



**MATTHEW CONSTANTINE**  
DIRECTOR

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November 30, 2019

Dr. Dave Duncan, MD  
Director, California EMS Authority  
10901 Gold Center Drive, Suite 400  
Rancho Cordova, CA 95670

#### KERN COUNTY EMS PLAN SUBMISSION

Dear Dr. Duncan:

In accordance with Section 1797.254 of the Health and Safety Code, please find enclosed Kern County EMS Program's EMS Plan Update for 2019. Included in this plan you will find copies of our STEMI Policy Update, Stroke Policy Update, Pediatric Receiving Center Policy Update, Trauma System Update and our Paramedic First Responder Policy for your review.

If you have any questions or if you need additional information, please feel free to contact me at (661) 868-5216 or by email at [farissj@kerncounty.com](mailto:farissj@kerncounty.com).

Sincerely,

Jeff Fariss  
EMS Program Manager

November 30, 2019

### **2019 EMS Plan Update – Kern County**

Kern County EMS is pleased to present the 2019 EMS Plan Update. The purpose of this notice is to provide a summary of the contents of the EMS Plan Update and highlight some of the work the Program has completed and is working toward for the future.

2019 has been an exciting year that has brought many developments to our system. One such development was the creation of a system for the use of the discretionary portion of the Maddy Fund. EMS developed a request form that can be filled out and submitted from our website for requesting a piece of equipment, service or software that would tentatively improve the county EMS system. These requests are researched by EMS staff and a report that includes a recommendation is presented at the next EMCAB meeting.

From May 8th through May 13th, Kern County hosted the largest event in recent history in the Lightning in a Bottle Festival. This is a large music festival that attracts people from all over the United States as well as multiple countries. EMS Staff Members George Baker and Nick Lidgett were assigned to prepare EMS for this event. Together, they developed a comprehensive operations plan for this huge event that was shared with Kern County Fire, Sheriff, Behavioral Health, as well as our local ambulance services. EMS staff were present at the event 24hrs per day throughout to provide centralized dispatch of ambulances, ensure that the event promoters' medical plan was executed appropriately, to manage large scale incidents that might have occurred and assured the timely requisition of additional resources in the event they were needed. This was an extremely important event for Kern County and it was our goal to make sure that it was successful and had as little impact on our system as possible. As a result of our planning and participation in this event we saw only 6 ambulance transports, 5 AMA's, and 3 5150's during this huge event.

At approximately 10:33am, on July 4th, 2019, a 6.4 magnitude earthquake struck the desert outside of Ridgecrest. The EMS Department Operations Center was immediately activated and EMS staff responded and began disaster operations. The county wide Emergency Operations Center was activated very shortly thereafter and together we began the processes of managing the disaster.

EMS' role in managing this disaster included supporting the establishment of a shelter, ordering the transportation of supplies and nurses to respond to and man the shelter, contacting Public Health Nursing to begin the process of recruiting nurses to staff the shelter for an undetermined timeframe, contacting behavioral health and requesting CISM teams respond to provide psychiatric first aid and sending situational reports to the region preparing other areas in case we needed outside assistance. Additionally, The Kern Medical Reserve Corps were polled for volunteer availability. We received 137

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responses of which 54 members indicated they were available and ready to respond. 4 registered nurses, 1 EMT, 1 Paramedic and 1 Physicians assistant were deployed and staffed the Kerr McGee Shelter for a total of 96 hours.

Shortly after the large temblor hit, Ridgecrest Regional Hospital notified us that they were evacuating the facility and requested an ambulance strike team. Hall Ambulance service was immediately contacted and provided 7 ambulances, the Disaster Medical Support Unit and one supervisor unit. These resources responded to Ridgecrest Regional Hospital and successfully evacuated 23 patients to other facilities.

At approximately 8:19pm on July, 5th, 2019, a 7.1 magnitude earthquake struck the Ridgecrest area again. For the second time in 36 hours, the EMS Department Operations Center and the countywide Emergency Operations Centers were activated.

During these two events the 911 call volume in the Ridgecrest area increased by 300%. Liberty ambulance did an outstanding job in managing the call volume over this period. On July 6th, a resource request was made by Ridgecrest Regional Hospital for a second ambulance strike team to respond to the Ridgecrest area in order to provide a break for the Liberty ambulance crews allowing them to get some, much needed, sleep and help relieve first responder fatigue.

The Kern County Fire Department responded to hundreds of calls for gas leaks, fires and assisted in the evacuation of Ridgecrest hospital on July 4th and continued to provide support for the community throughout the event. The Kern County Fire Department Operations Center that was activated on sight in Ridgecrest, was pivotal in assisting EMS in the communication with the hospital command center and vital in the organization of the evacuation.

From July 4th to July 7th, EMS staff manned both the Department Operations Center and the Emergency Operations Center 24 hours per day monitoring and providing resources as requested throughout the system. It should be noted that this is the second large scale disaster that Kern County EMS in conjunction with Kern County Fire, Hall Ambulance, Liberty ambulance as well as other county departments, has managed without needing to reach outside of our county for assistance.

I am very proud of my staff for the outstanding work they performed over these days in July, for their dedication to their work and to the county they service.

EMS is currently in the process of building a Duty Officer Response Vehicle that will act as a mobile command post allowing for response to incidents such as the Ridgecrest earth quakes providing eyes on scene for the MHOAC and thus allowing for a more accurate evaluation and response by EMS.

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On October 9<sup>th</sup>, 2019, the Request for Proposal for Exclusive Operating Areas 1, 7 and 11 was presented to the public and distributed throughout the state. The RFP remained open for 45 days and we are expecting to complete the process and have new contracts signed by April of 2020.

On October 22<sup>nd</sup>, Kern County Public Health, Emergency Medical Services hosted the first of its kind, Mental Health Symposium focusing on overcoming PTSD for first responders. Featured speakers included San Diego Firefighter/Paramedic Ben Vernon, California National Guard Behavioral Health Officer Captain Danial Burns and licensed clinical social worker and division president for Aspire Behavioral Health Courtney S. Rayne. The over 300 attendees included 1<sup>st</sup> responders from Fire, Ambulance and Law enforcement were provided resources and began the discussion that hopefully will lead to a change in the culture of silence equaling strength. More than 20 1<sup>st</sup> responders reached out for assistance from the Kern Behavioral Health CISM team that was present and over 60 individuals have requested assistance in the weeks following the event.

EMS continues its efforts to teach the community hands only CPR, AED, and Stop the Bleed training. In 2019 so far, we have provided hands only cpr and stop the bleed training to hundreds of county employees, teachers and the general public.

EMS continues focusing our attention on Identifying trends and opportunities to improve the health and safety of the community. In 2019 we are implementing an Inappropriate 911 User Policy that should help cut down the number of repeated unnecessary transports.

First response is provided predominately through three (3) fire departments, and on limited availability the Sheriff's Office. Bakersfield City Fire Department provides primarily BLS first response with one ALS response engine. Kern County Fire Department provides BLS services, maintains station in the Pine Mountain Club and one station in Buttonwillow that provide ALS level service. In addition, Kern County Fire has an ALS squad that they staff intermittently for training purposes. California City Fire Department provides ALS first responder services. All three fire departments also operate Fireline Paramedic programs. Kern County Fire Department provides an ALS as well as BLS rescue helicopter services and Kern County Sheriff's Office provides BLS rescue helicopter services. The Sheriff's Office also provides BLS services as part of Search and Rescue teams, training division, and SWAT team operations.

Kern has ten (10) general acute care hospitals that provide basic or stand-by emergency services. The following is a summary of the hospitals providing services pertaining to the EMS system:

Adventist Health Hospital – Bakersfield

- Basic Emergency Services
- Base Hospital
- STEMI Receiving Center

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- Primary Stroke Center
- Level III Pediatric Receiving Center
- Case specific: cardiac, obstetrical, orthopedic, sexual assault

Adventist Health Hospital – Tehachapi

- Basic Emergency Services
- EMS Receiving Hospital

Mercy Hospital – Bakersfield

- Basic Emergency Services
- Base Hospital
- Primary Stroke Center
- Case specific: orthopedic

Mercy Southwest Hospital – Bakersfield

- Basic Emergency Services
- Base Hospital
- Primary Stroke Center
- Case specific: obstetrical, orthopedic

Bakersfield Memorial Hospital – Bakersfield

- Basic Emergency Services
- Base Hospital
- Burn Receiving Center
- STEMI Receiving Center
- Primary Stroke Center
- Level II Pediatric Receiving Center
- Case specific: cardiac, obstetrical, orthopedic

Kern Medical – Bakersfield

- Basic Emergency Services
- Base Hospital
- Level II Trauma Center
- Primary Stroke Center
- Level II Pediatric Receiving Center
- Case specific: obstetrical, orthopedic

Bakersfield Heart Hospital – Bakersfield

- Basic Emergency Services

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- Base Hospital
- STEMI Receiving Center
- Case specific: cardiac

Delano Regional Medical Center – Delano

- Basic Emergency Services
- Base Hospital
- Level IV Pediatric Receiving Center

Kern Valley Healthcare District – Mountain Mesa (Lake Isabella)

- Stand-by Emergency Services
- EMS Receiving Hospital

Ridgecrest Regional Hospital – Ridgecrest

- Basic Emergency Services
- Base Hospital
- Level IV Trauma Center
- Level III Pediatric Receiving Center

Sincerely,

Jeff Fariss  
EMS Program Manager

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**A. SYSTEM ORGANIZATION AND MANAGEMENT**

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Agency Administration:</b>						
1.01	LEMSA Structure		X			
1.02	LEMSA Mission		X			
1.03	Public Input		X			
1.04	Medical Director		X	X		
<b>Planning Activities:</b>						
1.05	System Plan		X			
1.06	Annual Plan Update		X			
1.07	Trauma Planning*		X	X		
1.08	ALS Planning*		X			
1.09	Inventory of Resources		X			
1.10	Special Populations		X	X		
1.11	System Participants		X	X		
<b>Regulatory Activities:</b>						
1.12	Review & Monitoring		X			
1.13	Coordination		X			
1.14	Policy & Procedures Manual		X			
1.15	Compliance w/Policies		X			
<b>System Finances:</b>						
1.16	Funding Mechanism		X			
<b>Medical Direction:</b>						
1.17	Medical Direction*		X			
1.18	QA/QI		X	X		
1.19	Policies, Procedures, Protocols		X	X		

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**A. SYSTEM ORGANIZATION AND MANAGEMENT (continued)**

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
1.20	DNR Policy		X			
1.21	Determination of Death		X			
1.22	Reporting of Abuse		X			
1.23	Interfacility Transfer		X			
<b>Enhanced Level: Advanced Life Support</b>						
1.24	ALS Systems		X	X		
1.25	On-Line Medical Direction		X	X		
<b>Enhanced Level: Trauma Care System:</b>						
1.26	Trauma System Plan		X			
<b>Enhanced Level: Pediatric Emergency Medical and Critical Care System:</b>						
1.27	Pediatric System Plan		X			
<b>Enhanced Level: Exclusive Operating Areas:</b>						
1.28	EOA Plan		X			



**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**B. STAFFING/TRAINING**

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Local EMS Agency:</b>						
2.01	Assessment of Needs		X			
2.02	Approval of Training		X			
2.03	Personnel		X			
<b>Dispatchers:</b>						
2.04	Dispatch Training		X	X		
<b>First Responders (non-transporting):</b>						
2.05	First Responder Training		X	X		
2.06	Response		X			
2.07	Medical Control		X			
<b>Transporting Personnel:</b>						
2.08	EMT-I Training		X	X		
<b>Hospital:</b>						
2.09	CPR Training		X			
2.10	Advanced Life Support		X			
<b>Enhanced Level: Advanced Life Support:</b>						
2.11	Accreditation Process		X			
2.12	Early Defibrillation		X			
2.13	Base Hospital Personnel		X			

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**C. COMMUNICATIONS**

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Communications Equipment:</b>						
3.01	Communication Plan*		X	X		
3.02	Radios		X	X		
3.03	Interfacility Transfer*		X			
3.04	Dispatch Center		X			
3.05	Hospitals		X	X		
3.06	MCI/Disasters		X			
<b>Public Access:</b>						
3.07	9-1-1 Planning/Coordination		X	X		
3.08	9-1-1 Public Education		X			
<b>Resource Management:</b>						
3.09	Dispatch Triage		X	X		
3.10	Integrated Dispatch		X	X		

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**D. RESPONSE/TRANSPORTATION**

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Universal Level:</b>						
4.01	Service Area Boundaries*		X	X		
4.02	Monitoring		X	X		
4.03	Classifying Medical Requests		X			
4.04	Prescheduled Responses		X			
4.05	Response Time*		X	X		
4.06	Staffing		X			
4.07	First Responder Agencies		X			
4.08	Medical & Rescue Aircraft*		X			
4.09	Air Dispatch Center		X			
4.10	Aircraft Availability*	X			X	
4.11	Specialty Vehicles*		X	X		
4.12	Disaster Response		X			
4.13	Intercounty Response*		X			
4.14	Incident Command System		X			
4.15	MCI Plans		X			
<b>Enhanced Level: Advanced Life Support:</b>						
4.16	ALS Staffing		X	X		
4.17	ALS Equipment		X			
<b>Enhanced Level: Ambulance Regulation:</b>						
4.18	Compliance		X			
<b>Enhanced Level: Exclusive Operating Permits:</b>						
4.19	Transportation Plan		X			
4.20	“Grandfathering”		X			
4.21	Compliance		X			
4.22	Evaluation		X			

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**E. FACILITIES/CRITICAL CARE**

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Universal Level:</b>						
5.01	Assessment of Capabilities		X	X		
5.02	Triage & Transfer Protocols*		X			
5.03	Transfer Guidelines*		X			
5.04	Specialty Care Facilities*		X			
5.05	Mass Casualty Management		X	X		
5.06	Hospital Evacuation*		X			
<b>Enhanced Level: Advanced Life Support:</b>						
5.07	Base Hospital Designation*		X			
<b>Enhanced Level: Trauma Care System:</b>						
5.08	Trauma System Design		X			
5.09	Public Input		X			
<b>Enhanced Level: Pediatric Emergency Medical and Critical Care System:</b>						
5.10	Pediatric System Design		X			
5.11	Emergency Departments		X	X		
5.12	Public Input		X			
<b>Enhanced Level: Other Specialty Care Systems:</b>						
5.13	Specialty System Design		X			
5.14	Public Input		X			

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**F. DATA COLLECTION/SYSTEM EVALUATION**

	Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Universal Level:</b>					
6.01 QA/QI Program		X	X		
6.02 Prehospital Records		X			
6.03 Prehospital Care Audits		X	X		
6.04 Medical Dispatch		X			
6.05 Data Management System*		X			
6.06 System Design Evaluation		X			
6.07 Provider Participation		X			
6.08 Reporting		X			
<b>Enhanced Level: Advanced Life Support:</b>					
6.09 ALS Audit		X			
<b>Enhanced Level: Trauma Care System:</b>					
6.10 Trauma System Evaluation		X			
6.11 Trauma Center Data		X	X		

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES****G. PUBLIC INFORMATION AND EDUCATION**

		<b>Does not currently meet standard</b>	<b>Meets minimum standard</b>	<b>Meets recommended guidelines</b>	<b>Short-range plan</b>	<b>Long-range plan</b>
<b>Universal Level:</b>						
7.01	Public Information Materials		X			
7.02	Injury Control		X			
7.03	Disaster Preparedness		X			
7.04	First Aid & CPR Training		X			

**TABLE 1: MINIMUM STANDARDS/RECOMMENDED GUIDELINES**

**H. DISASTER MEDICAL RESPONSE**

		Does not currently meet standard	Meets minimum standard	Meets recommended guidelines	Short-range plan	Long-range plan
<b>Universal Level:</b>						
8.01	Disaster Medical Planning*		X			
8.02	Response Plans		X	X		
8.03	HazMat Training		X			
8.04	Incident Command System		X	X		
8.05	Distribution of Casualties*		X	X		
8.06	Needs Assessment		X	X		
8.07	Disaster Communications*		X			
8.08	Inventory of Resources		X	X		
8.09	DMAT Teams		X	X		
8.10	Mutual Aid Agreements*		X			
8.11	CCP Designation*		X			
8.12	Establishment of CCPs		X			
8.13	Disaster Medical Training		X	X		
8.14	Hospital Plans		X	X		
8.15	Interhospital Communications		X			
8.16	Prehospital Agency Plans		X	X		
<b>Enhanced Level: Advanced Life Support:</b>						
8.17	ALS Policies		X			
<b>Enhanced Level: Specialty Care Systems:</b>						
8.18	Specialty Center Roles		X			
<b>Enhanced Level: Exclusive Operating Areas/Ambulance Regulations:</b>						
8.19	Waiving Exclusivity		X			

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.01 LEMSA STRUCTURE

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#### MINIMUM STANDARDS:

Each local EMS agency shall have a formal organization structure which includes both agency staff and non-agency resources and which includes appropriate technical and clinical expertise.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STADARDS

In Kern County the Board of Supervisors designated the EMS Department as the Local EMS Agency. The Kern County Ambulance Ordinance, which governs the majority of the prehospital system in the County, was adopted by the Board of Supervisors in November 1990, and became effective on February 28, 1991. As a result of this ordinance and the subsequent regulations, the EMS System in Kern County became more structured and included, for the first time, measurable standards for the response of paramedic level of care to the citizens of Kern County during an emergency.

#### EMS includes:

- Public safety dispatch
- Fire services first response and treatment
- Private ground and air ambulance response, treatment and transport
- Law enforcement agencies
- Hospitals and specialty care centers
- Training institutions and programs for EMS personnel
- Managed care organizations
- Preventative health care
- Citizen and medical advisory groups

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.02 LEMSA MISSION

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#### MINIMUM STANDARDS:

Each local EMS agency shall plan, implement, and evaluate the EMS system. The agency shall use its quality assurance/quality improvement (QA/QI) and evaluation processes to identify system changes.

#### RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: MEETS MINIMUM STANDARDS

KERN COUNTY HAS A ROBUST QA/QI PROGRAM FOR THE EVALUATION OF OUR SYSTEM. WE HAVE QUARTERLY QI MEETINGS, SYSTEM COLLABORATIVE MEETINGS, SPECIALTY DESIGNATION REVIEWS AND EPCR REVIEWS ALL DESIGNED TO IMPROVE OUR SYSTME.

Our EMS QI Plan is included in this document.

NEED(S):

OBJECTIVE:

TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.03 PUBLIC INPUT

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#### MINIMUM STANDARDS:

Each local EMS agency shall have a mechanism (including EMCCs and other sources) to seek and obtain appropriate consumer and health care provider input regarding the development of plans, policies and procedures, as described in the State EMS Authority's EMS Systems Standards and Guidelines.

#### RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: MEETS MINIMUM STANDARDS

THE EMERGENCY CARE ADVISORY BOARD – A SUB COMMITTEE OF THE BOARD OF SUPERVISORS - MEETS QUARTERLY  
ADDITIONALLY, WE HAVE SYSTEM COLLABORATIVE MEETINGS EVERY OTHER MONTH

NEED(S):

OBJECTIVE:

TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.04 MEDICAL DIRECTOR

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#### MINIMUM STANDARDS:

Each local EMS agency shall appoint a medical director who is a licensed physician who has substantial experience in the practice of emergency medicine.

#### RECOMMENDED GUIDELINES:

The local EMS agency medical director should have administrative experience in emergency medical services systems.

Each local EMS agency medical director should establish clinical specialty advisory groups composed of physicians with appropriate specialties and non-physician providers (including nurses and pre-hospital providers), and/or should appoint medical consultants with expertise in trauma care, pediatrics, and other areas, as needed.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

DR. KRISTOPHER LYON. (BOARD CERTIFIED IN EMERGENCY MEDICINE). EMERGENCY ROOM PHYSICIAN UNDER CONTRACT WITH KERN COUNTY.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.05 SYSTEM PLAN

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#### MINIMUM STANDARDS:

Each local EMS agency shall develop an EMS System Plan, based on community need and utilization of appropriate resources, and shall submit it to the EMS Authority.

The plan shall:

- assess how the current system meets these guidelines,
- identify system needs for patients within each of the targeted clinical categories (as identified in Section II), and
- provide a methodology and time-line for meeting these needs.

#### RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: MEETS MINIMUM STANDARD

PLEASE SEE INFORMATION INCLUDED IN THIS PLAN.

NEED(S):

OBJECTIVE

TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.06 ANNUAL PLAN UPDATE

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#### MINIMUM STANDARDS:

Each local EMS agency shall develop an annual update to its EMS System Plan and shall submit it to the EMS Authority. The update shall identify progress made in plan implementation and changes to the planned system design.

#### RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: MEETS MINIMUM STANDARD

PLEASE SEE THE INFORMATION IN THIS PLAN

NEED(S):

OBJECTIVE:

TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.07 TRAUMA PLANNING

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#### MINIMUM STANDARDS:

The local EMS agency shall plan for trauma care and shall determine the optimal system design for trauma care in its jurisdiction.

#### RECOMMENDED GUIDELINES:

The local EMS agency should designate appropriate facilities or execute agreements with trauma facilities in other jurisdictions.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

KERN COUNTY HAS ONE LEVEL II TRAUMA CENTER, KERN MEDICAL, AND ONE LEVEL IV TRAUMA CENTER, RIDGECREST REGIONAL HOSPITAL. KERN HAS TRAUMA POLICIES AND PROCEDURES IN PLACE. [https://kernpublichealth.com/wp-content/uploads/2019/10/TraumaPoliciesandProcedures\\_07012015.pdf](https://kernpublichealth.com/wp-content/uploads/2019/10/TraumaPoliciesandProcedures_07012015.pdf)

#### COORDINATION WITH OTHER EMS AGENCIES:

KERN COUNTY PARTICIPATES IN REGIONAL TRAUMA COMMITTEES.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.08 ALS PLANNING

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#### MINIMUM STANDARDS:

Each local EMS agency shall plan for eventual provision of advanced life support services throughout its jurisdiction.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

COUNTY WIDE AMBULANCE COVERAGE WITH ALS PROVIDERS IN 100% OF THE COUNTY THROUGH PROVIDER CONTRACTS AND EXCLUSIVE OPERATIONAL AREAS. KERN ALSO UTILIZES THE AMBULANCE SERVICE PERFORMANCE STANDARDS AS WELL AS THE AMBULANCE ORDINANCE TO MANDATE ALS USE.

#### COORDINATION WITH OTHER EMS AGENCIES:

KERN COUNTY ROUTINELY PROVIDES SERVICES IN NEIGHBORING COUNTIES SUCH AS TULARE, SAN BERNARDINO, AND LOS ANGELES.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.09 INVENTORY OF RESOURCES

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#### MINIMUM STANDARDS:

Each local EMS agency shall develop a detailed inventory of EMS resources (e.g., personnel, vehicles, and facilities) within its area and, at least annually, shall update this inventory.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

REQUIRED ANNUAL REPORTING. THE AMBULANCE PERFORMANCE STANDARDS MANDATE AN ANNUAL REPORTING OF ALL RESOURCES. THESE INCLUDE PERSONNEL, VEHICLES, EQUIPMENT, AND FACILITIES. KERN COUNTY EMS SUBMITS THESE ANNUAL REPORTS TO BOTH EMCAB AND THE BOARD OF SUPERVISORS.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.10 SPECIAL POPULATIONS

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#### MINIMUM STANDARDS:

Each local EMS agency shall identify population groups served by the EMS system which require specialized services (e.g., elderly, handicapped, children, non-English speakers).

#### RECOMMENDED GUIDELINES:

Each local EMS agency should develop services, as appropriate, for special population groups served by the EMS system which require specialized services (e.g., elderly, handicapped, children, non-English speakers).

#### CURRENT STATUS: MEETS MINIMUM STANDARD

KERN COUNTY EMS WORKS WITH OUR EOC AND DISASTER MEDICAL PLANNING. ADDITIONALLY, EMS MANAGES BOTH THE HEALTH CARE COALITION AND THE MRC SYSTEM. WE HAVE IMPLEMENTED A PEDIATRIC SYSTEM OF CARE AND WORK WITH LOCAL HOSPITALS TO PROVIDE PUBLIC EDUCATION AND OUTREACH.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.11 SYSTEM PARTICIPANTS

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#### MINIMUM STANDARDS:

Each local EMS agency shall identify the optimal roles and responsibilities of system participants.

#### RECOMMENDED GUIDELINES:

Each local EMS agency should ensure that system participants conform with their assigned EMS system roles and responsibilities, through mechanisms such as written agreements, facility designations, and exclusive operating areas.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

ALL PROVIDERS OPERATING WITHIN THE COUNTY OF KERN ARE APPROVED THROUGH AGREEMENTS. WE CURRENTLY HAVE 6 EXCLUSIVE OPERATING AREAS UNDER AGREEMENT AND 3 NON-EXCLUSIVE OPERATING AREAS WITH PROVIDERS UNDER AGREEMENT.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.12 REVIEW AND MONITORING

---

**MINIMUM STANDARDS:**

Each local EMS agency shall provide for review and monitoring of EMS system operations.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

ALL GROUND AMBULANCE PROVIDERS SUBMIT MONTHLY COMPLIANCE REPORTS TO EMS. THESE REPORTS ARE PROCESSED FOR DETERMINATION OF COMPLIANCE WITH ALL AGREEMENTS WITH THE COUNTY. ADDITIONALLY, EMS COMPLETES EPCR REVIEWS MONTHLY TO DETERMIN COMPLIANCE WITH POLICIES, PROCEDURES AND PROTOCOLS.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.13 COORDINATION

---

**MINIMUM STANDARDS:**

Each local EMS agency shall coordinate EMS system operations.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

KERN COUNTY EMS COORDINATES OUR SYSTEM THROUGH OUR POLICIES, PROCEDURES AND PROTOCOLS THAT ARE REVIEWED AND UPDATED REGULARY. OUR STAFF MONITOR RADIO FREQUENCIES DAILY TO ASSURE THE SYSTEM IS RUNNING PROPERLY. WE HAVE AN ON-CALL PROGRAM THAT ASSURES THAT SOMEONE IS AVAILABLE 24/7.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.14 POLICY & PROCEDURES MANUAL

---

#### MINIMUM STANDARDS:

Each local EMS agency shall develop a policy and procedures manual that includes all EMS agency policies and procedures. The agency shall ensure that the manual is available to all EMS system providers (including public safety agencies, ambulance services, and hospitals) within the system.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

KERN COUNTIES POLICIES, PROCEDURES AND PROTOCOLS ARE AVAILABLE AT: <https://kernpublichealth.com/ems-policies/>

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.15 COMPLIANCE WITH POLICIES

---

#### MINIMUM STANDARDS:

Each local EMS agency shall have a mechanism to review, monitor, and enforce compliance with system policies.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

KERN COUNTY EMS MONITORS OUR SYSTEM THROUGH MONITORING RADIO FREQUENCIES, MONTHLY COMPLIANCE DATA REPORTING, ON CALL PERSONNEL, REVIEWING EPCR'S, AND INVESTIGATION OF COMPLAINTS,.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.16 FUNDING MECHANISM

---

#### MINIMUM STANDARDS:

Each local EMS agency shall have a funding mechanism, which is sufficient to ensure its continued operation and shall maximize use of its Emergency Medical Services Fund.

#### RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: MEETS MINIMUM STANDARD

KERN COUNTY EMS USES THE EMS FUND, CERTIFICATION/ACCREDITATION FEES, PROVIDER FEES, AND FACILITY FEES IN ORDER TO PROVIDE SUFFICIENT FUNDING. SEE TABLE 2

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.17 MEDICAL DIRECTION

---

#### MINIMUM STANDARDS:

Each local EMS agency shall plan for medical direction within the EMS system. The plan shall identify the optimal number and role of base hospitals and alternative base stations and the roles, responsibilities, and relationships of pre-hospital and hospital providers.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Medical direction is provided by the EMS Agency Medical Director and through a well delineated system of on-line medical direction through the 8 base hospitals (All of which are specialty care centers) via liaison physicians and MICN's; Qi activities are activated by both ALS providers and base hospitals. Base hospital physicians, MICN's and first responders are all represented on the EMS Agency QI and Clinical Advisory committees. The EMS Agency Medical Director is a contributing member of EMDAAC.

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.18 QA/QI

---

#### MINIMUM STANDARDS:

Each local EMS agency shall establish a quality assurance/quality improvement (QA/QI) program. This may include use of provider-based programs which are approved by the local EMS agency and which are coordinated with other system participants.

#### RECOMMENDED GUIDELINES:

Pre-hospital care providers should be encouraged to establish in-house procedures, which identify methods of improving the quality of care provided.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

The EMS Agency has existing policies to assist providers to develop and implement QI programs. The EMS Agency works with providers to review system performance, and resolve issues identified through the QI process by training and discussion. See attached EQUIP.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.19 POLICIES, PROCEDURES, PROTOCOLS

---

#### MINIMUM STANDARDS:

Each local EMS agency shall develop written policies, procedures, and/or protocols including, but not limited to:

- triage,
- treatment,
- medical dispatch protocols,
- transport,
- on-scene treatment times,
- transfer of emergency patients,
- standing orders,
- base hospital contact,
- on-scene physicians and other medical personnel, and
- local scope of practice for pre-hospital personnel.

#### RECOMMENDED GUIDELINES:

Each local EMS agency should develop (or encourage the development of) pre-arrival/post dispatch instructions.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

The EMS Agency maintains policies and procedures for EMS operations. Through continuous communication with providers and advisory committees, the EMS Agency is responsive to the revision and development of policies and procedures for prehospital care. All information is posted to the Kern County EMS Website located at: <https://kernpublichealth.com/ems-policies/>

Kern County EMS has a county-wide Emergency Medical Dispatch system that is split between the Emergency Communications Center (ECC) and Operation Control Dispatch (OCD). Between these two dispatch centers all fire, ground ambulance and air ambulance services are dispatched.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.20 DNR POLICY

---

#### MINIMUM STANDARDS:

Each local EMS agency shall have a policy regarding "Do Not Resuscitate (DNR)" situations in the pre-hospital setting, in accordance with the EMS Authority's DNR guidelines.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County has developed a Withholding Resuscitation Measures Policy, located at: [http://kernpublichealth.com/wp-content/uploads/2014/09/WithholdResuscMeas\\_01012017.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/WithholdResuscMeas_01012017.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.21 DETERMINATION OF DEATH

---

#### MINIMUM STANDARDS:

Each local EMS agency, in conjunction with the county coroner(s) shall develop a policy regarding determination of death, including deaths at the scene of apparent crimes.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has developed a Determination of Death protocol located at: [https://kernpublichealth.com/wp-content/uploads/2019/10/ParamedicProtocols\\_10\\_25\\_19.pdf](https://kernpublichealth.com/wp-content/uploads/2019/10/ParamedicProtocols_10_25_19.pdf)  
Page 13, Protocol #107.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.22 REPORTING OF ABUSE

---

**MINIMUM STANDARDS:**

Each local EMS agency shall ensure that providers have a mechanism for reporting child abuse, elder abuse, and suspected SIDS deaths.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

All providers are required to comply with existing state law and are trained as such.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.23 INTERFACILITY TRANSFER

---

**MINIMUM STANDARDS:**

The local EMS medical director shall establish policies and protocols for scope of practice of pre-hospital medical personnel during interfacility transfers.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

Paramedic Protocols: [https://kernpublichealth.com/wp-content/uploads/2019/10/ParamedicProtocols\\_10\\_25\\_19.pdf](https://kernpublichealth.com/wp-content/uploads/2019/10/ParamedicProtocols_10_25_19.pdf)

EMT Protocols: [https://kernpublichealth.com/wp-content/uploads/EMTProtocols\\_01262018\\_nl\\_lyon-approved\\_CPAP.pdf](https://kernpublichealth.com/wp-content/uploads/EMTProtocols_01262018_nl_lyon-approved_CPAP.pdf)

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.24 ALS SYSTEMS

---

#### MINIMUM STANDARDS:

Advanced life support services shall be provided only as an approved part of a local EMS system and all ALS providers shall have written agreements with the local EMS agency.

#### RECOMMENDED GUIDELINES:

Each local EMS agency, based on state approval, should, when appropriate, develop exclusive operating areas for ALS providers.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Within Kern County we have three ground ambulance services that provide ALS services under written agreements. Additionally, we have three fire departments, operating under first responder policies, that are staffed as follows:

Kern County Fire – Primarily BLS with assessment ALS engines in Pine Mountain Club and Buttonwillow as well as an ALS squad operating intermittently for ALS training.

Bakersfield City Fire – Primarily BLS with an ALS assessment engine at station 15.

and

California City Fire – All ALS assessment/non transport

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.25 ON-LINE MEDICAL DIRECTION

---

#### MINIMUM STANDARDS:

Each EMS system shall have on-line medical direction, provided by a base hospital (or alternative base station) physician or authorized registered nurse/mobile intensive care nurse.

#### RECOMMENDED GUIDELINES:

Each EMS system should develop a medical control plan that determines:

- the base hospital configuration for the system,
- the process for selecting base hospitals, including a process for designation which allows all eligible facilities to apply, and
- the process for determining the need for in-house medical direction for provider agencies.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS policies exist for determination of both base hospital and specialty care center destination. Ground transport providers will transport to the closest, most appropriate, facility. Kern County EMS provides policies and procedures to field providers which include standing orders. The field providers also have the ability to contact the base hospital physician for additional direction. MICN designation is required and provided by Kern County EMS, and MICN's serve as the field provider liaison with the base hospital and the physicians.

NEED(S):

OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.26 TRAUMA SYSTEM PLAN

---

#### MINIMUM STANDARDS:

The local EMS agency shall develop a trauma care system plan, based on community needs and utilization of appropriate resources, which determines:

- the optimal system design for trauma care in the EMS area, and
- the process for assigning roles to system participants, including a process which allows all eligible facilities to apply.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS maintains an active Trauma Advisory Committee (TEC) inclusive of Trauma Center hospital and non-Trauma Center hospitals. Policies are in place for a hospital to pursue a designation.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.27 PEDIATRIC SYSTEM PLAN

---

#### MINIMUM STANDARDS:

The local EMS agency shall develop a pediatric emergency medical and critical care system plan, based on community needs and utilization of appropriate resources, which determines:

- the optimal system design for pediatric emergency medical and critical care in the EMS area, and
- the process for assigning roles to system participants, including a process which allows all eligible facilities to apply.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has developed a robust Pediatric System of Care. It includes 2 advanced pediatric receiving centers, 2 general receiving centers and 1 basic receiving center. We have obtained multiple transfer agreements with out of county comprehensive pediatric receiving centers including Valley Children's, Los Angeles Children's, USC and Loma Linda. In addition, we have the pediatric advisory committee that meets quarterly to review the system and assure proper quality of patient care and system operations.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## SYSTEM ORGANIZATION AND MANAGEMENT

### 1.28 EOA PLAN

---

#### MINIMUM STANDARDS:

The local EMS agency shall develop and submit for State approval, a plan, based on community needs and utilization of appropriate resources, for granting of exclusive operating areas, that determines: a) the optimal system design for ambulance service and advanced life support services in the EMS area, and b) the process for assigning roles to system participants, including a competitive process for implementation of exclusive operating areas.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS currently has 6 EOA agreements in place with three transport providers. These 6 EOA's were "grandfathered", thereby not requiring a competitive bid process. A Request for Proposal has been initiated and is currently open for EOA's 1, 7, and 11. Expected completion of the process is April 2020.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.01 ASSESSMENT OF NEEDS

---

#### MINIMUM STANDARDS:

The local EMS agency shall routinely assess personnel and training needs.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Personnel and training needs are assessed by Kern County EMS through various committees (QI, System Collaborative, Tec, STEMI, Stroke, and Pac) and through feedback from base hospital physicians, MICNs and provider agencies. The Kern County EMS conducts and coordinates provider training for new or revised policies and procedures, as well as Advanced Protocol Review (APR) for all paramedics on a regular basis; a requirement for accreditation/reaccreditation. All initial paramedic accreditations as well as paramedic recert's are required to pass an accreditation test with an 80% or better. All paramedics wanting to obtain a Paramedic Preceptor accreditation must pass the accreditation test with a 90% or higher.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.02 APPROVAL OF TRAINING

---

**MINIMUM STANDARDS:**

The EMS Authority and/or local EMS agencies shall have a mechanism to approve EMS education programs that require approval (according to regulations) and shall monitor them to ensure that they comply with state regulations.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS: MEETS MINIMUM STANDARD**

Kern County EMS complies with State regulations regarding the approval and monitoring of EMS education programs: These approved programs include EMT and Paramedic curriculum provided by a local community colleges. Kern County EMS provides an in-house authorization of MICN's.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.03 PERSONNEL

---

#### MINIMUM STANDARDS:

The local EMS agency shall have mechanisms to accredit, authorize, and certify pre-hospital medical personnel and conduct certification reviews, in accordance with state regulations. This shall include a process for pre-hospital providers to identify and notify the local EMS agency of unusual occurrences that could impact EMS personnel certification.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS maintains policies and procedures to satisfy this requirement.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.04 DISPATCH TRAINING

---

#### MINIMUM STANDARDS:

Public safety answering point (PSAP) operators with medical responsibility shall have emergency medical orientation and all medical dispatch personnel (both public and private) shall receive emergency medical dispatch training in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

#### RECOMMENDED GUIDELINES:

Public safety answering point (PSAP) operators with medical dispatch responsibilities and all medical dispatch personnel (both public and private) should be trained and tested in accordance with the EMS Authority's Emergency Medical Dispatch Guidelines.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS currently has 2 PSAP's that fall under the Medical Responsibility Operator definition. Dispatch staff from both Emergency Communications Center (ECC) and Operations Control Dispatch (OCD) are mandated to carry a certification from the International Academies of Emergency Dispatch. Both dispatch agencies have attained Accredited Centers of Excellence (ACE) accreditation.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.05 FIRST RESPONDER TRAINING

---

#### MINIMUM STANDARDS:

At least one person on each non-transporting EMS first response unit shall have been trained to administer first aid and CPR within the previous three years.

#### RECOMMENDED GUIDELINES:

At least one person on each non-transporting EMS first response unit should be currently certified to provide defibrillation and have available equipment commensurate with such scope of practice, when such a program is justified by the response times for other ALS providers.

At least one person on each non-transporting EMS first response unit should be currently certified at the EMT level and have available equipment commensurate with such scope of practice.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

All persons on each non-transporting EMS first response unit are required to be EMT level certified. Policies are in place to assure this level of certification is maintained.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.06 RESPONSE

---

**MINIMUM STANDARDS:**

Public safety agencies and industrial first aid teams shall be encouraged to respond to medical emergencies and shall be utilized in accordance with local EMS agency policies.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

Kern County EMS has implemented a Public Safety First Aid program. Kern County Sheriff is our largest Public Safety First Aid responder providing AED, CPR and Narcan administration. We have agreements with several industrial agencies to provide First Aid and EMT services throughout the county.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.07 MEDICAL CONTROL

---

#### MINIMUM STANDARDS:

Non-transporting EMS first responders shall operate under medical direction policies, as specified by the local EMS agency medical director.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

All first response policies as well as first response agreements mandate medical control to the medical director.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.08 EMT-I TRAINING

---

#### MINIMUM STANDARDS:

All emergency medical transport vehicle personnel shall be currently certified at least at the EMT-I level.

#### RECOMMENDED GUIDELINES:

If advanced life support personnel are not available, at least one person on each emergency medical transport vehicle should be trained to provide defibrillation.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

All emergency medical transport vehicle personnel are mandated to be EMT level at minimum. All transport vehicles are equipped with AED's and the personnel are trained in its use.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.09 CPR TRAINING

---

#### MINIMUM STANDARDS:

All allied health personnel who provide direct emergency patient care shall be trained in CPR.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS mandates all EMTs and Paramedics maintain current CPR cards as part of our local accreditation policy.

<https://kernpublichealth.com/ems-certification/>

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.10 ADVANCED LIFE SUPPORT

---

#### MINIMUM STANDARDS:

All emergency department physicians and registered nurses that provide direct emergency patient care shall be trained in advanced life support.

#### RECOMMENDED GUIDELINES:

All emergency department physicians should be certified by the American Board of Emergency Medicine.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Current agreements with all receiving emergency rooms/hospitals require "a physician licensed in the State of California, who is experienced in emergency medical care, assigned to the emergency department and available at all times..."

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.11 ACCREDITATION PROCESS

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish a procedure for accreditation of advanced life support personnel that includes orientation to system policies and procedures, orientation to the roles and responsibilities of providers within the local EMS system, testing in any optional scope of practice, and enrollment into the local EMS agency's quality assurance/quality improvement process.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County Accreditation Policy meets this standard:

[https://kernpublichealth.com/wp-content/uploads/2019/11/Accreditation\\_revised\\_cn.kt..1-jf-1.pdf](https://kernpublichealth.com/wp-content/uploads/2019/11/Accreditation_revised_cn.kt..1-jf-1.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.12 EARLY DEFIBRILLATION

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish policies for local accreditation of public safety and other basic life support personnel in early defibrillation.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

All fire first responders are equipped and trained to provide early defibrillation. Kern County EMS has developed a Public Safety First Aid Optional Skills policy to allow for law to provide early defibrillation and narcan administration.

[http://kernpublichealth.com/wp-content/uploads/2014/09/Public-Safety-FSOS\\_11132015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/Public-Safety-FSOS_11132015_Newformat.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## STAFFING/TRAINING

### 2.13 BASE HOSPITAL PERSONNEL

---

**MINIMUM STANDARDS:**

All base hospital/alternative base station personnel who provide medical direction to pre-hospital personnel shall be knowledgeable about local EMS agency policies and procedures and have training in radio communications techniques.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

Kern County EMS requires MICN Authorization and "Refresher" training curriculum which encompasses both knowledge of policies, procedures and protocols, radio communications, and disaster response.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.01 COMMUNICATIONS PLAN

---

#### MINIMUM STANDARDS:

The local EMS agency shall plan for EMS communications. The plan shall specify the medical communications capabilities of emergency medical transport vehicles, non-transporting advanced life support responders, and acute care facilities and shall coordinate the use of frequencies with other users.

#### RECOMMENDED GUIDELINES:

The local EMS agency's communications plan should consider the availability and use of satellites and cellular telephones.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Several policies detail communication requirements. Kern uses a Tactile Interoperable Communications Plan as well for interagency communications coordination.

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.02 RADIOS

---

#### MINIMUM STANDARDS:

Emergency medical transport vehicles and non-transporting advanced life support responders shall have two-way radio communications equipment which complies with the local EMS communications plan and which provides for dispatch and ambulance-to-hospital communication.

#### RECOMMENDED GUIDELINES:

Emergency medical transport vehicles should have two-way radio communications equipment that complies with the local EMS communications plan and that provides for vehicle-to-vehicle (including both ambulances and non-transporting first responder units) communication.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

All radios currently in use by first responders are capable of interoperable communications with each other and the hospitals:  
[http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory_12012015_Newformat.pdf)

NEED(S):

OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.03 INTERFACILITY TRANSFER

#### MINIMUM STANDARDS:

Emergency medical transport vehicles used for interfacility transfers shall have the ability to communicate with both the sending and receiving facilities. This could be accomplished by cellular telephone.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

All ambulances operating within Kern County conduct interfacility transfers and are properly equipped:

[http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory_12012015_Newformat.pdf)

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.04 DISPATCH CENTER

---

#### MINIMUM STANDARDS:

All emergency medical transport vehicles where physically possible, (based on geography and technology), shall have the ability to communicate with a single dispatch center or disaster communications command post.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Dispatch communication is mandated in the EMD policy:

[http://kernpublichealth.com/wp-content/uploads/2014/09/EMD\\_Policy\\_09012016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMD_Policy_09012016.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.05 HOSPITALS

---

#### MINIMUM STANDARDS:

All hospitals within the local EMS system shall (where physically possible) have the ability to communicate with each other by two-way radio.

#### RECOMMENDED GUIDELINES:

All hospitals should have direct communications access to relevant services in other hospitals within the system (e.g., poison information, pediatric and trauma consultation).

#### CURRENT STATUS: MEETS MINIMUM STANDARD

All base hospitals are required to maintain radio and telephone dedicated to paramedic/EMT communications. Specialty center policies require agreement with higher level specialty care.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.06 MCI/DISASTERS

---

#### MINIMUM STANDARDS:

The local EMS agency shall review communications linkages among providers (pre-hospital and hospital) in its jurisdiction for their capability to provide service in the event of multi-casualty incidents and disasters.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Use of county-wide communications via MED channels, local channels, and interoperable communication channels. Managed by the Communications Division of Kern County General Services.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.07 9-1-1 PLANNING/COORDINATION

---

#### MINIMUM STANDARDS:

The local EMS agency shall participate in ongoing planning and coordination of the 9-1-1 telephone service.

#### RECOMMENDED GUIDELINES:

The local EMS agency should promote the development of enhanced 9-1-1 systems.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Emergency Communications Center (ECC) is e9-1-1 equipped and capable of ANI/ALI.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.08 9-1-1 PUBLIC EDUCATION

---

**MINIMUM STANDARDS:**

The local EMS agency shall be involved in public education regarding the 9-1-1 telephone service as it impacts system access.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

Kern County EMS offers free training to the public for 9-1-1 education as requested.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.09 DISPATCH TRIAGE

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish guidelines for proper dispatch triage that identifies appropriate medical response.

#### RECOMMENDED GUIDELINES:

The local EMS agency should establish a emergency medical dispatch priority reference system, including systemized caller interrogation, dispatch triage policies, and pre-arrival instructions.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS mandates the International Academies of Emergency Dispatch protocols, priority dispatch with local medical control of response configurations. Currently Emergency Communications Center is an ACE accredited dispatch center.

[http://kernpublichealth.com/wp-content/uploads/2014/09/EMD\\_Policy\\_09012016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMD_Policy_09012016.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## COMMUNICATIONS

### 3.10 INTEGRATED DISPATCH

---

#### MINIMUM STANDARDS:

The local EMS system shall have a functionally integrated dispatch with system-wide emergency services coordination, using standardized communications frequencies.

#### RECOMMENDED GUIDELINES:

The local EMS agency should develop a mechanism to ensure appropriate system-wide ambulance coverage during periods of peak demand.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Interoperability exists between fire and EMS dispatch centers and individual units. All fire departments are dispatched by one agency, and all ambulance providers are dispatched through one other agency.

[http://kernpublichealth.com/wp-content/uploads/2014/09/EMD\\_Policy\\_09012016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMD_Policy_09012016.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.01 SERVICE AREA BOUNDARIES

---

#### MINIMUM STANDARDS:

The local EMS agency shall determine the boundaries of emergency medical transportation service areas.

#### RECOMMENDED GUIDELINES:

The local EMS agency should secure a county ordinance or similar mechanism for establishing emergency medical transport service areas (e.g., ambulance response zones).

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Established through Ordinance: <https://kernpublichealth.com/wp-content/uploads/2015/09/AmbOrd812.pdf>

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.02 MONITORING

---

#### MINIMUM STANDARDS:

The local EMS agency shall monitor emergency medical transportation services to ensure compliance with appropriate statutes, regulations, policies, and procedures.

#### RECOMMENDED GUIDELINES:

The local EMS agency should secure a county ordinance or similar mechanism for licensure of emergency medical transport services. These should be intended to promote compliance with overall system management and should, wherever possible, replace any other local ambulance regulatory programs within the EMS area.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Established in Ordinance, contracts, performance standards, and monthly/annual reporting.

<https://kernpublichealth.com/wp-content/uploads/2015/09/AmbOrd812.pdf>

[http://kernpublichealth.com/wp-content/uploads/2014/09/AmbPerfStds\\_NewFormat\\_06172007.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/AmbPerfStds_NewFormat_06172007.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.03 CLASSIFYING MEDICAL REQUESTS

---

#### MINIMUM STANDARDS:

The local EMS agency shall determine criteria for classifying medical requests (e.g., emergent, urgent, and non-emergent) and shall determine the appropriate level of medical response to each.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Established through EMD response configurations and dispatch policies.

[http://kernpublichealth.com/wp-content/uploads/2014/09/EMD\\_Policy\\_09012016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMD_Policy_09012016.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.04 PRESCHEDULED RESPONSES

---

#### MINIMUM STANDARDS:

Service by emergency medical transport vehicles that can be prescheduled without negative medical impact shall be provided only at levels that permit compliance with local EMS agency policy.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Established in the Ambulance Performance Standards.

<https://kernpublichealth.com/wp-content/uploads/AmbPerfStds-8-23-2018.pdf>

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.05 RESPONSE TIME STANDARDS

---

#### MINIMUM STANDARDS:

Each local EMS agency shall develop response time standards for medical responses. These standards shall take into account the total time from receipt of call at the primary public safety answering point (PSAP) to arrival of the responding unit at the scene, including all dispatch time intervals and driving time.

#### RECOMMENDED GUIDELINES:

Emergency medical service areas (response zones) shall be designated so that, for ninety percent of emergency responses, response times shall not exceed:

	Metropolitan/Urban Area	Suburban/Rural Area	Wilderness Area
BLS and CPR Capable First Responder	5 minutes	15 minutes	As quickly as possible
Early Defibrillation – Capable Responder	5 minutes	As quickly as possible	As quickly as possible
ALS Capable Responder (not functioning as first responder)	8 minutes	20 minutes	As quickly as possible
EMS Transportation Unit (not functioning as first responder)	8 minutes	20 minutes	As quickly as possible

**CURRENT STATUS:** MEETS MINIMUM STANDARD

Established in the Ambulance Performance Standards.

<https://kernpublichealth.com/wp-content/uploads/AmbPerfStds-8-23-2018.pdf>

**COORDINATION WITH OTHER EMS AGENCIES:**

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.06 STAFFING

---

#### MINIMUM STANDARDS:

All emergency medical transport vehicles shall be staffed and equipped according to current state and local EMS agency regulations and appropriately equipped for the level of service provided.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Requirement for performance standards, policy, and mandatory equipment requirements.

<https://kernpublichealth.com/wp-content/uploads/AmbPerfStds-8-23-2018.pdf>

[http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory_12012015_Newformat.pdf)

[http://kernpublichealth.com/wp-content/uploads/2014/09/MICU\\_Ground\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/MICU_Ground_12012015_Newformat.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.07 FIRST RESPONDER AGENCIES

---

#### MINIMUM STANDARDS:

The local EMS agency shall integrate qualified EMS first responder agencies (including public safety agencies and industrial first aid teams) into the system.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS provides for EMT first responders, industrial first responders and Public Safety First Aid responders.

[http://kernpublichealth.com/wp-content/uploads/2014/09/EMTProviderPolicy\\_-05112017.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMTProviderPolicy_-05112017.pdf)

[https://kernpublichealth.com/wp-content/uploads/2014/09/Public-Safety-FSOS\\_11132015\\_Newformat.pdf](https://kernpublichealth.com/wp-content/uploads/2014/09/Public-Safety-FSOS_11132015_Newformat.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.08 MEDICAL & RESCUE AIRCRAFT

---

#### MINIMUM STANDARDS:

The local EMS agency shall have a process for categorizing medical and rescue aircraft and shall develop policies and procedures regarding:

- authorization of aircraft to be utilized in pre-hospital patient care,
- requesting of EMS aircraft,
- dispatching of EMS aircraft,
- determination of EMS aircraft patient destination,
- orientation of pilots and medical flight crews to the local EMS system, and
- addressing and resolving formal complaints regarding EMS aircraft.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: *MEET MINIMUM STANDARD*

Kern County EMS is unable to enter into agreements with air ambulances due to the Department of Transportation determination that air ambulances are protected by the Airline Deregulation Act. However, we have the following policies:

[http://kernpublichealth.com/wp-content/uploads/2014/09/Air\\_Ambulance\\_Performance\\_Standards\\_Final.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/Air_Ambulance_Performance_Standards_Final.pdf)

[http://kernpublichealth.com/wp-content/uploads/2014/09/EMSAircraftUse\\_03012012\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMSAircraftUse_03012012_Newformat.pdf)

[http://kernpublichealth.com/wp-content/uploads/2014/09/BLSRescueAircraftPolicies\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/BLSRescueAircraftPolicies_12012015_Newformat.pdf)

[http://kernpublichealth.com/wp-content/uploads/2014/09/MICURotorFixed\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/MICURotorFixed_12012015_Newformat.pdf)

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.09 AIR DISPATCH CENTER

---

**MINIMUM STANDARDS:**

The local EMS agency shall designate a dispatch center to coordinate the use of air ambulances or rescue aircraft.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

The Emergency Communications Center (ECC) coordinates the use of aircraft.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.10 AIRCRAFT AVAILABILITY

---

#### MINIMUM STANDARDS:

The local EMS agency shall identify the availability and staffing of medical and rescue aircraft for emergency patient transportation and shall maintain written agreements with aeromedical services operating within the EMS area.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: DOES NOT MEETS MINIMUM STANDARD

Kern County EMS is unable to enter into agreements with aeromedical services due to the Department of Transportation's determination that air ambulances are protected by the Airline Deregulation Act. Currently, QI and Medical Direction agreements are verbal in nature with our air providers.

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

The ability to enter into agreements with air ambulance services. Department of Transportation to change its view.

#### OBJECTIVE:

Develop and execute air ambulance service agreements for ALS air ambulance providers in Kern County.

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.11 SPECIALTY VEHICLES

---

#### MINIMUM STANDARDS:

Where applicable, the local EMS agency shall identify the availability and staffing of all-terrain vehicles, snow mobiles, and water rescue and transportation vehicles.

#### RECOMMENDED GUIDELINES:

The local EMS agency should plan for response by and use of all-terrain vehicles, snow mobiles, and water rescue vehicles areas where applicable. This plan should consider existing EMS resources, population density, environmental factors, dispatch procedures and catchment area.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has created, ALS and BLS bike medic programs, boat medic programs, and Kern County Sheriff Office Search and Rescue is approved EMT level provider.

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.12 DISASTER RESPONSE

---

#### MINIMUM STANDARDS:

The local EMS agency, in cooperation with the local office of emergency services (OES), shall plan for mobilizing response and transport vehicles for disaster.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS is integrated into the MHOAC function and coordinates EMS resources as needed with the County Office of Emergency Services.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.13 INTERCOUNTY RESPONSE

---

#### MINIMUM STANDARDS:

The local EMS agency shall develop agreements permitting inter-county response of emergency medical transport vehicles and EMS personnel.

#### RECOMMENDED GUIDELINES:

The local EMS agency should encourage and coordinate development of mutual aid agreements that identify financial responsibility for mutual aid responses.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Both formal and informal agreements exist (RDMHS, MHOAC, Fire Mutual Aid, Ambulance provider agreements with neighboring counties).

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.14 INCIDENT COMMAND SYSTEM

---

#### MINIMUM STANDARDS:

The local EMS agency shall develop multi-casualty response plans and procedures that include provision for on-scene medical management using the Incident Command System.

#### RECOMMENDED GUIDELINES:

None.

CURRENT STATUS: MEETS MINIMUM STANDARD

Incident command is addressed in the scene control policy as well as the Kern County Emergency Operations Plan:

[http://kernpublichealth.com/wp-content/uploads/2014/09/SceneControlPolicy\\_NewFormat\\_03012012.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/SceneControlPolicy_NewFormat_03012012.pdf)

[http://www.kerncountyfire.org/images/stories/emergency\\_preparedness/Kern\\_Annex\\_B4\\_Med\\_043008.pdf](http://www.kerncountyfire.org/images/stories/emergency_preparedness/Kern_Annex_B4_Med_043008.pdf)

NEED(S):

OBJECTIVE:

TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.15 MCI PLANS

---

#### MINIMUM STANDARDS:

Multi-casualty response plans and procedures shall utilize state standards and guidelines.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Multi-casualty incidents are addressed in the scene control policy as well as the EMD policy:

[http://kernpublichealth.com/wp-content/uploads/2014/09/EMD\\_Policy\\_09012016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMD_Policy_09012016.pdf)

[http://kernpublichealth.com/wp-content/uploads/2014/09/SceneControlPolicy\\_NewFormat\\_03012012.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/SceneControlPolicy_NewFormat_03012012.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.16 ALS STAFFING

---

#### MINIMUM STANDARDS:

All ALS ambulances shall be staffed with at least one person certified at the advanced life support level and one person staffed at the EMT-I level.

#### RECOMMENDED GUIDELINES:

The local EMS agency should determine whether advanced life support units should be staffed with two ALS crew members or with one ALS and one BLS crew member.

On an emergency ALS unit which is not staffed with two ALS crew members, the second crew member should be trained to provide defibrillation, using available defibrillators.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

The Ambulance Performance Standards mandate the staffing levels.

[http://kernpublichealth.com/wp-content/uploads/2014/09/AmbPerfStds\\_NewFormat\\_06172007.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/AmbPerfStds_NewFormat_06172007.pdf)

NEED(S):

OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.17 ALS EQUIPMENT

---

**MINIMUM STANDARDS:**

All emergency ALS ambulances shall be appropriately equipped for the scope of practice of its level of staffing.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

Equipment is addressed in the Provider Mandatory Inventory List:

[http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/ProviderMandatory-Inventory_12012015_Newformat.pdf)

and the Mobile Intensive Care Unit (MICU) Policy:

[http://kernpublichealth.com/wp-content/uploads/2014/09/MICU\\_Ground\\_12012015\\_Newformat.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/MICU_Ground_12012015_Newformat.pdf)

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.18 TRANSPORT COMPLIANCE

---

#### MINIMUM STANDARDS:

The local EMS agency shall have a mechanism (e.g., an ordinance and/or written provider agreements) to ensure that EMS transportation agencies comply with applicable policies and procedures regarding system operations and clinical care.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Ordinance in place, Written agreements in place.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.19 TRANSPORTATION PLAN

---

#### MINIMUM STANDARDS:

Any local EMS agency that desires to implement exclusive operating areas, pursuant to Section 1797.224, H&S Code, shall develop an EMS transportation plan which addresses: a) minimum standards for transportation services; b) optimal transportation system efficiency and effectiveness; and c) use of a competitive bid process to ensure system optimization.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Established in Ordinance, Written agreements, Ambulance Service Performance Standards:

<https://kernpublichealth.com/wp-content/uploads/AmbPerfStds-8-23-2018.pdf> See AZS Forms

See: <https://kernpublichealth.com/wp-content/uploads/2015/09/AmbOrd812.pdf>

#### NEED(S):

#### OBJECTIVE:

I

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.20 "GRANDFATHERING"

---

#### MINIMUM STANDARDS:

Any local EMS agency which desires to grant an exclusive operating permit without use of a competitive process shall document in its EMS transportation plan that its existing provider meets all of the requirements for non-competitive selection ("grandfathering") under Section 1797.224, H&SC.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Grandfathering established by Resolution of the Board of Supervisors. See AZS tables.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.21 EOA COMPLIANCE

---

#### MINIMUM STANDARDS:

The local EMS agency shall have a mechanism to ensure that EMS transportation and/or advanced life support agencies to whom exclusive operating permits have been granted, pursuant to Section 1797.224, H&SC, comply with applicable policies and procedures regarding system operations and patient care.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Ordinance, written agreements and performance measures require compliance with all federal, state, and local laws, including local policies and procedures.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## RESPONSE AND TRANSPORTATION

### 4.22 EOA EVALUATION

---

#### MINIMUM STANDARDS:

The local EMS agency shall periodically evaluate the design of exclusive operating areas.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Each EOA is evaluated monthly and annually for response compliance.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.01 ASSESSMENT OF CAPABILITIES

---

#### MINIMUM STANDARDS:

The local EMS agency shall assess and periodically reassess the EMS related capabilities of acute care facilities in its service area.

#### RECOMMENDED GUIDELINES:

The local EMS agency should have written agreements with acute care facilities in its service area.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Written agreements in place with all hospital facilities receiving patients.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.02 TRIAGE & TRANSFER PROTOCOLS

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish pre-hospital triage protocols and shall assist hospitals with the establishment of transfer protocols and agreements.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Protocols established, multiple policies in place. Transfer agreements required in specialty care policies.

#### COORDINATION WITH OTHER EMS AGENCIES:

HOSPITALS HAVE WRITTEN AGREEMENTS IN PLACE WITH HIGHER LEVEL AND SPECIALTY FACILITIES OUTSIDE OF KERN COUNTY.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.03 TRANSFER GUIDELINES

---

#### MINIMUM STANDARDS:

The local EMS agency, with participation of acute care hospital administrators, physicians, and nurses, shall establish guidelines to identify patients who should be considered for transfer to facilities of higher capability and shall work with acute care hospitals to establish transfer agreements with such facilities.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Established, patients identified in policies and protocols. Transfer agreements required in specialty care policies

#### COORDINATION WITH OTHER EMS AGENCIES:

Hospital facilities coordinate with higher level of care and specialty facilities outside of Kem

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.04 SPECIALTY CARE FACILITIES

---

#### MINIMUM STANDARDS:

The local EMS agency shall designate and monitor receiving hospitals and, when appropriate, specialty care facilities for specified groups of emergency patients.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Hospitals identified, included in policies. Policies specific to specialty care centers. See tables) 9

#### COORDINATION WITH OTHER EMS AGENCIES:

Hospital facilities coordinate with higher level of care and specialty facilities outside of Kern

#### NEED(S):

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.05 MASS CASUALTY MANAGEMENT

---

#### MINIMUM STANDARDS:

The local EMS agency shall encourage hospitals to prepare for mass casualty management.

#### RECOMMENDED GUIDELINES:

The local EMS agency should assist hospitals with preparation for mass casualty management, including procedures for coordinating hospital communications and patient flow.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

FACILITIES PARTICIPATE IN THE KERN COUNTY HEALTH CARE COALATION (KCHCC), DISASTER EXERCISES AND DRILLS, AND COMMUNICATIONS

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.06 HOSPITAL EVACUATION

---

#### MINIMUM STANDARDS:

The local EMS agency shall have a plan for hospital evacuation, including its impact on other EMS system providers.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Coordination with other facilities and alternate destinations. Communications, disaster mutual aid responses. Med-alert system. In 2019 Kern County EMS successfully orchestrated and oversaw the evacuated Ridgecrest Regional Hospital following a 6.4 earthquake.

#### COORDINATION WITH OTHER EMS AGENCIES:

RDMHS/C program

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.07 BASE HOSPITAL DESIGNATION

---

#### MINIMUM STANDARDS:

The local EMS agency shall, using a process which allows all eligible facilities to apply, designate base hospitals or alternative base stations as it determines necessary to provide medical direction of pre-hospital personnel.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Title 22 requirements must be met. Communications in place. Written agreements, and training.

8 of our 10 hospitals are currently Base Hospitals.

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.08 TRAUMA SYSTEM DESIGN

---

#### MINIMUM STANDARDS:

Local EMS agencies that develop trauma care systems shall determine the optimal system (based on community need and available resources) including, but not limited to:

- the number and level of trauma centers (including the use of trauma centers in other counties),
- the design of catchment areas (including areas in other counties, as appropriate), with consideration of workload and patient mix,
- identification of patients who should be triaged or transferred to a designated center, including consideration of patients who should be triaged to other specialty care centers,
- the role of non-trauma center hospitals, including those that are outside of the primary triage area of the trauma center, and
- a plan for monitoring and evaluation of the system.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has one level II and one level IV Trauma Center. Policies and procedures exist for patient triage, destination, and interaction with base hospitals. A Trauma Evaluation Committee was established in conjunction with the trauma center designations and meets quarterly.

[http://kernpublichealth.com/wp-content/uploads/2014/09/TraumaPoliciesandProcedures\\_07012015.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/TraumaPoliciesandProcedures_07012015.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.09 PUBLIC INPUT

---

#### MINIMUM STANDARDS:

In planning its trauma care system, the local EMS agency shall ensure input from both pre-hospital and hospital providers and consumers.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has numerous committees in place including the Emergency Care Advisory Board (EMCAB), System Collaborative and TEC. Both the EMCAB and System Collaborative meetings are open to the public and provide for consumer representatives.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.10 PEDIATRIC SYSTEM DESIGN

---

#### MINIMUM STANDARDS:

Local EMS agencies that develop pediatric emergency medical and critical care systems shall determine the optimal system, including:

- the number and role of system participants, particularly of emergency departments,
- the design of catchment areas (including areas in other counties, as appropriate), with consideration of workload and patient mix,
- identification of patients who should be primarily triaged or secondarily transferred to a designated center, including consideration of patients who should be triaged to other specialty care centers,
- identification of providers who are qualified to transport such patients to a designated facility,
- identification of tertiary care centers for pediatric critical care and pediatric trauma,
- the role of non-pediatric specialty care hospitals including those which are outside of the primary triage area, and
- a plan for monitoring and evaluation of the system.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern county EMS has designated 5 pediatric receiving centers. Two advanced, two general and one basic. Additionally, we have a Pediatric Advisory Committee that meets quarterly to review the system.

[http://kernpublichealth.com/wp-content/uploads/2014/09/PedRC\\_Policy\\_11112016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/PedRC_Policy_11112016.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.11 EMERGENCY DEPARTMENTS

---

#### MINIMUM STANDARDS:

Local EMS agencies shall identify minimum standards for pediatric capability of emergency departments including:

- staffing,
- training,
- equipment,
- identification of patients for whom consultation with a pediatric critical care center is appropriate,
- quality assurance/quality improvement, and
- data reporting to the local EMS agency.

#### RECOMMENDED GUIDELINES:

Local EMS agencies should develop methods of identifying emergency departments which meet standards for pediatric care and for pediatric critical care centers and pediatric trauma centers.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern county EMS has designated 5 pediatric receiving centers. Two advanced, two general and one basic. Additionally, we have a Pediatric Advisory Committee that meets quarterly to review the system.

[http://kernpublichealth.com/wp-content/uploads/2014/09/PedRC\\_Policy\\_11112016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/PedRC_Policy_11112016.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.12 PUBLIC INPUT

---

#### MINIMUM STANDARDS:

In planning its pediatric emergency medical and critical care system, the local EMS agency shall ensure input from both pre-hospital and hospital providers and consumers.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has numerous committees in place including the Emergency Care Advisory Board (EMCAB), System Collaborative and PAC. Both the EMCAB and System Collaborative meetings are open to the public and provide for consumer representatives.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.13 SPECIALTY SYSTEM DESIGN

---

#### MINIMUM STANDARDS:

Local EMS agencies developing specialty care plans for EMS-targeted clinical conditions shall determine the optimal system for the specific condition involved, including:

- the number and role of system participants,
- the design of catchment areas (including inter-county transport, as appropriate) with consideration of workload and patient mix,
- identification of patients who should be triaged or transferred to a designated center,
- the role of non-designated hospitals including those which are outside of the primary triage area, and
- a plan for monitoring and evaluation of the system.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS currently has the following specialty designations:

Trauma System of Care

Stroke System of Care

STEMI System of Care

Emergency Medical Services for Children

Burn System of Care

All policies, procedures, and protocols can be located at: <https://kernpublichealth.com/ems-updates-news/policies-procedures-and-protocols/>

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## FACILITIES AND CRITICAL CARE

### 5.14 PUBLIC INPUT

---

#### MINIMUM STANDARDS:

In planning other specialty care systems, the local EMS agency shall ensure input from both pre-hospital and hospital providers and consumers.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has numerous committees in place including the Emergency Care Advisory Board (EMCAB), System Collaborative, STEMI QI Committee, Stroke QI Committee, and Pediatric Advisory Committee. Both the EMCAB and System Collaborative meetings are open to the public and provide for consumer representatives.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.01 QA/QI PROGRAM

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish an EMS quality assurance/quality improvement (QA/QI) program to evaluate the response to emergency medical incidents and the care provided to specific patients. The programs shall address the total EMS system, including all pre-hospital provider agencies, base hospitals, and receiving hospitals. It shall address compliance with policies, procedures, and protocols, and identification of preventable morbidity and mortality, and shall utilize state standards and guidelines. The program shall use provider based QA/QI programs and shall coordinate them with other providers.

#### RECOMMENDED GUIDELINES:

The local EMS agency should have the resources to evaluate response to, and the care provided to, specific patients.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has the following QI Committees:

STEMI QI Committee  
Stroke QI Committee  
Burn QI Committee  
Trauma Evaluation Committee  
Pediatric Advisory Committee

In addition, Kern County EMS has created an EQUIP located at: [https://kernpublichealth.com/wp-content/uploads/EQIP\\_07312019-final.pdf](https://kernpublichealth.com/wp-content/uploads/EQIP_07312019-final.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.02 PREHOSPITAL RECORDS

---

#### MINIMUM STANDARDS:

Pre-hospital records for all patient responses shall be completed and forwarded to appropriate agencies as defined by the local EMS agency.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has developed the following ePCR policy: [http://kernpublichealth.com/wp-content/uploads/2014/09/ePCRPolicies\\_05122017.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/ePCRPolicies_05122017.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.03 PREHOSPITAL CARE AUDITS

---

#### MINIMUM STANDARDS:

Audits of pre-hospital care, including both system response and clinical aspects, shall be conducted.

#### RECOMMENDED GUIDELINES:

The local EMS agency should have a mechanism to link pre-hospital records with dispatch, emergency department, in-patient and discharge records.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Pre-hospital care audits are performed on a regular basis as outlined in the EQUIP: [https://kernpublichealth.com/wp-content/uploads/EQIP\\_07312019-final.pdf](https://kernpublichealth.com/wp-content/uploads/EQIP_07312019-final.pdf)

#### NEEDS:

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.04 MEDICAL DISPATCH

---

#### MINIMUM STANDARDS:

The local EMS agency shall have a mechanism to review medical dispatching to ensure that the appropriate level of medical response is sent to each emergency and to monitor the appropriateness of pre-arrival/post dispatch directions.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Both dispatch agencies must submit call data to EMS monthly for review, as outlined in the EMD Policy: [http://kernpublichealth.com/wp-content/uploads/2014/09/EMD\\_Policy\\_09012016.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/EMD_Policy_09012016.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.05 DATA MANAGEMENT SYSTEM

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish a data management system that supports its system-wide planning and evaluation (including identification of high risk patient groups) and the QA/QI audit of the care provided to specific patients. It shall be based on state standards.

#### RECOMMENDED GUIDELINES:

The local EMS agency should establish an integrated data management system which includes system response and clinical (both pre-hospital and hospital) data.

The local EMS agency should use patient registries, tracer studies, and other monitoring systems to evaluate patient care at all stages of the system.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS mandates that all approved EMS providers complete and submit electronic patient care reports. Currently NEMSIS 3.4 is being accepted: [http://kernpublichealth.com/wp-content/uploads/2014/09/ePCR Policies\\_05122017.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/ePCR Policies_05122017.pdf)

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEEDS:

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.06 SYSTEM DESIGN EVALUATION

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish an evaluation program to evaluate EMS system design and operations, including system effectiveness at meeting community needs, appropriateness of guidelines and standards, prevention strategies that are tailored to community needs, and assessment of resources needed to adequately support the system. This shall include structure, process, and outcome evaluations, utilizing state standards and guidelines.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS is constantly evaluating our system. This is accomplished through various policies and procedures such as the Ambulance Performance Standards, the EQUIP, Specialty Care Center Policies, and EMS Dispatch Policies.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.07 PROVIDER PARTICIPATION

---

#### MINIMUM STANDARDS:

The local EMS agency shall have the resources and authority to require provider participation in the system-wide evaluation program.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS mandates participation through Health and Safety Code, Title 22 regulations, local ordinance, contracts, policies, procedures and protocols.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.08 REPORTING

---

#### MINIMUM STANDARDS:

The local EMS agency shall, at least annually, report on the results of its evaluation of EMS system design and operations to the Board(s) of Supervisors, provider agencies, and Emergency Medical Care Committee(s).

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS reports annually to the Emergency Care Advisory Board (EMCAB) as well as the County Board of Supervisors. These reports are posted for public review on the EMS website.

#### NEEDS:

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.09 ALS AUDIT

---

#### MINIMUM STANDARDS:

The process used to audit treatment provided by advanced life support providers shall evaluate both base hospital (or alternative base station) and pre-hospital activities.

#### RECOMMENDED GUIDELINES:

The local EMS agency's integrated data management system should include pre-hospital, base hospital, and receiving hospital data.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

ALS PCR audits are conducted on a regular basis as outlined in the EQUIP: [https://kernpublichealth.com/wp-content/uploads/EQIP\\_07312019-final.pdf](https://kernpublichealth.com/wp-content/uploads/EQIP_07312019-final.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.10 TRAUMA SYSTEM EVALUATION

---

#### MINIMUM STANDARDS:

The local EMS agency, with participation of acute care providers, shall develop a trauma system evaluation and data collection program, including: a trauma registry, a mechanism to identify patients whose care fell outside of established criteria, and a process for identifying potential improvements to the system design and operation.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern Medical submits trauma data through Trauma One and to CEMIS. See Trauma System of Care: [http://kernpublichealth.com/wp-content/uploads/2014/09/TraumaPoliciesandProcedures\\_07012015.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/TraumaPoliciesandProcedures_07012015.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## DATA COLLECTION AND SYSTEM EVALUATION

### 6.11 TRAUMA CENTER DATA

---

#### MINIMUM STANDARDS:

The local EMS Agency shall ensure that designated trauma centers provide required data to the EMS agency, including patient specific information that is required for quality assurance/quality improvement and system evaluation.

#### RECOMMENDED GUIDELINES:

The local EMS agency should seek data on trauma patients who are treated at non-trauma center hospitals and shall include this information in their QA/QI and system evaluation program.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Trauma system data is mandated by policy: [http://kernpublichealth.com/wp-content/uploads/2014/09/TraumaPoliciesandProcedures\\_07012015.pdf](http://kernpublichealth.com/wp-content/uploads/2014/09/TraumaPoliciesandProcedures_07012015.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## PUBLIC INFORMATION AND EDUCATION

### 7.01 PUBLIC INFORMATION MATERIALS

---

#### MINIMUM STANDARDS:

The local EMS agency shall promote the development and dissemination of information materials for the public that addresses:

- understanding of EMS system design and operation,
- proper access to the system,
- self-help (e.g., CPR, first aid, etc.),
- patient and consumer rights as they relate to the EMS system,
- health and safety habits as they relate to the prevention and reduction of health risks in target areas, and
- appropriate utilization of emergency departments.

#### RECOMMENDED GUIDELINES:

The local EMS agency should promote targeted community education programs on the use of emergency medical services in its service area.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS is actively engaged in Public Education. EMS participates and coordinates Side-Walk CPR, Stop the Bleed, AED, Start Triage and Narcan trainings, conducts public education as requested, and participates in Health Fairs. Specialty Care Centers have requirements to provide for public education in policy. EMS is a Division of Public Health, which is also active in promoting EMS and community health initiatives.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## PUBLIC INFORMATION AND EDUCATION

### 7.02 INJURY CONTROL

---

#### MINIMUM STANDARDS:

The local EMS agency, in conjunction with other local health education programs, shall work to promote injury control and preventive medicine.

#### RECOMMENDED GUIDELINES:

The local EMS agency should promote the development of special EMS educational programs for targeted groups at high risk of injury or illness.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS is a Division of Public Health, EMS is active in participating in promotion of public health and safety. Trauma Centers have policy requirement to provide education to public. Other specialty care centers have requirement to promote specific public education requirements to targeted groups. Currently we are focusing on Narcan, STOP the BLEED, Hands Only CPR and Start Triage training. EMS has purchased and installed Stop the Bleed Cabinets as well as AEDs with cabinets in public areas of numerous county buildings.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## PUBLIC INFORMATION AND EDUCATION

### 7.03 DISASTER PREPAREDNESS

---

#### MINIMUM STANDARDS:

The local EMS agency, in conjunction with the local office of emergency services, shall promote citizen disaster preparedness activities.

#### RECOMMENDED GUIDELINES:

The local EMS agency, in conjunction with the local office of emergency services (OES), should produce and disseminate information on disaster medical preparedness.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS has absorbed the Division of Emergency Preparedness (EP). As a result materials for education to the public on disaster preparedness. Kern Medical Reserve Corp and the Kern Health Care Coalition, are also active in promoting emergency preparedness. EMS participates in health fairs and other events as requested.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## PUBLIC INFORMATION AND EDUCATION

### 7.04 FIRST AID & CPR TRAINING

---

#### MINIMUM STANDARDS:

The local EMS agency shall promote the availability of first aid and CPR training for the general public.

#### RECOMMENDED GUIDELINES:

The local EMS agency should adopt a goal for training of an appropriate percentage of the general public in first aid and CPR. A higher percentage should be achieved in high risk groups.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS coordinates an annual Sidewalk CPR event to promote education of citizens in hands-only CPR. Additionally, EMS provides Stop the Bleed, Sidewalk CPR, Narcan, AED and Start Triage training as requested to public. Kern County EMS has created a request for training form and placed it on our website: <https://kernpublichealth.com/wp-content/uploads/2019/11/TRAINING-REQUEST-FORM-FILLABLE.pdf>

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.01 DISASTER MEDICAL PLANNING

---

#### MINIMUM STANDARDS:

In coordination with the local office of emergency services (OES), the local EMS agency shall participate in the development of medical response plans for catastrophic disasters, including those involving toxic substances.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern County EMS frequently participates in coordination meetings at the EOC to prepare for disasters. Two EMS coordinators are members of Kern County Operational Area Work Group to develop mutual aid plans and procedures for the entire county and we hold the RDMHS contract for region 5. EMS is also represented on the Emergency Council by Environmental Health Division Director.

#### COORDINATION WITH OTHER EMS AGENCIES:

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.02 RESPONSE PLANS

---

#### MINIMUM STANDARDS:

Medical response plans and procedures for catastrophic disasters shall be applicable to incidents caused by a variety of hazards, including toxic substances.

#### RECOMMENDED GUIDELINES:

The California Office of Emergency Services' multi-hazard functional plan should serve as the model for the development of medical response plans for catastrophic disasters.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

The LEMSA Administrator is the MHOAC as well as the Director of the Public Health Department and participates regularly in the development of plans as well as participating in exercises to test the plans.

[http://www.kerncountyfire.org/images/stories/emergency\\_preparedness/Kern\\_Annex\\_B4\\_Med\\_043008.pdf](http://www.kerncountyfire.org/images/stories/emergency_preparedness/Kern_Annex_B4_Med_043008.pdf)

NEED(S):

OBJECTIVE:

TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.03 HAZMAT TRAINING

---

#### MINIMUM STANDARDS:

All EMS providers shall be properly trained and equipped for response to hazardous materials incidents, as determined by their system role and responsibilities.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

The ambulance provider contract requires all field level employees to be trained to the first responder orientation (FRO) level for hazardous materials incidents.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.04 INCIDENT COMMAND SYSTEM

---

#### MINIMUM STANDARDS:

Medical response plans and procedures for catastrophic disasters shall use the Incident Command System (ICS) as the basis for field management.

#### RECOMMENDED GUIDELINES:

The local EMS agency should ensure that ICS training is provided for all medical providers.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

ICS is addressed and referenced in policies regarding response to emergencies. Provided in initial training through EMT and Paramedic training programs.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.05 DISTRIBUTION OF CASUALTIES

---

#### MINIMUM STANDARDS:

The local EMS agency, using state guidelines, shall establish written procedures for distributing disaster casualties to the medically most appropriate facilities in its service area.

#### RECOMMENDED GUIDELINES:

The local EMS agency, using state guidelines, and in consultation with Regional Poison Centers, should identify hospitals with special facilities and capabilities for receipt and treatment of patients with radiation and chemical contamination and injuries.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

EMS distribution is accomplished through use of Reddinet system and use of patient destination protocols.

#### COORDINATION WITH OTHER EMS AGENCIES:

Kern houses the Region V RDMHS. Coordination through MHOAC/RDMHC program

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.06 NEEDS ASSESSMENT

---

#### MINIMUM STANDARDS:

The local EMS agency, using state guidelines, shall establish written procedures for early assessment of needs and shall establish a means for communicating emergency requests to the state and other jurisdictions.

#### RECOMMENDED GUIDELINES:

The local EMS agency's procedures for determining necessary outside assistance should be exercised yearly.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Kern EMS houses the Regional Disaster Medical Health Specialist position as an avenue for requesting mutual aid resources from Region V and beyond. EMS has a seat in Public Health DOC, and Kern OA EOC for coordination and request of resources. EMS participates in the annual statewide Med/Health disaster drills.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.07 DISASTER COMMUNICATIONS

---

#### MINIMUM STANDARDS:

A specific frequency (e.g., CALCORD) or frequencies shall be identified for interagency communication and coordination during a disaster.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Hospitals and EMS have access to MED channels with identified channel and frequency assignment. Use of Reddinet for communications is in place as well. Kern has EMS TAC channels, interoperability channels, and has drafted a Tactical Interoperable Communication Plan for Emergency Council approval.

#### COORDINATION WITH OTHER EMS AGENCIES:

Kern houses the Region V RDMHS. Coordination through MHOAC/RDMHC program

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.08 INVENTORY OF RESOURCES

---

#### MINIMUM STANDARDS:

The local EMS agency, in cooperation with the local OES, shall develop an inventory of appropriate disaster medical resources to respond to multi-casualty incidents and disasters likely to occur in its service area.

#### RECOMMENDED GUIDELINES:

The local EMS agency should ensure that emergency medical providers and health care facilities have written agreements with anticipated providers of disaster medical resources.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

The Public Health Emergency Preparedness Program (PREP) is in the same division of the Public Health Department with the EMS Agency. The PREP program maintains a robust set of Plans and Standard Operating Procedures which are authenticated by EMS providers and health care facilities.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.09 DMAT TEAMS

---

#### MINIMUM STANDARDS:

The local EMS agency shall establish and maintain relationships with DMAT teams in its area.

#### RECOMMENDED GUIDELINES:

The local EMS agency should support the development and maintenance of DMAT teams in its area.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Accomplished through Master Mutual Aid Agreement

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.10 MUTUAL AID AGREEMENTS

---

#### MINIMUM STANDARDS:

The local EMS agency shall ensure the existence of medical mutual aid agreements with other counties in its OES region and elsewhere, as needed, that ensure sufficient emergency medical response and transport vehicles, and other relevant resources will be made available during significant medical incidents and during periods of extraordinary system demand.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Accomplished through Master Mutual Aid Agreement

#### COORDINATION WITH OTHER EMS AGENCIES:

Kern houses the Region V RDMHS. Coordination through MHOAC/RDMHC program

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.11 CCP DESIGNATION

---

#### MINIMUM STANDARDS:

The local EMS agency, in coordination with the local OES and county health officer(s), and using state guidelines, shall designate Field Treatment Sites (FTS).

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Identification of two Field Treatment Sites in Kern County.

#### COORDINATION WITH OTHER EMS AGENCIES:

Kern houses the Region V RDMHS. Coordination through MHOAC/RDMHC program

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.12 ESTABLISHMENT OF CCP

---

#### MINIMUM STANDARDS:

The local EMS agency, in coordination with the local OES, shall develop plans for establishing Casualty Collection Points (CCP) and a means for communicating with them.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Standard met through:

[http://www.kerncountyfire.org/images/stories/emergency\\_preparedness/Kern\\_Annex\\_B4\\_Med\\_043008.pdf](http://www.kerncountyfire.org/images/stories/emergency_preparedness/Kern_Annex_B4_Med_043008.pdf)

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.13 DISASTER MEDICAL TRAINING

---

#### MINIMUM STANDARDS:

The local EMS agency shall review the disaster medical training of EMS responders in its service area, including the proper management of casualties exposed to and/or contaminated by toxic or radioactive substances.

#### RECOMMENDED GUIDELINES:

The local EMS agency should ensure that EMS responders are appropriately trained in disaster response, including the proper management of casualties exposed to or contaminated by toxic or radioactive substances.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Initial training provided through EMT and Paramedic training programs. Annual disaster drills. Basic Haz-Mat awareness training provided in initial training curriculum. Kern County EMS is conducting an Isopod drill to test our ability to wrap an ambulance and transport an exposed patient.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.14 HOSPITAL PLANS

---

#### MINIMUM STANDARDS:

The local EMS agency shall encourage all hospitals to ensure that their plans for internal and external disasters are fully integrated with the county's medical response plan(s).

#### RECOMMENDED GUIDELINES:

At least one disaster drill per year conducted by each hospital should involve other hospitals, the local EMS agency, and pre-hospital medical care agencies.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Outlined in specific policy for disaster planning. Participation in Disaster Medical Planning Group. Hospital Surge Policy:  
<http://kernpublichealth.com/wp-content/uploads/2014/09/HospitalSurgeProtocol06102008.pdf>

NEED(S):

OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.15 INTERHOSPITAL COMMUNICATIONS

---

**MINIMUM STANDARDS:**

The local EMS agency shall ensure that there is an emergency system for inter-hospital communications, including operational procedures.

**RECOMMENDED GUIDELINES:**

None.

**CURRENT STATUS:** MEETS MINIMUM STANDARD

Hospitals have MED radio channels/ frequencies. Use of Reddinet for communications, and deployment of Amateur Radio Operators if needed.

**NEED(S):**

**OBJECTIVE:**

**TIME FRAME FOR MEETING OBJECTIVE:**

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.16 PREHOSPITAL AGENCY PLANS

---

#### MINIMUM STANDARDS:

The local EMS agency shall ensure that all pre-hospital medical response agencies and acute-care hospitals in its service area, in cooperation with other local disaster medical response agencies, have developed guidelines for the management of significant medical incidents and have trained their staffs in their use.

#### RECOMMENDED GUIDELINES:

The local EMS agency should ensure the availability of training in management of significant medical incidents for all pre-hospital medical response agencies and acute-care hospital staffs in its service area.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Emergency plans in place, hospital policies mandate emergency/disaster plans, hospital surge policies, Med-Alert policies and communications, hospital implementation of HICS training and use.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.17 ALS POLICIES

---

#### MINIMUM STANDARDS:

The local EMS agency shall ensure that policies and procedures allow advanced life support personnel and mutual aid responders from other EMS systems to respond and function during significant medical incidents.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Master Mutual Aid Agreement, reciprocity processes in place, if needed.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.18 SPECIALTY CENTER ROLES

---

#### MINIMUM STANDARDS:

Local EMS agencies developing trauma or other specialty care systems shall determine the role of identified specialty centers during a significant medical incidents and the impact of such incidents on day-to-day triage procedures.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Specialty Care Centers are required to have disaster plans in place, plans for surge, HICS, and participation in Med-Alert procedures. Participation in Disaster Medical Planning Group is requirement in written agreement.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)

# SYSTEM ASSESSMENT FORMS

## DISASTER MEDICAL RESPONSE

### 8.19 WAIVING EXCLUSIVITY

---

#### MINIMUM STANDARDS:

Local EMS agencies which grant exclusive operating permits shall ensure that a process exists to waive the exclusivity in the event of a significant medical incident.

#### RECOMMENDED GUIDELINES:

None.

#### CURRENT STATUS: MEETS MINIMUM STANDARD

Ordinance, and Ambulance Service Performance Standards allow the Division to waive exclusivity in the event of mutual aid.

#### NEED(S):

#### OBJECTIVE:

#### TIME FRAME FOR MEETING OBJECTIVE:

- Short-Range Plan (one year or less)
- Long-Range Plan (more than one year)



**TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT**

Reporting Year: 2019

**NOTE:** Number (1) below is to be completed for each county. The balance of Table 2 refers to each agency.

1. Percentage of population served by each level of care by county:  
(Identify for the maximum level of service offered; the total of a, b, and c should equal 100%.)

County: KERN

- A. Basic Life Support (BLS) 0 %
- B. Limited Advanced Life Support (LALS) 0 %
- C. Advanced Life Support (ALS) 100 %

2. Type of agency
- a) Public Health Department**
  - b) County Health Services Agency
  - c) Other (non-health) County Department
  - d) Joint Powers Agency
  - e) Private Non-Profit Entity
  - f) Other: \_\_\_\_\_

3. The person responsible for day-to-day activities of the EMS agency reports to
- a) Public Health Officer
  - b) Health Services Agency Director/Administrator**
  - c) Board of Directors
  - d) Other: \_\_\_\_\_

4. Indicate the non-required functions which are performed by the agency:

- Implementation of exclusive operating areas (ambulance franchising) X\_\_\_\_\_
- Designation of trauma centers/trauma care system planning X\_\_\_\_\_
- Designation/approval of pediatric facilities X\_\_\_\_\_
- Designation of other critical care centers X\_\_\_\_\_
- Development of transfer agreements \_\_\_\_\_
- Enforcement of local ambulance ordinance X\_\_\_\_\_
- Enforcement of ambulance service contracts X\_\_\_\_\_
- Operation of ambulance service \_\_\_\_\_
- Continuing education X\_\_\_\_\_
- Personnel training X\_\_\_\_\_
- Operation of oversight of EMS dispatch center X\_\_\_\_\_
- Non-medical disaster planning X\_\_\_\_\_
- Administration of critical incident stress debriefing team (CISD) \_\_\_\_\_

**TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)**

Administration of disaster medical assistance team (DMAT)	_____
Administration of EMS Fund [Senate Bill (SB) 12/612]	X_____
Other: _____	_____
Other: _____	_____
Other: _____	_____

**5. EXPENSES (FY18/19 ACTUAL)**

Salaries and benefits (All but contract personnel)	\$ 685,748
Contract Services (e.g. medical director)	\$ 103,292
Operations (e.g. copying, postage, facilities)	\$ 186,635
Travel	\$ 9,350
Fixed assets	\$ 0
Indirect expenses (overhead)	\$ 123,549
Ambulance subsidy	\$ 0
EMS Fund payments to physicians/hospital	\$ 1,502,368
Dispatch center operations (non-staff)	\$ 0
Training program operations	\$ 0
Other: COMMUNICATIONS	\$ 0
Other: _____	_____
Other: _____	_____
<b>TOTAL EXPENSES</b>	<b>\$2,610,942</b>

**6. SOURCES OF REVENUE**

Special project grant(s) [from EMSA] (ALJ)	\$5,372
Preventive Health and Health Services (PHHS) Block Grant	0
Office of Traffic Safety (OTS)	0
State general fund	0
County general fund	\$ 138,601
Other local tax funds (e.g., EMS district)	0
County contracts (e.g. multi-county agencies) (PMC)	\$ 0
Certification fees	\$ 44,331
Training program approval fees	0
Training program tuition/ <del>Average daily attendance funds (ADA)</del>	\$ 5,559
Job Training Partnership ACT (JTPA) funds/other payments	0
Base hospital /receiving application fees	\$ 270,464

**TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)**

Trauma center application fees	\$ 0
Trauma center <del>designation</del> oversight fees	\$159,432
Pediatric facility approval fees	0
Pediatric facility designation fees	0
Other critical care center application fees	\$25,000
Type: _____	
Other critical care center designation fees	0
Type: _____	
Ambulance service/vehicle fees	\$ 178,651
Contributions	0
EMS Fund (SB 12/612)	\$ 342,059
Other grants: (HPP/PHEP)	\$ 0
(RDMHS)	\$ 105,223
Other fees: Misc Reimbursement	\$ 1,849
Other (specify): Penalties	\$ 30,000
Other (specify): Budget Savings	\$ 0
<b>TOTAL REVENUE</b>	<b>\$ 2,610,942</b>

*TOTAL REVENUE SHOULD EQUAL TOTAL EXPENSES.  
IF THEY DON'T, PLEASE EXPLAIN.*

**TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)**

**7. Fee structure**

We do not charge any fees

Our fee structure is:

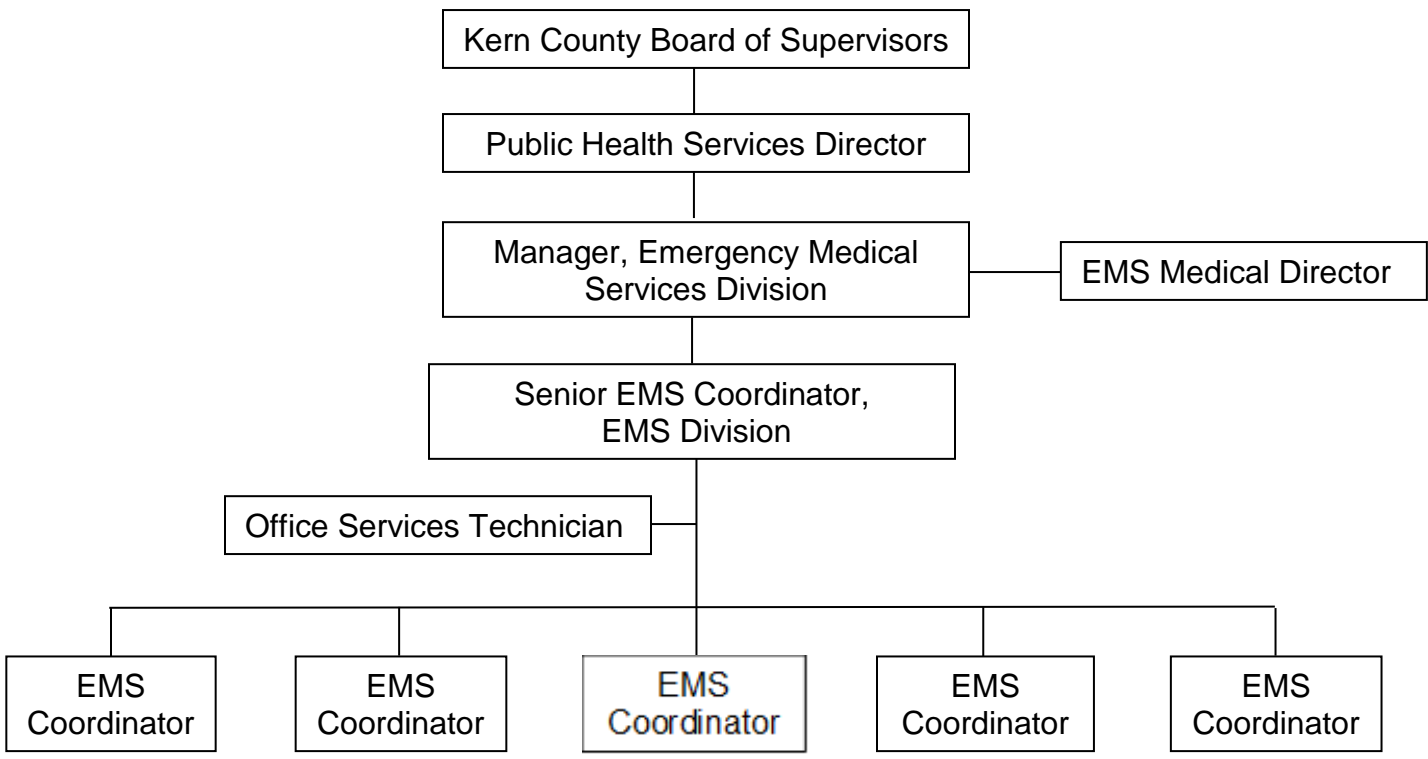
First responder certification	\$ _____
EMS dispatcher certification	\$100.00
EMT-I certification (In county/Out of County)	\$100.00/\$100.00
EMT-I recertification (In County/Out of County)	\$100.00/\$100.00
EMT-defibrillation certification	
EMT-defibrillation recertification	_____
AEMT certification	_____
AEMT recertification	_____
EMT-P accreditation (Initial/Expired)	\$100.00
Mobile Intensive Care Nurse/Authorized Registered Nurse certification	\$100.00
MICN/ARN recertification	\$100.00
EMT-I training program approval	_____
AEMT training program approval	_____
EMT-P training program approval	_____
MICN/ARN training program approval	_____
Base hospital application	_____
Base hospital designation (Urban/Rural)	\$0
Trauma center application	\$0
Trauma center designation	\$159,432
Pediatric facility approval	_____
Pediatric facility designation	_____
Other critical care center application	
Type: _____	
Other critical care center designation	
Type: _____	
Ambulance service license (Ground/Air)	\$178,651
Ambulance vehicle permits (Ground/Air)	\$0
Other: EMT Optional Scope Accreditation	\$0
Other: Receiving Hospital Permit	\$0
Other: Training programs	\$92.00/hour
Other: CE Programs	\$92.00/hour
Other: Classroom Rental	\$0

**TABLE 2: SYSTEM ORGANIZATION AND MANAGEMENT (cont.)**

CATEGORY	ACTUAL TITLE	FTE POSITIONS (EMS ONLY)	TOP SALARY BY HOURLY EQUIVALENT	BENEFITS (%of Salary)	COMMENTS
EMS Admin./Coord./Director	EMS Program Manager	1	\$46.05	78.30%	
Asst. Admin./Admin.Asst./Admin. Mgr.	Senior EMS Coordinator	1	\$37.89	83.84%	
ALS Coord./Field Coord./Trng Coordinator	EMS Coordinator	5	\$34.29	82.88%	1 assigned to RDMHS Region V duties
Program Coordinator/Field Liaison (Non-clinical)					
Trauma Coordinator					
Medical Director	Medical Director		\$103,292/year	N/A	Contracted per year
Other MD/Medical Consult/Training Medical Director					
Disaster Medical Planner					
Dispatch Supervisor					
Medical Planner					
Data Evaluator/Analyst					
QA/QI Coordinator					
Public Info. & Education Coordinator					
Executive Secretary					
Other Clerical	Office Services Technician	1	\$17.57	78.30%	
Data Entry Clerk					

Other					
-------	--	--	--	--	--

Include an organizational chart of the local EMS agency and a county organization chart(s) indicating how the LEMSA fits within the county/multi-county structure.



**TABLE 3: STAFFING/TRAINING**

Reporting Year: 2019

**NOTE:** Table 3 is to be reported by agency.

	EMT - Is	EMT - IIs	EMT - Ps	MICN
Total Certified	1940	0		153
Number newly certified this year	204	0		34
Number recertified this year	981	0		48
Total number of accredited personnel on July 1 of the reporting year	1940	0	256	153
Number of certification reviews resulting in:				
a) formal investigations	51	0		2
b) probation	8	0	0	0
c) suspensions	0	0	0	0
d) revocations	3	0		0
e) denials	1	0		0
f) denials of renewal	1	0		0
g) no action taken	15	0	0	0

1. Early defibrillation:

a) Number of EMT-I (defib) authorized to use AEDs

  All  

b) Number of public safety (defib) certified (non-EMT-I)

  419  

2. Do you have an EMR training program

yes  no

## TABLE 4: COMMUNICATIONS

**Note:** Table 4 is to be answered for each county.

County: Kern

Reporting Year: 2019

- |   |                                   |
|---|-----------------------------------|
| 1. Number of primary Public Service Answering Points (PSAP)   | <u>9</u>                          |
| 2. Number of secondary PSAPs  | <u>1</u>                          |
| 3. Number of dispatch centers directly dispatching ambulances   | <u>1</u>                          |
| 4. Number of EMS dispatch agencies utilizing EMD guidelines   | <u>2</u>                          |
| 5. Number of designated dispatch centers for EMS Aircraft   | <u>1</u>                          |
| 6. Who is your primary dispatch agency for day-to-day emergencies?<br>Emergency Communication Center                      |                                   |
| 7. Who is your primary dispatch agency for a disaster?<br>Emergency Communication Center                                  |                                   |
| 8. Do you have an operational area disaster communication system?   | X Yes <input type="checkbox"/> No |
| a. Radio primary frequency      462.9500/467.9500   |                                   |
| b. Other methods                      other Med Channels, Cell, Reddinet  |                                   |
| c. Can all medical response units communicate on the same disaster<br>communications system?                              | X Yes <input type="checkbox"/> No |
| d. Do you participate in the Operational Area Satellite Information System<br>(OASIS)?                                    | X Yes <input type="checkbox"/> No |
| e. Do you have a plan to utilize the Radio Amateur Civil Emergency Services<br>(RACES) as a back-up communication system? | X Yes <input type="checkbox"/> No |
| 1) Within the operational area?   | X Yes <input type="checkbox"/> No |
| 2) Between operation area and the region and/or state?  | X Yes <input type="checkbox"/> No |
-



**TABLE 5: RESPONSE/TRANSPORTATION**

Reporting Year: 2019

**Note:** Table 5 is to be reported by agency.

**Early Defibrillation Providers**

- 1. Number of EMT-Defibrillation providers 8

**SYSTEM STANDARD RESPONSE TIMES (90<sup>TH</sup> PERCENTILE)**

Enter the response times in the appropriate boxes:

	METRO/URBAN	SUBURBAN/ RURAL	WILDERNESS	SYSTEMWIDE
BLS and CPR capable first responder	-	-	-	-
Early defibrillation responder	-	-	-	-
Advanced life support responder (PMC Only)	8 min/15 min	-	-	-
Transport Ambulance	8 min/15 min	25 min/50 min	75 min	-

## TABLE 6: FACILITIES/CRITICAL CARE

Reporting Year: 2019

**NOTE:** Table 6 is to be reported by agency.

### Trauma

Trauma patients:

1. Number of patients meeting trauma triage criteria (Step 1 & 2)	1181
2. Number of major trauma victims transported directly to a trauma center by ambulance (Step 1 & 2)	549
3. Number of major trauma patients transferred to a trauma center	56
4. Number of patients meeting triage criteria who weren't treated at a trauma center (Step 1 & 2)	26

### Emergency Departments

Total number of emergency departments	10
1. Number of referral emergency services	0
2. Number of standby emergency services	1
3. Number of basic emergency services	9
4. Number of comprehensive emergency services	0

### Receiving Hospitals

1. Number of receiving hospitals with written agreements	2
2. Number of base hospitals with written agreements	8

## TABLE 7: DISASTER MEDICAL

Reporting Year: 2019

County: Kern

**NOTE:** Table 7 is to be answered for each county.

### SYSTEM RESOURCES

1. Casualty Collections Points (CCP)
  - a. Where are your CCPs located? High schools throughout Kern County
  - b. How are they staffed? Prehospital personnel, public health nurses, medical reserve corp
  - c. Do you have a supply system for supporting them for 72 hours? X Yes  No
  
2. CISD  
Do you have a CISD provider with 24 hour capability? X Yes  No
  
3. Medical Response Team
  - a. Do you have any team medical response capability? X Yes  No
  - b. For each team, are they incorporated into your local response plan? X Yes  No
  - c. Are they available for statewide response? X Yes  No
  - d. Are they part of a formal out-of-state response system? X Yes  No
  
4. Hazardous Materials
  - a. Do you have any HazMat trained medical response teams? X Yes  No
  - b. At what HazMat level are they trained? Tech & Spec
  - c. Do you have the ability to do decontamination in an emergency room? X Yes  No
  - d. Do you have the ability to do decontamination in the field? X Yes  No

### OPERATIONS

1. Are you using a Standardized Emergency Management System (SEMS) that incorporates a form of Incident Command System (ICS) structure? X Yes  No
  
2. What is the maximum number of local jurisdiction EOCs you will need to interact with in a disaster? 9
  
3. Have you tested your MCI Plan this year in a:
  - a. real event? X Yes  No
  - b. exercise? X Yes  No

**TABLE 7: DISASTER MEDICAL (cont.)**

4. List all counties with which you have a written medical mutual aid agreement:  
All counties under the California Master Mutual Aid Agreement
5. Do you have formal agreements with hospitals in your operational area to participate in disaster planning and response?  Yes  No
6. Do you have a formal agreements with community clinics in your operational areas to participate in disaster planning and response?  Yes  No
7. Are you part of a multi-county EMS system for disaster response?  Yes  No  
Kern does manage the RDMHS program for Region V
8. Are you a separate department or agency?  Yes  No
9. If not, to whom do you report? Department of Public Health Services
8. If your agency is not in the Health Department, do you have a plan to coordinate public health and environmental health issues with the Health Department?  Yes  No



**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

**County:** Kern **Provider:** Borax Ambulance Service **Response Zone:** Borax Mine

**Address:** 14468 Borax Road  
Boron, CA 93516

**Number of Ambulance Vehicles in Fleet:** 1

**Phone Number:** 760-762-7616

**Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day:** 1

<p><b><u>Written Contract:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p><input type="checkbox"/> Transport <input checked="" type="checkbox"/> ALS <input type="checkbox"/> 9-1-1 <input checked="" type="checkbox"/> Ground  <input checked="" type="checkbox"/> Non-Transport <input type="checkbox"/> BLS <input type="checkbox"/> x 7-Digit <input type="checkbox"/> Air  <input type="checkbox"/> CCT <input type="checkbox"/> Water  <input type="checkbox"/> IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input type="checkbox"/> Public <input checked="" type="checkbox"/> Private</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> Fire <input type="checkbox"/> Law <input type="checkbox"/> Other Explain: _____</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Fire District <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p><input type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

3 Total number of responses  
3 Number of emergency responses  
0 Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**Air Ambulance Services**

\_\_\_\_\_ Total number of responses  
 \_\_\_\_\_ Number of emergency responses  
 \_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

County: Kern Provider: California City Fire Department Response Zone: California City  
 Address: 20890 Hacienda Blvd Number of Ambulance Vehicles in Fleet: 0  
California City, CA 93505  
 Phone Number: 760-373-4841 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: N/A

<p><b><u>Written Contract:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p><input type="checkbox"/> Transport <input checked="" type="checkbox"/> ALS <input checked="" type="checkbox"/> 9-1-1 <input checked="" type="checkbox"/> Ground  <input checked="" type="checkbox"/> Non-Transport <input type="checkbox"/> BLS <input type="checkbox"/> 7-Digit <input type="checkbox"/> Air  <input type="checkbox"/> CCT <input type="checkbox"/> Water  <input type="checkbox"/> IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input checked="" type="checkbox"/> Public  <input type="checkbox"/> Private</p>	<p><b><u>If Public:</u></b></p> <p><input checked="" type="checkbox"/> Fire  <input type="checkbox"/> Law  <input type="checkbox"/> Other                  Explain:</p>	<p><b><u>If Public:</u></b></p> <p><input checked="" type="checkbox"/> City <input type="checkbox"/> County  <input type="checkbox"/> State <input type="checkbox"/> Fire District  <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p><input type="checkbox"/> Rotary  <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue  <input type="checkbox"/> Air Ambulance  <input type="checkbox"/> ALS Rescue  <input type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

285 Total number of responses  
254 Number of emergency responses  
31 Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**Air Ambulance Services**

\_\_\_\_\_ Total number of responses  
 \_\_\_\_\_ Number of emergency responses  
 \_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

**County:** Kern **Provider:** Delano Ambulance Services **Response Zone:** 3

**Address:** 403 Main Street  
Delano, CA 93215

**Number of Ambulance Vehicles in Fleet:** 5

**Phone Number:** 661-725-3374

**Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day:** Performance based on response time, not unit inventory

<p><b><u>Written Contract:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p>X Transport      X ALS      X 9-1-1      X Ground  <input type="checkbox"/> Non-Transport      <input type="checkbox"/> BLS      X 7-Digit      <input type="checkbox"/> Air  <input type="checkbox"/> CCT      <input type="checkbox"/> Water  X IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input type="checkbox"/> Public  X Private</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> Fire  <input type="checkbox"/> Law  <input type="checkbox"/> Other  Explain: _____</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City      <input type="checkbox"/> County  <input type="checkbox"/> State      <input type="checkbox"/> Fire District  <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p><input type="checkbox"/> Rotary  <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue  <input type="checkbox"/> Air Ambulance  <input type="checkbox"/> ALS Rescue  <input type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

3786 Total number of responses  
2811 Number of emergency responses  
961 Number of non-emergency responses

3244 Total number of transports  
177 Number of emergency transports  
3049 Number of non-emergency transports

**Air Ambulance Services**

\_\_\_\_\_ Total number of responses  
\_\_\_\_\_ Number of emergency responses  
\_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
\_\_\_\_\_ Number of emergency transports  
\_\_\_\_\_ Number of non-emergency transports



**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

County: Kern Provider: US Air Force, Edwards Base Response Zone: Edwards AFB  
 Address: 30 Hospital Road Number of Ambulance Vehicles in Fleet: 2  
Edwards, CA 93524  
 Phone Number: 661-277-2330 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: N/A

<p><b><u>Written Contract:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p><input checked="" type="checkbox"/> Transport <input checked="" type="checkbox"/> ALS <input type="checkbox"/> 9-1-1 <input checked="" type="checkbox"/> Ground  <input type="checkbox"/> Non-Transport <input type="checkbox"/> BLS <input type="checkbox"/> x 7-Digit <input type="checkbox"/> Air  <input type="checkbox"/> CCT <input type="checkbox"/> Water  <input type="checkbox"/> IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input checked="" type="checkbox"/> Public  <input type="checkbox"/> Private</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> Fire  <input type="checkbox"/> Law  <input checked="" type="checkbox"/> Other                  Explain: Military</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City <input type="checkbox"/> County  <input type="checkbox"/> State <input type="checkbox"/> Fire District  <input checked="" type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p><input type="checkbox"/> Rotary  <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue  <input type="checkbox"/> Air Ambulance  <input type="checkbox"/> ALS Rescue  <input type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

294 Total number of responses  
267 Number of emergency responses  
27 Number of non-emergency responses

147 Total number of transports  
40 Number of emergency transports  
107 Number of non-emergency transports

**Air Ambulance Services**

\_\_\_\_\_ Total number of responses  
 \_\_\_\_\_ Number of emergency responses  
 \_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

**County:** Kern      **Provider:** Hall Ambulance Service      **Response Zone:** 1,2,4,8,9,11, A

**Address:** 1001 21<sup>st</sup> Street  
Bakersfield, CA 93301      **Number of Ambulance Vehicles in Fleet:** 93+ 1 DMSU + 7 Supervisor vehicles + 1 helicopter

**Phone Number:** 661-332-8741      **Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day:** Performance based on response time, not unit inventory

<p><b><u>Written Contract:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p>X Transport      X ALS      X 9-1-1      X Ground  <input type="checkbox"/> Non-Transport      <input type="checkbox"/> BLS      X 7-Digit      X Air  X CCT      <input type="checkbox"/> Water  X IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input type="checkbox"/> Public  X Private</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> Fire  <input type="checkbox"/> Law  <input type="checkbox"/> Other  Explain: _____</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City      <input type="checkbox"/> County  <input type="checkbox"/> State      <input type="checkbox"/> Fire District  <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p>X Rotary  <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue  X Air Ambulance  <input type="checkbox"/> ALS Rescue  <input type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

106699 Total number of responses  
96496 Number of emergency responses  
10203 Number of non-emergency responses

74656 Total number of transports  
3850 Number of emergency transports  
70806 Number of non-emergency transports

**Air Ambulance Services**

319 Total number of responses  
312 Number of emergency responses  
7 Number of non-emergency responses

277 Total number of transports  
178 Number of emergency transports  
99 Number of non-emergency transports

**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

**County:** Kern **Provider:** Kern County Sheriff's Office **Response Zone:** Countywide

**Address:** 1350 Norris Road  
Bakersfield, CA 93308

**Number of Ambulance Vehicles in Fleet:** 1 Hoist Helicopter

**Phone Number:** 661-391-7500

**Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day:** 0.5 (not available everyday)

<p><b><u>Written Contract:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p><input type="checkbox"/> Transport <input type="checkbox"/> ALS <input checked="" type="checkbox"/> 9-1-1 <input type="checkbox"/> Ground  <input checked="" type="checkbox"/> Non-Transport <input checked="" type="checkbox"/> BLS <input type="checkbox"/> 7-Digit <input checked="" type="checkbox"/> Air  <input type="checkbox"/> CCT <input type="checkbox"/> Water  <input type="checkbox"/> IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input checked="" type="checkbox"/> Public <input type="checkbox"/> Private</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> Fire <input checked="" type="checkbox"/> Law <input type="checkbox"/> Other Explain:</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City <input checked="" type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Fire District <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p><input checked="" type="checkbox"/> Rotary <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue <input type="checkbox"/> Air Ambulance <input type="checkbox"/> ALS Rescue <input checked="" type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

\_\_\_\_\_ Total number of responses  
 \_\_\_\_\_ Number of emergency responses  
 \_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**Air Ambulance Services**

\_\_\_\_\_ Total number of responses  
 \_\_\_\_\_ Number of emergency responses  
 \_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

**County:** Kern      **Provider:** Kern County Fire Department      **Response Zone:** Countywide; ALS /BLS

**Address:** 5642 Victor Street      **Number of Ambulance Vehicles in Fleet:** 2 ALS FR stations, 1 ALS squad, 1 ALS Rescue Helicopter, 2 Hoist Helicopters all other BLS

Bakersfield, CA 93308

**Phone Number:** 661-391-7000      **Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day:** N/A

<p><b><u>Written Contract:</u></b></p> <p>X Yes   <input type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p>X Yes   <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p>X Yes   <input type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p><input type="checkbox"/> Transport      X ALS      X 9-1-1      X Ground  <input checked="" type="checkbox"/> Non-Transport      X BLS      <input type="checkbox"/> 7-Digit      X Air  <input type="checkbox"/> CCT      <input type="checkbox"/> Water  <input type="checkbox"/> IFT</p>	
<p><b><u>Ownership:</u></b></p> <p>X Public  <input type="checkbox"/> Private</p>	<p><b><u>If Public:</u></b></p> <p>X Fire  <input type="checkbox"/> Law  <input type="checkbox"/> Other          Explain:</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City      X County  <input type="checkbox"/> State      <input type="checkbox"/> Fire District  <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p>X Rotary  <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue  <input type="checkbox"/> Air Ambulance          X ALS Rescue          X BLS Rescue</p>

**Transporting Agencies**

\_\_\_\_\_ Total number of responses  
 \_\_\_\_\_ Number of emergency responses  
 \_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**Air Ambulance Services**

21 Total number of responses  
17 Number of emergency responses  
4 Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

County: Kern Provider: Liberty Ambulance Services Response Zone: 6, 7

Address: 1325 W. Ridgecrest Blvd Number of Ambulance Vehicles in Fleet: 12  
Ridgecrest, CA 93555

Phone Number: 760-375-6565 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: Performance based on response time, not unit inventory

<p><b><u>Written Contract:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p>X Yes <input type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p>X Transport      X ALS      X 9-1-1      X Ground  <input type="checkbox"/> Non-Transport      <input type="checkbox"/> BLS      X 7-Digit      <input type="checkbox"/> Air  <input type="checkbox"/> CCT      <input type="checkbox"/> Water  X IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input type="checkbox"/> Public  X Private</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> Fire  <input type="checkbox"/> Law  <input type="checkbox"/> Other  Explain: _____</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City      <input type="checkbox"/> County  <input type="checkbox"/> State      <input type="checkbox"/> Fire District  <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p><input type="checkbox"/> Rotary  <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue  <input type="checkbox"/> Air Ambulance  <input type="checkbox"/> ALS Rescue  <input type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

6449 Total number of responses  
4555 Number of emergency responses  
1894 Number of non-emergency responses

5044 Total number of transports  
230 Number of emergency transports  
4814 Number of non-emergency transports

**Air Ambulance Services**

\_\_\_\_\_ Total number of responses  
\_\_\_\_\_ Number of emergency responses  
\_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
\_\_\_\_\_ Number of emergency transports  
\_\_\_\_\_ Number of non-emergency transports

**TABLE 8: Response/Transportation/Providers**

**Note:** Table 8 is to be completed for each provider by county. Make copies as needed.

County: Kern Provider: Mercy Air Response Zone: County-wide  
 Address: 1670 Miro Way Number of Ambulance Vehicles in Fleet: 1 helicopter  
Rialto, CA 92376  
 Phone Number: 909-357-9006 Average Number of Ambulances on Duty At 12:00 p.m. (noon) on Any Given Day: 1

<p><b><u>Written Contract:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Medical Director:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>System Available 24 Hours:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>Level of Service:</u></b></p> <p><input checked="" type="checkbox"/> Transport <input checked="" type="checkbox"/> ALS <input checked="" type="checkbox"/> 9-1-1 <input type="checkbox"/> Ground  <input type="checkbox"/> Non-Transport <input type="checkbox"/> BLS <input checked="" type="checkbox"/> 7-Digit <input checked="" type="checkbox"/> Air  <input checked="" type="checkbox"/> CCT <input type="checkbox"/> Water  <input checked="" type="checkbox"/> IFT</p>	
<p><b><u>Ownership:</u></b></p> <p><input type="checkbox"/> Public  <input checked="" type="checkbox"/> Private</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> Fire  <input type="checkbox"/> Law  <input type="checkbox"/> Other                  Explain: _____</p>	<p><b><u>If Public:</u></b></p> <p><input type="checkbox"/> City <input type="checkbox"/> County  <input type="checkbox"/> State <input type="checkbox"/> Fire District  <input type="checkbox"/> Federal</p>	<p><b><u>If Air:</u></b></p> <p><input checked="" type="checkbox"/> Rotary  <input type="checkbox"/> Fixed Wing</p>	<p><b><u>Air Classification:</u></b></p> <p><input type="checkbox"/> Auxiliary Rescue  <input checked="" type="checkbox"/> Air Ambulance  <input type="checkbox"/> ALS Rescue  <input type="checkbox"/> BLS Rescue</p>

**Transporting Agencies**

\_\_\_\_\_ Total number of responses  
 \_\_\_\_\_ Number of emergency responses  
 \_\_\_\_\_ Number of non-emergency responses

\_\_\_\_\_ Total number of transports  
 \_\_\_\_\_ Number of emergency transports  
 \_\_\_\_\_ Number of non-emergency transports

**Air Ambulance Services**

223 Total number of responses  
221 Number of emergency responses  
2 Number of non-emergency responses

223 Total number of transports  
219 Number of emergency transports  
4 Number of non-emergency transports

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #1</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Hall Ambulance Service, Inc.</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of Wasco and Lost Hills and surrounding unincorporated areas</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Non Exclusive – <u>Competitive Bid process underway</u></p>
<p><b>Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). N/A</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers. N/A</p>

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #2</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Hall Ambulance Service, Inc. since 3/16/1999.</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of Shafter, Buttonwillow and surrounding unincorporated areas</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Exclusive</p>
<p><b>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). Emergency Ambulance Services for 9-1-1, 7-digit, All ALS Ambulance Services, IFT, CCT, Non-Emergency, Standby Transportation only within the specified area or sub-area.</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  Hall Ambulance Service, Inc. is the successor to Shafter Ambulance service which provided service to the area since 1/1/81.</p>



**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #3</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Delano Ambulance Service since 1/1/81</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of Delano, McFarland, Woody and surrounding unincorporated areas.</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Exclusive</p>
<p><b>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). Emergency Ambulance Services for 9-1-1, 7-digit, All ALS Ambulance Services, IFT, CCT, Non-Emergency, Standby Transportation only within the specified area or sub-area.</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  Delano Ambulance Service is the provider of service to the area since 1/1/81.</p>

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #4</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Hall Ambulance Service, Inc.</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes community of Bakersfield, Glennville and surrounding unincorporated areas.</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Exclusive</p>
<p><b>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). Emergency Ambulance Services for 9-1-1, 7-digit, All ALS Ambulance Services, IFT, CCT, Non-Emergency, Standby Transportation only within the specified area or sub-area.</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  Hall Ambulance Service, Inc. is the provider of service to the area since 1/1/81.</p>

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #6</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Liberty Ambulance, since 11/1/2011. Purchased CARE Ambulance.</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of Kernville, Lake Isabella, Wofford Heights and surrounding unincorporated areas.</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Exclusive</p>
<p><b>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). Emergency Ambulance Services for 9-1-1, 7-digit, All ALS Ambulance Services, IFT, CCT, Non-Emergency, Standby Transportation only within the specified area or sub-area.</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  Liberty Ambulance is the successor to CARE Ambulance which provided services to the area since 1/1/80.</p>

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #7</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Liberty Ambulance Service since 12/96. Ownership not changed since 1972.</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of Ridgecrest, Inyokern and surrounding unincorporated areas.</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Non-Exclusive – Competitive Bid process underway</p>
<p><b>Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). N/A</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  N/A</p>

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #8</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Hall Ambulance Service, Inc. since 1/1/81.</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of Lamont, Arvin, Tehachapi, Frazier Park and surrounding unincorporated areas.</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Exclusive</p>
<p><b>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). Emergency Ambulance Services for 9-1-1, 7-digit, All ALS Ambulance Services, IFT, CCT, Non-Emergency, Standby Transportation only within the specified area or sub-area.</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  Hall Ambulance Service, Inc. provide service to the area since 1/1/81 without interruption.</p>

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #9</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Hall Ambulance Service, Inc. since 3/6/1995. Purchased Taft Ambulance</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of Taft, Maricopa, McKittrick and surrounding unincorporated areas.</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Exclusive</p>
<p><b>Type of Exclusivity, "Emergency Ambulance", "ALS", or "LALS" (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). Emergency Ambulance Services for 9-1-1, 7-digit, All ALS Ambulance Services, IFT, CCT, Non-Emergency, Standby Transportation only within the specified area or sub-area.</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  Hall Ambulance Service, Inc. is the successor of Taft Ambulance Service which provided service to the area since 1/1/81.</p>

**EMS PLAN  
AMBULANCE ZONE SUMMARY FORM**

In order to evaluate the nature of each area or subarea, the following information should be compiled for each zone individually. Please include a separate form for each exclusive and/or nonexclusive ambulance zone.

<p><b>Local EMS Agency or County Name:</b> Kern County</p>
<p><b>Area or subarea (Zone) Name or Title:</b> Operational Area #11</p>
<p><b>Name of Current Provider(s):</b> Include company name(s) and length of operation (uninterrupted) in specified area or subarea. Hall Ambulance Service, Inc. since 5/19/1994.</p>
<p><b>Area or subarea (Zone) Geographic Description:</b> Includes communities of California City, Boron, Mojave, Rosamond and surrounding unincorporated areas.</p>
<p><b>Statement of Exclusivity, Exclusive or non-Exclusive (HS 1797.6):</b> Include intent of local EMS agency and Board action. Non-Exclusive – Competitive Bid process underway</p>
<p><b>Type of Exclusivity, “Emergency Ambulance”, “ALS”, or “LALS” (HS 1797.85):</b> Include type of exclusivity (Emergency Ambulance, ALS, LALS, or combination) and operational definition of exclusivity (i.e., 911 calls only, all emergencies, all calls requiring emergency ambulance service, etc.). N/A</p>
<p><b>Method to achieve Exclusivity, if applicable (HS 1797.224):</b> If grandfathered, pertinent facts concerning changes in scope and manner of service. Description of current provider including brief statement of uninterrupted service with no changes to scope and manner of service to zone. Include chronology of all services entering or leaving zone, name or ownership changes, service level changes, zone area modifications, or other changes to arrangements for service.  If competitively-determined, method of competition, intervals, and selection process. Attach copy/draft of last competitive process used to select provider or providers.  N/A</p>

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Adventist Health Bakersfield Telephone Number: 661-395-3000  
**Address:** 2615 Eye Street  
Bakersfield, CA 93303

<b><u>Written Contract:</u></b>  X Yes <input type="checkbox"/> No	<b><u>Service:</u></b>  <input type="checkbox"/> Referral Emergency <input type="checkbox"/> Standby Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Comprehensive Emergency	<b><u>Base Hospital:</u></b>  X Yes <input type="checkbox"/> No	<b><u>Burn Center:</u></b>  <input type="checkbox"/> Yes X No
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<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>  <input type="checkbox"/> Yes X No	<b><u>If Trauma Center what level:</u></b>  <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Level IV
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<b><u>STEMI Center:</u></b>  X Yes <input type="checkbox"/> No	<b><u>Stroke Center:</u></b>  X Yes <input type="checkbox"/> No
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<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*

<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*

<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*



**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Adventist Health Tehachapi Telephone Number: 661-822-3241  
**Address:** 115 W. "E" Street  
Tehachapi, CA 93581

<b><u>Written Contract:</u></b>	<b><u>Service:</u></b>	<b><u>Base Hospital:</u></b>	<b><u>Burn Center:</u></b>
X Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Standby Emergency <input type="checkbox"/> Comprehensive Emergency	<input type="checkbox"/> Yes X No	<input type="checkbox"/> Yes X No

<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>	<b><u>If Trauma Center what level:</u></b>
		<input type="checkbox"/> Yes X No	<input type="checkbox"/> Level I <input type="checkbox"/> Level III <input type="checkbox"/> Level II <input type="checkbox"/> Level IV

<b><u>STEMI Center:</u></b>	<b><u>Stroke Center:</u></b>
<input type="checkbox"/> Yes X No	<input type="checkbox"/> Yes X No

<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*

<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*

<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Bakersfield Heart Hospital Telephone Number: 661-316-6000  
**Address:** 3001 Sillect Ave  
Bakersfield, CA 93308

<b><u>Written Contract:</u></b>	<b><u>Service:</u></b>	<b><u>Base Hospital:</u></b>	<b><u>Burn Center:</u></b>
X Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Standby Emergency <input type="checkbox"/> Comprehensive Emergency	X Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes X No

<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>	<b><u>If Trauma Center what level:</u></b>
		<input type="checkbox"/> Yes X No	<input type="checkbox"/> Level I <input type="checkbox"/> Level III <input type="checkbox"/> Level II <input type="checkbox"/> Level IV

<b><u>STEMI Center:</u></b>	<b><u>Stroke Center:</u></b>
X Yes <input type="checkbox"/> No	Yes x No

<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*  
<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*  
<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Bakersfield Memorial Hospital Telephone Number: 661-327-4647  
**Address:** 420 34<sup>th</sup> Street  
Bakersfield, CA 93303

<b><u>Written Contract:</u></b>  X Yes <input type="checkbox"/> No	<b><u>Service:</u></b>  <input type="checkbox"/> Referral Emergency <input type="checkbox"/> Standby Emergency X Basic Emergency <input type="checkbox"/> Comprehensive Emergency	<b><u>Base Hospital:</u></b>  X Yes <input type="checkbox"/> No	<b><u>Burn Center:</u></b>  X Yes <input type="checkbox"/> No
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<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No X Yes <input type="checkbox"/> No X Yes <input type="checkbox"/> No	<b><u>Trauma Center:</u></b>  <input type="checkbox"/> Yes X No	<b><u>If Trauma Center what level:</u></b>  <input type="checkbox"/> Level I <input type="checkbox"/> Level II <input type="checkbox"/> Level III <input type="checkbox"/> Level IV
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<b><u>STEMI Center:</u></b>  X Yes <input type="checkbox"/> No	<b><u>Stroke Center:</u></b>  X Yes <input type="checkbox"/> No
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<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*  
<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*  
<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Delano Regional Medical Center Telephone Number: 661-725-4800  
**Address:** 1401 Garces Hwy  
Delano CA, 93216

<b><u>Written Contract:</u></b>	<b><u>Service:</u></b>	<b><u>Base Hospital:</u></b>	<b><u>Burn Center:</u></b>
X Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Standby Emergency <input type="checkbox"/> Comprehensive Emergency	X Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes X No

<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>	<b><u>If Trauma Center what level:</u></b>
		<input type="checkbox"/> Yes X No	<input type="checkbox"/> Level I <input type="checkbox"/> Level III <input type="checkbox"/> Level II <input type="checkbox"/> Level IV

<b><u>STEMI Center:</u></b>	<b><u>Stroke Center:</u></b>
<input type="checkbox"/> Yes X No	<input type="checkbox"/> Yes X No

<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*  
<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*  
<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Kern Medical Telephone Number: 661-326-1000  
**Address:** 1830 Flower Street  
Bakersfield, CA 93306

<b><u>Written Contract:</u></b>	<b><u>Service:</u></b>	<b><u>Base Hospital:</u></b>	<b><u>Burn Center:</u></b>
X Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Standby Emergency <input type="checkbox"/> Comprehensive Emergency	X Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes X No

<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>	<b><u>If Trauma Center what level:</u></b>
		X Yes <input type="checkbox"/> No	<input type="checkbox"/> Level I <input type="checkbox"/> Level III <input checked="" type="checkbox"/> Level II <input type="checkbox"/> Level IV

<b><u>STEMI Center:</u></b>	<b><u>Stroke Center:</u></b>
<input type="checkbox"/> Yes X No	X Yes <input type="checkbox"/> No

<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*

<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*

<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Kern Valley Healthcare District Telephone Number: 760-379-2681  
**Address:** 6412 Laurel Ave  
Lake Isabella, CA 93240

<p><b><u>Written Contract:</u></b></p> <p><input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p><b><u>Service:</u></b></p> <p><input type="checkbox"/> Referral Emergency  <input type="checkbox"/> Basic Emergency</p> <p><input checked="" type="checkbox"/> Standby Emergency  <input type="checkbox"/> Comprehensive Emergency</p>	<p><b><u>Base Hospital:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Burn Center:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
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<p><b>Pediatric Critical Care Center<sup>1</sup></b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <b>EDAP<sup>2</sup></b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No  <b>PICU<sup>3</sup></b> <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Trauma Center:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>If Trauma Center what level:</u></b></p> <p><input type="checkbox"/> Level I <input type="checkbox"/> Level II  <input type="checkbox"/> Level III <input type="checkbox"/> Level IV</p>
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<p><b><u>STEMI Center:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>	<p><b><u>Stroke Center:</u></b></p> <p><input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
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<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*

<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*

<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Mercy Hospital Telephone Number: 661-632-5000  
**Address:** 2215 Truxtun Ave  
Bakersfield, CA 93301

<b><u>Written Contract:</u></b>	<b><u>Service:</u></b>	<b><u>Base Hospital:</u></b>	<b><u>Burn Center:</u></b>
X Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Standby Emergency <input type="checkbox"/> Comprehensive Emergency	X Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes X No

<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>	<b><u>If Trauma Center what level:</u></b>
		<input type="checkbox"/> Yes X No	<input type="checkbox"/> Level I <input type="checkbox"/> Level III <input type="checkbox"/> Level II <input type="checkbox"/> Level IV

<b><u>STEMI Center:</u></b>	<b><u>Stroke Center:</u></b>
<input type="checkbox"/> Yes X No	X Yes <input type="checkbox"/> No

<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*  
<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*  
<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Mercy Southwest Hospital Telephone Number: 661-663-6000  
**Address:** 400 Old River Road  
Bakersfield, CA 93311

<b><u>Written Contract:</u></b>	<b><u>Service:</u></b>	<b><u>Base Hospital:</u></b>	<b><u>Burn Center:</u></b>
X Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Standby Emergency <input type="checkbox"/> Comprehensive Emergency	X Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes X No

<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>	<b><u>If Trauma Center what level:</u></b>
		<input type="checkbox"/> Yes X No	<input type="checkbox"/> Level I <input type="checkbox"/> Level III <input type="checkbox"/> Level II <input type="checkbox"/> Level IV

<b><u>STEMI Center:</u></b>	<b><u>Stroke Center:</u></b>
<input type="checkbox"/> Yes X No	X Yes <input type="checkbox"/> No

<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*  
<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*  
<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*



**TABLE 9: FACILITIES**

**County:** Kern

**Note:** Complete information for each facility by county. Make copies as needed.

**Facility:** Ridgecrest Regional Hospital Telephone Number: 760-446-3551  
**Address:** 1081 N. China Lake Blvd  
Ridgecrest, CA 93555

<b><u>Written Contract:</u></b>	<b><u>Service:</u></b>	<b><u>Base Hospital:</u></b>	<b><u>Burn Center:</u></b>
X Yes <input type="checkbox"/> No	<input type="checkbox"/> Referral Emergency <input checked="" type="checkbox"/> Basic Emergency <input type="checkbox"/> Standby Emergency <input type="checkbox"/> Comprehensive Emergency	X Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes X No

<b>Pediatric Critical Care Center<sup>1</sup></b> <b>EDAP<sup>2</sup></b> <b>PICU<sup>3</sup></b>	<input type="checkbox"/> Yes X No <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes X No	<b><u>Trauma Center:</u></b>	<b><u>If Trauma Center what level:</u></b>
		X Yes <input type="checkbox"/> No	<input type="checkbox"/> Level I <input type="checkbox"/> Level III <input type="checkbox"/> Level II <input checked="" type="checkbox"/> Level IV

<b><u>STEMI Center:</u></b>	<b><u>Stroke Center:</u></b>
<input type="checkbox"/> Yes X No	X Yes <input type="checkbox"/> No

<sup>1</sup> Meets EMSA *Pediatric Critical Care Center (PCCC) Standards*  
<sup>2</sup> Meets EMSA *Emergency Departments Approved for Pediatrics (EDAP) Standards*  
<sup>3</sup> Meets California Children Services (CCS) *Pediatric Intensive Care Unit (PICU) Standards*

**TABLE 10: APPROVED TRAINING PROGRAMS**

County: Kern

Reporting Year: 2019

**NOTE:** Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution:	<u>Bakersfield College</u>	Telephone Number:	<u>661-395-4284</u>
Address:	<u>1801 Panorama Drive</u> <u>Bakersfield, CA 93305</u>		
Student Eligibility*:	<u>General Public</u>	**Program Level	<u>Paramedic</u>
Cost of Program:		Number of students completing training per year:	
Basic:	<u>\$5,000</u>	Initial training:	<u>40</u>
Refresher:		Refresher:	<u>-</u>
		Continuing Education:	<u>-</u>
		Expiration Date:	<u>11/30/2019</u>
		Number of courses:	
		Initial training:	<u>2</u>
		Refresher:	<u>-</u>
		Continuing Education:	<u>-</u>

\*Open to general public or restricted to certain personnel only.

\*\* Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

Training Institution:	<u>Bakersfield College</u>	Telephone Number:	<u>661-395-4284</u>
Address:	<u>1801 Panorama Drive</u> <u>Bakersfield, CA 93305</u>		
Student Eligibility*:	<u>General Public</u>	**Program Level	<u>EMT</u>
Cost of Program:		Number of students completing training per year:	
Basic:	<u>360</u>	Initial training:	<u>60</u>
Refresher:	<u>46</u>	Refresher:	<u>-</u>
		Continuing Education:	<u>-</u>
		Expiration Date:	<u>11/30/2019</u>
		Number of courses:	
		Initial training:	<u>2</u>
		Refresher:	<u>2</u>

Continuing Education:

-

\*Open to general public or restricted to certain personnel only.

\*\* Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

**TABLE 10: APPROVED TRAINING PROGRAMS**

County: Kern

Reporting Year: 2019

**NOTE:** Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution:	<u>Cerro Coso Community College</u>	Telephone Number:	<u>760-375-5001</u>
Address:	<u>3000 College Heights Blvd</u> <u>Ridgecrest, CA 93555</u>		
Student Eligibility*:	<u>General Public</u>	**Program Level	<u>EMT</u>
	Cost of Program:	Number of students completing training per year:	
	Basic: <u>299</u>	Initial training:	<u>50</u>
	Refresher: <u>46</u>	Refresher:	<u>-</u>
		Continuing Education:	<u>-</u>
		Expiration Date:	<u>4/30/2020</u>
		Number of courses:	
		Initial training:	<u>2</u>
		Refresher:	<u>2</u>
		Continuing Education:	<u>-</u>

\*Open to general public or restricted to certain personnel only.

\*\* Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

**TABLE 10: APPROVED TRAINING PROGRAMS**

County: Kern

Reporting Year: 2019

**NOTE:** Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution:	<u>Kern County Sheriff's Office</u>		Telephone Number:	<u>661-391-7414</u>
Address:	<u>962 Norris Road</u>			
	<u>Bakersfield, CA 93308</u>			
Student Eligibility*:	<u>Restricted</u>	**Program Level	<u>EMT</u>	
		Cost of Program:		
		Basic:	<u>0</u>	Number of students completing training per year:
		Refresher:	<u>0</u>	Initial training:
				<u>20</u>
		Refresher:		<u>20</u>
		Continuing Education:		<u>-</u>
		Expiration Date:		<u>1/31/2020</u>
		Number of courses:		
		Initial training:		<u>1</u>
		Refresher:		<u>1</u>
		Continuing Education:		<u>-</u>

\*Open to general public or restricted to certain personnel only.

\*\* Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

Training Institution:	<u>Kern County EMS Division</u>		Telephone Number:	<u>661-321-3000</u>
Address:	<u>1800 Mt. Vernon Ave</u>			
	<u>Bakersfield, CA 93306</u>			
Student Eligibility*:	<u>Restricted</u>	**Program Level	<u>MICN</u>	
		Cost of Program:		
		Basic:	<u>100</u>	Number of students completing training per year:
		Refresher:	<u>100</u>	Initial training:
				<u>68</u>
		Refresher:		<u>46</u>
		Continuing Education:		<u>-</u>
		Expiration Date:		<u>11/30/2020</u>
		Number of courses:		
		Initial training:		<u>4</u>
		Refresher:		<u>4</u>

Continuing Education:

-

\*Open to general public or restricted to certain personnel only.

\*\* Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

**TABLE 10: APPROVED TRAINING PROGRAMS**

**County:** Kern

**Reporting Year:** 2019

**NOTE:** Table 10 is to be completed by county. Make copies to add pages as needed.

Training Institution:	<u>Taft College</u>	Telephone Number:	<u>661-243-5014</u>
Address:	<u>29 Emmons Park Drive</u>		
	<u>Taft, CA 93268</u>		
Student Eligibility*:	<u>General Public</u>	**Program Level	<u>EMT</u>
	Cost of Program:		
	Basic: <u>253</u>	Number of students completing training per year:	
	Refresher: <u>69</u>	Initial training:	<u>60</u>
		Refresher:	<u>-</u>
		Continuing Education:	<u>-</u>
		Expiration Date:	<u>11/30/2019</u>
		Number of courses:	
		Initial training:	<u>2</u>
		Refresher:	<u>2</u>
		Continuing Education:	<u>-</u>

\*Open to general public or restricted to certain personnel only.

\*\* Indicate whether EMT-I, AEMT, EMT-P, MICN, or EMR; if there is a training program that offers more than one level complete all information for each level.

**TABLE 11: DISPATCH AGENCY**

**County:** Kern

**Reporting Year:** 2019

**NOTE:** Make copies to add pages as needed. Complete information for each provider by county.

Name:	<u>Emergency Communication Center</u>		Primary Contact:	<u>Brandon Smith</u>
Address:	<u>2601 Panorama Drive</u>			
	<u>Bakersfield, CA 93305</u>			
Telephone Number:	<u>661-861-2521</u>			
Written Contract:	Medical Director:	X Day-to-Day	Number of Personnel Providing Services:	
<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	X Disaster	33 EMD Training _____ EMT-D _____ ALS	
			_____ BLS _____ LALS _____ Other	
Ownership:		If Public:	If Public: X City X County <input type="checkbox"/> State <input type="checkbox"/> Fire District <input type="checkbox"/> Federal	
X Public <input type="checkbox"/> Private		X Fire	Joint City/County Fire communications	
		<input type="checkbox"/> Law		
		<input type="checkbox"/> Other		
		Explain: _____		

Name:	<u>Hall Ambulance Service, Inc</u>		Primary Contact:	<u>John Surface</u>
Address:	<u>1001 21<sup>st</sup> Street</u>			
	<u>Bakersfield, CA 93301</u>			
Telephone Number:	<u>661-322-8741</u>			
Written Contract:	Medical Director:	X Day-to-Day	Number of Personnel Providing Services:	
X Yes <input type="checkbox"/> No	X Yes <input type="checkbox"/> No	X Disaster	26 EMD Training _____ EMT-D _____ ALS	
			_____ BLS _____ LALS _____ Other	
Ownership:		If Public:	If Public: <input type="checkbox"/> City <input type="checkbox"/> County <input type="checkbox"/> State <input type="checkbox"/> Fire District <input type="checkbox"/> Federal	
<input type="checkbox"/> Public X Private		<input type="checkbox"/> Fire		
		<input type="checkbox"/> Law		
		<input type="checkbox"/> Other		
		Explain: _____		



## ***STEMI System of Care Policy (4003.00)***

### **PURPOSE**

This policy defines the requirements for designation as a STEMI Receiving Center (SRC) in Kern County and establishes the concept of operations of the STEMI System of Care.

### **AUTHORITY**

- A. Health and Safety Code, Division 2.5, Sections 1797.67, 1797.88, 1797.220, 1798, 1798.170

### **DEFINITIONS**

- A. “Percutaneous Coronary Intervention” (PCI): A broad group of percutaneous techniques used for the diagnosis and treatment of patients with STEMI.
- B. “EMS Division” or “County”: the Kern County Public Health Services Department, Emergency Medical Services Division.
- C. “EMS System”: a specially organized arrangement that provides for the personnel, facilities, and equipment for the effective and coordinated delivery in an EMS area of medical care services under emergency conditions.
- D. “STEMI”: Any patient with an acute myocardial infarction that generates ST-segment elevation on a 12-lead ECG of greater than 1mm in 2 contiguous leads and/or prehospital 12-lead computer interpretation of \*\*\*Acute MI\*\*\* / STEMI.
- E. “STEMI System of Care”: an integrated prehospital and hospital program that is intended to direct patients with field identified ST Segment Elevation Myocardial Infarction directly to hospitals with specialized capabilities to promptly treat these patients.
- F. EMS “STEMI Alert”: A prehospital activation that notifies a STEMI Receiving Center, as early as possible (goal  $\leq$  10 minutes from FMC), of a patient with a SRH STEMI Alert allows the SRC to activate the internal STEMI processes. to provide appropriate and rapid treatment interventions.
- G. “STEMI Receiving Center” (SRC): An acute care hospital designated by the Local EMS Agency that is capable of appropriately treating a patient having a STEMI with PCI and other interventional cardiology procedures to restore circulation to a blocked artery.

- H. "STEMI Referral Hospital" (SRH): An acute care hospital in the County that is not designated as a STEMI Receiving Center contacts the SRC for STEMI Alert by calling the SRC hotlines and implements rapid initial interventions and rapid door-in/door-out transfer to the SRC.
- I.
- J. "STEMI QI Committee": the multi-disciplinary peer-review committee, composed of representatives as specified in this policy, which monitors and analyzes the STEMI System of Care metrics, makes recommendations for STEMI system for process, performance, and quality improvements, and functions in an advisory capacity to the EMS Division.

## DESIGNATION

- A. Hospitals seeking formal designation as SRC shall meet the following requirements:
  - 1. Possess current California licensure as an acute care hospital providing Basic Emergency Medical Services, and possess a special permit for cardiac surgery service, including catheterization laboratory pursuant to the provisions of Title 22, Division 5, Chapter 1, Article 5 of the California Code of Regulations.
  - 2. Possess a current designation and valid contract with the County as a Paramedic Base Hospital, as part of the EMS System.
  - 3. Maintains current *accreditation with an EMS approved body*. Accept the Kern County STEMI System of Care Memorandum of Understanding for STEMI transfers whereby SRC agrees to immediately and rapidly accept the transfer of a STEMI Patient from the transferring SRH/SRC upon notification of STEMI ALERT and request by the SRH/SRC-affiliated physician.
- B. Any designated SRC hospital which is unable to meet the following requirements shall be subject to a deficiency notice and plan of action and/or termination of designation Inability to maintain Designation criteria, listed in A., above, or
  - 1. Failure to meet the SRC Performance Standards, listed below and as may be amended from time to time, or
  - 2. Failure to comply with any Local, State, or Federal Government policy, procedure, or regulation of the STEMI System of Care.

If the EMS Division finds a SRC to be deficient in meeting the above criteria, the EMS Division will give the SRC written notice, return receipt requested, setting forth with

reasonable specificity the nature of the apparent deficiency. Within ten (10) calendar days of receipt of such notice, the SRC must deliver to the EMS Division, in writing, a plan to cure the deficiency, or a statement of reasons why it disagrees with the EMS Division's notice. If the Hospital fails to cure the deficiency within 90 days or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication for possible Interim Designation. EMCAB may make a recommendation to the EMS Division for resolving the issue.

## **INTERIM DESIGNATION**

A hospital meeting all of the Designation criteria listed in Section A., above except No. 3 (*accreditation as approved by EMS n*) may be granted an SRC designation on an interim basis. The interim designation shall allow the hospital to receive STEMI Patients by ambulance. The interim designation time period shall be specified in the SRC agreement with the County of Kern, and the time period shall not exceed 18 months.

Interim Designation allows a hospital seeking accreditation to participate as an SRC Designated facility. All performance standards are applicable to a hospital with Interim Designation, and the SRC application process for Interim Designation shall be the same as the application process for SRC Designation.

## **APPLICATION PROCESS FOR SRC DESIGNATION**

- A. The following milestones outline the application process for a hospital to become designated as a STEMI Receiving Center.
  1. Review list of requirements and checklist of documents, found at *Appendix B - STEMI Receiving Center Designation Criteria Application and Evaluation Tool*, which must be compiled and submitted with the application.
  2. Submit letter of application to the EMS Division. The letter will contain:
    - a. Specify intent to obtain SRC designation;
    - b. Identify the names and contact information, including email addresses for the key STEMI personnel: the STEMI Medical Director, RN Program Manager, and Administrative contact;
    - c. Identify the anticipated target date for SRC designation; and
    - d. List of supporting documents being submitted with the letter to fulfill the designation requirements.

3. Compile and submit to the EMS Division all information and documents requested in *Appendix B*, Column 2, “objective measurement” of the *STEMI Receiving Center Designation Criteria Application and Evaluation Tool*.
4. All application materials will be reviewed for completeness. Additional information will be requested, if needed. Upon determination that the application is complete, the applicant and EMS Division will work towards execution of the designation agreement.
5. STEMI Center Designation agreement will be presented to the Board of Supervisors for approval and formal designation.

### **SRC PERFORMANCE STANDARDS**

Hospitals obtaining SRC designation meet a high standard of cardiac care. The SRC ensures that the clinical processes, equipment, and personnel are in place to provide a higher standard of care than that available at a non-designated facility. The performance standards listed below are intended to reflect the accreditation requirements and to ensure that each designated SRC continually strives to meet each of these standards.

- A. SRC designated hospitals shall be in continuous compliance with the following general standards:
  1. HOSPITAL shall provide for the triage and treatment of simultaneously presenting STEMI patients regardless of ICU/CCU or ED overload status.
  2. HOSPITAL shall provide STEMI Receiving Center services to any STEMI Patient that comes to the emergency department, regardless of the STEMI Patient’s ability to pay physician fees and/or hospital costs. For the purpose of this Agreement, the phrase “comes to the emergency department” shall have the same meaning as set forth in the Emergency Medical Treatment and Active Labor Act (42 U.S.C § 1395dd) and the regulations promulgated thereunder (EMTALA).
  3. HOSPITAL shall notify the EMS Division within twenty-four (24) hours of any failure to meet STEMI Designation Policy performance standards. Hospital will identify its action to correct the deficiency.
  4. HOSPITAL shall maintain a designated telephone number (Hotline) to facilitate rapid interfacility transfer and access to SRC physician for consultation with SRH physicians and other providers regarding care and transfer of STEMI Patients.

5. HOSPITAL shall accept all STEMI patients from SRH facilities, within the County, upon notification of “STEMI ALERT” and request by the transferring physician.
  6. HOSPITAL shall actively and cooperatively participate in the “STEMI QI Committee,” and such other related committees that may, from time to time, be named and organized by the EMS Division related to the STEMI System of Care.
  7. HOSPITAL shall maintain an agreement with the nationally –recognized STEMI database approved by EMS, and agree to allow for the release of all STEMI data directly from said database to EMS for the purpose of oversight, to produce System reports. HOSPITAL shall collect, maintain, and report any additional data points adopted by the STEMI QI Committee and/or mandated by EMS.
- B. SRC designated hospitals shall be in continuous compliance with the following service standards:
1. Maintain intra-aortic balloon pump and Impella capability with necessary staff at all times.
  2. Possess a California permit for cardiovascular surgery, *or* have a written plan for emergency transport to a facility with cardiovascular surgery available within 1 hour of transfer. If the facility does not have a cardiovascular surgery permit, a transfer agreement with the cardiovascular surgery facility shall be in full effect.
  3. Provide continuous availability of PCI resources at all times.
- C. SRC designated hospitals shall be in continuous compliance with the following personnel standards:
1. SRC Medical Director - The SRC shall designate a medical director for the STEMI program who shall be a physician certified by the American Board of Internal Medicine (ABIM) with current ABIM sub-specialty certification in Cardiovascular Disease and Interventional Cardiology, who will ensure compliance with these SRC standards and perform ongoing Quality Improvement (QI) as part of the hospital and system QI Program.
  2. SRC Program Manager - The SRC shall designate a program manager for the STEMI program who shall be a registered nurse with experience in Emergency Medicine or Cardiovascular Care, who shall collaborate with the SRC Medical Director to oversee and ensure compliance with these SRC standards and the QI program.

3. Cardiovascular Lab Coordinator - The SRC shall have a Cardiovascular Lab Coordinator who shall assist the SRC Medical Director and the SRC Program Manager to ensure compliance with these SRC Standards and the QI Program.
4. Interventional Cardiologists (IC) – Specialty trained physicians with privileges for SRC and credentialed by the hospital in accordance with the American College of Cardiology/American Heart Association national standards.
  - i. The SRC shall maintain a daily roster of STEMI on-call physicians who must be present within 30 minutes or less when a STEMI patient presents to the hospital or notification of “STEMI Alert” is received from pre-hospital personnel via radio or telephone communications or SRH ED physician, whichever occurs first.
  - ii. The on-call physician can take call only at one facility at a time unless has a backup cardiologist and/or team that can immediately step in if simultaneous activations occur at both locations.  
*Any group or back up cardiologist must be available at a single phone number.*
5. Other personnel who must be promptly available and present in the SRC within 30 minutes of the activation of the SRC’s internal STEMI/PCI system including:
  - i. Appropriate cardiac catheterization nursing and support personnel.
  - ii. RN or CV perfusionist trained in intra-aortic balloon pump management.

D. SRC designated hospitals shall comply with the clinical performance standards:

1. The SRC attains and maintains specialty accreditation by an EMS approved accrediting body, which is an indicator of competency and high performance.
  - i. Cardiac Catheterization Laboratory Standards per Title 22
2. Performance (timeliness) and outcome measures will be assessed initially in the accreditation process, and will be monitored closely on an ongoing basis by the SRC and the EMS Division through the STEMI QI Committee.
3. The SRC shall develop internal operational policies and procedures which includes the following activities/areas:
  - i. Cardiac interventionist activation

- ii. Cardiac catheterization lab team activation
- iii. STEMI contingency plans for personnel and equipment
- iv. Coronary angiography
- v. PCI and use of fibrinolytics
- vi. Inter-facility transfer policies/protocols for STEMI
- vii. Transfer agreements for cardiac surgery, as appropriate If not available at SRC
- viii. STEMI patient triage

E. SRC designated hospitals shall participate in performance improvement program for EMS Patients including:

1. An SRC shall provide the following representatives to participate in the countywide EMS Division STEMI QI Committee:
  - i. The SRC Medical Director
  - ii. The SRC Program Manager
  - iii. One QI staff member
2. The countywide STEMI QI Committee will hold regular multidisciplinary meetings that include representatives from each STEMI Receiving Center (SRC), each STEMI Referral Hospital (SRH), prehospital providers, and representatives from EMS. In order to maintain STEMI designation, all SRC facilities must attend a minimum of 75% of all committee meetings. An SRC shall implement a written internal SRC QI plan/program with an internal review process that includes:
  - i. Door-to Balloon times
  - ii. Death rate (within 30 days, related to procedure regardless of mechanism)
  - iii. Emergency CABG rate (result of procedure failure or complication)
  - iv. Vascular complications (access site, transfusion, coronary perforation or operative intervention required)
  - v. Cerebrovascular accident rate (peri-procedure)
  - vi. Sentinel event, system and organization issue review and resolution processes

3. An SRC shall participate in prehospital STEMI-related educational activities as may be required by the EMS Division
- F. SRC designated hospitals shall be in continuous compliance with the following data collection, submission, and analysis standards:
1. An SRC shall participate in data collection as defined in Appendix A: *Mandatory Data Elements for STEMI Receiving Centers*. Data element requirements are subject to change at Division's discretion.
  2. Data shall be used for quality improvement purposes by the STEMI QI Committee, and data submitted by SRC and SRH facilities is considered to confidential under the provisions of Evidence Code Section 1157.7.
  3. The Division may publicly report aggregated data about the STEMI system which is derived from any of the individual data elements.

### **EMS DIVISION Performance Standards**

KC EMS will:

1. Facilitate collaborative leadership and consensus among all stakeholders of the KC STEMI System of Care
2. Provide minutes and sign-in sheets for all meetings within 2 weeks of next meeting
3. Participate in CPC accreditation activities with each SRC
4. Initiate and maintain transfer agreements among all Kern County System of Care hospitals

### **CONCEPT OF OPERATIONS OF THE STEMI SYSTEM OF CARE**

#### **A. Pre-Hospital: Ambulance/Paramedic Responsibilities**

1. 12-Lead ECG: Upon an assessment finding of possible cardiac origin, paramedic shall conduct a 12-Lead ECG, if ambulance is so equipped.
2. 12-Lead ECG monitor will display a finding. Paramedic will use the finding provided by the monitor to determine if the patient is positive for STEMI \*\*\*Suspected Acute MI\*\*\*.
  - i. The ECG should be repeated frequently during prolonged transports for patients with ongoing chest pain but no STEMI finding on initial 12-lead to assess for evolving STEMI
3. STEMI Alert Early Notification: Upon receiving a positive STEMI finding on the 12-Lead ECG monitor, paramedic shall immediately contact the



destination hospital and issue a “STEMI ALERT”. The goal for STEMI Alert activation is 10 minutes or less. Paramedic will send the 12-Lead report to the E.D., if equipment is capable.

4. Destination: parameters for STEMI patient
    - i. Positive STEMI read on ECG monitor goes to closest, most appropriate SRC
    - ii. If anticipated transport time is greater than 60 minutes to SRC, and another hospital is closer, patient shall be transported to closest hospital
  5. Paramedic shall follow appropriate treatment protocols during transport
- B. Hospital Relationships and Coordination
1. Transfer Agreements/Requirements
    - i. Rapid Transfer – SRC Automatic Acceptance of STEMI Patient from Transferring Hospital per the KC STEMI System of Care inter-facility memorandum of agreement.
  2. Each STEMI Receiving Center (SRC) agrees to accept all “STEMI ALERT” patients from any Non-PCI Hospital (SRH) located within Kern County. Specific Language to initiate rapid transfer
    - i. The term, “STEMI ALERT” will be used by paramedics as well as STEMI Referring Hospital (SRH) staff in order to notify the SRC of an incoming STEMI patient. “STEMI ALERT” shall be understood by all hospital staff as well as ambulance dispatchers to mean an emergent cardiac event is in progress with rapid treatment and transport necessary.
  3. Standardized treatment protocol for non-STEMI hospitals
    - ii. SRC and SRH will collaborate in the development, implementation, and monitoring of treatment procedure/protocols for the Non-PCI hospitals (SRH) within the County.
    - iii. The STEMI System of Care will operate as a cohesive and comprehensive organization to consistently address the needs of the STEMI Patient by implementing best practice standards, regardless of the point of entry into the system.

### C. Community STEMI Education

1. Awareness - It is imperative that each SRC and SRH recognize the need for community awareness as we work together to improve heart health in Kern County.
2. Actions to take - Each SRC and SRH must be active participants in and working together to promote public awareness activities, i.e. public service announcements, print ads, community events, task forces and classes. Education should focus on Early Heart Attack Care (EHAC) and the “Chain of Survival” for a heart attack and sudden cardiac arrest, and include:
  - i. Recognition of a cardiac emergency
  - ii. Calling “911” immediately because “time is muscle” and “EMS brings the emergency room to the patient”
  - iii. Initiation of hands-only CPR through use of appropriate chest compressions
  - iv. Use of an automated external defibrillator (AED)
3. Other community education themes might include:
  - i. Hands-only CPR training including Side-walk CPR Day
  - ii. Risk factors for cardiovascular disease
  - iii. Symptoms and signs of acute coronary syndrome (ACS)
  - iv. Early warning or prodromal symptoms
  - v. Less common or atypical heart attack presentations
  - vi. Importance of calling 911
  - vii. Female ACS presentations
4. Public Reporting of Performance Data - A large part of public awareness begins with data reporting. Pertinent aggregated STEMI System data showing the performance of the STEMI System of Care shall be posted publicly. The following aggregated performance measurements will be publicly released, and additional reports may published upon recommendation of the STEMI QI Committee.
  - i. Symptom onset time to EMS Call Time
  - ii. EMS first medical contact (FMC) time to First 12-Lead ECG Time
  - iii. EMS First 12-Lead time to contact SRC

- iv. E.D. arrival time
- v. E.D. arrival time to Cath Lab Activation time
- vi. Cath Lab Activation time to Cath Lab Arrival Time
- vii. E.D. Door to PCI /Balloon Time
- viii. First Medical Contact to PCI/balloon time
- ix. SRH door-in to door-out time
- x. SRH door-in time to PCI time
- xi. Door to needle time

## **Appendix A - Mandatory Data Elements for STEMI Receiving Centers**

HOSPITAL shall maintain a STEMI Database and submit the data elements to an EMS approved national registry, at established time intervals in order to produce reports. Each SRC shall submit data elements that achieves compliance with the Premier level data and reporting standard. HOSPITAL shall, collect maintain, and report any additional data points adopted by the STEMI QI Committee or mandated by EMS.

## APPENDIX B - STEMI Receiving Center Designation Criteria Application and Evaluation Tool

Column 1	Column 2	Column 3	Column 4
STEMI Designation Contract Standard	Objective Measurement	Meets Standards	Comments
<b>HOSPITAL SERVICES</b>			
Current license to provide Basic Emergency Services in Kern County	Copy of License	Y N	Required for designation & renewal
Current Certification to operate as a Paramedic Base Station in Kern County		Y N	Required for designation & renewal
Cardiac Catheterization Laboratory Services & Required Services	Copy of License. Number Cardiac Catheterization Labs ___ on License	Y N	Required for designation & renewal
Intra-aortic balloon pump capability with staffing available to operate 24/7/365	Intra-aortic balloon pump capability # patients: _____ Staffing policies/protocols supporting operations	Y N	Required for designation
Inter-facility TRANSFER GUIDELINES or COOPERATIVE ARRANGEMENTS	Description of current cooperative practice or copy of supporting policies, procedures or guidelines. List all hospitals collaborating with and for what type services	Y N	Required for designation List of facilities and description of cooperative arrangements (SRC's and Non STEMI centers) for CV surgery and PCI interventions within STEMI time frame standards
California permit for cardiovascular surgery	CA permit number and effective and expiration dates. Number of Operating Suites on License	Y N	<b>Desired not required</b> ACC/AHA Guideline conformance for centers without back up CV surgery will be evaluated in consideration of waiver by EMS medical director Required for designation & renewal

If no cardiac surgery capability, must have: Plan for emergency transfer	Plan, Policy, Procedure with estimated travel time	Y	N	Required for designation. Hospitals without surgical services: Written guidelines or description of current processes for rapid transfer of patients requiring additional care. Including elective or emergency cardiac surgery or PCI. Required for designation & renewal Required for designation & renewal
Plan to transfer within 1 hour	Supporting policies and procedures	Y	N	Required if no CV Surgery Required for designation & renewal
Written transfer guidelines for service	Transfer policies and procedures	Y	N	Required if no CV Surgery Required for designation & renewal
Continuous availability of PCI resources 24 hours a day 7 days a week 365 days a year.	On-Call Schedules for 3 months. On-Call Policy/Procedure	Y	N	Required for designation & Renewal
<b>HOSPITAL PERSONNEL</b>				
SRC PROGRAM MEDICAL DIRECTOR Responsibilities: 1. Oversight of STEMI program patient Care 2. Coordinating staff and services 3. Authority and accountability for quality /performance improvement 4. Participates in protocol development 5. Establishes and monitors quality control, including Mortality and Morbidity 6. Voting Member Cardiac Audit Committee	Copy of Current Board Certification  Copy of Job Description	Y	N	Required for designation & Renewal



	documentation showing primary and total PCI volume, per physician for previous 12 months			ACC/AHA Recommendations:  11 Primary PCI / 75 PCI Cases  This requirement may be met based on activity at more than one hospital
Process Performance:	Door to balloon inflation times for previous 12 months	Y	N	Required for designation ACC/AHA Recommendations: Door to balloon inflation times <90 minutes (75% compliance)
<b>POLICIES AND PROCEDURES</b>				
Comprehensive STEMI policy outlining the STEMI processes with contingency and back-up plans. Interventional Cardiologist Activation	Policy/Procedure	Y	N	Required for designation & Renewal
Cardiac catheterization laboratory team activation	Policy/Procedure	Y	N	Required for designation
STEMI contingency plans 1. Personnel 2. Cath Lab facility & equipment	Pertinent policy & procedures to minimize disruption	Y	N	Required for designation Expectation of NO DIVERSION
Coronary angiography	Policy, Procedure, and/or Guidelines	Y	N	Required for designation
PCI and use of fibrinolytics	Policy, Procedure, and/or Guidelines	Y	N	Required for designation Process by which fibrinolytic therapy and PCI can be delivered rapidly to meet the following goals: Fibrinolytics within 30 minutes of ED and Door-to-balloon time within 90 minutes of ED arrival.
Interfacility transfer for STEMI policies or protocols	Policy, Procedure, and/or Guidelines	Y	N	Required for designation
<b>PERFORMANCE IMPROVEMENT</b>				
Systematic Internal Review Program consistent with accreditation	Review protocol/program description to deal with:	Y	N	Policy and procedure or program description only required for initial designation Ongoing expectation
KC STEMI System of Care performance improvement program	Door-to-Balloon times			



	<p>Deaths</p> <p>Emergency CABG</p> <p>Vascular complications</p> <p>Sentinel event</p> <p>System issues</p> <p>Organizational issue</p>			
Systematic Prehospital Review Program	<p>Written quality improvement plan or program description for EMS-transported STEMI patients supporting:</p> <p>Timely prehospital feedback,</p> <p>Prehospital provider education,</p> <p>Cooperative STEMI QI data management</p>	Y	N	<p>QI plan or policy only required for initial designation</p> <p>Ongoing expectation</p> <p>Data Collection and Management based on STEMI EMS data elements</p>
Mechanism to participate in timely outcome field feedback of STEMI patients	Participation in Field QI process	Y	N	<p>EMS to act as point agency to facilitate communication of outcome information for field QI.</p> <p>Ongoing expectation</p>
Prehospital STEMI related educational activities	<p>Commitment to STEMI Prehospital Education Plan for prehospital education activities</p>	Y	N	<p>Plan required for initial designation</p> <p>Ongoing expectation</p>

DATA COLLECTION, SUBMISSION AND	ANALYSIS		
Participation in Kern County EMS data collection	Document agreeing to provide data elements deemed mandatory by Kern County EMS	Y    N	Name and contact information of responsible personnel required for designation

## APPENDIX C - STEMI QI Committee Purpose and Structure

### PURPOSE

Care of the STEMI patient requires a system approach to ensure optimal care. To assist the KC STEMI System of Care in its quest to achieve best care possible, the STEMI QI Committee shall assess, monitor, and facilitate the Quality Improvement (QI) process for the Kern County STEMI Centers.

### AUTHORITY

Health and Safety Code Division 2.5  
California Evidence Code, Section 1157.7  
California Civil Code, Part 2.6, Section 56

### DEFINITION

“STEMI QI Committee” means the multi-disciplinary peer-review committee, composed of representatives from the EMS, STEMI Receiving Centers, STEMI Referral Hospitals, Prehospital care providers, which monitors the STEMI Care System, makes recommendations for system improvements, and functions in an advisory capacity on other STEMI Care System issues.

### COMMITTEE MEMBERSHIP

1. Membership Composition
  - a. SRC Members:
    - i. SRC Medical Director
    - ii. SRC E.D. Director
    - iii. SRC Program Manager
  - b. SRH Members:
    - i. E.D. Medical Director
    - ii. E.D. Director
  - c. Prehospital Members:
    - i. Operations Manager
    - ii. Provider Medical Director
    - iii. Field Supervisor
    - iv. Field Paramedic
  - d. EMS Members:
    - i. Director

- ii. EMS Medical Director
- iii. EMS Coordinator
- iv. Public Health Epidemiologist

2. Confidentiality

To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The Committee's 1157.7 business, records and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures.

At each meeting members and attendees will sign a statement of confidentiality as a condition of participation.

3. Schedule/Location

The STEMI QI Committee shall meet quarterly on the third Thursday of the month at 1800 Mount Vernon Ave. Time and Conference room to be determined.

4. Case Review Instructions

On a rotating basis, each hospital and ambulance provider will present case reviews to the committee. These reviews should highlight difficult, challenging or exceptional cases that might provide valuable information to the other members of the committee. All re-triage of STEMI patients between SRC's will be reviewed by the Committee.

5. Recommendations for System Improvement

The Committee will develop and implement recommendations for an annual PI project based on data analysis and case reviews. Recommendations will be presented at the EMS System Collaborative meeting.

## APPENDIX D - STEMI QI Committee Bylaws

### 1. NAME

This Committee shall be referred to as the "STEMI QI Committee", hereinafter referred to as the "COMMITTEE".

### 2. IMPLEMENTATION AUTHORITY

- a. The COMMITTEE is established by the County of Kern, Emergency Medical Services Division (DIVISION) Medical Director as an advisory committee to the DIVISION. The DIVISION is responsible to receive hospital and service provider input and direction specific to STEMI patient emergency medical care in the County.
- b. The COMMITTEE is created pursuant to the requirements of California Evidence Code, Section 1157.7 and California Code of Regulations, Title 22, Division 9, Prehospital Emergency Medical Services, Chapter 12, EMS System Quality Improvement.

### 3. STATEMENT OF PURPOSE

- a. To decrease morbidity and mortality of the STEMI population
- b. To promote region-wide standardization of evidence-based STEMI care.

### 4. DUTIES

- a. Participate with EMS in monitoring, collecting data on, and evaluating STEMI patient identification, treatment and transport from the EMS providers and hospitals within the DIVISION'S jurisdiction.
- b. Evaluate, expand upon, and revise as needed, locally developed indicators used by the COMMITTEE for STEMI patient quality improvement.

### 5. MEMBERSHIP

Voting Membership will include the following representatives from the EMS Program's region:

- a. One Physician Medical Director from each SRC.
- b. One Program Manager from each SRC.
- c. One Emergency Department Medical Director representative from each SRH.
- d. One Emergency Department Director from each SRH.
- e. One Operations Manager from each prehospital agency.
- f. One Medical Director or Field Supervisor from each prehospital agency

Non-Voting membership will include representatives of the DIVISION.

Each member shall have a clinical person alternative available to assume the member's responsibility in their absence, but this is not a proxy vote in a member's absence. There is only one vote per voting member attending the meeting. Cardiac Catheterization Laboratory alternates may be another physician, a Registered Nurse (RN), a Registered Cardiovascular Invasive Specialist (RCIS), or program manager.

6. OFFICERS

- a. The COMMITTEE shall elect a Chair and Vice-Chair to serve for a 2 year period.
- b. The COMMITTEE shall elect a Secretary to serve for a 2 year period to maintain minutes, sign-in sheets and membership list with contact information.

7. TERMS

- a. Officers shall be elected by the COMMITTEE for yearly terms commencing July 1 through June 30<sup>th</sup>.
- b. If the Chair's office is vacated prior to the term's end, the Vice-Chair will assume the duties for the remainder of the term and a new Vice-Chair will be elected.
- c. If the Vice-Chair's office is vacated prior to term's end, a replacement will be elected.
- d. Members shall serve at the will of the COMMITTEE, or until removed, resigned or replaced.
- e. Members who are unable to attend a regularly scheduled meeting should notify the DIVISION of their absence prior to the meeting and should send an alternate in their place.

8. MEETINGS, VOTING, QUORUM

- a. Meetings shall be held no less than four (4) times in a calendar year. Meeting dates and times to be set or modified as agreed to by the COMMITTEE.
- b. Special meetings may be called by the DIVISION Medical Director or Chair as appropriate or upon written request of a majority of COMMITTEE members.
- c. A quorum to conduct business shall consist of five eligible voting members.
- d. A quorum to conduct a vote requires five eligible voting members with representation from each SRC
- e. The Chair will preside over meetings and participate with the DIVISION in the preparation of the agenda.
- f. Meetings will be conducted in a fair and professional manner.
- g. The COMMITTEE shall operate under commonly accepted procedures and Chair shall conduct of meetings in a fair and productive manner.
- h. Votes shall be recorded as:
  - a. In Favor
  - b. Opposed
  - c. Abstain
- i. The DIVISION will be responsible for preparing the agenda.
- j. Attendance by teleconference or videoconference is acceptable so long as communications are adequate to conduct the business of the Committee.

9. AMENDMENT OF BYLAWS

- a. Any rule or procedure of the COMMITTEE may be enacted, amended, repealed or suspended by a majority vote of the voting membership.

10. CONFLICT OF INTEREST

- a. Members and officers shall disclose any direct personal or pecuniary (momentary) interest in any subject or conversation before the COMMITTEE and will abstain from voting on any motion relative to that subject.

11. CONFIDENTIALITY

- a. To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The COMMITTEE'S 1157.7 business, records, and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures.
- b. Members and attendees will sign a statement of confidentiality as a condition of participation.

12. EFFECTIVE DATE

- a. These Bylaws shall be effective upon approval by the COMMITTEE.

APPROVED \_\_\_\_\_ DATE \_\_\_\_\_

This section is to establish the standard for treatment of STEMI patients that present at STEMI Referral Hospitals. It is expected that this standard of care will be implemented at all hospitals in the County that have not been designated as a STEMI Receiving Center.

STEMI patients presenting **without reasonable chance of reaching a SRC for emergency primary PCI within 60 minutes of First Medical Contact** should be directed to the nearest SRH to undergo thrombolysis within 30 minutes unless contraindicated" (based on AHA/ACC Class I evidence)

**In general, short symptom duration, age <75, large infarcts, anterior ST elevation, large reciprocal changes and clear ECG evidence of STEMI indicate patients who may derive the greatest benefit from early administration of thrombolytics if transport time to the SRC exceeds 60 minutes.**

**I. Consider thrombolytics as the preferred therapy if all the following are true:**

- Y / N \*\*Transportation time is likely more than 1 hour\*\*?**  
(Usually the case if air transport is not immediately available)
- Y / N Symptoms started less than 3 hours ago?**
- Y / N Clear ST elevation in 2 or more contiguous leads >1mm or new LBBB?**
- Y / N Patient has no absolute contraindications to thrombolytics? (listed below)**
- Y / N Patient stable w/o signs of cardiogenic shock? (for shock, PCI is preferred)**

**II. Absolute contraindications: Avoid thrombolytics if any answer is "yes"**

- Y / N Has the patient ever had an intracranial hemorrhage?**
- Y / N Does the patient have a known cerebral vascular lesion (i.e. AVM)?**
- Y / N Is the patient suffering from primary or metastatic brain cancer?**
- Y / N Has patient had an ischemic stroke within 3 months but not within 3 hrs?**
- Y / N Do you think the patient is having an aortic dissection?**
- Y / N Is the patient currently having active bleeding? (excluding menses)**
- Y / N Has patient had significant closed head or facial trauma within 3 months?**

**III. Relative contraindications: Benefit of PCI may be > thrombolytics, particularly if multiple factors are present. Reasonably assess combined factors.**

- A questionable dx of STEMI (ECG findings not clear or not diagnostic)?**
- History of chronic severe, poorly controlled hypertension?**



- Severe hypertension on presentation (SBP >180 or DBP >110)?
- History of stroke over (3) months ago or ? intracranial pathology (not ICH or CA)?
- Recent, vigorous CPR for > 10 minutes or major surgery within 3 weeks?
- Internal bleeding within 2-4 weeks but not currently?
- Non-compressible vascular punctures / Pregnancy?
- Prior multiple cardiac stents or known hx of severe CAD?
- Age over 80? (age alone is NOT a contraindication to thrombolytics)

**IV. If the patient clearly fits criteria for thrombolytic therapy and the transport time to an SRC is expected to be greater than 60 minutes, proceed to the nearest SRH immediately!** The goal for door-in to door-out from the SRH is 30 minutes or less if thrombolytics will not be administered. Stable post-lytic patients may not need air transport.

**V. TNK (Tenecteplase) Tissue Plasminogen Activator instructions and dosing**

**Remember, Time = Muscle! Door to needle goal <30 minutes!**

TNK is weight based. TNK is *a single bolus* injection only.

Patient's Weight	TNK dose	TNK Volume
a. < 60 Kg	30 mg	6 ml
b. 60-70 Kg	35 mg	7 ml
c. 70-80 Kg	40 mg	8 ml
d. 80-90 Kg	45 mg	9 ml
e. >90 Kg	50 mg	10 ml

**VI. Preparation**

1. Patient should have an IV of Normal saline.
2. Remove "shield assembly" from 10cc syringe. *Note;* do not discard.
3. Withdraw 10 ml of sterile water from (provided) vial using "red hub" device.
4. Gently inject sterile water into TNK vial onto TNK powder.
5. Gently swirl contents; *do not shake or agitate*. Concentration is 5 mg/ml. It should be colorless to clear - pale yellow.
6. When the decision to give TNK is made, **Heparin should be administered before or concurrently** with TNK.

**VII. Administration**

1. Withdraw appropriate patient dose from TNK mixture.

2. Stand "shield assembly" vertical on countertop (green cap down) and recap red hub
3. Remove entire shield assembly including red hub.
4. TNK is ready to inject as a bolus through a needleless hub into a saline solution IV line.
5. Inject TNK as bolus over 5 seconds.
6. Discard remaining TNK if physician concurs.

Remember to give Heparin in addition to TNK!

**I. Bypassing a STEMI Referral Hospital (non-PCI hospital)**

A. Bypassing an SRH is recommended if the patient is stable and the expected transport time to the SRC is 60 minutes or less, as long as the following criteria are met:

- Patient is displaying signs and symptoms of a cardiac related event
- Patient is **NOT** displaying signs and symptoms of an **Aortic Dissection** (i.e. Acute tearing, ripping, or shearing sensation to chest or back radiating to the neck and/or down back).
- A 12 Lead ECG has been completed with a reading of “Acute MI” or “Left Bundle Branch Block”
- The following questions have been answered with at least one (1) **YES** response:
  1. Yes/No Systolic blood pressure is greater than 180 mm Hg
  2. Yes/No Diastolic blood pressure greater than 110 mm Hg
  3. Yes/No Right vs. left arm systolic blood pressure difference is greater than 15mm Hg
  4. Yes/No History of structural central nervous system disease
  5. Yes/No Significant closed head/facial trauma within the previous three months
  6. Yes/No Major trauma, surgery (including laser eye surgery), GI/GU bleed (within six weeks)
  7. Yes/No Bleeding or clotting problem or taking blood thinners
  8. Yes/No CPR greater than 10 minutes
  9. Yes/No Pregnant female
  10. Yes/No Serious systemic disease (e.g., advanced/terminal cancer, severe liver or kidney disease)
  11. Yes/No Pulmonary edema (rales greater than halfway up)
  12. Yes/No Systemic hypoperfusion (cool, clammy)
- Base contact has been made with a STEMI Receiving Center confirming that the patient falls out of the thrombolytic therapy protocol and the base hospital physician concurs with the decision to bypass.

## Revision Log

04/25/2012 Initial draft finalized by STEMI Working Group

05/01/2012 Reformatted into final draft

05/07/2012 Amend "Designation, A.1." to include cardiac surgery service; amend Page 4 to insert provision for "Interim Designation"; and amend "Concept of Operations of STEMI System of Care, A.1." to reiterate avoidance of delay in treatment and transport to obtain 12-lead ECG.

05/10/2012 Policy approved by EMCAB

06/26/2012 Policy approved by Board of Supervisors

05/09/2013 Revisions approved by EMCAB: additions of Appendix E and F; clarification to use Action Registry in lieu of a home-grown database, per STEMI Workgroup agreement; and revise SRC performance standards

08/06/2013 Amend Page 8 to remove discouragement of obtaining 12-lead in the field if care is delayed; (this change reflects a previous change to paramedic protocol implemented earlier in the year); revision needed for consistency between policies.

11/14/2019 Updated and Amended definitions; added impella, amended QI Committee make up; amended direct to transport to PCI hospital time from 45 to 60 minutes; updated to meet state STEMI recommendations.

## ***Stroke System of Care (4002.00)***

### **I. PURPOSE**

The purpose of the Stroke System of Care Policies (policies) is to define the following:

- A. Requirements for Stroke Center application, designation, and re-designation by the Kern County EMS Program (Program);
- B. Requirement for training pre-hospital personnel in recognition of Stroke victims, understanding benefit of a Stroke Center, and making appropriate destination decisions;
- C. Requirements for on-going quality improvement review; and
- D. Requirements for data management and mandatory elements.

The objective of having a Stroke Center designation is to provide rapid evaluation and appropriate treatment for all eligible stroke cases in the shortest time possible. In addition, a Stroke Center must have a component that addresses comprehensive post treatment management/rehabilitation, and involvement in pre-hospital personnel training. The EMS system objective is to transport qualifying stroke patients to a designated Stroke Center.

### **II. AUTHORITY**

This policy is developed under the authority of Health and Safety Code, Division 2.5, California Evidence Code 1157.7, and California Code of Regulations (CCR) Title 22, Division 9, Chapter 7.2.

### **III. DEFINITIONS**

- A. American Board of Radiology (ABR): oversees the certification and ongoing professional development of specialists in [Diagnostic Radiology](#), [Radiation Oncology](#) and [Medical Physics](#). The ABR certifies through a comprehensive process involving educational requirements, professional peer evaluation, and examination.
- B. American Osteopathic Board of Radiology: an organization that provides board certification to qualified Doctors of Osteopathic Medicine (D.O.) who specialize in the use of imaging in the diagnosis and treatment of disease.
- C. American Osteopathic Board of Neurology and Psychiatry: an organization that provides board certification to qualified Doctors of Osteopathic Medicine (D.O.) who specialize in disorders of the nervous system (neurologists) and to qualified Doctors of Osteopathic Medicine who specialize in the diagnosis and treatment of mental disorders.

- D. American Board of Psychiatry and Neurology: Responsible for certifying physicians who have completed residency training in neurology and/or psychiatry in programs accredited by the American Osteopathic Association
- E. Board-certified: Means that a physician has fulfilled all requirements, has satisfactorily completed the written and oral examinations, and has been awarded a board diploma in a specialty field.
- F. Board-eligible: Means that a physician has applied to a specialty board and received a ruling that he or she has fulfilled the requirements to take the examination. Board certification must be obtained within five (5) years of the first appointment.
- G. Certificate of Added Qualification (CAQ): A CAQ enables a physician to add to his or her skill set and qualifications, without completing an additional full fellowship training program. A CAQ consists of additional coursework, clinical education, and testing of a sub-specialized technique, procedure or area of medicine within the physician's medical specialty
- H. Comprehensive Stroke Centers (CSC): These facilities are equipped with diagnostic and treatment facilities for stroke that are not found in other hospitals and are able to deliver time-sensitive treatment within an extended therapeutic time window. They also have advanced neurological and interventional neuroradiology capabilities. Neurosurgeons and interventional neuroradiologists play important roles for treating intracerebral hemorrhage and subarachnoid hemorrhage. In addition, brain tumors and subdural hematomas are common stroke mimics.
- I. Computed Tomography (CT): CT radiography in which a three-dimensional image of a body structure is constructed by computer from a series of plane cross-sectional images made along an axis
- J. Continuing Medical Education (CME): Education required for the maintenance of a license and refers to the highest level of continuing education approved or recognized by the national and/or state professional organization.
- K. ELVO Alert: A pre-arrival notification by pre-hospital personnel to the base hospital that a patient is suffering a possible Emergent Large Vessel Occlusion (ELVO) ischemic stroke.
- L. Emergency Medical Services Authority (Authority or EMSA): The department within the Health and Welfare Agency of the State of California that is responsible for the coordination and integration of all state activities concerning EMS.
- M. Immediately Available: Unencumbered by conflicting duties or responsibilities.
- N. Interventional Neuroradiologists: Board certified, medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases and must meet national accrediting body minimum requirements.

- O. Kern County Emergency Medical Services Program (Program): A Program of the Kern County Public Health Services Department. The local emergency medical services agency responsible for the regulation and oversight of the emergency medical services system in Kern County.
- P. Local Emergency Medical Services Agency (Local EMS Agency, or LEMSA): A county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agreement between counties or cities and which is designed pursuant to chapter 4 of the California Health and Safety Code, Division 2.5, Section 1797.200. The Program is the LEMSA for Kern County.
- Q. Magnetic Resonance Imaging (MRI): MRI a noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves
- R. Primary Stroke Center (PSC): stabilizes and treats acute stroke patients, providing initial acute care. PSCs are able to appropriately use an approved thrombolysis agent and other acute therapies such as stabilization of vital functions, provision of neuroimaging procedures, and management of intracranial and blood pressures. Based on patient needs and the hospital's capabilities, they either admit patients or transfer them to a comprehensive stroke center.
- S. Protocol: A predetermined, written medical care guideline, which may include standing orders.
- T. Satellite Stroke Centers/Acute Stroke Ready (SSC/ASR): These facilities are able to provide the minimum desirable level of care for stroke patients in the ED, particularly when paired with another hospital, but are not documented to provide the minimum level of care for admitted inpatients. These facilities should be regarded as stroke partners or "spokes" and should be aligned by formal agreement with a hospital that can provide the missing service (hub). The most common "missing service" is neurological expertise in the ED and inpatient Stroke Unit care for patients treated with recanalization therapies. In these hospitals, the necessary ED neurological expertise may be provided through telemedicine.
- U. Stroke: A condition of impaired blood flow to a patient's brain resulting in brain dysfunction.
- V. Stroke Call Roster: A schedule of licensed health professionals available twenty four (24) hours a day, seven (7) days a week for the care of the stroke patient as required by the level of designation criteria.
- W. Stroke Care: Emergency transport, triage, and acute intervention and other acute care service for stroke that potentially requires immediate medical or surgical intervention or treatment, and may include education, primary prevention, acute intervention, acute and subacute management,

prevention of complications, secondary stroke prevention, and rehabilitative services.

- X. Stroke Medical Director: A physician designated by the hospital who is responsible for the stroke service and performance improvement and patient safety programs related to stroke care.
- Y. Stroke Program Manager/Coordinator: A registered nurse or qualified individual designated by the hospital with the responsibility for monitoring and evaluating the care of stroke patients and the coordination of performance improvement and patient safety programs for the stroke center in conjunction with the stroke medical director.
- Z. Stroke Program: An organizational component of the hospital specializing in the care of stroke patients.
- AA. Clinical Stroke Team: A team of healthcare professionals involved in the care of the stroke patient and may include, but not be limited to: neurologists, neurointerventionalist, neurosurgeons, anesthesiologists, emergency medicine and other stroke center clinical staff.
- BB. Telemedicine: The use of medical information exchanged from one site to another via electronic communications to improve patients' health status. A neurology specialist will assist the physician in the center rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to the specialist.
- CC. Thrombectomy Capable Stroke Center: (TSC): "Thrombectomy-capable stroke center" means a primary stroke center with the ability to perform mechanical thrombectomy for the ischemic stroke patient when clinically warranted.

#### IV. DESIGNATION

- A. Hospitals seeking formal designation as a Stroke Center shall meet the following requirements:
  - 1. Possess current California licensure as an acute care hospital providing basic or standby emergency medical services.
  - 2. Must hold current designation and valid contract with the county as a paramedic base hospital; standby ER's excluded for Satellite Stroke Center designation.
  - 3. Obtain and maintain continuous accreditation as a Primary Stroke Center (PSC), Thrombectomy Capable Stroke Center (TSC) and Comprehensive Stroke Center (CSC) from The Joint Commission or other CMS approved accrediting body. Satellite Stroke Centers



(SSC) must obtain and maintain continuous designation with the County by completing the application documentation requirements every two (2) years as well as meet all provisions set forth in this policy.

4. Comply with California Emergency Medical Services Authority Stroke regulations
5. All Primary Stroke Centers (PSC), Comprehensive Stroke Centers (CSC) and Thrombectomy Capable Stroke Centers (TSC) shall contract with the American Heart Association to submit data to “Get with the Guidelines-Stroke” (GWTG) registry. All PSC, TSC, and CSC shall submit quarterly reports to the Program. All SSCs shall complete a data sheet to submit to the PSC or CSC upon transfer of patient.
6. The PSC, TSC, and CSC shall maintain a designated telephone number (Hotline) to facilitate rapid inter-facility transfer and access to the PSC, TSC, & CSC physician for consultation with SSC physicians and other providers regarding care and transfer of stroke patients.
7. Execute an agreement between the Stroke Center and the County of Kern to formally designate the hospital as a Primary, Thrombectomy Capable, Comprehensive, or Satellite Stroke Center.
8. All Stroke Center’s must be an approved Continuing Education provider with the County.
9. Neurological staff including neurosurgeons and interventionalists shall only be “On-Call” for one local SSC, PSC, TSC, or CSC at any given time
10. All Stroke Center’s shall provide for the triage and treatment of simultaneously presenting stroke patients so long as the Stroke Center’s Emergency Department is on “open” status.
11. All Stroke Center’s shall provide stroke center services to any stroke patient that comes to the emergency department, regardless of the stroke patient’s ability to pay physician fees and/or hospital costs. The phrase “comes to the emergency department” shall have the same meaning as set forth in the Emergency Medical

Treatment and Active Labor Act (42 U.S.C § 1395dd) and the regulations promulgated thereunder (EMTALA).

12. All Stroke Center's shall notify the Program within twenty-four (24) hours of any failure to meet the provisions set forth in the designation criteria. The Hospital will identify its action to correct the deficiency and submit within the next 7 days after the failure.

13. All Stroke Center's shall actively and cooperatively participate in the "Stroke QI Committee," and other related committees that may, from time to time, be named and organized by the Program related to the Stroke System of Care. Active Cooperation shall include attendance at ALL Stroke QI meetings by the Stroke Coordinator and the hospital stroke program medical director, or their hospital designee.

14. Primary Stroke Centers, Thrombectomy Capable Stroke Centers, and Comprehensive Stroke Centers shall accept all Stroke patients from all facilities within the County, upon notification of "Stroke Alert" and request by the transferring physician.

15. All Stroke Centers shall pay the established fee. The Program will charge for regulatory costs incurred as a result of Stroke Center application review, designation, and re-designation. The specific fees are based upon Program costs. Fee amounts shall be specified in the County Fee Ordinance Chapter 8.13, if applicable.

#### B. COMPREHENSIVE STROKE CENTERS SERVICE STANDARDS (CSC)

CSC a receiving hospital that has met the standards of an EMS Agency approved certifying body as a Comprehensive Stroke Center and has been approved as a Comprehensive Stroke Center by the Kern County EMS Program.

#### C. THROMBECTOMY CAPABLE STROKE CENTER SERVICE STANDARDS (TSC)

TSC a receiving hospital that has met the standards of an EMS Agency approved certifying body as a Thrombectomy Capable Stroke Center and has been approved as a Thrombectomy Capable Stroke Center by the Kern County EMS Program.

## PRIMARY STROKE CENTERS SERVICE STANDARDS (PSC)

PSC a receiving hospital that has met the standards of an EMS Agency approved certifying body as a Primary Stroke Center and has been approved as a Primary Stroke Center by the Kern County EMS Program.

### a. SATELLITE STROKE CENTERS/ACUTE STROKE READY SERVICE STANDARDS (SSC/ASR)

In Addition to the requirements listed in Section IV: A; 1-13, for all Stroke Centers, Satellite Stroke Centers must meet the following service standards as outlined in California Code of Regulations (CCR) Title 22, Division 9, Chapter 7.2.

1. The necessary emergency department neurological expertise may be provided in person or through telemedicine.
2. Evaluation of the SSC will include an assessment of the following components:
  - i. An acute Stroke Team available to see in person or via telemedicine a patient identified as a potential acute stroke patient within twenty (20) minutes following the patient's arrival at the hospital's emergency department or within twenty (20) minutes following a diagnosis of a patient's potential acute stroke.
  - ii. Written policies and procedures for emergency department stroke services that are reviewed a least every three (3) years, revised more frequently as needed, and implemented. Emergency department policies and procedures shall include written protocols and standardized orders for emergency care of stroke patients.
  - iii. Evidence based, continuous quality improvement including collection and monitoring of standardized performance measures.
  - iv. Neuro-imaging services capability that is available twenty four (24) hours a day, seven (7) days a week, such that imaging shall be performed within sixty (45) minutes following code entry. Such studies shall be reviewed by a physician with appropriate expertise, such as a board-

certified radiologist, board-certified neurologist, a board certified neurosurgeon, or residents who interpret such studies as part of their training in an Accreditation Council of Graduate Medical Education-approved radiology, neurology, or neurosurgery training program, within sixty (45) minutes of patient arrival at the emergency department.

- v. Neuro-imaging services shall, at a minimum, include CT scanning or MRI, as well as interpretation of the imaging.
- vi. In the event that tele-radiology is used in image interpretation, all staffing and staff qualification requirements shall remain in effect and shall be documented by the hospital.
  - a) A qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.
  - b) A qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
  - c) A qualified neurosurgeon shall be board-certified by the American Board of Neurological Surgery.
- vii. Laboratory services capability twenty four (24) hours a day, seven (7) days a week, such that services shall be performed within sixty (60) minutes following order entry. Laboratory services shall, at a minimum, include blood testing. Electrocardiography and x-ray services must also meet these time and availability standards.
- viii. Neurosurgical services that are available or under agreement with transfer, including operating room availability, either directly or under agreement with a PSC or CSC, within three (3) hours following admission of acute stroke patients to the SSC.

- ix. Transfer arrangements with one (1) or more PSC or CSC that facilitate transfer of patients with strokes to the Stroke Center(s) or care when clinically warranted.
- x. There shall be a director of the SSC, who may serve also as a member of the Stroke Team, who is a physician who maintains at least six (6) hours per year of educational time in cerebrovascular disease.
- xi. At a minimum, an acute care Stroke Team shall consist of a nurse and a physician with six (6) hours per year of educational time in cerebrovascular disease.

**V. APPLICATION PROCESS FOR STROKE CENTER DESIGNATION AND RE-DESIGNATION**

A. The following milestones outline the application process for a hospital to become designated as a Stroke Center.

1. Review list of requirements and checklist of documents, found in *Appendix A- Stroke Center Designation Criteria Application and Evaluation Tool*, which must be completed and submitted with the application.
2. Submit letter of application to the Program. The letter shall contain:
  - a. Intent to obtain Stroke Center designation;
  - b. Identify the names and contact information, including email addresses for the key stroke personnel whose roles and responsibilities are defined in section III of this document: the Stroke Medical Director, RN Program Manager, and Administrative contact; and
  - c. Identify the anticipated target date for Stroke Center designation from an EMS agency certifying body.
3. Complete and submit to the EMS Program all information and documents requested in *Appendix A, Column 2, "objective measurement"* of the *Stroke Center Designation Criteria Application and Evaluation Tool*.
4. All application materials will be reviewed for completeness. Additional information may be requested, if needed. Upon

determination that the application is complete, the applicant and the Program will work towards execution of the designation agreement.

5. Stroke Center Designation agreement will be presented to the Board of Supervisors for approval and formal designation.
6. Stroke Centers shall be eligible for re-designation every two (2) years. In order to be eligible for re-designation, the Stroke Center shall meet all of the provisions of this policy. Re-designation of a stroke center will require the documentation from sections #1, #2b and #3 above to be resubmitted to the Program by February 28th before the end of the term. . Hospitals who hold accreditation by a nationally recognized accrediting body may submit proof to the Program in lieu of the above mentioned documentation to maintain current destination status.

## **VI. REVOCATION OF STROKE CENTER DESIGNATION**

Any designated Stroke Center which is unable to meet the following requirements shall be subject to removal of designation as a Stroke Center:

- A. A Stroke Center must comply with any policy, procedure, or regulation mandated by the Local, State, or Federal Government.
- B. If the Program finds a Stroke Center to be deficient in meeting the above criteria, the Program will give the Stroke Center written notice, return receipt requested, setting forth with reasonable specificity the nature of the apparent deficiency. Within ten (10) calendar days of receipt of such notice, the Stroke Center must deliver to the Program, in writing, a plan to cure the deficiency, or a statement of reasons why it disagrees with the Program's notice. The Stroke Center shall cure the deficiency within thirty (30) calendar days of receipt of notice of violation. If the Hospital fails to cure the deficiency within the allowed period or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication. EMCAB may make a recommendation to the Program for resolving the issue.
- C. At least every two (2) years, the Stroke Center shall submit documentation to the Program showing the facility has obtained re-certification as a Primary Stroke Center, Thrombectomy Capable Stroke Center (TSC) Comprehensive Stroke Center (PSC or CSC) by a nationally recognized accrediting body to maintain the current destination status..

## VII. QUALITY IMPROVEMENT

Stroke Center designated hospitals shall participate in performance improvement program for EMS patients including:

- A. All Stroke Centers shall provide the following representatives to participate in the countywide EMS Program Stroke QI Committee:
  1. The Stroke Program Medical Director or medical staff representative
  2. The Stroke Program Manager/Coordinator
- B. The countywide Stroke QI Committee will hold regular multidisciplinary meetings that include representatives from each Primary Stroke Center, Thrombectomy Capable Stroke Center, Comprehensive Stroke Center, Satellite Stroke Center, prehospital provider, and representatives from the Program as listed in Appendix E.
- C. A Stroke Center shall implement a written internal QI plan/program with an internal review process that includes, but is not limited to:
  1. Last known well to door times
  2. Last known well to IV approved thrombolysis agent times
  3. Door to CT times
  4. Door to IV approved thrombolysis agent times
  5. Time to Thrombectomy (1<sup>st</sup> pass, % LVO)
  6. Total Stroke Cases
  7. Percent of total cases arrived by EMS
  8. Of those that arrived by EMS what percent were activated as Stroke Alerts prior to arrival
  9. What percent of total cases are Hemorrhagic Stroke
  10. What percent of total cases are Ischemic Stroke
  11. What percent of total cases are Transient Ischemic Attack
  12. Disposition on discharge (i.e. deceased, hospice care, nursing facility, rehab, home)

13. Transfers door in → door out

- D. A Stroke Center shall participate in prehospital stroke-related educational activities as determined by the Program.

## **VIII. DATA COLLECTION, SUBMISSION, AND ANALYSIS**

Stroke Center designated hospitals shall be in continuous compliance with the following data collection, submission, and analysis standards:

- A. Data element, submission, and analysis requirements are subject to change at Program's discretion.
- B. Data shall be used for quality improvement purposes by the Stroke QI Committee, and data submitted by Stroke Centers are considered to be confidential under the provisions of Evidence Code Section 1157.7.
- C. The Program may publicly report data about the stroke system which is derived from any of the individual data elements.
- D. Each designated Stroke Center shall submit quarterly data reports to the Program. Data reports shall consist of all relevant information to document achievement measures established by the American Heart Association's *Get With The Guidelines: Stroke* (GWTG) at an 85% compliance rate for the Silver and Gold Plus recognition.
- F. In addition to performance standards established by TJC and GWTG the quarterly report shall include the following symptom timeline performance measures, breakdown of arrival status, and type of stroke treated:
  - 1. Last known well to door times
  - 2. Last known well to IV approved thrombolysis agent times
  - 3. Door to CT times
  - 4. Door to IV approved thrombolysis agent times
  - 5. Door to CTA times
  - 6. Door to Groin Puncture
  - 7. Total patients treated with an approved thrombolysis agent
  - 8. Total Stroke Cases
  - 9. Percent of total cases arrived by EMS



10. Of those that arrived by EMS what percent were activated as Stroke Alerts prior to arrival
  11. Stroke patients arrived by POV
  12. What percent of total cases are Subarachnoid Hemorrhage Stroke
  13. What percent of total cases are Intracerebral Hemorrhage
  14. What percent of total cases are Ischemic Stroke
  15. What percent of total cases are Transient Ischemic Attack
  16. Disposition on discharge by diagnosis: ICH cases, SAH cases, Ischemic cases, and TIA cases (i.e. deceased, hospice care, nursing facility, rehab, home)
  17. Overall data trends (Excluding TIA) (i.e. deceased, hospice care, nursing facility, rehab, home)
  18. Outcome disposition at 90 days (i.e. deceased, hospice care, nursing facility, rehab, home)
  19. Demographics: age, gender, ethnicity, race.
- G. Data reports shall be submitted to the Program within 60 days of the end of the preceding quarter. All strokes received or encountered by the designated Stroke Center shall be included in the data report. This includes all stroke cases received by ambulance (prehospital and interfacility transfer), private vehicle, or walk in, including acute strokes occurring at the designated Stroke Center.
- H. Falling below the 85% compliance requires a written action plan for improvement to be submitted with the quarterly reports.
- I. Quarterly data reports will include a listing of the continuing education classes provided, including date, location, and topic made available to prehospital personnel during the quarter reported. Trainings will be provided by one Stroke Center each quarter and be rotated until all Stroke Centers have participated. If no trainings were offered a clear explanation of the circumstances surrounding the failure to provide education shall be documented.
1. EMS personnel initial and continuing education training will be provided by Stroke Center staff

2. The curriculum shall be submitted to the Program for approval before the training is conducted
  3. Initial curriculum shall include competency in recognizing stroke patients, understanding the importance of the Stroke Center, and demonstrate competency in Stroke Center activation criteria and hospital destination decision criteria. Continuing education topics should address system deficiencies as discovered through the Quality Improvement process.
  4. Stroke Centers shall provide EMS personnel appropriate continuing education credits. The Program may require changes in the continuing education training content for EMS personnel.
- J. The Stroke Center will provide an annual report summary of final stroke case outcomes during the period of July 1<sup>st</sup> through June 30<sup>th</sup> of the previous year. The annual report is due 60 days after the end of the fiscal year (August 31).
- K. The Stroke Center shall continuously examine on-going case data and summary data reports and will advise the Program of any trends, positive and/or negative, that are shown by the data. Improvement strategies and operational changes made as a result of data analysis will be included in the quarterly and annual reports. The Program may participate in the Stroke Center quality improvement process.
- L. The Stroke Center shall promptly (within 3 business days) provide any data requested by the EMS Program related to stroke patients treated at The Stroke Center.
- M. In addition to the above listed data elements, the EMS Program shall compile the following data points for review during quarterly QI meetings:
1. Time from receipt of 911 call to dispatch of EMS resource(s);
  2. Time of dispatch of EMS resource(s) to time of EMS resource(s) arrival;
  3. Patient contact time to depart scene time;
  4. Inter-facility transport time, if applicable;
  5. Transport time from scene to ED arrival;
  6. Time from patient contact to ED arrival;
  7. Total EMS contact time;
  8. Stroke patient routed to designated stroke center or other hospital;
  9. Use of validated stroke screening tool by EMS responders;

10. Results of validated stroke screening tool;
11. Pre-arrival notification of receiving hospital performed.
12. Demographics: age, gender.

## **IX. CONCEPT OF OPERATIONS OF THE STROKE SYSTEM OF CARE**

### **A. Pre-Hospital: Ambulance/Paramedic Responsibilities**

1. Recognize Signs and Symptoms of CVA: Upon an assessment finding of possible neurological distress with hypoglycemia and narcosis ruled out, paramedic shall conduct the Cincinnati Pre-hospital Stroke Scale (CPSS).
2. Facial droop, arm drift, abnormal speech: Paramedic will use any abnormal finding to determine if the patient has an abnormal CPSS.
3. Stroke Alert Early Notification: Upon receiving an abnormal CPSS and determining the onset was observed by a valid historian within the last four (4) hours, or the patient has questionable time of onset, paramedic shall immediately contact the destination hospital and issue a "Stroke Alert".
4. Destination: parameters for stroke patient
  - a. Abnormal CPSS goes to closest, most appropriate Stroke Center
  - b. If the Stroke Center is more than 30 minutes away and the patient meets Thrombolytic inclusion criteria located in Appendix D; the patient may be transported to the closest ED regardless of designation
  - c. Paramedic shall follow appropriate treatment protocol during transport

### **B. Hospital Relationships and Coordination**

1. Transfer Agreements/Requirements
  - a. Rapid Transfer – Stroke Center Automatic Acceptance of Stroke Patient from Transferring Hospital
  - b. Each Stroke Center agrees to immediately accept all "Stroke Alert" patients from any E. D. located within Kern County, so long as the Stroke Center's E.D. is on "Open" status.
2. Specific Language to initiate immediate rapid transfer. The term, "Stroke Alert" will be used by paramedics as well as Satellite Stroke Centers and non-Stroke Hospital staff in order to notify the Stroke Center of an incoming Stroke patient. "Stroke Alert" shall be

understood by all hospital staff as well as ambulance dispatchers to mean an emergent neurologic event is in progress with rapid treatment and transport necessary.

- a. Non-Stroke hospitals shall have written transfer agreements with PSC, TSC and CSC.
- b. The agreement shall include a one-call policy transfer/transport protocol to a designated PSC, TSC and CSC.

### C. Community Education

1. It is imperative that each Stroke Center recognize the need for community awareness as we work together to improve health in Kern County.
2. Each Stroke Center must be active participants and work together to promote public awareness activities, i.e. public service announcements, print ads, community events, task forces and classes. Education should focus on;
  - a. Stroke disease factors
  - b. The signs and symptoms of Stroke
  - c. The need to call 911
3. Other community education themes might include:
  - a. Stroke is preventable. People can reduce their chance of having a Stroke by controlling risk factors such as obesity, high blood pressure, and high cholesterol.
  - b. Time-sensitive window for EMS/treatment response
4. Public Reporting of Performance Data - A large part of public awareness begins with data reporting. Pertinent stroke system data showing the performance of the Stroke System of Care may be posted publicly. The following performance measurements may be publicly released, and additional reports may be published upon recommendation of the Stroke QI Committee.
  - a. Symptom onset time to EMS Call Time
  - b. EMS First contact to E.D. arrival time
  - c. E.D. arrival time to CT time
  - d. CT time to IV an approved thrombolysis agent

## APPENDIX A - Stroke Center Designation Criteria Application and Evaluation Tool

Stroke Designation Standard	Objective Measurement	Meets Standard	Comments
<b>PRIMARY STROKE CENTER</b>			
<b>HOSPITAL SERVICES</b>			
Current License to provide Basic Emergency Services in Kern County	Copy of License	Y N	
Current Designation to operate as a Paramedic Base Station in Kern County	Copy of contract	Y N	
Current Copy of Joint Commission Certification.	Copy of Certification	Y N	
An acute Stroke team available within 15 minutes	On-call schedules for 3 months. On-call policy and procedure	Y N	In person or telemedicine
Written policies and procedures for Stroke services	Copy of policies, procedures	Y N	Include protocols and standardized orders
Data-reporting mechanism	Copy of agreement with AHA	Y N	AHA Get with the Guidelines-Stroke
Neuro-imaging capability 24/7/365	Policies/protocols supporting operations	Y N	CT or MRI
One of the following: Qualified Radiologist, Qualified Neurologist, Or Qualified Neurosurgeon	Copy of appropriate board certification  On-call schedules for 3 months	Y N	If using telemedicine, hospital must document this standard
Laboratory services 24/7	Copy of policies/procedures/protocols for lab services	Y N	Blood testing, EKG, and x-ray services
Immediate, telemetry or critical care beds	Immediate: ____ Telemetry: ____ Critical Care: _____	Y N	
Neurosurgical services including operating room	Number of operating rooms ____ on license	Y N	May be under agreement with another PSC or CSC

If no neurosurgical services available: Plan to transfer within 2 hours	Supporting policies and procedures	Y N	Required if no Neurosurgery
In-patient acute care rehabilitation	Policies/procedures for in-patient rehabilitation	Y N	
Designated Telephone Number	Actual Number on File	Y N	
Written transfer guidelines for higher level of service	Transfer policies/procedures Copy of agreement	Y N	
Copy of Designation Agreement Between Hospital and County	Copy of Contract	Y N	
Continuing Education Provider	Copy of Approval Letter with CE provider Number	Y N	
Stroke contingency plans 1. Personnel 2. Imaging equipment	Pertinent policy and procedures to minimize disruption	Y N	Expectation of NO DIVERSION
<b>STAFFING</b>			
Acute Stroke Care Team:			
One of the following: Neurologist Neurosurgeon Interventional-neuroradiologist Emergency physician	Copy of appropriate board certification  On-call schedule for 3 months  Copy of job description	Y N	Board certified or Board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, with experience and expertise in dealing with cerebral vascular disease
One of the following: Registered nurse Physician assistant Nurse practitioner	Copy of license  Copy of job description	Y N	Demonstrated competency in caring for acute Stroke patients
<b>COMPREHENSIVE</b>			<b>All of the above PLUS</b>
Written policies and procedures for comprehensive Stroke services	Copies of policies/procedures/protocols for activation of Stroke care	Y N	Reviewed every two years and revised as needed

Data driven CQI Including collection and monitoring of standardized Comprehensive Stroke Center performance measures	Copies of data collection procedures  Copies of internal CQI process	Y N	
Transfer agreements with primary Stroke Centers to accept transfer of patients with complex Strokes	Copies of transfer agreements  Policies/ procedures/ protocols in place to accept patients	Y N	
Provide guidance and continuing education to hospitals designated as Primary Stroke Centers with which they have agreements	Copies of policies/ procedures/ guidelines to provide CME  Copies of agreements	Y N	
<b>Thrombectomy Capable Stroke Center</b>			<b>All of PSC requirements plus</b>
Neurointerventionist on call 24/7 and available on-site at TSC within 45 minutes of notification of an ELVO alert.	Copies of policies/ procedures/ guidelines	Y N	
Neurosurgeon on call 24/7 and available to provide care as indicated.	Copies of policies/ procedures/ guidelines	Y N	
Neurologist, with hospital privileges to provide ICU level of care for acute stroke patients, on call 24/7 and available to provide care as indicated.	Copies of policies/ procedures/ guidelines	Y N	
An individual Neurointerventionalist or Neurosurgeon may not be simultaneously on call for a separate hospital.		Y N	

Appropriate endovascular catheterization laboratory personnel available on-site within 30 minutes of notification of an ELVO alert	Copies of policies/ procedures/ guidelines	Y N	
Will create policies and procedures detailing how the TSC will notify the appropriate personnel of an ELVO alert.	Copies of policies/ procedures/ guidelines	Y N	
Will accept all ELVO alert patients, regardless of ICU or ED saturation status, except in the event of internal disaster or no catheterization laboratory availability.	Copies of policies/ procedures/ guidelines	Y N	
Will create policies and procedures detailing how the TSC will manage the presentation of concurrent ELVO alerts.	Copies of policies/ procedures/ guidelines	Y N	
Will create policies and procedures that allow the automatic acceptance of any ELVO patient upon notification by the transferring physician.	Copies of policies/ procedures/ guidelines	Y N	
Ability to perform endovascular procedures as indicated for emergent large vessel occlusions.	Copies of policies/ procedures/ guidelines	Y N	
Have CT or MRI perfusion capabilities.	Copies of policies/ procedures/ guidelines	Y N	
Maintain appropriate staff and facility availability to address complications of	Copies of policies/ procedures/ guidelines	Y N	



emergent endovascular procedures.			
<b>SATELLITE STROKE</b>	<b>CENTERS</b>		
Current License to provide Basic Emergency Services in Kern County or Standby Services	Copy of License	Y N	
Current Designation to operate as a Paramedic Base Station in Kern County	Copy of contract	Y N	Standby ER's Excluded
Acute Stroke care team	Copies of policies/ procedures/ protocols  On call schedule	Y N	May be via telemedicine
Emergency Department policies and procedures	Copies of ED policies/ procedures/ protocols/ standard orders for Stroke care	Y N	
Data driven CQI  Collection and monitoring of performance measures	CQI polices/ procedures/ guidelines/ standards	Y N	
Neuro-imaging capability 24/7/365	Policies/protocols supporting operations	Y N	CT or MRI, as well as interpretation
Physician with appropriate expertise: Radiologist Neurologist Neurosurgeon Residents	Copy of Board certificates	Y N	Telemedicine may be used for interpretation  All staff qualification requirements shall be documented by the hospital
Laboratory Services 24/7/365	Policies/protocols supporting operations	Y N	Minimum include blood testing, ECG, and x-ray services
Neurosurgical services, including OR availability, within 3 hours of admission	Supporting policies and procedures  Number of operating rooms ___ on license	Y N	OR may be under agreement with PSC or CSC

Transfer arrangements with PSC or CSC	Copies of agreements	Y N	
Director: Physician or Advanced Practice Nurse	Copy of license  Documentation of training  Copy of job description	Y N	Maintains 6 hours per year education in cerebrovascular disease
Acute Stroke Care Team: At a minimum- Registered Nurse and Physician	Copy of Licenses  Documentation of Training	Y N	Some training and expertise in acute Stroke care

## APPENDIX B - STROKE CENTER ACTIVATION PROTOCOL

SIGNS/SYMPTOMS OF CEREBRAL VASCULAR  
ACCIDENT

CHECK GLUCOSE TO RULE OUT HYPOGLYCEMIA.  
RULE OUT NARCOSIS AS APPROPRIATE

ASSESS ONSET OF SIGNS OR SYMPTOMS

ASSESS PATIENT IN ACCORDANCE WITH  
CINCINNATI PREHOSPITAL STROKE SCALE (CPSS)

**FACIAL DROOP** (Have the Patient Show Teeth or Smile)

- Normal: Both Sides of Face Move Equally
- Abnormal: One Side of Face does not Move as Well as the Other Side

**ARM DRIFT** (Patient Closes Eyes and Extends Both Arms Straight Out, with Palms Up, for 10 Seconds)

- Normal: Both Arms Move the Same or Do Not Move at All
- Abnormal: One Arm does Not Move or One Arm Drifts Down Compared to the Other

**ABNORMAL SPEECH** (Have the Patient Say "You can't teach an old dog new tricks")

- Normal: Patient Uses Correct Words with No Slurring of Words
- Abnormal: Patient Slurs Words, Uses Wrong Words, or is Unable to Speak

IF ONE OR MORE ABNORMAL CPSS ARE PRESENT

**AND**

ONSET OBSERVED WITHIN 4 HOURS BY VALID HISTORIAN; **OR** QUESTIONABLE ONSET TIME

- EXPEDITE CONTACT WITH DESIGNATED STROKE CENTER BASE HOSPITAL

## PRE-HOSPITAL ASSESSMENT, STROKE CENTER ALERT AND TRANSPORT DESTINATION

- A. The patient shall be immediately assessed and managed in accordance with the Stroke Center Activation Protocol.
- B. If the patient meets Stroke Center Activation Protocol indications for transport to a Stroke Center, prehospital personnel shall provide immediate notice to the Stroke Center emergency department. The notice shall include a description of the patient problem, treatment provided, current location of the ambulance, and estimated time of arrival.
- C. The Stroke Center emergency department shall immediately alert and request response of the Stroke Center Stroke Team, neurologist, and/or neurosurgeon as indicated by the patient problem.
- D. In Exclusive Ambulance Operational Areas (EOA) 1, 2, 4, 5, 9, or 8 (excluding the Tehachapi area) where transport to a Bakersfield area hospital is the closest destination, Stroke patients that meet the Stroke Center Activation Protocol indications shall be transported to a Stroke Center. This is applicable to both ALS and BLS level ambulance transports.
- E. In EOA 3, 6, or Tehachapi area of 8:
  - 1. ALS Ambulance: A stroke patient that meets Stroke Center Activation Protocol indications shall be transported to a stroke center. A stroke patient from these areas may be transported to the closest hospital emergency department if the patient meets thrombolytic inclusion criteria; airway cannot be managed appropriately; or if the patient condition is deteriorating rapidly.
  - 2. BLS Ambulance: A stroke patient that meets Stroke Center Activation Protocol indications shall be transported to the closest hospital emergency department.
- F. In EOA 7 or 11:
  - 1. ALS Ambulance: A stroke patient that meets Stroke Center Activation Protocol and thrombolytic inclusion criteria shall be transported to the closest hospital emergency department. For patients who fall out of thrombolytic therapy, contact with a stroke center shall be made to request bypass of closest facility and shall be transported to a Stroke Center. Air transport is indicated in compliance with *EMS Aircraft Dispatch-Response-Utilization Policies and Procedures*.
  - 2. BLS Ambulance: A stroke patient that meets Stroke Center Activation Protocol indications shall be transported to the closest hospital emergency department unless air transport is indicated in compliance with *EMS Aircraft Dispatch-Response-Utilization Policies and Procedures*.
- G. The Program may authorize certain exceptions to transport destinations or mode of transport defined above for documented hospital-based arrangements and protocols that are clearly in the best interest of Stroke patient management. The Program will coordinate any exemptions with appropriate hospitals, ambulance providers and air ambulance providers.
- H. Air transport shall be used if an air ambulance is available and the overall time savings will be 10 minutes or more in comparison with ground transport in compliance with EMS Aircraft Dispatch-Response-Utilization Policies and Procedures. Generally, 10 minutes time-savings cannot be attained with ground transport times of 30 minutes or less, if patient is ready for transport and air ambulance has not yet launched.
- I. The designated Stroke Center emergency department shall be notified by prehospital personnel as early as possible. This enables the designated Stroke Center to begin mobilizing resources.

**APPENDIX C- PRE-HOSPITAL THROMBOLYTIC SCREEN (CVA)**

Patient Name: \_\_\_\_\_  
 (Last Name) (First Name)

Patient Information:  
 A. Age \_\_\_\_\_ B. Sex \_\_\_\_\_ Last known well \_\_\_\_\_  
 C. Past medical History: \_\_\_\_\_  
 D. Current medications: \_\_\_\_\_  
 E. Drug allergies: \_\_\_\_\_

F. Initial B/P:	(Right Arm)	(Military Time)	(Left Arm)	(Military Time)
		YES	NO	
g. Age less than or = 18 years		{ }	{ }	
h. Onset of symptoms greater than or = 4 hours		{ }	{ }	
i. Patient was asleep when symptoms started		{ }	{ }	
j. Rapidly improving or minor symptoms		{ }	{ }	
k. History of intracranial hemorrhage		{ }	{ }	
l. Seizure at onset of symptoms		{ }	{ }	
m. Stroke or serious head injury in less than or = 3 months		{ }	{ }	
n. Major surgery or other serious trauma in less than or = 2 weeks		{ }	{ }	
o. GI or urinary tract hemorrhage in less than or = 3 weeks		{ }	{ }	
p. Systolic B/P greater than or = 185 mmHg		{ }	{ }	
q. Diastolic B/P greater than or = 110 mmHg		{ }	{ }	
r. Aggressive treatment to lower B/P (use of vasodilators)		{ }	{ }	
s. Blood glucose less than or = 60		{ }	{ }	
t. Blood glucose greater than or = 400		{ }	{ }	
u. Symptoms of subarachnoid hemorrhage (sudden severe headache followed by a brief loss of consciousness)		{ }	{ }	
v. Arterial puncture at non-compressible site or lumbar puncture less than or = 1 week		{ }	{ }	
w. Pregnant or lactating females		{ }	{ }	

If all of the **Pre-hospital Thrombolytic Screen (CVA)** criteria are met (all **NO's**), alert the receiving facility of a possible thrombolytic candidate as soon as possible.  
 If not (one or more YES), make base contact with a Stroke Center to verify bypass of the nearest hospital for transport directly to a Stroke Center.

Form Completed By: \_\_\_\_\_

## **APPENDIX D - Stroke Center QI Committee Purpose and Structure**

### **PURPOSE**

Care of the Stroke patient requires a system approach to ensure optimal care. To assist the EMS Program in its quest to achieve best care possible, the Stroke QI Committee shall assess, monitor, and facilitate the Quality Improvement (QI) process for the Kern County Stroke Centers.

### **AUTHORITY**

Health and Safety Code Division 2.5

California Evidence Code, Section 1157.7

California Civil Code, Part 2.6, Section 5

California Code of Regulations Title 22, Division 9, Chapter 7.2

### **DEFINITION**

“Stroke QI Committee” means the multi-disciplinary peer-review committee, composed of representatives from the Stroke Center’s, prehospital care providers, and other professionals designated by the Program, which audits the Stroke System of Care, makes recommendations for system improvements, and functions in an advisory capacity on other Stroke System of Care issues.

### **COMMITTEE MEMBERSHIP**

1. Membership Composition
  - a. PSC, TSC & CSC Members:
    - i. PSC, TSC & CSC Stroke Program Medical Director
    - ii. PSC, TSC & CSC Program Manager/Coordinator
    - iii. ED Physician optional
    - iv. QI Staff Member
    - v. Ad Hoc Members as necessary
  - b. Satellite Stroke Center Members:
    - i. E.D. Physician
    - ii. E.D. Nurse
    - iii. QI Staff Member
  - c. Prehospital Members:
    - i. At least one (1) representative from each prehospital agency
  - d. EMS Members:
    - i. EMS Coordinator

2. Confidentiality

To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The Committee's 1157.7 business, records and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures. At each meeting members and attendees will sign a statement of confidentiality as a condition of participation.

3. Schedule/Location

The Stroke Center QI Committee shall meet quarterly on the *third Thursday* of the month following the end of the quarter at (*time TBD*) Mount Vernon Ave. Time and Conference room to be determined.

4. Case Review Instructions

Each meeting participants will present the results of the quarterly data submitted by each Stroke Center. Each Stroke Center's data will be discussed and evaluated in a structured process focusing on outcomes. The committee will work together to identify root causes of problems, intervene to reduce or eliminate those causes, and take steps to correct the process and recognize excellence in performance and delivery of patient care.

In addition, on a rotating basis, each Stroke Center will present case reviews to the committee. These reviews should highlight difficult, challenging or exceptional cases that might provide valuable information to the other members of the committee.

5. PowerPoint format

All presentations are to be formatted in PowerPoint and sent to the EMS Coordinator assigned to the committee one (1) week prior to the quarterly meeting. Any audio or video files should accompany the PowerPoint.

6. Recommendations for System Improvement

The Committee will develop recommendations for improvement of the Stroke system of care. Recommendations will be presented at the EMS System Collaborative meeting and to the EMS Medical Director.

## Revision Log

11/2014 Initial draft  
11/13/2014 EMCAB Approved  
11/12/2015 Revised contracts deadlines. Added Division QI requirements. EMCAB approved.



***Pediatric Receiving Center Designation Policy (4004.00)***

**I. PURPOSE:**

This policy defines the requirements for designation as a Pediatric Receiving Center (PedRC) in Kern County and establishes that pediatric patients are transported to the most appropriate facility, which is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of pediatric patients.

**II. AUTHORITY:**

- A. California Health and Safety Code, Division 2.5, Section 1797.103, 1797.204, 1797.220, 1797.250, 1797.252, 1798.150, 1798.170, 1799.204, 1799.205.
- B. California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100147 and Chapter 14 (Draft).

**III. DEFINITIONS:**

- A. California Children Services (CCS): A State of California program for children with certain illnesses or health problems. Through this program, children up to twenty-one (21) years old can obtain necessary health care and required services.
- B. Continuous Quality Improvement (CQI): A method of evaluation composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care.
- C. Emergency Medical Services (EMS) Authority (EMSA or Authority): A department in California that is responsible for the coordination and integration of all state activities concerning EMS.
- D. Emergency Medical Services for Children (EMSC): The prevention, pre-hospital, emergency department (ED), in-patient and rehabilitation services specific for the care of children within an EMS system.

- E. Emergency Medical Services for Children Technical Advisory Committee (EMSC-TAC or TAC): A multidisciplinary committee, as appointed by the Authority. The TAC is advisory to the Authority on EMSC related issues.
- F. Emergency Medical Services Program (Program): The Kern County Public Health Services Department, Emergency Medical Services Program. The Program is the Local Emergency Medical Services Agency or LEMSA for Kern County (EMSP).
- G. Interfacility Transfer: The transfer of an admitted or non-admitted pediatric patient from one licensed health care facility to another.
- H. Neonatal Intensive Care Unit (NICU): A designated area of the hospital that specializes in the care of critically ill or injured newborn infants.
- I. Neonatologist: A physician who is board certified or board eligible in neonatology.
- J. Neonatology Fellow: A post residency trained physician who is a board certified or board eligible physician currently enrolled in a subspecialty fellowship program in neonatology.
- K. On-Call: Agreeing to be available to respond to a Pediatric Receiving Center (PedRC) in order to provide a defined service.
- L. Pediatric Critical Care Fellow: A pediatric board certified or board eligible residency trained physician currently enrolled in a subspecialty fellowship program in pediatric critical care medicine.
- M. Pediatric Critical Care Service: A clinical service within a hospital that has oversight and responsibility for the care of pediatric critically-ill or injured patients in a licensed pediatric intensive care unit (PICU).
- N. Pediatric emergency care coordinator: a physician or registered nurse who is qualified in the emergency care of pediatric patients (PECC)
- O. Pediatric Intensivist: A physician who is board certified or board eligible in pediatric critical care medicine, or pediatrics and anesthesia and anesthesia critical care.

- P. Pediatric Intensive Care Unit (PICU): A designated area with licensed pediatric intensive care beds within the hospital that specializes in the care of critically ill or injured infant, children, and teenagers.
- Q. Pediatric patient: Children Under 14 years of age.
- R. Pediatric Receiving Center (PedRC): The licensed general acute care hospital with, at a minimum, a permit for basic or standby emergency services that has been formally designated by the Program. The PedRC Levels are Comprehensive Pediatric Receiving Center (Comprehensive PedRC), Advanced Pediatric Receiving Center (advanced PedRC), General Pediatric Receiving Center (General PedRC), and Basic Pediatric Receiving Center (Basic PedRC).
- S. Promptly Available: Responding without delay when notified and requested to respond to the hospital and being physically available to the specified area of the PedRC within a fifteen (15) minute period of time in accordance with Program policies and procedures. When there are limited resources, telemedicine or video consultation is an acceptable alternative.
- T. Qualified Emergency Specialist: A qualified specialist who is board certified or board eligible in emergency medicine or pediatric emergency medicine, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- U. Qualified Pediatric Specialist: A qualified specialist who is board certified or board eligible in a pediatric specialty, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- V. Qualified Specialist: A physician licensed in California who has 1) taken special postgraduate medical training, or has met other specified requirements, and 2) has become board certified or is board eligible in the corresponding specialty, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty. A non-board certified physician may be recognized as a “qualified specialist” by the Program upon substantiation of need by the PedRC if: a) the

physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada; b) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing pediatric critically-ill or injured patients, which shall be tracked by a pediatric performance improvement program; and c) the physician has successfully completed a residency program.

W. Trauma Center: A licensed hospital, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the Program, in accordance with CCR Title 22, Division 9, Chapter 7.

#### **IV. GENERAL PROVISIONS:**

- A. No healthcare facility shall advertise in any manner or otherwise hold itself out to be a PedRC unless it has been designated by the Program.
- B. No provider of pre-hospital care shall advertise in any manner, or otherwise hold itself out, as affiliated with EMSC or a PedRC unless they have been so designated by the Program.
- C. PedRCs are designated by the Program in accordance with state regulations and local policies. PedRC designation and re-designation shall be on three (3) year cycles and include written agreements between the PedRC and the County of Kern.
- D. Every PedRC within the County shall be aligned with at least one (1) Comprehensive PedRC for the purposes of outreach and education. Where geography precludes designation of a Comprehensive PedRC within the County, the PedRC may align with a Comprehensive PedRC within the State of California.
- E. All PedRCs shall participate in the Program's Pediatric Advisory Committee.
- F. All PedRCs shall be an approved pre-hospital continuing education provider and provide training and education relating to pediatrics for EMS personnel and MICNs. Continuing education programs shall be conducted in compliance with Program.

- G. Comprehensive PedRC and Advanced PedRCs shall be designated Base Hospitals. These facilities shall provide on-line medical direction in pediatric care to pre-hospital personnel regardless of patient destination either in County or transports out of County.
- H. All PedRCs shall participate in community education activities relating to pediatric illness and injury prevention efforts.
- I. Air transport for pediatric patients within Kern County shall be in accordance with *EMS Aircraft Dispatch-Response-Utilization Policies*.
- J. The Program shall approve marketing and advertising of EMSC capabilities by PedRCs consistent with the designation process by the Program.
- K. The Program will charge for regulatory costs incurred as a result of pediatric receiving center application review, designation, and re-designation. The specific fees are based upon Program costs. Fee amounts shall be as specified in the County Fee Ordinance Chapter 8.13, if applicable.

**V. PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

- A. **A Pediatric Receiving Center (PedRC)** is a licensed general acute care hospital with, at a minimum, a permit for basic emergency services or, in a rural area, licensed standby emergency services, that has been designated by the Program as a Comprehensive PedRC, Advanced PedRC, General PedRC, or Basic PedRC.
- B. **CQI Program-** All PedRCs shall have a CQI Program which addresses the needs of children, to include structure, process, and outcome evaluations. The CQI Program at a minimum shall provide for:
  - 1. A process which integrates the ED CQI activities with the pre-hospital, trauma, inpatient pediatrics, pediatric critical care, and hospital-wide CQI activities, as applicable.
  - 2. A mechanism to provide for integration of findings from CQI audits and reviews into education and clinical competency evaluations of staff.
  - 3. A review of pre-hospital, ED, and inpatient pediatric patient care to include the following pediatric indicators:
    - a. Deaths
    - b. Transfers

- c. Child maltreatment cases
  - d. Cardiopulmonary or respiratory arrests
  - e. Trauma admissions
  - f. Operating room admissions
  - g. ICU admissions
  - h. Selected return visits to the ED
  - i. Patient safety including adverse events
4. Compliance with all federal and state laws protecting and governing patient safety, quality and confidentiality including compliance with applicable provisions of Evidence Code 1157.7 to ensure confidentiality with CQI activities.

**C. Policies, procedures, or protocols** for care of children in emergency settings, that are not limited to, but shall include, the following:

- 1. Illness and injury triage
- 2. Pediatric assessment
- 3. Physical or chemical restraint of patients
- 4. Child maltreatment
- 5. Consent
- 6. Death of a child
- 7. Procedural sedation
- 8. Immunization status and delivery
- 9. Mental health emergencies
- 10. Family centered care
- 11. Communication with patient's primary health care provider
- 12. Pain assessment and treatment
- 13. A disaster preparedness plan that addresses pediatric issues
- 14. Medication safety, including:
  - a. A process to weigh children on scales in kilograms only
  - b. A process to solicit feedback from staff including reporting of medical errors
  - c. Involvement of families in the medication safety process
  - d. Medication orders that are clear and unambiguous
  - e. Mental health and behavioral emergencies including drug and alcohol abuse

**D. Data Requirements-** The PedRC shall submit, at a minimum, the following data to the Program on a quarterly basis. This data will facilitate system management and allow for evaluation of system performance. Data will be collected by each PedRC on the Program approved data reporting tool. Data will be aggregated

and reported as numerical measurements for Countywide PedRC evaluation. Aggregated reports, with facility names removed, may be shared with the Pediatric Advisory Committee, the EMS System Collaborative, the Emergency Medical Care Advisory Board, Kern County Board of Supervisors, or posted for public viewing, if applicable. If mandated by regulation, aggregated data may be reported to the Authority by the Program as a representation of EMSC in Kern County. The following data elements shall be included:

1. Baseline data, including ambulance transports, to describe the system, including, but not limited to:
  - a. Arrival time/date to ED
  - b. Date of Birth
  - c. Gender
  - d. Ethnicity
  - e. Mode of arrival
  - f. Primary impression
2. Cause of illness and injury, and basic outcomes for CQI to include but not limited to the following:
  - a. Discharge or transfer diagnoses
  - b. External cause of injury (E codes)
  - c. Injury location
  - d. Disposition
  - e. Principal procedures
  - f. Other procedures
  - g. Discharge or transfer time and date from ED
  - h. Admitting facility name if applicable
  - i. Residence zip code

E. Each PedRC shall have written guidelines in place for patients, parents of minor children who are patients, legal guardians of children who are patients, and primary caretakers of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child.

F. **ED Requirements:** All designated PedRCs shall comply with the following emergency department (ED) requirements:

1. ED administrative personnel including:
  - a. A Medical Director for the ED; and
  - b. A Physician Coordinator for pediatric emergency care (may be met by staff currently assigned to other roles in the department and may be shared between EDs). The Physician Coordinator shall:

- i. Be a qualified emergency specialist *or* a physician who is a qualified specialist in Pediatrics or Family Medicine *and* shall demonstrate competency in resuscitation of children of all ages from neonates to adolescents.
  - ii. Assume administrative responsibilities that may include, but not be limited to:
    - Oversight of ED pediatric CQI process
    - Liaison with appropriate hospital-based pediatric care committees
    - Liaison with PedRCs, Trauma Centers, the Program, base hospitals, pre-hospital care providers, and community hospitals
    - Facilitation of pediatric emergency education for ED staff
    - Ensuring pediatric disaster preparedness.
  - c. met by staff currently assigned other roles in the emergency department, or in-house departments, and may be shared between EDs). The Nursing Coordinator shall:
    - i. Be a registered nurse (RN) with at least two (2) years' experience in pediatrics or emergency nursing within the previous five (5) years
    - ii. Demonstrate competency in resuscitation of children of all ages from neonates to adolescents
    - iii. Assume administrative responsibilities that may include but not be limited to:
      - Coordinate with the pediatric Physician Coordinator for pediatric CQI activities
      - Facilitate ED nursing continuing education and competency evaluations in pediatrics
      - Liaison with pediatric critical care centers, trauma centers, the Program, base hospitals, pre-hospital care providers, and community hospitals
      - Liaison with appropriate hospital-based pediatric care committees
      - Coordination with the Physician Coordinator to ensure emergency pediatric disaster preparedness
2. Personnel staffing the ED shall include, but not limited to:
- a. Physicians that are qualified emergency specialists, *or* qualified specialists who demonstrate competency in resuscitation of children of all ages from neonates to adolescents



- b. Registered Nurses (RNs) with at least one (1) ED RN per shift with current completion of PALS, APLS, ENPC, or other equivalent pediatric emergency care nursing course
  - c. Midlevel practitioners that may include Nurse Practitioners and/or Physician Assistants, as applicable, regularly assigned to the ED who care for pediatric patients and demonstrate competency in resuscitation of children of all ages from neonates to adolescents
  - d. Other services/personnel: Back-up personnel to the ED including, but not limited to:
    - i. A qualified pediatric specialist available for in-house consultation, *or* through real time consultation (e.g. phone telemedicine) or via agreed upon process within transfer agreements
    - ii. Pediatric qualified subspecialists (as a minimum pediatric Intensivist) available for in-house consultation, *or* through phone consultation and transfer agreements
    - iii. Support services including laboratory, radiology, and pharmacy to include qualified staff and necessary equipment
    - iv. Respiratory care specialists who respond to the emergency department.
      - 1. Respiratory care specialists shall verify their competence to support oxygenation and ventilation of pediatric patients to the Director of Respiratory Services. This verification may include, but is not limited to:
        - o Current completion of the American Heart Association Pediatric Advanced Life Support course, *or*
        - o The American Academy of Pediatrics and American College of Emergency Physicians sponsored Advanced Pediatric Life Support Course, *or*
        - o Continuing education courses specific to resuscitation of pediatric patients.
3. Pediatric equipment and supplies. Use of pediatric equipment and supplies requires:
- a. A pediatric chart, length-based resuscitation tape, medical software, or other system available to assure ready access to

- proper sizing of resuscitation equipment and proper dosing of medications
- b. Pediatric equipment, supplies, and medications easily accessible, labeled, and logically organized, including, but not limited to. the following:
    - i. Portable resuscitation supplies (crash cart) with a method of verification of contents on a regular basis
    - ii. General equipment for patient and fluid warming, patient restraint, weight scale (in kilograms), and pain scale tools for all age children
    - iii. Monitoring equipment appropriate for children in all pediatric sizes including blood pressure cuffs, Doppler device, ECG monitor/defibrillator, hypothermia thermometer, pulse oximeter, and end tidal CO<sub>2</sub> monitor
    - iv. Respiratory equipment and supplies appropriate for pediatric patients including clear oxygen masks, bag-mask devices, intubation equipment, tracheostomy equipment, oral and nasal airways, nasogastric tubes, and suction equipment
    - v. Vascular access supplies and equipment appropriate for pediatric patients including intravenous catheters, intraosseous needles, umbilical and central venous catheters, infusion devices, and IV solutions
    - vi. Fracture management devices appropriate for pediatric patients including extremity and femur splints, and spinal stabilization devices
    - vii. Specialized pediatric trays or kits including lumbar puncture tray, difficult airway kit to include laryngeal mask airways and other devices to provide assisted ventilation if bag-mask ventilation or intubation are unsuccessful, tube thoracostomy tray to include chest tubes sizes for children of all ages, newborn delivery and resuscitation kit to include supplies for immediate delivery and resuscitation of the newborn, and urinary catheter trays to include urinary catheters for children of all ages

G. **Medications** for the care of children requiring resuscitation shall be consistent with the most current evidence-based recommendations (e.g. American Heart Association Pediatric Advanced Life Support). These shall be available in the ED.

## VI. COMPREHENSIVE PEDIATRIC RECEIVING CENTER REQUIREMENTS:

In addition to the requirements in Section V of this policy, a Comprehensive PedRC shall:

- A. Meet all criteria of an Advanced PedRC.
- B. Be a CCS Approved Tertiary Hospital with specialized in-patient intensive care and diagnostic, operative, therapeutic services and equipment, and with in-house and/or promptly available physician specialists in pediatric subspecialties. A facility may be designated by the Program if the facility has full, provisional, or conditional CCS approval. Documentation of CCS eligibility must be on file at CCS.
- C. Be capable of providing comprehensive specialized pediatric medical and surgical care to any acutely ill and injured child.
- D. Provide ED services which include a separate pediatric ED or designated area for emergency care of children within an ED and includes physician staff who are qualified emergency specialists in emergency medicine or pediatric emergency medicine.
- E. Have in-patient resources including at a minimum:
  1. Twenty-five (25) licensed pediatric beds (exclusive of licensed intensive care neonatal nursery or intensive care beds)
  2. A NICU
  3. A PICU
- F. Plan and implement ongoing outreach to PedRCs (Advanced, General, and Basic) including:
  1. Collaborate for education in emergency care of pediatric patients
  2. Consultation via phone, telemedicine or onsite regarding:
    - a. Emergency care and stabilization
    - b. Transfer
    - c. Transport
- G. Accept patients from Kern County who require specialized care not available at lower-level hospitals within the county through:
  1. Comprehensive PedRC shall accept any patient that meets “emergent medical pediatric” criteria (see section X.A for description) for inter-emergency department transfer originating within the county

2. Prearranged transfer agreements for pediatric patients needing specialized care not available at the Comprehensive PedRC (such as burn centers, spinal cord injury centers, rehabilitation facilities)
- H. Serve as a county referral center for the specialized care of pediatric patients or in special circumstances provide safe and timely transfer of children to other resources for specialized care.

## **VII. ADVANCED PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

In addition to the requirements in Section V of this policy, a Advanced PedRC shall:

- A. Be a CCS approved Pediatric Community Hospital which has most specialized diagnostic, operative, therapeutic services and equipment, and with promptly available pediatric subspecialists. A facility may be designated by the if the facility has full, provisional, or conditional CCS approval. Documentation of CCS eligibility must be on file at CCS.
- B. Have inpatient resources including at a minimum:
  1. Eight (8) licensed pediatric beds (exclusive of licensed intensive care neonatal nursery)
  2. Community neonatal intensive care unit (NICU) or as an intermediate NICU if it meets the following requirements, as per:
    - a. Article 6, Section 70545 et seq., for the provision of perinatal services and licensed by DHS, Licensing and Certification Division as a perinatal service;
    - b. Article 6, Section 70481 et seq., for the provision of neonatal intensive care services and licensed by DHS, Licensing and Certification Division as an Intensive Care Newborn Nursery (ICNN)
- C. If the hospital has a PICU then it shall be licensed by DHS, Licensing and certification Division for intensive care services, and meet the requirements for the provision of intensive care services pursuant to CCR Title 22, Division 5, Chapter 1, Article 6, Section 70491 et seq.
- D. Include ED services with physician staff who are qualified emergency specialists.
- E. Have a department of pediatrics within the medical staff structure.

- F. Establish formal written agreements with a minimum of one (1) Comprehensive PedRC as approved by the Program, for education, consultation, and transfer of pediatric patients for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- G. Collaborate with Comprehensive PedRC for education in emergency care of pediatric patients and consultation including, but not limited to:
  - 1. Emergency care and stabilization
  - 2. Transfer
  - 3. Transport
- H. Accept patients from Kern County who require specialized care not available at lower-level hospitals within the county through:
  - 1. Advanced PedRC shall accept any patient that meets “emergent medical pediatric” criteria (see section X.A. for description) for inter-emergency department transfer originating within the county
  - 2. Prearranged transfer agreements for pediatric patients needing specialized care not available at the Comprehensive PedRC (such as trauma centers, burn centers, spinal cord injury centers, rehabilitation facilities)
- I. All Advanced PedRCs shall meet the following personnel requirements:
  - 1. Have a physician and nurse Pediatric Emergency Care Coordinator (PECC).
  - 2. 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.
  - 3. Social work services in the pediatric service department 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.
  - 4. Behavioral health specialists with pediatric experience to include, but not be limited to, psychiatrists, psychologists, and nurses.
  - 5. The following specialties shall be on-call, and available for consultation to the ED or NICU within 30 minutes by telephone and in-person within one hour:
    - a. Neonatologist.
    - b. General Surgeon with pediatric experience.

- c. Anesthesiologist with pediatric experience.
- d. Pediatric Cardiologist.
- 6. The following specialties shall be on-call, and available to the NICU or ED either in-person, by phone, or by telehealth, within 30 minutes:
  - a. Radiologist with pediatric experience.
  - b. Otolaryngologist with pediatric experience.
  - c. Orthopedist with pediatric experience.
- 7. The following qualified specialists shall be available twenty-four (24) hours a day, 7 days a week, for consultation which may be met through a transfer agreement or telehealth:
  - a. Pediatric Gastroenterologist.
  - b. Pediatric Hematologist/Oncologist.
  - c. Pediatric Infectious Disease.
  - d. Pediatric Nephrologist.
  - e. Pediatric Neurologist.
  - f. Pediatric Surgeon.
  - g. Cardiac Surgeon with pediatric experience.
  - h. Neurosurgeon with pediatric experience.
  - i. Obstetrics/gynecologist with pediatric experience.
  - j. Pulmonologist with pediatric experience.
  - k. Pediatric Endocrinologist.

## **VIII. GENERAL PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

A hospital with basic emergency services staffed with a qualified specialist twenty-four hours a day, seven days a week (24/7), which may have limited inpatient services. The General PedRC is a general community hospital that has adult in-patient specialty care and has no dedicated inpatient pediatric services; however diagnostic, operative, therapeutic services and equipment, and selected pediatric physician specialists are available for consultation.

In addition to the requirements in section V of this policy, a General PedRC shall:

- A. Establish formal agreements with a minimum of one Comprehensive PedRC as approved by the Program, for education, consultation, and transfer of pediatric patients.
- B. Collaborate with Comprehensive and/or Advanced PedRC for:
  - 1. Education in emergency care of pediatric patients

2. Consultation regarding
  - a. Emergency care and stabilization
  - b. Transfer
  - c. Transport
- C. Develop written agreements with Comprehensive and/or Advanced PedRCs to transfer pediatric patients for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- D. Develop transfer agreements for pediatric patients needing specialized care (such as trauma center, burn center, spinal cord injury center, rehabilitation facilities).

#### **IX. BASIC PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

A small and/or rural hospital, as defined by state rural criteria, with limited or no inpatient care capability and limited physician specialists available for consultation.

ED services may include physician staffing twenty-four hours and day, seven days a week (24/7), or a physician available for consultation (e.g. stand-by or critical access hospital).

In addition to the requirements in Section V. of this policy a Basic PedRC shall:

- A. Establish formal agreements with a minimum of one (1) Comprehensive PedRC as approved by the Program, for education, consultation, and transfer of pediatric patients.
- B. Develop written agreements with Comprehensive and/or Advanced PedRCs to transfer all pediatrics for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- C. Collaborate with a Comprehensive and/or Advanced PedRC for:
  1. Education in emergency care of pediatric patients
  2. Consultation regarding:
    - a. Emergency care and stabilization
    - b. Transfer
    - c. Transport

- D. Develop transfer agreements for pediatric patients needing specialized care (such as trauma centers, burn centers, spinal cord injury centers, rehabilitation facilities).
- E. At minimum, one licensed registered nurse or advanced care practitioner per shift in the emergency department shall have current completion of the American Heart Association Pediatric Advanced Life Support, Advanced Pediatric Life Support, completion of an Emergency Nursing Pediatric Course, or other equivalent pediatric emergency care nursing course, as determined by Emergency Medical Services Program (EMSP).

#### **X. PREHOSPITAL DESTINATION DECISION:**

Pre-hospital personnel shall transport pediatric patients to a pediatric receiving facility that is capable of providing the most appropriate care. Pediatric trauma patients shall be transported in accordance with Prehospital Trauma policies and procedures. Pediatric patients who meet extremis criteria shall be transported in accordance with Destination Decision policies and procedures. The following criteria apply to medical non-extremis pediatric patients only:

- A. Emergent Medical Pediatric: Patients that are under the age of fourteen (14) years with an emergent medical complaint shall be transported to a Comprehensive or Advanced PedRC if ground transport time is thirty (30) minutes or less. Ground transport times that are greater than thirty (30) minutes may be transported to the closest, most appropriate receiving hospital. The use of air ambulance transport shall be in accordance with *EMS Aircraft Dispatch-Response-Utilization Policies*. Emergent medical complaints are defined as:
  - 1. Cardiac dysrhythmia
  - 2. Evidence of poor perfusion
  - 3. Severe respiratory distress
  - 4. Cyanosis
  - 5. Persistent altered mental status
  - 6. Status epilepticus
  - 7. Any apparent life-threatening event in less than one (1) year of age
- B. Non-Emergent Medical Pediatric: Patients that are under the age of fourteen (14) years with a medical complaint who do not meet trauma, medical extremis or emergent medical criteria shall be transported to any level PedRC.
- C. Pre-hospital personnel may consider base contact with the highest level of PedRC available to assist in destination decision.



## **XI. TRANSFER OF PEDIATRIC PATIENTS:**

Each PedRC shall have an Interfacility Transfer Plan for pediatric patients. Patients may be transferred between and from PedRCs providing that:

- A. Interfacility transfer process that is streamlined to include rapid acceptance and transfer of pediatric patients with evaluation and communication with one or more of the following:
  - 1. A qualified pediatric specialist
  - 2. A qualified emergency medicine physician
  - 3. A pediatric intensivist
  - 4. A neonatologist
  - 5. A pediatric critical care fellow
  - 6. A neonatology fellow
  
- B. The process for transfers of pediatric patients between PedRCs shall be in accordance with Title 22 and EMTALA requirements.
  
- C. Any transfer which is determined by the ED physician of record, or pediatric inpatient service, medically prudent, and in accordance with Program interfacility transfer policies.
  
- D. The PedRC has written criteria for consultation and transfer of patients needing a higher level of care.
  
- E. Hospitals receiving pediatric emergency patients participate in EMSC and CQI activities for those pediatric emergency patients who have been transferred.

## **XII. APPLICATION PROCESS FOR PEDIATRIC RECEIVING CENTER (PedRC):**

- A. The following milestones outline the application process for a hospital to become designated as a Pediatric Receiving Center.
  - 1. Submit letter of application to the Program, the letter shall:
    - a. Specify intent to obtain PedRC designation and level
    - b. Identify names and contact information, including email addresses, for key pediatric personnel: Emergency Department Medical Director, Pediatric Physician Coordinator, Pediatric Nursing Coordinator, and administrative contact
    - c. Identify the anticipated target date for PedRC designation

- d. List supporting documents being submitted with the letter to fulfill the designation requirements
  2. Compile and submit to the Program all information and documents requested in Appendix B, Column 2, "Objective Measurement" of the *Pediatric Receiving Center Designation Self Evaluation Tool*.
  3. All application materials will be reviewed for completeness. Additional information may be requested, if needed. Upon determination that the application is complete, the applicant and the Program will work towards execution of the designation agreement.
  4. Pediatric Receiving Center Designation agreement will be presented to the Board of Supervisors for approval and formal designation.
- B. The process for re-designation will be the same as stated above. Re-designation of PedRCs shall be every three (3) years with the exception of the letter of intent. Re-designation materials must be submitted to the Program ninety (90) days in advance of the expiration date of the designation.

### **XIII. LOSS OF DESIGNATION:**

- A. Any designated PedRC which is unable to meet the following requirements shall be subject to termination or loss of PedRC designation:
1. Inability to maintain designation criteria as stated in this policy.
  2. Failure to comply with any policy, procedure, or regulation mandate by Local, State, or Federal Government.
- B. If the Program finds a PedRC to be deficient in meeting the above criteria, the Program will issue the PedRC a written notice, return receipt requested, setting forth with reasonable specificity the nature of the apparent deficiency.
- C. Within ten (10) calendar days of receipt of such notice, the PedRC must deliver to the Program, in writing, a plan to cure the deficiency, or a statement of reasons why the PedRC disagrees with the Division notice.
- D. The PedRC shall cure the deficiency within thirty (30) calendar days of receipt of notice of violation.
- E. If the PedRC fails to cure the deficiency within the allowed period or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication. EMCAB may make a recommendation to the Program for resolving the issue.

Revision Log:

01/10/13: Creation of Policy  
10/25/13: Comments received. Policy amended.  
01/07/14: Comments received. Policy amended.  
03/04/14: Comments received via Pediatric Designation meeting. Policy amended with agreement from all in attendance.  
05/08/14: EMCAB Approval- Implementation Date set 05/09/2014  
08/14/15: EMCAB Approval- Remove requirement for transfer agreements for Level I&II, add acceptance of patients meeting emergent medical criteria.  
11/11/2016 EMCAB Approval- Addition of PAC as Appendix C.  
9/18/19: Changed "Division" to "Program." Updated policy to reflect EMSA Tittle 22, Chapter 14. Removed links to EMSA Policies that were removed once Chapter 14 was published.

## APPENDIX A: PEDIATRIC RECEIVING CENTER DATA ELEMENTS

At a minimum, each PedRC shall collect and submit the following mandatory data elements to the Program on a quarterly basis.

Baseline Data	Cause of Illness or Injury
Arrival time/date to ED	Discharge or transfer diagnosis
Date of Birth	External Cause of Injury (E Codes)
Gender	Injury location
Ethnicity	Disposition
Mode of Arrival	Principal Procedures
Primary Impression	Other Procedures
	Discharge or transfer time and date from ED
	Admitting facility name
	Residence Zip Code

## **APPENDIX B: PEDIATRIC RECEIVING CENTER DESIGNATION SELF-EVALUATION TOOL**

The Following pages need completion by applicant for Pediatric Receiving Center designation and re-designation (every three (3) years). “Pediatric Designation Contract Standard” and “Objective Measurement” refers to all standards required. The “PedRC Level” section is what level of PedRC requires the standard of the preceding section, circle “Yes” or “No” as applicable. A completed copy of the Pediatric Receiving Center Designation Criteria Application and Evaluation Tool and copies of any agreements and licensing that are requested are to be placed in the front of the application binder.

## Pediatric Receiving Center Designation Self Evaluation Tool

Pediatric Designation Contract Standard	Objective Measurement	PedRC Level	Meets Standard		Comments
<b>GENERAL PROVISIONS</b>					
Current license as a general acute care hospital	Copy of license	C A G B	Y	N	Required for designation
Permit for basic emergency services in Kern County (rural standby emergency services)	Copy of permit	C A G B	Y	N	Required for designation
Current designation as a Paramedic base station in Kern County	Hospital Contracts	C A	Y	N	Required for designation
Participation in Pediatric Advisory Committee	Provide name, position for person designated to attend	C A G B	Y	N	Required for designation
Approved pre-hospital continuing education provider	Copy of schedule of courses available for prehospital personnel  Copy of CE certificate to be issued for continuing education courses with all required information	C A G B	Y	N	Required for designation
Alignment with Comprehensive PedRC  Alignment for outreach and education.	Provide evidence of alignment or copy of contract with Comprehensive	A G B	Y	N	Required for designation
Community Education Participation	Provide evidence of community education program relating to pediatric illness and injury prevention efforts	C A G B	Y	N	Required for designation
<b>PEDIATRIC RECEIVING CENTER REQUIREMENTS</b>					
California Children Service approved at appropriate level	Documentation on file at CCS	C A	Y	N	Required for designation

Continuous availability of PedRC resources 24 hours a day 7 days a week 365 days a year.	On-Call Schedules for 3 months. On-Call Policy/Procedure	C A	Y	N	Required for designation
Pediatric in-patient services	Verification of appropriate number of licensed pediatric beds	C A	Y	N	Required for designation
Separate Department of Pediatrics within the medical staff structure	Verification of a Department of Pediatrics	C A	Y	N	Required for designation
Neonatal Intensive Care Unit	Verification of a NICU	C A	Y	N	Required for designation. Advanced must have NICU, PICU is optional
CQI Program to include structure, process, and outcome evaluations	Written quality improvement plan or program description.  <input type="checkbox"/> Integrate ED, Pre-hospital, trauma, inpatient, critical care <input type="checkbox"/> Integrate findings into education and clinical competency evaluation for staff	C A G B	Y	N	CQI plan or policy only required for initial designation Ongoing expectation  Data Collection and Management based on Pediatric EMS data elements
CQI Program Pediatric Indicators	Review protocol/program description to deal with:  <input type="checkbox"/> Deaths <input type="checkbox"/> Transfers <input type="checkbox"/> Child Maltreatment Cases <input type="checkbox"/> Cardiopulmonary/Respiratory Arrest <input type="checkbox"/> Trauma Admission <input type="checkbox"/> Operating Room Admissions <input type="checkbox"/> ICU Admissions <input type="checkbox"/> Selected Return Visits to the ED	C A G B	Y	N	Policy and procedure or program description only required for initial designation Ongoing expectation

	<input type="checkbox"/> Patient Safety including adverse events				
Pediatric Emergency Care Policies, Procedures, or Protocols	Review policies/ procedures/protocols <input type="checkbox"/> Illness and injury triage <input type="checkbox"/> Pediatric assessment <input type="checkbox"/> Physical and chemical restraint <input type="checkbox"/> Child maltreatment <input type="checkbox"/> Consent <input type="checkbox"/> Death of a child <input type="checkbox"/> Procedural sedation <input type="checkbox"/> Immunization status and delivery <input type="checkbox"/> Mental health emergencies <input type="checkbox"/> Family centered care <input type="checkbox"/> Communication with primary care provider of patient <input type="checkbox"/> Pain assessment and treatment <input type="checkbox"/> Disaster Preparedness Plan for Pediatrics	C A G B	Y	N	Required for designation
Medication Safety policy, procedure or protocol	Review policies/ procedures/protocols for medication safety to address the following: <input type="checkbox"/> Kilogram only scale <input type="checkbox"/> A Process to solicit feedback from staff including medication errors	C A G B	Y	N	Required for designation



	<input type="checkbox"/> Involvement of families in the medication safety <input type="checkbox"/> Orders that are clear and unambiguous <input type="checkbox"/> Mental health and behavioral emergencies including drug and alcohol abuse				
Participation in Kern County EMS data collection	Document agreeing to provide data elements deemed mandatory by Kern County EMS Program	C A G B	Y	N	Name and contact information of responsible personnel required for designation
Written Guidelines for patients, parents/guardians of patients to provide input and feedback regarding care of the patient	Guidelines for Patients, Review documentation of guideline or feedback policy	C A G B	Y	N	Designation Ongoing Expectation
<b>ED PERSONNEL REQUIREMENTS</b>					
ED Medical Director	Copy of medical license or contract	C A G B	Y	N	Required for designation
Physician Coordinator for pediatric emergency care  Responsibilities: Oversight of ED pediatric CQI process  Liaison with appropriate hospital-based pediatric care committees  Liaison with PedRCs, trauma centers, Program, base hospitals, pre-	Copy of current Board Certifications  Copy of Job description  Verification of competency in resuscitation of children of all ages  May be met by staff currently assigned other roles in the department, and may be shared between ED	C A G B	Y	N	Required for designation

<p>hospital care providers, community hospitals</p> <p>Participates in protocol development</p> <p>Facilitate pediatric emergency education for ED staff</p> <p>Coordinate with RN Coordinator to ensure pediatric disaster preparedness.</p>				
<p>RN Coordinator for pediatric emergency care</p> <p>Responsibilities:</p> <p>Coordinate with pediatric Physician Coordinator for CQI</p> <p>Facilitate ED nursing continuing education and competency evaluations in pediatrics</p> <p>Liaison with ped critical care centers, trauma centers, Program, base hospitals, pre-hospital care providers, community hospitals</p> <p>Liaison with appropriate hospital-based pediatric care committees</p>	<p>Copy of RN License</p> <p>Evidence of experience in pediatrics or emergency nursing</p> <p>Verification of competency in resuscitation of children of all ages</p> <p>Copy of Job description</p> <p>May be met by staff currently assigned other roles in the department, and may be shared between ED</p>	<p>C A G B</p>	<p>Y    N</p>	<p>Required for designation</p>

Coordinate with Physician Coordinator in ensure pediatric disaster preparedness					
Emergency Department Staffing:  Physicians	Copy of current Board Certifications  Verification of competency in resuscitation of children of all ages  Evidence of ED physician coverage by at a minimum one physician with appropriate qualifications for 3 months	C A G B	Y	N	Required for designation  Ongoing expectation
Emergency Department Staffing:  Registered Nurses	Evidence of at least one ED RN per shift with qualifications for 3 months  Copy of RN license  Copy of course completion/card with current PALS, APLS, ENPC, or equivalent	C A G B	Y	N	Required for designation  Ongoing expectation
Emergency Department Staffing:  Midlevel practitioners if regularly assigned to ED and who care for pediatric patients	Copy of license  Verification of competency in resuscitation of children of all ages	C A G B	Y	N	Required for designation  Ongoing expectation
Qualified pediatric specialist -Neonatologist.	Copy of Board Certifications	C A	Y	N	Required for designation  Ongoing expectation

-General Surgeon with pediatric experience. -Anesthesiologist with pediatric experience. -Pediatric Cardiologist.  Available on-call, and available for consultation to the ED or NICU within 30 minutes by telephone and in-person within one hour.	Verification of process, policy, procedure, job description or work schedule for 3 months				
Qualified pediatric specialist  Available for in-house consultation, or telemedicine, or transfer process	Copy of Board Certifications  Verification of process, policy, procedure, job description or work schedule for 3 months	C A G B	Y	N	Required for designation  Ongoing expectation
Pediatric qualified subspecialist (as a minimum pediatric Intensivist)  Available for in-house consultation, or telemedicine and transfer process	Copy of Board Certifications  Verification of process, policy, procedure, job description or work schedule for 3 months	C A G B	Y	N	Required for designation  Ongoing expectation
Support Services:  a. Respiratory Care b. Laboratory c. Radiology d. Pharmacy	Evidence of availability of services with qualified staff	C A G B	Y	N	Required for designation
<b>ED SUPPLIES AND EQUIPMENT</b>					
Pediatric General Supplies and Equipment (easily accessible and labeled)	<input type="checkbox"/> Pediatric chart; length-based resuscitation tape, medical software, or other system equivalent <input type="checkbox"/> Portable resuscitation	C A G B	Y	N	Required for designation

	<p>supplies “Crash Cart”</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient and fluid warming device</li> <li><input type="checkbox"/> Patient restraint</li> <li><input type="checkbox"/> Kilogram only scale</li> <li><input type="checkbox"/> Pain scale appropriate for children</li> </ul> <p>Pediatric size monitoring equipment:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood pressure cuff</li> <li><input type="checkbox"/> Doppler Device</li> <li><input type="checkbox"/> Electrocardiography Monitor/Defibrillator</li> <li><input type="checkbox"/> Hypothermia thermometer</li> <li><input type="checkbox"/> Pulse Oximeter</li> <li><input type="checkbox"/> End Tidal CO2 monitoring device</li> </ul> <p>Fracture management:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Splints</li> <li><input type="checkbox"/> Traction splints</li> <li><input type="checkbox"/> Spinal stabilization devices</li> </ul> <p>Specialized Pediatric Trays/Kits:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lumbar puncture <ul style="list-style-type: none"> <li><input type="checkbox"/> Infant</li> <li><input type="checkbox"/> Child</li> </ul> </li> <li><input type="checkbox"/> Difficult airway <ul style="list-style-type: none"> <li><input type="checkbox"/> Supraglottic</li> <li><input type="checkbox"/> Needle/Surgical Cricothyrotomy</li> </ul> </li> <li><input type="checkbox"/> Tube thorachostomy tray <ul style="list-style-type: none"> <li><input type="checkbox"/> 12-36F</li> </ul> </li> <li><input type="checkbox"/> Newborn Delivery Kit</li> </ul>			
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	<input type="checkbox"/> Newborn Resuscitation equipment <input type="checkbox"/> Umbilical clamp <input type="checkbox"/> Scissors <input type="checkbox"/> Bulb syringe <input type="checkbox"/> towel <input type="checkbox"/> Urinary Catheterization <input type="checkbox"/> 6F-22F				
Respiratory Equipment and Supplies	<input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Non-Rebreather Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Simple Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Nebulizer Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Bag-Mask Device with appropriate size mask <input type="checkbox"/> Neonatal <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Endotracheal Tubes <input type="checkbox"/> Uncuffed/cuffed 2.5mm-5.5 mm <input type="checkbox"/> Cuffed 6.0mm-8.0 mm <input type="checkbox"/> Stylets for ET Tubes <input type="checkbox"/> Pediatric <input type="checkbox"/> Oropharyngeal Airways <input type="checkbox"/> Size 0-5 <input type="checkbox"/> Nasopharyngeal Airway <input type="checkbox"/> Infant <input type="checkbox"/> Child	C A G B	Y	N	Required for designation

	<input type="checkbox"/> Laryngoscope Blades <input type="checkbox"/> Straight 0-3 <input type="checkbox"/> Curved 2-3 <input type="checkbox"/> Laryngoscope handle <input type="checkbox"/> Magill Forceps <input type="checkbox"/> Pediatric <input type="checkbox"/> Suction Catheter <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Yankauer Suction Tip <input type="checkbox"/> Tracheostomy Tubes (0-6) <input type="checkbox"/> Neonatal <input type="checkbox"/> pediatric <input type="checkbox"/> Nasogastric Tubes <input type="checkbox"/> Infant 8F <input type="checkbox"/> Child 10F <input type="checkbox"/> Laryngeal Mask Airway <input type="checkbox"/> Size 1-5 <input type="checkbox"/> Feeding tubes <input type="checkbox"/> 5F <input type="checkbox"/> 8F				
Intravenous Equipment and Supplies	<input type="checkbox"/> Arm Boards <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Catheter-Over-Needle <input type="checkbox"/> 14-24 gauge <input type="checkbox"/> Intraosseous Needles/Devices <input type="checkbox"/> Pediatric <input type="checkbox"/> Umbilical Vein Catheter <input type="checkbox"/> Central Venous Catheter <input type="checkbox"/> 4.0-7.0F double lumen <input type="checkbox"/> Intravenous solutions	C A G B	Y	N	Required for designation

	<input type="checkbox"/> Normal Saline <input type="checkbox"/> Dextrose 5%in Normal Saline <input type="checkbox"/> Dextrose 10% in water <input type="checkbox"/> Fluid warmer <input type="checkbox"/> IV administration sets with calibrated chambers and extension tubing <input type="checkbox"/> Infusion devices with ability to regulate rate and volume of infusion.			
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**MEDICATIONS**

Medications (easily accessible and labeled)	Medications Requirements: <input type="checkbox"/> Alprostadil (PGE1) <input type="checkbox"/> Albumin <input type="checkbox"/> Albuterol <input type="checkbox"/> Atropine <input type="checkbox"/> Adenosine <input type="checkbox"/> Amiodarone <input type="checkbox"/> Antiemetic <input type="checkbox"/> Calcium Chloride 10% <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Dextrose (D <sub>10</sub> W, D <sub>25</sub> W, D <sub>50</sub> W) <input type="checkbox"/> Diphenhydramine <input type="checkbox"/> Dobutamine <input type="checkbox"/> Dopamine <input type="checkbox"/> Epinephrine (1:1000; 1:10,000 Solution) <input type="checkbox"/> Furosemide <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Ipratropium bromide <input type="checkbox"/> Lidocaine <input type="checkbox"/> Magnesium Sulfate <input type="checkbox"/> Methylprednisone <input type="checkbox"/> Milrinone <input type="checkbox"/> Naloxone Hydrochloride <input type="checkbox"/> Nitroglycerin	C A G B	Y	N	Required for designation  Approved Medications by The American Heart Association Pediatric Advanced Life Support
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	<input type="checkbox"/> Norepinephrine <input type="checkbox"/> Oxygen <input type="checkbox"/> Procainamide <input type="checkbox"/> Sodium Bicarbonate (4.2%, 8.4%) <input type="checkbox"/> Sodium nitroprusside <input type="checkbox"/> Terbutaline <input type="checkbox"/> Topical, Oral, and Parenteral Analgesics <input type="checkbox"/> Antimicrobial Agents (Parenteral and Oral) <input type="checkbox"/> Anticonvulsants Medications <input type="checkbox"/> Antidotes should be accessible to the ED <input type="checkbox"/> Antipyretic drugs <input type="checkbox"/> Bronchodilators <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Inotropic Agents <input type="checkbox"/> Neuromuscular Blockers <input type="checkbox"/> Sedatives <input type="checkbox"/> Vaccines <input type="checkbox"/> Vasopressors			
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**TRANSFER INFORMATION**

Accept in county "emergent medical pediatric" criteria for inter emergency department transfer	Statement verifying acknowledgement	C A	Y	N	Required for designation Shall accept patients meeting "emergent medical pediatric criteria"
Inter-Facility Transfer Guidelines or Cooperative Arrangement	Description of current cooperative practice or copy of supporting policies, procedures or guidelines. List all hospitals collaborating with and for what type services	C A G B	Y	N	Required for designation List of facilities and description of cooperative arrangements (PedRC's and Non-Pediatric Receiving centers)
Copy of transfer agreement:	Plan, Policy, Procedure with estimated travel time	C A G	Y	N	Required for designation. Hospitals

Trauma, spinal cord injury, rehabilitation, or burn patient		B		without trauma or burn unit. Written guidelines or description of current processes for rapid transfer of patients requiring additional care. Including elective or emergency Trauma and/or Burns.
Copy of written transfer agreements with higher level PedRC and Comprehensive PedRC	Transfer policies and procedures.	A G B	Y    N	Required for stabilization and post-stabilization

## Appendix C- Pediatric Advisory Committee (PAC)

- A. The Program shall be responsible to maintain policy compliance within the EMS system, and reserves the right to revise or modify this policy when necessary to protect public health and safety.
- B. Pediatric Advisory Committee (PAC) is an ad hoc subcommittee of the EMS System Collaborative.
- C. Pediatric Advisory Committee (PAC) shall be established to review certain potential problem cases and system trends identified through the submission of data (as described in the (*Pediatric Receiving Center Designation Policy*)).
  1. The Committee shall be composed of the following members:
    - a. Pediatric Emergency Care Coordinator
    - b. EMS Program Coordinator
    - c. Pediatric Program Director
    - d. Emergency Dept. MICN
    - e. EMS Dept. Medical Director
    - f. School Representative/ Consumer Representative
    - g. Community Based Pediatrician and Pediatric Intensivist
    - h. Metro Hospital Emergency Department Representative
    - i. Rural Hospital Emergency Department Representative
    - j. Rural Paramedic Representative
    - k. Metro Paramedic Representative
    - l. Air Ambulance/Critical Care Transport Representative
    - m. Communications Center Representative Ad Hoc
    - n. Law Enforcement Representative
    - o. Child Protective Services Representative

- p. Fire Department Representative
  - q. California Children's Services Representative Ad Hoc
  - r. Social Services Representative
  - s. Respiratory Therapist Ad Hoc
2. This Committee shall respond to the EMS Medical Director and EMCAB's inquiries and requests.
  3. The Committee shall consider and monitor identified issues and advise the Director on policy level recommendations and systemic or process issues as follows:
    - a. Create and monitor quality core measures
    - b. Conduct evidence-based studies relevant to the unique needs and trends of pediatric care county wide.
      - i. The Committee will be responsible for establishing the criteria for cases to be brought to the committee.
      - ii. Each case reviewed by the committee will have a finding of appropriateness of care rendered and will, where appropriate, make recommendations for change.
    - c. Recommend revisions to policies and procedures based on study findings
    - d. Additional review of transfers or major complicated Pediatric patients as requested by a Pediatric receiving center.
    - e. Organize and administer pediatric specific programs as needed.
    - f. Review all cases of prehospital pediatric cardiac arrest.
  4. Meetings will be conducted in accordance with §1040, §1157.5, and 1157.7 of the California Evidence Code, and the California Business and Professions Code 805, 809 and be compliant with HIPAA and HCFA requirements.
  5. All members and invitees of the Committee will be required to maintain confidentiality of patient specific information.

- D. All pediatric organizational providers will submit to the Program the required documentation, as specified by the Program, to verify ongoing compliance with pediatric triage, treatment, and transport protocols.
- E. The Program, in conjunction with organizational providers, will collect data on a regular basis for system evaluation and continued quality improvement.
- F. Any deviations, specific problems, or deficiencies from policies, procedures and protocols shall be documented.
  - 1. This information will be subject to review by the Program and/or the Pediatric Advisory Committee (PAC).

# TRAUMA SYSTEM STATUS REPORT YEAR 2018 - 2019

## **TRAUMA SYSTEM SUMMARY:**

Kern County's land area is 8,073 square miles. Kern County is California's third-largest county in land area. Kern County hosts a major freeway system with corridors through the state and across the country. Highway 99 and Interstate 5 (Haz Mat allowable Freeway), running north and south, cover the entire west coast, meeting at Interstate 80 in Sacramento. Highway 99 connects with Highway 46, which provides access to the central coast. Highway 58 runs east and west and connects with Interstate 40 and 15, which provide access to Arizona, Nevada, Utah and other major eastward destinations.

The general character of Kern County is rural, except for one large metropolitan area. The City of Bakersfield and the surrounding unincorporated area (Metropolitan Bakersfield) has 384,188 people, approximately 43 percent of the County's 896,764 total population (2018 Census Estimate).

Population growth has slowed in recent years but is expected to accelerate through 2019 with a growth rate of 0.75%. Kern County remains one of the fastest growing areas of the state. The County's population is expected to reach 1,016,214 by the year 2022, an increase of more than 12 percent over the current population (U.S. Census Bureau, 2015).

A 2018 Occupational Employment Statistics Survey showed the mean hourly wage earned in California to be \$27.81, however Kern County's median wage was \$4.62 less per hour at \$23.19 (California Employment Development Department). According to 2018 census data, the County's median household income is \$49,854, in comparison to \$63,783 for the State.

Kern County's 2018 annual average unemployment rate of 8.0 percent remains more than 2.4 percent higher than the State's and the nation's unemployment rates. These rates do not consider the agricultural work force, jobs that are traditionally low paying and seasonal. An additional 128,000 uninsured seasonal workers reside in the County for six to eight months each year.

The geography and the large populous in rural communities along with the distances between these communities create a challenge to provide a rapid access to trauma

care. The extensive freeway system through Kern County contributes to a high demand on Kern Medical for trauma services. Rapid population growth, below average median incomes and higher than average unemployment rates contribute to ongoing struggles for financial reimbursement.

The Kern County Trauma System is an inclusive system, which operates with nine hospitals that are capable of receiving trauma patients. The designated trauma receiving hospitals consist of one Level II Trauma Center, Kern Medical, and one level IV Trauma Center, Ridgecrest Regional Hospital. Kern Medical serves all of Kern County and provides resources to patients from surrounding counties on a mutual aid basis. Ridgecrest serves the eastern areas of Kern County along with China Lake Naval Air Weapons military base.

Kern Medical worked diligently to update the registry by submitting data with a new Trauma Cloud Database system for ease of information relay to the American College of Surgeons (ACS) as well as the state. Currently Kern Medical has uploaded 2018 data to the registry successfully. They are on track to enter in data for 2019 Q1/Q2. Kern Medical data submission to both state as well as National Trauma Data Bank January through March 2019 is currently in process.

During fiscal year 2018 Kern Medical treated 2,885 patients who met Kern County trauma triage criteria. Of those 2,885, patients, 2,557 were from scene, 211 from outside hospitals/urgent care/clinics. Of those 2,885, patients, 2,768 met the trauma registry inclusion criteria for California EMS Information System (CEMSIS). Trauma patients' mechanism of injury for FY 2018 were identified as 82% blunt trauma, and 18% penetrating. Kern Medical experienced trauma numbers increase of 11% from 2017 to 2018. The age group with highest incidents of trauma for 2018 were 25 – 34 (688 patients, 24%), followed by 34 – 44 (456 patients, 16%), 20 – 24 (379 patients, 13%), & 45 – 54 (336 patients, 12%). Kern County currently experiences an under-triage rate of 7%.

Ridgecrest Regional Hospital has begun retrieving and assembling the 2018 trauma data and has assured Kern County Public Health that fiscal year 2018 trauma data and stats will be collected, entered, and submitted to the National Trauma Data Bank and to the state by the required date. Ridgecrest Regional Hospital is also in the process of compiling 2019 trauma data for Q1/Q2 to prepare for submittal to the state as well.

#### **CHANGES IN TRAUMA SYSTEM:**

Kern County EMS Program made changes to the *Trauma Policies and Procedures*, which took three separate policies and condensed them into one policy. Additionally, the Program updated the criteria for Step 3 trauma triage criteria to be more in-line with ACS standards.

The Program submits Core Measure data to EMSA on an annual basis. TEC reviews the Core Measures on a quarterly basis, along with other (QI) quality improvement indicators (case study's) that are requested and under the purview of TEC. The Program has recently completed the EMS Quality Improvement Program to include TEC in the quality improvement program.

Kern County EMS Program is currently applying for an approval of undefined scope of practice for Tranexamic Acid (TXA), Ketamine, and Pediatric King Airways. If approved, TXA will be used in two protocols Shock and Epistaxis. We feel it is important to give our Paramedics a tool for internal bleeding to improve the outcome for our patients. Studies have shown the fluid challenges do little to no good, and in some cases can cause more harm. Like many other systems we are looking at Ketamine as a first line pain medication. This is especially important in our trauma patients that are hypotensive or at risk for respiratory depression. The pediatric King Airways will allow our Paramedics to better manage our pediatric trauma patient airways in the field.

Kern County EMS Program is participating in the regional trauma initiative for the Central California Region. The affiliation between Kern's Level II Trauma Center and CCEMS's Level I Trauma Center in Fresno provides for open dialogue and opportunities for system improvements.

Additionally, Kern Medical continues to participate in ACS verification. The EMS Program has helped to secure some additional funding to help Kern Medical move toward the goal. The administration and staff have committed to maintaining this verification in the future and estimate it being possible in the next one (1) to three (3) years. Kern Medical has completed a consultation with ACS in May 2016 and went through a Verification review in 2017.

#### **NUMBER AND DESIGNATION LEVEL OF TRAUMA CENTERS:**

Kern County currently is served by one Level II Trauma Center- Kern Medical and one Level IV Trauma Center- Ridgecrest Regional Hospital.

#### **TRAUMA SYSTEM GOALS AND OBJECTIVES:**

Goal #1: Encourage Receiving Hospitals to seek designation as Level III or Level IV Trauma Centers.

1. Objective: Establish at least one Level III trauma center in a rural area by December 2020.

Note: One rural hospital has expressed interest in attaining Level III Trauma Center designation. The Program will assist and encourage these hospitals in their endeavor. But, ultimately attainment of this objective is out of the Program's control.

Goal #2: Help support Kern Medical to continue to strive and achieve ACS verification.



1. Objective: Work with Kern Medical to maintain ACS verification over the next two years.
2. Objective: Complete Kern Medical re-designation by end of 2019-2020 fiscal year.
3. Objective: Assist Kern Medical in the scheduled site review from ACS in 2019.

Goal #3: Continued Designated Trauma Hospital data transmission to Trauma Registry (CEMISIS).

1. Objective: Assist Kern Medical and Ridgecrest Regional Hospital in continued transmission of 2018 and 2019 data to CEMISIS for fiscal years 2018-2019.

**CHANGES TO IMPLEMENTATION SCHEDULE: N/A**

### **SYSTEM PERFORMANCE IMPROVEMENT:**

Trauma Evaluation Committee (TEC) is an ad hoc subcommittee of the Kern County EMS System Collaborative and was established to review certain potential problem cases and system trends. The Trauma Operations Review Committee consisting of Kern Medical Trauma Operations personnel & Kern County Public Health Trauma Coordinator meet monthly usually on the 3<sup>rd</sup> Monday of the month to discuss current trauma operations and follow with trauma case reviews. Ridgecrest Regional Hospital is begun to hold Emergency Services Committee meetings on the 1<sup>st</sup> Thursday of the month with discussions involving the trauma teams and status of the emergency preparedness of the Emergency Department. Our most recent introduction to our trauma system has been the introduction of the use of Tranexamic Acid (TXA) Protocols optional scope, for shock and epistaxis, which was presented to in line with current medical studies and in conference with Kern County Emergency Medical Services Director.

The newly consolidated Trauma Policies will make it easier for field personnel comprehend and more readily and accurately triage trauma patients for treatment and selection of designated facility. Each meeting of the Trauma Operations Review and the Emergency Services Committee provide input and evaluation of “best practices” as they relate to core measures, reviews of field trauma deaths, recommends revisions to policies or protocols, reviews transfer or major complicated trauma patients’ records, reviews field deactivations of the Trauma System and verifies ongoing compliance with trauma triage, treatment and transport protocols. TEC also engages in research into best practices with regard to trauma care and is currently engaged in community intervention activities planning and implementation based on local trauma data.

TEC membership and Trauma Operations Review attendance at Kern Medical Hospital has been as follows:

June 15, 2018- 8 members attended  
September 17, 2018 – 8 members attended  
November 19, 2018 -7 members attended  
December 18, 2018 – 0 members attended (canceled)  
February 18, 2019 – 8 members attended  
March 18, 2019 – 11 members attended  
April 15, 2019 – 9 members attended  
May 29, 201 – 11 members attended  
June 17, 2019 -11 members attended  
July 15, 2019 – 10 members attended  
August 19, 2019 – 0 members attended (canceled)  
September 23, 2019 – 8 members attended  
October 21, 2019 – 11 members attended

#### **PROGRESS ON ADDRESSING EMS AUTHORITY TRAUMA SYSTEM PLAN COMMENTS:**

*Comment #1: Trauma System Summary (Required Action): “Data transmitted to CEMISIS-Trauma is to meet the National Trauma Data Bank Inclusion Criteria.” Started transmission of trauma data into CEMISIS-Trauma on January 1, 2014. Kern Medical has established an upload process with Image-trend for transmission of CEMISIS-Trauma data. KM has completed upload of 2016 and 2017 data and is on track for the upload of 2018 data as well. KM has committed financial resources to obtain a third-party contractor to complete the upload of past trauma data.*

*Comment #2: Changes in Trauma System (Comment): The affiliation between Kern Medical and Community Medical Center will assist Kern County in the review of trauma cases as selected by the Trauma Evaluation Committee. Kern Medical Trauma Peer Review monthly meetings attended by KCPHSD TEC Coordinator for case reviews, facility input, issues examination/review, and trauma system monitoring. Outside review is an excellent process for a system with only one designated Trauma Center. We also encourage your continued participation in the Central Regional Trauma Coordinating Committee. The Program will continue to support Kern Medical and Kern County in participation with the Central Regional Trauma Coordinating Committee.*

*Comment #3: System Performance Improvement (Required Action): “By January 1, 2018, provide the signature copy of the Trauma Center Trauma Policies.” “With the next annual Trauma System Status Report, provide a detailed report on the progress of the TEC including dates of meetings and attendance.” There was a delay in approval of*

the policies due to multiple public comment periods, and the timeliness of the quarterly meeting of the Emergency Medical Care Advisory Board for approval of the policies. The policies became effective July 1, 2017. The section titled "SYSTEM PERFORMANCE IMPROVEMENT" includes the requested information regarding the TEC. Even though TEC has been re-designed, it should be noted that the effective date of the policy outlining TEC and its duties is July 1, 2017.

**OTHER ISSUES: N/A**

The following document is the Kern County Paramedic First Responder Policy. The Kern County EMS Agency believes that this policy satisfies California Code of Regulations, Title 22, Division 9, Article 7, Sections 100168, Paramedic Service Provider. This policy sets the parameters for the operation of a paramedic service provider for our first response entities. They must comply with this policy in order to maintain their Paramedic Service Provider status. Any violation of this policy will result in the suspension of the providers approval to operate as a Paramedic Service Provider.

***Paramedic First Responder Policies and Procedures-  
(6004.00)***

**PURPOSE:**

The primary purpose of the Paramedic-FR Program is to provide expedient ALS response and care prior to transport unit scene arrival at emergency medical calls and/or to provide support for a transport unit already at scene which may require additional emergency medical personnel, equipment, supply; or resources for medical operations, communication and patient care. Additionally, the Paramedic-FR Program is intended to provide closest ALS response when the Paramedic-FR unit is closest or can provide the shortest response to an EMS call and immediate ALS access and care to patients in areas inaccessible to an ambulance.

**AUTHORITY:**

This policy is administered under the authority of Health and Safety Code Sections 1797.107, 1797.172, 1797.173, 1798, and California Code of Regulations, Title 22, Division 9, Chapter 4, Sections 100145.

**I. GENERAL PROVISIONS**

- A. The Paramedic First Responder Program is an optional prehospital advanced life support program administered by the Kern County EMS Division (Division) through Division authorized Kern County Paramedic First Responder (Paramedic-FR) Providers. The program functions in accordance with state and county Paramedic rules, regulations, policies, procedures, protocols and operates under medical control and authority of the Division Medical Director.
- B. A Kern County EMS Division authorized Paramedic First Responder Provider is limited to prehospital first responder BLS and ALS patient care and shall not provide patient transport services within the County of Kern. EMT-1 or Paramedic level transportation services shall only be provided by a Kern County Ambulance Service Permittee in accordance with Kern County Ordinance Code 8.12. and Ordinance Code 8.12. Regulations and Policies.
- C. The Paramedic-FR Program entails utilization of specially equipped and trained Paramedic(s) in the first responder, non-transport patient care capacity with valid state Paramedic licensure and local Paramedic accreditation. The Paramedic-FR operates from an emergency response vehicle that is not to be used for patient transport.

- D. The Paramedic-FR vehicle shall have and maintain valid emergency vehicle authorization from the California Highway Patrol and valid Paramedic-FR MICU authorization from the Division. The Paramedic-FR MICU shall only be operated in a Paramedic-FR capacity when staffed by a minimum of one (1) Paramedic that meets Paramedic-FR qualification and training requirements as specified in these policies.
- E. Use of Paramedic-FR shall not be construed, interpreted or allowed to replace or modify in any way transportation resources maintained by a Kern County Paramedic Provider or a Kern County Ambulance Service Permittee. The Paramedic-FR program shall be operated as an adjunct to the Kern County EMS System and not to replace or supplant any existing level of services.

## **II. PARAMEDIC FIRST RESPONDER SCOPE OF PRACTICE**

- A. The Paramedic-FR is authorized to provide prehospital Advanced Life Support within the scope of practice allowed by the State of California and the Division according to these policies and procedures.
- B. The Paramedic-FR is authorized to provide prehospital advanced life support skills and procedures according to Paramedic treatment protocols authorized by the Division Medical Director. This authorization shall be commensurate with the Paramedic-FR MICU advanced life support supplies and equipment inventory specified in these policies and specially refined for Paramedic-FR function.
- C. The Paramedic-FR shall comply with all Kern County Paramedic rules, regulations, policies, procedures and protocols at all times.
- D. The Paramedic-FR shall coordinate appropriate planning, notification, response, communications and utilization of local EMS resources.

## **III. PARAMEDIC FIRST RESPONDER PROVIDER**

- A. Valid Kern County EMS Division authorization as a Paramedic-FR Provider shall be required for a provider to operate the Paramedic-FR Program.
- B. Paramedic-FR Provider authorization shall immediately be terminated if the provider is unable to provide personnel meeting the requirements of these policies or the program is terminated.
- C. A provider wishing to be authorized as a Paramedic-FR Provider shall provide a written application to the Division. The written application shall include a thorough description of unit(s), Paramedic-FR personnel qualifications and

training, staffing, and availability with commitment to comply with Paramedic-FR policies and procedures.

- D. To be eligible for Paramedic-FR Provider authorization all of the following minimum requirements shall be met:
1. Be an existing EMT-1 First Responder Provider within Kern County authorized by the Division;
  2. Have a Medical Director responsible for all controlled substances and Quality Improvement.
  3. Have and maintain a Paramedic-FR training program which complies with the provisions of these policies and procedures;
  4. Have and maintain at least one (1) Paramedic-FR MICU authorized by the Division;
  5. Have and maintain a quality improvement mechanism for the Paramedic-FR program to ensure proper utilization and quality of care; and
  6. Have and maintain records, reports and Paramedic-FR activity data according to these policies.
- E. An authorized Paramedic-FR Provider shall ensure the Paramedic-FR program is continually operated according to these policies and procedures. The Division may terminate Paramedic-FR Provider authorization for non-compliance to these policies and procedures.

#### **IV. PARAMEDIC FIRST RESPONDER QUALIFICATIONS, ACCREDITATION AND TRAINING**

- A. The Paramedic-FR shall have and maintain active Kern County Paramedic accreditation.
- B. A Paramedic-FR shall receive a minimum of four (4) hours training in Paramedic-FR policies and procedures, Paramedic-FR scope of practice, and the EMS system before being authorized to operate in a Paramedic-FR capacity. The training shall only be provided by Division authorized instructors. Paramedic-FR training shall at minimum include a thorough briefing in Paramedic-FR policies and procedures, orientation in communications systems, Scene Control Policy, EMS resource utilization, ambulance service operating areas and prehospital care capability, dispatch and stand-by procedures, EMS aircraft utilization, multi-casualty incident and Med-Alert operations.

- C. The Paramedic-FR Provider shall maintain records of Paramedic personnel that have completed Paramedic-FR training and are authorized to operate in a Paramedic-FR capacity and shall maintain an active listing on file at the Division.
- D. The Division may withdraw Paramedic-FR authorization at any time for non-compliance with policies and procedures. The Division may also establish re-authorization training requirements or mandatory Paramedic-FR education sessions.
- E. Paramedic-FR programs shall maintain sufficient Paramedic Preceptors to train new paramedics and ensure skills maintenance of existing Paramedics
- F. Paramedic FR Preceptor candidates shall participate in the Division Preceptor program to obtain and maintain Preceptor accreditation.

## **V. PARAMEDIC FIRST RESPONDER ACTIVATION AND RESPONSE**

- A. The Paramedic-FR Provider shall ensure appropriate staffing, deployment, and utilization of all Paramedic-FR units.
- B. The Paramedic-FR unit may be used in either a first responder capacity (prior to ALS transport arrival) or in a backup or support capacity when requested by on-scene medical, fire or law enforcement personnel.
- C. Non-emergent activity, movement and positioning of Paramedic-FR unit(s) shall be at the discretion of the Paramedic-FR Provider within their jurisdiction.
- D. The Paramedic-FR unit shall be responded to medical emergencies by the Paramedic FR-Provider dispatch center in accordance with the *Emergency Medical Services Dispatch Policies and Procedures*.

## **VI. PARAMEDIC FIRST RESPONDER SCENE OPERATIONS**

- A. First Responder Capacity:
  - 1. First responder capacity means the Paramedic-FR unit is the first medical unit or first ALS level unit arriving at scene.
  - 2. In a first responder capacity, the Paramedic-FR is expected to assume patient health care authority. Upon arrival of an ALS ambulance, the Paramedic FR shall provide a verbal report and patient care authority shall



automatically transition with transfer of care to the transport paramedic, as required by the Division *Scene Control Policy*.

3. The Paramedic-FR is expected to establish medical control, complete scene and patient assessment and initiate BLS/ALS patient treatment intervention according to Kern County Paramedic Policies and Procedures and Kern County Paramedic Treatment Protocols as the patient condition necessitates. The Paramedic-FR is expected to initially bring necessary medical equipment and supplies to the patient for appropriate overall patient care management (avoid making patient contact, then leaving for equipment).
4. The normal focus of the Paramedic-FR program is to provide immediate care until an ALS ambulance arrives, transfer of patient care responsibility occurs, and the Paramedic-FR rapidly becomes available for additional responses or use. In certain cases warranting specialized personal protective equipment precautions and training (hazardous materials, heavy rescue or tactical operations) the Paramedic-FR transition of care responsibility to the ALS ambulance Paramedic may be delayed until the ALS ambulance Paramedic is able to safely access the patient.
5. The Paramedic-FR shall provide a verbal report to the ALS ambulance Paramedic upon arrival which includes the following patient information at minimum:
  - a. Chief complaint(s) and/or problem(s);
  - b. Signs and symptoms;
  - c. Vital signs;
  - d. Patient history; and
  - e. BLS, ALS treatment provided and patient response to treatment.
6. If a BLS ambulance arrives at scene and ALS patient care procedures are indicated, initiated or carried out, the Paramedic-FR must bring necessary equipment and supplies from the Paramedic-FR unit to manage the patient and attend the patient during transport to an ALS ambulance or the hospital. ALS to BLS Handoff shall only occur as specified in the paramedic protocol.
7. During a multi-casualty or mass casualty incident, the Paramedic-FR may use a BLS ambulance for patient transport when ALS procedures have been initiated, if an ALS ambulance is not reasonably available, or the patient(s) require rapid transport and the situation clearly indicates that the

Paramedic-FR remain at scene to administer ALS level care to additional patients.

**B. Paramedic-FR Backup or Support Capacity:**

1. Paramedic-FR backup or support capacity means that an ALS ambulance Paramedic is already on scene and the Paramedic-FR arrives on scene as an additional ALS level resource. In this situation the Paramedic-FR is to assist and at the discretion of the ALS ambulance Paramedic or incident commander.

**VII. EMS RESOURCE UTILIZATION**

- A. The Paramedic-FR shall be responsible for prudent notification, response and efficient utilization of all EMS resources in conjunction with the Scene Control Policy. During Med-Alert operations, the Paramedic-FR shall coordinate incident communications and resource utilization through the Kern County EMS Division.

**VIII. DOCUMENTATION AND QUALITY ASSURANCE**

- A. The Paramedic-FR shall complete a Kern County Patient Care (PCR) Data and Narrative Record in accordance with Kern County PCR Policies and Procedures for every public agency or 911 response (with or without patient contact) and for each individual patient contact. Completed PCR's shall be referred to the Division in accordance with Kern County PCR Policies and Procedures.
- B. For each case of patient transport, a copy of the ePCR shall be sent by facsimile or electronic means to the receiving hospital within one (1) hour of the start of patient transport. Emergency activity may reasonably preclude meeting the one (1) hour time requirement, but in no case shall the ePCR submission to the receiving hospital exceed twelve (12) hours.
- C. The Paramedic-FR provider shall provide Paramedic-FR incident reports, documentation, data or Paramedic-FR program evaluations to the Division upon request.
- D. The Division shall be notified in advance of any anticipated changes in Paramedic-FR unit(s), Paramedic-FR utilization, Paramedic-FR personnel or function of the Paramedic-FR program and shall monitor the program for operational and medical quality assurance.

- E. The Paramedic-FR provider shall allow Division personnel to ride-a-long for the purpose of direct observation of FR operations.

## **IX. REQUIRED PARAMEDIC FIRST RESPONDER MICU EQUIPMENT AND SUPPLIES**

- A. The Paramedic-FR and Paramedic-FR Provider shall be responsible to maintain a complete inventory of required Paramedic-FR MICU equipment and supplies (Paramedic-FR MICU Inventory) as specified in the *Provider Mandatory Inventory List*.
- B. A Paramedic-FR unit shall be inspected and designated by the Division as an Paramedic-FR MICU prior to use in an Paramedic-FR capacity. In order to be designated as a Paramedic-FR MICU, the unit shall meet all Paramedic-FR MICU inventory requirements and pass Division inspection.
- C. The Paramedic-FR MICU Inventory should be configured in the Paramedic-FR unit for efficient removal and transport to the patient or incident site.
- D. The Paramedic-FR and Paramedic-FR Provider shall be responsible for the care and maintenance of all Paramedic-FR MICU inventory. Paramedic-FR unit(s) MICU inventory shall also be subject to inspection by the Division. The Paramedic-FR Provider may obtain temporary authorization from the Division to operate another emergency vehicle in a Paramedic-FR MICU capacity.
- E. The following information shall be provided by the Paramedic-FR provider for Paramedic-FR MICU inspection by the Division:
  - 1. Vehicle make, model, year;
  - 2. Vehicle license number (if not available because of new vehicle - vehicle identification number will suffice);
  - 3. Vehicle identification number;
  - 4. Valid vehicle registration;
  - 5. Valid vehicle insurance documentation, name of carrier and policy number;
  - 6. Unit call sign.

PARAMEDIC-FR MOBILE INTENSIVE CARE UNIT  
INSPECTION RECORD

INSPECTION DATE:    /    /

APPROVED PARAMEDIC-FR PROVIDER: YES  NO

PARAMEDIC-FR PROVIDER SERVICE:

NAME OF OWNER(S):

SERVICE AREA:

PRIMARY ADDRESS:

CITY: ZIP CODE:

PHONE (    )    -

UNIT DESIGNATION: \_\_\_\_\_ MODEL: \_\_\_\_\_

YEAR: \_\_\_\_\_ LICENSE NUMBER: \_\_\_\_\_

V.I.N.: \_\_\_\_\_

CURRENT VEHICLE REGISTRATION (ATTACH COPY): YES  NO

CURRENT VEHICLE INSURANCE (ATTACH COPY): YES  NO

NAME OF CARRIER: \_\_\_\_\_ POLICY #: \_\_\_\_\_

CURRENT CALIFORNIA HIGHWAY PATROL INSPECTION  
CERTIFICATE AND/OR APPROVED INSPECTION SHEET YES  NO   
(ATTACH COPY)

CURRENT MICU MEDICAL SUPPLY AND EQUIPMENT YES  NO

REQUIREMENTS SATISFIED (COPY ATTACHED) YES  NO

ALL PRECEDING REQUIREMENTS SATISFIED: YES  NO   
SUMMARY OF DISCREPANCY(IES):

CONCLUSION:

EMS DIVISION REPRESENTATIVE NAME:

EMS DIVISION REPRESENTATIVE SIGNATURE:

DATE APPROVED:    /    /

Revision Log:

08/03/1999 – Initial Draft

09/15/1999 – Second Draft

10/20/1999 – Finalized

11/15/2001 – Addition of transcutaneous cardiac pacing, midazolam, and inventory adjustments

07/15/2004 - Increase minimum stock of midazolam to 12.0 mg

06/01/2010 – Added Amiodarone, MAD, ET confirmation, and ET securing device to inventory

10/01/2013 – Removed medication Furosemide from inventory and updated cover

08/15/2014 – Added Atrovent, Zofran, Fentanyl, oral glucose, multi-trauma dressing, petroleum gauze, shears, pulse oximetry. Remove pitocin, procainamide, electrode jell. Changed normal saline to isotonic balanced salt solution, pacing electrodes to multi-function pads. Removed outdated dispatch language, remove ICS position mandates. Added reference to *Emergency Medical Services Dispatch Policies and Procedures*, and *Scene Control Policy*

12/01/2015 - Removed the Mandatory Inventory List and placed in separate document

4/18/2018 – Removed California City from document. Added Division ride-a-long mandate, changed “may” to “shall” in dispatch statement.

8/1/2018 – All three ALS First Responder policies merged into one document.

**MEMORANDUM OF UNDERSTANDING**

KERN COUNTY EMERGENCY MEDICAL SERVICES DEPARTMENT

and

KERN COUNTY FIRE DEPARTMENT

for

PARAMEDIC FIRST RESPONDER SERVICES BASED AT PINE MOUNTAIN CLUB

THIS MEMORANDUM OF UNDERSTANDING ("MOU") is made and entered into this 17<sup>th</sup> day of Feb., 2009, by and between the KERN COUNTY EMERGENCY MEDICAL SERVICES DEPARTMENT (hereinafter referred to as "KCEMS"), and KERN COUNTY FIRE DEPARTMENT (hereinafter referred to as "KCFD"), both of which are departments of the COUNTY OF KERN, a political subdivision of the state of California.

WITNESSETH:

WHEREAS, KCEMS, located at 1400 "H" Street, Bakersfield, California 93301, and KCFD, located at 5642 Victor Street, Bakersfield, California 93308, are functional entities of the County of Kern (hereinafter referred to as "County") and both organizations are under the direct control of the Board of Supervisors (hereinafter referred to as "BOS"); and

WHEREAS, KCEMS is the designated local EMS agency (LEMSA) pursuant to California Health and Safety Code Section 1797.200 and Ordinance Code Chapter 2.23; and

WHEREAS, KCEMS is the responsible authority for managing the local emergency medical services system in accordance with the requirements of the California Health and Safety Code, California Code of Regulations Title 22, County Ordinance Code, and local regulations, policies, procedures, protocols, and other requirements; subject to direction from the BOS; and

WHEREAS, on November 7, 2008 property owners in the Pine Mountain Club area of the County approved by a super majority a special assessment on area property taxes to fund paramedic first responder services to be provided by KCFD; and

WHEREAS, KCFD has received BOS approval to implement and maintain paramedic first responder services based in Pine Mountain Club; and

WHEREAS, KCEMS and KCFD are required to have a written agreement in accordance with California Code of Regulations, Title 22, Article 7., Section 100167 (b) (4) entitled "Paramedic Service Provider" attached hereto and a part of herewith, for KCFD to participate in the EMS system, and to comply with all applicable State regulations and local policies and procedures, including participation in the KCEMS quality improvement program; and

WHEREAS, KCEMS and KCFD have developed "Paramedic First Responder Policies and Procedures - Kern County Fire Department Station 58 Pine Mountain Club" (hereinafter referred to as "Paramedic FR Policies"). Said policies define the detailed requirements for implementation, approval, operation, quality improvement oversight and other requirements for the paramedic first responder services provided by KCFD based in Pine Mountain Club.

NOW, THEREFORE, IT IS MUTUALLY AGREED AS FOLLOWS:

1. KCFD is approved by KCEMS as a paramedic first responder provider based at KCFD Station 58 in Pine Mountain Club in accordance with the terms and conditions of this MOU and Paramedic FR Policies.
2. KCEMS shall provide medical control oversight of the program through the KCEMS medical director.
3. KCFD may not expand paramedic first responder services beyond usual and customary responses to emergency medical services incidents by KCFD Station 58 in Pine Mountain Club, unless BOS authorized in coordination with KCEMS.

4. KCFD shall coordinate any expansion of paramedic first responder services to emergency medical services incidents in Pine Mountain Club with the KCEMS, prior to any such expansion.
5. KCEMS and KCFD shall comply with the requirements contained in the California Health and Safety Code, California Code of Regulations Title 22, Paramedic FR Policies and other local requirements to implement, operate and maintain the paramedic first responder services based at KCFD Station 58 in Pine Mountain Club.
6. Funding will be provided to KCEMS under CSA-40 to cover all costs to administer, authorize, oversee, and improve the paramedic first responder services based at KCFD Station 58 in Pine Mountain Club.
7. KCEMS shall report all costs to administer, authorize, oversee, and improve the paramedic first responder services based at KCFD Station 58 in Pine Mountain Club to KCFD, on a quarterly basis.
8. The term of this MOU shall commence upon execution and shall continue in effect until terminated by BOS. However, this MOU shall terminate immediately upon:
  - a. KCFD's non-compliance with the requirements of Paramedic FR Policies, as determined by BOS after hearing the recommendation of KCEMS; or
  - b. Withdrawal of funding necessary to implement, administer, operate or maintain the paramedic first responder program; or
  - c. Any changes to State law or local requirements that materially change continued paramedic first responder services provided through the KCFD, whereby the purpose of this MOU is overridden or rendered invalid; or
  - d. Upon direction to terminate this MOU from the BOS.
9. Nonassignment of MOU. KCFD shall not assign or transfer this MOU or any interest in it without the prior written consent of KCEMS, and if any assignment is approved, all provisions of this MOU shall extend to and include the successors of KCFD.
10. Notices. Any notice given by either party to the other under this MOU shall be in writing, served by prepaid certified mail or personally upon the other party, addressed as follows:
 


To KCEMS: (with copy to CAO)	Director Kern County EMS Department 1400 "H" Street Bakersfield, CA 93301
To KCFD:	Fire Chief Kern County Fire Department 5642 Victor Street Bakersfield, CA 93308
11. Nondiscrimination. Both parties agree to abide by all applicable federal and state laws prohibiting discrimination against any employee, applicant for employment, or patient because of race, color, religion, sex, age, handicap or place of national origin.
12. Partial Invalidity. If any provision in this MOU is held by a court of competent jurisdiction to be invalid, void or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.
13. Amendments. Any modification of this MOU shall be effective only if it is in writing and signed by the parties.

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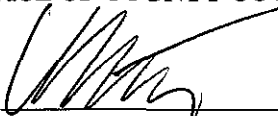
IN WITNESS WHEREOF, the parties have entered into this MOU as of the date first hereinabove written.

KCEMS:  
EMERGENCY MEDICAL SERVICES DEPARTMENT

By   
Ross Elliott, Director

Date 2/9/09

APPROVED AS TO FORM:  
OFFICE OF COUNTY COUNSEL

By   
Martin Lee, Deputy

ACKNOWLEDGED BY:  
COUNTY OF KERN

By   
Chairman, Board of Supervisors

KCFD:  
FIRE DEPARTMENT

By   
Dennis Thompson, Fire Chief

Date 2/4/2009

~~APPROVED AS TO FORM:  
OFFICE OF COUNTY COUNSEL~~

~~By \_\_\_\_\_  
Patricia Randolph, Deputy~~



## **California Code of Regulations (excerpt):**

### **CCR Title 22 Article 7. System Requirements**

#### **100167. Paramedic Service Provider.**

(a) A local EMS agency with an advanced life support system shall establish policies and procedures for the approval, designation, and evaluation through its QIP, of all paramedic service provider(s).

(b) An approved paramedic service provider shall:

(1) Provide emergency medical service response on a continuous twenty-four hours per day basis, unless otherwise specified by the local EMS agency, in which case there shall be adequate justification for the exemption (e.g., lifeguards, ski patrol personnel, etc.).

(2) Utilize and maintain telecommunications as specified by the local EMS agency.

(3) Maintain a drug and solution inventory as specified by the local EMS agency of equipment and supplies commensurate with the basic and local optional scope of practice of the paramedic.

(4) Have a written agreement with the local EMS agency to participate in the EMS system and to comply with all applicable State regulations and local policies and procedures, including participation in the local EMS agency's QIP as specified in Chapter 12 of this Division.

(5) Be responsible for assessing the current knowledge of their paramedics in local policies, procedures, and protocols and for assessing their paramedics' skills competency.

(6) If, through the QIP the employer or medical director of the local EMS agency determines that a paramedic needs additional training, observation or testing, the employer and the medical director may create a specific and targeted program of remediation based upon the identified need of the paramedic. If there is disagreement between the employer and the medical director, the decision of the medical director shall prevail.

(c) No paramedic service provider shall advertise itself as providing paramedic services unless it does, in fact, routinely provide these services on a continuous twenty-four hours per day basis and meets the requirements of subsection (b) of this section.

(d) No responding unit shall advertise itself as providing paramedic services unless it does, in fact, provide these services and meets the requirements of subsection (a) of this section.

(e) The local EMS agency may deny, suspend, or revoke the approval of a paramedic service provider for failure to comply with applicable policies, procedures, and regulations.

NOTE: Authority cited: Sections 1797.107, 1797.172, and 1798, Health and Safety Code. Reference: Sections 1797.172, 1797.178, 1797.180, 1797.204 and 1797.218, Health and Safety Code.

## **California Health and Safety Code (excerpts):**

**1797.94.** "Local EMS agency" means the agency, department, or office having primary responsibility for administration of emergency medical services in a county and which is designated pursuant to Chapter 4 (commencing with Section 1797.200).

**1797.206.** The local EMS agency shall be responsible for implementation of advanced life support systems and limited advanced life support systems and for the monitoring of training programs.  
[Amended by SB 595 (CH 1246) 1983.]

**1797.214.** A local EMS agency may require additional training or qualifications, for the use of drugs, devices, or skills in either the standard scope of practice or a local EMS agency optional scope of practice, which are greater than those provided in this chapter as a condition precedent for practice within such EMS area in an advanced life support or limited advanced life support prehospital care system consistent with standards adopted pursuant to this division.[Amended by SB 595 (CH 1246) 1983; and AB 1558 (CH 1134) and AB 2159 (CH 1362) 1989.]

**1797.220.** The local EMS agency, using state minimum standards, shall establish policies and procedures approved by the medical director of the local EMS agency to assure medical control of the EMS system.

The policies and procedures approved by the medical director may require basic life support emergency medical transportation services to meet any medical control requirements including dispatch, patient destination policies, patient care guidelines, and quality assurance requirements. [Amended by AB 3269 (CH 1390) 1988.]

**1798.** (a) The medical direction and management of an emergency medical services system shall be under the medical control of the medical director of the local EMS agency. This medical control shall be maintained in accordance with standards for medical control established by the authority.

(b) Medical control shall be within an EMS system which complies with the minimum standards adopted by the authority, and which is established and implemented by the local EMS agency.

(c) In the event a medical director of a base station questions the medical effect of a policy of a local EMS agency, the medical director of the base station shall submit a written statement to the medical director of the local EMS agency requesting a review by a panel of medical directors of other base stations. Upon receipt of the request, the medical director of a local EMS agency shall promptly convene a panel of medical directors of base stations to evaluate the written statement. The panel shall be composed of all the medical directors of the base stations in the region, except that the local EMS medical director may limit the panel to five members.

This subdivision shall remain in effect only until the authority adopts more comprehensive regulations that supersede this subdivision. [Amended by SB 1124 (CH 1391) 1984. Subsection (c) added by AB 214 (CH 1225) and SB 12 (CH 1240) 1987. Paragraphs (1), (2), and (3) under subsection (a) deleted by AB 3269 (CH 1390) 1988.]

**1799.112.** (a) EMT-P employers shall report in writing to the local EMS agency medical director and the authority and provide all supporting documentation within 30 days of whenever any of the following actions are taken:

(1) An EMT-P is terminated or suspended for disciplinary cause or reason.

(2) An EMT-P resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.

(3) An EMT-P is removed from paramedic duties for disciplinary cause or reason following the completion of an internal investigation.

(b) The reporting requirements of subdivision (a) do not require or authorize the release of information or records of an EMT-P who is also a peace officer protected by Section 832.7 of the Penal Code.

(c) For purposes of this section, "disciplinary cause or reason" means only an action that is substantially related to the qualifications, functions, and duties of a paramedic and is considered evidence of a threat to the public health and safety as identified in subdivision (c) of Section 1798.200.

(d) Pursuant to subdivision (i) of Section 1798.24 of the Civil Code, upon notification to the paramedic, the authority may share the results of its investigation into a paramedic's misconduct with the paramedic's employer, prospective employer when requested in writing as part of a preemployment background check, and the local EMS agency.

(e) The information reported or disclosed in this section shall be deemed in the nature of an investigative communication and is exempt from disclosure as a public record by subdivision (f) of Section 6254 of the Government Code.

(f) A paramedic applicant or licensee to whom the information pertains may view the contents, as set forth in subdivision (a) of Section 1798.24 of the Civil Code, of a closed investigation file upon request during the regular business hours of the authority.

[Added by AB 1655 (CH 513) 2004.]

**MEMORANDUM OF UNDERSTANDING  
BETWEEN THE KERN COUNTY PUBLIC HEALTH SERVICES DEPARTMENT,  
THE EMERGENCY MEDICAL SERVICES DIVISION  
and,  
THE KERN COUNTY FIRE DEPARTMENT  
for  
PARAMEDIC FIRST RESPONDER SERVICES FOR WILDLAND FIRES**

THIS MORANDUM OF UNDERSTANDING ("MOU") is made and entered into on July  
23, 2013, by and between the KERN COUNTY PUBLIC HEALTH SERVICES DEPARTMENT,  
EMERGENCY MEDICAL SERVICES DIVISION (hereinafter referred to as "KCEMS"), and KERN  
COUNTY FIRE DEPARTMENT (hereinafter referred to as "KCFD"), both of which are departments  
of the COUNTY OF KERN, a political subdivision of the state of California.

**WITNESSETH:**

WHEREAS, KCEMS, located at 1800 Mount Vernon Avenue, Bakersfield, California 93306,  
and KCFD, located at 5642 Victor Street, Bakersfield, California 93308, are functional entities of the  
County of Kern (hereinafter referred to as "County") and both organizations are under the direct  
control of the Board of Supervisors (hereinafter referred to as "BOS"); and

WHEREAS, KCEMS is the designated local EMS agency (LEMSA) pursuant to California  
Health and Safety Code Section 1797.200 and Ordinance Code Chapter 2.23; and

WHEREAS, KCEMS is the responsible authority for managing the local emergency medical  
services system in accordance with the requirements of the California Health and Safety Code,  
California  
Code of Regulations Title 22, County Ordinance Code, and local regulations, policies, procedures,  
protocols, and other requirements; subject to direction from the BOS; and

WHEREAS, KCFD has received BOS approval to implement and maintain fireline paramedic  
services; and

WHEREAS, KCEMS and KCFD are required to have a written agreement in accordance with  
California Code of Regulations, Title 22, Article 7, Section 100167 (b) (4) entitled "Paramedic  
Service  
Provider" attached hereto and a part of herewith, for KCFD to participate in the EMS system, and to  
comply with all applicable State regulations and local policies and procedures, including participation  
in the KCEMS quality improvement program; and

WHEREAS, KCEMS has developed "*Fireline Paramedic Policies and  
Procedures*" (hereinafter referred to as "FEMP Policies"). Said policies define the performance  
standards and detailed requirements for implementation, approval, operation, quality improvement  
oversight and other requirements for the fireline paramedic services provided by KCFD.

**NOW, THEREFORE, IT IS MUTUALLY AGREED** between the parties hereto as follows:

1. KCFD is approved by KCEMS as a fireline paramedic provider in accordance with the terms  
and conditions of this MOU and all requirements of the FEMP Policies which are incorporated herein  
by reference.
2. KCFD agrees to comply with all requirements contained in FEMP Policies and all other  
KCEMS policies and regulations to implement, operate and maintain the fireline paramedic services.

3. KCEMS shall provide medical control oversight of the program through the KCEMS medical director.

4. KCFD shall not provide paramedic services beyond the confines of the wildland fire assignment and base camp, unless subsequent BOS approval has been granted and a subsequent authorizing MOU with KCEMS is executed.

5. KCEMS and KCFD shall comply with the California Health and Safety Code, California Code of Regulations Title 22, and other local policies and regulations.

6. This MOU shall commence upon execution and shall continue in effect until terminated by either party upon 90-day written notice of intent to terminate. However, this MOU shall terminate immediately upon:

- a. KCFD's non-compliance with the requirements of FEMP Policies, as determined by BOS after hearing the recommendation of KCEMS; or
- b. Any changes to State law or local requirements that materially change continued fireline paramedic services provided through the KCFD, whereby the purpose of this MOU is overridden or rendered invalid; or
- c. Upon direction to terminate this MOU from the BOS.

7. **Nonassignment of MOU.** KCFD shall not assign or transfer this MOU or any interest in it without the prior written consent of KCEMS, and if any assignment is approved, all provisions of this MOU shall extend to and include the successors of KCFD.

8. **Notices.** Any notice given by either party to the other under this MOU shall be in writing, served by interoffice mail, email, or personally upon the other party, addressed as follows:

To KCEMS:  
(with copy to CAO)

Director  
Kern County Public Health Services Dept  
1800 Mount Vernon Avenue  
Bakersfield, CA 93306

To KCFD:

Fire Chief  
Kern County Fire Department  
5642 Victor Street  
Bakersfield, CA 93308

9. **Amendments.** Any modification of this MOU shall be effective only if it is in writing and signed by the parties.

IN WITNESS WHEREOF, the parties have entered into this MOU as of the date first hereinabove written.

KCPHSD:  
PUBLIC HEALTH SERVICES DEPARTMENT

By   
Matt Constantine, Director

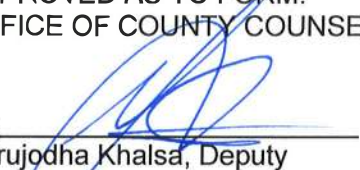
Date 7/12/13

KCFD:  
FIRE DEPARTMENT

By   
Brian Marshall, Fire Chief

Date 7/12/13

APPROVED AS TO FORM:  
OFFICE OF COUNTY COUNSEL

By   
Gurujodha Khalsa, Deputy

APPROVED AS TO FORM:  
OFFICE OF COUNTY COUNSEL

By   
Devin Brown, Deputy

ACKNOWLEDGED BY:  
COUNTY OF KERN

By   
Chairman, Board of Supervisors

Kern County  
Agt. # 903-2016

CITY OF BAKERSFIELD  
Agreement No. ED16-012  
Approved AUG 02 2016

AGREEMENT NO. \_\_\_\_\_

**AGREEMENT  
BETWEEN THE COUNTY OF KERN  
AND  
CITY OF BAKERSFIELD  
FOR THE PROVISION OF FIRELINE PARAMEDIC PROGRAM**

**THIS AGREEMENT** is made and entered into this 30<sup>th</sup> day of August, 2016, by and between the **COUNTY OF KERN**, a political subdivision of the State of California ("**County**"), **CITY OF BAKERSFIELD** ("**Provider**"), a political subdivision of the State of California, located at 1600 Truxtun Avenue, Bakersfield, CA 93301. County and Provider may be individually referred to as "**Party**" and collectively as "**Parties**."

**WITNESSETH:**

**WHEREAS:**

(a) The Legislature of the State of California, through Division 2.5, Chapter 4, beginning at Section 1797.200 of the Health and Safety Code, a chapter within the "EMERGENCY MEDICAL SERVICES SYSTEM and the PREHOSPITAL EMERGENCY MEDICAL CARE PERSONNEL ACT" (aka "**EMS ACT**"), delegates certain authority for the establishment, development, and regulation of emergency medical services, including paramedic first responder services, to counties; and

(b) The Kern County Board of Supervisors has directed the Emergency Medical Services Division ("**Division**"), located at 1800 Mount Vernon Avenue, Bakersfield, California 93306, be the local EMS Agency; and

(c) Division administers an advanced life support system and designates selected providers to function as an advanced life support fireline paramedic program ("**FEMP**") approved by the EMS Medical Director in accordance with California Code of Regulations, Title 22, Article 7, Section 100168 and the *Fireline Paramedic Policies and Procedures*; and

(d) The EMS Medical Director is responsible for maintaining medical control in accordance with the authority and responsibility specified in Section 100170 of Title 22 of the California Code of Regulations, and Section 1798 of the Health and Safety Code; and

(e) Division has found that Provider meets the criteria for approval of a FEMP Program as defined by the *Fireline Paramedic Policies and Procedures*; and

(f) Provider is willing to accept approval of an FEMP Program, as defined in the *Fireline Paramedic Policies and Procedures*; and

(g) Provider agrees to comply with all applicable Federal, State, and County laws, regulations, and requirements now in effect or which may become effective during the term of this Agreement; and

(h) Provider is willing and able to provide FEMP services during deployment to wildfire incidents under the terms and conditions set forth herein.

**NOW, THEREFORE, IT IS MUTUALLY AGREED AS FOLLOWS:**

**1. Term and Termination.**

A. The term of this Agreement shall be effective as of the date first hereinabove written and shall remain in effect until withdrawn by either Party according to the provisions of this Agreement. With or without cause, either Party may terminate this Agreement at any time upon giving written notice to the other Party not less than one hundred eighty (180) days in advance of the proposed termination date.

B. This Agreement shall terminate immediately upon:

1) Provider failure to meet the FEMP Program requirements as specified in *the latest version of Fireline Paramedic Policies and Procedures*, as determined by the Division, subject to appeal to the Emergency Medical Care Advisory Board (EMCAB); or

2) Changes to State law or local requirements that materially change continued paramedic first responder services provided through Provider, whereby the purpose of this Agreement is overridden or rendered invalid; or

3) Provider's failure to comply with any policy, procedure, or regulation mandated by the local, State, or federal government.

**2. Obligations of Provider.**

A. Provider shall fully comply with all requirements of the latest version of the Kern County *Fireline Paramedic Policies and Procedures*.

B. Provider shall pay County the annual FEMP Program fee, to support system-wide oversight and coordination of FEMP Services, if so established by the County at some future time through adoption or modification of an ordinance.

C. Provider may provide FEMP services, while deployed on wildland fire both within and outside of the county. Services shall be provided in accordance with the *Fireline Paramedic Policies and Procedures*. This Agreement does not authorize Provider to perform patient transport services.

D. Provider shall comply with all the requirements of the *Fireline Paramedic Policies and Procedures*, including scope of practice, deployment, documentation, quality improvement, inventory, and all other requirements of the policy

E. Provider shall comply with Health and Safety Code, California Code of Regulations Title 22, and other EMS Division requirements.

F. Provider shall gain approval of any proposed expansion of FEMP services from the County, prior to any such expansion.

**3. Obligations of Division.**

A. The Division shall provide medical control oversight of the program through the Division's Medical Director in accordance with Health and Safety Code §1797.202.

B. Division shall provide a reasonable process for electronically reporting of required documentation, and Division shall periodically report to the public through its website Provider's record of compliance with *Fireline Paramedic Policies and Procedures*.

4. **Assignment of Agreement.** Provider shall not assign or transfer this Agreement or any interest in it without the prior written consent of County, and if any assignment is approved, all provisions of this Agreement shall extend to and include the executors, administrators, heirs, and successors of Provider as specified by County approval.

**5. Confidentiality - HIPAA/HITECH Compliance.**

A. During the term of this Agreement, Provider may receive from County, or may receive or create on behalf of County certain confidential health or medical information ("**Protected Health Information**" or "**PHI**"). This PHI is subject to protection under State and federal law, including the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("**HIPAA**"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("**the HITECH Act**"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services ("**HIPAA Regulations**") and other applicable laws. Provider represents that it has in place policies and procedures that will adequately safeguard any PHI it receives or creates, and Provider specifically agrees, on behalf of itself, its subcontractors and agents, to safeguard and protect the confidentiality of PHI consistent with applicable law, including currently effective provisions of HIPAA, the HITECH Act, and the HIPAA Regulations.

B. For purposes of this section, PHI means any information, whether oral or recorded in any form or medium: (a) that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (b) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

C. The Parties acknowledge that State and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The Parties hereto specifically agree to take such action as is necessary to implement the requirements of HIPAA, the HITECH Act, and HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI including but not limited to the incorporation of a Business Associate Agreement (BAA) attached as **Exhibit "A"** and incorporated herein by this reference. The Parties understand and agree that Provider must provide to County, after request by County, written evidence that Provider is in compliance with the HITECH Act, and applicable HIPAA Regulations.

D. Notwithstanding any other provision of this Agreement, County may terminate this Agreement upon twenty (20) days notice in the event: (a) Provider does not promptly provide written evidence of compliance with the HITECH Act, and applicable HIPAA Regulations, or (b) County becomes aware that Provider or any of its subcontractors or agents discloses PHI in a manner that is not authorized by County or by applicable law.

E. Provider has established internal policies and procedures regarding HIPAA compliance and privacy and agrees to make such policies and procedures available to County upon request.

6. **Conflict of Interest.** The Parties to this Agreement have read and are aware of the provisions of Section 1090, et seq. and Section 87100, et seq. of the Government Code relating to conflict of interest of public officers and employees. All Parties hereto agree that they are unaware of any financial or economic interest of any public officer or employee of County relating to this Agreement. It is further understood and agreed that if such a financial interest does exist at the inception of this Agreement, County may immediately terminate this Agreement by giving written notice thereof. County and Provider shall comply with the requirements of Government Code Section 87100, et seq. during the term of this Agreement.

7. **Disqualified Persons.** Provider represents and warrants that no person providing services under the terms of this Agreement (i) has been convicted of a criminal offense related to healthcare (unless such individual has been officially reinstated into the federal healthcare programs by the Office of Inspector General ("OIG") and provided proof of such reinstatement to County), (ii) is currently under sanction, exclusion or investigation (civil or criminal) by any federal or state enforcement, regulatory, administrative or licensing agency or is ineligible for federal or state program participation, or (iii) is currently listed on the General Services Administration List of Parties Excluded from the Federal Procurement and Non-Procurement Programs. Provider agrees that if any individual providing services under the terms of this Agreement becomes involved in a pending criminal action or proposed civil debarment, exclusion or other sanctioning action related to any federal or state healthcare program (each, an "**Enforcement Action**"), Provider shall immediately notify County and such individual shall be immediately removed by Provider from any functions involving (i) the claims development and submission process, and (ii) any healthcare provider contact related to patients; provided, however, that if Provider is directly involved in the Enforcement Action, any agreement between County and Provider shall terminate immediately.

8. **Entire Agreement – Amendments.** This Agreement supersedes any and all prior Fireline Paramedic agreements, either oral or written, between the Parties hereto with respect to the rendering of services by Provider pursuant to the terms and conditions of this Agreement and contains all the covenants and agreements between the Parties with respect to the rendering of such services. Each Party to this Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any Party, or anyone acting on behalf of any Party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Any modification of the Agreement shall be effective only if it is in writing and signed by the Parties.

9. **Indemnification.**

A. Provider agrees to defend and indemnify County from any and all claims, expenses, liability, attorneys' fees, damages, costs, losses, actions, or damages to property or injury or death, arising or alleged to have arisen from the care of persons pursuant to this Agreement from the time



Provider receives such persons into their care but only to the extent caused in whole or in part by acts, errors, or omissions of Provider.

B. Provider agrees to indemnify, hold harmless and defend (at County's option and request) County, its governing board, officers, employees, and agents, and each of them, from any and all losses, costs, expenses, claims, liabilities, attorneys' fees, actions or damages of any nature whatsoever including, without limitation, liability for injuries or death of any person or persons, or damages to any property, arising in any manner out of or in connection with or incident to or alleged to have arisen in any manner out of or to be connected with or incident to any act, error, or omission, willful, negligent or otherwise, on the part of Provider, its officers, employees, and agents in the performance of services under this Agreement, or in connection with or as a result of this Agreement.

C. County agrees to indemnify, hold harmless and defend (at Provider's option and request) Provider, its governing board, officers, employees, and agents, and each of them, from any and all losses, costs, expenses, claims, liabilities, attorneys' fees, actions or damages of any nature whatsoever including, without limitation, liability for injuries or death of any person or persons, or damages to any property, arising in any manner out of or in connection with or incident to or alleged to have arisen in any manner out of or to be connected with or incident to any act, error, or omission, willful, negligent or otherwise, on the part of County, its officers, employees, and agents in the performance of services under this Agreement, or in connection with or as a result of this Agreement.

10. **Independent Contractor.** It is understood that Provider is an independent contractor and is not an employee or agent of County. This Agreement is not intended and shall not be construed in any manner to create an employee-agency or master-servant relationship, nor does this Agreement create a partnership, joint venture, or association between County and Provider. No employee, officer, or agent, as the case may be, of Provider shall have any claim whatsoever against County under this Agreement or otherwise for compensation or benefits of any kind including, without limitation, vacation, sick leave, retirement, Social Security, Workers' Compensation, unemployment, or disability insurance benefits. It shall be the sole obligation of Provider to withhold the appropriate amounts of federal and State income taxes and Social Security taxes from employee compensation and to provide Workers' Compensation, disability and/or unemployment insurance for its employees as required by law.

11. **Insurance.** Provider, in order to protect County and its board members, officials, agents, officers, and employees against all claims and liability for death, injury, loss and damage as a result of Provider's actions in connection with the performance of Provider's obligations, as required in this Agreement, shall secure and maintain insurance as described below. Provider shall not perform any work under this Agreement until Provider has obtained all insurance required under this section and the required certificates of insurance and all required endorsements have been filed with County's authorized insurance representative, Insurance Tracking Services, Inc. ("ITS") via e-mail to COK@instracking.com or fax to (562) 513-5461. Receipt of evidence of insurance that does not comply with all applicable insurance requirements shall not constitute a waiver of the insurance requirements set forth herein. The required documents must be signed by the authorized representative of the insurance company shown on the certificate. Upon request, Provider shall supply proof that such person is an authorized representative thereof, and is authorized to bind the named underwriter(s) and their company to the coverage, limits and termination provisions shown thereon. Provider shall promptly deliver to ITS a certificate of insurance, and all required endorsements, with respect to each renewal policy, as necessary to demonstrate the maintenance of the required insurance coverage for the term specified herein. Such certificates and endorsements shall be delivered to ITS not less than thirty (30) days prior to the expiration date of any policy and bear a notation evidencing payment of the premium thereof if so requested. Provider shall immediately pay any deductibles and self-insured retentions under all required insurance policies upon the submission of any claim by Provider or County as an additional insured.

A. Workers' Compensation and Employers Liability Insurance Requirement B: In the event Provider has employees who may perform any services pursuant to this Agreement, Provider

shall submit written proof that Provider is insured against liability for workers' compensation in accordance with the provisions of section 3700 of the California Labor Code. Provider shall require any subcontractors to provide workers' compensation in accordance with State law for all of the subcontractors' employees. If any class of employees engaged in work or services performed under this Agreement is not covered by California Labor Code section 3700, Provider shall provide and/or require each sub-contractor to provide adequate insurance in accordance with State law for the coverage of employees not otherwise covered. Provider shall also maintain employer's liability insurance with limits of one million dollars (\$1,000,000) for bodily injury or disease.

B. Liability Insurance Requirements:

1) Provider shall maintain in full force and effect, at all times during the term of this Agreement, the following insurance:

(a) Commercial General Liability Insurance including, but not limited to, Contractual Liability Insurance (specifically concerning the indemnity provisions of this Agreement with the County), Personal Injury (including bodily injury and death), and Property Damage for liability arising out of Provider's performance of work under this Agreement. The amount of said insurance coverage required by this Agreement shall be the policy limits, which shall be at least one million dollars (\$1,000,000) each occurrence and three million dollars (\$3,000,000) aggregate.

(b) Automobile Liability Insurance against claims of Personal Injury (including bodily injury and death) and Property Damage covering any vehicle and/or all owned, leased, hired and non-owned vehicles used in the performance of services pursuant to this Agreement with coverage equal to the policy limits, which shall be at least one million dollars (\$1,000,000) each occurrence.

(c) Professional Liability (Errors and Omissions) Insurance, for liability arising out of, or in connection with, the performance of required Provider services under this Agreement, with coverage equal to the policy limits, which shall not be less than one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) aggregate. Provider affirms any physicians providing services under this Agreement are required to carry their own Professional Liability policy limits of one million dollars (\$1,000,000) and three million dollars (\$3,000,000) in the aggregate.

2) The Commercial General Liability and Automobile Liability Insurance required in this **sub-paragraph B** shall include an endorsement naming the County and County's board members, officials, officers, agents and employees as additional insured's for liability arising out of this Agreement and any operations related thereto. Said endorsement shall be provided using one of the following three options: (i) on ISO form CG 20 10 11 85; or (ii) on ISO form CG 20 37 10 01 plus either ISO form CG 20 10 10 01 or CG 20 33 10 01; or (iii) on such other forms which provide coverage at least equal to or better than form CG 20 10 11 85.

3) Any self-insured retentions in excess of one hundred thousand dollars (\$100,000) must be declared on the Certificate of Insurance or other documentation provided to County and must be approved by the County Risk Manager.

4) If any of the insurance coverages required under this Agreement is written on a claims-made basis, Provider, at Provider's option, shall either (i) maintain said coverage for at least three (3) years following the termination of this Agreement with coverage extending back to the effective date of this Agreement; (ii) purchase an extended reporting period of not less than three (3) years following the termination of this Agreement; or (iii) acquire a full prior acts provision on any renewal or replacement policy.

C. Prior to Provider commencing any of its obligations under this Agreement, evidence of insurance in compliance with the requirements above shall be furnished to the County by Certificate of Insurance. Receipt of evidence of insurance that does not comply with above requirements shall not constitute a waiver of the insurance requirements set forth above.

D. Cancellation of Insurance: The above stated insurance coverages required to be maintained by Provider shall be maintained until the completion of all of Provider's obligations under this Agreement except as otherwise indicated herein. Each insurance policy supplied by the Provider must be endorsed to provide that the coverage shall not be suspended, voided, cancelled, or reduced in coverage or in limits except after ten (10) days written notice in the case of non-payment

of premiums, or thirty (30) days written notice in all other cases. Such notice shall be by certified mail, return receipt requested. This notice requirement does not waive the insurance requirements stated herein. Provider shall immediately obtain replacement coverage for any insurance policy that is terminated, canceled, non-renewed, or whose policy limits have been exhausted or upon insolvency of the insurer that issued the policy.

E. All insurance shall be issued by a company or companies admitted to do business in California and listed in the current "Best's Key Rating Guide" publication with a minimum rating of "A-; VII". Any exception to these requirements must be approved by the County Risk Manager.

F. If Provider is, or becomes during the term of this Agreement, self-insured or a member of a self-insurance pool, Provider shall provide coverage substantially equivalent to the insurance coverages and endorsements required above. The County will not accept such coverage unless the County determines, in its sole discretion and by written acceptance, that the coverage proposed to be provided by Provider is equivalent to the above-required coverages.

G. As respects the acts, errors, and omissions of Provider, all insurance afforded by Provider pursuant to this Agreement shall be primary to and not contributing to all insurance or self-insurance maintained by the County. An endorsement shall be provided on all policies, except professional liability/errors and omissions, which shall waive any right of recovery (waiver of subrogation) against the County.

H. Insurance coverages in the minimum amounts set forth herein shall not be construed to relieve Provider for any liability, whether within, outside, or in excess of such coverage, and regardless of solvency or insolvency of the insurer that issues the coverage; nor shall it preclude the County from taking such other actions as are available to it under any other provision of this Agreement or otherwise in law.

I. Failure by Provider to maintain all such insurance in effect at all times required by this Agreement shall be a material breach of this Agreement by Provider, and County, at its sole option, may terminate this Agreement immediately.

12. **Notices.** Any notice given by either Party to the other under this Agreement shall be in writing, served by prepaid certified mail or personally upon the other Party, addressed as follows:

TO COUNTY:

Kern County Public Health Services Department  
Attn: Contracts Unit  
1800 Mt. Vernon Avenue  
Bakersfield, CA 93306-3302

TO PROVIDER:

Bakersfield City Clerk  
City of Bakersfield  
1600 Truxtun Avenue.  
Bakersfield, CA 93301

13. **Nondiscrimination.** Both Parties agree to abide by all applicable federal and State laws prohibiting discrimination against any employee, applicant for employment, or patient because of race, color, religion, sex, age, handicap, or place of national origin.

14. **Partial Invalidity.** If any provision in this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

15. **Governing Law.** The validity, construction and effect of the Agreement are governed by the laws of the State of California.

(The rest of this page has been intentionally left blank)

IN WITNESS WHEREOF, the Parties have entered into this Agreement as of the date first hereinabove written.

APPROVED AS TO CONTENT:  
**PUBLIC HEALTH SERVICES DEPARTMENT**

By:   
**Matt Constantine**, Director  
"DEPARTMENT"

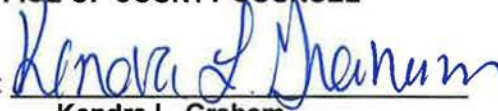
COUNTY OF KERN:

By:   
Chairman, Board of Supervisors  
"COUNTY"


PROVIDER:  
**CITY OF BAKERSFIELD**

By:   
**HARVEY L. HALL**, Mayor

APPROVED AS TO FORM:  
**OFFICE OF COUNTY COUNSEL**

By:   
**Kendra L. Graham**  
Deputy County Counsel

APPROVED AS TO CONTENT:  
**BAKERSFIELD FIRE DEPARTMENT**

By:   
**DOUGLAS R. GREENER**  
Fire Chief

APPROVED AS TO FORM:  
**VIRGINIA GENNARO**  
City Attorney

By:   
**JOSHUA H. RUDNICK**  
Deputy City Attorney

COUNTERSIGNED:

By:   
**NELSON SMITH**  
Finance Director

**EXHIBIT "A"**  
**BUSINESS ASSOCIATE AGREEMENT**

**THIS BUSINESS ASSOCIATE AGREEMENT** ("BAA") is by and between Kern County Public Health Services Department (Covered Entity ("CE")) and **CONTRACTOR** (Business Associate ("BA")).

**RECITALS:**

A. CE wishes to exchange certain information with BA pursuant to the terms of the Agreement, some of which may constitute Protected Health Information ("PHI") (defined below).

B. CE and BA intend to protect the privacy and provide for the security of PHI disclosed to BA pursuant to the Agreement in compliance with the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 ("HIPAA"), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 ("the HITECH Act"), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (the "HIPAA Regulations") and other applicable laws.

C. As part of the HIPAA Regulations, the Privacy Rule and the Security Rule (defined below) require CE to enter into a contract containing specific requirements with BA prior to the disclosure of PHI, as set forth in, but not limited to, Title 45, Sections 164.314(a), 164.502(e) and 164.504(e) of the Code of Federal Regulations ("CFR") and contained in this Exhibit.

In consideration of the mutual promises below and the exchange of information pursuant to this Agreement, the parties agree as follows:

1. **Definitions.**

**Catch-all definition:**

The following terms used in this Agreement shall have the same meaning as those terms in the HIPAA Rules: Breach, Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Minimum Necessary, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Security Incident, subcontractor, Unsecured Protected Health Information, and Use.

**Specific definitions:**

(a) **Business Associate.** "Business Associate" shall generally have the same meaning as the term "business associate" at 45 CFR 160.103, and in reference to the party to this Exhibit.

(b) **Covered Entity.** "Covered Entity" shall generally have the same meaning as the term "covered entity" at 45 CFR 160.103, and in reference to the party to this Exhibit.

(c) **HIPAA Rules.** "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and Part 164.

(d) **Electronic Health Record** shall have the meaning given to such term in the HITECH Act, including, but not limited to 42 U.S.C. Section 17921.

(e) **Privacy Rule** shall mean the HIPAA Regulation that is codified at 45 CFR Parts 160 and 164, Subparts A and E.

2. **Obligations and Activities of Business Associate.**

Business Associate agrees to:

(a) Not use or disclose protected health information other than as permitted or required by the Agreement or as required by law;

(b) Use appropriate safeguards, and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information, to prevent use or disclosure of protected health information other than as provided for by the Agreement;

(c) Report to covered entity any use or disclosure of protected health information not provided for by the Agreement of which it becomes aware, including breaches of unsecured protected health information as required at 45 CFR 164.410, and any security incident of which it becomes aware;

(d) In accordance with 45 CFR 164.502(e)(1)(ii) and 164.308(b)(2), if applicable, ensure that any subcontractors that create, receive, maintain, or transmit protected health information on behalf of the business associate agree to the same restrictions, conditions, and requirements that apply to the business associate with respect to such information;

(e) Make available protected health information in a designated record set to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.524;

(f) Make any amendment(s) to protected health information in a designated record set as directed or agreed to by the covered entity pursuant to 45 CFR 164.526, or take other measures as necessary to satisfy covered entity's obligations under 45 CFR 164.526;

(g) Maintain and make available the information required to provide an accounting of disclosures to the covered entity as necessary to satisfy covered entity's obligations under 45 CFR 164.528;

(h) To the extent the business associate is to carry out one or more of covered entity's obligation(s) under Subpart E of 45 CFR Part 164, comply with the requirements of Subpart E that apply to the covered entity in the performance of such obligation(s); and

(i) Make its internal practices, books, and records available to the Secretary of the U.S. Department of Health and Human Services (the "Secretary") for purposes of determining compliance with the HIPAA Rules.

**3. Permitted Uses and Disclosures by Business Associate.**

(a) Business associate may only use or disclose protected health information as necessary to perform the services set forth in the Agreement.

(b) Business associate may use or disclose protected health information as required by law.

(c) Business associate agrees to make uses and disclosures and requests for protected health information consistent with covered entity's minimum necessary policies and procedures.

(d) Business associate may not use or disclose protected health information in a manner that would violate Subpart E of 45 CFR Part 164 if done by covered entity except for the specific uses and disclosures set forth below.

(e) Business associate may use protected health information for the proper management and administration of the business associate or to carry out the legal responsibilities of the business associate.

(f) Business associate may disclose protected health information for the proper management and administration of business associate or to carry out the legal responsibilities of the business associate, provided the disclosures are required by law, or business associate obtains reasonable assurances from the person to whom the information is disclosed that the information will remain confidential and used or further disclosed only as required by law or for the purposes for which it was disclosed to the person, and the person notifies business associate of any instances of which it is aware in which the confidentiality of the information has been breached.

(g) Business associate may provide data aggregation services relating to the health care operations of the covered entity.

**4. Provisions for Covered Entity to Inform Business Associate of Privacy Practices and Restrictions.**

(a) Covered entity shall notify business associate of any limitation(s) in the notice of privacy practices of covered entity under 45 CFR 164.520, to the extent that such limitation may affect business associate's use or disclosure of protected health information.

(b) Covered entity shall notify business associate of any changes in, or revocation of, the permission by an individual to use or disclose his or her protected health information, to the extent that such changes may affect business associate's use or disclosure of protected health information.

(c) Covered entity shall notify business associate of any restriction on the use or disclosure of protected health information that covered entity has agreed to or is required to abide by under 45 CFR 164.522, to the extent that such restriction may affect business associate's use or disclosure of protected health information.

(d) Reporting of Improper Access, Use, or Disclosure. BA shall report to CE in writing of any access, use or disclosure of Protected Information not permitted by the Agreement, and any Breach of Unsecured PHI of which it becomes aware without unreasonable delay and in no case later than ten (10) calendar days after discovery [42 U.S.C. Section 17921; 45 CFR Section 164.504(e)(2)(ii)(C); 45 CFR Section 164.308(b)].

(e) Business Associate's Agents. BA shall ensure that any agents, including subcontractors, to whom it provides Protected Information, agree in writing to the same restrictions and conditions that apply to BA with respect to such PHI and implement the safeguards required by subsection c above with respect to Electronic PHI [45 CFR Section 164.504(e)(2)(ii)(D); 45 CFR Section 164.308(b)]. BA shall implement and maintain sanctions against agents and subcontractors that violate such restrictions and conditions and shall mitigate the effects of any such violation (see 45 CFR Sections 164.530(f) and 164.530(e)(1)).

(f) Amendment of PHI. If applicable within ten (10) days of receipt of a request from CE for an amendment of Protected Information or a record about an individual contained in a Designated Record Set, BA or its agents or subcontractors shall make such Protected Information available to CE for amendment and incorporate any such amendment to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.526. If any individual requests an amendment of Protected Information directly from BA or its agents or subcontractors. BA must notify CE in writing within five (5) days of the request. Any approval or denial of amendment of Protected Information maintained by BA or its agents or subcontractors shall be the responsibility of CE [45 CFR Section 164.504(e)(2)(ii)(F)].

(g) Accounting Rights. Within ten (10) days of notice by CE of a request for an accounting of disclosures of Protected Information, BA and its agents or subcontractors shall make available to CE the information required to provide an accounting of disclosures to enable CE to fulfill its obligations under the Privacy Rule, including, but not limited to, 45 CFR Section 164.528, and the HITECH Act, including but not limited to 42 U.S.C. Section 17935(c), as determined by CE. BA agrees to implement a process that allows for an accounting to be collected and maintained by BA and its agents or subcontractors for at least six (6) years prior to the request. However, accounting of disclosures from an Electronic Health Record for treatment, payment, or health care operations purposes are required to be collected and maintained for only three (3) years prior to the request, and only to the extent that BA maintains an electronic health record and is subject to this requirement. At a minimum, the information collected and maintained shall include: (i) the date of disclosure; (ii) the name of the entity or person who received Protected Information and, if known, the address of the entity or person; (iii) a brief description of Protected Information disclosed; and (iv) a brief statement of purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or a copy of the individual's authorization, or a copy of the written request for disclosure. In the event that the request for an accounting is delivered directly to BA or its agents or subcontractors, BA shall within five (5) days of a request forward it to CE in writing. It shall be CE's responsibility to prepare and deliver any such accounting requested. BA shall not disclose any Protected Information except as set forth in sections 2.b. of this Exhibit [45 CFR Sections 164.504(e)(2)(ii)(G) and 165.528]. The provisions of this subsection shall survive the termination of this Agreement.



(h) Governmental Access to Records. BA shall make its internal practices, books, and records relating to the use and disclosure of Protected Information available to CE and to the Secretary for purposes of determining BA's compliance with the Privacy Rule [45 C.F.R. Section 164.504(e)(2)(ii)(H)]. BA shall provide to CE a copy of any Protected Information that BA provides to the Secretary concurrently with providing such Protected Information to the Secretary.

(i) Data Ownership. BA acknowledges that BA has no ownership rights with respect to the Protected Information.

(j) Notification of Breach. During the term of the Agreement, BA shall notify CE within twenty-four (24) hours of any suspected or actual breach of security, intrusion or unauthorized use or disclosure of PHI of which BA becomes aware and/or any actual or suspected use or disclosure of data in violation of any applicable federal or state laws or regulations. BA shall take (i) prompt corrective action to cure any such deficiencies and (ii) any action pertaining to such unauthorized disclosure required by applicable federal and State laws and regulations.

(k) Breach Pattern or Practice by Covered Entity. Pursuant to 42 U.S.C. Section 17934(b), if the BA knows of a pattern of activity or practice of the CE that constitutes a material breach or violation of the CE's obligations under the Agreement, Exhibit, or other arrangement, the BA must take reasonable steps to cure the breach or end the violation. If the steps are unsuccessful, the BA must terminate the Agreement or other arrangement if feasible, or if termination is not feasible, report the problem to the Secretary of the U.S. Department of Health and Human Services ("DHHS"). BA shall provide written notice to CE of any pattern of activity or practice of CE that BA believes constitutes a material breach or violation of the CE's obligations under the Agreement, Exhibit, or other arrangement within five (5) days of discovery and shall meet with CE to discuss and attempt to resolve the problem as one of the reasonable steps to cure the breach or end the violation.

(l) Audits, Inspection and Enforcement. Within ten (10) days of a written request by CE, BA and its agents or subcontractors shall allow CE to conduct a reasonable inspection of the facilities, systems, books, records, agreements, policies and procedures relating to the use or disclosure of Protected Information pursuant to this Exhibit for the purpose of determining whether BA has complied with this Exhibit; provided, however, that (i) BA and CE shall mutually agree in advance upon the scope, timing, and location of such an inspection; (ii) CE shall protect the confidentiality of all confidential and proprietary information of BA to which CE has access during the course of such inspection; and (iii) CE shall execute a nondisclosure agreement, upon terms mutually agreed upon by the parties, if requested by BA. The fact that CE inspects, or fails to inspect, or has the right to inspect, BA's facilities, systems, books, records, agreements, policies and procedures does not relieve BA of its responsibility to comply with this Exhibit, nor does CE's (i) failure to detect or (ii) detection, but failure to notify BA or require BA's remediation of any unsatisfactory practices, constitute acceptance of such practice or a waiver of CE's enforcement rights under the Agreement or Exhibit, BA shall notify CE within ten (10) days of learning that BA has become the subject of an audit, compliance review, or complaint investigation by the Office for Civil Rights.

## 5. **Termination.**

a. Material Breach. A breach by BA of any provision of this Exhibit, as determined by CE, shall constitute a material breach of the Agreement and shall provide grounds for immediate termination of the Agreement, any provision in the Agreement to the contrary notwithstanding [45 CFR Section 164.504(e)(2)(iii)].

b. Judicial or Administrative Proceedings. CE may terminate the Agreement effective immediately, if (i) BA is named as a defendant in a criminal proceeding for a violation of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws or (ii) a finding or stipulation that the BA has violated any standard or requirement of HIPAA, the HITECH Act, the HIPAA Regulations or other security or privacy laws is made in any administrative or civil proceeding in which the party has been joined.

c. Obligations of Business Associate Upon Termination.

Upon termination of this Agreement for any reason, business associate, with respect to protected health information received from covered entity, or created, maintained, or received by business associate on behalf of covered entity, shall:

i. Retain only that protected health information which is necessary for business associate to continue its proper management and administration or to carry out its legal responsibilities;

ii. Return to covered entity the remaining protected health information that the business associate still maintains in any form;

iii. Continue to use appropriate safeguards and comply with Subpart C of 45 CFR Part 164 with respect to electronic protected health information to prevent use or disclosure of the protected health information, other than as provided for in this section, for as long as business associate retains the protected health information;

iv. Not use or disclose the protected health information retained by business associate other than for the purposes for which such protected health information was retained and subject to the same conditions set out in this Agreement above which applied prior to termination; and

v. Return to covered entity or, if agreed to by covered entity, destroy the protected health information retained by business associate when it is no longer needed by business associate for its proper management and administration or to carry out its legal responsibilities.

6. **Indemnification.** BA agrees to indemnify, defend and hold harmless County and County's agents, board members, elected and appointed officials and officers, employees, volunteers and authorized representatives from any and all losses, liabilities, charges, damages, claims, liens, causes of action, awards, judgments, costs, and expenses (including, but not limited to, reasonable attorneys' fees of County Counsel and counsel retained by County, expert fees, costs of staff time, and investigation costs) of whatever kind or nature, which arise out of or are in any way connected with any negligent act or omission of BA or BA's officers, agents, employees, independent BAs, subcontractor of any tier, or authorized representatives. Without limiting the

generality of the foregoing, the same shall include injury or death to any person or persons, damage to any property, regardless of where located, including the property of County; and any Workers' Compensation claim or suit arising from or connected with any services performed pursuant to this Agreement on behalf of BA by any person or entity.

7. **Disclaimer.** CE makes no warranty or representation that compliance by BA with this Exhibit, HIPAA, the HITECH Act, or the HIPAA Regulations will be adequate or satisfactory for BA's own purposes. BA is solely responsible for all decisions made by BA regarding the safeguarding of PHI.

8. **Certification.** To the extent that CE determines that such examination is necessary to comply with CE's legal obligations pursuant to HIPAA relating to certification of its security practices, CE or its authorized agents or contractors, may, at CE's expense, examine BA's facilities, systems, procedures and records as may be necessary for such agents or contractors to certify to CE the extent to which BA's security safeguards comply with HIPAA, the HITECH Act, the HIPAA Regulations or this Exhibit.

9. **Amendment.**

a. Amendment to Comply with Law. The parties acknowledge that State and federal laws relating to data security and privacy are rapidly evolving and that amendment of the Agreement or Exhibit may be required to provide for procedures to ensure compliance with such developments. The parties specifically agree to take such action as is necessary to implement the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule and other applicable laws relating to the security or confidentiality of PHI. The parties understand and agree that CE must receive satisfactory written assurance from BA that BA will adequately safeguard all Protected Information. Upon the request of either party, the other party agrees to promptly enter into negotiations concerning the terms of an amendment to this Exhibit embodying written assurances consistent with the standards and requirements of HIPAA, the HITECH Act, the Privacy Rule, the Security Rule or other applicable laws. CE may terminate the Agreement upon thirty (30) days written notice in the event (i) BA does not promptly enter into negotiations to amend the Agreement or Exhibit when requested by CE pursuant to this section or (ii) BA does not enter into an amendment to the Agreement or Exhibit providing assurances regarding the safeguarding of PHI that CE, in its sole discretion, deems sufficient to satisfy the standards and requirements of applicable laws.

10. **Assistance in Litigation or Administrative Proceedings.** BA shall make itself, and any subcontractors, employees, or agents assisting BA in the performance of its obligations under the Agreement or Exhibit, available to CE, at no cost to CE, to testify as witnesses, or otherwise, in the event of litigation or administrative proceedings being commenced against CE, its directors, officers, or employees based upon a claimed violation of HIPAA, the HITECH Act, The Privacy Rule, the Security Rule, or other laws relating to security and privacy, except where BA or its subcontractor, employee, or agent is a named adverse party.

11. **No Third-Party Beneficiaries.** Nothing express or implied in the Agreement or Exhibit is intended to confer, nor shall anything herein confer, upon any person other than CE, BA,

and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

12. **Effect on Agreement.** Except as specifically required to implement the purposes of this Exhibit, or to the extent inconsistent with this Exhibit, all other terms of the Agreement shall remain in force and effect.


13. **Interpretation.** The provisions of this Exhibit shall prevail over any provisions in the Agreement that may conflict or appear inconsistent with any provision in this Exhibit. This Exhibit and the Agreement shall be interpreted as broadly as necessary to implement and comply with HIPAA, the HITECH Act, the Privacy Rule, and the Security Rule. The parties agree that any ambiguity in this Exhibit shall be resolved in favor of a meaning that complies and is consistent with HIPAA, the HITECH Act, the Privacy Rule, and the Security Rule.

**WITNESS WHEREOF**, the parties hereto have duly executed this Addendum as of the Addendum Effective Date.

**COUNTY**

By:   
\_\_\_\_\_  
**Matthew Constantine**  
Director

**BUSINESS ASSOCIATE**

By:   
\_\_\_\_\_  
**Harvey Hall**  
Mayor

**BAKERSFIELD FIRE DEPARTMENT**

By:   
\_\_\_\_\_  
**DOUGLAS R. GREENER**  
Fire Chief

AGREEMENT FOR THE PROVISION  
OF  
FIRELINE PARAMEDIC PROGRAM  
(County of Kern – City of California City)

As of [date] OCT 15 2013 the COUNTY OF KERN, a political subdivision of the State of California (hereinafter “COUNTY”), and the city of California City (hereinafter “PROVIDER”), whose principal place of administration is located at 21000 Hacienda Boulevard, California City, CA 93505, agree as follows.

WITNESSETH:

Whereas, the Legislature of the State of California, through Division 2.5, Chapter 4, beginning at Section 1797 of the Health and Safety Code, also known as the “EMERGENCY MEDICAL SERVICES ACT” (hereinafter “EMS ACT”), delegates certain authority for the establishment, development, and regulation of emergency medical services, including paramedic first responder services, to counties;

Whereas, the Kern County Board of Supervisors (hereinafter “BOS”) created the Kern County Emergency Medical Services Division within the Public Health Services Department (hereinafter “DEPARTMENT”) to operate in the capacity of the Local Emergency Medical Services Agency (LEMSA) for COUNTY in accordance with the provisions of the California Health and Safety Code;

Whereas, the parties wish to enter into a written agreement for PROVIDER to participate in the EMS system with an ALS Fireline Paramedic Program (FEMP), in accordance with California Code of Regulations, Title 22, Article 7., Section 100168 (b) (4);

NOW, THEREFORE, IT IS MUTUALLY AGREED AS FOLLOWS:

1. TERM AND TERMINATION

- A. The term of this Agreement shall be effective as of the date first hereinabove written and shall remain in effect until withdrawn by either party according to the provisions of this Agreement. With or without cause, either party may terminate this Agreement at any time upon giving written notice to the other party not less than one hundred eight (180) days in advance of the proposed termination date.

- B. The COUNTY may immediately terminate this Agreement upon establishing:
- (1) PROVIDER non-compliance with the requirements of the latest version of the *Fireline Paramedic Policies and Procedures*, as determined by DEPARTMENT, subject to appeal to the Board of Supervisors; or
  - (2) Changes to State law or local requirements that materially change continued paramedic first responder services provided through PROVIDER, whereby the purpose of this AGREEMENT is overridden or rendered invalid; or
  - (3) PROVIDER'S failure to comply with any policy, procedure, or regulation mandated by the local, State, or federal government.

## 2. OBLIGATIONS OF THE PROVIDER

- A. PROVIDER may provide FEMP services, while deployed on wildland fire both within and outside of the county. Services shall be provided in accordance with the *Fireline Paramedic Policies and Procedures*. This agreement does not authorize PROVIDER to perform patient transport service.
- B. PROVIDER shall comply with the all requirements of the *Fireline Paramedic Policies and Procedures*, including scope of practice, deployment, documentation, quality improvement, inventory, and all other requirements of the policy.
- C. PROVIDER shall comply with Health and Safety Code, California Code of Regulations Title 22, and other EMS Division requirements.
- D. PROVIDER shall gain approval of any proposed expansion of FEMP services from the COUNTY, prior to any such expansion.

## 3. OBLIGATIONS OF THE DEPARTMENT

- A. DEPARTMENT shall provide medical control oversight of the program through the DEPARTMENT'S Medical Director in accordance with Health and Safety Code § 1979.202.
- B. DEPARTMENT shall provide a reasonable process for electronically reporting of required documentation, and DEPARTMENT shall periodically report to the public through its website PROVIDER's record of compliance with the *Fireline Paramedic Policies and Procedures*.

4. ASSIGNMENT OF AGREEMENT. PROVIDER shall not assign or transfer this Agreement or any interest in it without the prior written consent of County, and if any assignment is

approved, all provisions of this Agreement shall extend to and include the executors, administrators, heirs, and successors of PROVIDER as specified by County approval.

5. CONFIDENTIALITY - HIPAA/HITECH COMPLIANCE.

- A. During the term of this Agreement, PROVIDER may receive from County, or may receive or create on behalf of County certain confidential health or medical information (“Protected Health Information” or “PHI”). This PHI is subject to protection under State and federal law, including the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191 (“HIPAA”), the Health Information Technology for Economic and Clinical Health Act, Public Law 111-005 (“the HITECH Act”), and regulations promulgated thereunder by the U.S. Department of Health and Human Services (“HIPAA Regulations”) and other applicable laws. PROVIDER represents that it has in place policies and procedures that will adequately safeguard any PHI it receives or creates, and PROVIDER specifically agrees, on behalf of itself, its subcontractors and agents, to safeguard and protect the confidentiality of PHI consistent with applicable law, including currently effective provisions of HIPAA, the HITECH Act, and the HIPAA Regulations.
- B. For purposes of this section, PHI means any information, whether oral or recorded in any form or medium: (a) that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and (b) that identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.
- C. The parties acknowledge that State and federal laws relating to electronic data security and privacy are rapidly evolving and that amendment of this Agreement may be required to provide for procedures to ensure compliance with such developments. The parties hereto specifically agree to take such action as is necessary to implement the requirements of HIPAA, the HITECH Act, and HIPAA Regulations and other applicable laws relating to the security or confidentiality of PHI including but not limited to the incorporation of a Business Associate Agreement (BAA) attached as Exhibit "A" and incorporated herein by this reference. The parties understand and agree that PROVIDER must provide to County, after request by County, written evidence that PROVIDER is in compliance with the HITECH Act, and applicable HIPAA Regulations.
- D. Notwithstanding any other provision of this Agreement, County may terminate this Agreement upon twenty (20) days notice in the event: (a) PROVIDER does not promptly

provide written evidence of compliance with the HITECH Act, and applicable HIPAA Regulations, or (b) County becomes aware that PROVIDER or any of its subcontractors or agents discloses PHI in a manner that is not authorized by County or by applicable law.

- E. PROVIDER has established internal policies and procedures regarding HIPAA compliance and privacy and agrees to make such policies and procedures available to County upon request.
6. CONFLICT OF INTEREST. The parties to this Agreement have read and are aware of the provisions of Section 1090, et seq. and Section 87100, et seq. of the Government Code relating to conflict of interest of public officers and employees. All parties hereto agree that they are unaware of any financial or economic interest of any public officer or employee of County relating to this Agreement. It is further understood and agreed that if such a financial interest does exist at the inception of this Agreement, County may immediately terminate this Agreement by giving written notice thereof. County and PROVIDER shall comply with the requirements of Government Code Section 87100, et seq. during the term of this Agreement.
7. DISQUALIFIED PERSONS. PROVIDER represents and warrants that no person providing services under the terms of this Agreement (i) has been convicted of a criminal offense related to healthcare (unless such individual has been officially reinstated into the federal healthcare programs by the Office of Inspector General (“OIG”) and provided proof of such reinstatement to County), (ii) is currently under sanction, exclusion or investigation (civil or criminal) by any federal or state enforcement, regulatory, administrative or licensing agency or is ineligible for federal or state program participation, or (iii) is currently listed on the General Services Administration List of Parties Excluded from the Federal Procurement and Non-Procurement Programs. PROVIDER agrees that if any individual providing services under the terms of this Agreement becomes involved in a pending criminal action or proposed civil debarment, exclusion or other sanctioning action related to any federal or state healthcare program (each, an “Enforcement Action”), PROVIDER shall immediately notify County and such individual shall be immediately removed by PROVIDER from any functions involving (i) the claims development and submission process, and (ii) any healthcare provider contact related to patients; provided, however, that if PROVIDER is directly involved in the Enforcement Action, any agreement between County and PROVIDER shall terminate immediately.



8. ENTIRE AGREEMENT – AMENDMENTS. This Agreement supersedes any and all prior Fireline Paramedic agreements, either oral or written, between the parties hereto with respect to the rendering of services by PROVIDER pursuant to the terms and conditions of this Agreement and contains all the covenants and agreements between the parties with respect to the rendering of such services. Each party to this Agreement acknowledges that no representations, inducements, promises, or agreements, orally or otherwise, have been made by any party, or anyone acting on behalf of any party, which are not embodied herein, and that no other agreement, statement, or promise not contained in this Agreement shall be valid or binding. Any modification of the Agreement shall be effective only if it is in writing and signed by the parties.
  
9. INDEMNIFICATION.
  - A. PROVIDER agrees to indemnify County from any and all claims, expenses, liability, attorneys' fees, damages, costs, losses, actions, or damages to property or injury or death, arising or alleged to have arisen from the care of persons pursuant to this Agreement from the time PROVIDER arrives at scene of an incident but only to the extent caused in whole or in part by acts, errors, or omissions of PROVIDER.
  - B. PROVIDER agrees to indemnify, hold harmless and defend (at County's option and request) County, its governing board, officers, employees, and agents, and each of them, from any and all losses, costs, expenses, claims, liabilities, attorneys' fees, actions or damages of any nature whatsoever including, without limitation, liability for injuries or death of any person or persons, or damages to any property, arising in any manner out of or in connection with or incident to or alleged to have arisen in any manner out of or to be connected with or incident to any act, error, or omission, willful, negligent or otherwise, on the part of PROVIDER, its officers, employees, and agents in the performance of services under this Agreement, or in connection with or as a result of this Agreement.
  
10. INDEPENDENT CONTRACTOR. It is understood that PROVIDER is an independent contractor and is not an employee or agent of County. This Agreement is not intended and shall not be construed in any manner to create an employee-agency or master-servant relationship, nor does this Agreement create a partnership, joint venture, or association between County and PROVIDER. No employee, officer, or agent, as the case may be, of PROVIDER shall have any claim whatsoever against County under this Agreement or

otherwise for compensation or benefits of any kind including, without limitation, vacation, sick leave, retirement, Social Security, Workers' Compensation, unemployment, or disability insurance benefits. It shall be the sole obligation of PROVIDER to withhold the appropriate amounts of federal and State income taxes and Social Security taxes from employee compensation and to provide Workers' Compensation, disability and/or unemployment insurance for its employees as required by law.

11. INSURANCE. PROVIDER, in order to protect County and its board members, officials, agents, officers, and employees against all claims and liability for death, injury, loss and damage as a result of PROVIDER's actions in connection with the performance of PROVIDER's obligations, as required in this Agreement, shall secure and maintain insurance as described below. PROVIDER shall not perform any work under this Agreement until PROVIDER has obtained all insurance required under this section and the required certificates of insurance and all required endorsements have been filed with County's authorized insurance representative, Insurance Tracking Services, Inc. ("ITS") via e-mail to COK@instracking.com or fax to (562) 513-5461. Receipt of evidence of insurance that does not comply with all applicable insurance requirements shall not constitute a waiver of the insurance requirements set forth herein. The required documents must be signed by the authorized representative of the insurance company shown on the certificate. Upon request, PROVIDER shall supply proof that such person is an authorized representative thereof, and is authorized to bind the named underwriter(s) and their company to the coverage, limits and termination provisions shown thereon. PROVIDER shall promptly deliver to ITS a certificate of insurance, and all required endorsements, with respect to each renewal policy, as necessary to demonstrate the maintenance of the required insurance coverage for the term specified herein. Such certificates and endorsements shall be delivered to ITS not less than thirty (30) days prior to the expiration date of any policy and bear a notation evidencing payment of the premium thereof if so requested. PROVIDER shall immediately pay any deductibles and self-insured retentions under all required insurance policies upon the submission of any claim by PROVIDER or County as an additional insured.
  - A. Workers' Compensation and Employers Liability Insurance Requirement B: In the event PROVIDER has employees who may perform any services pursuant to this Agreement, PROVIDER shall submit written proof that PROVIDER is insured against liability for

workers' compensation in accordance with the provisions of section 3700 of the California Labor Code.

PROVIDER shall require any subcontractors to provide workers' compensation for all of the subcontractors' employees, unless the subcontractors' employees are covered by the insurance afforded by PROVIDER. If any class of employees engaged in work or services performed under this Agreement is not covered by California Labor Code section 3700, PROVIDER shall provide and/or require each sub-contractor to provide adequate insurance for the coverage of employees not otherwise covered.

PROVIDER shall also maintain employer's liability insurance with limits of one million dollars (\$1,000,000) for bodily injury or disease.

**B. Liability Insurance Requirements:**

- (1) PROVIDER shall maintain in full force and effect, at all times during the term of this Agreement, the following insurance:
  - (a) Commercial General Liability Insurance including, but not limited to, Contractual Liability Insurance (specifically concerning the indemnity provisions of this Agreement with the County), Products-Completed Operations Hazard, Personal Injury (including bodily injury and death), and Property Damage for liability arising out of PROVIDER's performance of work under this Agreement. The Commercial General Liability insurance shall contain no exclusions or limitation for independent contractors working on the behalf of the named insured. PROVIDER shall maintain the Products-Completed Operations Hazard coverage for the longest period allowed by law following termination of this Agreement. The amount of said insurance coverage required by this Agreement shall be the policy limits, which shall be at least one million dollars (\$1,000,000) each occurrence and two million dollars (\$2,000,000) aggregate.
  - (b) Automobile Liability Insurance against claims of Personal Injury (including bodily injury and death) and Property Damage covering any vehicle and/or all owned, leased, hired and non-owned vehicles used in the performance of services pursuant to this Agreement with coverage equal to the policy limits, which shall be at least one million dollars (\$1,000,000) each occurrence.

- (c) Professional Liability (Errors and Omissions) Insurance, for liability arising out of, or in connection with, the performance of all required services under this Agreement, with coverage equal to the policy limits, which shall not be less than one million dollars (\$1,000,000) per occurrence and two million dollars (\$2,000,000) aggregate.
  - (2) The Commercial General Liability and Automobile liability Insurance required in this subsection B. shall include an endorsement naming the County and County's board members, officials, officers, agents, and employees as additional insureds for liability arising out of this Agreement and any operations related thereto. Said endorsement shall be provided on ISO form CG 20 10 Edition date 11/85 or such other forms which provide coverage at least equal to or better than form CG 20 10 11 85.
  - (3) Any self-insured retentions in excess of ten thousand dollars (\$10,000) must be declared on the Certificate of Insurance or other documentation provided to County and must be approved by the County Risk Manager.
  - (4) If any of the insurance coverage required under this Agreement is written on a claims-made basis, PROVIDER, at PROVIDER's option, shall either (i) maintain said coverage for at least three (3) years following the termination of this Agreement with coverage extending back to the effective date of this Agreement; (ii) purchase an extended reporting period of not less than three (3) years following the termination of this Agreement; or (iii) acquire a full prior acts provision on any renewal or replacement policy.
- C. Cancellation of Insurance: The above stated insurance coverage required to be maintained by PROVIDER shall be maintained until the completion of all of PROVIDER's obligations under this Agreement except as otherwise indicated herein. Each insurance policy supplied by the PROVIDER must be endorsed to provide that the coverage shall not be suspended, voided, cancelled, or reduced in coverage or in limits except after ten (10) days written notice in the case of non-payment of premiums, or thirty (30) days written notice in all other cases. Such notice shall be by certified mail, return receipt requested. This notice requirement does not waive the insurance requirements stated herein. PROVIDER shall immediately obtain replacement coverage for any insurance policy that is terminated, canceled, non-renewed, or whose policy limits have been exhausted or upon insolvency of the insurer that issued the policy.

- D. All insurance shall be issued by a company or companies admitted to do business in California and listed in the current "Best's Key Rating Guide" publication with a minimum rating of "A-; VII". Any exception to these requirements must be approved by the County Risk Manager.
  - E. If PROVIDER is, or becomes during the term of this Agreement, self-insured or a member of a self-insurance pool, PROVIDER shall provide coverage equivalent to the insurance coverage and endorsements required above. The County will not accept such coverage unless the County determines, in its sole discretion and by written acceptance, that the coverage proposed to be provided by PROVIDER is equivalent to the above-required coverage.
  - F. All insurance afforded by PROVIDER pursuant to this Agreement shall be primary to and not contributing to all insurance or self-insurance maintained by the County. An endorsement shall be provided on all policies, except professional liability/errors and omissions, which shall waive any right of recovery (waiver of subrogation) against the County.
  - G. Insurance coverage in the minimum amounts set forth herein shall not be construed to relieve PROVIDER for any liability, whether within, outside, or in excess of such coverage, and regardless of solvency or insolvency of the insurer that issues the coverage; nor shall it preclude the County from taking such other actions as are available to it under any other provision of this Agreement or otherwise in law.
  - H. Failure by PROVIDER to maintain all such insurance in effect at all times required by this Agreement shall be a material breach of this Agreement by PROVIDER, and County, at its sole option, may terminate this Agreement immediately.
12. NOTICES. Any notice given by either party to the other under this Agreement shall be in writing, served by prepaid certified mail or personally upon the other party, addressed as follows:

TO COUNTY:

Director  
Kern County Public Health Services Dept.  
1800 Mt. Vernon Avenue  
Bakersfield, CA 93306

To PROVIDER:

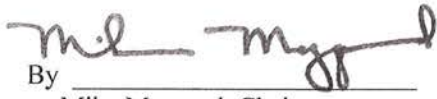
California City Manager  
California City  
21000 Hacienda Boulevard  
California City, CA 93505

13. NONDISCRIMINATION. Both parties agree to abide by all applicable federal and State laws prohibiting discrimination against any employee, applicant for employment, or patient because of race, color, religion, sex, age, handicap, or place of national origin.
14. PARTIAL INVALIDITY. If any provision in this Agreement is held by a court of competent jurisdiction to be invalid, void, or unenforceable, the remaining provisions shall nevertheless continue in full force without being impaired or invalidated in any way.

The remainder of this page is intentionally left blank.

IN WITNESS WHEREOF, the parties have entered into this AGREEMENT as of the date first hereinabove written.

COUNTY:  
COUNTY OF KERN

By   
Mike Maggard, Chairman,  
Board of Supervisors

PROVIDER:  
CITY OF CALIFORNIA CITY

By   
Tom Weil, City Manager

APPROVED AS TO CONTENT:  
EMERGENCY MEDICAL SERVICES  
DIVISION

By   
Matthew Constantine, Director

APPROVED AS TO FORM:  
OFFICE OF COUNTY COUNSEL

By   
Gurujodha Khalsa, Deputy

## ***STEMI System of Care Policy (4003.00)***

### **PURPOSE**

This policy defines the requirements for designation as a STEMI Receiving Center (SRC) in Kern County and establishes the concept of operations of the STEMI System of Care.

### **AUTHORITY**

- A. Health and Safety Code, Division 2.5, Sections 1797.67, 1797.88, 1797.220, 1798, 1798.170

### **DEFINITIONS**

- A. “Percutaneous Coronary Intervention” (PCI): A broad group of percutaneous techniques used for the diagnosis and treatment of patients with STEMI.
- B. “EMS Division” or “County”: the Kern County Public Health Services Department, Emergency Medical Services Division.
- C. “EMS System”: a specially organized arrangement that provides for the personnel, facilities, and equipment for the effective and coordinated delivery in an EMS area of medical care services under emergency conditions.
- D. “STEMI”: Any patient with an acute myocardial infarction that generates ST-segment elevation on a 12-lead ECG of greater than 1mm in 2 contiguous leads and/or prehospital 12-lead computer interpretation of \*\*\*Acute MI\*\*\* / STEMI.
- E. “STEMI System of Care”: an integrated prehospital and hospital program that is intended to direct patients with field identified ST Segment Elevation Myocardial Infarction directly to hospitals with specialized capabilities to promptly treat these patients.
- F. EMS “STEMI Alert”: A prehospital activation that notifies a STEMI Receiving Center, as early as possible (goal  $\leq$  10 minutes from FMC), of a patient with a SRH STEMI Alert allows the SRC to activate the internal STEMI processes. to provide appropriate and rapid treatment interventions.
- G. “STEMI Receiving Center” (SRC): An acute care hospital designated by the Local EMS Agency that is capable of appropriately treating a patient having a STEMI with PCI and other interventional cardiology procedures to restore circulation to a blocked artery.



- H. "STEMI Referral Hospital" (SRH): An acute care hospital in the County that is not designated as a STEMI Receiving Center contacts the SRC for STEMI Alert by calling the SRC hotlines and implements rapid initial interventions and rapid door-in/door-out transfer to the SRC.
- I.
- J. "STEMI QI Committee": the multi-disciplinary peer-review committee, composed of representatives as specified in this policy, which monitors and analyzes the STEMI System of Care metrics, makes recommendations for STEMI system for process, performance, and quality improvements, and functions in an advisory capacity to the EMS Division.

## DESIGNATION

- A. Hospitals seeking formal designation as SRC shall meet the following requirements:
  - 1. Possess current California licensure as an acute care hospital providing Basic Emergency Medical Services, and possess a special permit for cardiac surgery service, including catheterization laboratory pursuant to the provisions of Title 22, Division 5, Chapter 1, Article 5 of the California Code of Regulations.
  - 2. Possess a current designation and valid contract with the County as a Paramedic Base Hospital, as part of the EMS System.
  - 3. Maintains current *accreditation with an EMS approved body*. Accept the Kern County STEMI System of Care Memorandum of Understanding for STEMI transfers whereby SRC agrees to immediately and rapidly accept the transfer of a STEMI Patient from the transferring SRH/SRC upon notification of STEMI ALERT and request by the SRH/SRC-affiliated physician.
- B. Any designated SRC hospital which is unable to meet the following requirements shall be subject to a deficiency notice and plan of action and/or termination of designation Inability to maintain Designation criteria, listed in A., above, or
  - 1. Failure to meet the SRC Performance Standards, listed below and as may be amended from time to time, or
  - 2. Failure to comply with any Local, State, or Federal Government policy, procedure, or regulation of the STEMI System of Care.

If the EMS Division finds a SRC to be deficient in meeting the above criteria, the EMS Division will give the SRC written notice, return receipt requested, setting forth with

reasonable specificity the nature of the apparent deficiency. Within ten (10) calendar days of receipt of such notice, the SRC must deliver to the EMS Division, in writing, a plan to cure the deficiency, or a statement of reasons why it disagrees with the EMS Division's notice. If the Hospital fails to cure the deficiency within 90 days or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication for possible Interim Designation. EMCAB may make a recommendation to the EMS Division for resolving the issue.

## **INTERIM DESIGNATION**

A hospital meeting all of the Designation criteria listed in Section A., above except No. 3 (*accreditation as approved by EMS n*) may be granted an SRC designation on an interim basis. The interim designation shall allow the hospital to receive STEMI Patients by ambulance. The interim designation time period shall be specified in the SRC agreement with the County of Kern, and the time period shall not exceed 18 months.

Interim Designation allows a hospital seeking accreditation to participate as an SRC Designated facility. All performance standards are applicable to a hospital with Interim Designation, and the SRC application process for Interim Designation shall be the same as the application process for SRC Designation.

## **APPLICATION PROCESS FOR SRC DESIGNATION**

- A. The following milestones outline the application process for a hospital to become designated as a STEMI Receiving Center.
  1. Review list of requirements and checklist of documents, found at *Appendix B - STEMI Receiving Center Designation Criteria Application and Evaluation Tool*, which must be compiled and submitted with the application.
  2. Submit letter of application to the EMS Division. The letter will contain:
    - a. Specify intent to obtain SRC designation;
    - b. Identify the names and contact information, including email addresses for the key STEMI personnel: the STEMI Medical Director, RN Program Manager, and Administrative contact;
    - c. Identify the anticipated target date for SRC designation; and
    - d. List of supporting documents being submitted with the letter to fulfill the designation requirements.

3. Compile and submit to the EMS Division all information and documents requested in *Appendix B*, Column 2, “objective measurement” of the *STEMI Receiving Center Designation Criteria Application and Evaluation Tool*.
4. All application materials will be reviewed for completeness. Additional information will be requested, if needed. Upon determination that the application is complete, the applicant and EMS Division will work towards execution of the designation agreement.
5. STEMI Center Designation agreement will be presented to the Board of Supervisors for approval and formal designation.

### **SRC PERFORMANCE STANDARDS**

Hospitals obtaining SRC designation meet a high standard of cardiac care. The SRC ensures that the clinical processes, equipment, and personnel are in place to provide a higher standard of care than that available at a non-designated facility. The performance standards listed below are intended to reflect the accreditation requirements and to ensure that each designated SRC continually strives to meet each of these standards.

- A. SRC designated hospitals shall be in continuous compliance with the following general standards:
  1. HOSPITAL shall provide for the triage and treatment of simultaneously presenting STEMI patients regardless of ICU/CCU or ED overload status.
  2. HOSPITAL shall provide STEMI Receiving Center services to any STEMI Patient that comes to the emergency department, regardless of the STEMI Patient’s ability to pay physician fees and/or hospital costs. For the purpose of this Agreement, the phrase “comes to the emergency department” shall have the same meaning as set forth in the Emergency Medical Treatment and Active Labor Act (42 U.S.C § 1395dd) and the regulations promulgated thereunder (EMTALA).
  3. HOSPITAL shall notify the EMS Division within twenty-four (24) hours of any failure to meet STEMI Designation Policy performance standards. Hospital will identify its action to correct the deficiency.
  4. HOSPITAL shall maintain a designated telephone number (Hotline) to facilitate rapid interfacility transfer and access to SRC physician for consultation with SRH physicians and other providers regarding care and transfer of STEMI Patients.

5. HOSPITAL shall accept all STEMI patients from SRH facilities, within the County, upon notification of “STEMI ALERT” and request by the transferring physician.
  6. HOSPITAL shall actively and cooperatively participate in the “STEMI QI Committee,” and such other related committees that may, from time to time, be named and organized by the EMS Division related to the STEMI System of Care.
  7. HOSPITAL shall maintain an agreement with the nationally –recognized STEMI database approved by EMS, and agree to allow for the release of all STEMI data directly from said database to EMS for the purpose of oversight, to produce System reports. HOSPITAL shall collect, maintain, and report any additional data points adopted by the STEMI QI Committee and/or mandated by EMS.
- B. SRC designated hospitals shall be in continuous compliance with the following service standards:
1. Maintain intra-aortic balloon pump and Impella capability with necessary staff at all times.
  2. Possess a California permit for cardiovascular surgery, *or* have a written plan for emergency transport to a facility with cardiovascular surgery available within 1 hour of transfer. If the facility does not have a cardiovascular surgery permit, a transfer agreement with the cardiovascular surgery facility shall be in full effect.
  3. Provide continuous availability of PCI resources at all times.
- C. SRC designated hospitals shall be in continuous compliance with the following personnel standards:
1. SRC Medical Director - The SRC shall designate a medical director for the STEMI program who shall be a physician certified by the American Board of Internal Medicine (ABIM) with current ABIM sub-specialty certification in Cardiovascular Disease and Interventional Cardiology, who will ensure compliance with these SRC standards and perform ongoing Quality Improvement (QI) as part of the hospital and system QI Program.
  2. SRC Program Manager - The SRC shall designate a program manager for the STEMI program who shall be a registered nurse with experience in Emergency Medicine or Cardiovascular Care, who shall collaborate with the SRC Medical Director to oversee and ensure compliance with these SRC standards and the QI program.

3. Cardiovascular Lab Coordinator - The SRC shall have a Cardiovascular Lab Coordinator who shall assist the SRC Medical Director and the SRC Program Manager to ensure compliance with these SRC Standards and the QI Program.
4. Interventional Cardiologists (IC) – Specialty trained physicians with privileges for SRC and credentialed by the hospital in accordance with the American College of Cardiology/American Heart Association national standards.
  - i. The SRC shall maintain a daily roster of STEMI on-call physicians who must be present within 30 minutes or less when a STEMI patient presents to the hospital or notification of “STEMI Alert” is received from pre-hospital personnel via radio or telephone communications or SRH ED physician, whichever occurs first.
  - ii. The on-call physician can take call only at one facility at a time unless has a backup cardiologist and/or team that can immediately step in if simultaneous activations occur at both locations.  
*Any group or back up cardiologist must be available at a single phone number.*
5. Other personnel who must be promptly available and present in the SRC within 30 minutes of the activation of the SRC’s internal STEMI/PCI system including:
  - i. Appropriate cardiac catheterization nursing and support personnel.
  - ii. RN or CV perfusionist trained in intra-aortic balloon pump management.

D. SRC designated hospitals shall comply with the clinical performance standards:

1. The SRC attains and maintains specialty accreditation by an EMS approved accrediting body, which is an indicator of competency and high performance.
  - i. Cardiac Catheterization Laboratory Standards per Title 22
2. Performance (timeliness) and outcome measures will be assessed initially in the accreditation process, and will be monitored closely on an ongoing basis by the SRC and the EMS Division through the STEMI QI Committee.
3. The SRC shall develop internal operational policies and procedures which includes the following activities/areas:
  - i. Cardiac interventionist activation

- ii. Cardiac catheterization lab team activation
- iii. STEMI contingency plans for personnel and equipment
- iv. Coronary angiography
- v. PCI and use of fibrinolytics
- vi. Inter-facility transfer policies/protocols for STEMI
- vii. Transfer agreements for cardiac surgery, as appropriate If not available at SRC
- viii. STEMI patient triage

E. SRC designated hospitals shall participate in performance improvement program for EMS Patients including:

1. An SRC shall provide the following representatives to participate in the countywide EMS Division STEMI QI Committee:
  - i. The SRC Medical Director
  - ii. The SRC Program Manager
  - iii. One QI staff member
2. The countywide STEMI QI Committee will hold regular multidisciplinary meetings that include representatives from each STEMI Receiving Center (SRC), each STEMI Referral Hospital (SRH), prehospital providers, and representatives from EMS. In order to maintain STEMI designation, all SRC facilities must attend a minimum of 75% of all committee meetings. An SRC shall implement a written internal SRC QI plan/program with an internal review process that includes:
  - i. Door-to Balloon times
  - ii. Death rate (within 30 days, related to procedure regardless of mechanism)
  - iii. Emergency CABG rate (result of procedure failure or complication)
  - iv. Vascular complications (access site, transfusion, coronary perforation or operative intervention required)
  - v. Cerebrovascular accident rate (peri-procedure)
  - vi. Sentinel event, system and organization issue review and resolution processes

3. An SRC shall participate in prehospital STEMI-related educational activities as may be required by the EMS Division
- F. SRC designated hospitals shall be in continuous compliance with the following data collection, submission, and analysis standards:
1. An SRC shall participate in data collection as defined in Appendix A: *Mandatory Data Elements for STEMI Receiving Centers*. Data element requirements are subject to change at Division's discretion.
  2. Data shall be used for quality improvement purposes by the STEMI QI Committee, and data submitted by SRC and SRH facilities is considered to confidential under the provisions of Evidence Code Section 1157.7.
  3. The Division may publicly report aggregated data about the STEMI system which is derived from any of the individual data elements.

### **EMS DIVISION Performance Standards**

KC EMS will:

1. Facilitate collaborative leadership and consensus among all stakeholders of the KC STEMI System of Care
2. Provide minutes and sign-in sheets for all meetings within 2 weeks of next meeting
3. Participate in CPC accreditation activities with each SRC
4. Initiate and maintain transfer agreements among all Kern County System of Care hospitals

### **CONCEPT OF OPERATIONS OF THE STEMI SYSTEM OF CARE**

#### **A. Pre-Hospital: Ambulance/Paramedic Responsibilities**

1. 12-Lead ECG: Upon an assessment finding of possible cardiac origin, paramedic shall conduct a 12-Lead ECG, if ambulance is so equipped.
2. 12-Lead ECG monitor will display a finding. Paramedic will use the finding provided by the monitor to determine if the patient is positive for STEMI \*\*\*Suspected Acute MI\*\*\*.
  - i. The ECG should be repeated frequently during prolonged transports for patients with ongoing chest pain but no STEMI finding on initial 12-lead to assess for evolving STEMI
3. STEMI Alert Early Notification: Upon receiving a positive STEMI finding on the 12-Lead ECG monitor, paramedic shall immediately contact the

destination hospital and issue a “STEMI ALERT”. The goal for STEMI Alert activation is 10 minutes or less. Paramedic will send the 12-Lead report to the E.D., if equipment is capable.

4. Destination: parameters for STEMI patient
    - i. Positive STEMI read on ECG monitor goes to closest, most appropriate SRC
    - ii. If anticipated transport time is greater than 60 minutes to SRC, and another hospital is closer, patient shall be transported to closest hospital
  5. Paramedic shall follow appropriate treatment protocols during transport
- B. Hospital Relationships and Coordination
1. Transfer Agreements/Requirements
    - i. Rapid Transfer – SRC Automatic Acceptance of STEMI Patient from Transferring Hospital per the KC STEMI System of Care inter-facility memorandum of agreement.
  2. Each STEMI Receiving Center (SRC) agrees to accept all “STEMI ALERT” patients from any Non-PCI Hospital (SRH) located within Kern County. Specific Language to initiate rapid transfer
    - i. The term, “STEMI ALERT” will be used by paramedics as well as STEMI Referring Hospital (SRH) staff in order to notify the SRC of an incoming STEMI patient. “STEMI ALERT” shall be understood by all hospital staff as well as ambulance dispatchers to mean an emergent cardiac event is in progress with rapid treatment and transport necessary.
  3. Standardized treatment protocol for non-STEMI hospitals
    - ii. SRC and SRH will collaborate in the development, implementation, and monitoring of treatment procedure/protocols for the Non-PCI hospitals (SRH) within the County.
    - iii. The STEMI System of Care will operate as a cohesive and comprehensive organization to consistently address the needs of the STEMI Patient by implementing best practice standards, regardless of the point of entry into the system.



### C. Community STEMI Education

1. Awareness - It is imperative that each SRC and SRH recognize the need for community awareness as we work together to improve heart health in Kern County.
2. Actions to take - Each SRC and SRH must be active participants in and working together to promote public awareness activities, i.e. public service announcements, print ads, community events, task forces and classes. Education should focus on Early Heart Attack Care (EHAC) and the “Chain of Survival” for a heart attack and sudden cardiac arrest, and include:
  - i. Recognition of a cardiac emergency
  - ii. Calling “911” immediately because “time is muscle” and “EMS brings the emergency room to the patient”
  - iii. Initiation of hands-only CPR through use of appropriate chest compressions
  - iv. Use of an automated external defibrillator (AED)
3. Other community education themes might include:
  - i. Hands-only CPR training including Side-walk CPR Day
  - ii. Risk factors for cardiovascular disease
  - iii. Symptoms and signs of acute coronary syndrome (ACS)
  - iv. Early warning or prodromal symptoms
  - v. Less common or atypical heart attack presentations
  - vi. Importance of calling 911
  - vii. Female ACS presentations
4. Public Reporting of Performance Data - A large part of public awareness begins with data reporting. Pertinent aggregated STEMI System data showing the performance of the STEMI System of Care shall be posted publicly. The following aggregated performance measurements will be publicly released, and additional reports may published upon recommendation of the STEMI QI Committee.
  - i. Symptom onset time to EMS Call Time
  - ii. EMS first medical contact (FMC) time to First 12-Lead ECG Time
  - iii. EMS First 12-Lead time to contact SRC

- iv. E.D. arrival time
- v. E.D. arrival time to Cath Lab Activation time
- vi. Cath Lab Activation time to Cath Lab Arrival Time
- vii. E.D. Door to PCI /Balloon Time
- viii. First Medical Contact to PCI/balloon time
- ix. SRH door-in to door-out time
- x. SRH door-in time to PCI time
- xi. Door to needle time

## **Appendix A - Mandatory Data Elements for STEMI Receiving Centers**

HOSPITAL shall maintain a STEMI Database and submit the data elements to an EMS approved national registry, at established time intervals in order to produce reports. Each SRC shall submit data elements that achieves compliance with the Premier level data and reporting standard. HOSPITAL shall, collect maintain, and report any additional data points adopted by the STEMI QI Committee or mandated by EMS.

## APPENDIX B - STEMI Receiving Center Designation Criteria Application and Evaluation Tool

Column 1	Column 2	Column 3	Column 4
STEMI Designation Contract Standard	Objective Measurement	Meets Standards	Comments
<b>HOSPITAL SERVICES</b>			
Current license to provide Basic Emergency Services in Kern County	Copy of License	Y    N	Required for designation & renewal
Current Certification to operate as a Paramedic Base Station in Kern County		Y    N	Required for designation & renewal
Cardiac Catheterization Laboratory Services & Required Services	Copy of License. Number Cardiac Catheterization Labs ___ on License	Y    N	Required for designation & renewal
Intra-aortic balloon pump capability with staffing available to operate 24/7/365	Intra-aortic balloon pump capability # patients: _____ Staffing policies/protocols supporting operations	Y    N	Required for designation
Inter-facility TRANSFER GUIDELINES or COOPERATIVE ARRANGEMENTS	Description of current cooperative practice or copy of supporting policies, procedures or guidelines. List all hospitals collaborating with and for what type services	Y    N	Required for designation List of facilities and description of cooperative arrangements (SRC's and Non STEMI centers) for CV surgery and PCI interventions within STEMI time frame standards
California permit for cardiovascular surgery	CA permit number and effective and expiration dates. Number of Operating Suites on License	Y    N	<b>Desired not required</b> ACC/AHA Guideline conformance for centers without back up CV surgery will be evaluated in consideration of waiver by EMS medical director Required for designation & renewal

If no cardiac surgery capability, must have: Plan for emergency transfer	Plan, Policy, Procedure with estimated travel time	Y	N	Required for designation. Hospitals without surgical services: Written guidelines or description of current processes for rapid transfer of patients requiring additional care. Including elective or emergency cardiac surgery or PCI. Required for designation & renewal Required for designation & renewal
Plan to transfer within 1 hour	Supporting policies and procedures	Y	N	Required if no CV Surgery Required for designation & renewal
Written transfer guidelines for service	Transfer policies and procedures	Y	N	Required if no CV Surgery Required for designation & renewal
Continuous availability of PCI resources 24 hours a day 7 days a week 365 days a year.	On-Call Schedules for 3 months. On-Call Policy/Procedure	Y	N	Required for designation & Renewal
<b>HOSPITAL PERSONNEL</b>				
SRC PROGRAM MEDICAL DIRECTOR Responsibilities: 1. Oversight of STEMI program patient Care 2. Coordinating staff and services 3. Authority and accountability for quality /performance improvement 4. Participates in protocol development 5. Establishes and monitors quality control, including Mortality and Morbidity 6. Voting Member Cardiac Audit Committee	Copy of Current Board Certification  Copy of Job Description	Y	N	Required for designation & Renewal



	documentation showing primary and total PCI volume, per physician for previous 12 months			ACC/AHA Recommendations:  11 Primary PCI / 75 PCI Cases  This requirement may be met based on activity at more than one hospital
Process Performance:	Door to balloon inflation times for previous 12 months	Y	N	Required for designation ACC/AHA Recommendations: Door to balloon inflation times <90 minutes (75% compliance)
<b>POLICIES AND PROCEDURES</b>				
Comprehensive STEMI policy outlining the STEMI processes with contingency and back-up plans. Interventional Cardiologist Activation	Policy/Procedure	Y	N	Required for designation & Renewal
Cardiac catheterization laboratory team activation	Policy/Procedure	Y	N	Required for designation
STEMI contingency plans 1. Personnel 2. Cath Lab facility & equipment	Pertinent policy & procedures to minimize disruption	Y	N	Required for designation Expectation of NO DIVERSION
Coronary angiography	Policy, Procedure, and/or Guidelines	Y	N	Required for designation
PCI and use of fibrinolytics	Policy, Procedure, and/or Guidelines	Y	N	Required for designation Process by which fibrinolytic therapy and PCI can be delivered rapidly to meet the following goals: Fibrinolytics within 30 minutes of ED and Door-to-balloon time within 90 minutes of ED arrival.
Interfacility transfer for STEMI policies or protocols	Policy, Procedure, and/or Guidelines	Y	N	Required for designation
<b>PERFORMANCE IMPROVEMENT</b>				
Systematic Internal Review Program consistent with accreditation	Review protocol/program description to deal with:	Y	N	Policy and procedure or program description only required for initial designation Ongoing expectation
KC STEMI System of Care performance improvement program	Door-to-Balloon times			

	<p>Deaths</p> <p>Emergency CABG</p> <p>Vascular complications</p> <p>Sentinel event</p> <p>System issues</p> <p>Organizational issue</p>			
Systematic Prehospital Review Program	<p>Written quality improvement plan or program description for EMS-transported STEMI patients supporting:</p> <p>Timely prehospital feedback,</p> <p>Prehospital provider education,</p> <p>Cooperative STEMI QI data management</p>	Y	N	<p>QI plan or policy only required for initial designation</p> <p>Ongoing expectation</p> <p>Data Collection and Management based on STEMI EMS data elements</p>
Mechanism to participate in timely outcome field feedback of STEMI patients	Participation in Field QI process	Y	N	<p>EMS to act as point agency to facilitate communication of outcome information for field QI.</p> <p>Ongoing expectation</p>
Prehospital STEMI related educational activities	<p>Commitment to STEMI Prehospital Education Plan for prehospital education activities</p>	Y	N	<p>Plan required for initial designation</p> <p>Ongoing expectation</p>



DATA COLLECTION, SUBMISSION AND	ANALYSIS		
Participation in Kern County EMS data collection	Document agreeing to provide data elements deemed mandatory by Kern County EMS	Y    N	Name and contact information of responsible personnel required for designation

## APPENDIX C - STEMI QI Committee Purpose and Structure

### PURPOSE

Care of the STEMI patient requires a system approach to ensure optimal care. To assist the KC STEMI System of Care in its quest to achieve best care possible, the STEMI QI Committee shall assess, monitor, and facilitate the Quality Improvement (QI) process for the Kern County STEMI Centers.

### AUTHORITY

Health and Safety Code Division 2.5  
California Evidence Code, Section 1157.7  
California Civil Code, Part 2.6, Section 56

### DEFINITION

“STEMI QI Committee” means the multi-disciplinary peer-review committee, composed of representatives from the EMS, STEMI Receiving Centers, STEMI Referral Hospitals, Prehospital care providers, which monitors the STEMI Care System, makes recommendations for system improvements, and functions in an advisory capacity on other STEMI Care System issues.

### COMMITTEE MEMBERSHIP

1. Membership Composition
  - a. SRC Members:
    - i. SRC Medical Director
    - ii. SRC E.D. Director
    - iii. SRC Program Manager
  - b. SRH Members:
    - i. E.D. Medical Director
    - ii. E.D. Director
  - c. Prehospital Members:
    - i. Operations Manager
    - ii. Provider Medical Director
    - iii. Field Supervisor
    - iv. Field Paramedic
  - d. EMS Members:
    - i. Director

- ii. EMS Medical Director
- iii. EMS Coordinator
- iv. Public Health Epidemiologist

2. Confidentiality

To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The Committee's 1157.7 business, records and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures.

At each meeting members and attendees will sign a statement of confidentiality as a condition of participation.

3. Schedule/Location

The STEMI QI Committee shall meet quarterly on the third Thursday of the month at 1800 Mount Vernon Ave. Time and Conference room to be determined.

4. Case Review Instructions

On a rotating basis, each hospital and ambulance provider will present case reviews to the committee. These reviews should highlight difficult, challenging or exceptional cases that might provide valuable information to the other members of the committee. All re-triage of STEMI patients between SRC's will be reviewed by the Committee.

5. Recommendations for System Improvement

The Committee will develop and implement recommendations for an annual PI project based on data analysis and case reviews. Recommendations will be presented at the EMS System Collaborative meeting.

## APPENDIX D - STEMI QI Committee Bylaws

### 1. NAME

This Committee shall be referred to as the "STEMI QI Committee", hereinafter referred to as the "COMMITTEE".

### 2. IMPLEMENTATION AUTHORITY

- a. The COMMITTEE is established by the County of Kern, Emergency Medical Services Division (DIVISION) Medical Director as an advisory committee to the DIVISION. The DIVISION is responsible to receive hospital and service provider input and direction specific to STEMI patient emergency medical care in the County.
- b. The COMMITTEE is created pursuant to the requirements of California Evidence Code, Section 1157.7 and California Code of Regulations, Title 22, Division 9, Prehospital Emergency Medical Services, Chapter 12, EMS System Quality Improvement.

### 3. STATEMENT OF PURPOSE

- a. To decrease morbidity and mortality of the STEMI population
- b. To promote region-wide standardization of evidence-based STEMI care.

### 4. DUTIES

- a. Participate with EMS in monitoring, collecting data on, and evaluating STEMI patient identification, treatment and transport from the EMS providers and hospitals within the DIVISION'S jurisdiction.
- b. Evaluate, expand upon, and revise as needed, locally developed indicators used by the COMMITTEE for STEMI patient quality improvement.

### 5. MEMBERSHIP

Voting Membership will include the following representatives from the EMS Program's region:

- a. One Physician Medical Director from each SRC.
- b. One Program Manager from each SRC.
- c. One Emergency Department Medical Director representative from each SRH.
- d. One Emergency Department Director from each SRH.
- e. One Operations Manager from each prehospital agency.
- f. One Medical Director or Field Supervisor from each prehospital agency

Non-Voting membership will include representatives of the DIVISION.

Each member shall have a clinical person alternative available to assume the member's responsibility in their absence, but this is not a proxy vote in a member's absence. There is only one vote per voting member attending the meeting. Cardiac Catheterization Laboratory alternates may be another physician, a Registered Nurse (RN), a Registered Cardiovascular Invasive Specialist (RCIS), or program manager.

6. OFFICERS

- a. The COMMITTEE shall elect a Chair and Vice-Chair to serve for a 2 year period.
- b. The COMMITTEE shall elect a Secretary to serve for a 2 year period to maintain minutes, sign-in sheets and membership list with contact information.

7. TERMS

- a. Officers shall be elected by the COMMITTEE for yearly terms commencing July 1 through June 30<sup>th</sup>.
- b. If the Chair's office is vacated prior to the term's end, the Vice-Chair will assume the duties for the remainder of the term and a new Vice-Chair will be elected.
- c. If the Vice-Chair's office is vacated prior to term's end, a replacement will be elected.
- d. Members shall serve at the will of the COMMITTEE, or until removed, resigned or replaced.
- e. Members who are unable to attend a regularly scheduled meeting should notify the DIVISION of their absence prior to the meeting and should send an alternate in their place.

8. MEETINGS, VOTING, QUORUM

- a. Meetings shall be held no less than four (4) times in a calendar year. Meeting dates and times to be set or modified as agreed to by the COMMITTEE.
- b. Special meetings may be called by the DIVISION Medical Director or Chair as appropriate or upon written request of a majority of COMMITTEE members.
- c. A quorum to conduct business shall consist of five eligible voting members.
- d. A quorum to conduct a vote requires five eligible voting members with representation from each SRC
- e. The Chair will preside over meetings and participate with the DIVISION in the preparation of the agenda.
- f. Meetings will be conducted in a fair and professional manner.
- g. The COMMITTEE shall operate under commonly accepted procedures and Chair shall conduct of meetings in a fair and productive manner.
- h. Votes shall be recorded as:
  - a. In Favor
  - b. Opposed
  - c. Abstain
- i. The DIVISION will be responsible for preparing the agenda.
- j. Attendance by teleconference or videoconference is acceptable so long as communications are adequate to conduct the business of the Committee.

9. AMENDMENT OF BYLAWS

- a. Any rule or procedure of the COMMITTEE may be enacted, amended, repealed or suspended by a majority vote of the voting membership.

10. CONFLICT OF INTEREST

- a. Members and officers shall disclose any direct personal or pecuniary (momentary) interest in any subject or conversation before the COMMITTEE and will abstain from voting on any motion relative to that subject.

11. CONFIDENTIALITY

- a. To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The COMMITTEE'S 1157.7 business, records, and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures.
- b. Members and attendees will sign a statement of confidentiality as a condition of participation.

12. EFFECTIVE DATE

- a. These Bylaws shall be effective upon approval by the COMMITTEE.

APPROVED \_\_\_\_\_ DATE \_\_\_\_\_

This section is to establish the standard for treatment of STEMI patients that present at STEMI Referral Hospitals. It is expected that this standard of care will be implemented at all hospitals in the County that have not been designated as a STEMI Receiving Center.

STEMI patients presenting **without reasonable chance of reaching a SRC for emergency primary PCI within 60 minutes of First Medical Contact** should be directed to the nearest SRH to undergo thrombolysis within 30 minutes unless contraindicated" (based on AHA/ACC Class I evidence)

**In general, short symptom duration, age <75, large infarcts, anterior ST elevation, large reciprocal changes and clear ECG evidence of STEMI indicate patients who may derive the greatest benefit from early administration of thrombolytics if transport time to the SRC exceeds 60 minutes.**

**I. Consider thrombolytics as the preferred therapy if all the following are true:**

- Y / N \*\*Transportation time is likely more than 1 hour\*\*?**  
(Usually the case if air transport is not immediately available)
- Y / N Symptoms started less than 3 hours ago?**
- Y / N Clear ST elevation in 2 or more contiguous leads >1mm or new LBBB?**
- Y / N Patient has no absolute contraindications to thrombolytics? (listed below)**
- Y / N Patient stable w/o signs of cardiogenic shock? (for shock, PCI is preferred)**

**II. Absolute contraindications: Avoid thrombolytics if any answer is "yes"**

- Y / N Has the patient ever had an intracranial hemorrhage?**
- Y / N Does the patient have a known cerebral vascular lesion (i.e. AVM)?**
- Y / N Is the patient suffering from primary or metastatic brain cancer?**
- Y / N Has patient had an ischemic stroke within 3 months but not within 3 hrs?**
- Y / N Do you think the patient is having an aortic dissection?**
- Y / N Is the patient currently having active bleeding? (excluding menses)**
- Y / N Has patient had significant closed head or facial trauma within 3 months?**

**III. Relative contraindications: Benefit of PCI may be > thrombolytics, particularly if multiple factors are present. Reasonably assess combined factors.**

- A questionable dx of STEMI (ECG findings not clear or not diagnostic)?**
- History of chronic severe, poorly controlled hypertension?**

- Severe hypertension on presentation (SBP >180 or DBP >110)?
- History of stroke over (3) months ago or ? intracranial pathology (not ICH or CA)?
- Recent, vigorous CPR for > 10 minutes or major surgery within 3 weeks?
- Internal bleeding within 2-4 weeks but not currently?
- Non-compressible vascular punctures / Pregnancy?
- Prior multiple cardiac stents or known hx of severe CAD?
- Age over 80? (age alone is NOT a contraindication to thrombolytics)

**IV. If the patient clearly fits criteria for thrombolytic therapy and the transport time to an SRC is expected to be greater than 60 minutes, proceed to the nearest SRH immediately!** The goal for door-in to door-out from the SRH is 30 minutes or less if thrombolytics will not be administered. Stable post-lytic patients may not need air transport.

**V. TNK (Tenecteplase) Tissue Plasminogen Activator instructions and dosing**

**Remember, Time = Muscle! Door to needle goal <30 minutes!**

TNK is weight based. TNK is *a single bolus* injection only.

Patient's Weight	TNK dose	TNK Volume
a. < 60 Kg	30 mg	6 ml
b. 60-70 Kg	35 mg	7 ml
c. 70-80 Kg	40 mg	8 ml
d. 80-90 Kg	45 mg	9 ml
e. >90 Kg	50 mg	10 ml

**VI. Preparation**

1. Patient should have an IV of Normal saline.
2. Remove "shield assembly" from 10cc syringe. *Note;* do not discard.
3. Withdraw 10 ml of sterile water from (provided) vial using "red hub" device.
4. Gently inject sterile water into TNK vial onto TNK powder.
5. Gently swirl contents; *do not shake or agitate*. Concentration is 5 mg/ml. It should be colorless to clear - pale yellow.
6. When the decision to give TNK is made, **Heparin should be administered before or concurrently** with TNK.

**VII. Administration**

1. Withdraw appropriate patient dose from TNK mixture.



2. Stand "shield assembly" vertical on countertop (green cap down) and recap red hub
3. Remove entire shield assembly including red hub.
4. TNK is ready to inject as a bolus through a needleless hub into a saline solution IV line.
5. Inject TNK as bolus over 5 seconds.
6. Discard remaining TNK if physician concurs.

Remember to give Heparin in addition to TNK!

**I. Bypassing a STEMI Referral Hospital (non-PCI hospital)**

A. Bypassing an SRH is recommended if the patient is stable and the expected transport time to the SRC is 60 minutes or less, as long as the following criteria are met:

- Patient is displaying signs and symptoms of a cardiac related event
- Patient is **NOT** displaying signs and symptoms of an **Aortic Dissection** (i.e. Acute tearing, ripping, or shearing sensation to chest or back radiating to the neck and/or down back).
- A 12 Lead ECG has been completed with a reading of “Acute MI” or “Left Bundle Branch Block”
- The following questions have been answered with at least one (1) **YES** response:
  1. Yes/No Systolic blood pressure is greater than 180 mm Hg
  2. Yes/No Diastolic blood pressure greater than 110 mm Hg
  3. Yes/No Right vs. left arm systolic blood pressure difference is greater than 15mm Hg
  4. Yes/No History of structural central nervous system disease
  5. Yes/No Significant closed head/facial trauma within the previous three months
  6. Yes/No Major trauma, surgery (including laser eye surgery), GI/GU bleed (within six weeks)
  7. Yes/No Bleeding or clotting problem or taking blood thinners
  8. Yes/No CPR greater than 10 minutes
  9. Yes/No Pregnant female
  10. Yes/No Serious systemic disease (e.g., advanced/terminal cancer, severe liver or kidney disease)
  11. Yes/No Pulmonary edema (rales greater than halfway up)
  12. Yes/No Systemic hypoperfusion (cool, clammy)
- Base contact has been made with a STEMI Receiving Center confirming that the patient falls out of the thrombolytic therapy protocol and the base hospital physician concurs with the decision to bypass.

## Revision Log

04/25/2012 Initial draft finalized by STEMI Working Group

05/01/2012 Reformatted into final draft

05/07/2012 Amend "Designation, A.1." to include cardiac surgery service; amend Page 4 to insert provision for "Interim Designation"; and amend "Concept of Operations of STEMI System of Care, A.1." to reiterate avoidance of delay in treatment and transport to obtain 12-lead ECG.

05/10/2012 Policy approved by EMCAB

06/26/2012 Policy approved by Board of Supervisors

05/09/2013 Revisions approved by EMCAB: additions of Appendix E and F; clarification to use Action Registry in lieu of a home-grown database, per STEMI Workgroup agreement; and revise SRC performance standards

08/06/2013 Amend Page 8 to remove discouragement of obtaining 12-lead in the field if care is delayed; (this change reflects a previous change to paramedic protocol implemented earlier in the year); revision needed for consistency between policies.

11/14/2019 Updated and Amended definitions; added impella, amended QI Committee make up; amended direct to transport to PCI hospital time from 45 to 60 minutes; updated to meet state STEMI recommendations.

## ***Stroke System of Care (4002.00)***

### **I. PURPOSE**

The purpose of the Stroke System of Care Policies (policies) is to define the following:

- A. Requirements for Stroke Center application, designation, and re-designation by the Kern County EMS Program (Program);
- B. Requirement for training pre-hospital personnel in recognition of Stroke victims, understanding benefit of a Stroke Center, and making appropriate destination decisions;
- C. Requirements for on-going quality improvement review; and
- D. Requirements for data management and mandatory elements.

The objective of having a Stroke Center designation is to provide rapid evaluation and appropriate treatment for all eligible stroke cases in the shortest time possible. In addition, a Stroke Center must have a component that addresses comprehensive post treatment management/rehabilitation, and involvement in pre-hospital personnel training. The EMS system objective is to transport qualifying stroke patients to a designated Stroke Center.

### **II. AUTHORITY**

This policy is developed under the authority of Health and Safety Code, Division 2.5, California Evidence Code 1157.7, and California Code of Regulations (CCR) Title 22, Division 9, Chapter 7.2.

### **III. DEFINITIONS**

- A. American Board of Radiology (ABR): oversees the certification and ongoing professional development of specialists in [Diagnostic Radiology](#), [Radiation Oncology](#) and [Medical Physics](#). The ABR certifies through a comprehensive process involving educational requirements, professional peer evaluation, and examination.
- B. American Osteopathic Board of Radiology: an organization that provides board certification to qualified Doctors of Osteopathic Medicine (D.O.) who specialize in the use of imaging in the diagnosis and treatment of disease.
- C. American Osteopathic Board of Neurology and Psychiatry: an organization that provides board certification to qualified Doctors of Osteopathic Medicine (D.O.) who specialize in disorders of the nervous system (neurologists) and to qualified Doctors of Osteopathic Medicine who specialize in the diagnosis and treatment of mental disorders.

- D. American Board of Psychiatry and Neurology: Responsible for certifying physicians who have completed residency training in neurology and/or psychiatry in programs accredited by the American Osteopathic Association
- E. Board-certified: Means that a physician has fulfilled all requirements, has satisfactorily completed the written and oral examinations, and has been awarded a board diploma in a specialty field.
- F. Board-eligible: Means that a physician has applied to a specialty board and received a ruling that he or she has fulfilled the requirements to take the examination. Board certification must be obtained within five (5) years of the first appointment.
- G. Certificate of Added Qualification (CAQ): A CAQ enables a physician to add to his or her skill set and qualifications, without completing an additional full fellowship training program. A CAQ consists of additional coursework, clinical education, and testing of a sub-specialized technique, procedure or area of medicine within the physician's medical specialty
- H. Comprehensive Stroke Centers (CSC): These facilities are equipped with diagnostic and treatment facilities for stroke that are not found in other hospitals and are able to deliver time-sensitive treatment within an extended therapeutic time window. They also have advanced neurological and interventional neuroradiology capabilities. Neurosurgeons and interventional neuroradiologists play important roles for treating intracerebral hemorrhage and subarachnoid hemorrhage. In addition, brain tumors and subdural hematomas are common stroke mimics.
- I. Computed Tomography (CT): CT radiography in which a three-dimensional image of a body structure is constructed by computer from a series of plane cross-sectional images made along an axis
- J. Continuing Medical Education (CME): Education required for the maintenance of a license and refers to the highest level of continuing education approved or recognized by the national and/or state professional organization.
- K. ELVO Alert: A pre-arrival notification by pre-hospital personnel to the base hospital that a patient is suffering a possible Emergent Large Vessel Occlusion (ELVO) ischemic stroke.
- L. Emergency Medical Services Authority (Authority or EMSA): The department within the Health and Welfare Agency of the State of California that is responsible for the coordination and integration of all state activities concerning EMS.
- M. Immediately Available: Unencumbered by conflicting duties or responsibilities.
- N. Interventional Neuroradiologists: Board certified, medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases and must meet national accrediting body minimum requirements.

- O. Kern County Emergency Medical Services Program (Program): A Program of the Kern County Public Health Services Department. The local emergency medical services agency responsible for the regulation and oversight of the emergency medical services system in Kern County.
- P. Local Emergency Medical Services Agency (Local EMS Agency, or LEMSA): A county health department, an agency established and operated by the county, an entity with which the county contracts for the purposes of local emergency medical services administration, or a joint powers agreement between counties or cities and which is designed pursuant to chapter 4 of the California Health and Safety Code, Division 2.5, Section 1797.200. The Program is the LEMSA for Kern County.
- Q. Magnetic Resonance Imaging (MRI): MRI a noninvasive diagnostic technique that produces computerized images of internal body tissues and is based on nuclear magnetic resonance of atoms within the body induced by the application of radio waves
- R. Primary Stroke Center (PSC): stabilizes and treats acute stroke patients, providing initial acute care. PSCs are able to appropriately use an approved thrombolysis agent and other acute therapies such as stabilization of vital functions, provision of neuroimaging procedures, and management of intracranial and blood pressures. Based on patient needs and the hospital's capabilities, they either admit patients or transfer them to a comprehensive stroke center.
- S. Protocol: A predetermined, written medical care guideline, which may include standing orders.
- T. Satellite Stroke Centers/Acute Stroke Ready (SSC/ASR): These facilities are able to provide the minimum desirable level of care for stroke patients in the ED, particularly when paired with another hospital, but are not documented to provide the minimum level of care for admitted inpatients. These facilities should be regarded as stroke partners or "spokes" and should be aligned by formal agreement with a hospital that can provide the missing service (hub). The most common "missing service" is neurological expertise in the ED and inpatient Stroke Unit care for patients treated with recanalization therapies. In these hospitals, the necessary ED neurological expertise may be provided through telemedicine.
- U. Stroke: A condition of impaired blood flow to a patient's brain resulting in brain dysfunction.
- V. Stroke Call Roster: A schedule of licensed health professionals available twenty four (24) hours a day, seven (7) days a week for the care of the stroke patient as required by the level of designation criteria.
- W. Stroke Care: Emergency transport, triage, and acute intervention and other acute care service for stroke that potentially requires immediate medical or surgical intervention or treatment, and may include education, primary prevention, acute intervention, acute and subacute management,

prevention of complications, secondary stroke prevention, and rehabilitative services.

- X. Stroke Medical Director: A physician designated by the hospital who is responsible for the stroke service and performance improvement and patient safety programs related to stroke care.
- Y. Stroke Program Manager/Coordinator: A registered nurse or qualified individual designated by the hospital with the responsibility for monitoring and evaluating the care of stroke patients and the coordination of performance improvement and patient safety programs for the stroke center in conjunction with the stroke medical director.
- Z. Stroke Program: An organizational component of the hospital specializing in the care of stroke patients.
- AA. Clinical Stroke Team: A team of healthcare professionals involved in the care of the stroke patient and may include, but not be limited to: neurologists, neurointerventionalist, neurosurgeons, anesthesiologists, emergency medicine and other stroke center clinical staff.
- BB. Telemedicine: The use of medical information exchanged from one site to another via electronic communications to improve patients' health status. A neurology specialist will assist the physician in the center rendering a diagnosis. This may involve a patient "seeing" a specialist over a live, remote consult or the transmission of diagnostic images and/or video along with patient data to the specialist.
- CC. Thrombectomy Capable Stroke Center: (TSC): "Thrombectomy-capable stroke center" means a primary stroke center with the ability to perform mechanical thrombectomy for the ischemic stroke patient when clinically warranted.

#### IV. DESIGNATION

- A. Hospitals seeking formal designation as a Stroke Center shall meet the following requirements:
  - 1. Possess current California licensure as an acute care hospital providing basic or standby emergency medical services.
  - 2. Must hold current designation and valid contract with the county as a paramedic base hospital; standby ER's excluded for Satellite Stroke Center designation.
  - 3. Obtain and maintain continuous accreditation as a Primary Stroke Center (PSC), Thrombectomy Capable Stroke Center (TSC) and Comprehensive Stroke Center (CSC) from The Joint Commission or other CMS approved accrediting body. Satellite Stroke Centers

(SSC) must obtain and maintain continuous designation with the County by completing the application documentation requirements every two (2) years as well as meet all provisions set forth in this policy.

4. Comply with California Emergency Medical Services Authority Stroke regulations
5. All Primary Stroke Centers (PSC), Comprehensive Stroke Centers (CSC) and Thrombectomy Capable Stroke Centers (TSC) shall contract with the American Heart Association to submit data to “Get with the Guidelines-Stroke” (GWTG) registry. All PSC, TSC, and CSC shall submit quarterly reports to the Program. All SSCs shall complete a data sheet to submit to the PSC or CSC upon transfer of patient.
6. The PSC, TSC, and CSC shall maintain a designated telephone number (Hotline) to facilitate rapid inter-facility transfer and access to the PSC, TSC, & CSC physician for consultation with SSC physicians and other providers regarding care and transfer of stroke patients.
7. Execute an agreement between the Stroke Center and the County of Kern to formally designate the hospital as a Primary, Thrombectomy Capable, Comprehensive, or Satellite Stroke Center.
8. All Stroke Center’s must be an approved Continuing Education provider with the County.
9. Neurological staff including neurosurgeons and interventionalists shall only be “On-Call” for one local SSC, PSC, TSC, or CSC at any given time
10. All Stroke Center’s shall provide for the triage and treatment of simultaneously presenting stroke patients so long as the Stroke Center’s Emergency Department is on “open” status.
11. All Stroke Center’s shall provide stroke center services to any stroke patient that comes to the emergency department, regardless of the stroke patient’s ability to pay physician fees and/or hospital costs. The phrase “comes to the emergency department” shall have the same meaning as set forth in the Emergency Medical



Treatment and Active Labor Act (42 U.S.C § 1395dd) and the regulations promulgated thereunder (EMTALA).

12. All Stroke Center's shall notify the Program within twenty-four (24) hours of any failure to meet the provisions set forth in the designation criteria. The Hospital will identify its action to correct the deficiency and submit within the next 7 days after the failure.

13. All Stroke Center's shall actively and cooperatively participate in the "Stroke QI Committee," and other related committees that may, from time to time, be named and organized by the Program related to the Stroke System of Care. Active Cooperation shall include attendance at ALL Stroke QI meetings by the Stroke Coordinator and the hospital stroke program medical director, or their hospital designee.

14. Primary Stroke Centers, Thrombectomy Capable Stroke Centers, and Comprehensive Stroke Centers shall accept all Stroke patients from all facilities within the County, upon notification of "Stroke Alert" and request by the transferring physician.

15. All Stroke Centers shall pay the established fee. The Program will charge for regulatory costs incurred as a result of Stroke Center application review, designation, and re-designation. The specific fees are based upon Program costs. Fee amounts shall be specified in the County Fee Ordinance Chapter 8.13, if applicable.

#### B. COMPREHENSIVE STROKE CENTERS SERVICE STANDARDS (CSC)

CSC a receiving hospital that has met the standards of an EMS Agency approved certifying body as a Comprehensive Stroke Center and has been approved as a Comprehensive Stroke Center by the Kern County EMS Program.

#### C. THROMBECTOMY CAPABLE STROKE CENTER SERVICE STANDARDS (TSC)

TSC a receiving hospital that has met the standards of an EMS Agency approved certifying body as a Thrombectomy Capable Stroke Center and has been approved as a Thrombectomy Capable Stroke Center by the Kern County EMS Program.

## PRIMARY STROKE CENTERS SERVICE STANDARDS (PSC)

PSC a receiving hospital that has met the standards of an EMS Agency approved certifying body as a Primary Stroke Center and has been approved as a Primary Stroke Center by the Kern County EMS Program.

### a. SATELLITE STROKE CENTERS/ACUTE STROKE READY SERVICE STANDARDS (SSC/ASR)

In Addition to the requirements listed in Section IV: A; 1-13, for all Stroke Centers, Satellite Stroke Centers must meet the following service standards as outlined in California Code of Regulations (CCR) Title 22, Division 9, Chapter 7.2.

1. The necessary emergency department neurological expertise may be provided in person or through telemedicine.
2. Evaluation of the SSC will include an assessment of the following components:
  - i. An acute Stroke Team available to see in person or via telemedicine a patient identified as a potential acute stroke patient within twenty (20) minutes following the patient's arrival at the hospital's emergency department or within twenty (20) minutes following a diagnosis of a patient's potential acute stroke.
  - ii. Written policies and procedures for emergency department stroke services that are reviewed a least every three (3) years, revised more frequently as needed, and implemented. Emergency department policies and procedures shall include written protocols and standardized orders for emergency care of stroke patients.
  - iii. Evidence based, continuous quality improvement including collection and monitoring of standardized performance measures.
  - iv. Neuro-imaging services capability that is available twenty four (24) hours a day, seven (7) days a week, such that imaging shall be performed within sixty (45) minutes following code entry. Such studies shall be reviewed by a physician with appropriate expertise, such as a board-

certified radiologist, board-certified neurologist, a board certified neurosurgeon, or residents who interpret such studies as part of their training in an Accreditation Council of Graduate Medical Education-approved radiology, neurology, or neurosurgery training program, within sixty (45) minutes of patient arrival at the emergency department.

- v. Neuro-imaging services shall, at a minimum, include CT scanning or MRI, as well as interpretation of the imaging.
- vi. In the event that tele-radiology is used in image interpretation, all staffing and staff qualification requirements shall remain in effect and shall be documented by the hospital.
  - a) A qualified radiologist shall be board-certified by the American Board of Radiology or the American Osteopathic Board of Radiology.
  - b) A qualified neurologist shall be board-certified by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry.
  - c) A qualified neurosurgeon shall be board-certified by the American Board of Neurological Surgery.
- vii. Laboratory services capability twenty four (24) hours a day, seven (7) days a week, such that services shall be performed within sixty (60) minutes following order entry. Laboratory services shall, at a minimum, include blood testing. Electrocardiography and x-ray services must also meet these time and availability standards.
- viii. Neurosurgical services that are available or under agreement with transfer, including operating room availability, either directly or under agreement with a PSC or CSC, within three (3) hours following admission of acute stroke patients to the SSC.

- ix. Transfer arrangements with one (1) or more PSC or CSC that facilitate transfer of patients with strokes to the Stroke Center(s) or care when clinically warranted.
- x. There shall be a director of the SSC, who may serve also as a member of the Stroke Team, who is a physician who maintains at least six (6) hours per year of educational time in cerebrovascular disease.
- xi. At a minimum, an acute care Stroke Team shall consist of a nurse and a physician with six (6) hours per year of educational time in cerebrovascular disease.

**V. APPLICATION PROCESS FOR STROKE CENTER DESIGNATION AND RE-DESIGNATION**

A. The following milestones outline the application process for a hospital to become designated as a Stroke Center.

1. Review list of requirements and checklist of documents, found in *Appendix A- Stroke Center Designation Criteria Application and Evaluation Tool*, which must be completed and submitted with the application.
2. Submit letter of application to the Program. The letter shall contain:
  - a. Intent to obtain Stroke Center designation;
  - b. Identify the names and contact information, including email addresses for the key stroke personnel whose roles and responsibilities are defined in section III of this document: the Stroke Medical Director, RN Program Manager, and Administrative contact; and
  - c. Identify the anticipated target date for Stroke Center designation from an EMS agency certifying body.
3. Complete and submit to the EMS Program all information and documents requested in *Appendix A, Column 2, "objective measurement"* of the *Stroke Center Designation Criteria Application and Evaluation Tool*.
4. All application materials will be reviewed for completeness. Additional information may be requested, if needed. Upon

determination that the application is complete, the applicant and the Program will work towards execution of the designation agreement.

5. Stroke Center Designation agreement will be presented to the Board of Supervisors for approval and formal designation.
6. Stroke Centers shall be eligible for re-designation every two (2) years. In order to be eligible for re-designation, the Stroke Center shall meet all of the provisions of this policy. Re-designation of a stroke center will require the documentation from sections #1, #2b and #3 above to be resubmitted to the Program by February 28th before the end of the term. . Hospitals who hold accreditation by a nationally recognized accrediting body may submit proof to the Program in lieu of the above mentioned documentation to maintain current destination status.

## **VI. REVOCATION OF STROKE CENTER DESIGNATION**

Any designated Stroke Center which is unable to meet the following requirements shall be subject to removal of designation as a Stroke Center:

- A. A Stroke Center must comply with any policy, procedure, or regulation mandated by the Local, State, or Federal Government.
- B. If the Program finds a Stroke Center to be deficient in meeting the above criteria, the Program will give the Stroke Center written notice, return receipt requested, setting forth with reasonable specificity the nature of the apparent deficiency. Within ten (10) calendar days of receipt of such notice, the Stroke Center must deliver to the Program, in writing, a plan to cure the deficiency, or a statement of reasons why it disagrees with the Program's notice. The Stroke Center shall cure the deficiency within thirty (30) calendar days of receipt of notice of violation. If the Hospital fails to cure the deficiency within the allowed period or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication. EMCAB may make a recommendation to the Program for resolving the issue.
- C. At least every two (2) years, the Stroke Center shall submit documentation to the Program showing the facility has obtained re-certification as a Primary Stroke Center, Thrombectomy Capable Stroke Center (TSC) Comprehensive Stroke Center (PSC or CSC) by a nationally recognized accrediting body to maintain the current destination status..

## VII. QUALITY IMPROVEMENT

Stroke Center designated hospitals shall participate in performance improvement program for EMS patients including:

- A. All Stroke Centers shall provide the following representatives to participate in the countywide EMS Program Stroke QI Committee:
  1. The Stroke Program Medical Director or medical staff representative
  2. The Stroke Program Manager/Coordinator
- B. The countywide Stroke QI Committee will hold regular multidisciplinary meetings that include representatives from each Primary Stroke Center, Thrombectomy Capable Stroke Center, Comprehensive Stroke Center, Satellite Stroke Center, prehospital provider, and representatives from the Program as listed in Appendix E.
- C. A Stroke Center shall implement a written internal QI plan/program with an internal review process that includes, but is not limited to:
  1. Last known well to door times
  2. Last known well to IV approved thrombolysis agent times
  3. Door to CT times
  4. Door to IV approved thrombolysis agent times
  5. Time to Thrombectomy (1<sup>st</sup> pass, % LVO)
  6. Total Stroke Cases
  7. Percent of total cases arrived by EMS
  8. Of those that arrived by EMS what percent were activated as Stroke Alerts prior to arrival
  9. What percent of total cases are Hemorrhagic Stroke
  10. What percent of total cases are Ischemic Stroke
  11. What percent of total cases are Transient Ischemic Attack
  12. Disposition on discharge (i.e. deceased, hospice care, nursing facility, rehab, home)

13. Transfers door in → door out

- D. A Stroke Center shall participate in prehospital stroke-related educational activities as determined by the Program.

## **VIII. DATA COLLECTION, SUBMISSION, AND ANALYSIS**

Stroke Center designated hospitals shall be in continuous compliance with the following data collection, submission, and analysis standards:

- A. Data element, submission, and analysis requirements are subject to change at Program's discretion.
- B. Data shall be used for quality improvement purposes by the Stroke QI Committee, and data submitted by Stroke Centers are considered to be confidential under the provisions of Evidence Code Section 1157.7.
- C. The Program may publicly report data about the stroke system which is derived from any of the individual data elements.
- D. Each designated Stroke Center shall submit quarterly data reports to the Program. Data reports shall consist of all relevant information to document achievement measures established by the American Heart Association's *Get With The Guidelines: Stroke* (GWTG) at an 85% compliance rate for the Silver and Gold Plus recognition.
- F. In addition to performance standards established by TJC and GWTG the quarterly report shall include the following symptom timeline performance measures, breakdown of arrival status, and type of stroke treated:
  - 1. Last known well to door times
  - 2. Last known well to IV approved thrombolysis agent times
  - 3. Door to CT times
  - 4. Door to IV approved thrombolysis agent times
  - 5. Door to CTA times
  - 6. Door to Groin Puncture
  - 7. Total patients treated with an approved thrombolysis agent
  - 8. Total Stroke Cases
  - 9. Percent of total cases arrived by EMS

10. Of those that arrived by EMS what percent were activated as Stroke Alerts prior to arrival
  11. Stroke patients arrived by POV
  12. What percent of total cases are Subarachnoid Hemorrhage Stroke
  13. What percent of total cases are Intracerebral Hemorrhage
  14. What percent of total cases are Ischemic Stroke
  15. What percent of total cases are Transient Ischemic Attack
  16. Disposition on discharge by diagnosis: ICH cases, SAH cases, Ischemic cases, and TIA cases (i.e. deceased, hospice care, nursing facility, rehab, home)
  17. Overall data trends (Excluding TIA) (i.e. deceased, hospice care, nursing facility, rehab, home)
  18. Outcome disposition at 90 days (i.e. deceased, hospice care, nursing facility, rehab, home)
  19. Demographics: age, gender, ethnicity, race.
- G. Data reports shall be submitted to the Program within 60 days of the end of the preceding quarter. All strokes received or encountered by the designated Stroke Center shall be included in the data report. This includes all stroke cases received by ambulance (prehospital and interfacility transfer), private vehicle, or walk in, including acute strokes occurring at the designated Stroke Center.
- H. Falling below the 85% compliance requires a written action plan for improvement to be submitted with the quarterly reports.
- I. Quarterly data reports will include a listing of the continuing education classes provided, including date, location, and topic made available to prehospital personnel during the quarter reported. Trainings will be provided by one Stroke Center each quarter and be rotated until all Stroke Centers have participated. If no trainings were offered a clear explanation of the circumstances surrounding the failure to provide education shall be documented.
1. EMS personnel initial and continuing education training will be provided by Stroke Center staff



2. The curriculum shall be submitted to the Program for approval before the training is conducted
  3. Initial curriculum shall include competency in recognizing stroke patients, understanding the importance of the Stroke Center, and demonstrate competency in Stroke Center activation criteria and hospital destination decision criteria. Continuing education topics should address system deficiencies as discovered through the Quality Improvement process.
  4. Stroke Centers shall provide EMS personnel appropriate continuing education credits. The Program may require changes in the continuing education training content for EMS personnel.
- J. The Stroke Center will provide an annual report summary of final stroke case outcomes during the period of July 1<sup>st</sup> through June 30<sup>th</sup> of the previous year. The annual report is due 60 days after the end of the fiscal year (August 31).
- K. The Stroke Center shall continuously examine on-going case data and summary data reports and will advise the Program of any trends, positive and/or negative, that are shown by the data. Improvement strategies and operational changes made as a result of data analysis will be included in the quarterly and annual reports. The Program may participate in the Stroke Center quality improvement process.
- L. The Stroke Center shall promptly (within 3 business days) provide any data requested by the EMS Program related to stroke patients treated at The Stroke Center.
- M. In addition to the above listed data elements, the EMS Program shall compile the following data points for review during quarterly QI meetings:
1. Time from receipt of 911 call to dispatch of EMS resource(s);
  2. Time of dispatch of EMS resource(s) to time of EMS resource(s) arrival;
  3. Patient contact time to depart scene time;
  4. Inter-facility transport time, if applicable;
  5. Transport time from scene to ED arrival;
  6. Time from patient contact to ED arrival;
  7. Total EMS contact time;
  8. Stroke patient routed to designated stroke center or other hospital;
  9. Use of validated stroke screening tool by EMS responders;

10. Results of validated stroke screening tool;
11. Pre-arrival notification of receiving hospital performed.
12. Demographics: age, gender.

## **IX. CONCEPT OF OPERATIONS OF THE STROKE SYSTEM OF CARE**

### **A. Pre-Hospital: Ambulance/Paramedic Responsibilities**

1. Recognize Signs and Symptoms of CVA: Upon an assessment finding of possible neurological distress with hypoglycemia and narcosis ruled out, paramedic shall conduct the Cincinnati Pre-hospital Stroke Scale (CPSS).
2. Facial droop, arm drift, abnormal speech: Paramedic will use any abnormal finding to determine if the patient has an abnormal CPSS.
3. Stroke Alert Early Notification: Upon receiving an abnormal CPSS and determining the onset was observed by a valid historian within the last four (4) hours, or the patient has questionable time of onset, paramedic shall immediately contact the destination hospital and issue a "Stroke Alert".
4. Destination: parameters for stroke patient
  - a. Abnormal CPSS goes to closest, most appropriate Stroke Center
  - b. If the Stroke Center is more than 30 minutes away and the patient meets Thrombolytic inclusion criteria located in Appendix D; the patient may be transported to the closest ED regardless of designation
  - c. Paramedic shall follow appropriate treatment protocol during transport

### **B. Hospital Relationships and Coordination**

1. Transfer Agreements/Requirements
  - a. Rapid Transfer – Stroke Center Automatic Acceptance of Stroke Patient from Transferring Hospital
  - b. Each Stroke Center agrees to immediately accept all "Stroke Alert" patients from any E. D. located within Kern County, so long as the Stroke Center's E.D. is on "Open" status.
2. Specific Language to initiate immediate rapid transfer. The term, "Stroke Alert" will be used by paramedics as well as Satellite Stroke Centers and non-Stroke Hospital staff in order to notify the Stroke Center of an incoming Stroke patient. "Stroke Alert" shall be

understood by all hospital staff as well as ambulance dispatchers to mean an emergent neurologic event is in progress with rapid treatment and transport necessary.

- a. Non-Stroke hospitals shall have written transfer agreements with PSC, TSC and CSC.
- b. The agreement shall include a one-call policy transfer/transport protocol to a designated PSC, TSC and CSC.

### C. Community Education

1. It is imperative that each Stroke Center recognize the need for community awareness as we work together to improve health in Kern County.
2. Each Stroke Center must be active participants and work together to promote public awareness activities, i.e. public service announcements, print ads, community events, task forces and classes. Education should focus on;
  - a. Stroke disease factors
  - b. The signs and symptoms of Stroke
  - c. The need to call 911
3. Other community education themes might include:
  - a. Stroke is preventable. People can reduce their chance of having a Stroke by controlling risk factors such as obesity, high blood pressure, and high cholesterol.
  - b. Time-sensitive window for EMS/treatment response
4. Public Reporting of Performance Data - A large part of public awareness begins with data reporting. Pertinent stroke system data showing the performance of the Stroke System of Care may be posted publicly. The following performance measurements may be publicly released, and additional reports may be published upon recommendation of the Stroke QI Committee.
  - a. Symptom onset time to EMS Call Time
  - b. EMS First contact to E.D. arrival time
  - c. E.D. arrival time to CT time
  - d. CT time to IV an approved thrombolysis agent

## APPENDIX A - Stroke Center Designation Criteria Application and Evaluation Tool

Stroke Designation Standard	Objective Measurement	Meets Standard	Comments
<b>PRIMARY STROKE CENTER</b>			
<b>HOSPITAL SERVICES</b>			
Current License to provide Basic Emergency Services in Kern County	Copy of License	Y N	
Current Designation to operate as a Paramedic Base Station in Kern County	Copy of contract	Y N	
Current Copy of Joint Commission Certification.	Copy of Certification	Y N	
An acute Stroke team available within 15 minutes	On-call schedules for 3 months. On-call policy and procedure	Y N	In person or telemedicine
Written policies and procedures for Stroke services	Copy of policies, procedures	Y N	Include protocols and standardized orders
Data-reporting mechanism	Copy of agreement with AHA	Y N	AHA Get with the Guidelines-Stroke
Neuro-imaging capability 24/7/365	Policies/protocols supporting operations	Y N	CT or MRI
One of the following: Qualified Radiologist, Qualified Neurologist, Or Qualified Neurosurgeon	Copy of appropriate board certification  On-call schedules for 3 months	Y N	If using telemedicine, hospital must document this standard
Laboratory services 24/7	Copy of policies/procedures/protocols for lab services	Y N	Blood testing, EKG, and x-ray services
Immediate, telemetry or critical care beds	Immediate: ____ Telemetry: ____ Critical Care: ____	Y N	
Neurosurgical services including operating room	Number of operating rooms ____ on license	Y N	May be under agreement with another PSC or CSC

If no neurosurgical services available: Plan to transfer within 2 hours	Supporting policies and procedures	Y N	Required if no Neurosurgery
In-patient acute care rehabilitation	Policies/procedures for in-patient rehabilitation	Y N	
Designated Telephone Number	Actual Number on File	Y N	
Written transfer guidelines for higher level of service	Transfer policies/procedures Copy of agreement	Y N	
Copy of Designation Agreement Between Hospital and County	Copy of Contract	Y N	
Continuing Education Provider	Copy of Approval Letter with CE provider Number	Y N	
Stroke contingency plans 1. Personnel 2. Imaging equipment	Pertinent policy and procedures to minimize disruption	Y N	Expectation of NO DIVERSION
<b>STAFFING</b>			
Acute Stroke Care Team:			
One of the following: Neurologist Neurosurgeon Interventional-neuroradiologist Emergency physician	Copy of appropriate board certification  On-call schedule for 3 months  Copy of job description	Y N	Board certified or Board eligible in neurology, neurosurgery, endovascular neurosurgical radiology, with experience and expertise in dealing with cerebral vascular disease
One of the following: Registered nurse Physician assistant Nurse practitioner	Copy of license  Copy of job description	Y N	Demonstrated competency in caring for acute Stroke patients
<b>COMPREHENSIVE</b>			<b>All of the above PLUS</b>
Written policies and procedures for comprehensive Stroke services	Copies of policies/procedures/protocols for activation of Stroke care	Y N	Reviewed every two years and revised as needed

Data driven CQI Including collection and monitoring of standardized Comprehensive Stroke Center performance measures	Copies of data collection procedures  Copies of internal CQI process	Y N	
Transfer agreements with primary Stroke Centers to accept transfer of patients with complex Strokes	Copies of transfer agreements  Policies/ procedures/ protocols in place to accept patients	Y N	
Provide guidance and continuing education to hospitals designated as Primary Stroke Centers with which they have agreements	Copies of policies/ procedures/ guidelines to provide CME  Copies of agreements	Y N	
<b>Thrombectomy Capable Stroke Center</b>			<b>All of PSC requirements plus</b>
Neurointerventionist on call 24/7 and available on-site at TSC within 45 minutes of notification of an ELVO alert.	Copies of policies/ procedures/ guidelines	Y N	
Neurosurgeon on call 24/7 and available to provide care as indicated.	Copies of policies/ procedures/ guidelines	Y N	
Neurologist, with hospital privileges to provide ICU level of care for acute stroke patients, on call 24/7 and available to provide care as indicated.	Copies of policies/ procedures/ guidelines	Y N	
An individual Neurointerventionalist or Neurosurgeon may not be simultaneously on call for a separate hospital.		Y N	

Appropriate endovascular catheterization laboratory personnel available on-site within 30 minutes of notification of an ELVO alert	Copies of policies/ procedures/ guidelines	Y N	
Will create policies and procedures detailing how the TSC will notify the appropriate personnel of an ELVO alert.	Copies of policies/ procedures/ guidelines	Y N	
Will accept all ELVO alert patients, regardless of ICU or ED saturation status, except in the event of internal disaster or no catheterization laboratory availability.	Copies of policies/ procedures/ guidelines	Y N	
Will create policies and procedures detailing how the TSC will manage the presentation of concurrent ELVO alerts.	Copies of policies/ procedures/ guidelines	Y N	
Will create policies and procedures that allow the automatic acceptance of any ELVO patient upon notification by the transferring physician.	Copies of policies/ procedures/ guidelines	Y N	
Ability to perform endovascular procedures as indicated for emergent large vessel occlusions.	Copies of policies/ procedures/ guidelines	Y N	
Have CT or MRI perfusion capabilities.	Copies of policies/ procedures/ guidelines	Y N	
Maintain appropriate staff and facility availability to address complications of	Copies of policies/ procedures/ guidelines	Y N	

emergent endovascular procedures.			
<b>SATELLITE STROKE</b>	<b>CENTERS</b>		
Current License to provide Basic Emergency Services in Kern County or Standby Services	Copy of License	Y N	
Current Designation to operate as a Paramedic Base Station in Kern County	Copy of contract	Y N	Standby ER's Excluded
Acute Stroke care team	Copies of policies/ procedures/ protocols  On call schedule	Y N	May be via telemedicine
Emergency Department policies and procedures	Copies of ED policies/ procedures/ protocols/ standard orders for Stroke care	Y N	
Data driven CQI  Collection and monitoring of performance measures	CQI polices/ procedures/ guidelines/ standards	Y N	
Neuro-imaging capability 24/7/365	Policies/protocols supporting operations	Y N	CT or MRI, as well as interpretation
Physician with appropriate expertise: Radiologist Neurologist Neurosurgeon Residents	Copy of Board certificates	Y N	Telemedicine may be used for interpretation  All staff qualification requirements shall be documented by the hospital
Laboratory Services 24/7/365	Policies/protocols supporting operations	Y N	Minimum include blood testing, ECG, and x-ray services
Neurosurgical services, including OR availability, within 3 hours of admission	Supporting policies and procedures  Number of operating rooms ___ on license	Y N	OR may be under agreement with PSC or CSC



Transfer arrangements with PSC or CSC	Copies of agreements	Y N	
Director: Physician or Advanced Practice Nurse	Copy of license  Documentation of training  Copy of job description	Y N	Maintains 6 hours per year education in cerebrovascular disease
Acute Stroke Care Team: At a minimum- Registered Nurse and Physician	Copy of Licenses  Documentation of Training	Y N	Some training and expertise in acute Stroke care

## APPENDIX B - STROKE CENTER ACTIVATION PROTOCOL

SIGNS/SYMPTOMS OF CEREBRAL VASCULAR  
ACCIDENT

CHECK GLUCOSE TO RULE OUT HYPOGLYCEMIA.  
RULE OUT NARCOSIS AS APPROPRIATE

ASSESS ONSET OF SIGNS OR SYMPTOMS

ASSESS PATIENT IN ACCORDANCE WITH  
CINCINNATI PREHOSPITAL STROKE SCALE (CPSS)

**FACIAL DROOP** (Have the Patient Show Teeth or Smile)

- Normal: Both Sides of Face Move Equally
- Abnormal: One Side of Face does not Move as Well as the Other Side

**ARM DRIFT** (Patient Closes Eyes and Extends Both Arms Straight Out, with Palms Up, for 10 Seconds)

- Normal: Both Arms Move the Same or Do Not Move at All
- Abnormal: One Arm does Not Move or One Arm Drifts Down Compared to the Other

**ABNORMAL SPEECH** (Have the Patient Say "You can't teach an old dog new tricks")

- Normal: Patient Uses Correct Words with No Slurring of Words
- Abnormal: Patient Slurs Words, Uses Wrong Words, or is Unable to Speak

IF ONE OR MORE ABNORMAL CPSS ARE PRESENT

**AND**

ONSET OBSERVED WITHIN 4 HOURS BY VALID HISTORIAN; **OR** QUESTIONABLE ONSET TIME

- EXPEDITE CONTACT WITH DESIGNATED STROKE CENTER BASE HOSPITAL

## PRE-HOSPITAL ASSESSMENT, STROKE CENTER ALERT AND TRANSPORT DESTINATION

- A. The patient shall be immediately assessed and managed in accordance with the Stroke Center Activation Protocol.
- B. If the patient meets Stroke Center Activation Protocol indications for transport to a Stroke Center, prehospital personnel shall provide immediate notice to the Stroke Center emergency department. The notice shall include a description of the patient problem, treatment provided, current location of the ambulance, and estimated time of arrival.
- C. The Stroke Center emergency department shall immediately alert and request response of the Stroke Center Stroke Team, neurologist, and/or neurosurgeon as indicated by the patient problem.
- D. In Exclusive Ambulance Operational Areas (EOA) 1, 2, 4, 5, 9, or 8 (excluding the Tehachapi area) where transport to a Bakersfield area hospital is the closest destination, Stroke patients that meet the Stroke Center Activation Protocol indications shall be transported to a Stroke Center. This is applicable to both ALS and BLS level ambulance transports.
- E. In EOA 3, 6, or Tehachapi area of 8:
  - 1. ALS Ambulance: A stroke patient that meets Stroke Center Activation Protocol indications shall be transported to a stroke center. A stroke patient from these areas may be transported to the closest hospital emergency department if the patient meets thrombolytic inclusion criteria; airway cannot be managed appropriately; or if the patient condition is deteriorating rapidly.
  - 2. BLS Ambulance: A stroke patient that meets Stroke Center Activation Protocol indications shall be transported to the closest hospital emergency department.
- F. In EOA 7 or 11:
  - 1. ALS Ambulance: A stroke patient that meets Stroke Center Activation Protocol and thrombolytic inclusion criteria shall be transported to the closest hospital emergency department. For patients who fall out of thrombolytic therapy, contact with a stroke center shall be made to request bypass of closest facility and shall be transported to a Stroke Center. Air transport is indicated in compliance with *EMS Aircraft Dispatch-Response-Utilization Policies and Procedures*.
  - 2. BLS Ambulance: A stroke patient that meets Stroke Center Activation Protocol indications shall be transported to the closest hospital emergency department unless air transport is indicated in compliance with *EMS Aircraft Dispatch-Response-Utilization Policies and Procedures*.
- G. The Program may authorize certain exceptions to transport destinations or mode of transport defined above for documented hospital-based arrangements and protocols that are clearly in the best interest of Stroke patient management. The Program will coordinate any exemptions with appropriate hospitals, ambulance providers and air ambulance providers.
- H. Air transport shall be used if an air ambulance is available and the overall time savings will be 10 minutes or more in comparison with ground transport in compliance with EMS Aircraft Dispatch-Response-Utilization Policies and Procedures. Generally, 10 minutes time-savings cannot be attained with ground transport times of 30 minutes or less, if patient is ready for transport and air ambulance has not yet launched.
- I. The designated Stroke Center emergency department shall be notified by prehospital personnel as early as possible. This enables the designated Stroke Center to begin mobilizing resources.

**APPENDIX C- PRE-HOSPITAL THROMBOLYTIC SCREEN (CVA)**

Patient Name: \_\_\_\_\_  
 (Last Name) (First Name)

Patient Information:  
 A. Age \_\_\_\_\_ B. Sex \_\_\_\_\_ Last known well \_\_\_\_\_  
 C. Past medical History: \_\_\_\_\_  
 D. Current medications: \_\_\_\_\_  
 E. Drug allergies: \_\_\_\_\_

F. Initial B/P:	(Right Arm)	(Military Time)	(Left Arm)	(Military Time)
		YES	NO	
g. Age less than or = 18 years		{ }	{ }	
h. Onset of symptoms greater than or = 4 hours		{ }	{ }	
i. Patient was asleep when symptoms started		{ }	{ }	
j. Rapidly improving or minor symptoms		{ }	{ }	
k. History of intracranial hemorrhage		{ }	{ }	
l. Seizure at onset of symptoms		{ }	{ }	
m. Stroke or serious head injury in less than or = 3 months		{ }	{ }	
n. Major surgery or other serious trauma in less than or = 2 weeks		{ }	{ }	
o. GI or urinary tract hemorrhage in less than or = 3 weeks		{ }	{ }	
p. Systolic B/P greater than or = 185 mmHg		{ }	{ }	
q. Diastolic B/P greater than or = 110 mmHg		{ }	{ }	
r. Aggressive treatment to lower B/P (use of vasodilators)		{ }	{ }	
s. Blood glucose less than or = 60		{ }	{ }	
t. Blood glucose greater than or = 400		{ }	{ }	
u. Symptoms of subarachnoid hemorrhage (sudden severe headache followed by a brief loss of consciousness)		{ }	{ }	
v. Arterial puncture at non-compressible site or lumbar puncture less than or = 1 week		{ }	{ }	
w. Pregnant or lactating females		{ }	{ }	

If all of the **Pre-hospital Thrombolytic Screen (CVA)** criteria are met (all **NO's**), alert the receiving facility of a possible thrombolytic candidate as soon as possible.  
 If not (one or more YES), make base contact with a Stroke Center to verify bypass of the nearest hospital for transport directly to a Stroke Center.

Form Completed By: \_\_\_\_\_

## **APPENDIX D - Stroke Center QI Committee Purpose and Structure**

### **PURPOSE**

Care of the Stroke patient requires a system approach to ensure optimal care. To assist the EMS Program in its quest to achieve best care possible, the Stroke QI Committee shall assess, monitor, and facilitate the Quality Improvement (QI) process for the Kern County Stroke Centers.

### **AUTHORITY**

Health and Safety Code Division 2.5

California Evidence Code, Section 1157.7

California Civil Code, Part 2.6, Section 5

California Code of Regulations Title 22, Division 9, Chapter 7.2

### **DEFINITION**

“Stroke QI Committee” means the multi-disciplinary peer-review committee, composed of representatives from the Stroke Center’s, prehospital care providers, and other professionals designated by the Program, which audits the Stroke System of Care, makes recommendations for system improvements, and functions in an advisory capacity on other Stroke System of Care issues.

### **COMMITTEE MEMBERSHIP**

#### **1. Membership Composition**

##### **a. PSC, TSC & CSC Members:**

- i. PSC, TSC & CSC Stroke Program Medical Director
- ii. PSC, TSC & CSC Program Manager/Coordinator
- iii. ED Physician optional
- iv. QI Staff Member
- v. Ad Hoc Members as necessary

##### **b. Satellite Stroke Center Members:**

- i. E.D. Physician
- ii. E.D. Nurse
- iii. QI Staff Member

##### **c. Prehospital Members:**

- i. At least one (1) representative from each prehospital agency

##### **d. EMS Members:**

- i. EMS Coordinator

2. Confidentiality

To the extent Evidence Code Section 1157.7 is applicable, closed meetings will occur when business addressed by 1157.7 is being transacted. The Committee's 1157.7 business, records and minutes shall be considered confidential and all members are prohibited from any unauthorized disclosures. At each meeting members and attendees will sign a statement of confidentiality as a condition of participation.

3. Schedule/Location

The Stroke Center QI Committee shall meet quarterly on the *third Thursday* of the month following the end of the quarter at (*time TBD*) Mount Vernon Ave. Time and Conference room to be determined.

4. Case Review Instructions

Each meeting participants will present the results of the quarterly data submitted by each Stroke Center. Each Stroke Center's data will be discussed and evaluated in a structured process focusing on outcomes. The committee will work together to identify root causes of problems, intervene to reduce or eliminate those causes, and take steps to correct the process and recognize excellence in performance and delivery of patient care.

In addition, on a rotating basis, each Stroke Center will present case reviews to the committee. These reviews should highlight difficult, challenging or exceptional cases that might provide valuable information to the other members of the committee.

5. PowerPoint format

All presentations are to be formatted in PowerPoint and sent to the EMS Coordinator assigned to the committee one (1) week prior to the quarterly meeting. Any audio or video files should accompany the PowerPoint.

6. Recommendations for System Improvement

The Committee will develop recommendations for improvement of the Stroke system of care. Recommendations will be presented at the EMS System Collaborative meeting and to the EMS Medical Director.

## Revision Log

11/2014 Initial draft  
11/13/2014 EMCAB Approved  
11/12/2015 Revised contracts deadlines. Added Division QI requirements. EMCAB approved.

***Pediatric Receiving Center Designation Policy (4004.00)***

**I. PURPOSE:**

This policy defines the requirements for designation as a Pediatric Receiving Center (PedRC) in Kern County and establishes that pediatric patients are transported to the most appropriate facility, which is staffed, equipped, and prepared to administer emergency and/or definitive care appropriate to the needs of pediatric patients.

**II. AUTHORITY:**

- A. California Health and Safety Code, Division 2.5, Section 1797.103, 1797.204, 1797.220, 1797.250, 1797.252, 1798.150, 1798.170, 1799.204, 1799.205.
- B. California Code of Regulations, Title 22, Division 9, Chapter 4, Section 100147 and Chapter 14 (Draft).

**III. DEFINITIONS:**

- A. California Children Services (CCS): A State of California program for children with certain illnesses or health problems. Through this program, children up to twenty-one (21) years old can obtain necessary health care and required services.
- B. Continuous Quality Improvement (CQI): A method of evaluation composed of structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process and recognize excellence in performance and delivery of care.
- C. Emergency Medical Services (EMS) Authority (EMSA or Authority): A department in California that is responsible for the coordination and integration of all state activities concerning EMS.
- D. Emergency Medical Services for Children (EMSC): The prevention, pre-hospital, emergency department (ED), in-patient and rehabilitation services specific for the care of children within an EMS system.



- E. Emergency Medical Services for Children Technical Advisory Committee (EMSC-TAC or TAC): A multidisciplinary committee, as appointed by the Authority. The TAC is advisory to the Authority on EMSC related issues.
- F. Emergency Medical Services Program (Program): The Kern County Public Health Services Department, Emergency Medical Services Program. The Program is the Local Emergency Medical Services Agency or LEMSA for Kern County (EMSP).
- G. Interfacility Transfer: The transfer of an admitted or non-admitted pediatric patient from one licensed health care facility to another.
- H. Neonatal Intensive Care Unit (NICU): A designated area of the hospital that specializes in the care of critically ill or injured newborn infants.
- I. Neonatologist: A physician who is board certified or board eligible in neonatology.
- J. Neonatology Fellow: A post residency trained physician who is a board certified or board eligible physician currently enrolled in a subspecialty fellowship program in neonatology.
- K. On-Call: Agreeing to be available to respond to a Pediatric Receiving Center (PedRC) in order to provide a defined service.
- L. Pediatric Critical Care Fellow: A pediatric board certified or board eligible residency trained physician currently enrolled in a subspecialty fellowship program in pediatric critical care medicine.
- M. Pediatric Critical Care Service: A clinical service within a hospital that has oversight and responsibility for the care of pediatric critically-ill or injured patients in a licensed pediatric intensive care unit (PICU).
- N. Pediatric emergency care coordinator: a physician or registered nurse who is qualified in the emergency care of pediatric patients (PECC)
- O. Pediatric Intensivist: A physician who is board certified or board eligible in pediatric critical care medicine, or pediatrics and anesthesia and anesthesia critical care.

- P. Pediatric Intensive Care Unit (PICU): A designated area with licensed pediatric intensive care beds within the hospital that specializes in the care of critically ill or injured infant, children, and teenagers.
- Q. Pediatric patient: Children Under 14 years of age.
- R. Pediatric Receiving Center (PedRC): The licensed general acute care hospital with, at a minimum, a permit for basic or standby emergency services that has been formally designated by the Program. The PedRC Levels are Comprehensive Pediatric Receiving Center (Comprehensive PedRC), Advanced Pediatric Receiving Center (advanced PedRC), General Pediatric Receiving Center (General PedRC), and Basic Pediatric Receiving Center (Basic PedRC).
- S. Promptly Available: Responding without delay when notified and requested to respond to the hospital and being physically available to the specified area of the PedRC within a fifteen (15) minute period of time in accordance with Program policies and procedures. When there are limited resources, telemedicine or video consultation is an acceptable alternative.
- T. Qualified Emergency Specialist: A qualified specialist who is board certified or board eligible in emergency medicine or pediatric emergency medicine, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- U. Qualified Pediatric Specialist: A qualified specialist who is board certified or board eligible in a pediatric specialty, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- V. Qualified Specialist: A physician licensed in California who has 1) taken special postgraduate medical training, or has met other specified requirements, and 2) has become board certified or is board eligible in the corresponding specialty, as applicable, by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty. A non-board certified physician may be recognized as a “qualified specialist” by the Program upon substantiation of need by the PedRC if: a) the

physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education (ACGME) or the Royal College of Physicians and Surgeons of Canada; b) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing pediatric critically-ill or injured patients, which shall be tracked by a pediatric performance improvement program; and c) the physician has successfully completed a residency program.

W. Trauma Center: A licensed hospital, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the Program, in accordance with CCR Title 22, Division 9, Chapter 7.

#### **IV. GENERAL PROVISIONS:**

- A. No healthcare facility shall advertise in any manner or otherwise hold itself out to be a PedRC unless it has been designated by the Program.
- B. No provider of pre-hospital care shall advertise in any manner, or otherwise hold itself out, as affiliated with EMSC or a PedRC unless they have been so designated by the Program.
- C. PedRCs are designated by the Program in accordance with state regulations and local policies. PedRC designation and re-designation shall be on three (3) year cycles and include written agreements between the PedRC and the County of Kern.
- D. Every PedRC within the County shall be aligned with at least one (1) Comprehensive PedRC for the purposes of outreach and education. Where geography precludes designation of a Comprehensive PedRC within the County, the PedRC may align with a Comprehensive PedRC within the State of California.
- E. All PedRCs shall participate in the Program's Pediatric Advisory Committee.
- F. All PedRCs shall be an approved pre-hospital continuing education provider and provide training and education relating to pediatrics for EMS personnel and MICNs. Continuing education programs shall be conducted in compliance with Program.

- G. Comprehensive PedRC and Advanced PedRCs shall be designated Base Hospitals. These facilities shall provide on-line medical direction in pediatric care to pre-hospital personnel regardless of patient destination either in County or transports out of County.
- H. All PedRCs shall participate in community education activities relating to pediatric illness and injury prevention efforts.
- I. Air transport for pediatric patients within Kern County shall be in accordance with *EMS Aircraft Dispatch-Response-Utilization Policies*.
- J. The Program shall approve marketing and advertising of EMSC capabilities by PedRCs consistent with the designation process by the Program.
- K. The Program will charge for regulatory costs incurred as a result of pediatric receiving center application review, designation, and re-designation. The specific fees are based upon Program costs. Fee amounts shall be as specified in the County Fee Ordinance Chapter 8.13, if applicable.

**V. PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

- A. **A Pediatric Receiving Center (PedRC)** is a licensed general acute care hospital with, at a minimum, a permit for basic emergency services or, in a rural area, licensed standby emergency services, that has been designated by the Program as a Comprehensive PedRC, Advanced PedRC, General PedRC, or Basic PedRC.
- B. **CQI Program-** All PedRCs shall have a CQI Program which addresses the needs of children, to include structure, process, and outcome evaluations. The CQI Program at a minimum shall provide for:
  - 1. A process which integrates the ED CQI activities with the pre-hospital, trauma, inpatient pediatrics, pediatric critical care, and hospital-wide CQI activities, as applicable.
  - 2. A mechanism to provide for integration of findings from CQI audits and reviews into education and clinical competency evaluations of staff.
  - 3. A review of pre-hospital, ED, and inpatient pediatric patient care to include the following pediatric indicators:
    - a. Deaths
    - b. Transfers

- c. Child maltreatment cases
  - d. Cardiopulmonary or respiratory arrests
  - e. Trauma admissions
  - f. Operating room admissions
  - g. ICU admissions
  - h. Selected return visits to the ED
  - i. Patient safety including adverse events
4. Compliance with all federal and state laws protecting and governing patient safety, quality and confidentiality including compliance with applicable provisions of Evidence Code 1157.7 to ensure confidentiality with CQI activities.

**C. Policies, procedures, or protocols** for care of children in emergency settings, that are not limited to, but shall include, the following:

- 1. Illness and injury triage
- 2. Pediatric assessment
- 3. Physical or chemical restraint of patients
- 4. Child maltreatment
- 5. Consent
- 6. Death of a child
- 7. Procedural sedation
- 8. Immunization status and delivery
- 9. Mental health emergencies
- 10. Family centered care
- 11. Communication with patient's primary health care provider
- 12. Pain assessment and treatment
- 13. A disaster preparedness plan that addresses pediatric issues
- 14. Medication safety, including:
  - a. A process to weigh children on scales in kilograms only
  - b. A process to solicit feedback from staff including reporting of medical errors
  - c. Involvement of families in the medication safety process
  - d. Medication orders that are clear and unambiguous
  - e. Mental health and behavioral emergencies including drug and alcohol abuse

**D. Data Requirements-** The PedRC shall submit, at a minimum, the following data to the Program on a quarterly basis. This data will facilitate system management and allow for evaluation of system performance. Data will be collected by each PedRC on the Program approved data reporting tool. Data will be aggregated

and reported as numerical measurements for Countywide PedRC evaluation. Aggregated reports, with facility names removed, may be shared with the Pediatric Advisory Committee, the EMS System Collaborative, the Emergency Medical Care Advisory Board, Kern County Board of Supervisors, or posted for public viewing, if applicable. If mandated by regulation, aggregated data may be reported to the Authority by the Program as a representation of EMSC in Kern County. The following data elements shall be included:

1. Baseline data, including ambulance transports, to describe the system, including, but not limited to:
  - a. Arrival time/date to ED
  - b. Date of Birth
  - c. Gender
  - d. Ethnicity
  - e. Mode of arrival
  - f. Primary impression
2. Cause of illness and injury, and basic outcomes for CQI to include but not limited to the following:
  - a. Discharge or transfer diagnoses
  - b. External cause of injury (E codes)
  - c. Injury location
  - d. Disposition
  - e. Principal procedures
  - f. Other procedures
  - g. Discharge or transfer time and date from ED
  - h. Admitting facility name if applicable
  - i. Residence zip code

E. Each PedRC shall have written guidelines in place for patients, parents of minor children who are patients, legal guardians of children who are patients, and primary caretakers of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child.

F. **ED Requirements:** All designated PedRCs shall comply with the following emergency department (ED) requirements:

1. ED administrative personnel including:
  - a. A Medical Director for the ED; and
  - b. A Physician Coordinator for pediatric emergency care (may be met by staff currently assigned to other roles in the department and may be shared between EDs). The Physician Coordinator shall:

- i. Be a qualified emergency specialist *or* a physician who is a qualified specialist in Pediatrics or Family Medicine *and* shall demonstrate competency in resuscitation of children of all ages from neonates to adolescents.
  - ii. Assume administrative responsibilities that may include, but not be limited to:
    - Oversight of ED pediatric CQI process
    - Liaison with appropriate hospital-based pediatric care committees
    - Liaison with PedRCs, Trauma Centers, the Program, base hospitals, pre-hospital care providers, and community hospitals
    - Facilitation of pediatric emergency education for ED staff
    - Ensuring pediatric disaster preparedness.
  - c. met by staff currently assigned other roles in the emergency department, or in-house departments, and may be shared between EDs). The Nursing Coordinator shall:
    - i. Be a registered nurse (RN) with at least two (2) years' experience in pediatrics or emergency nursing within the previous five (5) years
    - ii. Demonstrate competency in resuscitation of children of all ages from neonates to adolescents
    - iii. Assume administrative responsibilities that may include but not be limited to:
      - Coordinate with the pediatric Physician Coordinator for pediatric CQI activities
      - Facilitate ED nursing continuing education and competency evaluations in pediatrics
      - Liaison with pediatric critical care centers, trauma centers, the Program, base hospitals, pre-hospital care providers, and community hospitals
      - Liaison with appropriate hospital-based pediatric care committees
      - Coordination with the Physician Coordinator to ensure emergency pediatric disaster preparedness
2. Personnel staffing the ED shall include, but not limited to:
- a. Physicians that are qualified emergency specialists, *or* qualified specialists who demonstrate competency in resuscitation of children of all ages from neonates to adolescents

- b. Registered Nurses (RNs) with at least one (1) ED RN per shift with current completion of PALS, APLS, ENPC, or other equivalent pediatric emergency care nursing course
  - c. Midlevel practitioners that may include Nurse Practitioners and/or Physician Assistants, as applicable, regularly assigned to the ED who care for pediatric patients and demonstrate competency in resuscitation of children of all ages from neonates to adolescents
  - d. Other services/personnel: Back-up personnel to the ED including, but not limited to:
    - i. A qualified pediatric specialist available for in-house consultation, *or* through real time consultation (e.g. phone telemedicine) or via agreed upon process within transfer agreements
    - ii. Pediatric qualified subspecialists (as a minimum pediatric Intensivist) available for in-house consultation, *or* through phone consultation and transfer agreements
    - iii. Support services including laboratory, radiology, and pharmacy to include qualified staff and necessary equipment
    - iv. Respiratory care specialists who respond to the emergency department.
      - 1. Respiratory care specialists shall verify their competence to support oxygenation and ventilation of pediatric patients to the Director of Respiratory Services. This verification may include, but is not limited to:
        - o Current completion of the American Heart Association Pediatric Advanced Life Support course, *or*
        - o The American Academy of Pediatrics and American College of Emergency Physicians sponsored Advanced Pediatric Life Support Course, *or*
        - o Continuing education courses specific to resuscitation of pediatric patients.
3. Pediatric equipment and supplies. Use of pediatric equipment and supplies requires:
- a. A pediatric chart, length-based resuscitation tape, medical software, or other system available to assure ready access to



- proper sizing of resuscitation equipment and proper dosing of medications
- b. Pediatric equipment, supplies, and medications easily accessible, labeled, and logically organized, including, but not limited to. the following:
    - i. Portable resuscitation supplies (crash cart) with a method of verification of contents on a regular basis
    - ii. General equipment for patient and fluid warming, patient restraint, weight scale (in kilograms), and pain scale tools for all age children
    - iii. Monitoring equipment appropriate for children in all pediatric sizes including blood pressure cuffs, Doppler device, ECG monitor/defibrillator, hypothermia thermometer, pulse oximeter, and end tidal CO<sub>2</sub> monitor
    - iv. Respiratory equipment and supplies appropriate for pediatric patients including clear oxygen masks, bag-mask devices, intubation equipment, tracheostomy equipment, oral and nasal airways, nasogastric tubes, and suction equipment
    - v. Vascular access supplies and equipment appropriate for pediatric patients including intravenous catheters, intraosseous needles, umbilical and central venous catheters, infusion devices, and IV solutions
    - vi. Fracture management devices appropriate for pediatric patients including extremity and femur splints, and spinal stabilization devices
    - vii. Specialized pediatric trays or kits including lumbar puncture tray, difficult airway kit to include laryngeal mask airways and other devices to provide assisted ventilation if bag-mask ventilation or intubation are unsuccessful, tube thoracostomy tray to include chest tubes sizes for children of all ages, newborn delivery and resuscitation kit to include supplies for immediate delivery and resuscitation of the newborn, and urinary catheter trays to include urinary catheters for children of all ages

G. **Medications** for the care of children requiring resuscitation shall be consistent with the most current evidence-based recommendations (e.g. American Heart Association Pediatric Advanced Life Support). These shall be available in the ED.

## VI. COMPREHENSIVE PEDIATRIC RECEIVING CENTER REQUIREMENTS:

In addition to the requirements in Section V of this policy, a Comprehensive PedRC shall:

- A. Meet all criteria of an Advanced PedRC.
- B. Be a CCS Approved Tertiary Hospital with specialized in-patient intensive care and diagnostic, operative, therapeutic services and equipment, and with in-house and/or promptly available physician specialists in pediatric subspecialties. A facility may be designated by the Program if the facility has full, provisional, or conditional CCS approval. Documentation of CCS eligibility must be on file at CCS.
- C. Be capable of providing comprehensive specialized pediatric medical and surgical care to any acutely ill and injured child.
- D. Provide ED services which include a separate pediatric ED or designated area for emergency care of children within an ED and includes physician staff who are qualified emergency specialists in emergency medicine or pediatric emergency medicine.
- E. Have in-patient resources including at a minimum:
  1. Twenty-five (25) licensed pediatric beds (exclusive of licensed intensive care neonatal nursery or intensive care beds)
  2. A NICU
  3. A PICU
- F. Plan and implement ongoing outreach to PedRCs (Advanced, General, and Basic) including:
  1. Collaborate for education in emergency care of pediatric patients
  2. Consultation via phone, telemedicine or onsite regarding:
    - a. Emergency care and stabilization
    - b. Transfer
    - c. Transport
- G. Accept patients from Kern County who require specialized care not available at lower-level hospitals within the county through:
  1. Comprehensive PedRC shall accept any patient that meets "emergent medical pediatric" criteria (see section X.A for description) for inter-emergency department transfer originating within the county

2. Prearranged transfer agreements for pediatric patients needing specialized care not available at the Comprehensive PedRC (such as burn centers, spinal cord injury centers, rehabilitation facilities)
- H. Serve as a county referral center for the specialized care of pediatric patients or in special circumstances provide safe and timely transfer of children to other resources for specialized care.

## **VII. ADVANCED PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

In addition to the requirements in Section V of this policy, a Advanced PedRC shall:

- A. Be a CCS approved Pediatric Community Hospital which has most specialized diagnostic, operative, therapeutic services and equipment, and with promptly available pediatric subspecialists. A facility may be designated by the if the facility has full, provisional, or conditional CCS approval. Documentation of CCS eligibility must be on file at CCS.
- B. Have inpatient resources including at a minimum:
  1. Eight (8) licensed pediatric beds (exclusive of licensed intensive care neonatal nursery)
  2. Community neonatal intensive care unit (NICU) or as an intermediate NICU if it meets the following requirements, as per:
    - a. Article 6, Section 70545 et seq., for the provision of perinatal services and licensed by DHS, Licensing and Certification Division as a perinatal service;
    - b. Article 6, Section 70481 et seq., for the provision of neonatal intensive care services and licensed by DHS, Licensing and Certification Division as an Intensive Care Newborn Nursery (ICNN)
- C. If the hospital has a PICU then it shall be licensed by DHS, Licensing and certification Division for intensive care services, and meet the requirements for the provision of intensive care services pursuant to CCR Title 22, Division 5, Chapter 1, Article 6, Section 70491 et seq.
- D. Include ED services with physician staff who are qualified emergency specialists.
- E. Have a department of pediatrics within the medical staff structure.

- F. Establish formal written agreements with a minimum of one (1) Comprehensive PedRC as approved by the Program, for education, consultation, and transfer of pediatric patients for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- G. Collaborate with Comprehensive PedRC for education in emergency care of pediatric patients and consultation including, but not limited to:
  - 1. Emergency care and stabilization
  - 2. Transfer
  - 3. Transport
- H. Accept patients from Kern County who require specialized care not available at lower-level hospitals within the county through:
  - 1. Advanced PedRC shall accept any patient that meets “emergent medical pediatric” criteria (see section X.A. for description) for inter-emergency department transfer originating within the county
  - 2. Prearranged transfer agreements for pediatric patients needing specialized care not available at the Comprehensive PedRC (such as trauma centers, burn centers, spinal cord injury centers, rehabilitation facilities)
- I. All Advanced PedRCs shall meet the following personnel requirements:
  - 1. Have a physician and nurse Pediatric Emergency Care Coordinator (PECC).
  - 2. 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.
  - 3. Social work services in the pediatric service department 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.
  - 4. Behavioral health specialists with pediatric experience to include, but not be limited to, psychiatrists, psychologists, and nurses.
  - 5. The following specialties shall be on-call, and available for consultation to the ED or NICU within 30 minutes by telephone and in-person within one hour:
    - a. Neonatologist.
    - b. General Surgeon with pediatric experience.

- c. Anesthesiologist with pediatric experience.
- d. Pediatric Cardiologist.
- 6. The following specialties shall be on-call, and available to the NICU or ED either in-person, by phone, or by telehealth, within 30 minutes:
  - a. Radiologist with pediatric experience.
  - b. Otolaryngologist with pediatric experience.
  - c. Orthopedist with pediatric experience.
- 7. The following qualified specialists shall be available twenty-four (24) hours a day, 7 days a week, for consultation which may be met through a transfer agreement or telehealth:
  - a. Pediatric Gastroenterologist.
  - b. Pediatric Hematologist/Oncologist.
  - c. Pediatric Infectious Disease.
  - d. Pediatric Nephrologist.
  - e. Pediatric Neurologist.
  - f. Pediatric Surgeon.
  - g. Cardiac Surgeon with pediatric experience.
  - h. Neurosurgeon with pediatric experience.
  - i. Obstetrics/gynecologist with pediatric experience.
  - j. Pulmonologist with pediatric experience.
  - k. Pediatric Endocrinologist.

## **VIII. GENERAL PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

A hospital with basic emergency services staffed with a qualified specialist twenty-four hours a day, seven days a week (24/7), which may have limited inpatient services. The General PedRC is a general community hospital that has adult in-patient specialty care and has no dedicated inpatient pediatric services; however diagnostic, operative, therapeutic services and equipment, and selected pediatric physician specialists are available for consultation.

In addition to the requirements in section V of this policy, a General PedRC shall:

- A. Establish formal agreements with a minimum of one Comprehensive PedRC as approved by the Program, for education, consultation, and transfer of pediatric patients.
- B. Collaborate with Comprehensive and/or Advanced PedRC for:
  - 1. Education in emergency care of pediatric patients

2. Consultation regarding
  - a. Emergency care and stabilization
  - b. Transfer
  - c. Transport
- C. Develop written agreements with Comprehensive and/or Advanced PedRCs to transfer pediatric patients for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- D. Develop transfer agreements for pediatric patients needing specialized care (such as trauma center, burn center, spinal cord injury center, rehabilitation facilities).

#### **IX. BASIC PEDIATRIC RECEIVING CENTER REQUIREMENTS:**

A small and/or rural hospital, as defined by state rural criteria, with limited or no inpatient care capability and limited physician specialists available for consultation.

ED services may include physician staffing twenty-four hours and day, seven days a week (24/7), or a physician available for consultation (e.g. stand-by or critical access hospital).

In addition to the requirements in Section V. of this policy a Basic PedRC shall:

- A. Establish formal agreements with a minimum of one (1) Comprehensive PedRC as approved by the Program, for education, consultation, and transfer of pediatric patients.
- B. Develop written agreements with Comprehensive and/or Advanced PedRCs to transfer all pediatrics for stabilization and post-stabilization care ensuring the highest level of care appropriate and available.
- C. Collaborate with a Comprehensive and/or Advanced PedRC for:
  1. Education in emergency care of pediatric patients
  2. Consultation regarding:
    - a. Emergency care and stabilization
    - b. Transfer
    - c. Transport

- D. Develop transfer agreements for pediatric patients needing specialized care (such as trauma centers, burn centers, spinal cord injury centers, rehabilitation facilities).
- E. At minimum, one licensed registered nurse or advanced care practitioner per shift in the emergency department shall have current completion of the American Heart Association Pediatric Advanced Life Support, Advanced Pediatric Life Support, completion of an Emergency Nursing Pediatric Course, or other equivalent pediatric emergency care nursing course, as determined by Emergency Medical Services Program (EMSP).

#### **X. PREHOSPITAL DESTINATION DECISION:**

Pre-hospital personnel shall transport pediatric patients to a pediatric receiving facility that is capable of providing the most appropriate care. Pediatric trauma patients shall be transported in accordance with Prehospital Trauma policies and procedures. Pediatric patients who meet extremis criteria shall be transported in accordance with Destination Decision policies and procedures. The following criteria apply to medical non-extremis pediatric patients only:

- A. Emergent Medical Pediatric: Patients that are under the age of fourteen (14) years with an emergent medical complaint shall be transported to a Comprehensive or Advanced PedRC if ground transport time is thirty (30) minutes or less. Ground transport times that are greater than thirty (30) minutes may be transported to the closest, most appropriate receiving hospital. The use of air ambulance transport shall be in accordance with *EMS Aircraft Dispatch-Response-Utilization Policies*. Emergent medical complaints are defined as:
  - 1. Cardiac dysrhythmia
  - 2. Evidence of poor perfusion
  - 3. Severe respiratory distress
  - 4. Cyanosis
  - 5. Persistent altered mental status
  - 6. Status epilepticus
  - 7. Any apparent life-threatening event in less than one (1) year of age
- B. Non-Emergent Medical Pediatric: Patients that are under the age of fourteen (14) years with a medical complaint who do not meet trauma, medical extremis or emergent medical criteria shall be transported to any level PedRC.
- C. Pre-hospital personnel may consider base contact with the highest level of PedRC available to assist in destination decision.

## **XI. TRANSFER OF PEDIATRIC PATIENTS:**

Each PedRC shall have an Interfacility Transfer Plan for pediatric patients. Patients may be transferred between and from PedRCs providing that:

- A. Interfacility transfer process that is streamlined to include rapid acceptance and transfer of pediatric patients with evaluation and communication with one or more of the following:
  - 1. A qualified pediatric specialist
  - 2. A qualified emergency medicine physician
  - 3. A pediatric intensivist
  - 4. A neonatologist
  - 5. A pediatric critical care fellow
  - 6. A neonatology fellow
  
- B. The process for transfers of pediatric patients between PedRCs shall be in accordance with Title 22 and EMTALA requirements.
  
- C. Any transfer which is determined by the ED physician of record, or pediatric inpatient service, medically prudent, and in accordance with Program interfacility transfer policies.
  
- D. The PedRC has written criteria for consultation and transfer of patients needing a higher level of care.
  
- E. Hospitals receiving pediatric emergency patients participate in EMSC and CQI activities for those pediatric emergency patients who have been transferred.

## **XII. APPLICATION PROCESS FOR PEDIATRIC RECEIVING CENTER (PedRC):**

- A. The following milestones outline the application process for a hospital to become designated as a Pediatric Receiving Center.
  - 1. Submit letter of application to the Program, the letter shall:
    - a. Specify intent to obtain PedRC designation and level
    - b. Identify names and contact information, including email addresses, for key pediatric personnel: Emergency Department Medical Director, Pediatric Physician Coordinator, Pediatric Nursing Coordinator, and administrative contact
    - c. Identify the anticipated target date for PedRC designation



- d. List supporting documents being submitted with the letter to fulfill the designation requirements
  2. Compile and submit to the Program all information and documents requested in Appendix B, Column 2, "Objective Measurement" of the *Pediatric Receiving Center Designation Self Evaluation Tool*.
  3. All application materials will be reviewed for completeness. Additional information may be requested, if needed. Upon determination that the application is complete, the applicant and the Program will work towards execution of the designation agreement.
  4. Pediatric Receiving Center Designation agreement will be presented to the Board of Supervisors for approval and formal designation.
- B. The process for re-designation will be the same as stated above. Re-designation of PedRCs shall be every three (3) years with the exception of the letter of intent. Re-designation materials must be submitted to the Program ninety (90) days in advance of the expiration date of the designation.

### **XIII. LOSS OF DESIGNATION:**

- A. Any designated PedRC which is unable to meet the following requirements shall be subject to termination or loss of PedRC designation:
1. Inability to maintain designation criteria as stated in this policy.
  2. Failure to comply with any policy, procedure, or regulation mandate by Local, State, or Federal Government.
- B. If the Program finds a PedRC to be deficient in meeting the above criteria, the Program will issue the PedRC a written notice, return receipt requested, setting forth with reasonable specificity the nature of the apparent deficiency.
- C. Within ten (10) calendar days of receipt of such notice, the PedRC must deliver to the Program, in writing, a plan to cure the deficiency, or a statement of reasons why the PedRC disagrees with the Division notice.
- D. The PedRC shall cure the deficiency within thirty (30) calendar days of receipt of notice of violation.
- E. If the PedRC fails to cure the deficiency within the allowed period or disputes the validity of the alleged deficiency, the issue will be brought to the Emergency Medical Care Advisory Board (EMCAB) for adjudication. EMCAB may make a recommendation to the Program for resolving the issue.

Revision Log:

01/10/13: Creation of Policy  
10/25/13: Comments received. Policy amended.  
01/07/14: Comments received. Policy amended.  
03/04/14: Comments received via Pediatric Designation meeting. Policy amended with agreement from all in attendance.  
05/08/14: EMCAB Approval- Implementation Date set 05/09/2014  
08/14/15: EMCAB Approval- Remove requirement for transfer agreements for Level I&II, add acceptance of patients meeting emergent medical criteria.  
11/11/2016 EMCAB Approval- Addition of PAC as Appendix C.  
9/18/19: Changed "Division" to "Program." Updated policy to reflect EMSA Title 22, Chapter 14. Removed links to EMSA Policies that were removed once Chapter 14 was published.

## APPENDIX A: PEDIATRIC RECEIVING CENTER DATA ELEMENTS

At a minimum, each PedRC shall collect and submit the following mandatory data elements to the Program on a quarterly basis.

Baseline Data	Cause of Illness or Injury
Arrival time/date to ED	Discharge or transfer diagnosis
Date of Birth	External Cause of Injury (E Codes)
Gender	Injury location
Ethnicity	Disposition
Mode of Arrival	Principal Procedures
Primary Impression	Other Procedures
	Discharge or transfer time and date from ED
	Admitting facility name
	Residence Zip Code

## **APPENDIX B: PEDIATRIC RECEIVING CENTER DESIGNATION SELF-EVALUATION TOOL**

The Following pages need completion by applicant for Pediatric Receiving Center designation and re-designation (every three (3) years). “Pediatric Designation Contract Standard” and “Objective Measurement” refers to all standards required. The “PedRC Level” section is what level of PedRC requires the standard of the preceding section, circle “Yes” or “No” as applicable. A completed copy of the Pediatric Receiving Center Designation Criteria Application and Evaluation Tool and copies of any agreements and licensing that are requested are to be placed in the front of the application binder.

## Pediatric Receiving Center Designation Self Evaluation Tool

Pediatric Designation Contract Standard	Objective Measurement	PedRC Level	Meets Standard		Comments
<b>GENERAL PROVISIONS</b>					
Current license as a general acute care hospital	Copy of license	C A G B	Y	N	Required for designation
Permit for basic emergency services in Kern County (rural standby emergency services)	Copy of permit	C A G B	Y	N	Required for designation
Current designation as a Paramedic base station in Kern County	Hospital Contracts	C A	Y	N	Required for designation
Participation in Pediatric Advisory Committee	Provide name, position for person designated to attend	C A G B	Y	N	Required for designation
Approved pre-hospital continuing education provider	Copy of schedule of courses available for prehospital personnel  Copy of CE certificate to be issued for continuing education courses with all required information	C A G B	Y	N	Required for designation
Alignment with Comprehensive PedRC  Alignment for outreach and education.	Provide evidence of alignment or copy of contract with Comprehensive	A G B	Y	N	Required for designation
Community Education Participation	Provide evidence of community education program relating to pediatric illness and injury prevention efforts	C A G B	Y	N	Required for designation
<b>PEDIATRIC RECEIVING CENTER REQUIREMENTS</b>					
California Children Service approved at appropriate level	Documentation on file at CCS	C A	Y	N	Required for designation

Continuous availability of PedRC resources 24 hours a day 7 days a week 365 days a year.	On-Call Schedules for 3 months. On-Call Policy/Procedure	C A	Y	N	Required for designation
Pediatric in-patient services	Verification of appropriate number of licensed pediatric beds	C A	Y	N	Required for designation
Separate Department of Pediatrics within the medical staff structure	Verification of a Department of Pediatrics	C A	Y	N	Required for designation
Neonatal Intensive Care Unit	Verification of a NICU	C A	Y	N	Required for designation. Advanced must have NICU, PICU is optional
CQI Program to include structure, process, and outcome evaluations	Written quality improvement plan or program description.  <input type="checkbox"/> Integrate ED, Pre-hospital, trauma, inpatient, critical care <input type="checkbox"/> Integrate findings into education and clinical competency evaluation for staff	C A G B	Y	N	CQI plan or policy only required for initial designation Ongoing expectation  Data Collection and Management based on Pediatric EMS data elements
CQI Program Pediatric Indicators	Review protocol/program description to deal with:  <input type="checkbox"/> Deaths <input type="checkbox"/> Transfers <input type="checkbox"/> Child Maltreatment Cases <input type="checkbox"/> Cardiopulmonary/Respiratory Arrest <input type="checkbox"/> Trauma Admission <input type="checkbox"/> Operating Room Admissions <input type="checkbox"/> ICU Admissions <input type="checkbox"/> Selected Return Visits to the ED	C A G B	Y	N	Policy and procedure or program description only required for initial designation Ongoing expectation

	<input type="checkbox"/> Patient Safety including adverse events				
Pediatric Emergency Care Policies, Procedures, or Protocols	Review policies/ procedures/protocols <input type="checkbox"/> Illness and injury triage <input type="checkbox"/> Pediatric assessment <input type="checkbox"/> Physical and chemical restraint <input type="checkbox"/> Child maltreatment <input type="checkbox"/> Consent <input type="checkbox"/> Death of a child <input type="checkbox"/> Procedural sedation <input type="checkbox"/> Immunization status and delivery <input type="checkbox"/> Mental health emergencies <input type="checkbox"/> Family centered care <input type="checkbox"/> Communication with primary care provider of patient <input type="checkbox"/> Pain assessment and treatment <input type="checkbox"/> Disaster Preparedness Plan for Pediatrics	C A G B	Y	N	Required for designation
Medication Safety policy, procedure or protocol	Review policies/ procedures/protocols for medication safety to address the following: <input type="checkbox"/> Kilogram only scale <input type="checkbox"/> A Process to solicit feedback from staff including medication errors	C A G B	Y	N	Required for designation

	<input type="checkbox"/> Involvement of families in the medication safety <input type="checkbox"/> Orders that are clear and unambiguous <input type="checkbox"/> Mental health and behavioral emergencies including drug and alcohol abuse				
Participation in Kern County EMS data collection	Document agreeing to provide data elements deemed mandatory by Kern County EMS Program	C A G B	Y	N	Name and contact information of responsible personnel required for designation
Written Guidelines for patients, parents/guardians of patients to provide input and feedback regarding care of the patient	Guidelines for Patients, Review documentation of guideline or feedback policy	C A G B	Y	N	Designation Ongoing Expectation
<b>ED PERSONNEL REQUIREMENTS</b>					
ED Medical Director	Copy of medical license or contract	C A G B	Y	N	Required for designation
Physician Coordinator for pediatric emergency care  Responsibilities: Oversight of ED pediatric CQI process  Liaison with appropriate hospital-based pediatric care committees  Liaison with PedRCs, trauma centers, Program, base hospitals, pre-	Copy of current Board Certifications  Copy of Job description  Verification of competency in resuscitation of children of all ages  May be met by staff currently assigned other roles in the department, and may be shared between ED	C A G B	Y	N	Required for designation



<p>hospital care providers, community hospitals</p> <p>Participates in protocol development</p> <p>Facilitate pediatric emergency education for ED staff</p> <p>Coordinate with RN Coordinator to ensure pediatric disaster preparedness.</p>				
<p>RN Coordinator for pediatric emergency care</p> <p>Responsibilities:</p> <p>Coordinate with pediatric Physician Coordinator for CQI</p> <p>Facilitate ED nursing continuing education and competency evaluations in pediatrics</p> <p>Liaison with ped critical care centers, trauma centers, Program, base hospitals, pre-hospital care providers, community hospitals</p> <p>Liaison with appropriate hospital-based pediatric care committees</p>	<p>Copy of RN License</p> <p>Evidence of experience in pediatrics or emergency nursing</p> <p>Verification of competency in resuscitation of children of all ages</p> <p>Copy of Job description</p> <p>May be met by staff currently assigned other roles in the department, and may be shared between ED</p>	<p>C A G B</p>	<p>Y    N</p>	<p>Required for designation</p>

Coordinate with Physician Coordinator in ensure pediatric disaster preparedness					
Emergency Department Staffing:  Physicians	Copy of current Board Certifications  Verification of competency in resuscitation of children of all ages  Evidence of ED physician coverage by at a minimum one physician with appropriate qualifications for 3 months	C A G B	Y	N	Required for designation  Ongoing expectation
Emergency Department Staffing:  Registered Nurses	Evidence of at least one ED RN per shift with qualifications for 3 months  Copy of RN license  Copy of course completion/card with current PALS, APLS, ENPC, or equivalent	C A G B	Y	N	Required for designation  Ongoing expectation
Emergency Department Staffing:  Midlevel practitioners if regularly assigned to ED and who care for pediatric patients	Copy of license  Verification of competency in resuscitation of children of all ages	C A G B	Y	N	Required for designation  Ongoing expectation
Qualified pediatric specialist -Neonatologist.	Copy of Board Certifications	C A	Y	N	Required for designation  Ongoing expectation

-General Surgeon with pediatric experience. -Anesthesiologist with pediatric experience. -Pediatric Cardiologist.  Available on-call, and available for consultation to the ED or NICU within 30 minutes by telephone and in-person within one hour.	Verification of process, policy, procedure, job description or work schedule for 3 months				
Qualified pediatric specialist  Available for in-house consultation, or telemedicine, or transfer process	Copy of Board Certifications  Verification of process, policy, procedure, job description or work schedule for 3 months	C A G B	Y	N	Required for designation  Ongoing expectation
Pediatric qualified subspecialist (as a minimum pediatric Intensivist)  Available for in-house consultation, or telemedicine and transfer process	Copy of Board Certifications  Verification of process, policy, procedure, job description or work schedule for 3 months	C A G B	Y	N	Required for designation  Ongoing expectation
Support Services:  a. Respiratory Care b. Laboratory c. Radiology d. Pharmacy	Evidence of availability of services with qualified staff	C A G B	Y	N	Required for designation
<b>ED SUPPLIES AND EQUIPMENT</b>					
Pediatric General Supplies and Equipment (easily accessible and labeled)	<input type="checkbox"/> Pediatric chart; length-based resuscitation tape, medical software, or other system equivalent <input type="checkbox"/> Portable resuscitation	C A G B	Y	N	Required for designation

	<p>supplies “Crash Cart”</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Patient and fluid warming device</li> <li><input type="checkbox"/> Patient restraint</li> <li><input type="checkbox"/> Kilogram only scale</li> <li><input type="checkbox"/> Pain scale appropriate for children</li> </ul> <p>Pediatric size monitoring equipment:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Blood pressure cuff</li> <li><input type="checkbox"/> Doppler Device</li> <li><input type="checkbox"/> Electrocardiography Monitor/Defibrillator</li> <li><input type="checkbox"/> Hypothermia thermometer</li> <li><input type="checkbox"/> Pulse Oximeter</li> <li><input type="checkbox"/> End Tidal CO2 monitoring device</li> </ul> <p>Fracture management:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Splints</li> <li><input type="checkbox"/> Traction splints</li> <li><input type="checkbox"/> Spinal stabilization devices</li> </ul> <p>Specialized Pediatric Trays/Kits:</p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lumbar puncture <ul style="list-style-type: none"> <li><input type="checkbox"/> Infant</li> <li><input type="checkbox"/> Child</li> </ul> </li> <li><input type="checkbox"/> Difficult airway <ul style="list-style-type: none"> <li><input type="checkbox"/> Supraglottic</li> <li><input type="checkbox"/> Needle/Surgical Cricothyrotomy</li> </ul> </li> <li><input type="checkbox"/> Tube thorachostomy tray <ul style="list-style-type: none"> <li><input type="checkbox"/> 12-36F</li> </ul> </li> <li><input type="checkbox"/> Newborn Delivery Kit</li> </ul>			
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	<input type="checkbox"/> Newborn Resuscitation equipment <input type="checkbox"/> Umbilical clamp <input type="checkbox"/> Scissors <input type="checkbox"/> Bulb syringe <input type="checkbox"/> towel <input type="checkbox"/> Urinary Catheterization <input type="checkbox"/> 6F-22F				
Respiratory Equipment and Supplies	<input type="checkbox"/> Nasal Cannula <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Non-Rebreather Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Simple Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Nebulizer Mask <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Bag-Mask Device with appropriate size mask <input type="checkbox"/> Neonatal <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Endotracheal Tubes <input type="checkbox"/> Uncuffed/cuffed 2.5mm-5.5 mm <input type="checkbox"/> Cuffed 6.0mm-8.0 mm <input type="checkbox"/> Stylets for ET Tubes <input type="checkbox"/> Pediatric <input type="checkbox"/> Oropharyngeal Airways <input type="checkbox"/> Size 0-5 <input type="checkbox"/> Nasopharyngeal Airway <input type="checkbox"/> Infant <input type="checkbox"/> Child	C A G B	Y	N	Required for designation

	<input type="checkbox"/> Laryngoscope Blades <input type="checkbox"/> Straight 0-3 <input type="checkbox"/> Curved 2-3 <input type="checkbox"/> Laryngoscope handle <input type="checkbox"/> Magill Forceps <input type="checkbox"/> Pediatric <input type="checkbox"/> Suction Catheter <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Yankauer Suction Tip <input type="checkbox"/> Tracheostomy Tubes (0-6) <input type="checkbox"/> Neonatal <input type="checkbox"/> pediatric <input type="checkbox"/> Nasogastric Tubes <input type="checkbox"/> Infant 8F <input type="checkbox"/> Child 10F <input type="checkbox"/> Laryngeal Mask Airway <input type="checkbox"/> Size 1-5 <input type="checkbox"/> Feeding tubes <input type="checkbox"/> 5F <input type="checkbox"/> 8F			
<b>Intravenous Equipment and Supplies</b>	<input type="checkbox"/> Arm Boards <input type="checkbox"/> Infant <input type="checkbox"/> Child <input type="checkbox"/> Catheter-Over-Needle <input type="checkbox"/> 14-24 gauge <input type="checkbox"/> Intraosseous Needles/Devices <input type="checkbox"/> Pediatric <input type="checkbox"/> Umbilical Vein Catheter <input type="checkbox"/> Central Venous Catheter <input type="checkbox"/> 4.0-7.0F double lumen <input type="checkbox"/> Intravenous solutions	<b>C A G B</b>	<b>Y    N</b>	<b>Required for designation</b>

	<input type="checkbox"/> Normal Saline <input type="checkbox"/> Dextrose 5%in Normal Saline <input type="checkbox"/> Dextrose 10% in water <input type="checkbox"/> Fluid warmer <input type="checkbox"/> IV administration sets with calibrated chambers and extension tubing <input type="checkbox"/> Infusion devices with ability to regulate rate and volume of infusion.			
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**MEDICATIONS**

Medications (easily accessible and labeled)	Medications Requirements: <input type="checkbox"/> Alprostadil (PGE1) <input type="checkbox"/> Albumin <input type="checkbox"/> Albuterol <input type="checkbox"/> Atropine <input type="checkbox"/> Adenosine <input type="checkbox"/> Amiodarone <input type="checkbox"/> Antiemetic <input type="checkbox"/> Calcium Chloride 10% <input type="checkbox"/> Dexamethasone <input type="checkbox"/> Dextrose (D <sub>10</sub> W, D <sub>25</sub> W, D <sub>50</sub> W) <input type="checkbox"/> Diphenhydramine <input type="checkbox"/> Dobutamine <input type="checkbox"/> Dopamine <input type="checkbox"/> Epinephrine (1:1000; 1:10,000 Solution) <input type="checkbox"/> Furosemide <input type="checkbox"/> Hydrocortisone <input type="checkbox"/> Ipratropium bromide <input type="checkbox"/> Lidocaine <input type="checkbox"/> Magnesium Sulfate <input type="checkbox"/> Methylprednisone <input type="checkbox"/> Milrinone <input type="checkbox"/> Naloxone Hydrochloride <input type="checkbox"/> Nitroglycerin	C A G B	Y	N	Required for designation  Approved Medications by The American Heart Association Pediatric Advanced Life Support
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	<input type="checkbox"/> Norepinephrine <input type="checkbox"/> Oxygen <input type="checkbox"/> Procainamide <input type="checkbox"/> Sodium Bicarbonate (4.2%, 8.4%) <input type="checkbox"/> Sodium nitroprusside <input type="checkbox"/> Terbutaline <input type="checkbox"/> Topical, Oral, and Parenteral Analgesics <input type="checkbox"/> Antimicrobial Agents (Parenteral and Oral) <input type="checkbox"/> Anticonvulsants Medications <input type="checkbox"/> Antidotes should be accessible to the ED <input type="checkbox"/> Antipyretic drugs <input type="checkbox"/> Bronchodilators <input type="checkbox"/> Corticosteroids <input type="checkbox"/> Inotropic Agents <input type="checkbox"/> Neuromuscular Blockers <input type="checkbox"/> Sedatives <input type="checkbox"/> Vaccines <input type="checkbox"/> Vasopressors			
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**TRANSFER INFORMATION**

Accept in county "emergent medical pediatric" criteria for inter emergency department transfer	Statement verifying acknowledgement	C A	Y	N	Required for designation Shall accept patients meeting "emergent medical pediatric criteria"
Inter-Facility Transfer Guidelines or Cooperative Arrangement	Description of current cooperative practice or copy of supporting policies, procedures or guidelines. List all hospitals collaborating with and for what type services	C A G B	Y	N	Required for designation List of facilities and description of cooperative arrangements (PedRC's and Non-Pediatric Receiving centers)
Copy of transfer agreement:	Plan, Policy, Procedure with estimated travel time	C A G	Y	N	Required for designation. Hospitals



Trauma, spinal cord injury, rehabilitation, or burn patient		B		without trauma or burn unit. Written guidelines or description of current processes for rapid transfer of patients requiring additional care. Including elective or emergency Trauma and/or Burns.
Copy of written transfer agreements with higher level PedRC and Comprehensive PedRC	Transfer policies and procedures.	A G B	Y    N	Required for stabilization and post-stabilization

## Appendix C- Pediatric Advisory Committee (PAC)

- A. The Program shall be responsible to maintain policy compliance within the EMS system, and reserves the right to revise or modify this policy when necessary to protect public health and safety.
- B. Pediatric Advisory Committee (PAC) is an ad hoc subcommittee of the EMS System Collaborative.
- C. Pediatric Advisory Committee (PAC) shall be established to review certain potential problem cases and system trends identified through the submission of data (as described in the (*Pediatric Receiving Center Designation Policy*)).
  1. The Committee shall be composed of the following members:
    - a. Pediatric Emergency Care Coordinator
    - b. EMS Program Coordinator
    - c. Pediatric Program Director
    - d. Emergency Dept. MICN
    - e. EMS Dept. Medical Director
    - f. School Representative/ Consumer Representative
    - g. Community Based Pediatrician and Pediatric Intensivist
    - h. Metro Hospital Emergency Department Representative
    - i. Rural Hospital Emergency Department Representative
    - j. Rural Paramedic Representative
    - k. Metro Paramedic Representative
    - l. Air Ambulance/Critical Care Transport Representative
    - m. Communications Center Representative Ad Hoc
    - n. Law Enforcement Representative
    - o. Child Protective Services Representative

- p. Fire Department Representative
  - q. California Children's Services Representative Ad Hoc
  - r. Social Services Representative
  - s. Respiratory Therapist Ad Hoc
2. This Committee shall respond to the EMS Medical Director and EMCAB's inquiries and requests.
  3. The Committee shall consider and monitor identified issues and advise the Director on policy level recommendations and systemic or process issues as follows:
    - a. Create and monitor quality core measures
    - b. Conduct evidence-based studies relevant to the unique needs and trends of pediatric care county wide.
      - i. The Committee will be responsible for establishing the criteria for cases to be brought to the committee.
      - ii. Each case reviewed by the committee will have a finding of appropriateness of care rendered and will, where appropriate, make recommendations for change.
    - c. Recommend revisions to policies and procedures based on study findings
    - d. Additional review of transfers or major complicated Pediatric patients as requested by a Pediatric receiving center.
    - e. Organize and administer pediatric specific programs as needed.
    - f. Review all cases of prehospital pediatric cardiac arrest.
  4. Meetings will be conducted in accordance with §1040, §1157.5, and 1157.7 of the California Evidence Code, and the California Business and Professions Code 805, 809 and be compliant with HIPAA and HCFA requirements.
  5. All members and invitees of the Committee will be required to maintain confidentiality of patient specific information.

- D. All pediatric organizational providers will submit to the Program the required documentation, as specified by the Program, to verify ongoing compliance with pediatric triage, treatment, and transport protocols.
- E. The Program, in conjunction with organizational providers, will collect data on a regular basis for system evaluation and continued quality improvement.
- F. Any deviations, specific problems, or deficiencies from policies, procedures and protocols shall be documented.
  - 1. This information will be subject to review by the Program and/or the Pediatric Advisory Committee (PAC).

# TRAUMA SYSTEM STATUS REPORT YEAR 2018 - 2019

## **TRAUMA SYSTEM SUMMARY:**

Kern County's land area is 8,073 square miles. Kern County is California's third-largest county in land area. Kern County hosts a major freeway system with corridors through the state and across the country. Highway 99 and Interstate 5 (Haz Mat allowable Freeway), running north and south, cover the entire west coast, meeting at Interstate 80 in Sacramento. Highway 99 connects with Highway 46, which provides access to the central coast. Highway 58 runs east and west and connects with Interstate 40 and 15, which provide access to Arizona, Nevada, Utah and other major eastward destinations.

The general character of Kern County is rural, except for one large metropolitan area. The City of Bakersfield and the surrounding unincorporated area (Metropolitan Bakersfield) has 384,188 people, approximately 43 percent of the County's 896,764 total population (2018 Census Estimate).

Population growth has slowed in recent years but is expected to accelerate through 2019 with a growth rate of 0.75%. Kern County remains one of the fastest growing areas of the state. The County's population is expected to reach 1,016,214 by the year 2022, an increase of more than 12 percent over the current population (U.S. Census Bureau, 2015).

A 2018 Occupational Employment Statistics Survey showed the mean hourly wage earned in California to be \$27.81, however Kern County's median wage was \$4.62 less per hour at \$23.19 (California Employment Development Department). According to 2018 census data, the County's median household income is \$49,854, in comparison to \$63,783 for the State.

Kern County's 2018 annual average unemployment rate of 8.0 percent remains more than 2.4 percent higher than the State's and the nation's unemployment rates. These rates do not consider the agricultural work force, jobs that are traditionally low paying and seasonal. An additional 128,000 uninsured seasonal workers reside in the County for six to eight months each year.

The geography and the large populous in rural communities along with the distances between these communities create a challenge to provide a rapid access to trauma

care. The extensive freeway system through Kern County contributes to a high demand on Kern Medical for trauma services. Rapid population growth, below average median incomes and higher than average unemployment rates contribute to ongoing struggles for financial reimbursement.

The Kern County Trauma System is an inclusive system, which operates with nine hospitals that are capable of receiving trauma patients. The designated trauma receiving hospitals consist of one Level II Trauma Center, Kern Medical, and one level IV Trauma Center, Ridgecrest Regional Hospital. Kern Medical serves all of Kern County and provides resources to patients from surrounding counties on a mutual aid basis. Ridgecrest serves the eastern areas of Kern County along with China Lake Naval Air Weapons military base.

Kern Medical worked diligently to update the registry by submitting data with a new Trauma Cloud Database system for ease of information relay to the American College of Surgeons (ACS) as well as the state. Currently Kern Medical has uploaded 2018 data to the registry successfully. They are on track to enter in data for 2019 Q1/Q2. Kern Medical data submission to both state as well as National Trauma Data Bank January through March 2019 is currently in process.

During fiscal year 2018 Kern Medical treated 2,885 patients who met Kern County trauma triage criteria. Of those 2,885, patients, 2,557 were from scene, 211 from outside hospitals/urgent care/clinics. Of those 2,885, patients, 2,768 met the trauma registry inclusion criteria for California EMS Information System (CEMSIS). Trauma patients' mechanism of injury for FY 2018 were identified as 82% blunt trauma, and 18% penetrating. Kern Medical experienced trauma numbers increase of 11% from 2017 to 2018. The age group with highest incidents of trauma for 2018 were 25 – 34 (688 patients, 24%), followed by 34 – 44 (456 patients, 16%), 20 – 24 (379 patients, 13%), & 45 – 54 (336 patients, 12%). Kern County currently experiences an under-triage rate of 7%.

Ridgecrest Regional Hospital has begun retrieving and assembling the 2018 trauma data and has assured Kern County Public Health that fiscal year 2018 trauma data and stats will be collected, entered, and submitted to the National Trauma Data Bank and to the state by the required date. Ridgecrest Regional Hospital is also in the process of compiling 2019 trauma data for Q1/Q2 to prepare for submittal to the state as well.

#### **CHANGES IN TRAUMA SYSTEM:**

Kern County EMS Program made changes to the *Trauma Policies and Procedures*, which took three separate policies and condensed them into one policy. Additionally, the Program updated the criteria for Step 3 trauma triage criteria to be more in-line with ACS standards.

The Program submits Core Measure data to EMSA on an annual basis. TEC reviews the Core Measures on a quarterly basis, along with other (QI) quality improvement indicators (case study's) that are requested and under the purview of TEC. The Program has recently completed the EMS Quality Improvement Program to include TEC in the quality improvement program.

Kern County EMS Program is currently applying for an approval of undefined scope of practice for Tranexamic Acid (TXA), Ketamine, and Pediatric King Airways. If approved, TXA will be used in two protocols Shock and Epistaxis. We feel it is important to give our Paramedics a tool for internal bleeding to improve the outcome for our patients. Studies have shown the fluid challenges do little to no good, and in some cases can cause more harm. Like many other systems we are looking at Ketamine as a first line pain medication. This is especially important in our trauma patients that are hypotensive or at risk for respiratory depression. The pediatric King Airways will allow our Paramedics to better manage our pediatric trauma patient airways in the field.

Kern County EMS Program is participating in the regional trauma initiative for the Central California Region. The affiliation between Kern's Level II Trauma Center and CCEMS's Level I Trauma Center in Fresno provides for open dialogue and opportunities for system improvements.

Additionally, Kern Medical continues to participate in ACS verification. The EMS Program has helped to secure some additional funding to help Kern Medical move toward the goal. The administration and staff have committed to maintaining this verification in the future and estimate it being possible in the next one (1) to three (3) years. Kern Medical has completed a consultation with ACS in May 2016 and went through a Verification review in 2017.

#### **NUMBER AND DESIGNATION LEVEL OF TRAUMA CENTERS:**

Kern County currently is served by one Level II Trauma Center- Kern Medical and one Level IV Trauma Center- Ridgecrest Regional Hospital.

#### **TRAUMA SYSTEM GOALS AND OBJECTIVES:**

Goal #1: Encourage Receiving Hospitals to seek designation as Level III or Level IV Trauma Centers.

1. Objective: Establish at least one Level III trauma center in a rural area by December 2020.

Note: One rural hospital has expressed interest in attaining Level III Trauma Center designation. The Program will assist and encourage these hospitals in their endeavor. But, ultimately attainment of this objective is out of the Program's control.

Goal #2: Help support Kern Medical to continue to strive and achieve ACS verification.

1. Objective: Work with Kern Medical to maintain ACS verification over the next two years.
2. Objective: Complete Kern Medical re-designation by end of 2019-2020 fiscal year.
3. Objective: Assist Kern Medical in the scheduled site review from ACS in 2019.

Goal #3: Continued Designated Trauma Hospital data transmission to Trauma Registry (CEMSIS).

1. Objective: Assist Kern Medical and Ridgecrest Regional Hospital in continued transmission of 2018 and 2019 data to CEMISIS for fiscal years 2018-2019.

**CHANGES TO IMPLEMENTATION SCHEDULE: N/A**

### **SYSTEM PERFORMANCE IMPROVEMENT:**

Trauma Evaluation Committee (TEC) is an ad hoc subcommittee of the Kern County EMS System Collaborative and was established to review certain potential problem cases and system trends. The Trauma Operations Review Committee consisting of Kern Medical Trauma Operations personnel & Kern County Public Health Trauma Coordinator meet monthly usually on the 3<sup>rd</sup> Monday of the month to discuss current trauma operations and follow with trauma case reviews. Ridgecrest Regional Hospital is begun to hold Emergency Services Committee meetings on the 1<sup>st</sup> Thursday of the month with discussions involving the trauma teams and status of the emergency preparedness of the Emergency Department. Our most recent introduction to our trauma system has been the introduction of the use of Tranexamic Acid (TXA) Protocols optional scope, for shock and epistaxis, which was presented to in line with current medical studies and in conference with Kern County Emergency Medical Services Director.

The newly consolidated Trauma Policies will make it easier for field personnel comprehend and more readily and accurately triage trauma patients for treatment and selection of designated facility. Each meeting of the Trauma Operations Review and the Emergency Services Committee provide input and evaluation of “best practices” as they relate to core measures, reviews of field trauma deaths, recommends revisions to policies or protocols, reviews transfer or major complicated trauma patients’ records, reviews field deactivations of the Trauma System and verifies ongoing compliance with trauma triage, treatment and transport protocols. TEC also engages in research into best practices with regard to trauma care and is currently engaged in community intervention activities planning and implementation based on local trauma data.



TEC membership and Trauma Operations Review attendance at Kern Medical Hospital has been as follows:

June 15, 2018- 8 members attended  
September 17, 2018 – 8 members attended  
November 19, 2018 -7 members attended  
December 18, 2018 – 0 members attended (canceled)  
February 18, 2019 – 8 members attended  
March 18, 2019 – 11 members attended  
April 15, 2019 – 9 members attended  
May 29, 201 – 11 members attended  
June 17, 2019 -11 members attended  
July 15, 2019 – 10 members attended  
August 19, 2019 – 0 members attended (canceled)  
September 23, 2019 – 8 members attended  
October 21, 2019 – 11 members attended

#### **PROGRESS ON ADDRESSING EMS AUTHORITY TRAUMA SYSTEM PLAN COMMENTS:**

*Comment #1: Trauma System Summary (Required Action): “Data transmitted to CEMISIS-Trauma is to meet the National Trauma Data Bank Inclusion Criteria.” Started transmission of trauma data into CEMISIS-Trauma on January 1, 2014. Kern Medical has established an upload process with Image-trend for transmission of CEMISIS-Trauma data. KM has completed upload of 2016 and 2017 data and is on track for the upload of 2018 data as well. KM has committed financial resources to obtain a third-party contractor to complete the upload of past trauma data.*

*Comment #2: Changes in Trauma System (Comment): The affiliation between Kern Medical and Community Medical Center will assist Kern County in the review of trauma cases as selected by the Trauma Evaluation Committee. Kern Medical Trauma Peer Review monthly meetings attended by KCPHSD TEC Coordinator for case reviews, facility input, issues examination/review, and trauma system monitoring. Outside review is an excellent process for a system with only one designated Trauma Center. We also encourage your continued participation in the Central Regional Trauma Coordinating Committee. The Program will continue to support Kern Medical and Kern County in participation with the Central Regional Trauma Coordinating Committee.*

*Comment #3: System Performance Improvement (Required Action): “By January 1, 2018, provide the signature copy of the Trauma Center Trauma Policies.” “With the next annual Trauma System Status Report, provide a detailed report on the progress of the TEC including dates of meetings and attendance.” There was a delay in approval of*

the policies due to multiple public comment periods, and the timeliness of the quarterly meeting of the Emergency Medical Care Advisory Board for approval of the policies. The policies became effective July 1, 2017. The section titled "SYSTEM PERFORMANCE IMPROVEMENT" includes the requested information regarding the TEC. Even though TEC has been re-designed, it should be noted that the effective date of the policy outlining TEC and its duties is July 1, 2017.

**OTHER ISSUES: N/A**