CHAPTER 6. CRITICAL AND SPECIALTY CARE PROGRAMS

Article 1. General Provisions

§ 100135.01. Purpose.

The purpose of this chapter is to establish minimum standards for the development, implementation, and evaluation of critical and specialty care systems within the statewide emergency medical services (EMS) system. These standards ensure coordinated patient care across the continuum of emergency services, from prehospital response through definitive hospital care for trauma, ST-elevation myocardial infarction (STEMI), stroke, and emergency medical services for children (EMSC) programs.

Note: Authority: Sections 1797.103, 1797.105, 1797.172, and 1798.150, Health and Safety Code. Reference: Sections 1797.72, 1797.105, 1797.122, 1798.150, and 1798.170, Health and Safety Code.

§ 100135.02. Application of Chapter.

This chapter applies to the establishment, implementation, and evaluation of critical and specialty care systems that are components of California's emergency medical services system. These systems include, but are not limited to, trauma, STEMI, stroke, and EMSC programs.

The provisions of this chapter apply to the Emergency Medical Services Authority (EMSA), local emergency medical services agencies (LEMSAs), and participating entities involved in the organization, operation, and evaluation of these systems of care, including designated specialty care centers, hospitals, EMS providers, and dispatch centers.

Note: Authority: Sections 1797.103, 1797.105, 1797.172, and 1798.150, Health and Safety Code. Reference: Sections 1797.72, 1797.105, 1797.122, 1798.150, and 1798.170, Health and Safety Code.

§ 100135.03. Severability.

If any provision of this chapter or the application thereof to any person or circumstances is held invalid, that invalidity shall not affect other provisions or applications of this chapter which can be given effect without the invalid provision or application, and to this end the provisions of this chapter are severable.

Note: Authority: Sections 1797.103, and 1797.105, Health and Safety Code. Reference: Sections 1797.105, Health and Safety Code.

§ 100135.04 Relationship to Other Regulations.

(a) Nothing in this chapter shall be construed to supersede or conflict with the statutory or regulatory authority of the California Department of Public Health (CDPH) to license and regulate health facilities under Division 5 of Title 22 of the California Code of Regulations.

(b) The provisions of this chapter are intended to complement and be consistent with statewide emergency medical services statutes and with regulations adopted by the Emergency Medical Services Authority (EMSA) in accordance with applicable law and guidance.

(c) Local emergency medical services agencies (LEMSAs) shall incorporate specialty care system components developed under this chapter into their local emergency medical services plans for submission to EMSA in accordance with applicable law and guidance.

Note: Authority: Sections 1797.103, and1797.105, Health and Safety Code.
Reference: Division 2.5 (commencing with Section 1797), Health and Safety Code.

§ 100135.05. Advertising Restrictions.

Unless it has been so designated by a local emergency medical services agency (LEMSA) in accordance with this chapter:

(a) No health care facility shall advertise in any manner or otherwise hold itself out to be designated as a:

(1) Trauma center, pediatric trauma receiving center, or trauma receiving hospital;

(2) ST-elevation myocardial infarction (STEMI) receiving center;

(3) Stroke center; or

(4) Pediatric receiving center (PedRC).

(b) No provider of prehospital care shall advertise in any manner or otherwise hold itself out to be affiliated with a:

(1) Trauma care system;

(2) STEMI critical care system;

(3) Stroke critical care system; or

(4) Emergency Medical Services for Children (EMSC) program.

Note: Authority cited: Sections 1797.107, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.103, 1797.104, 1797.176, 1797.220, 1797.257, 1798.161,1798.163, 1798.165, and 1798.166, Health and Safety Code.

Article 2: Chapter-Level Definitions

§ 100136.01. Advanced Practice Practitioner.

"Advanced practice practitioner" means a physician assistant, nurse practitioner, certified nurse anesthetist, or certified nurse midwife.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections1797.103 and 1797.176, Health and Safety Code.

§ 100136.02. Board-Certified.

"Board-certified" means a physician who has fulfilled all the Accreditation

Council for Graduate Medical Education or American Osteopathic Association requirements in a specialty field of practice and has been awarded a certification by an American Board of Medical Specialties approved program.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections1797.103 and 1797.176, Health and Safety Code.

§ 100136.03. Board-Eligible.

"Board-eligible" means a physician who has met all the training requirements to sit for a board-certification exam in their specialty. Board-certification must be obtained within the allowed time by the American Board of Medical Specialties.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100136.04. California Emergency Medical Services System Information.

"California emergency medical services information system" or "CEMSIS" means the secure, standardized, and centralized electronic information and data collection system administered by the Emergency Medical Services Authority which is used to collect statewide EMS and trauma data.

Note: Authority cited: Sections 1797.107, 1797.122, 1797.176, Health and Safety Code.
Reference: Sections 1797.1, 1797.78, 1797.90, 1797.103, 1797.121, 1797.122, 1797.123, 1797.174 ,1797.176, and 1797.204, 1797.228, 1797.229, 1797.252, Health and Safety Code.

§ 100136.05. Clinical Staff.

"Clinical staff" means individuals that have specific training and experience in the treatment and management of critical or specialty care patients. This includes, but is not limited to, physicians, registered nurses, advanced practice practitioner, pharmacists, and technologists.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100136.06. Critical or Specialty Care Transfer.

For the purposes of this chapter, "critical or specialty care transfer" means an interfacility transfer of an acute critical or specialty care patient from one general acute care hospital (GACH) to another GACH for higher level of care services not available at the sending facility.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103, 1797.176 and 1798.170, 1797.52, 1797.121, 1797.218 Health and Safety Code.

§ 100136.07. Emergency Medical Services.

"Emergency medical services" or "EMS" means the services utilized in responding to a medical emergency, as set forth in section 1797.72 of the Health and Safety Code.

Note: Authority cited: 1797.107, Health and Safety Code.
Reference: Sections 1797.100 and 1797.103, Health and Safety Code.

§ 100136.08. First Medical Contact.

"First Medical Contact" or "FMC" refers to the point at which a patient is initially assessed by a trained medical professional, such as an Emergency Medical Dispatcher, paramedic EMS provider, physician, or nurse, who can assess the patient's condition, provide dispatch pre-arrival instructions, obtain an electrocardiogram, or provide initial interventions.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103, 1797.176 and 1798.170, 1797.52, 1797.121, 1797.218, Health and Safety Code.

§ 100136.09. Implementation.

For the purposes of this chapter, "implementation" or "implemented" or "has implemented" means the development and activation of a specialty care plan by a local EMS agency, including the triage, transport, and treatment of patients in accordance with the plan.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100136.10. National Emergency Medical Services (NEMSIS) Information.

"National Emergency Medical Services Information System" or "NEMSIS" is the national system used to collect, store and share EMS data from the U.S. States and Territories.

Note: Authority cited: Sections 1797.107, 1797.122, 1797.176, Health and Safety Code.
Reference: Sections 1797.1, 1797.78, 1797.90, 1797.103, 1797.121, 1797.122, 1797.123, 1797.174 ,1797.176, and 1797.204, 1797.227, 1797.228, 1797.229, 1797.252, Health and Safety Code.

§ 100136.11. Organized Medical Staff.

The organized medical staff consist primarily of independent practicing physicians who are not hospital employees, but who have privileges to practice at the facility, who perform essential hospital functions. The core responsibilities of the organized medical staff are the promotion of patient safety and the quality of care.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.107 and 1798.150, Health and Safety Code.

§ 100136.12. Patient Care.

For the purposes of this chapter, "patient care" is care provided to critical or specialty care patients from first medical contact until transfer of care at a receiving destination facility.

Note: Authority cited: Sections 1797.107, 1798.150, 1798.161, and 1799.204, Health and Safety Code.
Reference: Sections 1797.107, 1798.150, 1798.161, and 1799.204, Health and Safety Code.

§ 100136.13. Qualified Emergency Specialist.

"Qualified emergency specialist" means a physician who is licensed in California, board-certified or board-eligible in emergency medicine or pediatric emergency medicine by the

American Board of Medical Specialties (ABMS), the American Osteopathic Association Bureau of Osteopathic Specialties, or other appropriate foreign specialty board as determined by the ABMS.

Note: Authority cited: Sections 1797.107, 1798.150, 1798.161, and 1799.204, Health and Safety Code.
Reference: Sections 1797.107, 1798.150, 1798.161, and 1799.204, Health and Safety Code.

§ 100136.14. Qualified Specialist.

(a) "Qualified specialist" or "qualified surgical specialist" or "qualified nonsurgical specialist" means a physician licensed in California who is board-certified or board-eligible in a specialty by the American Board of Medical Specialties (ABMS), the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS), or other appropriate foreign specialty board as determined by the ABMS for that specialty.

(b) For Trauma Care System Plans only, a non-board-certified physician may be recognized as a "qualified specialist" or "board-eligible" by the local EMS agency upon substantiation of need by a trauma center if:

(1) The physician can demonstrate to the appropriate general acute care hospital (GACH), as defined by the California Department of Public Health (CDPH) in Title 22, California Code of Regulations, Section 70005, and the GACH is able to document that the physician has completed a residency program which was approved by the Accreditation Council for Graduate Medical Education, the Royal College of Physicians and Surgeons of Canada, or the College of Family Physicians of Canada; and

(2) The physician can clearly demonstrate to the appropriate GACH body that they have substantial education, training, and experience in treating and managing trauma patients which shall be documented and tracked through the trauma center's trauma quality improvement program.

Note: Authority cited: Sections 1797.107, 1798.150, 1798.161, 1799.204, Health and Safety Code.
Reference: Sections 1797.107, 1798.150, 1798.161, and 1799.204, Health and Safety Code.

§ 100136.15. Quality Improvement.

"Quality Improvement" or "QI" is the process of making system-level changes in clinical, operational, administrative, processes with a continuous reassessment to improve the delivery of high-quality pre-hospital care.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.174, 1797.176 and 1798.150, Health and Safety Code.
Reference: Sections 1797.122, 1797.125.01, 1797.174, 1797.202, 1797.204, 1797.220 and 1798.175, 1830 and 1831, Health and Safety Code.

§ 100136.16. Telehealth.

"Telehealth" means the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code; and Section 2290.5, Business and Professions Code.

Subchapter 1: Trauma Care Systems

Article 1: General Provisions

§100137.01. Purpose and Authority.

(a) The purpose of this subchapter is to establish minimum standards for the development, implementation, designation, and evaluation of trauma care systems as components of California's emergency medical services (EMS) system.

(b) These standards ensure coordinated patient care for the assessment, triage, transport, treatment, and rehabilitation of trauma patients across the continuum of emergency medical services, from prehospital response through definitive care and recovery.

(c) The intent of these regulations is to provide consistency among local trauma systems while allowing flexibility for local implementation based on regional needs and resources, in accordance with Sections 1798.150 and 1798.160 of the Health and Safety Code.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

Article 2: Trauma Care Systems Definitions

§ 100138.01. Abbreviated Injury Scale.

"Abbreviated injury scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 15. For the purpose of volume performance measurement auditing, the standard to be followed is AIS 15 using AIS code derived or computer derived scoring.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100138.02. Prehospital Trauma Triage Criteria.

"Prehospital trauma triage criteria" or "trauma triage criteria" means a measure or method of assessing the severity of a person's injuries that is used for patient evaluation and that utilizes anatomic, physiologic, and/or mechanism of injury considerations for destination decisions from the scene.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100138.03. Re-Triage.

"Re-triage" means the immediate evaluation, resuscitation and transport of a seriously injured

patient from a lower-level Trauma Center or non-trauma facility to a Trauma Center at a higher level of care. This process involves direct emergency department to emergency department transfer of patients.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100138.04. Service Area.

"Service area" means the geographic area defined by the local emergency services agency in its trauma care system plan as the area served by a designated trauma center.

Note: Authority cited: Sections 1797.107 and 1798.161, 1797.200, 1797.202, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100138.05. Trauma Care System.

"Trauma care system" or "trauma system" means an arrangement under which trauma patients are transported to, and treated by, the appropriate trauma facility.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Sections 1798.160 and 1798.161, Health and Safety Code.

§ 100138.06. Trauma Center.

"Trauma center" or "trauma facility," means a licensed general acute care hospital with a special permit for basic or comprehensive emergency services which is verified by the American College of Surgeons as a Level I, II, or III trauma center or a Level I or II pediatric trauma center, or meets the requirements for a Level IV under Section 100141.03 of this subchapter and has been designated as a trauma center or pediatric trauma receiving center by the local EMS agency according to the requirements of this chapter. A facility may be designated as a trauma center for specific types of trauma services based on local system needs and the facility's capabilities and is not required to provide the full range of trauma services.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Sections 1798.160 and 1798.161, Health and Safety Code.

§ 100138.07. Trauma Receiving Hospital.

"Trauma receiving hospital" means a licensed general acute care hospital (GACH) with a special permit for basic or comprehensive emergency service, which is not currently verified as a trauma center by the American College of Surgeons, but which has been formally assigned a role in the trauma care system by the local emergency services agency (LEMSA), including as set forth in Section 100141.01 of this subchapter. In rural areas, the LEMSA may approve GACHs to receive patients requiring emergency medical care services when verified trauma centers. are not reasonably accessible. Final trauma destination decisions are determined by the LEMSA Medical Director based on the level of trauma services available.

Note: Authority cited: Sections 1797.107, 1798.101 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100138.08. Trauma Service.

A "trauma service" is a clinical service established by the organized medical staff, in accordance with hospital governance and applicable law, of a trauma center that has oversight and responsibility of the care of the trauma patient. Trauma services include, but are not limited to, direct patient care services, administration, and as needed, support functions to provide medical care.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100138.09. Trauma Care System Plan.

"Trauma care system plan" means an initial implementation plan that summarizes the development and activation of a trauma care system by a local EMS agency.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

§ 100138.10. Trauma System Status Report.

"Trauma system status report" means the annual assessment of the performance, effectiveness, goals, and objectives of a local EMS agency's (LEMSA's) trauma care system.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

§ 100138.11. Trauma Team.

"Trauma team" means the multidisciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated trauma center. The trauma team consists of physicians, nurses and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and severity of injury which leads to trauma team activation.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

§ 100138.12. Trauma Team Activation Criteria.

"Trauma team activation criteria" means the criteria, as determined by the general acute care hospital (GACH), by which the GACH trauma team is activated.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code.
Reference: Section 1798.161, Health and Safety Code.

Article 3: Local EMS Agency Trauma System Requirements and Responsibilities

§ 100139.01. Trauma Care System Requirements.

(a) A local EMS agency (LEMSA) may develop and implement a trauma care system.

(b) **Plan Requirement.** A LEMSA that is implementing a new trauma care system program must develop a trauma care system plan in accordance with Section 100139.03 of this article and submit the plan to the Emergency Medical Services Authority (EMSA) for approval prior to implementation. For an EMSA-approved trauma care system, the LEMSA shall annually submit a trauma system status report in accordance with Section 100139.04 of this article. Each trauma care system plan and trauma system status report shall, at a minimum, comply with the provisions of Division 2.5 of the Health and Safety Code and the requirements set forth in this chapter. A LEMSA may establish additional requirements in addition to those mandated by statute and state minimum standards.

(c) **Planning Responsibilities.** For the development, implementation, and ongoing evaluation of its trauma care system plan under this subchapter, the LEMSA is responsible for, at a minimum:

(1) **System Design Justification.** A data-informed justification for the proposed trauma care system. The justification shall include an assessment of trauma system needs using LEMSA-defined measures of access to care, quality of patient care, outcomes, mortality rates, and system efficiency. The needs assessment shall incorporate, at a minimum, the following American College of Surgeons-recommended performance indicators to support its trauma system design:

(A) Number of Level I and Level II trauma centers per 1,000,000 population;

(B) Percentage of population within sixty (60) minutes of a Level I or Level II trauma center;

(C) EMS transport times;

(D) Percentage of severely injured patients who are treated at a trauma center;

(E) Trauma-related mortality rate within the jurisdiction;

(F) Frequency and nature of interhospital transfers (re-triage of trauma patients);

(G) Percentage of time trauma centers are on diversion status.

(2) **Trauma Care Committee.** Establishing a trauma care committee, as set forth in Section 100139.02 of this article.

(3) **Program Objectives.** Determine trauma care system goals and objectives.

(4) **Designation and Oversight.** Designate and review trauma centers, pediatric trauma receiving centers, and trauma receiving hospitals in accordance with Articles 4 and 5 of this subchapter.

(5) **Capabilities**.

(A) **Base Hospital Designation.** Designating base hospital(s) within the trauma care system, if applicable.

(B) **Helicopter Landing Sites.** If necessary, requiring trauma centers to have helicopter landing sites. Any helicopter landing site shall be approved by the Division of Aeronautics, Department of Transportation, pursuant to Title 21, California Code of Regulations, Division 2.5.

(C) **Communications.** Ensuring trauma patient transport vehicles are equipped with two-way telecommunications equipment capable of communicating with hospitals, in accordance with its local communication policies.

(D) **Transport Resources.** Ensuring sufficient transport resources to transport trauma patients to an appropriate level trauma center, including air transport and re-triage plans.

(E) **Personnel Training.** Ensuring that all prehospital emergency medical care personnel rendering trauma patient care within the trauma care system are trained in the local trauma triage and patient care policies and procedures.

(6) **Policies.** Developing and implementing policies, procedures and protocols for the treatment and transport of trauma patients. This shall include, at a minimum:

(A) **Prehospital Trauma Care Requirements.** A local field trauma triage policy. The policy shall require early notification from EMS providers to trauma centers, pediatric trauma receiving centers, and trauma receiving hospitals regarding the impending arrival of a trauma patient.

(B) **Patient Destination.** Destination policies of adult and pediatric trauma patients.

(C) **Re-triage.** EMS system policies and procedures designed to expedite and optimize the re-triage of trauma patients from non-trauma centers or lower-level of care trauma-designated hospitals to higher-level of care trauma centers, pediatric trauma receiving centers, or trauma receiving hospitals, when clinically appropriate. Re-triage policies shall be developed and implemented in collaboration with general acute care hospitals (GACHs) and EMS providers.

(7) **System Coordination Agreements.** Developing and implementing agreements necessary for the coordinated treatment and transport of trauma patients within the trauma care system and region, including:

(A) Coordination with Neighboring Local EMS Systems.

(B) Designated Trauma Center Agreements.

(C) Inter-LEMSA Agreements.

(8) **Disaster Preparedness.** Incorporating the trauma care system and its designated trauma centers, pediatric trauma receiving centers, and trauma-receiving hospitals into its regional disaster preparedness/response plans for adults and children.

(9) **Public Education and Outreach.** Implement programs for promoting public education specific to trauma care, including injury prevention.

(10) **Financial Transparency.** Collecting and reporting any fees collected from trauma centers, pediatric trauma receiving centers, and trauma-receiving hospitals in accordance with Section 1798.164, subdivision (b) of the of Health and Safety Code.

(11) **Data Collection, Quality Improvement, and Evaluation.** Collecting and reporting trauma patient care data, establishing and maintaining a QI process, and performing trauma care system evaluation in accordance with Article 5 of this subchapter.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

§ 100139.02. Trauma Care Committee.

(a) The LEMSA shall establish a trauma care committee which meets, at a minimum, twice a year and includes participation from public and private EMS providers, 911-receiving general acute care hospitals (GACHs), trauma centers and trauma receiving hospitals within the local EMS system, any regional trauma center or trauma receiving hospitals that receive re-triaged trauma patients from the LEMSA, and other relevant stakeholders.

(b) The trauma care committee will advise the LEMSA on trauma care policies and protocols and will participate in trauma care QI work.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.172, and 1798.150, Health and Safety Code.
Reference: Section 1797.104, 1797.257, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.168, and 1798.169, Health and Safety Code.

§ 100139.03. Trauma Care System Plan Requirements and Determination Process.

(a) **Plan Submission to EMSA.** Prior to the implementation of a new trauma care system, the local EMS agency (LEMSA) shall complete the Initial Trauma Care System Plan Template (Rev. 11/2025), incorporated by reference, and submit to the Emergency Medical Services Authority (EMSA) for approval, as set forth below.

(b) **Determination and Notification Process.** Following the submission of a trauma care system plan, EMSA shall review the plan for completeness and compliance with the requirements of Division 2.5 of the Health and Safety Code, this subchapter, and the Initial Trauma Care System Plan Template (Rev. 11/2025), incorporated by reference. EMSA shall:

(1) **Acknowledgement.** Within thirty (30) days of receiving the plan submission, provide written notification to the LEMSA to acknowledge receipt of the trauma care system plan and state whether the trauma care system plan is:

(A) Complete, meaning it contains all information required by the Initial Trauma Care System Plan Template (Rev. 11/2025), or

(B) Incomplete. If the trauma care system plan is incomplete, EMSA's notification shall identify the deficiencies.

(2) **Determination.** Within sixty (60) days of receiving the trauma care system plan, EMSA shall provide written notification to the LEMSA that the plan is:

(A) Approved, or

(B) Denied. If the plan is denied, the notice shall specify the reasons for denial, including identification of the plan's failure to meet applicable statutory or regulatory requirements.

(c) **LEMSA Response to a Denial.** If EMSA denies a trauma care system plan, the LEMSA shall have six (6) months from the date of the notification of the denial to:

(1) Submit a revised trauma care system plan which conforms to the requirements of Division 2.5 of the Health and Safety Code and this subchapter, or

(2) Appeal the decision pursuant to Section1797.105 of the Health and Safety Code. A proceeding before the Commission on EMS (the Commission) to hear an appeal of a trauma care system plan denial shall be conducted in accordance with the provisions of Section 100000.01of this Division.

(d) **Implementation of an Approved Plan.** If a trauma care system plan is approved by EMSA or following a successful appeal to the Commission, the LEMSA shall begin implementation of the trauma care system plan within six (6) months of the date of the plan approval.

(e) **Rescinding Approval.** A LEMSA's failure to implement its trauma care system in accordance with the approved trauma care system plan may result in EMSA rescinding approval of the trauma care system plan.

(1) For purposes of this section, "failure to implement" means a failure to execute the trauma care system plan in a manner consistent with the approved plan, including deviations that affect the structure, function, or effectiveness of the trauma care system. In determining whether a failure to implement has occurred, EMSA shall consider factors including but not limited to:
(A) The extent to which the trauma care system deviates from the approved plan;
(B) The impact of the deviation on patient care, system operations, or access to care;
(C) The duration and frequency of the deviation; and

(D) Whether the LEMSA has taken corrective action to address identified deficiencies.

(2) EMSA will consider any information, including but not limited to that received in connection with a subsequent trauma system status report, site visits, complaints, or pending litigation indicating that the LEMSA has failed to implement the trauma care system in accordance with the approved trauma care system plan. If EMSA determines that the trauma care system has not been implemented in accordance with the approved plan, EMSA may rescind approval of the trauma care system plan following written notice to the LEMSA. Any rescission shall be subject to a right of appeal in accordance with Section 1797.105 of the Health and Safety Code and the provisions of Section 100000.01 of this Division.

(f) **Trauma System Status Report Ongoing Review.** As part of its annual EMS plan update the LEMSA shall include a trauma system status report, as set forth in Section 100139.04 of this article.

(g) **Plan Modifications.** The LEMSA shall submit any significant changes to the trauma care system to EMSA for approval, prior to implementation of the change(s), utilizing the Annual Trauma System Status Report Template (Rev 11/2025), incorporated by reference. Significant changes include, but are not limited to, closures of general acute care hospital trauma services, changes to adult or pediatric trauma center American College of Surgeons verification level, and changes to critical LEMSA trauma destination policies. In instances where a delay in approval would adversely impact the current level of trauma care, the LEMSA may implement the changes after electronic notification to EMSA. Within thirty (30) days of implementation, the LEMSA shall submit an amended Annual Trauma System Status Report Template reflecting all changes to EMSA for approval.

(h) **Public Notice Requirement.** The LEMSA shall share the approved trauma care system plan on their website as part of its approved local EMS plan.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

§ 100139.04. Trauma System Status Report Requirements and Determination Process.

(a) For trauma care systems approved by the Emergency Medical Services Authority (EMSA), the local EMS agency (LEMSA) shall complete the Annual Trauma System Status Report Template (Rev. 11/2025), incorporated by reference, and include it as part of its annual EMS plan update. The trauma system status report shall include any changes to the trauma care system since submission of the trauma care system plan described in Section 100139.03 of this article or prior trauma system status report, as applicable. As part of its review of the LEMSA's EMS plan, EMSA will review the trauma system status report to ensure the plan's ongoing effectiveness in meeting the needs of the trauma care system.

(b) **Public Notice Requirement.** The LEMSA shall share the approved trauma system status

report on their website as part of its most recently approved local EMS plan.

Note: Authority cited: Sections 1797.107 and 1798.161, Health and Safety Code. Reference: Section 1797.104, 1797.257, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.168, and 1798.169, Health and Safety Code.

Article 4: Trauma Care System Hospital Designation and Requirements.

Subarticle 1: General Provisions.

§ 100140.01. General Acute Care Hospitals Not Designated as a Trauma Center, Pediatric Trauma Receiving Center, or a Trauma Receiving Hospital.

(a) A general acute care hospital (GACH) within a local EMS system that has implemented a trauma care system, but which has not been designated as a trauma center, pediatric trauma receiving center, or a trauma receiving hospital under this article, shall meet the requirements under Section 100142.01 of this subchapter in relation to the re-triage of trauma patients.

(b) Non-designated GACHs are subject to all applicable requirements under Article 5 of this subchapter.

(c) A LEMSA medical director may establish requirements for non-designated GACHs, in addition to that which is required under this section.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

Subarticle 2: Trauma Center, Pediatric Trauma Receiving Center, and Trauma Receiving Hospital Eligibility and Requirements.

§ 100141.01. Level I-III Adult Trauma Centers and Trauma Receiving Hospitals.

(a) **Eligibility.** A licensed general acute care hospital (GACH) may be designated by the local EMS agency (LEMSA) as a level I, II, or III trauma center if the GACH is verified by the American College of Surgeons (ACS) as meeting all requirements for ACS trauma verification as a level I, II, or III trauma center and satisfies the requirements under this section. ACS trauma verification requirements are set forth in the American College of Surgeons Resource for Optimal Care of the Injured Patient 2022 Standards, ISBN 978-1-7369212-9-6, released in March 2022, incorporated by reference.

(1) **ACS Verification Grace Period.**

(A) **GACHs Seeking Designation.** Licensed GACHs with a pending application for verification before the ACS may be provisionally designated as a Level I, II, or III trauma receiving hospital by the relevant LEMSA to receive trauma patients. The GACH must obtain ACS verification within twenty-four (24) months from the date of its application to the ACS.

(B) **Previously Designated GACHs without ACS Verification.** If, prior to the effective date of these regulations, a licensed GACH was designated by a LEMSA as a level II or III trauma receiving hospital without meeting the

eligibility requirements set forth in paragraph (1)of this section, the GACH must obtain appropriate ACS verification within twenty-four (24) months from the effective date of these regulations.

(C) **Discontinuation of Designation.** Except as specified in paragraph (2) of this section, a GACH may not continue to be designated as a trauma receiving hospital if it fails to obtain ACS verification within the designated timeframe.

(2) **ACS Verification Exemption.** A LEMSA may continue to designate a GACH that fails to obtain ACS verification as a level II, or III trauma receiving hospital if the following conditions are met:

(A) The LEMSA, in collaboration with the GACH, addresses any areas of ACS non-compliance and develops a plan to achieve compliance.

(B) The LEMSA can attest that the facility is capable of providing trauma care services consistent with ACS standards.

(C) The LEMSA applies for and receives a trauma designation exemption for the GACH from the Emergency Medical Services Authority. The application shall include:

(i) The ACS letter notification of failure of verification, to include the specific areas of non-compliance;

(ii) The LEMSA plan to achieve compliance;

(iii) The LEMSA attestation that, despite its failure to obtain ACS verification, the GACH is able to meet the standards set forth by the ACS in its provision of trauma care services.

(b) **Minimum Requirements**.

(1) **Re-Triage of Trauma Patients.** All trauma centers and trauma receiving hospitals are subject to the requirements of Section 100142.01 of this subchapter relating to the re-triage of trauma patients.

(2) **Data Collection, QI, and Evaluation.** All trauma centers and trauma receiving hospitals designated under this section are subject to the requirements of Article 5 of this subchapter.

(3) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as a Level I-III trauma center or trauma receiving hospital, in addition to those required under this section.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

§ 100141.02. Pediatric Trauma Receiving Centers.

(a) **Eligibility.** A licensed general acute care hospital (GACH) meeting the requirements under this section may be designated by the local EMS agency (LEMSA) as a pediatric trauma receiving center if:

(1) **ACS Verification.** The GACH is verified by the American College of Surgeons (ACS) as:

(A) **ACS Pediatric Trauma Center.** Meeting all the requirements for ACS trauma verification as a level I or II pediatric trauma center, or

(B) **ACS Adult Trauma Center Verification with Pediatric Capabilities.** The GACH is verified by the ACS as meeting all the requirements for an adult level I, II, or III trauma center and has the following capabilities:

(i) Pediatric emergency department area;

(ii) Pediatric intensive care area; and

(iii) Appropriate resuscitation equipment, as outlined in the pediatric readiness toolkit in the American College of Surgeons Resource for Optimal Care of the Injured Patient 2022 Standards, ISBN 978-1-7369212-9-6, released in March 2022 and incorporated by reference herein.

(2) **ACS Verification Grace Period**.

(A) **GACHs Seeking Designation.** Licensed GACHs with a pending application before the ACS for either type of verification specified in paragraph (1) and, as applicable, having the associated required capabilities may be provisionally designated as a pediatric trauma receiving center by the LEMSA to receive pediatric trauma patients. The GACH must obtain the requisite ACS verification, and any applicable capabilities, within twenty-four (24) months from the date of its application to the ACS.

(B) **Previously Designated GACHs without ACS Verification.** If, prior to the effective date of these regulations, a licensed GACH was designated by a LEMSA as a pediatric trauma receiving center without meeting the eligibility requirements set forth in paragraph (1) of this section, the GACH must obtain appropriate ACS verification within twenty-four (24) months from the effective date of these regulations.

(C) **Discontinuation of Designation.** A GACH may not continue to be designated as a pediatric trauma receiving center if it fails to obtain ACS verification within the designated timeframe.

(b) **Minimum Requirements**.

(1) **Re-triage of Trauma Patients.** All pediatric trauma receiving centers are subject to the requirements of Section 100142.01 of this subchapter relating to the re-triage of trauma patients.

(2) **Data Collection, QI, and Evaluation.** All pediatric trauma receiving centers are subject to the requirements of Article 5 of this subchapter.

(3) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as a pediatric trauma receiving center, in addition to those required under this section.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

§ 100141.03. Level IV Trauma Centers.

(a) **Eligibility.** A licensed general acute care hospital (GACH) meeting the requirements of this section may be designated by the local EMS agency (LEMSA) as a level IV trauma center.

(b) **Requirements.** The GACH shall have a trauma service that meets the requirements specified in this section and provides coordination of trauma care with the LEMSA.

(1) **Capabilities**. The GACH has the following capabilities:

(A) **Emergency Department.** The GAHC has an emergency department operating twenty-four (24) hours per day, seven (7) days per week, 365 days per year that is staffed by a physician or appropriate advanced practice practitioner, as determined by the GACH, and, at a minimum has:

(i) A physician director for the emergency department;

(ii) Current Advanced Trauma Life Support certification for any provider who is not board-certified or eligible by the American Board of Emergency Medicine or the American Osteopathic Board of Emergency Medicine.

(B) **Initial Stabilization and Personnel.** The GACH has the necessary equipment and resources for initial stabilization of a trauma patient as well as personnel who are knowledgeable in the treatment of both adult and pediatric trauma.

(C) **Trauma Care Functions.** The GACH shall have the capability, through necessary human and physical resources including facilities and equipment, to provide prompt assessment, resuscitation, and stabilization to trauma patients, consistent with a Level IV trauma center designation. In addition:

(i) The trauma team must be fully assembled within 30 minutes of patient arrival;

(ii) The GACH shall provide universal screening for alcohol use for all injured patients, in accordance with American College of Surgeons guidelines;

(iii) The GACH shall have protocols that define the clinical criteria and confirmatory testing required for the diagnosis of brain death.

(D) **Re-triage of Trauma Patients.** Level IV trauma centers are subject to the

requirements of Section 100142.01 of this subchapter relating to the re-triage of trauma patients.

(E) **Diagnostic and Therapeutic Support.** The following diagnostic and therapeutic support capabilities:

(i) Radiological service with twenty-four (24) hours per day, seven (7) days per week, 365 days a year availability of a radiological technician.

(ii) Clinical laboratory and therapeutic service, including:

(I) Twenty-four (24) hours per day, seven (7) days per week, 365 days a year availability of clinical laboratory services; and

(II) A comprehensive blood bank or access to a community central blood bank.

(2) **Program Staffing.** The GACH meets the following staffing requirements:

(A) **Trauma Program Medical Director.** A trauma program medical director whom the GACH has determined to be a qualified specialist. The duties of the trauma program medical director shall include responsibilities that affect all aspects of adult and pediatric trauma care such as:

(i) Recommending trauma team physician privileges;

(ii) Working with nursing administration to support the nursing needs of trauma patients;

(iii) Developing GACH trauma treatment protocols;

(iv) Authority and accountability for the quality improvement (QI) peer review process;

(v) Correcting deficiencies in trauma care, or excluding from trauma call, any trauma team member(s) who fail to meet the standards of the program; and

(vi) Assisting in the coordination of the budgetary process for the trauma program.

(B) **Trauma Nurse Coordinator.** A trauma nurse coordinator or manager who is a registered nurse with qualifications that include trauma care specific training, education, and clinical experience in the care of trauma patients, as well as experience in GACH administration. The duties of the trauma nurse coordinator shall include the following:

(i) Organizing the patient care services and administrative systems necessary for the multidisciplinary approach to the care of the injured patient;

(ii) Coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel; and

(iii) Collaborating with the trauma program medical director in carrying out the educational, clinical, administrative and outreach activities of the trauma program.

(3) **Policies.** A policy that clearly defines trauma team activation criteria.

(4) **Continuing Education.** Continuing education in trauma care shall be provided for:

(A) Organized medical staff;

(B) Staff nurses;

(C) Staff allied health personnel;

(D) EMS personnel; and

(E) Other community physicians and health care personnel.

(5) **Trauma Committee Participation.** Participate in local and regional trauma committees;

(6) **Disaster Coordination.** Facility participation in local and regional disaster management committees, planning, and exercises;

(7) **Outreach Program.** An outreach program, to include:

(A) A designated individual in a leadership position who has injury prevention as a defined responsibility part of his or her job description;

(B) Capability to provide both telephone and on-site consultation with physicians in the community and outlying areas;

(C) Trauma prevention activities directed toward the general public.

(8) **Data Collection, QI, and Evaluation**. All level IV trauma centers are subject to the requirements of Article 5 of this subchapter. In connection with the data collection, QI, and evaluation requirements therein, level IV trauma centers shall:

(A) **Performance Improvement and Patient Safety Program.** Have a trauma care Performance Improvement and Patient Safety (PIPS) program which shall include, at a minimum, the following:

(i) Ability to identify opportunities for improvement and implement actions to reduce the risk of patient harm, regardless of the department, service, or provider;

(ii) Review of all transfers to a higher level of care within the institution and re-triage of trauma patients;

(iii) A process for reporting events and actions to a departmental/GACH

PIPS program, enabling aggregation of data across the organization;

(iv) A process to provide feedback to the trauma program;

(v) A process to bring the providers across relevant disciplines and departments together to review and implement opportunities for improvement;

(vi) A written plan that documents all process and outcome measures shall and that is reviewed and updated on at least an annual basis;

(vii) Mechanisms in place to identify events for review by the trauma PIPS program. Once an event is identified, the trauma PIPS program shall verify and validate the event;

(viii) A process to document that timely and appropriate intensive care unit (ICU) care and coverage are being provided, if available.

(B) **Program Review**.

(i) **Trauma Program Medical Director Review.** The trauma program medical director shall conduct an annual review, in accordance with the general acute care hospital's (GACH's) internal policies and procedures, to ensure that the trauma program demonstrates appropriate orientation, credentialing, and skills maintenance of advanced practitioners. The medical director's review shall include, at a minimum, the evaluation of documentation, credentialing records, and compliance with applicable standards, to ensure alignment with the approved trauma care system plan and the requirements of this subchapter. Documentation of the review and determination shall be included as attachments with the Initial Trauma Care System Plan Template (Rev. 11/2025), incorporated by reference, or the Annual Trauma System Status Report Template (Rev. 11/2025), incorporated by reference, as applicable.

(ii) **Trauma Peer Review Committee.** A multidisciplinary trauma peer review committee that meets at least twice a year and includes medical staff who are actively involved in trauma resuscitation. The committee's review shall consist of assessing any systemic and care provider issues and proposing improvements to the care of injured patients. The review shall be conducted in accordance with the GACH policies and procedures for quality improvement.

(9) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as a Level IV trauma center in addition to those required under this section.

(c) **Level IV Trauma Centers Designated Prior to Effective Date of Regulations.** A level IV trauma center designated by the LEMSA pursuant to regulations in effect prior to the effective date of these regulations may continue to operate as a level IV trauma center; however, any such trauma center shall meet the requirements of this chapter within twelve (12) months following a program review described in

subdivision (b)(8)(B) of this section.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.254, 1798.150, 1798.160, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

Subarticle 3: Re-Triage of Trauma Patients.

§ 100142.01. Re-Triage of Trauma Patients.

General acute care hospitals (GACHs) within a trauma care system shall adhere to the local EMS agency (LEMSA) policy regarding the re-triage of trauma patients. This requirement applies to all GACHs, regardless of whether they have been designated as a trauma center, pediatric trauma receiving center, or trauma receiving hospital. In addition:

(a) **Re-Triage Requirements.** GACHs shall develop and implement re-triage policies, protocols, and guidelines that shall include the following requirements:

(1) Identification of critically injured trauma patients who are eligible for re-triage;

(2) Processes for selecting the appropriate partner trauma center(s);

(3) Clinical criteria for automatic acceptance of qualifying patients by the appropriate partner trauma center;

(4) Specific processes for re-triage that ensure continuous (twenty-four (24) hours per day, seven (7) days per week, 365 days per year) access to trauma center surgeons or other appropriate physicians at partner trauma centers for timely notification and coordination of incoming re-triage patient referrals;

(5) Standardized communication language to be used between the referring GACH and the receiving partner trauma center, including the minimum required patient information to be exchanged to facilitate rapid transfer;

(6) Guidance for selecting the appropriate transport service to match meet each patient's needs. Considerations shall include transport personnel scope of practice and identification of patients for whom more rapid departure to the destination trauma center (such as via emergency ambulance through the 911 response system) outweighs the benefit of delaying transport to await providers with broader scope of practice, such as a critical care transport registered nurse;

(7) Process for the transfer of patient consent forms, emergency department medical records, initial electronic patient care record, and personal belongings for the re-triaged patient;

(8) Process for providing information relating to the receiving trauma center, pediatric trauma receiving center, or trauma receiving hospital, including location and/or directions, to the re-triaged patient's family, care givers, or legal guardian.

(b) **Re-Triage Agreements to Fulfill Re-Triage Requirements.** To optimize patient safety and improve outcomes, the re-triage requirements set forth in subdivision (a) of this section may be met through the establishment of pre-arranged re-triage agreements. These agreements shall include, at a minimum:

(1) Criteria for automatic trauma center acceptance, as supported by LEMSA policies.

(2) Special considerations, including patient selection and destination for pediatric trauma patients.

Note: Authority: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.72, 1797.105, 1797.122, 1797.176, 1797.220, 1797.2541798.150, 1798.160, 1798.160, 1798.161, 1798.162, 1798.163, 1798.164, 1798.165, 1798.166, 1798.167, 1798.168, and 1798.169, Health and Safety Code.

Article 5: Trauma Care System Data Management, Quality Improvement, and Evaluation.

§ 100143.01. Trauma Data Management Requirements.

(a) **Data Collection and Reporting Process Requirements.**

(1) **LEMSA.** The local EMS agency (LEMSA) shall develop and implement a standardized data collection and reporting process for the trauma care system.

(A) The process shall include the collection of both prehospital trauma patient care data and general acute care hospital (GACH) trauma patient care data. The data shall include the elements specified in subdivision (b) and may include additional elements as specified by the LEMSA.

(B) The LEMSA, in collaboration with trauma centers, trauma receiving hospitals, and EMS providers, shall develop a process for the sharing of outcome data from the trauma center or trauma receiving hospital to the EMS providers for all transported trauma patients, including patients who were initially identified as potential trauma cases but were not ultimately included in the trauma center's or trauma receiving hospital's trauma registry.

(C) The LEMSA shall:

(i) Provide quarterly trauma system data reports to all trauma care system-participating general acute care hospitals (GACHs) that summarize the collected prehospital- and GACH-level trauma patient care data.

(ii) Share any National Trauma Data Bank® (NTDB) information collected for trauma centers within its local EMS system with the Emergency Medical Services Authority (EMSA).

(2) **GACHs.**

(a) All trauma centers and trauma receiving hospitals that receive patients via EMS shall maintain a LEMSA-approved trauma patient registry (trauma registry) within

which the GACH shall collect trauma patient care data. The GACH shall submit trauma registry data either directly to CEMSIS or the LEMSA in a manner that is compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191). When trauma registry data is submitted to the LEMSA, the LEMSA shall upload the data to CEMSIS.

(b) All GACHs within an approved trauma care system that receive trauma patients via EMS shall participate in the LEMSA data collection process in accordance with LEMSA policies and procedures.

(3) **Timing of submission.** The prehospital trauma patient care data and GACH trauma patient care data shall be collected and submitted to the Emergency Medical Services Authority (EMSA), either directly or through the LEMSA in accordance with the LEMSA's data policy, on at least a quarterly basis and within ninety (90) days of patient discharge.

(b) **Trauma Patient Care Data Requirements.**

(1) **Prehospital Trauma Patient Care Data Elements.** The prehospital trauma patient care data elements shall be compliant with the most current version of the CEMSIS and NEMSIS databases.

(2) **GACH Trauma Patient Care Data Elements.** GACH trauma patient care data elements shall include, at a minimum:

(A) Time of arrival in the emergency department (ED);

(B) Dates of:

(i) Initial admission;

(ii) Intensive care unit (ICU) admission; and

(iii) Discharge.

(C) Discharge data, including:

(i) Patient destination;

(ii) Discharge diagnosis;

(iii) Gender;

(iv) Date of Birth;

(v) Age;

(vi) ED/hospital arrival date;

(vii) ED/hospital arrival time;

(viii) ED disposition;

(ix) Hospital disposition;

(x) International Classification of Diseases, 10th Revision, Injury Diagnosis (ICD-10 Injury Dx) codes;

(xi) Abbreviated Injury Scale (AIS) severity codes;

(xii) Mode of arrival.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1798.161, 1798.162, 1798.163, 1798.165, and 1798.166, Health and Safety Code.

§ 100143.02. Local EMS Agency Trauma Quality Improvement and Evaluation Process.

(a) Trauma care shall be an integral part of the local EMS agency's (LEMSA's) overall QI program. A LEMSA with a trauma care system shall have a QI process that includes, at a minimum:

(1) **Policy Development.** A trauma center physician, who is a surgeon or an emergency department physician, assisting in the development of LEMSA prehospital care policies, procedures, and protocols relevant to the care of trauma patients;

(2) **Multidisciplinary QI Committee**. A trauma care or QI committee that addresses multidisciplinary trauma QI work.

(3) **System Participation.**

(A) Participation of all relevant prehospital providers as well as trauma centers and trauma receiving hospitals in:

(i) The trauma data management requirements set forth in Section 100143.01 of this article; and

(ii) The LEMSA's QI process under this section.

(B) All general acute care hospitals (GACHs) that send or receive trauma patients shall participate in system and trauma center QI activities for those trauma patients which have been transferred.

(4) **Regional Coordination Review.** Evaluation of the regional coordination and integration of trauma patient movement, including trauma destination policies or re-triage of trauma patients that involve GACHs outside the LEMSA's jurisdiction;

(5) **Case Review.** Review of trauma-related deaths, locally defined adverse events, and transfers;

(6) **System Performance Evaluation.** Evaluation of program structure, process, and outcomes;

(7) **Confidentiality Protections.** Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality and a disclosure-protected review of selected trauma cases.

(b) The LEMSA shall be responsible for ongoing performance evaluation and QI of the trauma care system.

(1) **Evaluation Support Process.** The LEMSA shall implement a process utilizing trauma committee work and regular data reporting, as set forth in this section, to share information bi-directionally with EMS providers, system-participating GACHs, and the local medical community. This process shall support ongoing trauma care system evaluation, including the trauma care system plan, to ensure that the plan meets the needs of the local EMS system.

(2) **Period Performance Evaluation.** The LEMSA shall periodically evaluate the performance of its trauma care system on a basis of at least every three (3) years. Results of the trauma care system evaluation shall be made available to system participants.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1798.161, 1798.162, 1798.163, 1798.165, and 1798.166, Health and Safety Code.

§ 100143.03. Designated GACH Quality Improvement and Evaluation Requirements.

(a) **Trauma Center Performance Improvement and Patient Safety.** Trauma centers, pediatric trauma receiving centers, and trauma receiving hospitals of all levels shall have a Performance Improvement and Patient Safety (PIPS) program and trauma care quality improvement process that is independent of, but reports to, the general acute care hospital's (GACH's) general performance or QI program, in accordance with Sections 100141.01, 100141.02, and 100141.03 of this subchapter.

(b) All trauma centers, pediatric trauma receiving centers, and trauma receiving hospitals shall have a process for reviewing trauma care and providing feedback to:

(1) The LEMSA, related to the accuracy of triage, re-triage, and provision of care; and

(2) Referring providers, related to the triage, re-triage, care and outcomes of referred patients and any potential opportunities for improvement in initial care.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1798.161, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1798.161, 1798.162, 1798.163, 1798.165, and 1798.166, Health and Safety Code.

Subchapter 2: ST-Elevation Myocardial Infarction (STEMI) Critical Care Systems.

Article 1: General Provisions

§100144.01 Purpose and Authority.

(a) The purpose of this subchapter is to establish minimum standards for the development, implementation, designation, operation, and evaluation of ST-Elevation Myocardial Infarction (STEMI) Critical Care Systems by local emergency medical services agencies (LEMSAs) as components of California's emergency medical services (EMS) system.

(b) These standards ensure coordinated, timely, and effective care for patients experiencing STEMI through the integration of prehospital and hospital services, designation of STEMI receiving and referring hospitals, and continuous system performance evaluation in accordance with Division 2.5 of the Health and Safety Code.

(c) The intent of these regulations is to provide consistency among local STEMI critical care systems while allowing flexibility for local implementation based on regional needs and resources, in accordance with Sections 1798.150 and 1798.160 of the Health and Safety Code.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Article 2: ST-Elevation Myocardial Infarction (STEMI) Critical Care Definitions

§ 100145.01. Cardiac Catheterization Laboratory.

"Cardiac catheterization laboratory" or "Cath lab" means the setting within the general acute care hospital, or an expanded area permitted under Title 22, California Code of Regulations section 70438.2, where diagnostic and therapeutic procedures are performed on patients with cardiovascular disease.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100145.02. Cardiac Catheterization Team.

"Cardiac catheterization team" means the specially trained health care professionals that is capable of performing percutaneous coronary intervention (PCI).

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100145.03. Percutaneous Coronary Intervention (PCI).

"Percutaneous coronary intervention" or "PCI" means a procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100145.04. ST-Elevation Myocardial Infarction (STEMI).

"ST-Elevation Myocardial Infarction" or "STEMI" means a clinical syndrome defined by symptoms of myocardial infarction in association with ST-segment elevation on Electrocardiogram (ECG) which meets diagnostic criteria for myocardial infarction.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§100145.05. STEMI Critical Care.

"STEMI critical care" means all emergency cardiac care which in addition to care for STEMI patients may include designation of PCI-capable general acute care hospital (GAHC) for Return of Spontaneous Circulation (ROSC) patients and specialized EMS and GACH treatment policies, including but not limited to post-resuscitation targeted temperature management, extra-corporeal membrane oxygenation (ECMO), decompensated heart failure management, and mechanical circulatory assist devices protocols.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100145.06. STEMI Critical Care System.

"STEMI critical care system" means a critical care component of the EMS system developed by a local EMS agency (LEMSA) that links prehospital and general acute care hospital care to deliver treatment to STEMI patients.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100145.07. STEMI Critical Care System Plan.

"STEMI critical care system plan" means an initial implementation plan that summarizes the development and activation of a STEMI care system by a local emergency services agency.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100145.08. STEMI Critical Care System Plan Update.

"STEMI critical care system plan update" means the annual assessment of the performance, effectiveness, goals, and objectives of a local EMS agency's (LEMSA's) STEMI critical care system.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100145.09. STEMI Medical Director.

"STEMI medical director" means a physician who is board-certified for cardiology and who meets the local emergency medical service agency's defined qualifications and is responsible for the general acute care hospital's STEMI program.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100145.10. STEMI Patient.

"STEMI patient" means a patient with symptoms of myocardial infarction in association with ST-Segment Elevation in an electrocardiogram (ECG) which meets diagnostic criteria for myocardial infarction.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100145.11. STEMI Program.

"STEMI program" means an organizational component of a general acute care hospital specializing in the care of STEMI patients.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections1797.103 and 1797.176, Health and Safety Code.

§100145.12. STEMI Program Manager.

"STEMI program manager" means a registered nurse or individual with a higher medical degree who is designated by the general acute care hospital to be responsible for monitoring and evaluating the care of STEMI patients, as well as for the coordination of performance improvement and patient safety programs for the STEMI center. The STEMI program manager performs these responsibilities in conjunction with the STEMI Medical Director.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100145.13. STEMI Receiving Center (SRC).

"STEMI receiving center" or "SRC" or "STEMI center" means a licensed, verified, general acute care hospital that meets the minimum standards for STEMI care pursuant to Section 100147.02 of this subchapter, has PCI capability, and is designated as a STEMI receiving center by the local EMS agency.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100145.14. STEMI Referring Hospital (SRH).

"STEMI referring hospital" or "SRH" means any licensed general acute care hospital (GACH) within a local EMS system that receives patients transported through the 911 emergency response system and that has not been designated as a STEMI receiving center. All STEMI referring hospitals must meet the minimum requirements set forth in Section 100147.01of this subchapter.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.
Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100145.15. STEMI Team.

"STEMI team" means the clinical personnel, support personnel, and administrative staff that function together as part of a general acute care hospital STEMI program.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

Article 3: Local EMS Agency STEMI Critical Care System Requirements and Responsibilities

§ 100146.01. STEMI Critical Care System Requirements.

(a) A local EMS agency (LEMSA) may develop and implement a STEMI critical care system.

(b) **Plan Requirement.** A LEMSA that is implementing a new STEMI critical care system program must develop a STEMI critical care system plan in accordance with Section 100146.03 of this article and submit the plan to the Emergency Medical Services Authority (EMSA) for approval prior to implementation. For an EMSA-approved STEMI critical care system, the LEMSA shall annually submit a STEMI critical care plan update in accordance with Section 100146.04 of this article. Each STEMI critical care system plan and update shall, at a minimum, comply with the provisions of Division 2.5 of the Health and Safety Code and the requirements set forth in this chapter. A LEMSA may establish additional requirements in addition to those mandated by statute and state minimum standards.

(c) **Planning Responsibilities.** For the development, implementation, and ongoing evaluation of its STEMI critical care system plan under this subchapter, the LEMSA is responsible for, at a minimum:

(1) **Cardiac Care Committee.** Establishing a cardiac care committee, as set forth in Section 100146.02 of this article.

(2) **Program Objectives.** Determine STEMI critical care system goals and objectives.

(3) **Designation and Oversight.** Designate and review STEMI receiving centers and STEMI referring hospitals in accordance with Articles 4 and 5 of this subchapter.

(4) **Policies**. Developing and implementing policies, procedures, and protocols for the treatment and transport of STEMI patients. This shall include, at a minimum:

(A) **Prehospital STEMI and Cardiac Care Requirements.** Policies and protocols for the identification, treatment, and appropriate destination of STEMI patient or other critical cardiac patients. These policies and protocols shall include:

(i) **Prehospital ECG Interpretation.** The findings of 12-lead electrocardiograms (ECGs) performed in the field shall be assessed and interpreted through one or more of the following methods:

(I) Direct paramedic interpretation;

(II) Automated computer algorithm;

(III) Wireless transmission to a receiving facility followed by physician interpretation or confirmation.

(ii) **Advance Notification to STEMI Center.** Notification of prehospital ECG findings of suspected STEMI patients, as defined by the LEMSA, shall be communicated by EMS personnel in advance of arrival to the STEMI center.

(i) **ECG Data Submission.** 12-lead ECGs performed in the field shall be uploaded with the electronic patient care record (ePCR) to the LEMSA. For LEMSAs that do not maintain a separate ePCR database, the ECGs shall be uploaded to CEMSIS.

(B) **Interfacility Transfer.** A policy facilitating the interfacility transfer of acute STEMI patients;

(C) **Regional Integration.** A policy integrating a receiving center or receiving centers located in a neighboring jurisdiction.

(5) **System Coordination Agreements**. Developing and implementing agreements necessary for the coordinated treatment and transport of STEMI patients within the STEMI critical care system and region, including:

(A) Coordination with neighboring local EMS systems;

(B) Designated STEMI receiving center agreements;

(C) Inter-LEMSA agreements.

(6) **Public Education and Outreach**. A description of programs that conduct or promote public education specific to cardiac care.

(7) **Data Collection, Quality Improvement, and Evaluation**. Collecting and reporting STEMI patient care data, establishing and maintaining a QI process, and performing STEMI critical care system evaluation in accordance with Article 5 of this subchapter.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100146.02. Cardiac Care Committee.

(a) The local EMS agency (LEMSA) developing and implementing a STEMI critical care system shall establish a cardiac care committee which meets, at a minimum, twice a year and includes participation from public and private EMS providers, 911-receiving general acute care hospitals (GACHs), STEMI referring hospitals and receiving centers within the local EMS system, any regional STEMI receiving centers that receive STEMI patient IFTs from the LEMSA, and other relevant stakeholders.

(b) The STEMI or cardiac care committee will advise the LEMSA on STEMI and cardiac care policies and protocols and will participate in STEMI and cardiac care QI work.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107,1797.250, 1797.254 and 1798.150, Health and Safety Code.
Reference: Sections 1797.176 and 1797.220, Health and Safety Code.

§ 100146.03. STEMI Critical Care System Plan Requirements and Determination Process.

(a) Plan Submission to EMSA. Prior to the implementation of a new STEMI critical care system, the local EMS agency (LEMSA) shall complete the Initial STEMI Critical Care System Plan Template (Rev. 11/2025), incorporated by reference, and submit to the Emergency Medical Services Authority (EMSA) for approval, as set forth below.

(b) **Determination and Notification Process.** Following the submission of a STEMI critical care system plan, EMSA shall review the plan for completeness and compliance with the requirements of Division 2.5 of the Health and Safety Code, this subchapter, and the Initial STEMI Critical Care System Plan Template (Rev. 11/2025), incorporated by reference. EMSA shall:

(1) **Acknowledgement.** Within thirty (30) days of receiving the plan submission, provide written notification to the LEMSA to acknowledge receipt of the STEMI critical care system plan and state whether the STEMI critical care system plan is:

(A) Complete, meaning it contains all information required by the Initial STEMI Critical Care System Plan Template (Rev. 11/2025); or

(B) Incomplete. If the STEMI critical care system plan submission is incomplete, EMSA's notification shall identify the deficiencies.

(2) **Determination.** Within sixty (60) days of receiving the plan, EMSA shall provide written notification to the LEMSA that its STEMI critical care system plan is:

(A) Approved, or

(B) Denied. If the plan is denied, the notice shall specify the reasons for denial, including identification of the plan's failure to meet applicable statutory or regulatory requirements.

(c) **LEMSA Response to a Denial.** If EMSA denies a STEMI critical care system plan, the LEMSA shall have six (6) months from the date of the notification of the denial to:

(1) Submit a revised STEMI critical care system plan which conforms to the requirements of Division 2.5 of the Health and Safety Code and this subchapter, or

(2) Appeal the decision to the Commission on EMS (the Commission). A proceeding before the Commission to hear an appeal of a STEMI critical care system plan shall be conducted in accordance with the provisions of Section 100000.01 of this division.

(d) **Implementation of an Approved Plan.** If a STEMI critical care system plan is approved by EMSA or following a successful appeal to the Commission, the LEMSA shall begin implementation of the STEMI critical care system plan within six (6) months of the date of the plan approval.

(e) **Rescinding Approval.** A LEMSA's failure to implement its STEMI critical care system in accordance with the approved STEMI critical care system plan may result in EMSA rescinding approval of the STEMI critical care system plan.

(1) For purposes of this section, "failure to implement" means a failure to execute the STEMI critical care system plan in a manner consistent with the approved plan, including deviations that affect the structure, function, or effectiveness of the STEMI care system. In determining whether a failure to implement has occurred, EMSA shall consider factors including but not limited to:

(A) The extent to which the STEMI care system deviates from the approved plan;

(B) The impact of the deviation on patient care, system operations, or access to care;

(C) The duration and frequency of the deviation; and

(D) Whether the LEMSA has taken corrective action to address identified deficiencies.

(2) EMSA will consider any information, including but not limited to that received in connection with a subsequent STEMI system status plan, site visits, complaints, or pending litigation indicating that the LEMSA has failed to implement the STEMI care system in accordance with the approved STEMI critical care system plan. If EMSA determines that the STEMI care system has not been implemented in accordance with the approved plan, EMSA may rescind approval of the STEMI care system plan following written notice to the LEMSA. Any rescission shall be subject to a right of appeal in accordance with Section 1797.105 of the Health and Safety Code and the provisions of Section 100000.01 of this Division.

(f) **STEMI Critical Care System Plan Updates.** As part of its annual EMS plan update the LEMSA shall include a STEMI critical care system plan update, as set forth in section 100146.04 of this article.

(g) **Plan Modifications.** The LEMSA shall submit any significant changes to the STEMI critical care system plan to EMSA for approval, prior to implementation of the change(s), utilizing the Annual STEMI Critical Care System Plan Update Template (Rev. 11/2025), incorporated by reference. Significant changes include, but are not limited to closures of a general acute care hospital's (GACH's) PCI services, changes to a GACH's PCI verification or designation status, and changes to LEMSA STEMI or cardiac care destination policies. In instances where a delay in approval would adversely impact the current level of STEMI critical care, the LEMSA may implement the changes after electronic notification to EMSA. Within thirty (30) days of implementation, the LEMSA shall submit an amended Annual STEMI Critical Care System Plan Update Template reflecting all changes to EMSA for approval.

(h) **Public Notice Requirement.** The LEMSA shall share the approved STEMI critical care system plan on their website, as part of its approved local EMS plan.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health

and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100146.04. STEMI Critical Care System Plan Update Requirements and Determination Process.

(a) For STEMI critical care systems approved by the Emergency Medical Services Authority (EMSA), the local EMS agency (LEMSA) shall complete the Annual STEMI Critical Care System Plan Update Template (Rev. 11/2025), incorporated by reference, and include it as part of its annual EMS plan update. The STEMI critical care system plan update shall include any changes to the STEMI critical care system since submission of the STEMI critical care system plan described in Section 100146.03 of this article or prior STEMI critical care system plan update, as applicable. As part of its review of the LEMSA's EMS plan, EMSA will review the STEMI critical care system plan update to ensure the plan's ongoing effectiveness in meeting the needs of the STEMI care system.

(b) **Public Notice Requirement.** The LEMSA shall share the approved STEMI critical care system plan update on their website, as part of its most recently approved local EMS plan.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Article 4: STEMI Critical Care System Hospital Designation and Requirements.

§ 100147.01. STEMI Referring Hospitals.

(a) **Eligibility.** Any licensed general acute care hospital (GACH) within a local EMS system having an approved STEMI critical care system that receives patients transported through the 911 emergency response system and that has not been designated as a STEMI receiving center pursuant to Section 100147.02 of this subarticle is a STEMI referring hospital. All STEMI referring hospitals shall meet the requirements of this section.

(b) **Requirements**.

(1) **Capabilities**. Twenty-four (24) hours per day, seven (7) days per week, 365 days per year availability to provide appropriate diagnostic care and thrombolytic therapy for STEMI patients.

(2) **STEMI Treatment and Operations**.

(A) Compliance with all LEMSA policies and protocols relevant to STEMI referring GACHs;

(B) A standardized procedure for the treatment of STEMI patients in the emergency department;

(C) A documented transfer process through IFT agreements or protocols and prearranged agreements with EMS providers for the rapid transport of acute STEMI patients to a STEMI receiving center.

(3) **Policies**. Written policies and protocols in place to identify STEMI patients and provide thrombolytic therapy for qualifying patients prior to transfer.

(4) **Data Collection, QI, and Evaluation**. STEMI referring hospitals under this section are subject to the requirements of Article 5 of this subchapter. In addition, STEMI referring hospitals shall have:

(A) A STEMI component to the GACH's QI program;

(B) A plan to collaborate with a STEMI receiving center and the LEMSA on QI processes;

(C) A compliance review of the GACH's STEMI program shall be conducted by the LEMSA at least once every three years.

(5) **Additional Requirements.** A LEMSA medical director may establish requirements for STEMI referring Hospitals in addition to those required under this section.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100147.02. STEMI Receiving Centers.

(a) **Eligibility.** A licensed general acute care hospital (GACH) meeting the requirements of this section may be designated by the local EMS agency (LEMSA) as a STEMI receiving center.

(b) **Requirements.**

(1) **Capabilities.**

(A) Twenty-four (24) hours per day, seven (7) days per week, 365 days a year availability for the treatment of STEMI patients;

(B) A call activation system to activate the cardiac catheterization team directly;

(C) An EMS system notification process developed with the LEMSA to be utilized when PCI services are unavailable;

(D) A process in place for the triage and treatment of STEMI patients arriving simultaneously;

(E) Compliance with the required minimum volume of PCI procedures performed for designation by the LEMSA;

(F) A STEMI receiving center without on-site cardiovascular surgery capability shall have a written transfer plan and agreements for transfer to a facility with cardiovascular surgery capability.

(2) **Program Staffing**.

(A) A STEMI program manager and a STEMI medical director;

(B) A cardiac catheterization team, including appropriate staff as determined by the GACH and LEMSA, that is immediately available at all times;

(C) Up-to-date STEMI team and cardiac catheterization team call roster(s);

(D) Documentation containing job descriptions and organizational structure that clarifies the relationship between the STEMI Medical Director, STEMI Program Manager, and the STEMI team, to be provided to the LEMSA upon request.

(3) **STEMI Treatment and Operations.** Agreement to:

(A) Accept all STEMI patients according to the LEMSA's STEMI destination policy;

(B) Adhere to the LEMSA's diversion policy or protocol.

(4) **Policies.** Written policies and protocols for triage, diagnosis, and cath lab activation following field notification.

(5) **Continuing Education.** Continuing education in STEMI critical care shall be provided for:

(A) Organized medical staff;

(B) Staff nurses;

(C) Staff allied health personnel;

(D) EMS personnel; and

(E) Other community physicians and health care personnel.

(6) **Data Collection, QI, and Evaluation**. STEMI receiving centers designated under this section are subject to the requirements of Article 5 of this subchapter. In addition, STEMI receiving centers shall have a review of its STEMI program conducted by the LEMSA, in accordance with LEMSA policies and procedures, or through a nationally recognized STEMI program, depending on the certification level, at least every three (3) years to ensure the program continues to meet state minimum standards as well as local and certification requirements. The review shall include, at a minimum, the evaluation of documentation, credentialing records, and compliance with applicable standards. Documentation of the review and determination shall be included as attachments with the Initial STEMI Critical Care

System Plan Template (Rev. 11/2025), incorporated by reference, or the Annual STEMI Critical Care System Plan Update Template (Rev. 11/2025), incorporated by reference, as applicable.

(7) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as a STEMI receiving center in addition to those required under this section.

(c) **STEMI Receiving Centers Designated Prior to Effective Date of Regulations.** A STEMI receiving center designated by the LEMSA pursuant to regulations in effect prior to the effective date of these regulations may continue to operate as a STEMI receiving center; however, any such STEMI receiving center shall meet the requirements of these regulations within twelve(12) months following a STEMI program review described in subdivision (b)(6) of this section.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Article 5: STEMI Critical Care System Data Management, Quality Improvement and Evaluation

§ 100148.01 STEMI Data Management Requirements.

(a) **Data Collection and Reporting Process Requirements.**

(1) **LEMSA.** The local EMS agency (LEMSA) shall develop and implement a standardized data collection and reporting process for the STEMI critical care system.

(A) The process shall include the collection of both prehospital STEMI patient care data and general acute care hospital (GACH) STEMI patient care data. The data shall include the elements specified in subdivision(b) and may include additional elements as specified by the LEMSA.

(B) The LEMSA, in collaboration with STEMI receiving centers and EMS providers, shall develop a process for the sharing of outcome data from the STEMI receiving center to the EMS provider for all transported STEMI patients, including patients who were initially identified as potential STEMI cases but were ultimately not included in the STEMI receiving center's STEMI registry.

(2) **GACHs.**

(A) All STEMI receiving centers and STEMI referring hospitals shall maintain a LEMSA-approved STEMI patient registry (STEMI registry) within which the GACH shall submit STEMI registry data either directly to CEMSIS or to the LEMSA in a manner that is compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191). When the STEMI registry data is submitted to the LEMSA, the LEMSA shall upload the data to CEMSIS.

(B) All GACHs that receive STEMI patients via EMS shall participate in the LEMSA data collection process in accordance with LEMSA policies and procedures.

(3) **Timing of submission.** Prehospital STEMI patient care data elements and GACH STEMI patient care data elements shall be collected and submitted to the Emergency Medical Services Authority (EMSA), either directly or through the LEMSA in accordance with the LEMSA's data policy, on at least a quarterly basis and within ninety (90) days of patient discharge.

(b) **STEMI Patient Care Data Requirements.**

(1) **Prehospital STEMI Patient Care Data Elements.**

(A) Prehospital STEMI patient care data elements selected by the LEMSA shall be compliant with the most current version of the CEMSIS and NEMSIS databases.

(B) Prehospital STEMI patient care data elements collected by EMS providers and uploaded to CEMSIS shall include the following for any patient with a primary or secondary impression of STEMI:

(i) EMS electronic patient care record (ePCR) number (NEMSIS element eResponse.03 - Incident Number; eResponse.04 -EMS Response Number);

(ii) Receiving facility (NEMSIS element eDisposition.01 Destination/Transferred To, Name; eDisposition.02 Destination/Transferred To, Code);

(iii) Name: last, first (NEMSIS element ePatient.02 Last Name; ePatient.03 First Name);

(iv) Date of Birth (NEMSIS element ePatient.17);

(v) Age (NEMSIS element ePatient.15 Age; ePatient.16 Age Units);

(vi) Gender (NEMSIS element ePatient.13 Gender);

(vii) Race. (NEMSIS element ePatient.14 Race);

(viii) Public Safety Answering Point (PSAP) Call Date/Time (NEMSIS element eTimes.01) for any call processed using Emergency Medical Dispatch (EMD);

(ix) Unit Notified by Dispatch Date/Time (NEMSIS element eTimes.03);

(x) Arrived at Patient Date/Time (NEMSIS element eTimes.07);

(xi) Field electrocardiogram (ECG) Performed (NEMSIS element eProcedures.03);

(xii) 1st ECG Date/Time Procedure Performed (NEMSIS element eProcedures.01);

(xiii) Unit Left Scene Date/Time (NEMSIS element eTimes.09);

(xiv) Destination Team Pre-Arrival Alert or Activation (NEMSIS element eDisposition.24);

(xv) Date/Time of Destination Prearrival Alert or Activation (NEMSIS element eDisposition.25);

(xvi) Patient Arrived at Destination Date/Time (NEMSIS element eTimes.11).

(2) **GACH STEMI Patient Care Data.** The required STEMI patient care data elements are specified in the STEMI Patient Care Data Dictionary (Rev. 11/2025), incorporated by reference, which identifies the minimum data fields required for submission to CEMSIS and ensures statewide consistency in reporting.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100148.02. Local EMS Agency STEMI Program Quality Improvement and Evaluation Process.

(a) STEMI care shall be an integral part of the local EMS agency's (LEMSA's) overall QI program. A LEMSA with a STEMI critical care system shall have a QI process that includes, at a minimum:

(1) **Policy Development** – A cardiologist assisting in the development of LEMSA prehospital care policies, procedures, and protocols relevant to the care of STEMI patients.

(2) **Multidisciplinary QI Committee**. A multidisciplinary STEMI QI Committee, including representation from prehospital providers and general acute care hospitals (GACHs).

(3) **System Participation.** Participation of all relevant prehospital providers as well as designated STEMI receiving centers and STEMI referring hospitals in:

(A) The STEMI data management requirements set forth in Section 100148.01 of this article.
(B) The LEMSA's QI process under this section.

(4) **Regional Coordination Review.** Evaluation of regional coordination and integration of STEMI patient movement, including STEMI destination policies or STEMI IFTs that involve GACHs outside the LEMSA's jurisdiction.

(5) **Case Review.** Review of STEMI-related deaths, locally defined adverse events, and transfers.

(6) **System Performance Evaluation.** Evaluation of program structure, process, and outcomes.

(7) **Confidentiality Protections.** Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality and disclosure-protected review of selected STEMI cases.

(b) The LEMSA shall be responsible for ongoing performance evaluation and QI of the STEMI critical care system.

(1) **Evaluation Support Process**. The LEMSA shall implement a process utilizing cardiac care committee work and regular data reporting to share information bi-directionally with EMS providers, system-participating GACHs, and the local medical community. This process shall support ongoing STEMI critical care system evaluation, including the STEMI critical care system plan, to ensure that the plan meets the needs of the local EMS system.

(2) **Periodic Performance Evaluation.** The LEMSA shall periodically evaluate the performance of its STEMI critical care system on a basis of at least every three (3) years. Results of the STEMI critical care system evaluation shall be made available to system participants.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Subchapter 3: Stroke Critical Care Systems.

Article 1: General Provisions

§100149.01. Purpose and Authority.

(a) The purpose of this subchapter is to establish minimum standards for the development, implementation, designation, and evaluation of Stroke Critical Care Systems as components of California's emergency medical services (EMS) system.

(b) These standards ensure coordinated patient care for the assessment, triage, transport, treatment, and recovery of patients experiencing stroke across the continuum of emergency medical services, from prehospital response through definitive hospital care and rehabilitation.

(c) The intent of these regulations is to provide consistency among local stroke critical care systems while allowing flexibility for local implementation based on regional needs and resources, in accordance with Sections 1798.150 and 1798.160 of the Health and Safety Code.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Article 2: Stroke Critical Care System Definitions

§ 100150.01. Clinical Stroke Team.

"Clinical stroke team" means a team of healthcare professionals who provide care for the stroke patient.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.176, Health and Safety Code.

§ 100150.02. Mobile Stroke Program.

"Mobile Stroke Program" means a component of a stroke system of care that includes at least one ambulance meeting the requirements of Section 1797.95 of the Health and Safety Code, that responds to 911 scene calls and has a neurologist available in person or via telehealth communication for direct medical control for patient treatment and destination decisions.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.

Reference: Sections 1797.94, 1797.103 and 1797.176, Health and Safety Code.

§ 100150.03. Stroke Call Roster.

"Stroke call roster" means a schedule that defines the twenty-four (24) hours a day, seven (7) days a week, 365 days a year availability of licensed health professionals to provide care for stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103 and 1797.220, Health and Safety Code.

§100150.04 Stroke Center.

"Stroke Center" means a licensed, certified, and LEMSA designated GACH that meets the criteria in this chapter for either an Acute Stroke Ready Hospital (ASRH), a Primary Stroke Center (PSC), a Thrombectomy Capable Stroke Center (TCSC), or a Comprehensive Stroke Center (CSC). The stroke center provides a level of designated stroke care as defined by the LEMSA and a nationally recognized stroke certification program.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.94, 1797.103 and 1797.176, Health and Safety Code.

§100150.05 Stroke Certification Entity.

"Stroke certification entity" means either a nationally recognized stroke GACH certification organization such as the Joint Commission or the LEMSA that has a certification process to ensure stroke certified GACH meet all the requirements of these regulations.

Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code. Reference: Sections 1797.94, 1797.103 and 1797.176, Health and Safety Code.

§ 100150.06. Stroke Critical Care.

"Stroke critical care" means emergency transport, triage, diagnostic evaluation, acute intervention and other acute care services for stroke patients that potentially require immediate medical or surgical intervention treatment, and may include education, primary prevention, acute intervention, acute and subacute management, prevention of complications, secondary stroke prevention, and rehabilitative services.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100150.07. Stroke Critical Care System.

"Stroke critical care system" means a subspecialty care component of the EMS system developed by a local EMS agency. This critical care system links prehospital and general acute care hospital care to deliver optimal treatment to the population of stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100150.08. Stroke Critical Care System Plan.

"Stroke critical care system plan" means an initial implementation plan that summarizes the development and activation of a stroke critical care system by a local EMS agency.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100150.09. Stroke Critical Care System Plan Update.

"Stroke critical care system plan update" means the annual assessment of the performance, effectiveness, goals, and objectives of a local EMS agency's (LEMSA's) stroke critical care system.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100150.10. Stroke Medical Director.

"Stroke medical director" means a board-certified physician with sufficient experience and expertise dealing with cerebrovascular disease as determined by the general acute care hospital credentialing committee that is responsible for the stroke program.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100150.11. Stroke Program.

"Stroke program" means an organizational component of the general acute care hospital specializing in the care of stroke patients.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100150.12. Stroke Program Manager.

"Stroke program manager" or "stroke coordinator" means a registered nurse or individual with a higher medical degree designated by the general acute care hospital with the responsibility for administering the stroke program under the supervision of the Stroke Medical Director.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.176 and 1797.220, Health and Safety Code.

§ 100150.13. Stroke Referring Hospital.

"Stroke referring hospital" means any licensed general acute care hospital (GACH) within a local EMS system that receives patients transported through the 911 emergency response system and that has not been designated as a stroke center. All stroke referring hospitals must meet the minimum requirements set forth in Section 100152.01 of this subchapter.

Note: Authority cited: Sections 1797.107, 1797.176, 1797.250, 1797.254, and 1798.150, Health and Safety Code.
Reference: Section 1797.105, 1797.176, 1797.220, 1797.254, 1798.150, 1798.170, and 1798.172, Health and Safety Code.

§ 100150.14. Stroke Team.

"Stroke team" means the personnel, support personnel, and administrative staff that function together as part of the general acute care hospital's stroke program.

Note: Authority cited: Sections 1797.107, 1797.176, 1797.250, 1797.254, and 1798.150, Health and Safety Code.
Reference: Section 1797.105, 1797.176, 1797.220, 1797.254, 1798.150, 1798.170, and 1798.172, Health and Safety Code.

Article 3: Local EMS Agency Stroke Critical Care System Requirements and Responsibilities

§ 100151.01. Stroke Critical Care System Requirements.

(a) A local EMS agency (LEMSA) may develop and implement a stroke critical care system.

(b) **Plan Requirement.** A LEMSA that is implementing a new stroke critical care system program must develop a stroke critical care system plan in accordance with Section 100151.03 of this article and submit the plan to the Emergency Medical Services Authority (EMSA) for approval prior to implementation. For an EMSA-approved stroke critical care system, the LEMSA shall annually submit a stroke critical care plan update in accordance with Section 100151.04 of this article. Each stroke critical care system plan and update shall, at a minimum, comply with the provisions of Division 2.5 of the Health and Safety Code and the requirements set forth in this chapter. A LEMSA may establish additional requirements in addition to those mandated by statute and state minimum standards.

(c) **Planning Responsibilities.** For the development, implementation, and ongoing evaluation of its stroke critical care system plan under this subchapter, the LEMSA is responsible for, at a minimum:

(1) **Stroke Critical Care System Advisory Committee.** Establishing a stroke critical care system advisory committee, as set forth in Section 100151.02 of this article.

(2) **Program Objectives.** Determine stroke critical care system goals and objectives.

(3) **Designation and Oversight.** Designate and review stroke centers in accordance with Articles 4 and 5 of this subchapter.

(4) **Policies.** Developing and implementing policies, procedures, and protocols for the treatment and transport of stroke patients. This shall include, at a minimum:

(A) **Prehospital stroke care requirements**. Policies and protocols for the early recognition, treatment, and appropriate destination of stroke patients. These policies and protocols shall include:

(i) **Prehospital Stroke Screening.** The use of a prehospital strokescreening algorithm validated in the medical literature for early recognition and assessment, to include the LEMSA's definition of suspected stroke patient.

(ii) **Use of Online or Direct Medical Control.** Consider the use of online/direct medical control to determine the most appropriate stroke center for transport when a patient presents with confusing or complex findings suggestive of stroke.

(iii) **Advance Notification to Stroke Center.** Notification of prehospital findings of suspected stroke patients shall be communicated by EMS personnel in advance of arrival to the stroke center.

(B) **Interfacility transfer**. A policy to facilitate the interfacility transfer of acute stroke patients.

(C) **Regional Integration**. A policy for the integration of stroke centers located in neighboring jurisdictions.

(5) **System Coordination Agreements.** Developing and implementing agreements necessary for the coordinated treatment and transport of stroke patients within the stroke critical care system and region, including:

(A) Coordination with neighboring local EMS systems;

(B) Designated stroke center agreements;

(C) Inter-LEMSA agreements.

(6) **Public Education and Outreach.** A description of programs that conduct or promote public education specific to stroke care.

(7) **Data Collection, Quality Improvement, and Evaluation.** Collecting and reporting stroke patient care data, establishing and maintaining a QI process, and performing stroke critical care system evaluation in accordance with Article 5 of this subchapter.

(d) **Mobile Stroke Unit.** The LEMSA may develop a Mobile Stroke Unit (MSU) component within the stroke critical care system. A LEMSA incorporating an MSU shall be responsible for developing and implementing MSU policies and procedures as well as a QI plan for MSU operations.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100151.02. Stroke Critical Care System Advisory Committee.

(a) The local EMS agency (LEMSA) developing and implementing a stroke critical care system shall establish a stroke critical care system advisory committee, which shall meet at least twice per year and include participation from public and private EMS providers, 911-receiving general acute care hospitals (GACHs), stroke referring hospitals and stroke centers within the local EMS system, any regional stroke centers that receive stroke IFTs from the LEMSA, and other relevant stakeholders.

(b) The stroke critical care system advisory committee shall advise the LEMSA on stroke care policies and protocols and participate in stroke care QI work.

Note: Authority cited: Sections 1797.107, 1797.103, 1797.105, 1797.250, 1797.254 and 1798.150, Health and Safety Code.
Reference: Sections 1797.176 and 1797.220, Health and Safety Code.

§ 100151.03. Stroke Critical Care System Plan Requirements and Determination Process.

(a) **Plan Submission to EMSA.** Prior to the implementation of a new stroke critical care system, the local EMS agency (LEMSA) shall complete the Initial Stroke Critical Care System Plan Template (Rev. 11/2025), incorporated by reference, and submit to the Emergency Medical Services Authority (EMSA) for approval, as set forth below:

(b) **Determination and Notification Process.** Following the submission of a stroke critical care system plan, EMSA shall review the plan for completeness and compliance with the requirements of Division 2.5 of the Health and Safety Code, this subchapter, and the Initial Stroke Critical Care System Plan Template (Rev. 11/2025), incorporated by reference. EMSA shall:

(1) **Acknowledgement.** Within thirty (30) days of receiving the plan submission, provide written notification to the LEMSA to acknowledge receipt of the stroke critical care system plan and state whether the stroke critical care system plan is:

(A) Complete, meaning it contains all information required by the Initial Stroke Critical Care System Plan Template (Rev. 11/2025), containing all required information within the Initial Stroke Critical Care System Plan Template, or

(B) Incomplete. If the stroke critical care system plan submission is incomplete, EMSA's notification shall identify the deficiencies.

(2) **Determination.** Within sixty (60) days of receiving the plan, EMSA shall provide written notification to the LEMSA that its stroke critical care system plan is:

(A) Approved, or

(B) Denied. If the plan is denied, the notice shall specify the reasons for denial, including identification of the plan's failure to meet applicable statutory or regulatory requirements.

(c) **LEMSA Response to a Denial.** If EMSA denies a stroke critical care system plan, the LEMSA shall have six (6) months from the date of the notification of the denial to:

(1) Submit a revised stroke critical care system plan which conforms to the requirements of Division 2.5 of the Health and Safety Code and this subchapter; or

(2) Appeal the decision to the Commission on EMS (the Commission). A proceeding before the Commission to hear an appeal of a stroke critical care system plan shall be conducted in accordance with the provisions of Section 100000.01 of this Division.

(d) **Implementation of an Approved Plan.** If a stroke critical care system plan is approved by EMSA or following a successful appeal to the Commission, the LEMSA shall begin implementation of the stroke critical care system plan within six (6) months of the date of the plan approval.

(e) **Rescinding Approval.** A LEMSA's failure to implement its stroke critical care system in accordance with the approved stroke critical care system plan may result in EMSA rescinding approval of the stroke critical care system plan.

(1) For purposes of this section, "failure to implement" means a failure to execute the stroke critical care system plan in a manner consistent with the approved plan, including deviations that affect the structure, function, or effectiveness of the stroke critical care system. In determining whether a failure to implement has occurred, EMSA shall consider factors including but not limited to:
(A) The extent to which the stroke care system deviates from the approved plan;
(B) The impact of the deviation on patient care, system operations, or access to care;
(C) The duration and frequency of the deviation; and
(D) Whether the LEMSA has taken corrective action to address identified deficiencies.
(2) EMSA will consider any information, including but not limited to that received in connection with a subsequent stroke system status plan, site visits, complaints, or pending litigation indicating that the LEMSA has failed to implement the stroke care system in accordance with the approved stroke critical care system plan. If EMSA determines that the stroke care system has not been implemented in accordance with the approved plan, EMSA may rescind approval of the stroke critical care system plan following written notice to the LEMSA. Any rescission shall be subject to a right of appeal in accordance with Section 1797.105 of the Health and Safety Code and the provisions of Section 100000.01 of this Division.

(f) **Stroke Critical Care System Plan Updates.** As part of its annual EMS plan update, the LEMSA shall include a stroke critical care system plan update, as set forth in section 100151.04 of this article.

(g) **Plan Modifications.** The LEMSA shall submit any significant changes to the stroke critical care system plan to EMSA for approval, prior to implementation of the change(s), utilizing the Annual Stroke Critical Care System Plan Update Template (Rev. 11/2025), incorporated by reference. Significant changes include, but are not limited to closures of a general acute care hospital's (GACH's) stroke services, changes to a stroke center's certification level or designation status, and changes to LEMSA stroke destination policies. In instances where a delay in approval would adversely impact the current level of stroke critical care, the LEMSA may implement the changes after electronic notification to EMSA. Within thirty (30) days of implementation, the LEMSA shall submit an amended Annual Stroke Critical Care

System Plan Update Template reflecting all changes to EMSA for approval.

(h) **Public Notice Requirement.** The LEMSA shall share the approved stroke critical care system plan on their website, as part of its approved local EMS plan.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100151.04. Stroke Critical Care System Plan Updates.

(a) For Stroke critical care systems approved by the Emergency Medical Services Authority (EMSA), the local EMS agency (LEMSA) shall complete the Annual Stroke Critical Care System Plan Update Template (Rev. 11/2025), incorporated by reference, and include it as part of its annual EMS Plan update. The stroke critical care system plan update shall include any changes to the stroke critical care system since submission of the stroke critical care system plan described in Section 100151.03 of this article or prior stroke system plan update, as applicable. As part of its review of the LEMSA's EMS plan, EMSA will review the stroke critical care system status plan to ensure the plan's ongoing effectiveness in meeting the needs of the stroke critical care system.

(b) **Public Notice Requirement.** The LEMSA shall share the approved stroke critical care system plan update on its website, as part of its most recently approved local EMS plan.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.

Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Article 4: Stroke Critical Care System Hospital Designation and Requirements

Subarticle 1: Stroke Referring Hospitals

§ 100152.01. Stroke Referring Hospital.

(a) **Eligibility.** Any licensed general acute care hospital (GACH) within a local EMS system having an approved stroke critical care system that receives patients transported through the 911 emergency response system and that has not been otherwise designated as a stroke center pursuant to subarticle 2 of this article is a stroke referring hospital. All stroke referring hospitals shall meet the requirements of this section.

(b) **Requirements.**

(1) **Stroke Treatment and Operations**. The GACH shall:

(A) Have a documented transfer process utilizing IFT agreements or protocols;

(B) Collaborate and coordinate with the LEMSA to develop an EMS system notification process for when stroke services are unavailable and shall follow the LEMSA's diversion policy or protocol.

(2) **Data Collection, QI, and Evaluation.** EMS receiving GACHs under this section are subject to the requirements of Article 5 of this subchapter.

(3) **Additional Requirements.** A LEMSA medical director may establish requirements for EMS receiving GACHs in addition to those required under this section.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Subarticle 2: Stroke Centers

§ 100153.01. Acute Stroke Ready Hospitals.

(a) **Eligibility.** A licensed general acute care hospital (GACH) meeting the requirements of this section may be designated by the local EMS agency (LEMSA) as an acute stroke ready hospital.

(b) **Requirements.**

(1) **Capabilities**.

(A) **Neuro-Imaging Services.** Neuro-imaging services that include, at a minimum:

(i) Computed tomography (CT) services;

(ii) Twenty-four (24) hours a day, seven (7) days a week, 365 days per year availability for imaging to be performed and reviewed by a physician within forty-five (45) minutes of emergency department arrival. Neuro-imaging review must be performed by a physician with appropriate expertise such as a:

(I) Board-certified radiologist;

(II) Board-certified neurologist;

(III) Neurosurgeon who is board-certified by the American Board of Neurological Surgery; or

(IV) Residents who interpret such studies as part of their training in an Accreditation Council for Graduate Medical Education- (ACGME-) approved radiology, neurology, or neurosurgery training program.

(B) **Thrombolytic Services.** Provision of intravenous thrombolytic treatment when clinically indicated.

(C) **Other Clinical Services.** Other diagnostic services that include, at a minimum:

(i) Laboratory, cardiac, and x-ray services;

(ii) Twenty-four (24) hours a day, seven (7) days a week, 365 days per year availability for diagnostic services to be completed and reviewed by a physician within sixty (60) minutes of emergency department arrival.

(D) **Available Stroke Team.** Twenty-four (24) hours a day, seven (7) days a week, 365 days per year availability of the GACH's stroke team, as described in paragraph (2)(B) of this section, to evaluate a patient identified as a potential acute stroke patient, either in person or via telehealth, within fifteen (15) minutes of emergency department arrival.

(E) **Rapid Transfer Ability.** The ability to rapidly transfer stroke patients to a higher level of care stroke center when clinically appropriate. This capability shall include written transfer protocols or arrangements with one or more higher level of care stroke centers and prearranged agreements with EMS providers, in compliance with all LEMSA policies and procedures, as well as service provider contracts and designations.

(2) **Program Staffing**.

(A) **Stroke Medical Director.** A stroke medical director meeting the qualifications and responsible for the functions defined in Section 100150.10 of this subchapter.

(B) **Stroke Program Manager.** A stroke program manager that performs the functions described in Section 100150.12 of this subchapter and who is either a registered nurse or an individual with a higher medical degree. The stroke program manager shall complete at least four (4) hours of continuing education in cerebrovascular disease per calendar year and may also serve as a member of the stroke team.

(C) **Stroke Team.** A stroke team performing the functions described in Section 100150.14 of this subchapter and that, at a minimum, consists of a nurse and a physician with training and expertise in acute stroke care.

(3) **System Operations**. Collaboration between the GACH and the LEMSA to define policies and procedures for an EMS system notification when stroke care services are unavailable. Acute stroke ready hospitals shall follow the LEMSA's diversion policies.

(4) **Policies**. Written emergency department policies and procedures that shall include written protocols and standardized orders for the emergency care of stroke patients.

(5) **Continuing Education.** Continuing education in stroke critical care shall be provided for:

(A) Organized medical staff;

(B) Staff nurses;

(C) Staff allied health personnel;

(D) EMS personnel; and

(E) Other community physicians and health care personnel.

(6) **Data Collection, QI, and Evaluation.** Acute stroke ready hospitals designated under this section are subject to the requirements of Article 5 of this subchapter. In addition, acute stroke ready hospitals shall have:

(7) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as an acute stroke ready hospital in addition to those required under this section.

(c) **Acute Stroke Ready Hospitals Designated Prior to Effective Date of Regulations.** An acute stroke ready hospital designated by the LEMSA prior to the effective date of these regulations may continue to operate as an acute stroke ready hospital; however, any such acute stroke ready hospital shall meet the requirements of these regulations within twelve (12) months following a program review described in Article 5, Section 100154.03(a) of this subchapter.

Note: Authority cited: Sections 1797.107, 1797.176 and 1798.150, Health and Safety Code. Reference: Sections 1797.103, 1797.204, 1797.220, 1797.222 and 1798.172, Health and Safety Code.

§ 100153.02. Primary Stroke Centers.

(a) **Eligibility.** A licensed general acute care hospital (GACH) that meets all the requirements of this section may be designated by the local EMS agency (LEMSA) as a primary stroke center.

(b) **Requirements**. The GACH must meet all requirements for an acute stroke ready hospital, as set forth in Section 100153.01(b) of this subarticle, as well as the following additional requirements:

(1) **Capabilities**.

(A) **Neuro-Imaging Services.** Computed tomography (CT) completed within twenty-five (25) minutes and interpretation of the results within forty- five (45) minutes of patient arrival at the primary stroke center.

(B) **Laboratory Services.** Maintain twenty-four (24) hours a day, seven (7) days a week, 365 days per year availability of laboratory services, with results available within forty-five (45) minutes following a blood draw.

(C) **Neurosurgical Services.** Neurosurgical services, including operating rooms, that are available either on-site or through an agreement with a thrombectomy-capable, comprehensive, or other stroke center with neurosurgical services, within two (2) hours of acute stroke patient arrival at

the primary stroke center.

(D) **Rehabilitation Services.** Provide or contract for acute care rehabilitation services.

(2) **Program Staffing**. The stroke team shall include, at a minimum:

(A) The stroke program manager; and

(B) A neurologist, interventional neuroradiologist, or emergency physician who is board-certified or board-eligible in neurology, endovascular neurosurgical radiology, or emergency medicine, or another board-certified physician with sufficient experience in the management of acute cerebral vascular disease as determined by the GACH credentials committee.

(3) **Policies.** Written policies and procedures for stroke services, including written protocols and standardized orders for the emergency care of stroke patients.

(4) **Public Education and Outreach.** Conduct public education on acute stroke and stroke prevention;

(5) **Data Collection, QI, and Evaluation.** Primary stroke centers designated under this section are subject to the requirements of Article 5 of this subchapter.

(6) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as a primary stroke center in addition to those required under this section.

(c) **Primary Stroke Centers Designated Prior to Effective Date of Regulations.** A primary stroke center designated by the LEMSA prior to the effective date of these regulations, may continue to operate as a primary stroke center; however, any such primary stroke center shall meet the requirements of these regulations within twelve (12) months following a program review described in Article 5, Section 100154.03(a) of this subchapter.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100153.03. Thrombectomy-Capable Stroke Centers.

(a) **Eligibility.** A licensed general acute care hospital (GACH) that meets the requirements of this section may be designated by the local EMS agency (LEMSA) as a thrombectomy-capable stroke center.

(b) **Requirements.** The GACH must meet all requirements for a primary stroke center, as set forth in Section 100153.02(b) of this subarticle, as well as the following additional requirements:

(1) **Capabilities.**

(A) **Mechanical Thrombectomy Services.** Twenty-four (24) hours a day, seven (7) days a week, 365 days per year ability to perform mechanical thrombectomy for the treatment of ischemic stroke.

(B) **Bed Capacity.** Twenty-four (24) hours a day, seven (7) days a week, 365 days per year availability of sufficient dedicated neuro-intensive care unit beds to care for acute ischemic stroke patients.

(C) **Imaging.** Twenty-four (24) hours a day, seven (7) days a week, 365 days per year ability to perform advanced imaging including, at a minimum:

(i) Computed tomography angiography (CTA);

(ii) Diffusion-weighted magnetic resonance imaging (MRI) or computed tomography (CT) perfusion;

(iii) Catheter angiography;

(iv) Magnetic resonance angiography (MRA);

(v) The following modalities when clinically necessary:

(I) Carotid duplex ultrasound;

(II) Transesophageal echocardiography (TEE);

(III) Transthoracic Echocardiography (TTE).

(D) **Staff Qualifications.**

(i) Meet the following staffing and staff qualification requirements:

(I) A qualified physician who is board-certified by the American Board of Radiology, American Osteopathic Board of Radiology, American Board of Psychiatry and Neurology, or the American Osteopathic Board of Neurology and Psychiatry, with neuro-interventional angiographic training and skills confirmed by the GACH's credentialing committee;

(II) A qualified neuro-radiologist who is board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology; and

(III) A qualified vascular neurologist who is board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry, or with appropriate education and experience as defined by the GACH credentials committee.

(ii) If the GACH uses teleradiology for image interpretation, the remote physicians must still meet the same staffing and qualification standards set forth in clause (i) of this section and the GACH shall maintain

documentation of those roles and qualifications.

(2) **Transfer Acceptance.** Written transfer agreements with inter-LEMSA and regional comprehensive, primary stroke centers, and acute stroke ready hospitals to accept the transfer of patients needing neurosurgical intervention, when clinically appropriate.

(3) **Data Collection, QI, and Evaluation**. Thrombectomy-capable stroke centers designated under this section are subject to the requirements of Article 5 of this subdivision.

(4) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as a thrombectomy-capable stroke center in addition to those required under this section.

(c) **Thrombectomy-Capable Stroke Centers Designated Prior to Effective Date of Regulations.** A thrombectomy-capable stroke center designated by the LEMSA prior to the effective date of these regulations may continue to operate as a thrombectomy-capable stroke center; however, any such thrombectomy-capable stroke center shall meet the requirements of these regulations within twelve (12) months following a program review described in Article 5, Section 100154.03(a) of this subchapter.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100153.04. Comprehensive Stroke Centers.

(a) **Eligibility.** A licensed general acute care hospital (GACH) that meets all the requirements of this section may be designated by the local EMS agency (LEMSA) as a comprehensive stroke center.

(b) **Requirements.** The GACH must meet all requirements for a thrombectomy-capable stroke center, as set forth in Section 100153.03(b) of this subarticle, as well as the following additional requirements:

(1) **Capabilities**.

(A) **Transcranial Doppler Services.** Transcranial Doppler (TCD) that is available in a timeframe that is clinically appropriate.

(B) **Rehabilitation Services.** Provide comprehensive rehabilitation services, either on-site or through a written transfer agreement with another health care facility that is licensed to provide such services.

(C) **Staff Qualifications.** Meet the following staffing and staff qualification requirements:

(i) A neurosurgical team capable of assessing and treating hemorrhagic strokes and other neurosurgical emergencies.

(ii) A written call roster for attending neurointerventionalists, neurologists, and neurosurgeons providing for twenty-four (24) hours a day, seven (7) days a week, 365 days a year availability.

(D) **Research Program.** A stroke patient research program.

(E) **Transfer Acceptance.** Written transfer agreements with inter-LEMSA and regional thrombectomy-capable, primary stroke centers, and acute stroke ready hospitals to accept the transfer of patients needing neurosurgical intervention, when clinically appropriate.

(2) **System Operations.** At a minimum, provide guidance and continuing stroke-specific medical education to GACHs with which transfer agreements for stroke patients are in place.

(3) **Data Collection, QI, and Evaluation.** Comprehensive stroke centers designated under this section are subject to the requirements of Article 5 of this subchapter.

(4) **Additional Requirements.** A LEMSA medical director may establish requirements for designation as comprehensive stroke center in addition to those required under this section.

(c) **Comprehensive Stroke Centers Designated Prior to Effective Date of Regulations.** A comprehensive stroke center designated by the LEMSA prior to the effective date of these regulations may continue to operate as a comprehensive stroke center; however, any such comprehensive stroke center shall meet the requirements of these regulations within twelve (12) months following a program review described in Article 5, Section 100154.03(a) of this subchapter.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Article 5: Stroke Critical Care System Data Management, Quality Improvement and Evaluation

§ 100154.01. Stroke Data Management Requirements.

(a) **Data Collection and Sharing Requirements.**

(1) **LEMSA.** The local EMS agency (LEMSA) shall develop and implement a standardized data collection and reporting process for the stroke critical care system.

(A) The process shall include the collection of both the prehospital stroke patient care data and general acute care hospital (GACH) stroke patient care data. The data shall include the elements specified in subdivision (b) of this section and may include additional elements as specified by the LEMSA.

(B) The LEMSA, in collaboration with EMS receiving GACHS, acute stroke ready hospitals, stroke centers, and EMS providers, shall develop a process for the sharing of outcome data from the EMS receiving GACH, acute stroke ready

hospital, or stroke center to the EMS providers for all transported stroke patients, including patients who were initially identified as potential stroke cases but were not ultimately included in the EMS receiving GACH's, acute stroke ready hospital's, or stroke center's stroke registry.

(2) **GACHs.**

(A) All stroke centers shall maintain a LEMSA-approved stroke patient registry (stroke registry) within which the stroke center shall collect stroke patient care data. The stroke center shall submit stroke registry data either directly to CEMSIS or the LEMSA in a manner that is compliant with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191). When stroke registry data is submitted to the LEMSA, the LEMSA shall upload the data to CEMSIS.

(B) All GACHs that receive stroke patients via EMS shall participate in the LEMSA data collection process in accordance with LEMSA policies and procedures.

(3) **Timing of Submission.** The prehospital stroke patient care data and GACH stroke patient care data shall be collected and submitted to the Emergency Medical Services Authority (EMSA), either directly or through the LEMSA in accordance with the LEMSA's data policy, on at least a quarterly basis and within ninety (90) days of patient discharge.

(b) **Stroke Patient Care Data Requirements.**

(1) **Prehospital Stroke Patient Care Data Elements.**

(A) The prehospital stroke patient care elements shall be compliant with the most current version of the CEMSIS and NEMSIS databases.

(B) Prehospital stroke patient care data elements collected by EMS providers and uploaded into CEMSIS, shall include the following for any patient with a primary or secondary impression of stroke:

(i) EMS Electronic Patient Care Record (ePCR) Number (NEMSIS element eResponse.03 - Incident Number; eResponse.04 - EMS Response Number);

(ii) Receiving Facility (NEMSIS element eDisposition.01 Destination/Transferred To, Name; eDisposition.02 Destination/Transferred To, Code);

(iii) Name: Last, First (NEMSIS element ePatient.02 Last Name; ePatient.03 First Name);

(iv) Date of Birth (NEMSIS element ePatient.17);

(v) Patient Age (NEMSIS element ePatient.15 Age; ePatient.16 Age Units);

(vi) Patient Gender (NEMSIS element ePatient.13 Gender);

(vii) Patient Race (NEMSIS element ePatient.14 Race);

(viii) Stroke Scale Score (NEMSIS element eVitals.29);

(ix) Public safety answering point (PSAP) Call Date/Time (NEMSIS element eTimes.01);

(x) Unit Notified by Dispatch Date/Time (NEMSIS element eTimes.03);

(xi) Arrived at Patient Date/Time (NEMSIS element eTimes.07);

(xii) Unit Left Scene Date/Time (NEMSIS element eTimes.09);

(xiii) Destination Team Pre-Arrival Alert or Activation (NEMSIS element eDisposition.24);

(xiv) Date/Time of Destination Prearrival Alert or Activation (NEMSIS element eDisposition.25);

(xv) Patient Arrived at Destination Date/Time (NEMSIS element eTimes.11).

(2) **GACH Stroke Patient Care Data Elements.** The required stroke patient care data elements are specified in the Stroke Patient Care Data Dictionary (Rev. 11/2025), incorporated by reference, which identifies the minimum data fields required for submission to CEMSIS and ensures statewide consistency in reporting.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100154.02. Local EMS Agency Stroke Quality Improvement and Evaluation Process.

(a) Stroke care shall be an integral part of the local EMS agency's (LEMSA's) overall QI program. A LEMSA with a stroke critical care system shall have a QI process that includes, at a minimum:

(1) **Policy Development** – A neurologist assisting in the development of LEMSA prehospital care policies, procedures, and protocols relevant to the care of stroke patients.

(2) **Multidisciplinary QI Committee**. A multidisciplinary stroke QI committee, including both prehospital and GACH members;

(3) **System Participation.** Participation of all relevant prehospital providers as well as EMS receiving GACHs and designated stroke centers in:

(A) The stroke data management system requirements set forth in

Section 100154.01 of this article.

(B) The LEMSA's QI process under this section.

(4) **Regional Coordination Review.** Evaluation of regional coordination and integration of stroke patient movement, including stroke destination policies or stroke IFTs that involve GACHs outside the LEMSA's jurisdiction;

(5) **Case Review.** Review of stroke-related deaths, locally-defined adverse events, and transfers;

(6) **System Performance Evaluation.** Evaluation of program structure, process, and outcomes;

(7) **Confidentiality Protections.** Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality and a disclosure-protected review of selected stroke cases.

(b) The LEMSA shall be responsible for ongoing performance evaluation and QI of the stroke critical care system.

(1) **Evaluation Support Process**. The LEMSA shall implement a process utilizing stroke critical care committee work and regular data reporting to share information bi-directionally with EMS providers, system-participating GACHs, and the local medical community. This process shall support ongoing stroke critical care system evaluation, including the stroke critical care system plan, to ensure that the plan meets the needs of the local EMS system.

(2) **Periodic Performance Evaluation.** The LEMSA shall periodically evaluate the performance of its stroke critical care system on a basis of at least every three (3) years. Results of the stroke critical care system evaluation shall be made available to system participants.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

§ 100154.03. Designated GACH Quality Improvement and Evaluation Requirements.

At least once every three (3) years, all stroke centers designated under Article 4 of this subchapter shall have:

(a) A stroke program review by the stroke medical director to determine whether the stroke program is demonstrating the appropriate orientation, credentialing process, and skill maintenance for the advanced practitioners, and, if necessary, to revise the policies and procedures for emergency department stroke service.

(b) A review of its stroke program conducted by the LEMSA or through a nationally recognized stroke certification program, depending on the certification level to ensure the program continues to meet state minimum standards as well as local and certification requirements.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, and 1798.150, Health and Safety Code.

Subchapter 4: Emergency Medical Services for Children

Article 1: General Provisions

§ 100155.01. Purpose and Authority.

(a) The purpose of this subchapter is to establish minimum standards for the development, implementation, designation, operation, and evaluation of Emergency Medical Services for Children (EMSC) within California's emergency medical services (EMS) system.

(b) These standards ensure the availability of developmentally appropriate equipment, education, and coordinated care for infants, children, and adolescents across the continuum of emergency medical care — including prehospital response, hospital treatment, interfacility transfer, and rehabilitation.

(c) The intent of these regulations is to promote statewide consistency in pediatric emergency care while allowing flexibility for local implementation based on regional needs and resources, in accordance with Division 2.5 of the Health and Safety Code.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

Article 2: Emergency Medical Services for Children Definitions

§ 100156.01. Emergency Medical Services for Children (EMSC) Program.

"Emergency Medical Services for Children program" or "EMSC program" is a program regulated by EMSA including the prehospital and GACH pediatric care components integrated into an existing LEMSA's EMS Plan for pediatric emergency care.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100156.02. EMSC Program Plan.

"EMSC program plan" means an initial implementation plan that summarizes the development and activation of an EMSC program by a local emergency services agency (LEMSA).

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100156.03. EMSC Program Plan Update.

"EMSC program plan update" means the annual assessment of the performance, effectiveness, goals, and objectives of a local EMS agency's (LEMSA's) EMSC program.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100156.04. National Pediatric Readiness Project.

"National Pediatric Readiness Project" is led by the national EMSC Program in partnership with medical professional organizations involved in pediatric care, such as the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association, and exists to empower and provide guidance to emergency departments to improve their capability to provide high-quality care for children, also known as being "pediatric ready."

Note: Authority cited: Sections 1797.103, 1797.105, 1797.172, and 1798.150, Health and Safety Code.
Reference: Sections 1797.72, 1797.105, 1797.220, 1798.150, and 1798.160, Health and Safety Code.

§ 100156.05. Pediatric Emergency Care Coordinator (PECC).

"Pediatric emergency care coordinator" or "PECC" means an individual who is qualified in the emergency care of pediatric patients pursuant to Section 100160.01(b) of this subchapter. This individual(s) is responsible for ensuring EMS provider agencies or emergency departments follow national and state recommendations for pediatric emergency care which may include familiarizing colleagues with pediatric-specific policies and protocols, promoting pediatric quality improvement efforts, and managing pediatric equipment and supplies.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Section 1799.204, Health and Safety Code.

§ 100156.06. Pediatric Experience.

"Pediatric experience" means demonstrated competency through experience to care for children of all ages within their specialty as determined by GACH medical staff credentialing.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Section 1799.204, Health and Safety Code.

§ 100156.07. Pediatric Critical Care Physician.

"Pediatric Critical Care Physician" means a physician who is board-certified or board-eligible in pediatric critical care medicine by the American Board of Pediatrics (ABP), the American Osteopathic Board of Pediatrics, or other appropriate foreign specialty board as determined by the ABP for that specialty.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100156.08. Pediatric Patient.

"Pediatric patient" means a person who is less than 15 years of age.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100156.09. Pediatric Readiness.

"Pediatric Readiness" is the capacity of GACHs and prehospital providers to meet the unique needs of children during medical emergencies, ensuring they receive high-quality care. Pediatric readiness can be determined through use of the Pediatric Readiness Assessment of the Pediatric Readiness Project.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100156.10. Pediatric Receiving Center (PedRC).

"Pediatric Receiving Center" or "PedRC" means a licensed general acute care hospital with, at a minimum, a permit for standby, basic, or comprehensive emergency services that has been formally designated by the LEMSA as a basic, general, advanced, or comprehensive PedRC pursuant to Article 5 of this subchapter.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.67, 1797.88 and 1799.204, Health and Safety Code.

§ 100156.11. Pediatric Recognition Program.

"Pediatric Recognition Program" means the pediatric readiness recognition program described in Section 100157.01, conducted by the LEMSA to designate pediatric receiving GACHs and prehospital providers.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

§ 100156.12. Qualified Pediatric Specialist.

"Qualified pediatric specialist" means a physician who is licensed in California, board-certified or board-eligible in a pediatric specialty by the American Board of Medical Specialties (ABMS), or the American Osteopathic Association-Bureau of Osteopathic Specialties, as determined by the ABMS.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.107 and 1799.204, Health and Safety Code.

Article 3: Local EMS Agency EMSC Program Requirements and Responsibilities

§ 100157.01. EMSC Program Requirements.

(a) A local EMS agency (LEMSA) may develop and implement an EMSC Program.

(b) **Plan Requirement.** A LEMSA that is implementing a new EMSC program must develop an EMSC program plan in accordance with Section 100157.03 of this article and submit the plan to the Emergency Medical Services Authority (EMSA) for approval prior to implementation. For an EMSA-approved EMSC program, the LEMSA shall annually submit an EMSC program plan update in accordance with Section 100157.04 of this article. Each EMSC program plan and update shall, at a minimum, comply with the provisions of Division 2.5 of the Health and Safety Code and the requirements set forth in this chapter. A LEMSA may establish additional requirements in addition to those mandated by statute and state minimum standards.

(c) **Planning Responsibilities**. For the development, implementation, and ongoing evaluation of its EMSC program plan, including annual EMSC program plan updates, the LEMSA is responsible for, at a minimum:

(1) **EMSC Committee.** Establishing an EMSC committee, at set forth in Section 100157.02 of this article.

(2) **Program Objectives.** Determine EMSC program goals and objectives.

(3) **Designate and Oversight.** Designate and review pediatric receiving centers in accordance with Articles 5 and 6 of this subchapter.

(4) **Policies.** Developing and implementing policies, procedures, and protocols for the treatment and transport of pediatric patients. This shall include, at a minimum:

(A) **Prehospital pediatric care requirements.** Policies and protocols for the treatment and appropriate destination of pediatric patients. These policies and protocols shall address, at a minimum:

(i) Pediatric-specific personnel training, as defined by the LEMSA;

(ii) Pediatric ambulance equipment;

(iii) Level of service: first response non-transport, transport, interfacility transfer, and critical care.

(B) **Interfacility transfer.** A policy to facilitate the interfacility transfer of acute pediatric patients.

(C) **Regional integration.** A policy for the integration of pediatric receiving centers in neighboring jurisdictions.

(5) **Pediatric Readiness Recognition Program.** A pediatric readiness recognition program, as defined by the LEMSA, to honor and acknowledge emergency departments and EMS providers for achieving EMSC standards in pediatric emergency care set forth in this chapter and by the LEMSA.

(6) **System Coordination Agreements.** Developing and implementing agreements necessary for the coordinated treatment and transport of pediatric patients

within the local EMS system and region, including, as applicable:

(A) Development of injury and illness prevention activities;

(B) Field communication specific to the pediatric patient;

(C) Coordination with neighboring local EMS systems, such as through inter-LEMSA agreements;

(D) Designated pediatric center agreements;

(7) **Disaster preparedness.** Incorporating the EMSC program and its designated PedRCs into its regional disaster preparedness/response plan, including pediatric surge planning.

(8) **Public Education and Outreach.** A description of programs that conduct or promote public education specific to pediatric care.

(9) **Data Collection, QI, and Evaluation.** Collecting and reporting pediatric care data, establishing and maintaining a QI process, and performing EMSC program evaluation in accordance with Article 6 of this subchapter.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§100157.02. EMSC Committee.

(a) The local EMS agency (LEMSA) shall establish an EMSC committee, which shall meet at least twice a year and include participation from public and private EMS providers, 911-receiving general acute care hospitals (GACHs), any regional pediatric trauma receiving centers that receive pediatric IFTs from the LEMSA, and other relevant stakeholders.

(b) The EMSC Committee shall advise the LEMSA on EMSC care policies and participate in pediatric care QI work.

Note: Authority cited: Sections 1797.107, 1797.176, and 1798.150, Health and Safety Code.
Reference: Sections 1797.176, 1797,150, and 1797.220, Health and Safety Code.

§100157.03. EMSC Program Plan Requirements and Determination Process.

(a) **Plan Submission to EMSA.** Prior to implementation of a new EMSC program, the local EMS agency (LEMSA) shall complete the Initial EMSC Plan Template (Rev. 11/2025), incorporated by reference, and submit to the Emergency Medical Services Authority (EMSA) for approval, as set forth below:

(b) **Determination and Notification Process.** Following the submission of an EMSC program plan, including identification of the plan's failure to meet applicable statutory and regulatory requirements, EMSA shall:

(1) **Acknowledgement.** Within thirty (30) days of receiving the plan submission, provide written notification to the LEMSA to acknowledge receipt of the EMSC program plan and state whether the EMSC program plan is:

(A) Complete, meaning it contains all information required by the Initial EMSC Program Plan Template (Rev. 11/2025), or

(B) Incomplete. If the EMSC program plan submission in incomplete, EMSA's notification shall identify the deficiencies.

(2) **Determination.** Within sixty (60) days of receiving the plan, EMSA shall provide written notification to the LEMSA that its EMSC program plan is:

(A) Approved, or

(B) Denied. If the plan is denied, the notice shall specify the reasons for denial, including identification of the plan's failure to meet applicable statutory or regulatory requirements.

(c) **LEMSA Response to a Denial.** If EMSA denies an EMSC program plan, the LEMSA shall have six (6) months from the date of the notification of the denial to:

(1) Submit a revised EMSC program plan which conforms to the requirements of Division 2.5 of the Health and Safety Code and this subchapter, or

(2) Appeal the decision to the Commission on EMS (the Commission). A proceeding before the Commission to hear an appeal of an EMSC System Plan shall be conducted in accordance with the provisions of Section 100000.01 of this Division.

(d) **Implementation of an Approved Plan.** If an EMSC program plan is approved by EMSA or following a successful appeal to the Commission, the LEMSA shall begin implementation of the EMSC program plan within six (6) months of the date of the plan approval.

(e) **Rescinding Approval.** A LEMSA's failure to implement its EMSC program in accordance with the approved EMSC program plan may result in EMSA rescinding approval of the EMSC program plan.

(1) For purposes of this section, "failure to implement" means a failure to execute the EMSC program plan in a manner consistent with the approved plan, including deviations that affect the structure, function, or effectiveness of the EMSC program plan. In determining whether a failure to implement has occurred, EMSA shall consider factors including but not limited to:
(A) The extent to which the EMS program deviates from the approved plan;
(B) The impact of the deviation on patient care, system operations, or access to care;
(C) The duration and frequency of the deviation; and
(D) Whether the LEMSA has taken corrective action to address identified deficiencies.

(2) EMSA will consider any information, including but not limited to that received in connection with a subsequent EMSC status plan, site visits, complaints, or pending litigation indicating that the LEMSA has failed to implement the EMSC program in accordance with the approved EMSC program plan. If EMSA determines that the EMSC program has not been implemented in accordance with the approved plan, EMSA may rescind approval of the EMSC program plan following written notice to the LEMSA. Any

rescission shall be subject to a right of appeal in accordance with Section 1797.105 of the Health and Safety Code and the provisions of Section 100000.01 of this Division.

(f) **EMSC Program Plan Updates.** As part of its annual EMS plan update, the LEMSA shall include an EMSC program plan update, as set forth in Section 100157.04 of this article.

(g) **Plan Modifications.** The LEMSA shall submit any significant changes to the EMSC program plan to EMSA for approval, prior to implementation of the change(s), utilizing the Annual EMSC Program Plan Update Template (Rev. 11/2025), incorporated by reference. Significant changes include, but are not limited to closures of a PedRC general acute care hospital (GACH), changes to the pediatric service level of a PedRC, and changes to LEMSA pediatric destination policies. In instances where a delay in approval would adversely impact the current level of pediatric care, the LEMSA may implement the changes after electronic notification to EMSA. Within thirty (30) days of implementation, the LEMSA shall submit an amended Annual EMSC Program Plan Update Template reflecting all changes to EMSA for approval.

(h) **Public Notice.** The LEMSA shall share the approved EMSC plan on their website as part of its approved local EMS plan.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100157.04. EMSC Program Plan Update.

(a) For EMSC programs approved by the Emergency Medical Services Authority (EMSA), the local EMS agency (LEMSA) shall complete the Annual EMSC Program Plan Update Template (Rev. 11/25), incorporated by reference, and include it as part of its annual EMS Plan update, in accordance with Sections 1797.105 and 1797.254 of the Health and Safety Code. The EMSC program plan update shall include any changes to the EMSC program since submission of the EMSC program plan described in Section 100157.03 of this article or prior annual local EMS plan update, as applicable. As part of its review of the LEMSA's EMS plan, EMSA will review the EMSC program plan to ensure the plan's ongoing effectiveness in meeting the needs of the EMSC Program.

(b) **Public Notice.** The LEMSA shall share the approved EMSC program plan update on its website as part of its most recently approved local EMS plan.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

Article 4: EMS Provider EMSC Program Requirements and Responsibilities

§ 100158.01 EMS Provider EMSC Requirements.

(a) **PECC Requirement.** Each EMS provider responsible for 911 response within the jurisdiction of a LEMSA with an EMSC program shall designate a prehospital PECC, as defined in Section 100156.05 of this subchapter. This role may be assigned in combination with other duties and shall be filled by an EMS clinician.

(b) **PECC Duties.** The prehospital PECC shall be responsible for, at a minimum:

(1) **Training and Competency.** Ensuring that all EMS provider agency response personnel receive pediatric-specific training as to relevant LEMSA policies and protocols and maintain proficiency in pediatric assessment and treatment skills;

(2) **Equipment and Supplies.** Ensuring all EMS provider agency response vehicles maintain pediatric equipment and supplies;

(3) **Quality Improvement.** Overseeing EMS provider agency pediatric QI activities.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

Article 5: EMSC Program Hospital Designation and Requirements.

Subarticle 1: General Provisions.

§ 100159.01. General Acute Care Hospitals Not Designated as a PedRC.

(a) A general acute care hospital (GACH) within a local EMS system that has implemented an EMSC program, but which has not been designated as a PedRC, shall meet the requirements under this section regarding pediatric IFTs.

(1) Non-designated GACHs shall adhere to the LEMSA's policy regarding the IFT of pediatric patients. In addition:

(A) **Pediatric IFT Requirements.** GACHs shall develop and implement IFT policies, protocols, and guidelines for the transfer of pediatric patients that shall include the following:

(i) Identification of pediatric patients eligible for interfacility transfer;

(ii) Process for selecting the appropriate partner PedRC(s);

(iii) Clinical criteria for automatic acceptance of qualifying patients at the appropriate partner PedRC center;

(iv) Specific processes for IFTs that ensure continuous twenty-four (24) hours per day, seven (7) days per week, 365 days a year access to partner PedRC physician(s) for timely notification and coordination of incoming IFT patient referrals;

(v) Standardized communication language to be used between the referring GACH and the receiving partner PedRC to facilitate rapid transfer of the patient, including the minimum required patient information to be exchanged to facilitate rapid transfer;

(vi) Guidance for selecting the appropriate transport service to match each patient's needs. Considerations shall include transport personnel scope of practice and the identification of patients for whom more rapid departure to the destination PedRC (such as via emergency ambulance through the 911 response system) outweighs the benefit of delaying transport to await providers with broader scope of practice, such as a critical care transport registered nurse;

(vii) Process for the transfer of patient consent forms, emergency department medical record, initial electronic patient care record (ePCR) and personal belongings for the IFT patient;

(viii) Process for providing information relating to the receiving PedRC, including location and/or directions, to the IFT patient's family, care givers, or legal guardian.

(B) **Pediatric IFT Agreements.** To optimize patient safety and the potential for improved outcome, requirements set forth in subparagraph (A) of this section may be met by establishing IFT agreements in advance, supported by LEMSA policies. Agreements should address special considerations, including patient selection and destination for pediatric patients.

(b) Non-designated GACHs are subject to all applicable requirements under Article 6 of this subchapter.

(c) A LEMSA medical director may establish requirements for non-designated GACHs, in addition to that which is required under this section.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

Subarticle 2: PedRCs.

§ 100160.01. Requirements for all PedRCs.

All PedRC general acute care hospitals (GACHs) designated under this article shall meet the following requirements:

(a) **Capabilities.** Have, at a minimum, the following capabilities:

(1) **Consultant Availability.** Personnel available twenty-four (24) hours a day, seven (7) days a week, 365 days a year to provide consultation to the emergency department through live interactive telehealth or other means, as determined by the local EMS agency (LEMSA).

(A) PedRCs shall have a process for obtaining and providing consultation via phone or telehealth when needed and when IFT is not warranted or possible.

(B) Personnel available for consultation shall include, but are not limited to, the following:

(i) A qualified pediatric specialist;
(ii) A qualified pediatric critical care physician;
(iii) Respiratory care specialists who respond to the emergency department and have verified their competency to support oxygenation and ventilation of pediatric patients to the Director of Respiratory Services. Verification of competency may include, but is not limited to current completion of any of the following:

(I) Current completion of a nationally recognized Pediatric Advanced Life Support Course approved by the LEMSA; or

(II) The American Academy of Pediatrics and American College of Emergency Physicians-sponsored Advanced Pediatric Life Support Course; or

(III) Continuing education courses specific to resuscitation of pediatric patients.

(2) **Clinical Services.** Support services, including respiratory care, laboratory, radiology, and pharmacy that include appropriate staff and equipment for pediatric patient care.

(3) **Equipment, Supplies, and Medications.** Pediatric equipment, supplies, and medications appropriate for patients ranging from neonates to adolescents, including, but not limited to:

(A) A length-based resuscitation tape, medical software, or other system available to ensure proper sizing of resuscitation equipment and proper dosing of medication;

(B) Portable resuscitation supplies, such as a crash cart or bag, with a method of verification of contents on a regular basis;

(C) Equipment for patient and fluid warming, patient restraint, weight scale (in kilograms) and pain scale tools for all ages of pediatric patients;

(D) Monitoring equipment appropriate for pediatric patients including, but not limited to, blood pressure cuffs, doppler device, electrocardiogram monitor/defibrillator, hypothermia thermometer, pulse oximeter, and end tidal carbon dioxide monitor;

(E) Respiratory equipment and supplies appropriate for pediatric patients including, but not limited to, clear oxygen masks, bagmask devices, intubation equipment, supraglottic airways, oral and nasal airways, nasogastric tubes, and suction equipment;

(F) Vascular access supplies and equipment for pediatric patients including, but not limited to, intravenous catheters, intraosseous needles, infusion devices, and Intravenous solutions;

(G) Fracture management devices for pediatric patients including extremity splints and spinal motion restriction devices;

(H) Medications for the care of pediatric patients requiring resuscitation;

(I) Specialized pediatric trays or kits including, but not limited to:

(i) Lumbar puncture tray;

(ii) Difficult airway kit with devices to assist intubation and ventilation;

(iii) Tube thoracostomy tray including chest tubes in sizes for pediatric patients.

(J) Newborn delivery kits including, but not be limited to:

(i) Towel;

(ii) Clamps and scissors for cutting the umbilical cord;

(iii) Bulb suction;

(iv) Warming pad;

(v) Neonatal bag-mask ventilation device with appropriate sized masks;

(vi) Urinary catheter for neonates.

(4) **Rapid Transfer Ability.** The ability to rapidly transfer pediatric patients to a higher level of care PedRC when clinically appropriate. This capability shall include written transfer protocols or arrangements with one or more higher level of care PedRC and prearranged agreements with EMS providers, in compliance with all LEMSA policies and procedures, as well as service provider contracts and designations.

(b) **Program Staffing.** Meet the following program staffing requirements:

(1) **PECC Requirement**. All PedRCs shall have one or more PECC who is either assigned to the emergency department or has emergency care responsibilities. PECCs shall meet the relevant qualifications set forth in paragraph (2) of this section and shall be designated as follows:

(A) **Basic PedRCs.** Basic PedRCs may have one or more PECC who shall be a nurse, nurse practitioner, PA, or a physician.

(B) **Higher Level PedRCs.** General, Advanced, or Comprehensive PedRCs shall have two PECCs. One PECC shall be a physician and the other shall be a physician or a nurse, nurse practitioner, or a Physician Assistant (PA).

(2) **PECC Qualifications**.

(A) **Nurse, Nurse Practitioner, Physician Assistant PECC.** Nurse, nurse practitioner, and physician assistant PECCs shall be licensed in California and meet, at a minimum, all the following requirements:

(i) Have at least two (2) years of pediatric emergency care experience within the previous five (5) years;

(ii) Demonstrated competency in resuscitation of pediatric patients of all ages, from neonates to adolescents, through a nationally recognized Pediatric Advanced Life Support or American College of Emergency Physicians-sponsored Advanced Pediatric Life Support course;

(iii) Every two (2) years, completion of a minimum of ten (10) continuing education contact hours in pediatric emergency care.

(B) **Physician PECC.** Physician PECCs shall be licensed in California and meet, at a minimum, all the following requirements:

(i) Have competency in resuscitation of pediatric patients;

(ii) Be either:

(I) A board-certified emergency medicine physician; or

(II) A qualified specialist in pediatrics or family medicine, with certification from a nationally recognized Pediatric Advanced Life Support course, such as an American College of Emergency Physicians-sponsored Advanced Pediatric Life Support course.

(3) **PECC Responsibilities.** PECCs are responsible for all the following:

(A) Ensuring family-centered care practices are in place;

(B) Acting as the liaison with:

(i) Appropriate GACH-based pediatric care committees;

(ii) Other PedRCs, the LEMSA, base hospitals, EMS providers, and GACHs in geographic proximity, as appropriate, to maximize the availability and quality of pediatric care.

(C) Facilitating pediatric emergency care continuing education and competency evaluations in pediatric care for emergency department staff;

(D) Coordinating pediatric disaster preparedness;

(E) Providing oversight for the pediatric components of the emergency department QI program.

(c) **System Participation and Coordination**.

(1) **Policy Development Participation.** Collaborate with the LEMSA and EMS providers, in the LEMSA's development of relevant policies and procedures to expedite and optimize the IFTs of pediatric patients from non-PedRC or lower-level PedRCs to higher level of care PedRCs, when medically appropriate.

(2) **IFT of Pediatric Patients.** PedRCs shall adhere to the LEMSA's policy regarding the IFT of pediatric patients. In addition:

(A) **Pediatric IFT Requirements.** PedRCs shall develop and implement IFT policies, protocols, and guidelines for the transfer of pediatric patients that shall include the following:

(i) Identification of pediatric patients eligible for interfacility transfer;

(ii) Process for selecting the appropriate partner PedRC(s);

(iii) Clinical criteria for automatic acceptance of qualifying patients at the appropriate partner PedRC center;

(iv) Specific processes for IFTs that ensure continuous twenty-four (24) hours per day, seven (7) days per week, 365 days a year access to partner PedRC physician(s) for timely notification and coordination of incoming IFT patient referrals;

(v) Standardized communication language to be used between the referring GACH and the receiving partner PedRC to facilitate rapid transfer of the patient, including the minimum required patient information to be exchanged to facilitate rapid transfer;

(vi) Guidance for selecting the appropriate transport service to match each patient's needs. Considerations shall include transport personnel scope of practice and the identification of patients for whom more rapid departure to the destination PedRC (such as via emergency ambulance through the 911 response system) outweighs the benefit of delaying transport to await providers with broader scope of practice, such as a critical care transport registered nurse;

(vii) Process for the transfer of patient consent forms, emergency department medical record, initial electronic patient care record (ePCR) and personal belongings for the IFT patient;

(viii) Process for providing information relating to the receiving PedRC, including location and/or directions, to the IFT patient's family, care givers, or legal guardian.

(B) **Pediatric IFT Agreements.** To optimize patient safety and the potential for improved outcome, requirements set forth in subparagraph (A) of this section may be met by establishing IFT agreements in advance, supported by LEMSA policies. Agreements should address special considerations, including patient selection and destination for pediatric patients.

(d) **Continuing Education.** Continuing education in pediatric care shall be provided for:

(1) Organized medical staff;

(2) Staff nurses;

(3) Staff allied health personnel;

(4) EMS personnel; and

(5) Other community physicians and health care personnel.

(e) **Data Collection, QI, and Evaluation.** All PedRCs are subject to the requirements of Article 6, of this subchapter.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100160.02. Basic PedRCs.

(a) **Eligibility**. A licensed general acute care hospital (GACH) meeting the requirements of this section may be designated by the local EMS agency (LEMSA) as a basic PedRC.

(b) **Requirements**. In addition to the requirements set forth in Section 100160.01 of this article, the GACH shall meet, at a minimum, the following:

(1) **ED Permit**. The GACH shall be licensed with a basic or standby emergency department permit.

(2) **Capabilities**.

(A) **Physician Availability.** Emergency department services shall include physician staffing or a physician available for consultation twenty-four (24) hours a day, seven (7) days a week, 365 days a year.

(B) **Staff Qualification**. At least one licensed registered nurse or advanced practice practitioner per shift in the emergency department having current completion of a nationally recognized Pediatric Advance Life course, Advanced Pediatric Life Support course, completion of an Emergency Nursing Pediatric Course, or other equivalent pediatric emergency care nursing course, as determined by the LEMSA.

(C) **Initial Stabilization**. The emergency department in the GACH shall be able to stabilize critically ill or injured infants, children, and adolescents prior to admission or transfer to a comprehensive PedRC facility.

(3) **Program Staffing**. All basic PedRCs shall have a PECC who is either a physician, nurse, nurse practitioner, or PA. This may be a shared PECC with other PedRCs.

(4) **Agreements with Higher Level PedRCs.**

(A) Establish agreements with at least one comprehensive PedRC, as approved by the LEMSA, for staff education, consultation, and transfer of critical pediatric patients;

(B) Establish agreements with an advanced or general PedRC, as approved by the LEMSA, for consultation and transfer of pediatric patients.

(5) **Transfer agreements.** Establish transfer agreements for pediatric patients needing specialized care, if the specialized care is not available at a comprehensive, advanced or general PedRC, such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health.

(6) **Additional Requirements.** Additional requirements for designation may be stipulated by the LEMSA Medical Director.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100160.03. General PedRCs.

(a) **Eligibility.** A licensed general acute care hospital (GACH) meeting the requirements of this section may be designated by the local EMS agency (LEMSA) as a general PedRC.

(b) **Requirements**. In addition to the requirements set forth in Section 100160.01 of this article, the GACH shall meet, at a minimum, the following:

(1) **ED Permit.** All designated general PedRCs shall be licensed as a GACH with a basic or comprehensive emergency department permit.

(2) **Capabilities**.

(A) **Initial Stabilization.** The emergency department in the GACH shall be able to stabilize critically ill or injured infants, children, and adolescents prior to admission or transfer to a comprehensive PedRC facility;

(B) **Neonatal Resuscitation.** All designated general PedRCs shall have neonatal resuscitation equipment, including:

(i) Pediatric laryngoscope with Miller 0 and 00 blades;

(ii) Size 2.5 and 3.0 endotracheal tubes, and;

(iii) Umbilical vein catheters.

(3) **Program Staffing**. All designated general PedRCs shall have a physician PECC and nurse, nurse practitioner, or PA PECC which may be shared with other PedRCs.

(4) **Continuing Education.** Participate with a comprehensive and/or advanced PedRC for pediatric emergency education for GACH staff and emergency care providers consistent with the LEMSA plan for ongoing pediatric education.

(5) **Agreements with Higher Level PedRCs**. Establish agreements with comprehensive and/or advanced PedRCs as approved by the LEMSA, for education, consultation, and transfer.

(6) **Transfer Agreements.** Establish transfer agreements for pediatric patients needing specialized care, if the specialized care is not available at a comprehensive, advanced, or general PedRC, such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health;

(7) **Additional Requirements**. Additional requirements for designation may be stipulated by the LEMSA Medical Director.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100160.04. Advanced PedRCs.

(a) **Eligibility.** A licensed general acute care hospital (GACH) meeting the requirements of this section may be designated by the local EMS agency (LEMSA) as an advanced PedRC.

(b) **Requirements**. In addition to the requirements set forth in Section 100160.01 of this article, the GACH shall meet, at a minimum, the following:

(1) **Licensing.** All designated advanced PedRCs shall be licensed in the following manner by the California Department of Public Health (CDPH) Licensing and Certification Division pursuant to Title 22, California Code of Regulations, Division 5, Chapter 1:

(A) As a GACH pursuant to Article 1, sections 70003 and 70005;

(B) For pediatric service pursuant to Article 6, section 70535 et seq;

(C) For basic or comprehensive emergency department pursuant to Article 6, section 70411, et seq, and Article 6, section 70451, et seq;

(D) For social services pursuant to Article 6, section 70629 et seq;

(E) As a Community Neonatal Intensive Care Unit (NICU) or as an Intermediate NICU, if it meets the following requirements, as per:

(i) Article 6, Section 70545 et seq., for the provision of perinatal services and licensed by CDPH, Licensing and Certification Division as a perinatal service;

(ii) Article 6, Section 70481 et seq., for the provision of neonatal intensive care services and licensed by CDPH, Licensing and Certification Division as an Intensive Care Newborn Nursery (ICNN).

(F) If the GACH has a PICU, it shall be licensed by CDPH, Licensing and Certification Division for intensive care services, and meet the requirements for the provision of intensive care services pursuant to Title 22, California Code of Regulations, Division 5, Chapter 1, Article 6, Section 70491 et seq.

(2) **Capabilities.**

(A) **Initial Stabilization.** The emergency department in the GACH shall be able to stabilize critically ill or injured infants, children, and adolescents prior to admission to the PICU or transfer to a comprehensive PedRC facility.

(B) **Equipment.** The pediatric equipment, supplies, and medications in all advanced PedRCs for pediatric patients shall include:

(i) All general PedRC equipment, and

(ii) Crash carts with pediatric resuscitation equipment that shall be standardized and available on all units where pediatric patients receive care, including but not limited to, the emergency department, radiology suite, and inpatient pediatric service.

(C) **In House Service Capability.** All advanced PedRCs shall meet the following service and personnel requirements twenty-four (24) hours a day, seven (7) days a week, 365 days a year:

(i) Respiratory care service in the pediatric service department and emergency department provided by respiratory care practitioners (RCPs) who are licensed in the state of California and who have completed formal training in pediatric respiratory care which includes clinical experience in the care of children;

(ii) Social work services provided by a medical social worker (MSW) holding a master's degree in social work who has expertise in the psychosocial issues affecting the families of seriously ill infants, children, and adolescents;

(iii) Behavioral health specialists with pediatric experience to include, but not be limited to, psychiatrists, psychologists, and nurses;

(D) **Consulting Service Capability.**

(i) The following specialties shall be on-call, and available for consultation to the ED, NICU, or PICU, if applicable, within thirty (30) minutes by telephone. Specialists must be able to arrive in-person within sixty (60) minutes when clinically necessary.

(I) Neonatologist;

(II) General surgeon with pediatric experience;

(III) Anesthesiologist or nurse anesthetist with pediatric experience.

(ii) The following specialties shall be on-call, and available to the ED, NICU, or PICU either in-person, by phone, or by telehealth, within 30 minutes:

(I) Radiologist with pediatric experience;

(II) Otolaryngologist with pediatric experience;

(III) Mental health professional with pediatric experience;

(IV) Orthopedist with pediatric experience;

(V) Pediatric cardiologist.

(iii) The following qualified specialists shall be available twenty-four (24) hours a day, seven (7) days a week, three hundred sixty-five (365) days a year for consultation which may be met through a transfer agreement or telehealth:

(I) Pediatric Gastroenterologist;

(II) Pediatric Hematologist/Oncologist;

(III) Pediatric Infectious Disease physician;

(IV) Pediatric Nephrologist;

(V) Pediatric Neurologist;

(VI) Pediatric Surgeon;

(VII) Cardiac Surgeon with pediatric experience;

(VIII) Neurosurgeon with pediatric experience;

(IX) Obstetrics/Gynecologist with pediatric experience;

(X) Pulmonologist with pediatric experience;

(I) Pediatric Endocrinologist.

(3) **Agreements with Higher Level PedRCs**.

(A) Establish agreements with a minimum of one comprehensive PedRC as approved by the LEMSA, for consultation;

(B) Establish transfer agreements with a comprehensive PedRC to transfer pediatric patients for stabilization, ensuring the highest level of care;

(C) Establish transfer agreements for pediatric patients needing specialized care, if the specialized care is not available at a comprehensive, advanced or general PedRC, such as trauma, burn, spinal cord injury, and rehabilitation, and behavioral health.

(4) **Continuing Education.** Participate with a comprehensive PedRC for pediatric emergency education for emergency care providers consistent with the LEMSA plan for ongoing pediatric education;

(5) **Program Staffing.** Advanced PedRCs shall have a physician and nurse Pediatric Emergency Care Coordinator (PECC).

(6) **Additional Requirements.** Additional requirements for designation may be stipulated by the LEMSA Medical Director.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100160.05. Comprehensive PedRCs.

(a) **Eligibility.** A licensed general acute care hospital (GACH) meeting the minimum requirements of this section may be designated by the local EMS agency (LEMSA) as a comprehensive PedRC.

(b) **Requirements**. In addition to the requirements set forth in Section 100160.01 of this article, the GACH must meet all requirements for an advanced PedRC pursuant to Section 100160.04(b) of this article as well as the following:

(1) **Licensing.** Approved by the Department of Health Care Services as a California Children's Service (CCS) Program tertiary hospital.

(2) **Capabilities.**

(A) **Level of Care.** Can provide comprehensive specialized pediatric medical and surgical care to any acutely ill or injured child;

(B) **Pediatric-Specific Emergency Services.** Emergency department services include a separate pediatric emergency department or a designated area for emergency care of pediatric patients within an emergency department, with physician staff who are qualified specialists in emergency medicine or pediatric emergency medicine;

(C) **Inpatient Resources.** Inpatient resources including a neonatal intensive care unit (NICU) and a pediatric intensive care unit (PICU);

(3) **Continuing Education.** Provide ongoing outreach and pediatric education for

community, general and basic PedRCs, and prehospital care providers, in collaboration with the LEMSA.

(4) **Transfer Agreements.** Establish transfer agreements or serve as a regional referral center for specialized care, such as trauma, burn, spinal cord injury, and rehabilitation and behavioral health, of pediatric patients.

(5) **Additional Requirements.** Additional requirements for designation may be stipulated by the local LEMSA Medical Director.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

Article 6: EMSC Program Data Management, Quality Improvement and Evaluation

§ 100161.01. EMSC Data Management Requirements.

(a) **Data Collection and Reporting Process Requirements**.

(1) **LEMSA**. The local EMS Agency (LEMSA) shall develop and implement a standardized data collection and reporting process for the EMSC program.

(A) The process shall include the collection of both prehospital EMSC patient care data and GACH EMSC patient care data, in accordance with subdivision (b) of this section.

(B) The LEMSA, in collaboration with PedRCs and EMS providers, shall develop a process for the sharing of outcome data from the PedRCs to the EMS providers for all transported pediatric patients.

(2) **GACHs**.

(A) All PedRCs shall collaborate with the LEMSA and EMS providers to provide pediatric patient outcome data as resources allow for prehospital QI activities.

(B) All GACHs that receive pediatric patients via EMS shall participate in the LEMSA data collection process in accordance with LEMSA polices and procedures.

(3) **Timing of submission**. GACH EMSC patient care data elements shall be collected and submitted to the Emergency Medical Services Authority (EMSA), either directly or through the LEMSA in accordance with the LEMSA's data policy, on at least a quarterly basis and within ninety (90) days of patient discharge.

(b) **EMSC Patient Care Data Requirements**.

(1) **Prehospital EMSC Patient Care Data Elements**. The prehospital EMSC patient care data elements selected by the LEMSA shall be compliant with the most current version of the CEMSIS and the NEMSIS databases.

(2) **GACH EMSC Patient Care Data Elements.** The GACH patient care data elements shall be selected by the LEMSA.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100161.02. Local EMS Agency EMSC Quality Improvement and Evaluation Process.

(a) Pediatric care shall be an integral part of the local EMS agency's (LEMSA's) overall QI program. A LEMSA with an EMSC program shall have a QI process that includes, at a minimum:

(1) **Policy Development.** An EMSC program Medical Director assisting in the development of LEMSA prehospital care policies, procedures, and protocols relevant to the care of pediatric patients.

(2) **Multidisciplinary QI Committee**. An EMSC or QI committee that addresses multidisciplinary EMSC QI work.

(3) **System Participation.**

(A) Participation of all relevant EMS providers as well as designated PedRCs in:

(i) The EMSC data management requirements set forth in Section 100161.01 of this article; and

(ii) The LEMSA's QI process under this section.

(B) All general acute care hospitals (GACHs) that send or receive pediatric patients shall participate in system and PedRC QI activities for those pediatric patients which have been transferred.

(4) **Regional Coordination Review.** Evaluation of the regional coordination and integration of pediatric patient movement, including pediatric destination policies or pedistric IFTs that involve GACHs outside the LEMSA's jurisdiction;

(5) **Case Review.** Review of pediatric deaths, locally defined adverse events, and transfers;

(6) **System Performance Evaluation.** Evaluation of program structure, process, and outcomes;

(7) **Confidentiality Protections.** Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality and a disclosure-protected review of selected pediatric cases.

(b) The LEMSA shall be responsible for ongoing performance evaluation and QI of the EMSC program.

(1) **Evaluation Support Process.** The LEMSA shall implement a process utilizing EMSC

committee work and regular data reporting, as set forth in this section, to share information bi-directionally with EMS providers, system-participating GACHs, and the local medical community. This process shall support ongoing EMSC program evaluation, including the EMSC program plan, to ensure that the plan meets the needs of the local EMS system.

(2) **Periodic Performance Evaluation.** The LEMSA shall periodically evaluate the performance of its EMSC program on a basis of at least every three (3) years. Results of the EMSC program evaluation shall be made available to system participants.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

§ 100161.03. Designated GACH Quality Improvement and Evaluation Requirements.

(a) All PedRCs shall have a QI program, that includes, at a minimum:

(1) **System Performance Evaluation.** A process that integrates:

(A) Emergency department QI activities with the prehospital, trauma, inpatient pediatrics, pediatric critical care, and hospital-wide quality QI activities, as applicable;

(B) Findings from quality improvement QI audits and reviews into education and clinical competency evaluations of staff.

(2) **Multidisciplinary QI Committee.** Participation in a multidisciplinary pediatric quality improvement (QI) committee that reviews prehospital, emergency department, and inpatient care. The committee shall include, but is not limited to:

(A) Cardiopulmonary or respiratory arrests;

(B) Child maltreatment cases;

(C) Deaths;

(D) Intensive care unit admissions and length of stay;

(E) Operating room admissions and type of surgery;

(F) Transfers and emergency department boarding;

(G) Trauma admissions.

(3) **National Pediatric Readiness Project Self-Assessment.** Completion of an online or paper assessment of the National Pediatric Readiness Project self-assessment, the results of which shall be shared with the local EMS agency LEMSA at a minimum

of every three (3) years.

(4) **Pediatric IFT.**

(A) Process improvement focused on pediatric IFT processes. PedRCs shall provide feedback to referring GACHs as well as to the LEMSA's QI programs.

(B) GACHs that send or receive pediatric patients shall participate in system and PedRC QI activities for transferred pediatric patients.

(5) **Confidentiality Protections.** Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure protected review of selected pediatric cases.

Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.176, 1798.150, and 1799.204, Health and Safety Code.
Reference: Sections 1797.1, 1797.52, 1797.72, 1797.102, 1797.103, 1797.122, 1797.176, 1797.204, 1797.220, 1797.250, 1797.252, 1797.254, 1798.150, 1799.200, and 1799.204, Health and Safety Code.

Emergency Medical Services Authority

Initial Trauma Care System Plan Template Pursuant to:

California Health and Safety Code Division 2.5, Chapter 4, Article 2, §1797.257 and

California Code of Regulations, Title 22, Division 9, Chapter 6.2, Article 1, §100139.03 A Local Emergency Medical Services Agency (LEMSA) implementing a trauma care system shall have a Trauma Care System Plan approved by the California Emergency Medical Services Authority (EMSA) prior to system implementation.

Projected Implementation Date: _____ _____
Date of Submission: _____

Submitted by:
LEMSA Name: _____
Agency Address: _____
City, State, ZIP: _____
Primary Contact Person: _____
Title: _____
Phone Number: _____ _____
Email Address:
_____

Disclosure:

If additional space is needed to fully respond to any section of this template, please attach a separate document clearly labeled with the name of the submitting LEMSA, the section number and section title on all supplemental pages.

Submission Instructions:

Submit completed reports to EMSA via email or mail:
Plans@emsa.ca.gov
California Emergency Medical Services Authority
Attention: EMS Plans Coordinator
11120 International Drive, Suite 200 Rancho
Cordova CA, 95670

1. Trauma System Plan Executive Summary

1.1. Provide a concise executive summary of the Trauma Care System Plan. The summary should provide a brief overview of key components of the trauma system, such as the number and levels of designated trauma centers, system goals and priorities, major system strengths, anticipated challenges, and any planned system development or expansion.

- Summary: _____

2. LEMSA Governance Structure

2.1. Using the table below, provide a list of the names, titles, and roles of all Local EMS Agency (LEMSA) personnel involved in the trauma system.

Name	Title	Role in the Trauma System

3. Fiscal and Resource Planning

3.1. Summarize the anticipated costs associated with trauma system operations and development, including identified and potential funding sources.

- Summary: _____

4. Trauma System Designations

4.1. Using the table below, identify all trauma centers and trauma receiving hospitals within the jurisdiction. For each facility, indicate the LEMSA designation level, ACS verification status, and whether the center provides adult services, pediatric services, or both. For any GACH that did not achieve ACS verification, specify whether the LEMSA has designated it as a trauma receiving hospital.

Trauma Center Name	LEMSA Designation Level (I–IV, Receiving)	ACS Verification (Yes/No)	Population Served (Adult / Peds / Both)	Failed ACS Verification (Yes/No)	Trauma Receiving Center Status
Example Medical Center	Level I	Yes	Both	No	No
County Hospital	Level II	No	Adult	Yes	Yes
Children's Hospital	Level I	Yes	Peds	No	No
Rural Hospital	Level IV	No	Adult	No	Yes

4.2. Using the table below, provide a list of all burn centers within the jurisdiction. For each center, include the LEMSA designation level, American Burn Association (ABA) verification status, and the patient population served (adult, pediatric, or both).

Burn Center Name	**LEMSA Designation Level**	**ABA Verification (Yes/No)**	**Population Served (Adult / Peds / Both)**
Example Burn Institute	Level I	Yes	Both
County Burn Unit	Level II	No	Adult
Children's Burn Center	Level I	Yes	Peds
Rural Burn Unit	Level II	No	Adult

5. Needs Assessment

5.1. Summarize identified gaps and system needs based on population demographics, geographic challenges, and trauma care outcomes.

- Summary: _____

6. Goals and Objectives

6.1. Using the table below, list strategic goals and clearly defined, measurable objectives for the development, enhancement, and continuous improvement of the trauma system.

Goal	**Objective**	**Target Date**	**Status**

7. Trauma System Clinical/Operational Policies

Provide a copy of each of the following policies:

Patient Identification, Triage, and Destination

7.1. Destination Criteria: Defines how EMS personnel determine the most appropriate receiving facility for trauma patients based on clinical presentation and system resources.

- Attachment Name(s): _____

7.2. Specialty Care Destination Policies: Defines how EMS personnel determine the appropriate receiving facility for trauma patients, including destination procedures for specialty care services such as burn, pediatric trauma, reimplantation, and other specialty services that may be unavailable within the jurisdiction.

- Attachment Name(s): _____

7.3. Field Prehospital Triage Criteria: Establishes criteria used by field personnel to identify trauma patients and assign a level of trauma response.

- Attachment Name(s): _____

7.4. Re-triage Policies or Protocol: Specifies when and how a patient initially transported to a non-trauma or lower-level facility should be transferred to a higher-level trauma center.

- Attachment Name(s): _____

Communications

7.5. Field Communication Policies and Protocols: Specifies communication procedures between field providers and receiving hospitals during trauma patient transport to ensure accurate and timely information exchange.

- Attachment Name(s): _____

7.6. Provider Early Notification Policy: Requires prehospital providers to notify the receiving trauma center of a trauma patient prior to arrival to ensure timely preparation and resource mobilization.

- Attachment Name(s): _____

Trauma System Access and Care Coordination

7.7. Coordination with Neighboring LEMSAs: Describes operational processes for trauma patient transfers and shared service responsibilities across jurisdictional lines.

- Attachment Name(s): _____

7.8. Inter-facility Transfer: Establishes procedures for safe and timely transfer of trauma patients between healthcare facilities to access required levels of care.

- Attachment Name(s): _____

7.9. Trauma Center Service Areas and Inter-Jurisdictional Integration: Describes the defined primary service area for each designated trauma center and explain how trauma center catchment/service areas interface with bordering LEMSA regions.

- Attachment Name(s): _____

7.10. Timely Access to Care within/between Jurisdictions: Describes operational processes, mutual aid agreements, and cross-jurisdictional coordination practices that ensure trauma patients can be routed or transferred across county or regional boundaries when necessary.

- Attachment Name(s): _____

7.11. Timely Access to Definitive Care: Defines standards, benchmarks, and time expectations to ensure patients rapidly reach facilities capable of providing definitive trauma care.

- Attachment Name(s): _____

Facility and System Capability Requirements

7.12. Critical Care Capability: Defines minimum critical care service capabilities (e.g., surgical, ICU, specialty services) that must be continuously available.

Attachment Name(s): _____

7.13. Facility Pediatric Care Capability: Identifies standards for trauma centers treating pediatric trauma patients, including staffing, equipment, and specialty availability.

- Attachment Name(s): _____

7.14. Pediatric GACH Integration Policy (if applicable): Describes how general acute care hospitals integrate pediatric trauma care resources or coordinate with regional pediatric trauma centers.

- Attachment Name(s): _____

7.15. Trauma Center Designation Levels: Specifies criteria and expectations for Level I, II, III, IV, and trauma receiving hospitals within the local trauma care system.

- Attachment Name(s): _____

7.16. Designation/Redesignation Policy: Describes the trauma center designation and redesignation process.

- Attachment Name(s): _____

7.17. Transportation Plan: Outlines ground and air transport resource availability, dispatch processes, and interfacility transport system coordination.

- Attachment Name(s): _____

System Management, Oversight, and Standards

7.18. Trauma System Organization Policy: Describes the organizational structure, governance, and administrative oversight of the trauma care system, including roles, responsibilities, committee structure, and authority of the LEMSA in trauma system management.

- Attachment Name(s): _____

7.19. Marketing and Advertising by Trauma Centers: Governs how trauma centers may represent or promote their trauma designation or capabilities to the public.

- Attachment Name(s): _____

7.20. Quality Assurance and Outcome Analysis Plan: Defines processes for performance improvement, case review, system evaluation, and reporting to support ongoing trauma system oversight.

- Attachment Name(s): _____

8. Trauma System Design

Provide data-supported reasoning for the proposed trauma care system design.

8.1. Trauma Volume and Access Needs: Summarize projected trauma patient volume and the number and level of trauma centers necessary to provide timely access to definitive trauma care for all ages.

- Summary: _____

8.2. Population-Based Trauma Center Requirements: Describe the current population of the service area and the number of Level I/II trauma centers designated or proposed.

Population of Service Area: _____

- Number of Level I/II Trauma Centers Proposed: _____

8.3. Trauma Center Location Map: Attach a map showing the location of designated trauma centers within the LEMSA service area, if applicable.

- Attachment Name(s): _____

8.4. Field Prehospital Triage Criteria: Summarize the criteria used by EMS personnel to identify and categorize trauma patients in the field.

- Summary: _____

8.5. Critical Care Capability: Summarize the availability and distribution of critical care resources, including trauma center levels and specialized services.

- Summary: _____

8.6. Transportation Plan: Summarize the protocols for patient transport, including destination decisions, air vs. ground transport, and interfacility transfers.

- Summary: _____

8.7. Coordination with Neighboring LEMSAs: Summarize the mutual aid agreements, cross-jurisdictional protocols, or collaborative processes in place to ensure regional trauma system integration.

- Summary: _____

9. Trauma System Infrastructure

9.1. Base Hospital Role: Summary of the role of the base hospital, if applicable, in determining trauma patient destination.

- Summary: _____

9.2. Helicopter Landing Sites: A local EMS agency (LEMSA) may require trauma centers to have helicopter landing sites. If helicopter landing sites are required, they shall be approved by the Division of Aeronautics, Department of Transportation, pursuant to Title 21, California Code of Regulations, Division 2.5.

- Response:

☐ Not applicable.

☐ All helicopter landing sites are approved by the Division of Aeronautics.

☐ One or more helicopter landing sites are not currently approved by the Division of Aeronautics.

☐ If not approved, explain below:

9.3. Communications: All trauma patient transport vehicles shall be equipped with two-way telecommunications equipment capable of communicating with hospitals, in accordance with LEMSA communication policies.

- Response:

☐ All trauma patient transport vehicles are equipped with two-way telecommunications equipment capable of communicating with hospitals.

☐ One or more trauma patient transport vehicles are not currently equipped with two-way telecommunications equipment capable of communicating with hospitals.

☐ If not equipped, explain below:

9.4. Transport Resources: Provide a summary of resources available to transport trauma patients to the appropriate level trauma center, to include air transport and plan for IFT.

- Summary: _____

9.5. Trauma Center Location Map: Provide a copy of the map showing the location of designated trauma centers.

- Attachment Name(s): _____

10. Trauma System Participating Facilities and Agreement Dates

10.1. Attach any intercounty trauma center agreements approved by the LEMSAs in each jurisdiction.

- Attachment Name(s): _____

10.2. Attach any written agreements between the LEMSA and the hospitals participating in the trauma system.

- Attachment Name(s): _____

10.3. Using the table below, provide a list of all trauma centers and the corresponding Memorandums of Agreement (MOA) expiration or anticipated execution dates.

Trauma Center Name	MOA Expiration Date	MOA Anticipated Execution Date

11. Fee Schedule

11.1. Attach the current fee schedule, including fees for application, designation, redesignation, and monitoring and evaluation.

- Attachment Name(s): _____

11.2. Attach the reporting form or template provided to trauma centers showing how fees are applied.

- Attachment Name(s): _____

11.3. Using the table below, provide a detailed report on the anticipated utilization of collected fees. The report should clearly inform facilities of the specific application of these fees and assure EMSA that all projected expenditures comply with the requirements of §1798.164.

Facility Name	Fees Charged (Annual)	Activities Covered by Fees	Detailed Summary of Fee Expenditures
Example Medical Center	$XXX,XXX	Personnel/Salary, Trauma Center Site Visits, Contracted Services, Data Collection, Performance Improvement Activities	Personnel / Salaries: $XX,XXX Contracted Reviewer Services: $XX,XXX Site Visit Travel & Lodging: $XX,XXX Data Registry Licensing/Maintenance: $XX,XXX PI Support Activities: $XX,XXX
County Hospital	$XXX,XXX	Personnel/Salary, Trauma Center Site Visits, Contracted Services, Data Collection, Performance Improvement Activities	Personnel / Salaries: $XX,XXX Contracted Reviewer Services: $XX,XXX Site Visit Travel & Lodging: $XX,XXX Data Registry Licensing/Maintenance: $XX,XXX PI Support Activities: $XX,XXX

12. Data Collection

12.1. Describe the methods that trauma-related data is collected from EMS providers and designated trauma centers to the LEMSA and to EMSA.

- Description: _____

13. Quality Improvement Integration

13.1. Describe the integration of trauma into an existing quality improvement committee. Include a description of any trauma-specific quality improvement committees.

- Description: _____

14. Public Education & Injury Prevention

14.1. Describe programs or campaigns focused on trauma-related public education, including injury prevention.

- Description: _____

15. GACH Data Submission

15.1. Each designated trauma center is required to collect and submit GACH data elements to EMSA. These data elements must be submitted to EMSA within ninety (90) days of the patient's discharge.

- Response:

☐ All trauma centers are positioned to be in compliance with the 90-day submission requirement upon plan approval.

☐ One or more trauma centers will not be in compliance with the 90-day submission requirement upon plan approval.

☐ If not in compliance, explain below:

16. Performance Improvement and Patient Safety (PIPS)

16.1. All trauma centers, regardless of level, must have a PIPS process that is independent of, but reports to, the GACH Performance or Quality Improvement program.

- Response:

☐ All trauma centers are positioned to be in compliance with the PIPS program requirement upon plan approval.

☐ One or more trauma centers will not be in compliance with the PIPS program requirement upon plan approval.

☐ If not in compliance, explain below:

17. Quality Improvement (QI) Program Integration

17.1. Trauma care must be integrated into the LEMSA's overall QI program.

- Response:

☐ The LEMSA is positioned to be in compliance with the QI program requirement upon plan approval.

☐ The LEMSA will not be in compliance with the QI program requirement upon plan approval.

☐ If not in compliance, explain below:

18. Periodic Performance Evaluation

18.1. Periodic performance evaluation of the trauma system shall be conducted at least every three (3) years.

- Response:

☐ A trauma system performance evaluation has been conducted within the past three (3) years. Date of last evaluation: _____

- Attach the most recent performance evaluation report.
- Attachment Name: _____

☐ A trauma system performance evaluation has not been conducted within the past three (3) years.

☐ If not conducted, explain below:

19. Level IV Trauma Center Minimum Requirements

19.1. A GACH meeting the minimum requirements of §100141.03 may be designated by the LEMSA as a Level IV trauma center.

- Response:

☐ Not applicable

☐ All Level IV trauma centers are positioned to be in compliance with the minimum requirements upon plan approval.

☐ One or more Level IV trauma centers will not be in compliance with the minimum requirements upon plan approval.

☐ If not in compliance, explain below:

20. Public Posting Requirement

20.1. The LEMSA is required to share this Trauma Care System Plan on its public website upon approval by EMSA for at least one (1) year. Provide the LEMSA Website URL where the report will be posted.

- LEMSA Website URL: _____

21. Comments to EMSA (optional)

21.1. Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your Trauma Care System Plan submission. This may include challenges encountered in developing or updating the plan, anticipated needs for technical assistance or support, data limitations or planned improvements in data collection, ongoing or upcoming projects that may impact trauma care delivery, or feedback on regulatory requirements or submission processes.

- Comments: _____

22. Certification

22.1. I hereby certify that the information provided in this Trauma Care System Plan is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.

Local EMS Agency Administrator/Director

*Name:*_____

*Title:*_____

*Signature:*_____

*Date:*_____

Emergency Medical Services Authority

Annual Trauma System Status Report Template Pursuant to:
California Health and Safety Code, Division 2.5, Chapter 4, Article 2, §1797.258 and
California Code of Regulations, Title 22, Division 9, Chapter 3.3, Article 8, §100097.01 &
Chapter 6.2 Article 1 §100139.01, Article 3 §100139.03, & Article §4 100139.04

The Local Emergency Medical Services Agency (LEMSA) shall submit a Trauma System Status Report to the California Emergency Medical Services Authority (EMSA) as part of its annual EMS Plan update. The report shall include any changes to the trauma system since submission of the previous annual plan update.

Reporting Period: _____
Date of Submission: _____

Submitted by:
LEMSA Name: _____
Agency Address: _____
City, State, ZIP: _____
Primary Contact Person: _____
Title: _____
Phone Number: _____ _____
Email Address:
_____

Disclosure:

If additional space is needed to fully respond to any section of this template, please attach a separate document clearly labeled with the name of the submitting LEMSA, the section number and section title on all supplemental pages.

Submission Instructions:

Submit completed reports to EMSA via email or mail:
Plans@emsa.ca.gov
California Emergency Medical Services Authority
Attention: EMS Plans Coordinator
11120 International Drive, Suite 200
Rancho Cordova, CA 95670

1. Trauma System Plan Executive Summary

1.1. Provide a concise executive summary of the Trauma System Status Report. The summary should provide a brief overview of key components of the trauma system, such as the number and levels of designated trauma centers, system goals and priorities, major system strengths, anticipated challenges, and any planned system development or expansion.

- Summary: _____

2. LEMSA Governance Structure

2.1. Using the table below, provide a list of the names, titles, and roles of all Local EMS Agency (LEMSA) personnel involved in the trauma system.

Name	Title	Role in the Trauma System

3. Fiscal and Resource Planning

3.1. Summarize the costs associated with trauma system operations and development, including identified and potential funding sources.

- Summary: _____

4. Trauma System Designations

4.1. Using the table below, identify all trauma centers and trauma receiving hospitals within the jurisdiction. For each facility, indicate the LEMSA designation level, ACS verification status, and whether the center provides adult services, pediatric services, or both. For any GACH that did not achieve ACS verification, specify whether the LEMSA has designated it as a trauma receiving hospital. Additionally, describe any changes to trauma center status during the reporting period, including new designations, changes in level, de-designations, or closures, if applicable.

Trauma Center Name	LEMSA Designation Level (I–IV, Receiving)	ACS Verification (Yes/No)	Population Served (Adult / Peds / Both)	Failed ACS Verification (Yes/No)	Trauma Receiving Center Status	Changes During Reporting Period
Example Medical Center	Level I	Yes	Both	No	No	Newly verified for pediatric population
County Hospital	Level II	No	Adult	Yes	Yes	None
Children's Hospital	Level I	Yes	Peds	No	No	None
Rural Hospital	Level IV	No	Adult	No	Yes	None

4.2. Using the table below, provide a list of all burn centers within the jurisdiction. For each center, include the LEMSA designation level, American Burn Association (ABA) verification status, and the patient population served (adult, pediatric, or both). Additionally, report any changes to burn center status during the reporting period, such as new designations, level modifications, de-designations, or closures, where applicable.

Burn Center Name	**LEMSA Designation Level**	**ABA Verification (Yes/No)**	**Population Served (Adult / Peds / Both)**	**Changes During Reporting Period**
Example Burn Institute	Level I	Yes	Both	None
County Burn Unit	Level II	No	Adult	None
Children's Burn Center	Level I	Yes	Peds	None
Rural Burn Unit	Level II	No	Adult	None

5. Needs Assessment

5.1. Summarize identified gaps and system needs based on population demographics, geographic challenges, and trauma care outcomes.

- Summary: _____

6. Goals and Objectives

6.1. Using the table below, list strategic goals and clearly defined, measurable objectives for the development, enhancement, and continuous improvement of the trauma system.

Goals/Objectives	**Description**	**Target Date**	**Status**

7. Trauma System Clinical/Operational Policies

Provide a copy of each of the following policies, including a summary of any policy updates made within the reporting period:

Patient Identification, Triage, and Destination

7.1. Destination Criteria: Defines how EMS personnel determine the most appropriate receiving facility for trauma patients based on clinical presentation and system resources.
- Attachment Name(s): _____

7.2. Specialty Care Destination Policies: Defines how EMS personnel determine the appropriate receiving facility for trauma patients, including destination procedures for specialty care services such as burn, pediatric trauma, reimplantation, and other specialty services that may be unavailable within the jurisdiction.
- Attachment Name(s): _____

7.3. Field Prehospital Triage Criteria: Establishes criteria used by field personnel to identify trauma patients and assign a level of trauma response.
- Attachment Name(s):

7.4. Re-triage Policy or Protocol: Specifies when and how a patient initially transported to a non-trauma or lower-level facility should be transferred to a higher-level trauma center.
- Attachment Name(s): _____

Communications

7.5. Field Communication Policies and Protocols: Specifies communication procedures between field providers and receiving hospitals during trauma patient transport to ensure accurate and timely information exchange.
- Attachment Name(s): _____

7.6. Provider Early Notification Policy: Requires prehospital providers to notify the receiving trauma center of a trauma patient prior to arrival to ensure timely preparation and resource mobilization.
- Attachment Name(s): _____

Trauma System Access and Care Coordination

7.7. Coordination with Neighboring LEMSAs: Describes operational processes for trauma patient transfers and shared service responsibilities across jurisdictional lines.
- Attachment Name(s): _____

7.8. Inter-facility Transfer: Establishes procedures for safe and timely transfer of trauma patients between healthcare facilities to access required levels of care.
- Attachment Name(s): _____

7.9. Trauma Center Service Areas and Inter-Jurisdictional Integration: Describes the defined primary service area for each designated trauma center and explain how trauma center catchment/service areas interface with bordering LEMSA regions.
- Attachment Name(s): _____

7.10. Timely Access to Care within/between Jurisdictions: Ensures critically injured patients receive definitive trauma care as quickly as possible, regardless of geographic or system boundaries.
- Attachment Name(s): _____

7.11. Timely Access to Definitive Care: Defines standards and time expectations to ensure patients rapidly reach facilities capable of providing definitive trauma care.
- Attachment Name(s): _____

Facility and System Capability Requirements

7.12. Critical Care Capability: Defines minimum critical care service capabilities (e.g., surgical, ICU, specialty services) required at designated trauma centers.
- Attachment Name(s): _____

7.13. Facility Pediatric Care Capability: Identifies standards for trauma centers treating pediatric trauma patients, including staffing, equipment, and specialty availability.
- Attachment Name(s): _____

7.14. Pediatric GACH Integration Policy (if applicable): Describes how general acute care hospitals integrate pediatric trauma care resources or coordinate with regional pediatric trauma centers.
- Attachment Name(s): _____

7.15. Trauma Center Designation Levels: Specifies criteria and expectations for Level I, II, III, IV, and trauma receiving hospitals within the local trauma care system.
- Attachment Name(s): _____

7.16. Designation/Redesignation Policy: Describes the trauma center designation and redesignation process.
- Attachment Name(s): _____

7.17. Transportation Plan: Outlines ground and air transport resource availability, dispatch processes, and interfacility transport system coordination.
- Attachment Name(s): _____

System Management, Oversight, and Standards

7.18. Trauma System Organization Policy: Describes the organizational structure, governance, and administrative oversight of the trauma care system, including roles, responsibilities, committee structure, and authority of the LEMSA in trauma system management.
- Attachment Name(s): _____

7.19. Marketing and Advertising by Trauma Centers: Governs how trauma centers may represent or promote their trauma designation or capabilities to the public.
- Attachment Name(s): _____

7.20. Quality Assurance and Outcome Analysis Plan: Defines processes for performance improvement, case review, system evaluation, and reporting to support ongoing trauma system oversight.
- Attachment Name(s): _____

8. Trauma System Design

Provide a summary of any updates, changes or developments related to the trauma care system design during the reporting period, including:

8.1. Trauma Volume and Access Needs: Summarize any changes in projected trauma patient volume or adjustments to the number and levels of trauma centers needed to maintain timely access to definitive trauma care for all ages.
- Summary: _____

8.2. Population-Based Trauma Center Requirements: Update the current population of the service area and the number of designated Level I/II trauma centers.
- Population of Service Area: _____
- Number of Level I/II Trauma Centers: _____

8.3. Trauma Center Location Map: Attach a map showing the location of designated trauma centers within the LEMSA service area, if applicable.
- Attachment Name(s): _____

8.4. Field Prehospital Triage Criteria: Summarize any revisions to EMS protocols or criteria used to identify and categorize trauma patients in the field.
- Summary: _____

8.5. Critical Care Capability: Summarize any changes in the availability and distribution of critical care resources, including trauma center levels and specialized services.
- Summary: _____

8.6. Transportation Plan: Summarize updates to patient transport protocols, including destination decisions, modes of transport, and interfacility transfer procedures.
- Summary: _____

8.7. Coordination with Neighboring LEMSAs: Summarize any new or modified mutual aid agreements, cross-jurisdictional protocols, or collaborative efforts supporting regional trauma system integration.
- Summary: _____

9. Trauma System Infrastructure

9.1. Base Hospital Role: Summarize any updates or changes made to the role of the base hospital, if applicable, in determining trauma patient destination.
- Summary: _____

9.2. Helicopter Landing Sites: A local EMS agency (LEMSA) may require trauma centers to have helicopter landing sites. If helicopter landing sites are required, they shall be approved by the Division of Aeronautics, Department of Transportation, pursuant to Title 21, California Code of Regulations, Division 2.5.
- Response:

☐ Not applicable.

☐ All helicopter landing sites are approved by the Division of Aeronautics.
☐ One or more helicopter landing sites are not currently approved by the Division of Aeronautics.

☐ If not approved, explain below:

9.3. Communications: All trauma patient transport vehicles shall be equipped with twoway telecommunications equipment capable of communicating with hospitals, in accordance with LEMSA communication policies.
- Response:

☐ All trauma patient transport vehicles are equipped with two-way telecommunications equipment capable of communicating with hospitals.

☐ One or more trauma patient transport vehicles are not currently equipped with two-way telecommunications equipment capable of communicating with hospitals.

☐ If not equipped, explain below:

9.4. Transport Resources: Summarize any updates or changes made to the resources available to transport trauma patients to the appropriate level of trauma center, to include air transport and plan for interfacility transport. Indicate any updates or changes made during the reporting period.
- Summary: _____

9.5. Trauma Center Location Map: Provide a copy of the map showing the location of designated trauma centers. Summarize any updates or changes made during the reporting period.
- Attachment Name(s): _____
- Summary: _____

10. Trauma System Participating Facilities and Agreement Dates

10.1. Attach any intercounty trauma center agreements approved by the LEMSAs in each jurisdiction.
- Attachment Name(s): _____

10.2. Attach any written agreements between the LEMSA and the hospitals participating in the trauma system.
- Attachment Name(s): _____

10.3. Using the table below, provide a list of all trauma centers and the corresponding Memorandums of Agreement (MOA) expiration or anticipated execution dates.

Trauma Center Name	MOA Expiration Date	MOA Anticipated Execution Date

11. Fee Schedule

11.1. Attach the current fee schedule, including fees for application, designation, redesignation, and monitoring and evaluation. Summarize any updates or changes made during the reporting period.
- Attachment Name(s): _____
- Summary: _____

11.2. Attach the reporting form or template provided to trauma centers showing how fees are applied. Summarize any updates or changes made during the reporting period.
- Attachment Name(s): _____
- Summary: _____

11.3. Using the table below, provide a detailed report on the utilization of collected fees. The report should clearly inform facilities of the specific application of these fees and assure EMSA that all expenditures comply with the requirements of §1798.164.

Facility Name	Fees Charged (Annual)	Activities Covered by Fees	Detailed Summary of Fee Expenditures
Example Medical Center	$XXX,XXX	Personnel/Salary, Trauma Center Site Visits, Contracted Services, Data Collection, Performance Improvement Activities	Personnel / Salaries: $XX,XXX Contracted Reviewer Services: $XX,XXX Site Visit Travel & Lodging: $XX,XXX Data Registry Licensing/Maintenance: $XX,XXX PI Support Activities: $XX,XXX

County Hospital	$XXX,XXX	Personnel/Salary, Trauma Center Site Visits, Contracted Services, Data Collection, Performance Improvement Activities	Personnel / Salaries: $XX,XXX Contracted Reviewer Services: $XX,XXX Site Visit Travel & Lodging: $XX,XXX Data Registry Licensing/Maintenance: $XX,XXX PI Support Activities: $XX,XXX

12. Data Collection

12.1. Summarize any updates or changes to the methods by which trauma-related data is collected and submitted from EMS providers and designated trauma centers to the LEMSA and to EMSA.
Summary: _____

13. Quality Improvement Integration

13.1. Summarize any updates or changes to the integration of trauma into an existing quality improvement committee and any trauma-specific quality improvement committees.

- Summary: _____

14. Public Education & Injury Prevention

14.1. Summarize any updates or changes to programs or campaigns focused on trauma-related public education, including injury prevention.

- Summary: _____

15. GACH Data Submission

15.1. Each designated trauma center is required to collect and submit GACH data elements to EMSA. These data elements must be submitted to EMSA within ninety (90) days of the patient's discharge.

- Response:
  ☐ All trauma centers are in compliance with the 90-day submission requirement.

  ☐ One or more trauma centers are not currently in compliance.

  ☐ If not in compliance, explain below:

16. Performance Improvement and Patient Safety (PIPS)

16.1. All trauma centers, regardless of level, must have a PIPS process that is independent of, but reports to, the GACH Performance or Quality Improvement program.

- Response:
  ☐ All trauma centers are in compliance with the PIPS program requirement.

  ☐ One or more trauma centers are not currently in compliance.

  ☐ If not in compliance, explain below:

17. Quality Improvement (QI) Program Integration

17.1. Trauma care must be integrated into the LEMSA's overall QI program.

- Response:

☐ LEMSA is in compliance with the QI program requirement.

☐ One or more trauma centers are not currently in compliance.

☐ If not in compliance, explain below:

18. Periodic Performance Evaluation

18.1. Periodic performance evaluation of the trauma system shall be conducted at least every three (3) years.

- Response:

☐ A trauma system performance evaluation has been conducted within the past three (3) years. Date of last evaluation: _____

  - Attach the most recent performance evaluation report.
  - Attachment Name: _____

☐ A trauma system performance evaluation has not been conducted within the past three (3) years.

☐ If not conducted, explain below:

19. Level IV Trauma Center Minimum Requirements

19.1. A GACH meeting the minimum requirements of §100142.03 may be designated by the LEMSA as a Level IV trauma center.

- Response:

☐ Not applicable

☐ All Level IV trauma centers are in compliance with the minimum requirements.

☐ One or more Level IV trauma centers are not in compliance with the minimum requirements.

☐ If not in compliance, explain below:

20. Public Posting Requirement

20.1. The LEMSA is required to share this Trauma System Status Report on its public website upon approval by EMSA for at least one (1) year. Provide the LEMSA Website URL where the report will be posted.

- LEMSA Website URL: _____

21. Comments to EMSA (optional)

21.1. Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your Trauma System Status Report submission. This may include challenges encountered in developing or updating the plan, anticipated needs for technical assistance or support, data limitations or planned improvements in data collection, ongoing or upcoming projects that may impact trauma care delivery, or feedback on regulatory requirements or submission processes.

- Comments: _____

22. Certification

22.1. I hereby certify that the information provided in this Trauma System Status Report is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.

Local EMS Agency Administrator/Director

Name: _____

Title: _____

Signature: _____

Date: _____

Emergency Medical Services Authority

Initial STEMI Critical Care System Plan Template Pursuant to:

California Health and Safety Code Division 2.5, Chapter 4, Article2, §1797.258 and

California Code of Regulations Title 22, Division 9, Chapter 6.2, Article 1, §100144.01 & §100146.03

A Local Emergency Medical Services Agency (LEMSA) implementing a STEMI critical care system plan approved by the California Emergency Medical Services Authority (EMSA) prior to system implementation.

Reporting Period: Date of Submission: _____

_____

Submitted by:

LEMSA Name: _____

Agency Address: _____

City, State, ZIP: _____

Primary Contact Person: _____

Title: _____

Phone Number: _____ _____

Email Address:

_____

Disclosure:

If additional space is needed to fully respond to any section of this template, please attach a separate document clearly labeled with the name of the submitting LEMSA, the section number and section title on all supplemental pages.

Submission Instructions:

Submit completed reports to EMSA via email or mail:

Plans@emsa.ca.gov

California Emergency Medical Services Authority

Attention: EMS Plans Coordinator

11120 International Drive, Suite 200 Rancho

Cordova, CA 95670

1. STEMI Critical Care System Plan Components

Please complete or attach documentation for each required element. All fields are mandatory unless otherwise stated.

2. Personnel

Names and Titles of LEMSA Personnel with Roles in STEMI Care: *(List all relevant staff and their roles)*

Name	Title	Role in STEMI System

3. STEMI Designated Facilities

Provide a list of designated STEMI Centers (in your Jurisdiction Only) and the expiration dates of current agreements with LEMSA.

Facility Name	Designation Level of Care (STEMI Referring Hospital/ STEMI Receiving Center)	Agreement Expiration Date

4. STEMI Patient Identification and Destination Policy

Attach or describe the LEMSA's policy on STEMI patient identification and destination, including other relevant cardiac protocols.

☐ Document Attached

☐ Policy Description Below:

5. Field Communication Policy

Attach or describe the communication protocol from field providers to the receiving General Acute Care Hospital (GACH) for STEMI patients.

☐ Document Attached

☐ Policy Description Below:

6. Interfacility Transfer Policy

Attach or describe the policy that facilitates the interfacility transfer of acute STEMI patients.

☐ Document Attached
☐ Policy Description Below:

7. Data Collection Method

Describe the method for data collection from EMS providers and STEMI receiving centers to both the LEMSA and EMSA.

8. Integration with Neighboring Jurisdictions

Attach or describe policy on integrating receiving centers in neighboring jurisdictions.

☐ Document Attached
☐ Policy Description Below:

9. Quality Improvement (QI)

Check and complete one of the following options:

☐ Description of how STEMI and cardiac care are integrated into an existing QI committee ☐ Description of a STEMI-specific QI committee

Explain Selected Description:

10. Public Education Programs

Describe programs conducted or promoted by the LEMSA for public education related to cardiac care.

11. Comments to EMSA (optional)

Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your STEMI critical care system plan submission. This may include:

- Challenges encountered in developing or updating the plan
- Anticipated needs for technical assistance or support
- Data limitations or planned improvements in data collection
- Ongoing or upcoming projects that may impact trauma care delivery
- Feedback on regulatory requirements or submission processes

12. Certification

I hereby certify that the information provided in this STEMI critical care system plan is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.

Local EMS Agency Administrator/Director

Name: _____

Title: _____

Signature _____

Date:

Emergency Medical Services Authority

Annual STEMI Critical Care System Plan Update Template Pursuant to:

California Health and Safety Code Division 2.5, Chapter 4, Article 2, §1797.258 and

California Code of Regulations Title 22, Division 9, Chapter 6.2 Article 1, §100144.01 & §100146.04

The Local Emergency Medical Services Agency (LEMSA) shall submit an annual update of its STEMI critical care system plan as part of its annual EMS plan submittal to the California Emergency Medical Services Authority (EMSA). The report shall include any changes to the STEMI critical care system since submission of the previous annual plan update.

Reporting Period: _____

Date of Submission: _____

Submitted by:

LEMSA Name: _____

Agency Address: _____

City, State, ZIP: _____

Primary Contact Person: _____

Title: _____

Phone Number: _____ _____

Email Address: _____

Disclosure:

If additional space is needed to fully respond to any section of this template, please attach a separate document clearly labeled with the name of the submitting LEMSA, the section number and section title on all supplemental pages.

Submission Instructions:

Submit completed reports to EMSA via email or mail:

Plans@emsa.ca.gov

California Emergency Medical Services Authority

Attention: EMS Plans Coordinator

11120 International Drive, Suite 200

Rancho Cordova, CA 95670

1. STEMI Critical Care System Plan Components

Please describe any changes in the STEMI critical care system since submission of the prior annual plan update.

2. Personnel

Names and Titles of LEMSA Personnel with Roles in STEMI Care:
(List all relevant staff and their roles)

Name	Title	Role in STEMI System

3. STEMI Designated Facilities

Please provide a list of designated STEMI Centers (in your Jurisdiction Only) and the expiration dates of current agreements with LEMSA.

Facility Name	~~Designation Level of Care (STEMI~~ Referring Hospital/ STEMI Receiving Center)	Agreement Expiration Date

4. Quality Improvement (QI)

Please describe the STEMI critical care system quality improvement activities and the existing QI committee.

5. STEMI Data Collection and Submission.

Please provide the status of collection and submission of the STEMI Data to the EMSA Data system.

6. STEMI Critical Care System Goals and Objectives.

Please describe the status of the STEMI critical care system goals and objectives, including progress made on addressing action items and any recommendations provided by EMSA within the previous reporting period.

7. Comments to EMSA (optional)

Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your STEMI critical care system Plan submission. This may include:

- Challenges encountered in developing or updating the plan
- Anticipated needs for technical assistance or support
- Data limitations or planned improvements in data collection
- Ongoing or upcoming projects that may impact trauma care delivery
- Feedback on regulatory requirements or submission processes

8. Certification

I hereby certify that the information provided in this STEMI critical care system plan Update is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.

Local EMS Agency Administrator/Director

Name: _____

Title: _____

Signature: _____

Date: _____

Emergency Medical Services Authority

Initial Stroke Critical Care System Plan Template Pursuant to:

California Health and Safety Code Division 2.5, Chapter 4, Article 2, §1797.258 and

California Code of Regulations Title 22, Division 9, Chapter 6.3 Article 1, §100149.01 & §100151.03

A Local Emergency Medical Services Agency (LEMSA) implementing a Stroke Critical Care System Plan approved by the California Emergency Medical Services Authority (EMSA) prior to system implementation.

Reporting Period: _____

Date of Submission: _____

Submitted by:

LEMSA Name: _____

Agency Address: _____

City, State, ZIP: _____

Primary Contact Person: _____

Title: _____

Phone Number: _____ _____

Email Address:

_____

Disclosure:

If additional space is needed to fully respond to any section of this template, please attach a separate document clearly labeled with the name of the submitting LEMSA, the section number and section title on all supplemental pages.

Submission Instructions:

Submit completed reports to EMSA via email or mail:

Plans@emsa.ca.gov

California Emergency Medical Services Authority

Attention: EMS Plans Coordinator

11120 International Drive, Suite 200

Rancho Cordova, CA 95670

(1) **Stroke Critical Care System Plan Components**

This form must be submitted with all required documentation or detailed descriptions attached or included below.

(2) **Personnel Roles**

List the names and titles of LEMSA personnel who have a role in the stroke critical care system.

(List all relevant staff and their roles)

Name	Title	Role in Stroke System

(3) **Stroke Designated Facilities**

Provide a list of designated stroke centers (in your Jurisdiction Only) and the expiration dates of current agreements with the LEMSA.

Facility Name	~~Designation Level of Care~~ (Stroke Referring Hospital/ Stroke Receiving Center)	Agreement Expiration Date

(4) **Stroke Identification and Destination Policies**

Attach or describe the LEMSA's stroke identification and destination protocols.

☐ Document(s) Attached

☐ Description Provided Below:

(5) **Field Communication Policy**

Attach or describe the communication protocol between field personnel and receiving General Acute Care Hospital (GACH) for stroke patients.

☐ Document(s) Attached

☐ Description Provided Below:

(6) **Interfacility Transfer (IFT) Policy**

Attach or describe the LEMSA policy that facilitates interfacility transfer of stroke patients.

☐ Document(s) Attached
☐ Description Provided Below:

(7) **Data Collection Methods**

Describe the data collection process from EMS providers and designated stroke GACHs to the LEMSA and EMSA.

(8) **Integration of Out-of-Jurisdiction Receiving Centers**

Attach or describe the policy on integrating stroke receiving centers in neighboring jurisdictions.

☐ Document(s) Attached
☐ Description Provided Below:

(9) **Quality Improvement (QI) Integration**

Select one of the following and provide the required description:
☐ Integration of stroke care into an existing QI committee
☐ Establishment of a stroke-specific QI committee

Description:

(10) **Public Education Programs**

Describe programs conducted or supported by the LEMSA that promote public education on stroke recognition and prevention.

(11) **Comments to EMSA** (optional)

Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your Stroke System Plan submission. This may include:

- Challenges encountered in developing or updating the plan
- Anticipated needs for technical assistance or support
- Data limitations or planned improvements in data collection
- Ongoing or upcoming projects that may impact trauma care delivery
- Feedback on regulatory requirements or submission processes

(12) **Certification**

I hereby certify that the information provided in this Stroke Critical Care System Plan is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.
Local EMS Agency Administrator/Director

Name: _____

Title: _____

Signature: _____

Date: _____

Emergency Medical Services Authority

Annual Stroke Critical Care System Plan Update Template Pursuant to:

California Health and Safety Code Division 2.5, Chapter 4, Article2, §1797.258

California Code of Regulations Title 22, Division 9, Chapter 6.3, Article 1 §100149.01 & §100151.04

The Local Emergency Medical Services Agency (LEMSA) shall submit a Stroke Critical Care Plan Update to the California Emergency Medical Services Authority (EMSA) as part of its annual EMS Plan update. The report shall include any changes to the Stroke Critical Care Plan since submission of the previous annual plan update.

Reporting Period: _____
Date of Submission: _____

Submitted by:
LEMSA Name: _____
Agency Address: _____
City, State, ZIP: _____
Primary Contact Person: _____
Title: _____
Phone Number: _____ _____
Email Address:
_____

Disclosure:

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Plans@emsa.ca.gov

California Emergency Medical Services Authority

Attention: EMS Plans Coordinator

11120 International Drive, Suite 200

Rancho Cordova, CA 95670

1. Stroke Critical Care System Plan Components

Please describe any changes in the Stroke Critical Care System since submission of the prior annual plan update.

2. Personnel Roles

List the names and titles of LEMSA personnel who have a role in the stroke critical care system.

(List all relevant staff and their roles)

Name	Title	Role in Stroke System

3. Stroke Designated Facilities

Please provide a list of designated Stroke Centers (in your Jurisdiction Only) and the expiration dates of current agreements with LEMSA.

Facility Name	Designation Level of Care	Agreement Expiration Date

4. Quality Improvement (QI)

Please describe the Stroke Critical Care System quality improvement activities and the existing QI committee.

5. Stroke Data Collection and Submission.

Please provide the status of collection and submission of the Stroke Data to the EMSA Data system.

6. Stroke Critical Care System Goals and Objectives.

Please describe the status of the Stroke Critical Care System goals and objectives, including progress made on addressing action items and any recommendations provided by EMSA within the previous reporting period.

7. Comments to EMSA (optional)

Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your Stroke Critical Care System Plan submission. This may include:

- Challenges encountered in developing or updating the plan
- Anticipated needs for technical assistance or support
- Data limitations or planned improvements in data collection
- Ongoing or upcoming projects that may impact trauma care delivery
- Feedback on regulatory requirements or submission processes

8. Certification

I hereby certify that the information provided in this Stroke Critical Care System Plan Update is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.

Local EMS Agency Administrator/Director

Name: _____

Title: _____

Signature: _____

Date: _____

Emergency Medical Services Authority

Initial Emergency Medical Services for Children (EMSC) Program Plan Template Pursuant to:

California Health and Safety Code Division 2.5, Chapter 12, §1799.205

California Code of Regulations Title 22, Division 9, Chapter 6.4 Article 3 §100157.03 The Local Emergency Medical Services Agency (LEMSA) shall submit an EMSC Program Plan approved by the California Emergency Medical Services Authority (EMSA) prior to plan implementation.

Reporting Period: _____
Date of Submission: _____

Submitted by:
LEMSA Name: _____
Agency Address: _____
City, State, ZIP: _____
Primary Contact Person: _____
Title: _____
Phone Number: _____
Email Address: _____

Disclosure:

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California Emergency Medical Services Authority

Attention: EMS Plans Coordinator

11120 International Drive, Suite 200 Rancho

Cordova CA, 95670

1. Required EMSC Components

Submit all required components either by completing the form below or attaching documents as specified. Select how information is provided:

☐ Document Attached

☐ Information Provided Below

2. EMSC Program Goals and Objectives

Provide goals and objectives for developing and implementing an EMSC program in alignment with EMSC regulations.

3. LEMSA Personnel

Provide the names and titles of personnel who have a role in planning, implementation, and management of the EMSC program.

Name	Title	Role in EMSC Program

4. Injury and Illness Prevention Summary

Provide a summary of the injury and illness prevention coordination efforts with public and private agencies and trauma centers to address pediatric patient needs.

5. Prehospital Pediatric Care Policies

Attach or describe protocols for each area of pediatric EMS services:

First Response Non-Transport:

☐ Attached ☐ Described: _____

Transport:

☐ Attached ☐ Described: _____

Interfacility Transfer (IFT):

☐ Attached ☐ Described: _____

Critical Care:

☐ Attached ☐ Described: _____

6. Pediatric-Specific Requirements

Personnel Training Policy

☐ Attached ☐ Described Below: _____

Pediatric Ambulance Equipment Policy☐ Attached ☐ Described Below:

7. Quality Improvement Plan

☐ QI Plan Attached

☐ Summary Provided Below:

8. Pediatric Critical Care & Trauma Facilities

Facility Name	Address	Designation (Pediatric Trauma, NICU, PICU, Burn Center, Pediatric Psych and etc.)

9. Designated GACHs Participating in EMSC System

Facility Name	Agreement Expiration Date

10. Pediatric Physical Rehabilitation Facilities

Facility Name	Type of Rehab Services Offered

11. Pediatric Readiness Recognition Program

Describe LEMSA's recognition program and implementation for EMS providers and EDs in achieving the EMSC standards.

12. Pediatric Patient Destination Policies

☐ Policies Attached

☐ Summary Provided Below:

13. Field Communication to Receiving GACH

Describe method used for EMSC patient communication to GACHs.

14. Data Collection Method

Describe how data is collected from EMS providers and GACHs to the LEMSA and EMSA.

15. Integration of Pediatric Receiving Centers (PedRCs) Across Jurisdictions

☐ Policy Attached
☐ Summary Provided Below:

16. Pediatric Surge Planning

Attach or describe LEMSA's pediatric surge preparedness plan.
☐ Plan Attached
☐ Summary Provided Below:

17. Comments to EMSA (optional)

Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your EMSC Program Plan submission. This may include:

- Challenges encountered in developing or updating the plan
- Anticipated needs for technical assistance or support
- Data limitations or planned improvements in data collection
- Ongoing or upcoming projects that may impact trauma care delivery
- Feedback on regulatory requirements or submission processes

18. Certification

I hereby certify that the information provided in this EMSC Program Plan is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.

Local EMS Agency Administrator/Director

Name: _____

Title: _____

Signature: _____

Date: _____

Emergency Medical Services Authority

Annual Emergency Medical Services for Children (EMSC) Program Plan Update Pursuant to:
California Health and Safety Code Division 2.5, Chapter 12, §1799.205
California Code of Regulations Title 22, Division 9, Chapter 6.4 Article 4 §100157.04 The Local Emergency Medical Services Agency (LEMSA) shall submit an EMSC Program Plan to the California Emergency Medical Services Authority (EMSA) as part of its annual EMS Plan update. The report shall include any changes to the EMSC Plan since submission of the previous annual plan update.

Reporting Period: _____
Date of Submission: _____

Submitted by:
LEMSA Name: _____
Agency Address: _____
City, State, ZIP: _____
Primary Contact Person: _____
Title: _____
Phone Number: _____
Email Address: _____

Disclosure:

If additional space is needed to fully respond to any section of this template, please attach a separate document clearly labeled with the name of the submitting LEMSA, the section number and section title on all supplemental pages.

Submission Instructions:

Submit completed reports to EMSA via email or mail:
Plans@emsa.ca.gov
California Emergency Medical Services Authority
Attention: EMS Plans Coordinator
11120 International Drive, Suite 200 Rancho
Cordova, CA 95670

1. Plan Update

Provide a summary of changes to the EMSC Program since the prior annual update.

2. Program Goals and Objectives

Provide status of the EMSC Program goals and objectives.

3. Performance Improvement

Provide a summary of the EMSC Program performance improvement activities for the reporting period.

4. Action Items & Recommendations (if applicable)

Provide the status of any outstanding action items and recommendations from EMSA related to the EMSC program or Status Report approval letter.

5. Comments to EMSA (optional)

Please use the space below to provide any additional comments, clarifications, or contextual information relevant to your EMSC Program Plan submission. This may include:

- Challenges encountered in developing or updating the plan
- Anticipated needs for technical assistance or support
- Data limitations or planned improvements in data collection
- Ongoing or upcoming projects that may impact trauma care delivery
- Feedback on regulatory requirements or submission processes

6. Certification Statement

I hereby certify that the information provided in this EMSC Program Plan Update is accurate and complete to the best of my knowledge, and that all statements made are truthful and made in good faith.

Local EMS Agency Administrator/Director

Name: _____

Title: _____

Signature: _____

Date: _____

STEMI Receiving Hospital STEMI patient data elements:

EMS Intervention EMS Incident Number

Column Header: runnum

Enter the emergency medical services agency Run number. The Run Number is assigned to the responding units through a dispatch process. Multiple EMS units may have the same or differing run numbers depending on the local dispatch processes.

EMS Run Number

Data Format [Text] **TR7.1**

Definition

The EMS Run number is assigned by the EMS agency that generated the incident. The NEMSIS data section is eResponse.03 (Incident Number)

Data Type	2		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No	**Maximum Constraint**	50

EMS First ECG Obtained Date Time

Column Header: firstecgdt

Enter the date and time of the first 12 lead ECG was obtained. The first ECG may have been obtained prior to the patient's arrival at your hospital.

- Select the MM/DD/YYYY HH24:MI format to record both the date and time
- If only the date is known, select the MM/DD/YYYY format
- 24-hour clock (military time)
- Select Unknown if the date is not known

Time First ECG Obtained

Data Format [DateTime] **ST7.1**

Definition

Indicate time of first ECG by pre-hospital provider

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Patient Date of Birth

Column Header: dob

Enter the month, day, and year the patient was born. Format: MM-DD-YYYY.

PatientDateofBirth

Data Format [Date] **TR1.7**

Definition

The Patient's age at the time of injury (best approximation)

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Patient Age

Column Header: age

Enter the patient age.

Patient's Age

Data Format [Number] **TR1.12**

Definition

The patient's age at the time of injury (best approximation).

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Patient Gender

Column Header: gender

Enter the gender identity, self-identified by the patient. This may or may not match sex assigned at birth.

Gender

Data Format [Combo] single-choice **TR1.15**

Definition

The patient's gender.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Field Values

1 Male
2 Female
3 Not Known/Not Recorded

Patient Race

Column Header: race

Enter the patient's self-assessed race/ethnicity, or if not available, the physician or institution's assessment of the patient's race. Assumptions should not be made based on physical characteristics. This data allows for analysis of race-related patterns of care. If patient is multiracial, select each race they designate.

Enter UTD if the race is not documented in the patient medical record.

Although the terms "Hispanic" and "Latino" are descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select "White". If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic - select "Black").

If the patient is Asian or Native Hawaiian/Pacific Islander, select the specific sub-category (or sub-categories) of race if known. If a subcategory is not documented, leave the subcategory options blank.

Race

Data Format
[Combo] multiple-choice

TR1.16

Definition

The patient's race.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Field Values

1 American Indian or Alaska Native
2 Black or African American
3 White
4 Asian
5 Native Hawaiian or Other Pacific Islander
6 Unable To Determine

Race Asian

Data Format
[Combo] multiple-choice

TR1.16.17

Definition

Race Asian

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Race Native Hawaiian

Data Format
[Combo] multiple-choice

TR1.16.18

Definition

Race Native Hawaiian

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Emergency Department Acute Care

Admission Time Column Header: arrdt

Enter the time the patient arrived at your hospital.

- Time should be recorded using the 24-hour clock (military time)

ED Admission Time

Data Format
[Time]

TR18.56

Definition

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Cath Lab Patient Arrival Time

Column Header: ptarvcth

Enter the time of when the patient arrived at the Cath Lab.

- 24-hour clock (military time)

Patient Cath Lab Arrival Time

Data Format
[Time]

ST3.3.2

Definition

Indicate the time the patient arrived to the cath lab where the PCI was being performed as documented in the medical record.

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

PCI Procedure Performed

Column Header: primarypci

Enter Yes if the patient received PCI at this hospital during this episode of care. Enter No if PCI was not performed at this hospital during this episode of care or unable to determine from medical record documentation.

PCI Procedure

Data Format
[Radio]

TR35.70

Definition

Indicate if the patient had a percutaneous coronary intervention (PCI).

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Yes **2** No

First PCI Date

Column Header: fstpci

Enter the Date of when the PCI was initiated in the Cath Lab. Team would consist of the minimum number of personnel to perform procedure needed. Additional information: This is a process measure about the timeliness of treatment. It is NOT a clinical outcomes measure based on TIMI flow or clinical reperfusion. It does not matter whether the baseline angiogram showed TIMI 3 flow or if the final post-PCI angiogram showed TIMI 0 flow.
What is being measured is the time of the first mechanical treatment of the culprit lesion, not the time when TIMI 3 flow was (or was not) restored.

Enter the date the guidewire was introduced if the lesion could not be crossed.

- Select the MM/DD/YYYY format

First PCI Date

Data Format
[Date]

TR35.FirstPCI_Date

Definition

First Percutaneous Coronary Intervention (PCI) Date

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

First PCI Time

Column Header: fstpci

Enter the Time of when the PCI was initiated in the Cath Lab. Team would consist of the minimum number of personnel to perform procedure needed. Additional information: This is a process measure about the timeliness of treatment. It is NOT a clinical outcomes measure based on TIMI flow or clinical reperfusion. It does not matter whether the baseline angiogram

showed TIMI 3 flow or if the final post-PCI angiogram showed TIMI 0 flow.
What is being measured is the time of the first mechanical treatment of the culprit lesion, not the time when TIMI 3 flow was (or was not) restored.

Enter the time the guidewire was introduced if the lesion could not be crossed.

- Select the MM/DD/YYYY HH24:MI format to record both the date and time
- 24-hour clock (military time)

First PCI Time

Data Format
[Time]

TR35.FirstPCI_Time

Definition

First Percutaneous Coronary Intervention (PCI) Time

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Reason no PCI

Column Header: nperfpci

Enter one primary reason that is documented in the medical record why primary PCI was not performed during this episode of care at this hospital. Select Not Performed if your hospital is not a PCI center and does not perform this procedure. If a reason is not documented in the medical record, enter No reason documented.

Reason no PCI

Data Format
[Combo]
single-choice

ST3.4

Definition

If reperfusion indicated and no PCI, why?

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Non-compressible vascular puncture(s)
10 Anatomy not suitable to primary PCI
11 Prior allergic reaction to IV contrast
2 Spontaneous reperfusion (documented by cath only)
3 Other
4 Active bleeding on arrival or within 24 hours
5 Patient/family refusal
6 Not performed (not a PCI center)
7 Quality of life decision
8 DNR at time of treatment decision
9 No reason documented

Thrombolytics Administered

Column Header: thromb

Enter Yes if a thrombolytic was administered at this hospital during this episode of care or

while en route to this hospital. Enter No if a thrombolytic was not administered at this hospital or during this episode of care or unable to determine from medical record documentation.

Thrombolytics

Data Format
[Radio]

ST3.20

Definition

Indicate if the patient received thrombolytic therapy as an urgent treatment for STEMI.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Yes **2** No

Thrombolytics Administered Start

Time Column Header: dosest

Enter the time of thrombolytic administered in patient.

- 24-hour clock (military time)

Thrombolytics Dose Start Time

Data Format
[Time]

ST3.23.1

Definition

Indicate the time of either the first bolus or the beginning of the thrombolytic infusion.

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Reason Thrombolytics Not Administered

Column Header: nadmlytc

Enter one primary reason that is documented in the medical record why thrombolytics were not administered during this episode of care at this hospital. If a reason is not documented in the medical record, enter No reason documented.

Reason Thrombolytics Not Administered

Data Format
[Radio]

ST3.26

Definition

Indicate the one primary reason, documented in the medical record, that thrombolytics were not administered as reperfusion therapy.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Known bleeding diathesis
10 Any prior intracranial hemorrhage
11 Pregnancy
12 Expected DTB < 90 minutes
13 Suspected aortic dissection
14 Intracranial neoplasm, AV malformation, or aneurysm
15 No reason documented
16 Prior allergic reaction to thrombolytics
17 Other
2 Recent surgery/trauma
3 Severe uncontrolled hypertension
4 Ischemic stroke w/in 3 months (except acute ischemic stroke within 3 hours)
5 Significant close head or facial trauma (within previous 3 months)
6 DNR at time of treatment decision
7 Recent bleeding within 4 weeks
8 Active peptic ulcer
9 Traumatic CPR that precludes thrombolytics

Facility Discharge Time

Column Header: disdate

Enter the time the patient was discharged from acute care, left against medical advice, or expired during this stay (at your hospital).

- 24-hour clock (military time)

Hospital Discharge Time

Data Format
[Time]

TR25.48

Definition

The time the patient was discharged from the hospital.

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Referring Facility Arrival Time

Column Header: outhosp

For STEMI patients referred for PCI from another facility, Enter the time the patient arrived to the **Referring** Hospital.

- 24-hour clock (military time)

Referring Hospital Arrival Time

Data Format [Time] **TR33.3**

Definition

Indicate the time the patient arrived at the outside facility.

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Referring Facility Discharge Time

Column Header: transout

For STEMI patients referred for PCI from another facility, enter the time the patient was discharged from Referring Hospital, left against medical advice, or expired during this stay (at your hospital).

- 24-hour clock (military time)

Referring Hospital Discharge Time

Data Format [Time] **TR33.31**

Definition

Indicate the time the patient left the outside facility.

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Name of Transferring Facility

Column Header: transfac

Enter the name of the transferring facility.

Referring Facility Name

Data Format
[Combo] single-choice

TR33.1

Definition

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Facility Discharge Disposition

Column Header: dschstat

Enter the place or setting to which the patient was discharged:

- Home
- Hospice – Home
- Hospice – Health Care Facility
- Acute Care Facility
- Other Health Care Facility
- Expired
- Left Against Medical Advice/AMA
- Not Documented or Unable to Determine (UTD)

Discharge Status

Data Format
[Combo] single-choice

TR25.27

Definition

The disposition of the patient when discharged from the hospital.

Data Type	2		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Field Values

1 Discharged to home or self-care (routine discharge)
2 Hospice - Home
3 Hospice - Health Care Facility
4 Acute care hospital
5 Other
6 Deceased/Expired

ICD-10 Diagnosis

The following list of the ICD-10-CM codes can be used to determine the facility's AMI patient population. ICD-10-CM Code/Categories Description All codes within the code range are

included

• I21.01 - I21.09 ST elevation (STEMI) myocardial infarction of anterior wall

• I21.11 - I21.19 ST elevation (STEMI) myocardial infarction of inferior wall

• I21.21 - I21.29 ST elevation (STEMI) myocardial infarction of other sites

• I21.3 ST elevation (STEMI) myocardial infarction of unspecified site

• I21.4 Non-ST elevated (NSTEMI) myocardial infarction I21.9 Acute myocardial infarction, unspecified

Other Cardiac Diagnoses

A facility may choose to also enter patients with other diagnoses pertaining to acute coronary syndrome such as unstable angina or coronary artery disease into CEMSIS; however, these cases are not included in any of the CEMSIS measure populations. Only records identified as STEMI or STEMI equivalent or with positive cardiac biomarkers in the first 24 hours are included in the measure initial patient populations.

Patient records with a diagnosis of myocardial infarction type 2, 3, 4a, 4b, 4c or 5 and without a code from the list below should NOT be entered into the registry.

Stroke Patient Care Data Dictionary

Stroke Receiving Hospital Stroke patient data elements:

EMS Intervention EMS Incident Number

Column Header: emsrunseq

Enter the emergency medical services agency Run number. The Run Number is assigned to the responding units through a dispatch process. Multiple EMS units may have the same or differing run numbers depending on the local dispatch processes.

EMS Run Number

Data Format [Text] **TR7.1**

Definition

The EMS Run number is assigned by the EMS agency that generated the incident. The NEMSIS data section is eResponse.03 (Incident Number)

Data Type	2			
Multiple Entry Configuration	No	**Accept NULL Value**	Yes	
NTDS Required	No		**Maximum Constraint**	50

EMS Intervention Service Name

Column Header: emsagencylist:ems_agency_name Enter the name

of the EMS service.

Name of EMS Service

Data Format [Combo] single-choice **TR7.3**

Definition

The name of the EMS service the patient was transferred from.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Patient Date of Birth

Column Header: dob

Enter the month, day, and year the patient was born. Format: MM-DD-YYYY.

PatientDateofBirth

Data Format [Date] **TR1.7**

Definition

The Patient's age at the time of injury (best approximation)

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Patient Age

Column Header: age

Enter the patient age.

Patient's Age

Data Format [Number] **TR1.12**

Definition

The patient's age at the time of injury (best approximation).

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Patient Gender Identity

Column Header: patgenid

Enter the gender identity, self-identified by the patient. This may or may not match sex assigned at birth.

Patient Gender Identity

Data Format [Combo] single-choice **TR1.51**

Definition

Patient Gender Identity

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Male
2 Female
3 Female-to-Male (FTM)/Transgender Male/Trans Man
4 Male-to-Female (MTF)/Transgender Female/Trans Woman
5 Genderqueer, neither exclusively male nor female
6 Additional gender category or other
7 Did not disclose

Patient Race

Column Header: race

Enter the patient's self-assessed race/ethnicity, or if not available, the physician or institution's assessment of the patient's race. Assumptions should not be made based on physical characteristics. This data allows for analysis of race-related patterns of care. If patient is multiracial, select each race they designate.

Enter UTD if the race is not documented in the patient medical record.

Although the terms "Hispanic" and "Latino" are descriptions of the patient's ethnicity, it is not uncommon to find them referenced as race. If the patient's race is documented only as Hispanic/Latino, select "White". If the race is documented as mixed Hispanic/Latino with another race, use whatever race is given (e.g., Black-Hispanic - select "Black").

If the patient is Asian or Native Hawaiian/Pacific Islander, select the specific sub-category (or sub-categories) of race if known. If a subcategory is not documented, leave the subcategory options blank.

Race

Data Format
[Combo]
multiple-
choice

TR1.16

Definition

The patient's race.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	Yes		

Field Values

1 American Indian or Alaska Native
2 Black or African American
3 White
4 Asian
5 Native Hawaiian or Other Pacific Islander
6 Unable To Determine

Race Asian

Data Format
[Combo]
multiple-
choice

TR1.16.17

Definition

Race Asian

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Race Native Hawaiian

Data Format
[Combo]
multiple-
choice

TR1.16.18

Definition

Race Native Hawaiian

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Emergency Department Acute Care Admission Time

Column Header: arrdt

Enter the time the patient arrived at your hospital.

• Time should be recorded using the 24-hour clock (military time)

ED Admission Time

Data Format
[Time]

TR18.56

Definition

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Thrombolytic Used

Column Header: thromboused
Enter the type of thrombolytic used.

Thrombolytic Used

Data Format
[Combo]
single-choice

SK36.97

Definition

Thrombolytic Used

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Alteplase (Class 1 evidence)

2 Tenecteplase (Class 2 evidence)

IV TPA or Other Thrombolytic Initiated At This Facility Time

Column Header: ivtpaordereddt

Enter the time IV TPA or Other Thrombolytic Initiated At This Facility.

• Time should be recorded using the 24-hour clock (military time)

Time IV tPA (alteplase) Ordered

Data Format
[Time]

SK36.ivtpa_ordered_time

Definition

Time IV tPA (alteplase) Ordered

Data Type	3		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

IV TPA or other thrombolytic At Outside Facility

Column Header: ivtpaoutside

IV tPA at outside hospital

Data Format
[Radio]

SK38.83

Definition

IV tPA at outside hospital

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Yes

2 No

Mechanical Endovascular Reperfusion ICA

Column Header: mer_ica

Mechanical Endovascular Reperfusion ICA

Data Format
[Combo]
single-choice

SK10.6

Definition

Mechanical endovascular reperfusion procedures include the use of retrievable stent and other clot retriever devices, clot suction and intracranial angioplasty.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 Intracranial ICA
2 Cervical ICA
3 Other/UTD

Mechanical Endovascular Reperfusion MCA
Column Header: mer_mca

Mechanical Endovascular Reperfusion MCA

Data Format
[Combo]
single-choice

SK10.7

Definition

Mechanical endovascular reperfusion procedures include the use of retrievable stent and other clot retriever devices, clot suction and intracranial angioplasty.

Data Type	1		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		

Field Values

1 M1
2 M2
3 Other/UTD

ICD 10 Diagnosis

Column Header: I10dschstkdx

ICD 10 Diagnosis

Data Format
[combo]
multiple-choice

TR200.1

Definition

Data Type	2		
Multiple Entry Configuration	No	**Accept NULL Value**	Yes
NTDS Required	No		