMS Agency must comply with the following requirements:

Approved By	Signatures on File at EMS Agency	Revision
EMS Division Manager		04/01/2007
EMS Medical Director	Signatures on File at EMS Agency	

Subject	Base Hospital Criteria	Policy Number 311
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1. Operations

- a. Procure operational radio communications equipment meeting specifications established by the County and install such equipment in the Emergency Department, for the purpose of communications with prehospital and interfacility transport units operating pursuant to this agreement. All radios and telephones to be used for communication with prehospital personnel must be equipped with recording devices.
- b. Assure that recordings are made on all prehospital communications concerning patient care.
- c. Maintain written records of Base Hospital/prehospital and interfacility runs for a minimum of seven years or in accordance with hospital policy. Maintain the tapes of paramedic calls for a minimum of 180 days.
- d. Operate communications equipment as directed by procedures and protocols established by the County and approved by the EMS Medical Director. Develop and utilize a workable maintenance plan and repair policy for communications equipment.
- e. Have a telephone immediately available in the Emergency Department for exclusive use in contacting a Receiving Hospital to provide medical information on patient's enroute to the receiving facility.
- f. Designate a Mobile Intensive Care Nurse certified by the EMS Agency who is employed by the Base Hospital as a Prehospital Liaison Nurse for the hospital.
- g. Designate an Emergency Department Physician as a Base Hospital Medical Director. Responsibilities are identified in the Base Hospital Director role description.
- h. Facilitate interfacility transfers in an appropriate manner as described in EMS Policy.
- i. Utilize the following which have been approved by the EMS Medical Director:
 - 1. Paramedic Field Treatment Protocols and Guidelines
 - 2. Base Hospital Report Form
 - 3. Patient Care Report (Field Assessment Form)
- j. Cooperate with the EMS Agency in gathering and providing statistics and information needed for monitoring and evaluating EMS programs.
- k. Comply with an infection control policy and notification procedure for all prehospital care providers and first responders developed by the designated County Health Services Agency.
- l. Comply with procedures for decontamination of patients and rescuers exposed to hazardous materials as outlined in the hazardous materials plan developed by the EMS Agency.
- m. Participate in EMS public education programs.

C. NEW BASE HOSPITALS

Newly designated Base Hospitals must establish a Base Hospital Committee within the hospital composed of, at a minimum, the Base Hospital Medical Director, the Prehospital Liaison Nurse

Subject	Base Hospital Criteria	Policy Number 311
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and a representative of hospital administration to meet and confer regarding operations of the Base Hospital and maintain liaison with members of the Prehospital Care Team and the EMS Agency. This committee will meet regularly for one year, or until Base Hospital operations are running smoothly, whichever is longer.

D. BASE HOSPITAL STAFFING AND PERSONNEL

The Base-Hospital shall have:

1. A currently certified Mobile Intensive Care Nurse or Base Hospital Physician in the Emergency Department immediately available at all times to give radio direction to prehospital personnel or interfacility transfer personnel according to the standards and protocols developed by the EMS Agency.
2. A Certified Base Hospital Physician available at all times to provide immediate medical direction to the Mobile Intensive Care Nurses and/or prehospital personnel or interfacility.

E. BASE HOSPITAL EDUCATION PROGRAMS, EVALUATION, AND QUALITY IMPROVEMENT

The Base Hospital will:

1. Provide for the continuing education of certified prehospital personnel and Mobile Intensive Care Nurses in accordance with criteria established by the EMS Medical Director including supervised clinical exposure for paramedics in the Emergency Department and other patient care divisions which would expand the paramedic's understanding of medical management.
2. Encourage prehospital personnel to attend in-house lectures, classes, demonstrations, and seminars which have been approved in advance by the EMS Agency for continuing education credits.
3. Provide patient follow-up information for purposes of education to paramedics.
4. Recommend Mobile Intensive Care Nurses for certification and recertification.
6. Advise the EMS Agency of any change in employment status of Mobile Intensive Care Nurses employed in the hospital.
7. Provide quality improvement of care provided by EMS personnel in accordance with Policy.

F. BASE HOSPITAL INTERFACE WITH EMS SYSTEM

The Base Hospital will:

1. See that the Base Hospital Medical Director and the Prehospital Liaison Nurse are scheduled to attend the Emergency Medical Services Operations Committee meetings and other EMS System meetings where their expertise would be valuable, e.g., Medical Control Committee, Base Hospital Committee, Tape Reviews, Emergency Medical Care Committee, and Continuous Quality Improvement.

Subject	Base Hospital Criteria	Policy Number 311
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2. Base Hospitals will be authorized through agreements between the approved hospital and the EMS Agency.

SELF-DEALING TRANSACTION DISCLOSURE FORM

In order to conduct business with the County of Fresno (hereinafter referred to as "County"), members of a contractor's board of directors (hereinafter referred to as "County Contractor"), must disclose any self-dealing transactions that they are a party to while providing goods, performing services, or both for the County. A self-dealing transaction is defined below:

"A self-dealing transaction means a transaction to which the corporation is a party and in which one or more of its directors has a material financial interest."

The definition above will be utilized for purposes of completing this disclosure form.

INSTRUCTIONS

- (1) Enter board member's name, job title (if applicable), and date this disclosure is being made.
- (2) Enter the board member's company/agency name and address.
- (3) Describe in detail the nature of the self-dealing transaction that is being disclosed to the County. At a minimum, include a description of the following:
 - a. The name of the agency/company with which the Corporation has the transaction; and
 - b. The nature of the material financial interest in the Corporation's transaction that the board member has.
- (4) Describe in detail why the self-dealing transaction is appropriate based on applicable provisions of the Corporations Code.
- (5) Form must be signed by the board member that is involved in the self-dealing transaction described in Sections (3) and (4).

(1) Company Board Member Information:			
Name:		Date:	
Job Title:			
(2) Company/Agency Name and Address:			
(3) Disclosure (Please describe the nature of the self-dealing transaction you are a party to):			
(4) Explain why this self-dealing transaction is consistent with the requirements of Corporations Code 5233 (a):			
(5) Authorized Signature			
Signature:		Date:	