

STATE OF CALIFORNIA
COMMISSION ON EMERGENCY MEDICAL SERVICES
December 5, 2018
09:00 A.M. – 11:30 A.M.
(Meeting may end early at the completion of all agenda items)
Marines' Memorial Club and Hotel
609 Sutter Street
San Francisco, CA 94102
(415) 673-6672

- 1. Call to Order and Pledge of Allegiance**
- 2. Review and Approval of June 20, 2018 Minutes**
- 3. Director's Report**
 - A. EMSA Program Updates DMS Personnel Systems
 - B. Legislative Report
- 4. Consent Calendar**
 - A. Administrative and Personnel Report
 - B. Legal Report
 - C. Enforcement Report
 - D. POLST eRegistry Update

Regular Calendar

- 5. EMS Administration**
 - A. Approval of Office of Administrative Law Rulemaking Calendar
- 6. EMS Personnel**
 - A. Community Paramedicine Pilot Project Status
 - B. Opioid Programs and EMS
- 7. EMS Systems**
 - A. EMS for Children Regulations
 - B. Health Information Exchange and EMS
- 8. Disaster Medical Services Division**
 - A. After-Action Issues from Recent Responses
- 9. Open Nominations for Election of Officers (March 2019 - March 2020)**

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10. Approval of 2020 Meeting Dates

11. Items for Next Agenda

12. Public Comment

13. Adjournment

A full agenda packet will not be provided at the meeting; however, you can print a full packet, including the agenda from the Department's website at www.emsa.ca.gov. This event will be held in an accessible facility. Individuals with disabilities requiring auxiliary aids or services to ensure accessibility such as language interpreting, assisted listening device, materials in alternate formats or other accommodation, should contact Sandi Baker at (916) 431-3701, no less than 7 days prior to the meeting.

**STATE OF CALIFORNIA
COMMISSION ON EMS
Wednesday, September 12, 2018
Holiday Inn Bayside San Diego
4875 North Harbor Drive
San Diego, 92106**

MINUTES

COMMISSIONERS PRESENT:

Steve Barrow, Dan Burch, Jaison Chand, James Dunford, M.D., Mark Hartwig, James Hinsdale, M.D., Richard O. Johnson, M.D., Daniel Margulies, M.D., David Rose, Jane Smith, Carole Snyder, Brent Stangeland, Lewis Stone, Atilla Uner, M.D., Susan Webb

COMMISSIONERS ABSENT:

Steve Drewniany, Nancy Gordon, Eric Rudnick, M.D.

EMS AUTHORITY STAFF PRESENT:

Howard Backer, M.D., Daniel R. Smiley, Craig Johnson, Jennifer Lim, Lou Meyer, Tom McGinnis, Sean Trask

AUDIENCE PRESENT (partial list):

Mike DuRee, California Fire Chiefs Association
Ross Elliott, California Ambulance Association
Todd Klingensmith, California Paramedic Foundation
Kristi Koenig, MD, County of San Diego EMS
Dave Magnino, Administrator, Sacramento County EMS Agency
Dan Manz, Recognition of EMS Personnel Licensure Interstate CompAct (REPLICA)
Mike McLaughlin, California League of Cities Fire Chiefs Department
Ken Miller, PhD, MD, Santa Clara County EMS
Ray Ramirez, California Fire Chiefs Association
Dave Rocha, California Metropolitan Fire Chiefs Association
Andrew Schouten, Wright, L'Estrange & Ergastolo

1. CALL TO ORDER AND PLEDGE OF ALLEGIANCE

Vice Chair Mark Hartwig called the meeting to order at 10:00 a.m. Fifteen Commissioners were present. Commissioner Johnson led the Pledge of Allegiance.

2. REVIEW AND APPROVAL OF JUNE 20, 2018, MINUTES

Action: Commissioner Johnson moved approval of the June 20, 2018, Commission on Emergency Medical Services Meeting Minutes as presented. Commissioner Hinsdale seconded. Motion carried unanimously with no abstentions.

3. DIRECTOR'S REPORT

Howard Backer, M.D., EMSA Medical Director, presented his report.

A. EMSA Program Updates

Budget

- The EMSA was awarded the following grants:
 - The Hospital Preparedness Grant
 - The Public Health Block Grant
 - The Homeland Security Grant
- The EMSA has the opportunity to apply for a California Centers for Medicare and Medicaid Services (CMS) Matching Grant for Health Information Exchange
- The EMSA lost the Office of Traffic Safety Grant, which was used to support the California EMS Information System (CEMSIS)

Department of Finance Review

Over the course of the next year, the EMSA will undergo a Department of Finance (DOF) mission-based review of activities, authorities, and resources to see if resources match activities and responsibilities.

Specialty Care System Regulations

The Stroke System and ST-Elevation Myocardial Infarction (STEMI) System Regulations will be presented to the Commission for approval in today's meeting.

The EMS for Children Regulations will be presented to the Commission for approval at the December meeting.

Alternate Destination

The EMSA received a letter from EMS administrators and medical directors advocating implementing alternate destination by policy rather than seeking it legislatively. Staff will work with EMS administrators and medical directors on best strategies to achieve this.

Disaster Medical

Medical care support in times of disaster is one of EMSA's key responsibilities. Medical and mental health care issues in shelters during large-scale evacuations are often underestimated. Individuals who end up in shelters often require a higher level of care because their usual home health care resources are unavailable in general population shelters. There is a need to explore alternative resources and concepts to medical shelters.

Questions and Discussion

Commissioner Barrow asked about Assembly Bill (AB) 3115, the Community Paramedicine or Triage to Alternate Destination Act. Dr. Backer stated a stakeholder group will quickly be formed to begin working on regulations if the bill becomes law.

Public Comment

Kristi Koenig, M.D., EMS Medical Director, San Diego County, and former Commissioner, stated AB 3115 is permissive. Many counties may not choose to enact such a program.

B. Legislative Report

Jennifer Lim, EMSA Deputy Director, Policy, Legislative, and External Affairs, reviewed the Legislative Activity Report of the bills currently being tracked and analyzed by staff, which was included in the meeting packet and posted on the website. She summarized the following bills:

- AB 1776 (Steinorth), emergency medical transport of police dogs: pilot project

This bill requires a state legislative report. The handler is at all times to be in the vehicle during transport; the responsibility for care also remains with the handler.

- SB 1305 (Glazer), emergency medical services providers: dogs and cats

This bill has not yet been signed. It specifies that the transport will be handled by the owner, and 911 calls specifically for a dog or cat will not be dispatched.

- AB 1812 (Ting), public safety omnibus

This bill has been signed by the governor. Staff will begin work on the necessary emergency regulations.

- AB 2293 (Reyes), emergency medical services: report

This bill has been signed by the governor.

- AB 2961 (O'Donnell) emergency medical services

This bill has been presented to the governor.

- AB 3115 (Gipson) Community Paramedicine or Triage to Alternative Destination Act

This bill has been enrolled and will soon be presented to the governor.

- SB 695 (Lara) professions and vocations: applications and renewals: individual tax identification number

This bill has been presented to the governor.

Questions and Discussion

Commissioner Uner asked where they transport police dogs. Ms. Lim stated the bill requires the handler to have a pre-determined vet location available.

Public Comment

Todd Klingensmith, Executive Director, California Paramedic Foundation, asked about the Commission's position on AB 3115. Dr. Backer stated the Commission does not take positions on bills.

4. CONSENT CALENDAR

- A. Administrative and Personnel Report
- B. Legal Report
- C. Enforcement Report
- D. POLST eRegistry Update
- E. Overview of Ambulance Zone Exclusivity

Commissioner Barrow asked to pull Consent Item E for a report.

Action: Commissioner Burch moved approval of Items A through D on the consent calendar. Commissioner Snyder seconded. Motion carried unanimously. The item was noted and filed.

Vice Chair Hartwig asked Dr. Backer to present the staff report on Consent Item E.

Dr. Backer stated the staff report, which was included in the meeting packet, was prepared at the request of Commissioner Barrow. Dr. Backer asked that a discussion of this issue be put on a future agenda due to the complex, controversial, and detailed nature of this item.

Questions and Discussion

Commissioner Barrow asked to provide an opportunity for public input today since the December meeting will be held in a different location.

Commissioner Stone suggested encapsulating some of the work of the Chapter 13 Task Force and some of the more recent court cases to provide a balanced look that considers public agencies that have 201 rights with exclusivity within their jurisdictions.

Commissioner Burch stated the EMSA has held workshops on 201/224 issues and can provide background material that may help Commissioner Barrow in his research to narrow the focus and questions on this large subject.

Public Comment

Andrew Schouten, Wright, L'Estrange & Ergastolo, stated the staff memo contains erroneous statements of federal antitrust law. Under numerous US Supreme Court and Ninth Circuit case law, including the Americare case, the EMSA's act of state supervision is not necessary for so-called state action antitrust immunity. Even under cases under Section 224, the Ninth Circuit has always looked at whether the statute authorizes the conduct, not whether EMSA supervises the conduct. This point was recently reaffirmed in the Americare case. That issue has been resolved by the Ninth Circuit. It is disconcerting that this is not disclosed in the staff memo.

Mr. Schouten stated Section 224 is not the only means for EMS providers or administrators to obtain state action antitrust immunity. Americare establishes that Section 201 is such an avenue. The EMS Act generally has been held to be sufficient to provide immunity, including other government code sections authorizing ambulance services.

Mr. Schouten stated there is a specific reference in this memorandum to Health and Safety Code Section 1797.6. He noted that the Ninth Circuit has previously held that

that statute expresses preexisting state policies to displace competition with regulation and monopoly public service.

Mr. Schouten stated his second concern is that the memorandum unduly limits its discussion of exclusivity to local EMS agencies (LEMSAs) in Section 224. The California statutes and case law on ambulance and EMS are extensive and there are numerous statutes and decisions which provide the local governments under state law may limit the number of ambulance providers operating within their jurisdictions and grants ambulance business monopolies to private providers. One would expect that EMSA, as the agency charged with coordinating and integrating all of the state's EMS systems, would also be looking to these other sources of state law to identify how these EMS systems can be integrated, coordinated, and administered in connection with the preference of local citizens, residents, and taxpayers.

Mr. Schouten stated his final concern may be mooted by this having been pulled off the Consent Calendar. This is somewhat of an unusual process. The policy statements in this memorandum actually fall within the mean of the term 'regulation' as used under the Administrative Procedures Act. It is purporting to set forth state policy but applies to more than one circumstance. As such, any policy statement of this nature should be formalized by submitting it to the Office of Administrative Law and obtaining public comment and approval; otherwise, it would result in a void, underground regulation.

Mike McLaughlin, California League of Cities Fire Chiefs Department, stated his concern about the exclusivity piece. The League of California Cities was instrumental in helping to ensure that 1797.201 was part of the EMS Act to help ensure the cities' rights to continue to provide the services that had been established. He asked why the Ninth Circuit ruling was not mentioned in the staff memo as it goes to the direct relevance of providing that antitrust immunity for cities.

Dave Rocha, California Metropolitan Fire Chiefs Association, echoed the comments of the previous speakers. He stated it is an issue of local control for the metropolitan fire departments in the cities and the districts and what exclusivity means.

Ray Ramirez stated he is an attorney representing himself for his comments today. He stated to the extent that the document purports to say there are only three EMS area classifications is an error. The purpose of classifying the EMS areas is to classify the area and then assign rules governing how that area interrelates with the system. As a recent court case indicates, 201 is a separate classification system subject to separate rules. Therefore, to the extent that the Authority's publications show three, that is in error.

Mr. Ramirez stated to the extent that the document purports to imply that local EMS agencies and counties are subject to active state supervision, in the federal antitrust context it is clearly an error of law, supported by many court cases. Local EMS agencies and their plans are subject to state oversight and review under state law, which is an important distinction, but, for the purpose of antitrust immunity, the federal courts, the exclusive arbitrators of this question, have determined that counties are, in fact, municipalities for the purposes of the act of state supervision.

Mr. Ramirez stated over the years the EMSA has issued several letters to several agencies stating they do not have federal antitrust immunity under 201. He requested that the EMSA consider re-sending those letters with the clarifications the Ninth Circuit has provided.

Mike DuRee, Fire Chief, Long Beach, and Past President, California Fire Chiefs Association, stated this is an item that has been debated in the state of California for decades and centers around departments and cities. This is not a fire service issue; it is a cities issue. The reality is cities across the state invested heavily in EMS systems decades before the EMSA was ever created, and the EMS Act of 1980 solidified the cities' rights to continue to provide the service that they provide their communities. He stated he found it concerning that after decades of discussion the staff is unable to provide a report on an issue that they hoped would go through Consent.

Mr. DuRee stated California Fire Chiefs would be happy to provide staff with legal opinions on this issue, including the Americare amicus brief and the legal opinions used to take that case forward. He stated he found it odd that there was no reference in this agenda item to the Americare case, either the lower district court ruling or the Ninth Circuit Court of Appeals. He stated he looked forward to a future discussion, answering this question once and for all, and continuing to provide the world class service constituents and residents expect, unimpeded by state EMS.

Daniel Smiley, EMSA Chief Deputy Director, clarified that this memo was produced for the Commission and published prior to the Americare decision. This was meant to be a high-level discussion piece at the request of a Commissioner, not an all-inclusive policy statement.

Action: Commissioner Burch moved approval of Item E on the consent calendar. Commissioner Hinsdale seconded. Motion carried unanimously with one abstention. The item was noted and filed.

REGULAR CALENDAR

5. RECOGNITION OF EMS PERSONNEL LICENSURE INTERSTATE COMPACT PRESENTATION

Dan Manz, former EMS Director in Vermont, provided an overview, with a slide presentation, of the background, benefits, features, and capabilities of the Recognition of EMS Personnel Licensure Interstate CompAct (REPLICA).

Questions and Discussion

Commissioner Stone asked where this program would show strength quickly. Mr. Manz stated REPLICA is a way to address EMS adjacent-border concerns.

Commissioner Dunford asked if liability follows the individual's agency that originally certified them as they travel across state boundaries. Mr. Manz stated it does. The protocol is the medical direction and oversight from their home state has to be with them.

6. EMS ADMINISTRATION

A. Regulations Update

Ms. Lim reviewed the Regulation Rulemaking Calendar, which was included in the meeting packet.

B. STEMI Regulations

Ms. Lim noted that the full text of the proposed final regulations is posted on the website. She summarized the stakeholder process prior to refining the package for regulations.

Questions and Discussion

Commissioner Burch stated most local EMS agencies have had STEMI and stroke designated facilities and systems of care in place for several years waiting for the regulations to be adopted. Both sets of regulations require submittal of a plan within 180 days for approval to the Authority explaining the current systems. He asked if there is any flexibility on the 180-day deadline. Dr. Backer assured him that existing programs would not be shut down on the deadline, but that 180 days is a reasonable timeframe.

Action: Commissioner Burch moved to adopt the STEMI regulations as presented. Commissioner Stone seconded. Motion carried unanimously with no abstentions.

C. Stroke Regulations

Ms. Lim noted that the full text of the proposed final regulations is posted on the website. She summarized the stakeholder process prior to refining the package for regulations.

Action: Commissioner Dunford moved to adopt the stroke regulations as presented. Commissioner Chand seconded. Motion carried unanimously with no abstentions.

7. EMS PERSONNEL

A. Community Paramedicine Pilot Project Status Update

Sean Trask, Chief of the EMS Personnel Division, deferred to Lou Meyer, Project Manager for the Community Paramedicine Project, to present the Community Paramedicine Pilot Project Status Update.

Mr. Myers reviewed the Issue Brief, which was included in the meeting packet. He stated the Community Paramedicine Pilot Projects are showing improved patient care, hospital readmission reductions, and fewer emergency department visits. The independent evaluator's report has been posted on the website. The report found no patient safety issues reported to EMSA or discovered by the independent evaluator during the last reporting period. Mr. Myers provided an update on the implementation of the additional pilot sites.

Questions and Discussion

Commissioner Dunford noted that the Grand Jury of San Diego County felt strongly that the San Diego pilot project, which was essentially defunded about a year and a half ago, is valuable, and stated the belief that there are plans underway to reintroduce the program.

Mr. Meyer stated, while it is not operational at the moment, the OSHPD community paramedic program and medical protocols are still approved, so it is up to San Diego to reactivate it.

Action: Commissioner Uner moved to accept the Community Paramedicine Pilot Project Status Update. Commissioner Smith seconded. Motion carried unanimously with no abstentions.

B. Medication Shortages Presentation by EMDAC

Mr. Trask stated this agenda item is being presented at the request of the Commission at the last meeting. He noted that the staff memo, which was provided in the meeting packet, provides a brief overview of medication shortages. He introduced Dr. Ken Miller, Medical Director, Santa Clara County EMS Agency, who was invited to provide a presentation on this topic.

Dr. Miller provided an overview, with a slide presentation, of the causes and EMS System mitigation of the EMS sterile injectable generic drug shortages, primarily involving generic drugs.

8. EMS SYSTEMS

A. EMS Quality Core Measures Guidelines

Tom McGinnis, Chief of the EMS Systems Division, provided a brief overview of the history and revisions made to the California EMS System of Core Quality Measures, EMSA publication #166, Appendix E, to accommodate the National EMS Information System (NEMSIS) version 3 data standard. He stated this year will be used as a test year to validate the measures to ensure that they are sound. Staff continues to receive feedback from local EMS agency partners. Recent feedback indicated that some measures need to be altered slightly to make them easier to report on.

Questions and Discussion

Vice Chair Hartwig asked if the additional changes will need to be made prior to Commission approval. Mr. McGinnis stated the changes requested are not substantive to the operation of the measures. They would not change the subject matter or the way the element is collected directly.

Commissioner Margulies asked whether TRA-3, TRA-4, and TRA-5 add additional time spent collecting data that would normally be used for transport.

Dr. Backer stated it does not because almost all medical protocols at the local level now include registering a pain scale. This has become the standard with pre-hospital practice as well as emergency department and hospital practice. The pain scale results determine which medication is used, and then are remeasured, depending on how long the transport time is, to determine the effectiveness of that medication.

Commissioner Burch made a motion to approve the core measures with the removal of TRA-3, TRA-4, and TRA-5. Commissioner Margulies seconded.

Commissioner Webb asked why TRA-3, TRA-4, and TRA-5 should be removed, as they can be assessed en route without a delay of transport.

Commissioner Burch stated these measurements reinforce the false premise that pain is under-treated in light of the opioid crisis.

Dr. Backer stated measures were recommended by medical directors, data managers, administrators, and others. The measurements are already integrated into medical pain treatment and medication protocols and are a part of the national standard Compass measures.

Commissioner Margulies stated the concern that gathering pain data may cause a delay in transportation time and that too much medication may be administered based on that data. However, as long as it has no negative effect, he stated he was willing to leave the measures in.

Vice Chair Hartwig asked if there is a way to make a motion that notes not to delay transport in the core measures.

Commissioner Burch stated the concern that these measures are an issue for providers and LEMSAs medical directors, not for the state.

Commissioner Barrow stated he could not support the motion with those items taken out.

Commissioner Uner asked about consequences for not reporting on the pain measures.

Dr. Backer stated there is no consequence. The measures encourage local jurisdictions to compare to standardized measures to improve their performance.

Commissioner Dunford stated the number one issue is ensuring that acute pain and chronic pain are considered separately to avoid promoting a false sense of the need to treat all kinds of pain in the field.

Action: Commissioner Burch moved to approve the core measures as presented with the omission of TRA-3, TRA-4 and TRA-5. Commissioner Margulies seconded. Motion carried 7 yes, 6 no, and 0 abstain, per roll call vote as follows.

The following Commissioners voted “Yes”: Commissioners Burch, Chand, Margulies, Rose, Stone, and Uner, and Vice Chair Hartwig.

The following Commissioners voted “No”: Commissioners Barrow, Dunford, Johnson, Snyder, Stangeland, and Webb.

B. Ambulance Patient Offload Time Update

Mr. McGinnis stated staff continues to collect and work with data from the Ambulance Patient Offload Time project. 17 LEMSAs have provided information this year compared to 18 last year. Staff is learning more about the ways to display this data. In working with the LEMSAs, staff learned that forms and ways data is collected can be difficult at times and is working to improve the process. Mr. McGinnis stated his hope that more submissions and more information will continue to come in and that, as staff learns

better ways to visually display the information, it will present a good picture of what is happening in the state.

Questions and Discussion

Commissioner Dunford asked if there is any trend in favor of showing improvement based on the limited capacity of the current data. Mr. McGinnis stated there is no definitive trend. Dr. Backer noted that the data is only for the first year, 2017. There is variation year by year.

Commissioner Dunford stated there are some significant outliers and asked if there is evidence of people trying to fix major problems. Mr. McGinnis stated it is early to say concretely.

Action: Commissioner Stone moved to accept the ambulance patient offload time update as presented. Commissioner Burch seconded. Motion carried with no abstentions.

C. California Unintentional Injuries Preventive Strategic Plan Project Presentation

Commissioner Barrow provided an overview, with a slide presentation, of the background, goals, areas of focus, outcome metrics, and data sources of the California Unintentional Injury Prevention Strategic Plan Project.

9. DISASTER MEDICAL SERVICES DIVISION

A. Disaster Healthcare Volunteers/Medical Reserve Corps Program Update

Craig Johnson, Chief of the Disaster Medical Services Division, provided a brief overview of the Disaster Healthcare Volunteers (DHV) Program. He reviewed the activities and deployments of the EMSA DHV Program staff and DHV and MRC volunteers since the last Commission meeting, which were included in the staff memo. EMSA is looking at ways to continue to advance the program, increase registration and utilization, and streamline resources.

Action: Commissioner Uner moved to accept the Disaster Health Volunteers/Medical Reserve Corps Program update as presented. Commissioner Snyder seconded. Motion carried with no abstentions.

10. ITEMS FOR NEXT AGENDA

Commissioner Dunford asked to look at the growing impact of the opioid epidemic in California and how EMS is dealing with that, and how state EMS data is used to cross over to address other issues like jail recidivism. He suggested inviting someone from Washington to present on the SAMHSA and Department of Justice Data Driven Justice Initiative. He suggested discussing how EMSA can become better at collecting data and how it can be used in confidence to address larger population health issues.

Commissioner Stone suggested that the discussion about transport and issues surrounding 201/224 rights also be pushed back to March of next year, due to the tight agenda in the December meeting.

11. PUBLIC COMMENT

Ross Elliott, California Ambulance Association, spoke in support of Proposition 11, a proposal that is important to the private ambulance industry. Proposition 11 will allow private ambulance companies to maintain contact and communication with ambulance crews at all times, including during breaks and meal periods.

Commissioner Stone asked if ambulance personnel have paid breaks. Mr. Elliott stated they are paid for breaks but paid meal times are dependent upon their agreements.

Dave Magnino, Administrator, Sacramento County EMS Agency, spoke as a member of the Muddy Angels, a group of bike riders who ride at five different fundraising-type bike rides throughout the nation to honor the EMS personnel who have given their lives to EMS. The West Coast EMS Memorial Bike Ride is a six-day ride from Reno to San Francisco and is happening at the end of September.

Mr. Magnino stated funds have been raised for over ten years through these bike rides and this year the National EMS Memorial Foundation received approval from Congress to build an EMS memorial in Washington, DC. He stated anyone who would like to support the bike ride by riding, being one of the support vehicles, or donating to the foundation can go to muddyangels.org.

Mr. Klingensmith asked if there was a recommendation for general support of community paramedicine programs from the Commission to Cal-EMSA.

Vice Chair Hartwig stated he did not believe there is formal Commission support for community paramedicine.

Mr. Klingensmith asked if there was a recommendation as far as oversight and whether local control versus state control would be more ideal. It is challenging to learn where the Commission is on this issue. He asked if they feel a balance is ideal to allowing all members of EMS providers to participate, if they feel there should be one or the other, or elimination of other participants. He asked for some kind of comment.

Commissioner Stone stated Commissioners serve different constituencies. Mr. Meyer may be available to lend technical expertise. He suggested that Mr. Klingensmith seek out individual stakeholders to discuss their positions.

Vice Chair Hartwig stated the Commission is in general support of community paramedicine programs.

Commissioner Snyder offered to speak with Mr. Klingensmith offline.

12. ADJOURNMENT

Action: Commissioner Stone moved to adjourn the meeting. Commissioner Johnson seconded. Motion carried unanimously.

Vice Chair Hartwig adjourned the meeting at 12:41 p.m.

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>1. Ambulance Strike Team (AST) – Medical Task Force (MTF)</p>	<p>Michael Frenn, ext. 435</p>	<p>AST/MTF Leader Trainings are conducted on an ongoing basis, as requested. There was significant utilization of the Program for the 2017 North Bay and Southern California wildfires as well as for the 2018 Carr and Mendocino Complex wildfires. Recent activity has resulted in a noticeable increase in interest for Strike Team Leader training. The most recent classes were conducted in September (Orange County and South Lake Tahoe) of this year. EMSA is working to refresh the ASTL Course materials and develop a packet to assist Counties with hosting the course. Requests for classes continue to be received and are scheduled on an as-needed basis.</p> <p>Use of ASTs over the past several years has also revealed issues with reimbursement, particularly with regards to standardization. EMSA has worked with the California Ambulance Association (CAA) and American Medical Response (AMR) on establishing a standardized rate which could be utilized Statewide. It is presently under review with the EMS Administrators Association of California (EMSAAC).</p> <p>A standardized post review process is being implemented to capture data after each deployment. This information will be utilized to modify and improve the curricula and establish appropriate operational parameters.</p> <p>The Disaster Medical Support Units (DMSU), which support and have affiliated ASTs, are strategically placed with local EMS Agencies and ambulance providers throughout the State. All available DMSUs have been distributed, providing a total of 41 DMSUs with affiliated ASTs in the State.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
2. California Medical Assistance Teams (CAL-MAT) Program	Michael Frenn, ext. 435	Hiring by EMSA for persons interested in participating in the CAL-MAT program continues, and program membership is growing. Initial recruitment has been targeted at existing federal Disaster Medical Assistance Team (DMAT) members (Phase I) and four Units have now been officially “stood up” (San Diego, San Francisco Bay Area, Orange County and Sacramento) in areas where DMATs exist. Efforts will now be directed at getting the Los Angeles Unit up. With the establishment of these Units the program has moved into Phase II hiring process allowing non-DMAT personnel to join. Last Spring CAL-FIRE approached EMSA to provide CAL-MAT response for fire base camp medical support. A 3-year contract was executed with CAL-FIRE in September.
3. CAL-MAT Cache	Markell Pierce, ext. 1443	EMSA is in the process of conducting bi-annual inventory and resupply of the (3) CAL-MAT medical supply caches. The bi-annual inventory ensures that all medical supplies are 100% accounted for and up to date. The first cache is now 100% complete and work has started on the second cache. Caches pending inventory are still deployment ready.

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
4. California Public Health and Medical Emergency Operations Manual (EOM)	Craig Johnson, ext. 4171	<p>CDPH and EMSA have released new content for the California Public Health and Medical Emergency Operations Manual (EOM). The EOM Workgroup, subject matter experts, and many reviewers collaborated to develop the new materials, which include:</p> <ul style="list-style-type: none"> • New chapter on Disaster Behavioral Health • New Resource Typing Tools for Disaster Behavioral Health personnel • New chapter on BioWatch • New chapter on Risk Communication • New chapter on Biological Hazards • New chapter on Drinking Water (updated to reflect movement of Drinking Water Program from CDPH to Cal EPA) <p>The materials are posted on the EMSA website at https://emsa.ca.gov/plans/.</p> <p>The Regional Disaster Medical and Health Specialists (RDMHS) continue to conduct EOM training on an ongoing basis.</p>
5. California Crisis Care Operations Guidelines	Jody Durden, ext. 702	Development of a Crisis Care/Scarce Resources guidance document is on hold until funding is made available. EMSA and CDPH recognize the importance of the guidance document so will keep this on our radar.

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>6. Disaster Healthcare Volunteers (DHV) of California (California's ESAR-VHP program): Registering, Credentialing & Mobilizing Health Care Personnel</p>	<p>Patrick Lynch, ext. 467</p>	<p>The DHV Program has over 24,000 volunteers registered. There are 49 healthcare occupations filled by registered volunteers. All 58 counties have trained DHV System Administrators in their MHOAC Programs.</p> <p>EMSA provides routine training and system drill opportunities for all DHV System Administrators on a quarterly basis. The last classes for Basic and Intermediate training were held on November 7 and 8 of this year.</p> <p>Over 9,300 of the 24,000 plus DHV registered responders are Medical Reserve Corps (MRC) members. EMSA trains and supports DHV System Administrators in each of the 36 participating MRC units.</p> <p>EMSA publishes the "DHV Journal" newsletter for all volunteers on a tri-annual basis. The most recent issue was released on January 29, 2018. The "DHV Journal" is available on the DHV webpage of the EMSA webpage: http://www.emsa.ca.gov/disaster_healthcare_volunteers_journal_page.</p> <p>The DHV website is: https://www.healthcarevolunteers.ca.gov.</p>

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>7. Training</p> <p>Weapons of Mass Destruction (WMD)</p> <p>Medical Health Operations Center Support Activities (MHOCSA)</p>	<p>Markell Pierce, ext. 1443</p> <p>Nirmala Badhan, ext. 1826</p>	<p>The California Emergency Medical Response to Weapons of Mass Destruction Incidents (with Med-Plus) course is offered on a continuous basis, requiring a minimum enrollment of 12 students. In October 2018 a course was taught in Chino Valley Medical Center. Next training courses are scheduled for December 2018 – February 2019.</p> <p>Medical Health Operations Center Support Activities (MHOCSA) Training Classes are scheduled in Region IV and V in January 2019.</p>
<p>8. 2018 Statewide Medical and Health Exercise (2018 SWMHE)</p>	<p>Kelly Coleman, ext. 726</p>	<p>The 2018 Statewide Medical and Health Exercise was held in two parts. Region IV focus Anthrax exercise was held November 5-8. The main exercise was held November 13-15 with an infectious disease scenario.</p>
<p>9. Hospital Available Beds for Emergencies and Disasters (HAvBED)</p>	<p>Nirmala Badhan, ext. 1826</p>	<p>Federal requirements for HAvBED reporting have been discontinued. However, EMSA is working with the California Department of Public Health (CDPH) and other partners to determine how to continue to integrate hospital data collection for California use.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>10. Hospital Incident Command System (HICS)</p>	<p>Craig Johnson, ext. 4171 hics@emsa.ca.gov</p>	<p>The Hospital Incident Command System (HICS) activities are sponsored by the California Emergency Medical Services Authority (EMSA).</p> <p>EMSA has assembled a National HICS Advisory Committee to assist with matters relating to the HICS Program. The committee serves as technical advisers on the development, implementation, and maintenance of EMSA's HICS program and activities.</p> <p>The HICS National Advisory Committee 3rd quarter meeting was held on September 27, 2018. The primary focus was to discuss the HICS Guidebook and Toolkit revision cycle and strategy needed to complete the next revision. The committee also discussed the bylaws, formation of workgroups, and future priorities. The next HICS National Advisory Committee meeting will convene in February 2019.</p> <p>The translation of the HICS Guidebook into Mandarin was completed in October of this year by stakeholders in Taiwan, the Republic of China. The translated materials support hospitals in mainland China, Taiwan, Hong Kong and Macau.</p> <p>The Fifth Edition of HICS, Frequently Asked Questions (FAQ), and additional program information are available on the recently revised EMSA website: http://www.emsa.ca.gov/disaster_medical_services_division_hospital_incident_command_system_resources.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
11. Mission Support Team (MST) System Development	Michael Frenn, ext. 435	<p>Activated by EMSA, the MST functions under the Medical/Health Branch of the Medical Health Coordination Center (MHCC), EMSA Department Operational Center (DOC) or Regional Emergency Operational Center (REOC) depending upon the nature of the event and the origin of the resources it supports. The MST provides the management oversight and logistical support for state deployed medical and health teams that may be assigned to the deployment.</p> <p>EMSA is working to increase participation of CAL-MAT members as Mission Support Team (MST) members. In response to the Carr Fire, an MST, staffed by CAL-MAT members and EMSA personnel, supported the CAL-MAT deployment to Shasta County. The deployment was a success and EMSA is using the deployment as a model to further enhance the program. EMSA is recruiting persons interested in filling these positions as part of the recruitment for the CAL-MAT Program.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
12. Response Resources	Markell Pierce, ext. 1443	<p>The bi-annual inventory maintenance of the Mobile Medical Assets caches is underway. The MST caches have been completed and refined based on after-action findings from recent exercises and deployments. The CAL-MAT caches are partially complete. The Response Resources Unit (RRU) continues to integrate updated I.T. and telecommunications equipment to improve MST/CAL-MAT networking infrastructure.</p> <p>The RRU continued audits on the 41 Disaster Medical Support Unit (DMSU) vehicles located around the State. During the audits, EMSA verified that all the DMSU vehicles are being properly maintained and utilized according to written agreements. New audits are in progress focusing on Regions 2, 4 & 5.</p> <p>Annual servicing of the biomedical equipment for the California Medical Assistance Teams (CAL-MAT) caches was completed in October 2018.</p> <p>Pharmacy full inventory and resupply of expired items is completed monthly. Two CAL-MAT pharmaceutical caches have been created for the Cal-Fire Base of Operations wild fire contract deliverables.</p>
13. Information Technology	Rick Stricklin, ext. 1445	<p>EMSA is continuing to design & expand the Meraki wireless system to provide connectivity for data (Cellular, VSAT, wired) and video capabilities during field deployments and incident response.</p> <p>EMSA has enhanced the use of the Mobile Ready Office (MRO) units to support field data operations during field training and incident response.</p> <p>Research and development continues with the C3 communications vehicle to implement new technologies to increase its capabilities and functionality in the field.</p>

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>14. Mobile Medical Shelter Program (MMSP)</p>	<p>Bill Hartley, ext. 1802</p>	<p>Working with other state agencies, and within existing resources, the EMS Authority has redesigned the Mobile Field Hospital (MFH) program into the California Mobile Medical Shelter program. The purpose of the redesign is to modify and expand the potential uses of the equipment into general staging, stabilization and shelter capacity.</p> <ol style="list-style-type: none"> 1. The structures and durable equipment of the first MFH stored at the EMS Authority have been separated by like items for ease of deployment to meet the mission requirements of the Mobile Medical Shelter program. 2. The EMS Authority has reconfigured the 2nd MFH into six (6) multiuse modules to distribute to local partners. We are working with the RDMHSs and LEMSAs to locate one module in each Cal OES Mutual Aid Region. The modules include the shelters, infrastructure equipment, and durable equipment, but does not include biomedical equipment and medical supplies. This redistribution of the MFH allows local partners to deploy this resource rapidly. Potential uses include field sites for Local/Regional incidents, triage/treatment during flu season surge, medical clinic, medical shelter, emergency operations center, staff quarters, disaster exercise, and any other use that requires a field facility. Deployment is at the discretion of the locals without requiring a state resource request. Modules have been placed in Long Beach, Riverside, Sacramento, San Mateo and Santa Cruz. We are targeting Northern Sacramento valley for the placement of the sixth module. 3. The third MFH was transferred on September 8, 2016, to the State Military Department for use by the California National Guard.

**Emergency Medical Services Authority
 Disaster Medical Services Division (DMS)
 Major Program Activities
 December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
15. Regional Disaster Medical/Health Specialists (RDMHS) Program and Medical Mutual Aid System	Nirmala Badhan, ext. 1826	The RDMHS program is a critical component of the Medical and Health Disaster Response System. The functions of the RDMHS are to manage and improve the regional medical and health mutual aid and mutual cooperation systems; coordinate medical and health resources; support development of the Operational Area Medical and Health Disaster Response System; and, support the State medical and health response system through the development of information and emergency management systems. The RDMHS' work closely with EMSA and California Department of Public Health (CDPH) staff to support major disaster planning activities in addition to supporting coordination of medical/health resources during an emergency response. The RDMHSs continue to be instrumental in coordination and support of regional major events and disasters as seen with the recent response to the 2017 and 18 wildfires.
16. Medical Reserve Corps (MRC)	Patrick Lynch, ext. 467	36 MRC units have trained Disaster Healthcare Volunteers (DHV) System Administrators. These MRCs are regular users of the DHV system and active participants in quarterly DHV drills and quarterly DHV user group webinars. Over 9,300 plus of the DHV Program's 24,000 plus volunteers are Medical Reserve Corps volunteers.
17. Statewide Emergency Plan (SEP) Update	Jody Durden, ext. 702	The California Governor's Office of Emergency Services (Cal OES) released the updated in October 2017. The updated version is located at: http://caloes.ca.gov/PlanningPreparednessSite/Documents/California_State_Emergency_Plan_2017.pdf . This version includes a brief description of the Public Health and Medical Mutual Aid System.

**Emergency Medical Services Authority
Disaster Medical Services Division (DMS)
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
18. Southern California Catastrophic Earthquake Response Plan	Kelly Coleman, ext. 726	The California Governor’s Office of Emergency Services (Cal OES) is currently leading the refresh of the Southern California Catastrophic Earthquake Plan. The Emergency Medical Services Authority continues to work with the Regional Disaster Medical Health Specialists, Medical Health Operational Area Coordinator, Emergency Support Functions, Cal OES, California Department of Public Health, California Department of Healthcare Services, Assistance Secretary of Preparedness and Response, and the Federal Emergency Management Agency to update the Public Health and Medical Fact Sheet, Survivor Movement plan, Mass Care Plan, Shelter Fact Sheet, and Course of Action.
19. Patient Movement Plan	Craig Johnson, ext. 4171	The California Patient Movement Plan is in final draft and will be released following final review and consent for distribution by key partner state agencies.
20. Bay Area Catastrophic Earthquake Plan	Kelly Coleman, ext. 726	EMSA participated in the Medical Planning Group for the Bay Area Catastrophic Earthquake Plan revision. EMSA continues to participate in the socialization of the plan.
21. Northern California Catastrophic Flood Response Plan	Nirmala Badhan, ext. 1826	EMSA worked with the Governor’s Office of Emergency Services (Cal OES) for the development of the Northern California Catastrophic Flood Response Plan. EMSA worked closely with the California Department of Public Health to develop a Public Health and Medical Information Analysis Brief. This document is the basis of the Public Health and Medical section of the response plan. The Plan has been signed and will be posted on Cal OES website.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
1. First Aid Practices for School Bus Drivers	Mark Olivas, ext. 445	There are nine (9) School Bus Driver training programs currently approved and no (0) pending review. Technical assistance to school staff and school bus drivers is ongoing. The EMSA Child Care Training website is updated monthly.
2. Child Care Provider First Aid/CPR Training Programs	Mark Olivas, ext. 445	There are currently 19 approved First Aid/CPR programs. Staff is reviewing one (1) program renewal. Technical assistance is being provided to child care training program instructors and directors, licensing staff, and child care providers. EMSA First Aid and CPR sticker sales are ongoing. EMSA is continuing work to revise the Chapter 1.1 Training Standards for Child Care Providers, which includes First Aid and CPR training standards.
3. Child Care Preventive Health Training Programs	Lucy Chaidez, ext. 434	There are 22 preventive health and safety practices training programs approved. There are five (5) programs in the review process. EMSA is implementing AB 2370, which was signed by the Governor in September to reduce children's risk of lead poisoning in child care. The new module will be incorporated into the existing training. EMSA presented at the Annual R&R Joint CAPPa Conference. EMSA will host the Child Care Regulatory Workgroup quarterly meeting in December. EMSA Preventive Health sticker sales are ongoing. Training standards for the program are being revised.
4. Child Care Training Provider Quality Improvement/Enforcement	Mark Olivas, ext. 445 and Lucy Chaidez, ext. 434	EMSA is continuing its work to revise the Chapter 1.1 Training Standards for Child Care Providers, including First Aid, CPR, and Preventive Health training standards. Technical assistance and education regarding compliance issues is provided to approved training programs, child care providers, DSS community care licensing, and child care resource and referral staff. Review of rosters as an auditing tool, is ongoing. There is 1 open complaint case involving EMSA-approved training program.
5. Automated External Defibrillator (AED) Requirements for EMT's, Public Safety and Layperson	Betsy Slavensky, ext. 461	Ongoing technical support and clarification is provided to public safety agencies, LEMSAs and the general public regarding AED statutes and regulations. There are different requirements for these programs found in Chapter 1.5 Section 100021 and Chapter 2 Section 100063.1. CHP, CAL FIRE and State Parks have approved public safety AED programs. CAL FIRE, State Parks and CHP have approved EMT AED service provider programs.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
6. BLS Training and Certification Issues	Betsy Slavensky, ext. 461	EMSA provides ongoing support and technical assistance to EMTs, prospective EMTs and 69 Certifying Entities. EMSA continues to assist all certifying entities with questions and clarification on the EMT regulations. EMSA fields calls/questions about Emergency Medical Responders (EMR) processes and relays that there are currently no regulations specific to EMR, but program approval and scope for public safety EMRs falls under Chapter 1.5. All other questions are directed to the local EMS agency to respond.
7. State Public Safety Program Monitoring	Betsy Slavensky, ext. 461	EMSA provides ongoing review, approval & monitoring of EMSA approved Public Safety First Aid/CPR, EMR, EMT and CE programs for statutory and regulatory compliance. The BLS Coordinator provides support and clarification to LEMSAs and all statewide public safety agencies regarding the Chapter 1.5 regulations and approval requirements. EMSA approved public safety first aid/CPR courses include POST, CA State Parks, Cal Fire, and CHP, some of which include optional skills training. EMSA approved EMT training programs include: CAL JAC and CA State Parks. EMSA approved EMT Refresher programs include CAL FIRE and CHP – both programs include epi, naloxone, glucometer & tactical. Prior EMSA approved EMR programs for CHP, DPR and CAL FIRE are expired. DPR is in the process of submitting for review/approval under Chapter 1.5 regulations. EMSA approved CE Provider programs include CHP, CAL FIRE, CE Solutions. CA State Parks CE provider program expired 5/31/18, but plan to renew. CDCR is in the process of review and approval for a new CE Provider program. Site visits to state wide public safety agency programs are pending fiscal approval and staffing.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
8. My License Office/ EMT Central Registry Audit	Betsy Slavensky, ext. 461	EMSA monitors the EMT Central Registry to verify that the 69 certifying entities are in compliance with the California Code of Regulations regarding data entry, including background checks and disciplinary notification for all EMT personnel. Correspondence is maintained via email, phone, and LEMSA Coordinator meetings with certifying entities to share updates, changes and corrections. The Personnel Standards newsletter remains on hold pending increased staff support. Ongoing development and updates of discipline and certification procedures support central registry processes and reduce time spent on technical support. Updates to the Central Registry software continue to enhance processes and reduce errors. Certifying entities continue to work with EMSA staff to find and correct erroneous certifications in the Registry. EMSA continues to alert certifying entities that need to correct erroneous live scan forms and update DOJ contracts to be compliant with regulation.
9. Epinephrine Auto-injector Training and Certification	Nicole Mixon, ext. 420	EMSA processes applications for Epinephrine training programs and certification for the administration of epinephrine auto-injectors to the general public and off-duty EMS personnel. EMSA has approved 12 training programs and has issued 873 lay rescuer certification cards.
10. Hemostatic Dressings	Lucy Chaidez, ext. 434	The EMS Authority is responsible for approving hemostatic dressings for use in the prehospital setting. EMSA has approved three (3) hemostatic dressings.
11. Paramedic Licensure	Kim Lew, ext. 427	The EMS Authority is responsible for receiving, processing, and auditing paramedic license applications for approval in compliance with the California Code of Regulations. During the past three (3) months, EMSA has approved the following: 282 Initial In-State applications, 23 Initial Out-of-State applications, 2,232 Renewal applications, and 94 Reinstatement applications.
12. eGov Online Licensure Project	Kim Lew, ext. 427	On March 26, 2018 the EMS Authority procured an online licensure application system, MyLicense eGov. Upon completion, paramedic training program graduates and paramedics requiring initial or renewal licensure will be able to apply online. Staff are currently conducting user testing to ensure the configuration of the system will meet public needs. The anticipated timeline for project completion is winter 2018.

**Emergency Medical Services Authority
EMS Personnel Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-9875	Updates
13. Administrative Actions Reporting System (AARS)	Kim Lew, ext. 427	On August 1, 2018, the EMS Authority began participation in a statewide project to enhance the current AARS system. Under the direction of the system vendor and the CA. Dept. of Social Services, the EMS Authority will be meeting bi-weekly over the course of a year to assist in system improvements.

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
1. Trauma	Elizabeth Winward ext. 460	<p><u>State Trauma Advisory Committee (STAC):</u> The STAC held a meeting on September 4, 2018 by teleconference. EMSA staff briefed STAC members on the status of the 2019 Trauma Summit, Re-triage Guidelines, EMSC and Stroke/STEMI regulations' progress. STAC was also briefed on the next steps planned for opening the trauma regulations. STAC members contributed presentation topic ideas and potential speakers for the 2019 Trauma Summit program. The next meeting will be in-person on January 16, 2019 at EMS Authority headquarters in Rancho Cordova.</p> <p><u>2019 Trauma Summit:</u> The tenth annual Trauma Summit will be held on April 23-24, 2019 at the Marines' Memorial Hotel in San Francisco. Speakers are confirmed, and registration will open in January 2019. Continuing Education credits will be offered, as in years past.</p> <p><u>Trauma Regulations</u> On November 30, 2018, the trauma regulations subcommittee will convene in-person in Burbank to review the last draft of trauma revisions for trauma regulations they created. Next steps will be to update the draft trauma regulations document and distribute to a wider group of local trauma partners input. The progress on the draft regulations will determine when the EMS Authority officially requests to open the trauma regulations. The EMS Authority is aiming for mid-summer of 2019.</p> <p><u>Regional Trauma Coordinating Committees (RTCC)</u> Each Regional Trauma Coordinating Committee representative provides regional activity updates at the STAC meeting and provides documents approved by the RTCC and available for statewide use. The EMSA Trauma Coordinator provided a presentation in-person at the North RTCC meeting in September 2018 and attended the Central RTCC meetings by teleconference in October 2018.</p> <p><u>Regional Trauma Network for Re-Triage Subcommittee</u> The Regional Trauma Network for Re-Triage guidance document has been updated and will be posted on the EMS Authority's website for public comment within the next 30 days. Once public comments are addressed, the final guidance document will be submitted to the Commission in 2019.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
2. STEMI/Stroke Systems of Care	Farid Nasr, ext. 424	<p><u>STEMI and Stroke Regulations</u> Rulemaking efforts for the STEMI and Stroke draft regulations with the Office of Administrative Law (OAL) have continued. After approval of the regulations draft by the commission in September meeting, EMSA has completed two packages for STEMI, and Stroke Regulations, including the drafts, public comments and responses, and all other documentation. The packages have been submitted to the OAL for the final approval.</p>
3. EMS System, Standards, and Guidelines	Lisa Galindo, ext. 423	<p><u>EMS Plan Automation</u> The EMS Authority has plans to develop an automated system for Local EMS Agencies (LEMSA) to submit EMS Plan submissions. This will also permit EMSA and the LEMSAs to run various reports. The EMS Authority has completed a Stage 1 Business Analysis (S1BA). The project has been placed on hold until FY 2019-20 due to funding availability and requirements of the Preventive Health and Health Services Block Grant.</p> <p><u>EMS Authority Guidelines</u> Proposed changes to EMS System Standards and Guidelines #101 (June 1993) and #103 (June 1994) have been developed. The revision process will resume upon the completion of the EMS Plan automation.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
4. EMS Transportation	Laura Little, ext. 412	<p><u>EMS Systems Regulations Work Group / Chapter 13 Task Force:</u> On hiatus, pending outcome of litigation, related to the subject matter involved in the regulation draft.</p> <p><u>Request for Proposals:</u> Request for Proposals (RFPs) for Exclusive Operating Areas continue to go through a dual review process, to ensure that they meet Federal and State statutory requirements, that there is no bid rigging, collusion, bid chilling, as well as address EMSA Guideline #141 “Competitive Process for Creating Exclusive Operating Areas”. EMSA continues to provide technical assistance to LEMSAs by in-person meetings, email, phone, and mail in order to help them create a RFP that meets all required criteria.</p> <p><u>EMS Plan Appeals</u> Review past EMS Plan submissions, correspondence, conduct public records requests, further historical documentation to map out the issue under appeal, and attend appeal hearings.</p> <p><u>Complaints/Allegations</u> Conduct an initial investigation into any allegations involving violations of Federal and State laws, including but not limited to Sherman Act Violations. If allegations are proven to be true, a formal investigation is conducted and action is taken.</p> <p><u>Technical Assistance:</u> Provide daily technical assistance to public and providers on exclusive operating areas, interpretation of statute and regulations, EMS provider information and direction on who to contact outside of EMSA for further information.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
<p>5. Poison Center Program</p>	<p>Lisa Galindo, ext. 423</p>	<p>The California Poison Control System (CPCS) is one of the largest single providers of poison control services in the U.S. The CPCS is made up of four designated Poison Control Centers. The CPCS receives approximately 330,000 calls a year from both public and health professionals through a toll-free hotline that is accessible 24-hours a day, 7 days a week.</p> <p><u>Quarterly Report</u> The Quarterly Report consists of data and narrative reports. The data report for the 1st quarter, July 1, 2018 - September 30, 2018, was received on October 12, 2018, and the narrative report was received on October 16, 2018. Both were reviewed for consistency with contractual objectives; there were no areas of concern.</p> <p><u>Contract</u> On September 27, 2018, a contract between the EMS Authority and the CPCS was executed for Fiscal Year 2018/2019.</p> <p><u>External Audit</u> In March 2018, the EMS Authority entered into contract with Sjoberg Evashenk Consulting, Inc., through December 31, 2018, to conduct a Fiscal Management Evaluation and Program Performance Review of the CPCS for the period of July 1, 2016, through June 30, 2017. Sjoberg Evashenk Consulting, Inc. has submitted six monthly status reports to date outlining progress on the project. An exit conference with the EMS Authority, the consulting firm, and the CPCS was held on October 16, 2019. The Evaluation/Review is anticipated to be completed in November 2018.</p> <p><u>Site Visits</u> The EMS Authority conducted two Poison Control Center (PCC) site visits with Sjoberg Evashenk Consulting, Inc. On May 22, 2018, the San Diego PCC was visited, and on May 24, 2018, the Sacramento PCC was visited. The site visits consisted of a tour of the facility, a walk-through of processes, observations of hotline staff, and interviews with management. At least one site visit (Fresno or San Francisco) is anticipated to be conducted between January and June 30, 2019.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
6. EMS Plans	Lisa Galindo, ext. 423	<p><u>Review</u> The EMS Authority continues to review EMS Plans and annual Plan Updates as they are submitted by Local EMS Agencies (LEMSA). As of November 1, 2018, the EMS Authority has approved 20 EMS Plans in 2018.</p> <p><u>Technical Assistance</u> Technical assistance is provided to the LEMSAs, as needed, on the EMS Plan development and submission process. Electronic reminders to the LEMSAs are provided approximately 2-3 months in advance of their scheduled submissions.</p>
7. EMS for Children Program	Heidi Wilkening, ext. 556	<p><u>Regulations:</u> The EMS for Children regulations were put out for an additional 15-day public comment period on October 26. The public comment period will close on November 10, 2018. It is expected the EMSC regulations will be presented at the December 2018 Commission meeting for the Commission's approval. Following approval from the EMS Commission, the EMSC regulations will be presented to the Office of Administrative Law for final approval.</p> <p><u>Educational Forum:</u> The 21st Annual EMS for Children Educational Forum will be held on Friday, November 9, 2018 in Fairfield, CA. The venue has changed to the NorthBay HealthCare Administration Center. Topics for this one day event include child abuse, drowning, information regarding the Tehama School Shooting and pediatric burns.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
8. CEMSIS Trauma	Elizabeth Winward, ext. 460	There are 27 Local EMS agencies (LEMSA) with designated Trauma Centers. Trauma Centers are physically located in 38 of the 58 counties. Currently, 27 LEMSAs are transmitting into CEMSIS-Trauma representing 79 of the 80 designated Trauma Centers.
9. CEMSIS EMS Data	Adrienne Kim, ext. 742	<p>CEMSIS now has 30 LEMSAs participating at some level in the submission of EMS data. On January 1, 2017, many LEMSAs transitioned to NEMSIS V3.4 and EMSA is providing technical assistance and guidance to LEMSAs that are still in the process of transitioning to NEMSIS Version 3.4 consistent with AB 1129 which implemented HSC 1797.227.</p> <p>As of November 1, 2018, CEMSIS has over 3.1 million records for 2018 in Version 3.4. Once the final 3 LEMSAs begin submitting data, CEMSIS will have submissions around 4.25 million records each year.</p> <p><u>Reports:</u> The CY 2017 Annual EMS Report is currently being developed.</p>
10. Communications	Heidi Wilkening, ext. 556	EMSA personnel is working on attending various California communications meetings to learn more on public concerns on issues related to NextGen 9-1-1. The Statewide EMS Operations and Communications Manual has been revised and the draft revision will be sent to the local EMS agencies for review. Once the review process is completed, the document will be posted on the EMSA website.
11. Core Measures	Adam Davis, ext. 409	29 of the 33 LEMSAs provided Core Measures Information for 2017 data. EMSA is developing a blinded report based on the submissions. EMSA is reviewing the comments and recommended changes to the measures to update the specifications for 2018 data. Per the recommendation of the Commission, measures TRA-3, TRA-4, and TRA-5 have been removed from the measures set. EMSA expects to release the updated Core Measure Instruction Manual prior to the end of December 2018.
12. Grant Activity/Coordination	Lori O'Brien, ext 401	<p><u>Health Resource Services Administration (HRSA) Grant:</u> The first EMSC Performance Report for the grant period ending 3/31/2019 was submitted on October 8, 2018. The Project Period End Performance Report for the grant period ending 3/31/2018 was reviewed and approved by HRSA on 10/26/2018.</p>

**Emergency Medical Services Authority
EMS Systems Division
Major Program Activities
December 5, 2018**

Activity & Description	Primary Contact EMSA (916) 322-4336	Updates
		<p>Staff continues the work associated with the Health Resources Services Administration (HRSA) grant in furthering the integration of the Emergency Medical Services for Children (EMSC) into the State EMS system.</p> <p><u>Preventive Health and Health Services Block Grant (PHHSBG):</u> The annual report for the FFY 2018 grant year were completed and submitted to CDPH on 11/9/2018. Success stories were completed and submitted on 11/16/2018. EMSA staff remains continually involved in the Preventive Health and Health Services Block Grant.</p>
13. Office Support	Tiffany Pierce ext. 900	<p><u>Documents and Letters:</u> Processed Systems Division letters and documents including the following:</p> <ol style="list-style-type: none"> 1. TSSR Approval letters for Napa, Northern California, Alameda, and Sacramento, 2. EMS Plan Updates for Napa, Alameda, Northern California, San Joaquin, Sierra-Sacramento Valley, and Sacramento 3. QI Approval letters for Los Angeles and Napa 4. RFP letters for Santa Clara and Santa Cruz 5. STAC Appointment letters <p><u>Pre-Hospital Cost Per Ambulance Response:</u> Tiffany Pierce updated the Pre-Hospital Cost Per Ambulance Response analysis spreadsheet on 10/11/18.</p>

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Jennifer Lim
Deputy Director of Legislative, Regulatory and External Affairs

SUBJECT: Legislative Summary

RECOMMENDED ACTION:

Receive information regarding the 2018 Legislative year affecting EMS.

FISCAL IMPACT:

None.

DISCUSSION:**AB 238 (Steinorth) Emergency response: trauma kits.**

Status: 8/31/2018-Failed Deadline pursuant to Rule 61(b)(18). (Last location was S. RLS. on 2/26/2018)

Location:8/31/2018-S. DEAD

Summary: Would define "trauma kit" to mean a first aid response kit that contains specified items, including, among other things, at least two tourniquets. The bill would require a person or entity that supplies a trauma kit to provide the person or entity that acquires the trauma kit with all information governing the use, installation, operation, training, and maintenance of the trauma kit. The bill would apply the provisions governing civil liability as specified to a lay rescuer or person who renders emergency care or treatment by using a trauma kit and to a person or entity that provides training in the use of a trauma kit to provide emergency medical treatment, or certifies certain persons in the use of a trauma kit.

AB 1116 (Grayson) Peer Support and Crisis Referral Services Pilot Program.

Status: 9/27/2018-Vetoed by Governor.

Location: 9/27/2018-A. VETOED

Summary: Would, until January 1, 2024, create the Peer Support and Crisis Referral Services Pilot Program. The bill would, for purposes of the act, define a "peer support team" as a team composed of emergency service personnel, as defined, hospital staff, clergy, and educators who have been appointed to the team by a Peer Support Labor-Management Committee, as defined, and who have completed a peer support training course developed and delivered by the California Firefighter Joint Apprenticeship Committee or the Commission on Correctional Peace Officer Standards and Training, as specified.

AB 1776 (Steinorth) Emergency medical transport of police dogs: pilot project.

Status: 9/6/2018-Approved by the Governor. Chaptered by Secretary of State - Chapter 272, Statutes of 2018.

Location: 9/6/2018-A. CHAPTERED

Summary: Would authorize the County of San Bernardino to work with the Inland Counties Emergency Medical Agency to conduct a pilot project, commencing January 1, 2019, that would authorize transportation for a police dog, as defined, injured in the line of duty to a facility that is capable of providing veterinary medical services to that dog, if certain conditions are met. The bill would require the Inland Counties Emergency Medical Agency to collect specified data about the pilot project and submit a report to the Legislature describing the data by January 1, 2022. The bill would repeal these provisions on January 1, 2022.

AB 1812 (Committee on Budget) Public safety omnibus.

Status: 6/27/2018-Approved by the Governor. Chaptered by Secretary of State - Chapter 36, Statutes of 2018.

Location: 6/27/2018-A. CHAPTERED

Summary: Among other items, this bill would authorize the Department of Forestry and Fire Protection (CAL-FIRE) to grant statewide certification to an individual as an Emergency Medical Responder (EMR), regardless of whether he or she committed specified crimes unless the action was committed after he or she received certification. The bill requires the individual is a graduate of a specified CAL-FIRE training program, received a letter of recommendation from the Director of CAL-FIRE, and, while participating in the training program, was working toward a high school diploma or its equivalent, unless he or she already earned one. This bill would also authorize CAL-FIRE to grant a provisional certification as an EMR to individuals for a period of up to two 2-year certification cycles, but for no more than four years. The bill would require EMSA to promulgate emergency regulations for the process of establishing the certification process pursuant to these provisions.

AB 1973 (Quirk) Reporting crimes.

Status: 8/20/2018-Approved by the Governor. Chaptered by Secretary of State - Chapter 164, Statutes of 2018.

Location: 8/20/2018-A. CHAPTERED

Summary: Current law requires specified health practitioners who have knowledge of or observe a patient who the practitioner knows or reasonably suspects has suffered from a wound or injury inflicted by specified types of conduct to report to a law enforcement agency, as specified. A violation of these provisions is a crime. This bill would extend those reporting duties to health practitioners, as defined, employed by local government agencies, including, among others, emergency medical technicians and paramedics, as specified and to employees of entities under contract with local government agencies to provide medical services.

AB 2102 (Rodriguez) State of emergency: out-of-state aid: reciprocity.

Status: 8/31/2018-Failed Deadline pursuant to Rule 61(b)(18). (Last location was S. INACTIVE FILE on 8/20/2018)

Location: 8/31/2018-S. DEAD

Summary: The Prehospital Emergency Medical Care Personnel Act authorizes state agencies to provide mutual aid, including personnel, equipment, and other available resources, to assist political subdivisions during a local emergency or in accordance with mutual aid agreements or at the direction of the Governor. This bill would require the Emergency Medical Services Authority to establish training standards and licensing reciprocity procedures for out-of-state paramedic personnel who are requested through the California Disaster and Civil Defense Master Mutual Aid Agreement to render aid in this state during a declared state of emergency.

AB 2262 (Wood) Coast Life Support District Act: urgent medical care services.

Status: 8/31/2018-Failed Deadline pursuant to Rule 61(b)(18). (Last location was S. INACTIVE FILE on 8/31/2018)

Location: 8/31/2018-S. DEAD

Summary: Current law, the Coast Life Support District Act, establishes the Coast Life Support District and specifies the powers of the district. The district is authorized, among other things, to supply the inhabitants of the district emergency medical services, as specified. This bill would additionally authorize the district to provide urgent medical care services.

AB 2293 (Reyes) Emergency medical services: report.

Status: 9/11/2018-Approved by the Governor. Chaptered by Secretary of State - Chapter 342, Statutes of 2018.

Location: 9/11/2018-A. CHAPTERED

Summary: The Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act governs local emergency medical services systems, and establishes the Emergency Medical Services Authority (authority), which is responsible for the coordination and integration of all state agencies concerning emergency medical services. The act creates the Commission on Emergency Medical Services (commission) to, among other things, advise the authority on the development of an emergency medical data collection system. This bill would require each local EMS agency and other certifying entities to annually submit to the authority, by July 1 of each year, data on the approval or denial of EMT-I or EMT-II applicants, containing specified information with respect to the preceding calendar year, including, among other things, the number of applicants with a prior criminal conviction who were denied, approved, or approved with restrictions.

AB 2370 (Holden) Lead exposure: child day care facilities: family day care homes.

Status: 9/22/2018-Approved by the Governor. Chaptered by Secretary of State - Chapter 676, Statutes of 2018.

Location: 9/22/2018-A. CHAPTERED

Summary: The California Child Day Care Facilities Act requires that, as a condition of licensure and in addition to any other required training, at least one director or teacher at each day care center, and each family day care home licensee who provides care, have at least 15 hours of health and safety training, covering specified components. This bill would require, as a condition of licensure for licenses issued on or after July 1, 2020, the health and safety training to include instruction in the prevention of lead exposure as a part of the preventive health practices course or courses component.

AB 2397 (Oberholte) Health and human services: information sharing: administrative actions.

Status: 9/7/2018-Vetoed by Governor.

Location: 9/7/2018-A. VETOED

Summary: In order to protect the health and safety of persons receiving care or services from individuals or facilities licensed by the state or from individuals certified or approved by a foster family agency, authorizes the California Department of Aging, the State Department of Public Health, the State Department of Health Care Services, the State Department of Social Services, and the Emergency Medical Services Authority to share information with respect to applicants, licensees, certificate holders, or individuals who have been the subject of any administrative action, as defined, resulting in one of specified actions, including, among others, the denial of a license, permit, or certificate of approval. Existing law also authorizes, for the same purpose, the State Department of Social Services and county child welfare agencies to share those same types of information. This bill would instead require the above-described agencies to share the information relating to administrative actions under the 2 respective provisions.

AB 2961 (O'Donnell) Emergency medical services.

Status: 9/21/2018-Approved by the Governor. Chaptered by Secretary of State - Chapter 656, Statutes of 2018.

Location: 9/21/2018-A. CHAPTERED

Summary: Would require a local EMS agency to submit quarterly data to the authority that, among other things, is sufficient for the Emergency Medical Services Authority to calculate ambulance patient offload time by local EMS agency jurisdiction and by each facility in a local EMS agency jurisdiction. The bill would require the authority to calculate ambulance patient offload time and report it twice per year to the Commission on Emergency Medical Services. The bill would also require the authority, in collaboration with local EMS agencies, on or before December 1, 2020, to submit a report to the Legislature on ambulance patient offload time and recommendations to reduce or eliminate ambulance patient offload time.

AB 3115 (Gipson) Community Paramedicine or Triage to Alternate Destination Act.

Status: 9/30/2018-Vetoed by Governor.

Location: 9/30/2018-A. VETOED

Summary: Current law, the Emergency Medical Services System and the Prehospital Emergency Medical Care Personnel Act, governs local emergency medical services (EMS) systems. The current act establishes the Emergency Medical Services Authority, which is responsible for the coordination and integration of EMS systems. This bill would establish within the act until January 1, 2025, the Community Paramedicine or Triage to Alternate Destination Act of 2018. The bill would authorize a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services.

SB 695 (Lara) Professions and vocations: applications and renewals: individual tax identification number.

Status: 9/27/2018-Approved by the Governor. Chaptered by Secretary of State. Chapter 838, Statutes of 2018.

Location: 9/27/2018-S. CHAPTERED

Summary: Current law governs professions and vocations that are regulated by various boards within the Department of Consumer Affairs. Current law requires those boards, the State Bar of California, and the Department of Real Estate to require a licensee, at the time of issuance of a license, to provide specified information, including his or her social security number or individual taxpayer identification number. Current law provides that the applicant's social security number or individual taxpayer identification number information is not a public record and is not open to the public for inspection. This bill would prohibit a licensing board from requiring an individual to disclose either citizenship status or immigration status for purposes of licensure, or from denying licensure to an otherwise qualified and eligible individual based solely on his or her citizenship status or immigration status.

SB 944 (Hertzberg) Community Paramedicine Act of 2018.

Status: 8/17/2018-Failed Deadline pursuant to Rule 61(b)(15). (Last location was A. APPR. SUSPENSE FILE on 8/8/2018)

Location: 8/17/2018-S. DEAD

Summary: Would create the Community Paramedicine Act of 2018. The bill would, until January 1, 2025, authorize a local EMS agency to develop a community paramedicine program, as defined, to provide specified community paramedic services. The bill would require the Emergency Medical Services Authority to review a local EMS agency's proposed community paramedicine program and approve, approve with conditions, or deny the proposed program within six months after it is submitted by the local EMS agency.

SB 1305 (Glazer) Emergency medical services providers: dogs and cats.

Status: 9/28/2018-Approved by the Governor. Chaptered by Secretary of State. Chapter 900, Statutes of 2018.

Location: 9/28/2018-S. CHAPTERED

Summary: Would authorize an emergency responder, as defined, to provide basic first aid to dogs and cats, as defined, to the extent that the provision of that care is not prohibited by the responder's employer. The bill would limit civil liability for specified individuals who provide care to a pet or other domesticated animal during an emergency by applying current provisions of state law. The definition of "basic first aid to dogs and cats" for purposes of these provisions would specifically include, among other acts, administering oxygen and bandaging for the purpose of stopping bleeding.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DRIVE, SUITE 400
RANCHO CORDOVA, CA 95670-6073
(916) 322-4336 FAX (916) 324-2875



DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP
Director

PREPARED BY: Rick Trussell, Chief
Fiscal and Administration Unit

SUBJECT: Administrative and Personnel Report

RECOMMENDED ACTION:

Information Only

FISCAL IMPACT:

None

DISCUSSION:**Emergency Medical Services Authority (EMSA) Budget:**

2018-19

The 2018-19 enacted California State budget includes expenditure authority in the amount of \$37.4 million and 70 permanent positions. Of this amount, \$16.4 million is delegated for State operations and \$21 million is delegated to local assistance.

As of November 8, 2018, accounting records indicate that the Department has expended and/or encumbered \$19.2 million or 51.2% of available expenditure authority. Of this amount, \$3.1 million or 18.7% of State Operations expenditure authority has been expended and/or encumbered and \$16.1 million or 76.6% of local assistance expenditure authority has been expended and/or encumbered.

We are continuing to monitor and adjust both State operations and local assistance budgets to meet changing program priorities. An updated report will be distributed prior to the next Commission meeting.

2017-18

The 2017-18 enacted California State budget includes departmental expenditure authority in the amount of \$37.2 million and 69 permanent positions. Of this amount, \$16.3 million is delegated for State operations and \$20.9 million is delegated to local assistance.

As of November 8, 2018, accounting records indicate that the Department has expended and/or encumbered \$28.1 million or 75.3% of available expenditure authority. Of this amount, \$12.1 million or 73.8% of State Operations expenditure authority has been expended and/or encumbered and \$16 million or 76% of local assistance expenditure authority has been expended and/or encumbered.

The Department is in the process of year-end closing (MEC) accounting activities and we are continuing to monitor and adjust both State operations and local assistance. An updated report will be distributed prior to the next Commission meeting.

EMSA Staffing Levels:

As of November 8, 2018, the Department is authorized 70 positions and also has 15 temporary (blanket positions and retired annuitants) positions for an overall staffing level of 85. Of the 85 positions, 12 positions are vacant at this time.

	Division				
	Admin/Exec	DMS	EMSP	EMS	Total
Authorized	19.0	20.0	22.0	9.0	70.0
Temporary Staff	3.0	3.0	2.0	7.0	15.0
Staffing Level	22.0	23.0	24.0	16.0	85.0
Authorized (Vacant)	-1.0	-5.0	-2.0	0.0	-8.0
Temporary (Vacant)	0.0	0.0	0.0	-4.0	-4.0
Current Staffing Level	21.0	18.0	22.0	12.0	73.0

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Steven A. McGee, Administrative Adviser

SUBJECT: Legal Report

RECOMMENDED ACTION:

Receive information on Legal Office Activities.

FISCAL IMPACT:

None

DISCUSSION:**Disciplinary Cases:**

From August 10, 2018, to November 5, 2018, the Authority issued seventeen new Accusations against existing paramedic licenses, three temporary suspension orders, six statements of issues, one administrative fine, and issued decisions on four petitions for reduction of penalties. Of the newly issued actions, two of the Respondents have requested that an administrative hearing be set. There are currently fifteen hearings scheduled, and seven waiting to be scheduled. There are currently forty-seven open active disciplinary cases in the legal office.

Litigation:

Tagliere v. Backer, Los Angeles County Superior Court #BS1707101, Writ of Administrative Mandamus. Plaintiff has filed a writ seeking to overturn the revocation of his license subsequent to an administrative hearing. Hearing was continued to February 14, 2019.

Local EMS Agency Plan Denial Appeals:

Contra Costa County EMS v. EMSA. The Authority is currently undertaking the process to determine hearing dates and request a hearing through OAH.

El Dorado County EMS v. EMSA. The Authority is waiting for a statement from El Dorado County of their basis for appeal and available hearing dates in order to undertaking the process to request a hearing through OAH.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: M. D. Smith, Supervising Special Investigator
Paramedic Enforcement Unit

SUBJECT: Enforcement Report

RECOMMENDED ACTION:

Receive information on Enforcement Unit activities.

FISCAL IMPACT:

None

DISCUSSION:**Unit Staffing:**

As of October 25, 2018, the Enforcement Unit is budgeted for 5 full-time Special Investigators (2 of these positions are currently vacant), 1 part-time retired annuitant Special Investigator and 1 full-time Associate Government Program Analyst (AGPA-Probation Monitor). The AGPA position was recently filled and is still in training under the guidance of one of the Special Investigators. The 2 vacant Special Investigator positions are awaiting approval from the Department of General Services (DGS) to advertise and hire. These vacant positions could potentially cause a backlog of cases under investigation.

Investigative Workload:

The following is a summary of currently available data extracted from the paramedic database:

Cases opened since January 1, 2018, including:

Cases opened:	217
Cases completed and/or closed:	186
EMT-Paramedics on Probation:	218

In 2017:

Cases opened:	282
Cases completed and/or closed:	307
EMT-Paramedics on Probation:	230

Status of Current Cases:

The Enforcement Unit currently has 107 cases in “open” status.

As of October 25, 2018, there are 30 cases that have been in “open” status for 180 days or longer: three (3) Fire Fighters’ Bill of Rights (FFBOR) cases and five (5) cases waiting for California Society of Addiction Medicine (CSAM) evaluations. Respondents are directed to a physician who specializes in addiction medicine for an examination/review in cases involving alcohol or other substance abuse.

Those 30 cases are divided among 4 Special Investigators and are in various stages of the investigative process. These stages include awaiting documents, preparing for and/or setting up interviews, report writing and corrections to be made, awaiting action by local law enforcement jurisdictions, the courts, etc.

Delays in the interview process are common due to unforeseen difficulties in obtaining certified copies of documents, court records, availability of witnesses and/or the subject(s) of an investigation due to medical action/disability issues, on-going investigations for FFBOR staff or on-going criminal investigations, court actions, plus the routine requirement for two or more follow-up interviews.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Priscilla Rivera, Manager
Personnel Standards Unit

Lou Meyer
EMSA POLST eRegistry Coordinator

SUBJECT: POLST eRegistry Update

RECOMMENDED ACTION:

Receive information regarding POLST eRegistry Pilot Project.

FISCAL IMPACT:

The California HealthCare Foundation has granted up to \$3 million to fund the different aspects of the POLST eRegistry Pilot Project that includes, but is not limited to, the local pilot sites, the technology vendor, independent evaluator, project director, project consultant.

DISCUSSION:

Decisions on end of life care for oneself and for that of loved ones are difficult for anyone to make. The Physician Orders for Life-Sustaining Treatment (POLST) is a process that encourages open and thoughtful discussion between physicians, and their patients regarding end of life care. To address some of the current limitations with accessibility to the POLST information, SB 19 (Wolk, Chapter 504, 2015) was signed by the Governor authorizing a POLST electronic registry (eRegistry) pilot project under the aegis of the EMS Authority (EMSA).

Multi-Agency Coordination Activity (MAC):

As a member of the MAC, EMSA's POLST eRegistry Coordinator, with the support of other members of the EMSA leadership team continues to participate in weekly and as needed MAC Conference Calls and in-person meetings throughout the last quarter.

Pilot Site Update:

Alameda-Contra Costa Medical Association (ACCMA)

Contra Costa Regional Medical Center (CCRMC) and Kaiser moved closer to participation over the past two-and-a-half months. CCRMC continues its contract negotiation process with Vynca (despite the health system's "no-edit" policy on Business Associates Agreements), and Kaiser has informed Vynca that they are supportive of conducting a pilot in Contra Costa County. Although timelines are unknown as to when each of these health systems will be using the eRegistry, their willingness to participate after many months of discussion is encouraging. CCRMC, in particular, only has a couple of agreements left to sign with Vynca to participate in the pilot. ACCMA has a good relationship with CCRMC/Contra Costa Health Services leadership, and discussions with them about supporting the eRegistry project have been positive. CCRMC's participation will bring onboard another acute care hospital and 11 ambulatory clinics serving a largely Medi-Cal patient population.

Contra Costa EMS (CC EMS), and Vynca's August usage reports show that EMS personnel in the field continue to use the eRegistry. In this time there have been 17 searches, none of which found POLST forms associated with the patients. The pilot site continues to address the need to have an appropriate number of forms in the system for EMS integration to be useful. Participation from CCRMC and Kaiser would undoubtedly help toward that end, as would increased participation from non-health system, non-EMS stakeholders. There has been a number of challenges getting providers to use the registry due to issues as to the usability of the technology

As reported earlier representatives from the Contra Costa EMS Agency and American Medical Response reported that the main difficulty being experienced from the field, is that they are unable to make access to the POLST eRegistry from the patient's residence if the ambulance, which contains the WiFi Hotspot, is more than 30 feet away. An earlier decision by Contra Costa EMS Agency to not use the backup call center has been revisited, and steps have been taken to set up access to a backup call center for the times that WiFi connectivity cannot be established from within the patient's residence. The backup call center is scheduled to go live on October 31, 2018.

Successful strategies to sustain engagement of field personnel will be important to fully test the value of the system.

San Diego Health Connect (SDHC)

The pilot site in the City of San Diego is being led by San Diego Health Connect (SDHC). They are also continuing to work with their hospital stakeholders to ensure active participation within the POLST eRegistry.

The most successful part of the SDHC Pilot Project has been through SDHC's collaboration with the San Diego County EMS Agency, City of San Diego Fire, and American Medical Response (AMR). The POLST eRegistry is live for use by EMS field personnel within the SDHC HIE capture area, coupled with the fact that over 800 fire and private paramedics attended refresher/update training in June 2018 that included the new POLST eRegistry functionality, as well as a refresher about Search, Alert, File, and Reconcile and the Health Information Exchange.

There continues to be challenges as it relates to utilization by other stakeholder groups. During the September POLST Workgroup meeting, SDHC discussed the topic and discovered that those who would need to consume POLST forms and the participants with access to submit POLST forms are not the same resources/roles that are interested in retrieval, instead they are the providers and their clinical team, specifically SNFs, hospices, ED providers, and EMS. SDHC asked workgroup members to provide contacts that would be interested in consuming POLST forms so that they could inform them of the pilot project and provide them access to the eRegistry.

SDHC reported that the following lessons have been learned during this period:

- 1) Those that need access to submit POLST forms are different than those that want to retrieve POLST forms;
- 2) Because there is no current state mandate to check the registry before creating a new POLST form, practices/organizations/participants are not engaging in this best practice;
- 3) Retrieving POLST forms must be easy for providers to use;
- 4) Automating form submission to the registry is a more reliable process;
- 5) EMS are heavy users to retrieve POLST forms;
- 6) Grassroots efforts in communicating and marketing provider access has been more successful than at the executive or administrative level; and
- 7) Quality of POLST forms must be audited at each entry point.

Given these challenges, SDHC has been in active communication with CHCF and MAC representatives to revise and finalize the pilot reporting and milestone schedule. Activities were shifted to accommodate the challenges faced in our region.

SDHC is looking to implement two (2) alternative milestones in Quarter 4. One intends to improve the quality of the POLST form completion and the other assists with automating retrieval of admitted patients through a provider subscription service.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DRIVE, SUITE 400
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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Jennifer Lim, Deputy Director
Legislative, Regulatory and External Affairs.

SUBJECT: Approval of Office of Administrative Law Rulemaking Calendar

RECOMMENDED ACTION:

Approve the 2019 Rulemaking Calendar.

FISCAL IMPACT:

There is no fiscal impact.

DISCUSSION:**Background:**

Government Code section 11017.6 requires every state agency responsible for implementing a statute pursuant to the Administrative Procedure Act to prepare, by January 30, a rulemaking calendar for that year. The rulemaking calendar must be (1) prepared in accordance with the format specified by the Office of Administrative Law (OAL), (2) approved by the head of the department or, if the rulemaking agency is an entity other than a department, by the officer, board, commission, or other entity which has been delegated the authority to adopt, amend, or repeal regulations, and (3) published in the California Regulatory Notice Register (Notice Register). (Gov. Code, sec. 11017.6).

2018 Rulemaking Calendar:

The rulemaking calendar represents estimation by the department, of rulemaking files that may be opened during the 2019 calendar year. Rulemaking files that may be opened to implement statutes enacted in the 2018 legislative session are listed on Schedule A. Schedule B contains rulemaking files that may be opened to implement statutes enacted prior to 2018. The rulemaking calendar provides OAL with an estimate

of the workload to be expected and offers the advance notification of potential regulation amendments that may be of interest to stakeholders and the public.

Attachments: Schedule A: Proposed Regulations Implementing Statutes Enacted
During the Year 2018.

Schedule B: Proposed Regulations Implementing Statutes Enacted Prior
to the Year 2018.

Health and Human Services
2019 RULEMAKING CALENDAR

SCHEDULE A: PROPOSED REGULATIONS IMPLEMENTING STATUTES ENACTED DURING THE YEAR 2018

Subject: Emergency Medical Responder Certification, Continuing Education, Recertification and Training Requirements		CCR Title & Sections Affected: Title 22, Division 9, New Chapter Pursuant to Health and Safety Code Section 1797.165(c), the Emergency Medical Services Authority, in consultation with CAL-FIRE, shall promulgate emergency regulations for the process of establishing the certification process for an Emergency Medical Responder (EMR).		Statute(s) Being Implemented: AB 1812, Statutes of 2018, Chapter 36 Health and Safety Code 1797.165	
Responsible Agency Unit: Emergency Medical Services Authority, Personnel Standards Department of Forestry and Fire Protection (CAL-FIRE)	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published:	Public Hearing:	Adoption by your agency: 09/2019	To OAL for review: 09/2019

Subject: Lead Exposure Preventive Health Training		CCR Title & Sections Affected: Title 22, Division 9, Chapter 1.1 Section §100000.30 In order to amend a regulatory provision to make consistent with a changed California statute, the Emergency Medical Services Authority (EMSA) will be requesting to amend Chapter 1.1 through a section 100 submission.		Statute(s) Being Implemented: AB 2370, Statutes of 2018, Chapter 676 Health and Safety Code Sections: 1596.866 and 1596.8661	
Responsible Agency Unit: Emergency Medical Services Authority, Personnel Standards	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published:	Public Hearing:	Adoption by your agency: 05/2019	To OAL for review: 04/2019

Subject: Individual Tax Identification Number		CCR Title & Sections Affected: Title 22, Division 9, Chapters 4, 5, 10 Sections §100164, 100167, 100190, 100344, 100346 In order to amend a regulatory provision to make consistent with a changed California statute, the Emergency Medical Services Authority (EMSA) will be requesting to amend Chapters 4, 5, and 10 through a section 100 submission.		Statute(s) Being Implemented: SB 695, Statutes of 2018, Chapter 838 Health and Safety Code Sections: 1797.170, 1797.171, and 1797.172	
Responsible Agency Unit: Emergency Medical Services Authority, Personnel Standards	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published:	Public Hearing:	Adoption by your agency: 02/2019	To OAL for review: 01/2019

Health and Human Services
2019 RULEMAKING CALENDAR

SCHEDULE B: PROPOSED REGULATIONS IMPLEMENTING STATUTES ENACTED PRIOR TO THE YEAR 2018

Subject: EMS for Children		CCR Title & Sections Affected: Title 22, Division 9, Chapter 14. Sections: New Chapter		Statute(s) Being Implemented: Health and Safety Code Sections 1797.107, 1799.202 – 1799.207		
Responsible Agency Unit: Emergency Medical Services Authority, Systems Division	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:				
		Notice Published: 03/2018	Public Hearing: 05/2018	Adoption by your agency: 04/2019	To OAL for review: 12/2018	
Report on the status of all uncompleted rulemaking described on previous calendars: This chapter was published in the California Regulatory Notice Register in March 2018. This chapter is projected to be submitted to OAL for Review in December 2018.						

Subject: Paramedic Regulations		CCR Title & Sections Affected: Title 22, Division 9, Chapter 4 Sections: 100137, 100140, 100141, 100141.1, 100143.1, 100143.2, 100146, 100148, 100149, 100150, 100153, 100154, 100155, 1001561- 001165, 100167, 100170-100172		Statute(s) Being Implemented: Health and Safety Code Sections 1797.227, 1797.116, 1797.134 Government Code 8588.10 Penal Code 13514.1 & 13519.12		
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Responsible Agency Unit: Emergency Medical Services Authority, Personnel Standards	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published: 01/2019	Public Hearing: 03/2019	Adoption by your agency: 9/2019	To OAL for review: 09/2019
Report on the status of all uncompleted rulemaking described on previous calendars:					
This regulatory proposal was projected to open in March 2018. This regulatory proposal is now projected to open in January 2019.					

Subject: Training Standards for Child Care Providers	CCR Title & Sections Affected: Title 22, Division 9, Chapter 1.1 Sections: 100000.1 – 100000.35	Statute(s) Being Implemented: Health and Safety Code Sections 1596.865, 1596.866 and 1596.8661			
Responsible Agency Unit: Emergency Medical Services Authority, Personnel Standards	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published: 06/2019	Public Hearing: 07/2019	Adoption by your agency: 01/2020	To OAL for review: 09/2019
Report on the status of all uncompleted rulemaking described on previous calendars:					
This regulatory proposal was projected to open in May 2018. This regulatory proposal is now projected to open in June 2019.					

Subject: California EMT Central Registry	CCR Title & Sections Affected: Title 22, Division 9, Chapter 10 Sections: 100342, 100344, 100345, 100346, 100347, 100348	Statute(s) Being Implemented: Health and Safety Codes 1797.107 and 1797.117			
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Responsible Agency Unit: Emergency Medical Services Authority, Personnel Standards	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published: 09/2019	Public Hearing: 10/2019	Adoption by your agency: 04/2020	To OAL for review: 12/2019
Report on the status of all uncompleted rulemaking described on previous calendars:					
<p>This regulatory proposal was projected to open in June 2018. This regulatory proposal is now projected to open in September 2019.</p>					

Subject: Process for EMT and Advanced EMT Disciplinary Action	CCR Title & Sections Affected: Title 22, Division 9, Chapter 6 Section 100214.3(c). In order to amend a regulatory provision held invalid by the California Superior Court in and for the County of Alameda, The Emergency Medical Services Authority (EMSA) will be requesting to amend Chapter 6 through a section 100.	Statute(s) Being Implemented: Health and Safety Code 1797.107 and 1798.200			
Responsible Agency Unit: Emergency Medical Services Authority, Personnel Standards	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published: NA	Public Hearing: NA	Adoption by your agency: NA	To OAL for review: 02/2019
Report on the status of all uncompleted rulemaking described on previous calendars:					
<p>This proposed amendment was projected to be submitted in March 2018. This proposed amendment is now projected to be submitted in February 2019.</p>					

Subject: EMS System Quality Improvement		CCR Title & Sections Affected: Title 22, Division 9, Chapter 12. Sections: 100390 - 100395		Statute(s) Being Implemented: Health and Safety Code Sections 1797.107, 1797.120, 1797.225, 1797.227	
Responsible Agency Unit: Emergency Medical Service Authority, Systems Division	Contact Person & Phone Number: Sergy (Esam) El-Morshedy (916) 431-3656	Projected Dates:			
		Notice Published: 09/2019	Public Hearing: 10/2019	Adoption by your agency: 01/2021	To OAL for review: 10/2020
Report on the status of all uncompleted rulemaking described on previous calendars: This regulatory proposal was projected to open in September 2018. This regulatory proposal is now projected to open in September 2019.					

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DR., SUITE 400
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(916) 322-4336 FAX (916) 324-2875



DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Priscilla Rivera, Manager
Personnel Standards Unit

Lou Meyer
Community Paramedicine Pilot Project Manager

SUBJECT: Community Paramedicine Pilot Project Status

RECOMMENDED ACTION:

Receive information regarding the Community Paramedicine Pilot.

FISCAL IMPACT:

The Community Paramedicine Project Manager and the Independent Evaluator are funded by the California Health Care Foundation. Local pilot site providers participate with in-kind contributions and any local grants or reimbursement.

DISCUSSION:

On November 14, 2014, the California Office of Statewide Health Planning and Development (OSHPD) approved an application from the California Emergency Medical Services Authority (EMSA) to establish a Health Workforce Pilot Project (HWPP) to test multiple community paramedicine concepts. OSHPD has since renewed the HWPP for one-year periods in 2015, 2016, and 2017. The community paramedicine HWPP has encompassed 17 projects in 13 communities across California that have tested seven different community paramedicine concepts.

EMSA has submitted a request to extend the HWPP#173 Pilot Project for one more year and OSHPD gave "Continued Approval" to carry the Community Paramedicine Pilot Project thru November 14, 2019, contingent upon continued funding of the Pilot Project Manager and Independent Evaluator as require by statute.

Community Paramedicine Pilot Project Status

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Twelve projects are currently enrolling patients. Eight projects launched in 2015, one launched in 2017, and three additional alternate destination projects launched in 2018 (Santa Clara, Fresno and San Francisco).

Strong progress continues with the remaining community paramedicine projects. The data, as well as the independent evaluator's public report continues to show these projects have improved patient care as well as having reduced hospital re-admissions and visits to emergency departments.

Independent Evaluation:

The Health Workforce Pilot Project (HWPP) regulations require organizations that sponsor pilot projects to retain an independent evaluator to assess trainee performance, patient acceptance, and cost effectiveness. A team of evaluators at the Philip R. Lee Institute for Health Policy Studies and the UCSF Healthforce Center, San Francisco continue to serve as the independent evaluators for the HWPP #173.

The UCSF's Healthforce Center issued its 2nd Quarter Evaluation Report on September 28, 2018 which presents a summary of major findings from the evaluation for policymakers. All data submitted by project sites are reported to OSHPD on a quarterly basis.

Project No.	Concept	Enrolled for the First Time			Total Enrolled			Cumulative Enrolled*
		Apr-18	May-18	Jun-18	Apr-18	May-18	Jun-18	
CP001	Alternate Destination – Urgent Care	Closed May 2017						12
CP002	Post-Discharge	Closed in August 2016						154
CP003	Alternate Destination – Urgent Care	Closed in November 2017						34
CP004	Post-Discharge	15	0	4	23	0	7	923
CP005	Tuberculosis	0	0	0	4	2	2	44
CP006	Hospice	5	2	3	n/a	n/a	n/a	335
CP007A	Frequent EMS Users	3	1	0	8	8	7	72
CP007B	Post-Discharge	2	1	2	3	3	3	124
CP008	Post-Discharge	2	0	0	2	0	0	219
CP009	Alternate Destination – Urgent Care	Closed in November 2017						2
CP010	Frequent EMS Users	Closed in December 2017						46
CP012	Alternate Destination – Behavioral Health	3	1	1	n/a	n/a	n/a	315
CP013	Post-Discharge	4	4	5	11	8	2	191

Community Paramedicine Pilot Project Status

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CP014	Alternate Destination – Sobering Center	71	69	93	n/a	n/a	n/a	963
CP015B	Alternate Destination – Behavioral Health	-	-	4	-	-	-	4
Total		105	78	112	51	21	21	3,438
<p>* Cumulative enrollment differs from the cumulative sum of total enrolled patients in each month because patients enrolled in these projects are not necessarily unique from month to month. Some patients participating in frequent 911 caller and tuberculosis pilot projects receive CP services for multiple months. Some patients enrolled in post-discharge pilot projects receive CP service for a 30-day period spanning two months (e.g. enrolled on April 20, 2018 and completed 30-day period on May 19, 2018).</p>								

Additional Pilot Sites:

In accordance with the California Code of Regulations (22 CCR §92604), EMSA submitted and OSHPD approved applications from the following healthcare agencies and/or EMS providers in collaboration with a local EMS agency (LEMSA) to become additional pilot sites within the HWPP#173 Pilot Project to run thru November 13, 2018.

The following is a status update on the current additional pilot projects:

Local EMS Agency	Sponsor	Concepts	Status
Santa Clara County	Santa Clara County EMS Agency	Alt Destination Behavioral Health Alt Destination Sobering Center	Implemented
Sierra Sacramento Valley	Dignity Health	Post Discharge	This project has notified EMSA of their interest in re-engaging in the Implementation Process
El Dorado County	Cal Tahoe JPA	Alt Destination Behavioral Health Post Discharge	This project has withdrawn due to lack of JPA Board approval and funding.
Marin County EMS Agency		Frequent 911 User	This project has withdrawn due to retirement of its LEMSAs Sponsor

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City & County of San Francisco	San Francisco Fire Department	Frequent 911 User Alt Destination – Behavioral Health	Implemented
Central California EMS Agency	Central California EMS Agency	Alt Destination - Behavioral	Implemented
Los Angeles County EMS Agency	Los Angeles City Fire Department	Alt Destination - Behavioral Health	Pending completion of implementation requirements
Los Angeles County EMS Agency	Los Angeles City Fire Department	Alt Destination – Sobering Center	Pending completion of implementation requirements

Patient Safety:

There were no patient safety issues reported to the EMSA pilot project manager or discovered by the independent evaluator during this reporting period.

Community Paramedicine Legislation

There were three pieces of legislation introduced that would have enabled Community Paramedicine Programs to be implemented throughout California. Both AB 1795 and SB 944 did not receive hearings within the Assembly Appropriations Committee and therefore died.

AB 3115 (Gipson) was introduced in the last days of the legislation session which would have established within the act until January 1, 2025, the Community Paramedicine or Triage to Alternate Destination Act of 2018 and was sent to the Governor for his signature.

The bill would have authorized a local EMS agency to develop a community paramedicine or triage to alternate destination program, as defined, to provide specified community paramedicine services and would have required:

- 1) EMSA to develop regulations to establish minimum standards for a program and would further require the Commission on Emergency Medical Services to review and approve those regulations.

- 2) EMSA to review a local EMS agency's proposed program and approve, approve with conditions, or deny the proposed program no later than 6 months after it is submitted by the local EMS agency.
- 3) A local EMS agency that opts to develop a program to perform specified duties that include, among others, integrating the proposed program into the local EMS agency's EMS plan.
- 4) EMSA to contract with an independent 3rd party to prepare a report on community paramedicine or triage to alternate destination programs on or before June 1, 2023.

Governor Brown returned AB 3115 to the Assembly without his signature, stating in part ***"I support these innovative local efforts and believe they should be expanded but without the restrictions contained in this bill."*** He further directed the continuation of the existing pilot project and encouraged all the interested parties to work together to make this program permanent.

<https://www.gov.ca.gov/wp-content/uploads/2018/09/AB-3115-veto.pdf>

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Sean Trask, Chief
EMS Personnel Division

SUBJECT: Opioid Programs and EMS

RECOMMENDED ACTION:

Receive information regarding opioid programs and EMS.

FISCAL IMPACT:

EMS service providers experience costs associated with managing inventories of naloxone.

DISCUSSION:**EMS Personnel Scope of Practice:**

The administration of naloxone by first aid trained peace officers, firefighters, and lifeguards is a local optional scope of practice item when approved by the local EMS agency. The administration of naloxone by EMT is currently a local optional scope of practice item and requires approval by the local EMS agency. Starting July 1, 2019 all EMTs will be required to complete training in the administration of naloxone to renew their EMT certification. After this time the local EMS agency may then approve EMTs operating in their jurisdiction to administer naloxone, if not currently approved. The administration of naloxone is currently in the basic scope of practice for Advanced EMTs and paramedics.

Department of Healthcare Services Naloxone Distribution Project:

The Department of Healthcare Services (DHCS) has received grant funding from the Federal Substance Abuse and Mental Health Services Administration to distribute naloxone kits to combat opioid overdose-related deaths in California. The purpose of the Naloxone Distribution Project is to distribute naloxone for intranasal administration to individuals who are at risk of opioid overdose, their family members and friends, or other persons in a position to assist during an opioid-related overdose.

Organizations and entities eligible to apply for free naloxone through the grant include:

1. First Responders
2. Emergency medical services
3. Fire authorities
4. Law enforcement, courts, and criminal justice partners
5. Veteran organizations
6. Homeless programs
7. Schools and universities
8. Libraries
9. Religious entities
10. Community organizations

Required Training:

Staff from organizations and entities who distribute naloxone kits under this grant are required to receive opioid overdose prevention and treatment training and are required to train individuals who receive naloxone kits from them.

Standing Order:

Many organizations and entities in California that are in a position to distribute naloxone under this grant may find it difficult to obtain the required standing order from a physician. The California Department of Public Health (CDPH) is authorized to issue a temporary, one year, standing order¹ for this purpose. In order to obtain this standing order the organization or entity must complete an application located on the CDPH web page².

Impact on EMS:

Depending on local EMS agency policy, most EMS personnel are authorized to administer naloxone either as a basic scope of practice item or a local optional scope of practice item. For those EMS service providers who wish to distribute naloxone under this grant, they may receive the standing order authorization from their LEMSA medical director or their provider agency's medical director. If a service provider is unable to obtain this authorization from a physician, the provider may apply to the CDPH for their standing order.

Personnel who distribute naloxone under this grant will need to complete the required training and provide that training to the individuals to whom they distribute the naloxone to.

Additional information is available on the DHCS web page at this link:

https://www.dhcs.ca.gov/individuals/Pages/Naloxone_Distribution_Project.aspx?utm_source=Homepage&utm_medium=Slider&utm_campaign=Naloxone-Distribution-Project

Attachments

¹ Civil Code, Section 1714.22

² <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Naloxone-Standing-Order.aspx>



Naloxone Distribution Project
Frequently Asked Questions
October 2018

1. What is the Naloxone Distribution Project (NDP)?

The Naloxone Distribution Project (NDP) is funded by the Substance Abuse and Mental Health Services Administration (SAMHSA) and administered by the Department of Health Care Services (DHCS) to combat opioid overdose-related deaths throughout California. The NDP aims to address the opioid crisis by reducing opioid overdose deaths through the provision of free naloxone, in its nasal spray formulation.

Starting October 1, 2018, qualified organizations and entities will be able to request free naloxone from DHCS.

2. What is the goal of the NDP?

NDP aims to address the opioid crisis in California by reducing opioid overdose deaths through the provision of free naloxone, in its nasal spray formulation.

3. What is Naloxone?

Naloxone is a life-saving medication that reverses an opioid overdose while having little to no effect on an individual if opioids are not present in their system. Naloxone works by blocking the opioid receptor sites, reversing the toxic effects of the overdose. Naloxone requires a prescription but is not a controlled substance. It has few known adverse effects, and no potential for abuse.

Naloxone is administered when a patient is showing signs of opioid overdose. The medication can be given by intranasal spray, intramuscular (into the muscle), subcutaneous (under the skin), or by intravenous injection.

4. What is NARCAN (naloxone HCl) Nasal Spray?

NARCAN® Nasal Spray is a prescription medicine used for the treatment of an opioid emergency such as an overdose or a possible opioid overdose, indicated by signs of breathing problems and severe sleepiness or not being able to

respond. NARCAN® Nasal Spray is to be given right away and does not take the place of emergency medical care. You can get additional information at <https://www.narcan.com>

5. Can naloxone be used for a fentanyl overdose?

Yes. Fentanyl is an opioid therefore naloxone can be used to reverse a fentanyl overdose.

6. Who is eligible to apply for the NDP?

DHCS will provide free naloxone to organizations and entities eligible to administer or distribute naloxone through a California Public Health standing order. Examples include:

- First responders
- Emergency medical services
- Fire authorities
- Law enforcement, courts, & criminal justice partners
- Veteran organizations
- Homeless programs
- Schools & universities
- Libraries
- Religious entities
- Community organizations

7. How can community organizations and entities in California apply to use the NDP?

If you would like to request free naloxone, complete the online application on the DHCS website: <http://www.dhcs.ca.gov/individuals/Pages/State-Targeted-Response-to-Opioid-Crisis-Grant.aspx>

The application includes instructions, as well as terms and conditions of participating in the NDP.

8. What documentation should be included with the application?

In addition to filling out the application form and agreeing to the terms and conditions, organizations must also submit a copy of their standing order for naloxone and other supporting documentation (as necessary). See questions 15 and 16 for more information on standing orders for naloxone.

Organizations submitting applications must also submit a copy of a valid and active business license, FEIN number or tax-exempt letter.

Applications that fail to submit all required documentation will be deemed incomplete & will result in application denial.

9. Is it acceptable to include a P.O. box as the mailing address?

No. FedEx (the shipping service utilized under this project) will not deliver to P.O. boxes.

10. How much does it cost to obtain naloxone through the NDP?

The product is free and shipped directly to the qualified applicant.

11. What is the minimum order that I can request through the NDP?

There is a minimum of 12 naloxone units (two 4mg devices per unit) per order; 12 units in one case. Please order in increments of 12 – for example, if you want three cases, please fill in “36” under the “units order” box in the NDP application.

12. Do I have to order in multiples of 12 units?

Yes. Each shipping case contains 12 units of naloxone.

13. What is the maximum order that I can request through the NDP?

There is no maximum limit that an entity or organization can order. For every order over 48 units, you must provide a brief and comprehensive summary that justifies your request.

If DHCS has additional questions about the quantity of naloxone requested, they may reach out to the applicant and request additional information to substantiate the request.

14. If DHCS denies an application, can the entity reapply?

Yes. If your application is denied, you may submit another application. Follow the application instructions, and the terms and conditions to qualify to receive the free shipment of naloxone.

15. If DHCS approves an application for a specific quantity of naloxone, can another application be submitted to request more naloxone?

Yes. You may request more naloxone by submitting a new application to DHCS. Prior approval does not guarantee automatic approval of the secondary request for additional naloxone.

16. What is the purpose of the naloxone standing order?

The standing order was issued by the state Public Health Officer (authorized by California Civil Code Section 1714.22) to: 1) allow community organizations and other entities in California that are not currently working with a physician, to distribute naloxone to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist; and 2) allow for the administration of naloxone by a family member, friend, or other person to a person experiencing or reasonably suspected of experiencing an opioid overdose.

For more information about naloxone standing orders, review this FAQ issued by the California Department of Public Health:

<https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/CDPH%20Document%20Library/Naloxone/Naloxone%20FAQs%20062118.pdf>

If your organization does not have a standing order, you may apply for one at <https://www.cdph.ca.gov/Programs/CCDPHP/DCDIC/SACB/Pages/Naloxone-Standing-Order.aspx>

17. How can an individual person obtain naloxone?

Some community organizations and other entities (see examples listed in question 6) may offer naloxone at low or no cost to members in their communities.

18. Is training required to distribute naloxone?

Yes. Staff of community organizations and other entities distributing naloxone under the NDP are required to receive opioid overdose prevention and treatment training, and are required to train individuals who receive naloxone from them. Minimum training requirements, and an example training resource, are included on the application information page:

<http://www.dhcs.ca.gov/individuals/Pages/State-Targeted-Response-to-Opioid-Crisis-Grant.aspx>

For additional training resources, please visit <https://www.getnaloxonenow.org/> and <http://harmreduction.org/issues/overdose-prevention/tools-best-practices/manuals-best-practice/od-manual/>

19. Are entities that receive free naloxone through the NDP permitted to sell naloxone?

No. The NDP program was established to allow community organizations and other entities that are in possession of naloxone to distribute it, and to allow individuals that receive naloxone to administer it.

The product may only be used by the applicant and may not be submitted for reimbursement of any type, including and not limited to, private pay, commercial, government authority, agency, or otherwise.

20. Once an application is approved, how long does the applicant have to wait to receive the shipment?

DHCS will contact you via email within two weeks of the date of receipt of application and confirm if your request has been approved or denied. The shipment will be mailed within a month of the date of approval of application.

21. Can I return the product?

No. The product is not returnable or refundable.

22. What should I do if there are issues with my naloxone shipment?

Please direct all questions regarding the product or shipment to customerservice@adaptpharma.com

Please direct any questions regarding the application process to DHCS at DHCSMATExpansion@dhcs.ca.gov

Naloxone Statewide Standing Order Frequently Asked Questions (FAQs)

1. What is naloxone?

Naloxone is an opioid antagonist that works almost immediately to reverse opiate overdose. Naloxone is a prescription drug, but it is not a controlled substance. Naloxone has few known adverse effects, no potential for abuse, and can be rapidly administered through intramuscular injection or nasal spray.

2. What is the purpose of the statewide naloxone standing order?

The standing order was issued by the state Public Health Officer (authorized by California Civil Code Section 1714.22) to: 1) allow community organizations and other entities in California (see response to questions #4 for examples) that are not currently working with a physician, to distribute naloxone to a person at risk of an opioid-related overdose or to a family member, friend, or other person in a position to assist; and 2) allow for the administration of naloxone by a family member, friend, or other person to a person experiencing or reasonably suspected of experiencing an opioid overdose.

3. Why is a statewide naloxone standing order needed?

Many community organizations and entities in California are in a position to help reduce deaths associated with opioid overdose by distributing naloxone, but may find it difficult to obtain the required standing order from a physician. The statewide naloxone standing order was issued to address this need.

4. Who is eligible to use the statewide standing order?

Any community organization or entity in California that can provide naloxone to those at risk of overdose and those in a position to intervene during an opioid-related overdose. Examples of eligible community organizations and entities include public health departments, harm reduction/syringe exchange programs, substance use disorder treatment providers, homeless programs, jails, emergency services providers, law enforcement, and others.

5. How can community organizations and entities in California apply to use the statewide standing order?

To apply for the statewide standing order, complete the [on-line application](#) on the California Department of Public Health's website. In addition to the application, the webpage provides more information, application instructions, and the terms and conditions for using the statewide standing order.

6. Can California pharmacists use the statewide standing order to distribute naloxone?

California pharmacists do not need to use the standing order. Pharmacists can dispense naloxone without a prescription from a health care provider as authorized and in compliance with Business and Profession Code Section 4052.01.

Naloxone Statewide Standing Order Frequently Asked Questions (FAQs)

7. Is training required to distribute naloxone?

Yes, staff of community organizations and other entities distributing naloxone under the statewide standing order are required to receive opioid overdose prevention and treatment training, and are also required to train individuals who receive naloxone from them. Minimum training requirements and an example of a training are included in the application information page. For additional training resources, please visit the California Department of Public Health's [Naloxone Grant Program](#).

8. Can the statewide standing order be used to purchase or sell naloxone?

No, the standing order was issued to allow community organizations and other entities that are in possession of naloxone to distribute it, and to allow individuals that receive naloxone to administer it.

9. Do individuals and family members need to apply to use the statewide standing order to obtain naloxone and have it covered under insurance benefits?

No, individuals and family members can obtain naloxone by: 1) obtaining a prescription for naloxone from their health care provider and having it filled at a pharmacy; or 2) purchasing naloxone from a pharmacist without a prescription from a health care provider (authorized by Business and Professions Code Section 4052.01). A pharmacist can determine if naloxone is covered by an individual's health care insurance, and can bill for this cost as appropriate.

10. How else can an individual person obtain naloxone?

Some community organizations and other entities (see examples listed in response to question #4) may offer naloxone at low or no cost.

11. How much does naloxone cost?

The price of naloxone varies depending on the type – injectable, auto injector, or nasal spray.

12. Have other states issued statewide naloxone standing orders?

Yes. Other state such as New Mexico, Pennsylvania, Maryland, and North Carolina have issued similar standing orders.

13. Can naloxone be used for a fentanyl overdose?

Yes, fentanyl is an opioid and naloxone can be used to reverse a fentanyl overdose.

Please submit additional questions to naloxonestandingorder@cdph.ca.gov.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Sergy El-Morshedy, Legislative Analyst
Legislative, Regulatory, and External Affairs

SUBJECT: EMS for Children Regulations Approval

RECOMMENDED ACTION:

Review and approve Emergency Medical Services for Children (EMSC) Regulations.

FISCAL IMPACT:

No fiscal impact exists, as this regulation does not impose a mandate for any local program or entity, state agency or program, and does not affect any federally funded State agency or program.

DISCUSSION:

The EMS Authority requests approval for the adoption of Chapter 14. Emergency Medical Services for Children, to Division 9, Title 22 of the California Code of Regulations.

The EMS Authority submitted a Notice of Proposed Regulatory Action and initial rulemaking documents to the Office of Administrative Law (OAL) on March 6, 2018. The 45-day public comment period concluded on April 30, 2018. Upon completion of the initial comment period, the EMS Authority reviewed all comments submitted by the public and revised the EMSC draft regulations accordingly.

The EMS Authority made amendments to the draft EMSC regulations based on comments received during the initial public comment period and held a 15-day public comment period, which concluded August 9, 2018. The EMS Authority made additional revisions based on comments received during the first 15-day public comment period and held a 30-day public comment period, which concluded on October 21, 2018. The EMS authority made additional revisions thereafter and held a second 15-day public comment period, which concluded on November 10, 2018.

The one-year rulemaking timeline for the proposed EMSC regulations will conclude March 16, 2019. The EMS Authority supports moving these regulations forward to OAL at this time and respectfully request the Commission's approval.

CLEAN REGULATION TEXT

1 **California Code of Regulations**
2 **Title 22. Social Security**
3 **Division 9. Prehospital Emergency Medical Services**
4 **Chapter 14. Emergency Medical Services for Children**
5

6
7 **ARTICLE 1. DEFINITIONS**
8

9 **§ 100450.200. California Emergency Medical Services Information System**
10 **(CEMSIS)**

11 “California emergency medical services information system” or “CEMSIS” means the
12 secure, standardized, and centralized electronic information and data collection system
13 administered by the California EMS Authority which is used to collect statewide
14 emergency medical services (EMS) and trauma data.
15

16 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
17 Reference: Sections 1797.102 and 1799.204, Health and Safety Code.
18

19 **§ 100450.201. Emergency Medical Services Authority**

20 “Emergency medical services authority” or “EMS authority” or “EMSA” means the
21 department in California responsible for the coordination and integration of all state
22 activities concerning emergency medical services.
23

24 Note: Authority cited: Sections 1797.107 and 1797.54, Health and Safety Code.
25 Reference: Sections 1797.100, 1797.103, and 1799.204, Health and Safety Code.
26

27 **§ 100450.202. Emergency Medical Services for Children (EMSC) Program**

28 “Emergency medical services for children program” or “EMSC program” means the
29 prehospital and hospital pediatric care components integrated into an existing local
30 EMS agency’s EMS Plan for pediatric emergency care.
31

32 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
33 Reference: Sections 1797.76, 1797.222, 1797.250, 1797.254, 1799.204, and 1799.205
34 Health and Safety Code.
35

36 **§ 100450.203. Interfacility Transfer**

37 “Interfacility transfer” means the transfer of an admitted or non-admitted pediatric patient
38 from one licensed health care hospital to another pursuant to the policies and
39 procedures of the local EMS agency.
40

41 Note: Authority cited: Sections 1797.107 and 1799.204(6), Health and Safety Code.
42 Reference: Sections 1798.170, 1798.172, 1799.204(c)(6) and 1799.205(e), Health and
43 Safety Code.
44

45 **§ 100450.204. Local Emergency Medical Services Agency**

CLEAN REGULATION TEXT

46 “Local emergency medical services agency” or “local EMS agency” or “LEMSA” means
47 the agency, department, or office having primary responsibility for administration of
48 emergency medical services in a county or multicounty region and which is designated
49 pursuant Health and Safety Code commencing with section 1797.200.

50

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

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

53

54 **§ 100450.205. National EMS Information System (NEMSIS)**

55 “National EMS information system” or “NEMSIS” means the national repository used to
56 store secure, standardized, and centralized electronic EMS data from every state in the
57 nation.

58

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

60 Reference: Section 1799.204, Health and Safety Code.

61

62 **§ 100450.206. Pediatric Emergency Care Coordinator (PECC)**

63 “Pediatric emergency care coordinator” or “PECC” means a physician or registered
64 nurse who is qualified in the emergency care of pediatric patients pursuant to California
65 Code of Regulations (CCR), Title 22, Chapter 14, Article 2, section 100450.216.

66

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

68 Reference: Section 1799.204, Health and Safety Code.

69

70 **§ 100450.207. Pediatric Experience**

71 “Pediatric experience” means demonstrated competency through experience to care
72 for children of all ages within their specialty as determined by hospital staff
73 credentialing.

74

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

76 Reference: Section 1799.204, Health and Safety Code.

77

78 **§ 100450.208. Pediatric Intensivist**

79 “Pediatric intensivist” means a physician who is board-certified or board-eligible in
80 pediatric critical care medicine as recognized by the American Board of Medical
81 Specialties, the Royal College of Physicians and Surgeons of Canada or the American
82 Osteopathic Board of Medical Specialties.

83

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

85 Reference: Section 1799.204, Health and Safety Code.

86

87 **§ 100450.209. Pediatric Patient**

88 “Pediatric patient” means a person who is less than 14 years of age, consistent with
89 Title 22, Division 5, section 70537 of the California Code of Regulations.

90

CLEAN REGULATION TEXT

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

93

94 **§ 100450.210. Pediatric Receiving Center (PedRC)**

95 “Pediatric Receiving Center” or “PedRC” means a licensed general acute care hospital
96 with, at a minimum, a permit for standby, basic or comprehensive emergency services
97 that has been formally designated as one of four types of PedRCs by the local EMS
98 agency for its role in an EMS system.

99

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

102

103 **§ 100450.211. Qualified Emergency Specialist**

104 “Qualified emergency specialist” means a physician who is licensed in California, board
105 certified or board eligible in emergency medicine or pediatric emergency medicine by
106 the American Board of Medical Specialties, the American Osteopathic Association
107 Bureau of Osteopathic Specialties, a Canadian Board or other appropriate foreign
108 specialty board as determined by the American Board of Medical Specialties.

109

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

112

113 **§ 100450.212. Qualified Pediatric Specialist**

114 “Qualified pediatric specialist” means a physician who is licensed in California, board
115 certified or board eligible in a pediatric specialty by the American Board of Medical
116 Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other
117 appropriate foreign specialty board as determined by the American Board of Medical
118 Specialties.

119

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

122

123 **§ 100450.213. Qualified Specialist**

124 “Qualified specialist” means a physician licensed in California who is board certified or
125 board eligible in the corresponding specialty by the American Board of Medical
126 Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other
127 appropriate foreign specialty board as determined by the American Board of Medical
128 Specialties.

129

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

132

133 **§ 100450.214. Quality Improvement**

134 “Quality Improvement” or “QI” means methods of evaluation that are comprised of
135 structure, process, and outcome evaluations that focus on improvement efforts to
136 identify root causes of problems, intervene to reduce or eliminate these causes and take

CLEAN REGULATION TEXT

137 steps to correct the process, and recognize excellence in performance and delivery of
138 care.

139

140 Note: Authority cited: Sections 1797.103, 1797.107, 1797.174, 1797.176 and 1798.150
141 119 Health and Safety Code. Reference: Sections 1797.174, 1797.202, 1797.204,
142 1797.220 120 and 1798.175, Health and Safety Code.

143

144 **§ 100450.215. Telehealth**

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

150

151 Note: Authority cited: Sections 1797.107 and 1799.204

152 Reference: Section 2290.5, California Business and Professions Code

153

154 **Article 2. LOCAL EMS AGENCY EMSC PROGRAM REQUIREMENTS**

155

156 **§ 100450.216. EMSC Program Approval**

157

158 (a) A local EMS agency may develop and implement an EMSC program.

159

160 (b) A local EMS agency implementing a new EMSC program shall have the EMSC
161 component of an EMS plan approved by the EMS Authority prior to implementation.

162

163 (c) The EMSC component of an EMS plan submitted to the EMS Authority shall include,
164 at a minimum, the following:

165

166 (1) EMSC program goals and objectives.

167

168 (2) The names and titles of the local EMS agency personnel who have a role in the
169 planning, implementation, and management of an EMSC program.

170

171 (3) Injury and illness prevention planning that includes coordination, education, and data
172 collection.

173

174 (4) (A) Policies for care and services rendered to pre-hospital EMS pediatric patients:

175

176 (i) First response non-transport.

177

178 (ii) Transport.

179

180 (iii) Interfacility Transfer.

181

182 (iv) Critical Care.

CLEAN REGULATION TEXT

- 183
184 (B) This shall include, but not be limited to:
185
186 (i) Pediatric-specific personnel training.
187
188 (ii) Pediatric ambulance equipment.
189
190 (5) A quality improvement plan containing process-outcome measures as referenced in
191 section 100450.223 of this Chapter.
192
193 (6) A list of facilities providing pediatric critical care and pediatric trauma services.
194
195 (7) List of designated hospitals with agreements to participate in the EMSC system of
196 care.
197
198 (8) A list of facilities providing pediatric physical rehabilitation resources.
199
200 (9) Copies of the local EMS agency's EMSC pediatric patient destination policies.
201
202 (10) A description of the method of field communication to the receiving hospital specific
203 to the EMSC patient.
204
205 (11) A description of the method of data collection from the EMS providers and
206 designated EMSC hospitals to the local EMS agency and the EMS Authority.
207
208 (12) A policy or description of how the local EMS agency integrates a PedRC in a
209 neighboring jurisdiction.
210
211 (13) Pediatric surge planning.
212
213 (d) The EMS Authority shall, within 30 days of receiving a request for approval, notify
214 the requesting local EMS agency in writing of approval or disapproval of its EMSC
215 program. If the EMSC program is disapproved, the response shall include the reason(s)
216 for the disapproval and any required corrective action items.
217
218 (e) The local EMS agency shall provide an amended plan to the EMS Authority within
219 60 days of receipt of the disapproval letter.
220
221 (f) A local EMS agency currently operating an EMSC program implemented prior to the
222 effective date of these regulations, shall submit, to the EMS Authority, an EMSC
223 component of an EMS plan as an addendum to its annual EMS plan update, or within
224 180 days of the effective date of these regulations, whichever comes first.
225
226 (g) No health care facility shall advertise in any manner or otherwise hold itself out to be
227 affiliated with an EMSC program or PedRC unless they have been designated by the
228 local EMS agency, in accordance with this chapter.

CLEAN REGULATION TEXT

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Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.220, 1797.250, 1797.254 1798.150, 1798.170, 1798.172, 1799.204 and 1799.205 Health and Safety Code. Reference: Section 1797.176 and 1797.220, Health and Safety Code.

§ 100450.217. Annual EMSC Program Update

(a) The local EMS agency shall submit an annual update to its EMSC program as part of its annual EMS plan submittal, which shall include, at a minimum, all the following:

- (1) Any changes in the EMSC program since submission of the prior annual EMS plan.
- (2) The status of EMSC program goals and objectives.
- (3) A summary of the EMSC program performance improvement activities.
- (4) Progress on addressing action items and recommendations provided by the EMS Authority within the EMSC program or Status Report approval letter, if applicable.

Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.250, 1797.254, 1798.150, and 1798.172 Health and Safety Code. Reference: Section 1797.176, 1797.220, 1797.222, 1798.170, 1799.204, and 1799.205 Health and Safety Code.

Article 3: Pediatric Receiving Centers

§ 100450.218. All PedRC Requirements

(a) All PedRCs shall meet the following facility requirements:

- (1) All PedRCs shall have an interfacility transfer plan for pediatric patients in accordance with Title 22, Division 9, Chapter 7.
- (2) Establish a process for obtaining and providing consultation via phone, telehealth, or onsite for emergency care and stabilization, transfer, and transport.

(b) All PedRCs shall meet the following personnel requirements:

- (1) All physician PECCs shall be licensed in California and meet all the following minimum requirements:
 - (A) Be a qualified emergency specialist, or
 - (B) Be a qualified specialist in Pediatrics or Family Medicine, and
 - (C) Shall have competency in resuscitation of pediatric patients of all ages from neonates to adolescents.

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(2) All nurse PECCs shall be licensed in California and meet all the following minimum requirements:

(A) Have at least two (2) years of experience in pediatric or emergency nursing within the previous five (5) years.

(B) Shall have competency in resuscitation of pediatric patients of all ages from neonates to adolescents through American Heart Association Pediatric Advanced Life Support or American College of Emergency Physicians sponsored Advanced Pediatric Life Support.

(3) The designated PECC shall be responsible for all of the following:

(A) Provide oversight of the emergency department pediatric quality improvement program.

(B) Liaison with appropriate hospital-based pediatric care committees.

(C) Liaison with other PedRCs, the local EMS agency, base hospitals, prehospital care providers, and neighboring hospitals.

(D) Facilitate pediatric emergency department continuing education and competency evaluations in pediatrics for emergency department staff.

(E) Coordinate pediatric disaster preparedness.

(F) Ensure family centered care practices are in place.

(4) All PedRCs shall have personnel available for consultation to the emergency department through live interactive telehealth or other means determined by the local EMS agency including, but not limited to:

(A) A qualified pediatric specialist

(B) A pediatric intensivist

(C) Support services including respiratory care, laboratory, radiology, and pharmacy shall include staff and equipment to care for the pediatric patient.

(D) Respiratory care specialists who respond to the emergency department

(i) 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:

CLEAN REGULATION TEXT

- 321 A. Current completion of the American Heart Association Pediatric Advanced Life
322 Support Course, or
323
- 324 B. The American Academy of Pediatrics and American College of Emergency
325 Physicians sponsored Advanced Pediatric Life Support Course, or
326
- 327 C. Continuing education courses specific to resuscitation of pediatric patients.
328
- 329 (c) The pediatric equipment, supplies and medications in all PedRCs, for pediatric
330 patients from neonates to adolescents, shall include, but not be limited to:
331
- 332 (1) A length-based resuscitation tape, medical software, or other system available to
333 assure proper sizing of resuscitation equipment and proper dosing of medication.
334
- 335 (2) Portable resuscitation supplies, such as a crash cart or bag with a method of
336 verification of contents on a regular basis.
337
- 338 (3) Equipment for patient and fluid warming, patient restraint, weight scale (in kilograms)
339 and pain scale tools for all ages of pediatric patients.
340
- 341 (4) Monitoring equipment appropriate for pediatric patients including, but not limited to,
342 blood pressure cuffs, doppler device, electrocardiogram monitor/defibrillator,
343 hypothermia thermometer, pulse oximeter, and end tidal carbon dioxide monitor.
344
- 345 (5) Respiratory equipment and supplies appropriate for pediatric patients including, but
346 not limited to, clear oxygen masks, bag-mask devices, intubation equipment,
347 supraglottic airways, oral and nasal airways, nasogastric tubes, and suction equipment.
348
- 349 (6) Vascular access supplies and equipment for pediatric patients including, but not
350 limited to, intravenous catheters, intraosseous needles, infusion devices, and
351 Intravenous solutions.
352
- 353 (7) Fracture management devices for pediatric patients including extremity splints and
354 spinal motion restriction devices.
355
- 356 (8) Medications for the care of pediatric patients requiring resuscitation.
357
- 358 (9) Specialized pediatric trays or kits which shall include, but not be limited to:
359
- 360 (A) Lumbar puncture tray.
361
- 362 (B) Difficult airway kit with devices to assist intubation and ventilation.
363
- 364 (C) Tube thoracostomy tray including chest tubes in sizes for pediatric patients of all
365 ages.
366

CLEAN REGULATION TEXT

367 (10) Newborn delivery kit to include, but not limited to, the following:

368

369 (A) towel,

370

371 (B) clamps and scissors for cutting the umbilical cord,

372

373 (C) bulb suction,

374

375 (D) warming pad, and

376

377 (E) neonatal bag-mask ventilation device with appropriate sized masks.

378

379 (F) Urinary catheter tray including urinary catheters for pediatric patients of all ages.

380

381 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety
382 Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172,
383 1799.204, and 1799.205, Health and Safety Code.

384

385 **§ 100450.219. Basic PedRC Requirements**

386

387 (a) A hospital may be designated as a Basic PedRC by the local EMS agency upon
388 meeting all the following criteria:

389

390 (1) All designated Basic PedRCs shall be licensed as a general acute care hospital with
391 a basic or standby Emergency Department permit.

392

393 (2) Emergency Department services may include physician staffing 24 hours a day, 7
394 days a week or a physician available for consultation.

395

396 (3) At minimum, one licensed registered nurse or advanced care practitioner per shift in
397 the emergency department shall have current completion American Heart Association of
398 Pediatric Advanced Life Support, Advanced Pediatric Life Support, completion of an
399 Emergency Nursing Pediatric Course, or other equivalent pediatric emergency care
400 nursing course, as determined by the local EMS agency.

401

402 (4) The emergency department in the hospital shall be able to stabilize critically ill or
403 injured infant, children, and adolescents prior to admission to the PICU or transfer to a
404 Comprehensive PedRC facility.

405

406 (5) Establish agreements with at least one Comprehensive PedRC as approved by the
407 local EMS agency, for education, consultation and transfer of critical pediatric patients.

408

409 (6) Establish agreements with an Advanced or General PedRC as approved by the local
410 EMS agency, for consultation and transfer of pediatric patients.

411

CLEAN REGULATION TEXT

412 (7) Establish transfer agreements for pediatric patients needing specialized care, if the
413 specialized care is not available at a Comprehensive, Advanced or General PedRC,
414 such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health.

415
416 (8) All Basic PedRCs shall have a physician and/or nurse PECC which may be shared
417 with other PedRCs.

418
419 (b) Additional requirements may be stipulated by the local EMS agency medical
420 director.

421
422 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety
423 Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172,
424 1799.204, and 1799.205, Health and Safety Code.

425
426 **§ 100450.220. General PedRC Requirements**

427
428 (a) A hospital may be designated as a General PedRC by the local EMS agency upon
429 meeting all the following criteria:

430
431 (1) All designated General PedRCs shall be licensed as a general acute care hospital
432 with a basic or comprehensive Emergency Department permit.

433
434 (2) Participate with a Comprehensive and/or Advanced PedRC for pediatric emergency
435 education for hospital staff and emergency care providers consistent with the local EMS
436 agency plan for ongoing pediatric education.

437
438 (3) The emergency department in the hospital shall be able to stabilize critically ill or
439 injured infant, children, and adolescents prior to admission to the PICU or transfer to a
440 Comprehensive PedRC facility.

441
442 (4) Establish agreements with a Comprehensive and/or Advanced PedRCs as approved
443 by the local EMS agency, for education, consultation and transfer.

444
445 (5) Establish transfer agreements for pediatric patients needing specialized care, if the
446 specialized care is not available at a Comprehensive, Advanced or General PedRC,
447 such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health.

448
449 (6) All designated General PedRCs shall have a physician and/or nurse PECC which
450 may be shared with other PedRCs.

451
452 (7) All designated General PedRCs shall meet the following additional equipment
453 requirements:

454
455 (A) neonatal resuscitation equipment, including:

456
457 (i) pediatric laryngoscope with Miller 0 and 00 blades,

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(ii) size 2.5 and 3.0 endotracheal tubes, and

(iii) umbilical vein catheters.

(b) Additional requirements may be stipulated by the local EMS agency medical director.

Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172, 1799.204 and 1799.205, Health and Safety Code.

§ 100450.221. Advanced PedRC Requirements

(a) A hospital may be designated as an Advanced PedRC by the local EMS agency upon meeting the following criteria:

(1) All designated Advanced PedRCs shall be licensed by the Department of Health Services (DHS), Licensing and Certification Division, under California Code of Regulations (CCR), Title 22, Division 5, Chapter 1, as follows:

(A) As an acute care hospital pursuant to Article 1, sections 70003 and 70005.

(B) For pediatric service pursuant to Article 6, section 70535 et seq.

(C) For basic or comprehensive emergency medical services pursuant to Article 6, section 70411, et seq.

(D) For social services pursuant to Article 6, section 70535 et seq

(E) Community neonatal intensive care unit (NICU) or as an Intermediate NICU if it meets the following requirements, as per:

(i) Article 6, Section 70545 et seq., for the provision of perinatal services and licensed by DHS, Licensing and Certification Division as a perinatal service;

(ii) Article 6, Section 70481 et seq., for the provision of neonatal intensive care services and licensed by DHS, Licensing and Certification Division as an Intensive Care Newborn Nursery (ICNN)

(F) If the hospital has a pediatric intensive care unit (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.

CLEAN REGULATION TEXT

503 (G) The emergency department in the hospital shall be able to stabilize critically ill or
504 injured infant, children, and adolescents prior to admission to the PICU or transfer to a
505 Comprehensive PedRC facility.

506
507 (2) Establish agreements with a minimum of one Comprehensive PedRC as approved
508 by the local EMS agency, for consultation.

509
510 (3) Participate with a Comprehensive PedRC for pediatric emergency education for
511 emergency care providers consistent with the local EMS agency plan for ongoing
512 pediatric education.

513
514 (4) Establish transfer agreements with a Comprehensive PedRC to transfer pediatric
515 patients for stabilization, ensuring the highest level of care.

516
517 (5) Establish transfer agreements for pediatric patients needing specialized care, if the
518 specialized care is not available at a Comprehensive, Advanced or General PedRC,
519 such as trauma, burn, spinal cord injury, and rehabilitation and behavioral health.

520
521 (b) All Advanced PedRCs shall meet the following personnel requirements:

522
523 (1) Advanced PedRCs shall have a physician and nurse Pediatric Emergency Care
524 Coordinator (PECC).

525
526 (2) Respiratory care service in the pediatric service/department and emergency
527 department provided by respiratory care practitioners (RCPs) who are licensed in the
528 state of California and who have completed formal training in pediatric respiratory care
529 which includes clinical experience in the care of children.

530
531 (3) Social work services in the pediatric service/department provided by a medical social
532 worker (MSW) holding a master's degree in social work who has expertise in the
533 psychosocial issues affecting the families of seriously ill infants, children, and
534 adolescents.

535
536 (4) Behavioral health specialists with pediatric experience to include but not limited to
537 psychiatrist, psychologist, and nurse.

538
539 (5) The following specialties shall be on-call, and available for consultation to the ED or
540 NICU within 30 minutes by telephone and in-person within one hour:

541
542 (A) Neonatologist

543
544 (B) General Surgeon with pediatric experience

545
546 (C) Anesthesiologist with pediatric experience

547
548 (D) Pediatric Cardiologist

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(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) Mental health professional with pediatric experience
- (D) 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

(8) The hospital or LEMSA may require additional specialists or more rapid response times.

(c) The pediatric equipment, supplies and medications in all Advanced PedRCs, for pediatric patients from neonates to adolescents, shall include all General PedRC equipment, and:

CLEAN REGULATION TEXT

594 (1) Crash carts with pediatric resuscitation equipment that shall be standardized and
595 available on all units including but not limited to the emergency department, radiology
596 suite and inpatient pediatric service.

597
598 (d) Additional requirements may be stipulated by the local EMS agency medical
599 director.

600
601 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
602 Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172, 1799.204, and
603 1799.205, Health and Safety Code.

604
605 **§ 100450.222. Comprehensive PedRC Requirements**

606
607 (a) A hospital may be designated as a Comprehensive PedRC by the local EMS agency
608 upon meeting all criteria of an Advanced PedRC, as well as the following facility
609 requirements:

610
611 (1) All designated Comprehensive PedRCs shall be licensed as a general acute care
612 hospital with a basic or comprehensive Emergency Department permit and have full,
613 provisional, or conditional California Children’s Services (CCS) approval by the
614 Department of Health Care Services as a tertiary hospital, or meet CCS criteria as a
615 tertiary hospital as approved by the local EMS agency.

616
617 (2) Can provide comprehensive specialized pediatric medical and surgical care to any
618 acutely ill or injured child.

619
620 (3) Inpatient resources including a neonatal intensive care unit (NICU) and a pediatric
621 intensive care unit (PICU).

622
623 (4) Provide ongoing outreach and pediatric education for Community, General and
624 Basic PedRCs, and prehospital care providers, in collaboration with the local EMS
625 agency.

626
627 (5) Establish transfer agreements or serve as a regional referral center for
628 specialized care, such as trauma, burn, spinal cord injury, and rehabilitation and
629 behavioral health, of pediatric patients.

630
631 (6) Emergency department services include a separate pediatric emergency department
632 or a designated area for emergency care of pediatric patients within an emergency
633 department, with physician staff who are qualified specialists in emergency medicine or
634 pediatric emergency medicine.

635
636 (7) All designated Comprehensive PedRCs shall meet the equipment requirements of
637 Advanced PedRCs.

638

CLEAN REGULATION TEXT

639 (b) Additional requirements may be stipulated by the local EMS agency medical
640 director.

641
642 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
643 Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.173, 1799.204, and
644 1799.205, Health and Safety Code.

645
646 **Article 4: Data Management, Quality Improvement and Evaluations**

647
648 **§ 100450.223. Data Management Requirements**

649
650 (a) The local EMS agency shall implement a standardized data collection and reporting
651 process for EMSC program.

652
653 (1) The EMSC program shall include the collection of both prehospital and hospital
654 patient care data, as determined by the local EMS agency.

655
656 (2) The prehospital EMSC patient care elements selected by the local EMS agency
657 shall be compliant with the most current version of the CEMISIS and the NEMISIS
658 databases.

659
660 (b) All PedRCs shall participate in the local EMS agency data collection process in
661 accordance with local EMS agency policies and procedures.

662
663 (c) Following approval of the EMSC program, PedRCs shall submit data to the local
664 EMS agency which shall include, but not be limited to:

665
666 (1) Baseline data from pediatric ambulance transports, including, but not limited to:

667
668 (A) Arrival time/date to the emergency department.

669
670 (B) Date of birth.

671
672 (C) Mode of arrival.

673
674 (D) Gender.

675
676 (E) Primary impression.

677
678 (2) Basic outcomes for EMS quality improvement activities, including but not limited to:

679
680 (A) Admitting hospital name if applicable.

681
682 (B) Discharge or transfer diagnosis.

683
684 (C) Time and date of discharge or transfer from the Emergency Department.

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(D) Disposition from the Emergency Department.

(E) External cause of injury.

(F) Injury location.

(G) Residence zip code.

(d) Pediatric data shall be integrated into the local EMS agency and the EMS Authority data management system through data submission on no less than a quarterly basis.

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

Reference: Sections 1799.204 and 1799.205, Health and Safety Code.

§ 100450.224. Quality Improvement and Evaluation Process

(a) Each local EMS agency shall have a quality improvement program in collaboration with all PedRCs.

(b) All PedRCs shall have a quality improvement program. This process shall include, at a minimum:

(1) Compliance with the California Evidence Code, Section 1157.7 to ensure confidentiality, and a disclosure protected review of selected pediatric cases.

(2) A process that integrates emergency department quality improvement activities with the prehospital, trauma, inpatient pediatrics, pediatric critical care and hospital-wide quality improvement activities.

(3) A process to integrate findings from quality improvement audits and reviews into education and clinical competency evaluations of staff.

(4) Each PedRC will complete an online or paper assessment of the National Pediatric Readiness Project self-assessment and share the results with the local EMS agency every three years at minimum.

(5) A multidisciplinary pediatric quality improvement committee to review prehospital, emergency department, and inpatient care which shall include, but not be limited to:

(A) Cardiopulmonary or respiratory arrests.

(B) Child maltreatment cases.

(C) Deaths.

CLEAN REGULATION TEXT

731 (D) Intensive care unit admissions.

732

733 (E) Operating room admissions.

734

735 (F) Transfers.

736

737 (G) Trauma admissions.

738

739 (c) The local EMS agency is responsible for:

740

741 (1) Ongoing performance evaluations of the local or regional EMSC programs.

742

743 (2) Ensuring the designated PedRCs, other hospitals that provide care to pediatric
744 patients, and prehospital providers involved in the EMSC program, participate in the
745 quality improvement program contained in this section.

746

747 Note: Authority cited: Sections 1797.102, 1797.103, 1797.107, 1797.176, 1797.204,
748 1797.220, 1797.250, 1797.254, 1798.150, and 1798.172. Health and Safety Code.

749 Reference: Section 1797.104, 1797.176, 1797.204, 1797.220, 1797.222, 1798.170
750 Health and Safety Code.

EMS Commission Meeting – December 5, 2018
ALL MODIFICATIONS TO THE REGULATION TEXT

1 The Emergency Medical Services Authority has illustrated changes to the original text in
2 the following manner:

- 3
- 4 • Additions to the original text from 45-day comment period are shown underlined.
- 5 • Deletions to the original text from 45-day comment period are shown in ~~strikeout~~.
- 6

7 The Emergency Medical Services Authority has illustrated changes to the modified text
8 from the 15-day comment period in the following manner:

- 9
- 10 • Additions to the modified text are shown in **highlighted italics underline**.
- 11 • Deletions to the modified text are shown in **highlighted ~~italics strikeout~~**.
- 12

13 The Emergency Medical Services Authority has illustrated changes to the modified text
14 from the 30-day comment period in the following manner:

- 15
- 16 • Additions to the modified text are shown in **highlighted double underline**.
- 17 • Deletions to the modified text are shown in **highlighted ~~double strikeout~~**.
- 18

19 The Emergency Medical Services Authority has illustrated NONSUBSTANTIVE
20 changes to the modified text from the second 15-day comment period in the following
21 manner:

- 22
- 23 • Nonsubstantive additions to the modified text are shown in **highlighted italics**
24 **double underline**.
- 25 • Nonsubstantive deletions to the modified text are shown in **highlighted italics**
26 **double strikeout**.
- 27
- 28

29 **California Code of Regulations**
30 **Title 22. Social Security**
31 **Division 9. Prehospital Emergency Medical Services**
32 **Chapter 14. Emergency Medical Services for Children**
33

34
35 **ARTICLE 1. DEFINITIONS**
36

37 **§ 100450.200. California Emergency Medical Services Information System**
38 **(CEMSIS)**

39 “California emergency medical services information system” or “CEMSIS” means the
40 secure, standardized, and centralized electronic information and data collection system
41 administered by the California EMS Authority which is used to collect statewide
42 emergency medical services (EMS) and trauma data.
43

44 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
45 Reference: Sections 1797.102 and 1799.204, Health and Safety Code.
46

47 **§ 100450.201. Emergency Medical Services Authority**
48 “Emergency medical services authority” or “EMS authority” **or “EMSA”** means the
49 department in California responsible for the coordination and integration of all state
50 activities concerning emergency medical services.

51
52 Note: Authority cited: Sections 1797.107 and 1797.54, Health and Safety Code.
53 Reference: Sections 1797.100, 1797.103, and 1799.204, Health and Safety Code.
54

55 **§ 100450.202. Emergency Medical Services for Children (EMSC) Program**
56 “Emergency medical services for children program” or “EMSC program” means the
57 **written EMSC program prehospital and hospital pediatric care** components integrated
58 into an existing local EMS agency’s EMS Plan for pediatric emergency care.

59
60 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
61 Reference: Sections 1797.76, 1797.222, 1797.250, 1797.254, 1799.204, and 1799.205
62 Health and Safety Code.
63

64 ~~**§ 100450.203. Emergency Medical Services Quality Improvement Program**~~
65 ~~“Emergency medical services quality improvement program” or “quality improvement” or~~
66 ~~“QI” means methods of evaluation that are composed of structure, process, and~~
67 ~~outcome evaluations which that focus on improvement efforts to identify root causes of~~
68 ~~problems, intervene to reduce or eliminate these causes, and take steps to correct the~~
69 ~~process and recognize achieve excellence in **performance and** delivery of care.~~

70
71 ~~Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.~~
72 ~~Reference: Section 1799.205(j), Health and Safety Code.~~
73

74 **§ 100450.204203. Interfacility Transfer**
75 “Interfacility transfer” means the transfer of an admitted or non-admitted pediatric patient
76 from one licensed health care hospital to another pursuant to the policies and
77 procedures of the local EMS agency **for the transfer of pediatric patients between health**
78 **care facilities.**

79
80 Note: Authority cited: Sections 1797.107 and 1799.204(6), Health and Safety Code.
81 Reference: Sections 1798.170, 1798.172, 1799.204(c)(6) and 1799.205(e), Health and
82 Safety Code.
83

84 **§ 100450.205204. Local Emergency Medical Services Agency**
85 **“Local emergency medical services agency” or “local EMS agency” or “LEMSA” means**
86 **the agency, department, or office having primary responsibility for administration of**
87 **emergency medical services in a county or multicounty region and which is designated**
88 **pursuant Health and Safety Code commencing with section 1797.200.**

89
90 **Note: Authority cited: Sections 1797.107 and 1798.150, Health and Safety Code.**
91 **Reference: Sections 1797.103 and 1797.176, Health and Safety Code.**
92

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93 **§ 100450.205206205. National EMS Information System (NEMSIS)**
94 “National EMS information system” or “NEMSIS” means the national repository used to
95 store secure, standardized, and centralized electronic EMS data from every state in the
96 nation.

97
98 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
99 Reference: Section 1799.204, Health and Safety Code.

100
101 **§ 100450.206207206. Pediatric Emergency Care Coordinator (PECC)**
102 “Pediatric emergency care coordinator” or “PECC” means a physician or **registered**
103 nurse who is assigned to an emergency department and demonstrates competence and
104 skill-qualified in the emergency care of pediatric patients pursuant to **Health and Safety**
105 **Code section 100450.220 California Code of Regulations (CCR), Title 22, Chapter 14,**
106 **Article 2, section 100450.216.**

107
108 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
109 Reference: Section 1799.204, Health and Safety Code.

110
111 **§ 100450.207. Pediatric Experience**
112 **“Pediatric experience” means demonstrated competency through experience to care**
113 **for children of all ages within their specialty as determined by hospital staff**
114 **credentialing.**

115
116 **Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.**
117 **Reference: Section 1799.204, Health and Safety Code.**

118
119 **§ 100450.207208. Pediatric Intensivist**
120 “Pediatric intensivist” means a physician who is board-certified or board-eligible in
121 pediatric critical care medicine, **or pediatrics, anesthesia, and anesthesia critical care as**
122 **recognized by the American Board of Medical Specialties, the Royal College of**
123 **Physicians and Surgeons of Canada or the American Osteopathic Board of Medical**
124 **Specialties.**

125
126 Note: Authority cited: Sections 1797.107 and 1799.204 Health and Safety Code.
127 Reference: Section 1799.204, Health and Safety Code.

128
129 **§ 100450.208209. Pediatric Patient**
130 “Pediatric patient” means a person who is less than **or equal to** 14 years of age,
131 **consistent with Title 22, Division 5, section 70537 of the California Code of Regulations.**

132
133 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
134 Reference: Section 1799.204, Health and Safety Code.

135
136 **§ 100450.209210. Pediatric Receiving Center (PedRC)**
137 “Pediatric Receiving Center” or “PedRC” means a licensed general acute care hospital
138 with, at a minimum, a permit for **standby, basic or comprehensive emergency services**

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139 that ~~have~~has been formally designated as one of four types of PedRCs by the local
140 EMS agency for its role in an EMS system.

141

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

143 Reference: Section 1797.67, 1797.88, 1799.204, Health and Safety Code.

144

145 **~~§ 100450.210. Pediatric Receiving Center – Level I~~**

146 ~~“Level I pediatric receiving center” means a California Children’s Services (CCS)~~
147 ~~approved tertiary hospital, pursuant to Health and Safety Code 213800 et seq (the~~
148 ~~Robert W. Crown California Children’s Services Act), with specialized in-patient~~
149 ~~intensive care, diagnostic, operative, therapeutic services and equipment, and with in-~~
150 ~~house and/or promptly available physician specialists in pediatric subspecialties. A~~
151 ~~Level I pediatric community hospital may be designated as a PedRC by the local EMS~~
152 ~~agency if the hospital has full, provisional, or CCS approval readily available.~~

153

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

155 Reference: Sections ~~1797.67, 1797.88, 1797.222, 1798.101, 1799.204, 124840,~~ Health
156 and Safety Code.

157

158 **~~§ 100450.211. Pediatric Receiving Center – Level II~~**

159 ~~“Level II pediatric receiving center” means a CCS approved pediatric community~~
160 ~~hospital. A level II pediatric community hospital may be designated as a PedRC by the~~
161 ~~local EMS agency if the hospital has full, provisional, or CCS approval readily available.~~

162

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

164 Reference: Sections ~~1797.67, 1797.88, 1797.222, 1798.101, 1799.204, 124840,~~ Health
165 and Safety Code.

166

167 **~~§ 100450.212. Pediatric Receiving Center – Level III~~**

168 ~~“Level III pediatric receiving center” means a hospital with basic emergency services,~~
169 ~~staffed 24 hours a day, 7 days a week, but which may have limited inpatient services. A~~
170 ~~level III PedRC is a general community hospital that has adult inpatient specialty care~~
171 ~~with no dedicated inpatient pediatric services. Diagnostic, operative, therapeutic~~
172 ~~services and equipment must be available, and selected physician specialists must be~~
173 ~~available for consultation. A level III pediatric community hospital may be designated as~~
174 ~~a PedRC by the local EMS agency if the hospital has full, provisional, or CCS approval~~
175 ~~readily available.~~

176

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

178 Reference: Sections ~~1797.67, 1797.88, 1797.222, 1798.101, 1799.204, 124840,~~ Health
179 and Safety Code.

180

181 **~~§ 100450.213. Pediatric Receiving Center – Level IV~~**

182 ~~“Level IV pediatric receiving center” means a small and rural hospital, with a basic~~
183 ~~emergency department permit, as defined in Section 124840 of the Health and Safety~~
184 ~~Code, with limited or no inpatient care capability and limited physician specialists~~

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185 available for consultation. Emergency department services may include physician
186 staffing 24 hours a day, 7 days a week or a physician available for consultation. A level
187 IV pediatric community hospital may be designated as a PedRC by the local EMS
188 agency if the hospital has full, provisional, or CCS approval readily available.

189
190 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
191 Reference: Sections 1797.67, 1797.88, 1797.222, 1798.101, 1799.204, 124840. Health
192 and Safety Code;

193
194 **§ 100450.214~~210211~~. Qualified Emergency Specialist**

195 “Qualified emergency specialist” means a qualified California physician who is licensed
196 in California, board certified or board eligible in emergency medicine or pediatric
197 emergency medicine by the American Board of Medical Specialties, the Advisory Board
198 for American Osteopathic Association Bureau of Osteopathic Specialties, a Canadian
199 Board or other appropriate foreign specialty board as determined by the American
200 Board of Medical Specialties.

201
202 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
203 Reference: Section 1799.204, Health and Safety Code.

204
205 **§ 100450.215~~211212~~. Qualified Pediatric Specialist**

206 “Qualified pediatric specialist” means a qualified California physician who is licensed in
207 California, board certified or board eligible in a pediatric specialty by the American
208 Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a
209 Canadian Board or other appropriate foreign specialty board as determined by the
210 American Board of Medical Specialties.

211
212 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
213 Reference: Section 1799.204, Health and Safety Code.

214
215 **§ 100450.216~~212213~~. Qualified Specialist**

216 “Qualified specialist” means a physician licensed in California who has taken special
217 postgraduate medical training, and has become is board certified or is board eligible in
218 the specified discipline of medicine as recognized corresponding specialty by the
219 American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties,
220 a Canadian Board or other appropriate foreign specialty board as determined by the
221 American Board of Medical Specialties.

222
223 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
224 Reference: Section 1799.204, Health and Safety Code.

225
226 **§ 100450.214. Quality Improvement**

227 “Quality Improvement” or “QI” means methods of evaluation that are composed
228 comprised of structure, process, and outcome evaluations that focus on improvement
229 efforts to identify root causes of problems, intervene to reduce or eliminate these

230 causes and take steps to correct the process, and recognize excellence in performance
231 and delivery of care.

232
233 Note: Authority cited: Sections 1797.103, 1797.107, 1797.174, 1797.176 and 1798.150
234 119 Health and Safety Code. Reference: Sections 1797.174, 1797.202, 1797.204,
235 1797.220 120 and 1798.175, Health and Safety Code.

236
237 **§ 100450.217~~213~~215. Telehealth**

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

243
244 Note: Authority cited: Sections 1797.107 and 1799.204
245 Reference: Section 2290.5, California Business and Professions Code

246
247 **§ 100450.218. Trauma Facility**

248 "~~Trauma facility" means a licensed hospital, which has been designated as a level I, II,~~
249 ~~III, or IV trauma facility and/or Level I or II pediatric trauma facility by the local EMS~~
250 ~~agency.~~

251
252 ~~Note: Authority cited: Sections 1797.107, 1798.160, 1798.165 and 1799.204, Health~~
253 ~~and Safety Code. Reference: Sections 1798.161, 1798.162, and 1799.204, Health and~~
254 ~~Safety Code.~~

255
256 **Article 2. LOCAL EMS AGENCY EMSC PROGRAM REQUIREMENTS**

257
258 **§ 100450.219~~214~~216. EMSC ~~p~~Program ~~a~~Approval**

259
260 (a) A local EMS agency may develop and implement an EMSC program.

261
262 (b) A local EMS agency implementing a new EMSC program shall have the EMSC
263 component of an EMS plan approved by the EMS Authority prior to implementation.

264
265 (c) The EMSC component of an EMS plan submitted to the EMS Authority shall include,
266 at a minimum, the following:

267
268 (1) EMSC program goals and objectives.

269
270 ~~(1)~~(2) The names and titles of the local EMS agency personnel who have a role in the
271 planning, implementation, and management of an EMSC program.

272
273 ~~(2)~~(3) Injury and illness prevention planning that includes coordination, education, and
274 data collection.

275

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- 276 ~~(3)(4)~~ (A) Policies for care and services rendered to pre-hospital EMS pediatric
277 patients outside the hospital readily available upon request.
278
- 279 (i) First response non-transport.
280
- 281 (ii) Transport.
282
- 283 (iii) Interfacility Transfer.
284
- 285 (iv) Critical Care.
286
- 287 (B) This shall include, but not be limited to:
288
- 289 (i) Pediatric-specific personnel training.
290
- 291 (ii) Pediatric ambulance equipment.
292
- 293 ~~(iii)(5)~~ A quality improvement plan containing process-outcome measures as referenced
294 in section 100450.223 of this Chapter.
295
- 296 ~~(4)(5)~~ An description overview of emergency department care available to pediatric
297 patients within the EMSC program.
298
- 299 ~~(5)(6)~~ A copy of the local EMS agency policy that facilitates directs interfacility,
300 consultation, transfer, and transport of EMSC patients.
301
- 302 ~~(6)(7)(6)~~ A list of facilities providing pediatric critical care and pediatric trauma services
303 readily available upon request.
304
- 305 ~~(7)(8)(7)~~ Copies of agreements with List of designated hospitals with pediatric
306 considerations readily available upon request agreements to participate in the EMSC
307 system of care.
308
- 309 ~~(8)(9)(8)~~ A list of facilities providing p Pediatric physical rehabilitation plans that include
310 data collection and evaluation, education on early detection of need for referral, and
311 proper referral of pediatric patients resources.
312
- 313 ~~(9)(10)~~ A description of care available for pediatric patients with special EMS needs
314 outside the hospital.
315
- 316 ~~(10)(11)~~ A description of the integration of EMSC into existing quality improvement
317 committees, including information management and system evaluation.
318
- 319 ~~(11)(12)(9)~~ Copies of the local EMS agency's EMSC pediatric patient identification and
320 destination policies.
321

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322 ~~(12)~~~~(13)~~~~(10)~~ A description of the method of field communication to the receiving hospital
323 specific to the EMSC patient.

324
325 ~~(13)~~~~(14)~~~~(11)~~ A description of the method of data collection from the EMS providers and
326 designated EMSC hospitals to the local EMS agency and the EMS Authority.

327
328 ~~(14)~~~~(15)~~ Copies List of agreements with neighboring local EMS agencies providing
329 pediatric care readily available with agreements for coordination of pediatric transports.

330
331 (12) A policy or description of how the local EMS agency integrates a PedRC in a
332 neighboring jurisdiction.

333
334 ~~(16)~~~~(13)~~ Pediatric surge planning.

335
336 (d) The EMS Authority shall, within ~~30~~ ~~60~~ ~~30~~ days of receiving a request for approval,
337 notify the requesting local EMS agency in writing of approval or disapproval of its EMSC
338 program. If the EMSC program is disapproved, the response shall include the reason(s)
339 for the disapproval and any required corrective action items.

340
341 (e) The local EMS agency shall provide an amended plan to the EMS Authority within
342 60 days of receipt of the disapproval letter.

343
344 (f) A local EMS agency currently operating an EMSC program implemented prior to the
345 effective date of these regulations, shall submit, to the EMS Authority, an EMSC
346 component of an EMS plan as an addendum to its annual EMS plan update, or within
347 180 days of the effective date of these regulations, whichever comes first.

348
349 (g) No health care facility shall advertise in any manner or otherwise hold itself out to be
350 affiliated with an EMSC program or PedRC unless they have been designated by the
351 local EMS agency, in accordance with this chapter.

352
353 Note: Authority cited: Sections 1797.103, 1797.105, 1797.107, 1797.220, 1797.250,
354 1797.254 1798.150, 1798.170, 1798.172, 1799.204 and 1799.205 Health and Safety
355 Code. Reference: Section 1797.176 and 1797.220, Health and Safety Code.

356
357 **§ 100450. ~~220~~ ~~215~~ ~~217~~. Annual EMSC ~~p~~Program Update**

358
359 (a) The local EMS agency shall submit an annual update to its EMSC program as part
360 of its annual EMS plan submittal, which shall include, but not be limited to a minimum,
361 all the following information:

362
363 (1) Any changes in the EMSC program since submission of the prior annual EMS plan.

364
365 (2) The status of EMSC program goals and objectives.

366
367 (3) A summary of the EMSC program performance improvement activities.

368
369 (4) Progress on addressing action items and recommendations provided by the EMS
370 Authority within the EMSC program or Status Report approval letter, if applicable.
371

372 Note: Authority cited: Sections 1797.103, 1797.107, 1797.176, 1797.250, 1797.254,
373 1798.150, and 1798.172 Health and Safety Code. Reference: Section 1797.176,
374 1797.220, 1797.222, 1798.170, 1799.204, and 1799.205 Health and Safety Code.
375

376 Article 3: Pediatric Receiving Centers

377 ~~§ 100450.221~~ 216. **Level I Comprehensive PedRC Requirements**

378 *(a) A hospital may be designated as a level I Comprehensive PedRC by the local EMS*
381 *agency upon meeting all the following criteria:*

382
383 *(1) All designated Comprehensive PedRCs shall be licensed, pursuant to the Robert W.*
384 *Crown California Children's Services Act as a basic Emergency Department as a*
385 *general acute care hospital with a basic or comprehensive Emergency Department*
386 *permit and approved by the Department of Health Care Services as a California*
387 *Children's Services (CCS) tertiary hospital.*

388
389 *(2) All PedRC personnel shall be qualified pursuant to section 100450.225 220 of this*
390 *Chapter.*

391
392 *(3) All PedRC shall have an interfacility transfer plan for pediatric patients in accordance*
393 *with Title 22, Division 9, Chapter 7.*

394
395 *(4) Have full, provisional, or conditional CCS approval.*

396
397 *(5) Have documentation of CCS approval readily available upon request.*

398
399 *(6) ~~(4)~~ Can provide comprehensive specialized pediatric medical and surgical care to*
400 *any acutely ill or injured child.*

401
402 *(7) ~~(5)~~ Plan and implement Provide ongoing outreach regarding provisions for pediatric*
403 *emergency education and level II, III, and IV PedRCs, and pediatric education for*
404 *Community, General and Basic PedRCs, and prehospital care providers, in*
405 *collaboration with the local EMS agency.*

406
407 *(8) ~~(6)~~ Provide May provide consultation via phone, telehealth, or onsite for emergency*
408 *care and stabilization, transfer, and transport.*

409
410 *(9) ~~(7)~~ Establish transfer agreements and serve as a regional referral center for the*
411 *specialized care, such as trauma, burn, spinal cord injury, and rehabilitation and*
412 *behavioral health, of pediatric patients.*

413

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414 ~~(8) Additional requirements may be required at the discretion of the local EMS agency~~
415 ~~medical director.~~

416
417 ~~(c)(b) Emergency department services include a separate pediatric emergency~~
418 ~~department or a designated area for emergency care of pediatric patients within an~~
419 ~~emergency department, with physician staff who are qualified specialists in emergency~~
420 ~~medicine or pediatric emergency medicine.~~

421
422 ~~(d)(c) Inpatient resources must include a neonatal intensive care unit (NICU) and a~~
423 ~~pediatric intensive care unit (PICU).~~

424
425 ~~Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.~~
426 ~~Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.173, 1799.204, and~~
427 ~~1799.205, Health and Safety Code.~~

428
429 **~~§ 100450.222217. Level II Advanced PedRC Requirements~~**

430
431 ~~(a) A hospital may be designated as a level II an Advanced PedRC by the local EMS~~
432 ~~agency upon meeting all the following criteria:~~

433
434 ~~(1) All designated Advanced PedRCs shall be licensed, pursuant to the Robert W.~~
435 ~~Crown California Children's Services Act as a basic Emergency Department as a~~
436 ~~general acute care hospital with a basic or comprehensive Emergency Department~~
437 ~~permit and approved by the Department of Health Services as a California Children's~~
438 ~~Services (CCS) Pediatric Community Hospital.~~

439
440 ~~(2) All PedRC personnel shall be qualified pursuant to section 100450.225220 of this~~
441 ~~Chapter.~~

442
443 ~~(3) All PedRCs shall have an interfacility transfer plan for pediatric patients in~~
444 ~~accordance with Title 22, Division 9, Chapter 7.~~

445
446 ~~(4) Establish formal agreements with a minimum of one level I Comprehensive PedRC~~
447 ~~as approved by the local EMS agency, for education, and consultation and transfer of~~
448 ~~pediatric patients;.~~

449
450 ~~(5) Participate with a level I Comprehensive PedRC for pediatric emergency education~~
451 ~~for emergency care providers consistent with the local EMS agency plan for ongoing~~
452 ~~pediatric education.~~

453
454 ~~(6) Develop written Establish transfer agreements with a level I Comprehensive PedRC~~
455 ~~to transfer pediatric patients for stabilization, ensuring the highest level of care.~~

456
457 ~~(7) Develop Establish transfer agreements with other pediatric centers for pediatric~~
458 ~~patients needing specialized care, if the specialized care is not available at a level I~~
459 ~~Comprehensive PedRC, such as trauma, burn, spinal cord injury, and rehabilitation and~~
460 ~~behavioral health.~~

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- 461
462 ~~(8) May provide consultation via phone, telehealth, or onsite for emergency care and~~
463 ~~stabilization, transfer, and transport.~~
464
465 ~~(9) Additional requirements may be required at the discretion of the local EMS agency~~
466 ~~medical director.~~
467
468 ~~Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.~~
469 ~~Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172, 1799.204, and~~
470 ~~1799.205, Health and Safety Code.~~
471
472 **~~§ 100450.223~~218. Level III **General PedRC Requirements****
473
474 ~~(a) A hospital may be designated as a level III General PedRC by the local EMS agency~~
475 ~~upon meeting all the following criteria:~~
476
477 ~~(1) All designated General PedRCs shall be licensed, pursuant to the Robert W. Crown~~
478 ~~California Children's Services Act as a basic Emergency Department as a general acute~~
479 ~~care hospital with a basic or comprehensive Emergency Department permit.~~
480
481 ~~(2) All General PedRC personnel shall be qualified pursuant to section 100450.225~~220~~~~
482 ~~of this Chapter.~~
483
484 ~~(3) All General PedRCs shall have an interfacility transfer plan for pediatric patients in~~
485 ~~accordance with Title 22, Division 9, Chapter 7.~~
486
487 ~~(4) Establish formal agreements with at least one level I Comprehensive PedRC, as~~
488 ~~approved by the local EMS agency, for education, consultation, and transfer of critical~~
489 ~~pediatric patients.~~
490
491 ~~(5) Participate with a level I and/or II PedsRC Comprehensive and/or Advanced PedRC~~
492 ~~for pediatric emergency education for hospital staff and emergency care providers~~
493 ~~consistent with the local EMS agency plan for ongoing pediatric education.~~
494
495 ~~(6) Develop written Establish formal agreements with a level I and/or Level II~~
496 ~~Comprehensive and/or Advanced PedRCs to transfer pediatric patients for stabilization~~
497 ~~ensuring the highest level of care as approved by the local EMS agency, for consultation~~
498 ~~and transfer.~~
499
500 ~~(7) Develop Establish transfer agreements with other centers for pediatric patients~~
501 ~~needing specialized care, if the specialized care is not available at a Comprehensive,~~
502 ~~Advanced or General PedRC, such as trauma, burn, spinal cord injury, rehabilitation,~~
503 ~~and behavioral health.~~
504
505 ~~(8) Establish a process for obtaining consultation via phone, telehealth, or onsite for~~
506 ~~emergency care and stabilization, transfer, and transport.~~

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507
508 (9) Additional requirements may be required at the discretion of the local EMS agency
509 medical director.

510
511 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety
512 Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172,
513 1799.204 and 1799.205, Health and Safety Code.

514
515 **§ 100450.224219. Level IV Basic PedRC Requirements**

516
517 (a) A hospital may be designated as a level IV Basic PedRC by the local EMS agency
518 upon meeting all the following criteria:

519
520 (1) All designated Basic PedRCs shall be licensed, pursuant to the Robert W. Crown
521 California Children's Services Act as a basic Emergency Department as a general acute
522 care hospital with a basic or standby Emergency Department permit.

523
524 (2) All PedRC personnel shall be qualified pursuant to section 100450.225 of this
525 Chapter. Emergency Department services may include physician staffing 24 hours a day,
526 7 days a week or a physician available for consultation.

527
528 (3) At minimum, one licensed registered nurse or advanced care practitioner per shift in
529 the emergency department shall have current completion of Pediatric Advanced Life
530 Support, Advanced Pediatric Life Support, completion of an Emergency Nursing
531 Pediatric Course, or other equivalent pediatric emergency care nursing course, as
532 determined by the local EMS agency.

533
534 (3)(4) All Basic PedRC shall have an interfacility transfer plan for pediatric patients in
535 accordance with Title 22, Division 9, Chapter 7.

536
537 (4)(5) Establish formal agreements with at least one level I Comprehensive PedRC as
538 approved by the local EMS agency, for education, consultation, and transfer of critical
539 pediatric patients.

540
541 (5)(6) Develop written Establish formal agreements with an level I, and/or level II
542 Advanced or General PedRCs to as approved by the local EMS agency, for consultation
543 and transfer of pediatric patients for stabilization ensuring the highest level of care.

544
545 (6)(7) Develop Establish transfer agreements with other centers for pediatric patients
546 needing specialized care, if the specialized care is not available at a Comprehensive,
547 Advanced or General PedRC, such as trauma, burn, spinal cord injury, rehabilitation,
548 and behavioral health.

549
550 (8) Establish a process for obtaining consultation via phone, telehealth, or onsite for
551 emergency care and stabilization, transfer, and transport.

552

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553 ~~(9) Additional requirements may be required at the discretion of the local EMS agency~~
554 ~~medical director.~~

555
556 ~~Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety~~
557 ~~Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172,~~
558 ~~1799.204, and 1799.205, Health and Safety Code.~~

559
560 ~~§ 100450.225220. Pediatric Receiving Center Personnel Requirements~~

561
562 ~~(a) All Comprehensive and Advanced PedRCs personnel shall meet the minimum~~
563 ~~qualifications: have a physician and nurse Pediatric Emergency Care Coordinator~~
564 ~~(PECC).~~

565
566 ~~(b) All General and Basic PedRCs shall have a physician and/or nurse PECC which~~
567 ~~may be shared with other PedRCs.~~

568
569 ~~(1) If a PECC is a physician, the A physician PECC shall be licensed in California and~~
570 ~~meet all the following minimum qualifications and responsibilities requirements:~~

571
572 ~~(A) Be a qualified emergency specialist, or~~

573
574 ~~(B) A physician who is Be a qualified specialist in Pediatrics or Family Medicine, and~~

575
576 ~~(C) Shall have verified competency in resuscitation of pediatric patients of all ages from~~
577 ~~neonates to adolescents.~~

578
579 ~~(D) Provide oversight of the emergency department pediatric quality improvement~~
580 ~~program.~~

581
582 ~~(E) Liaison with appropriate hospital-based pediatric care committees.~~

583
584 ~~(F) Liaison with other PedRCs, the local EMS agency, base hospitals, prehospital care~~
585 ~~providers, and neighboring hospitals.~~

586
587 ~~(G) Facilitate pediatric emergency education for emergency department staff.~~

588
589 ~~(H) Ensure pediatric disaster preparedness.~~

590
591 ~~(2) If the PECC is a nurse, the A nurse PECC shall meet all the following minimum~~
592 ~~qualifications and responsibilities requirements:~~

593
594 ~~(A) Be a California registered nurse (RN) with at least two (2) years of experience in~~
595 ~~pediatric or emergency nursing within the previous five (5) years.~~

596

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597 ~~(B) Have verified~~ Shall have competency in resuscitation of pediatric patients of all ages
598 from neonates to adolescents through Pediatric Advanced Life Support or Advanced
599 Pediatric Life Support.

600
601 ~~(C) Provide coordination with the pediatric physician coordinator for pediatric quality~~
602 ~~improvement activities.~~

603
604 ~~(D) Facilitate emergency department nursing continuing education and competency~~
605 ~~evaluations in pediatrics.~~

606
607 ~~(E) Liaison with pediatric critical care centers, trauma centers, the local EMS agency,~~
608 ~~base hospitals, prehospital care providers, and community hospitals.~~

609
610 ~~(F) Liaison with appropriate hospital-based pediatric care committees.~~

611
612 ~~(G) Coordinate with the physician coordinator to ensure pediatric disaster~~
613 ~~preparedness.~~

614
615 (3) The designated PEGC shall be responsible for all of the following:

616
617 (A) Provide oversight of the emergency department pediatric quality improvement
618 program.

619
620 (B) Liaison with appropriate hospital-based pediatric care committees.

621
622 (C) Liaison with other PedRCs, the local EMS agency, base hospitals, prehospital care
623 providers, and neighboring hospitals.

624
625 (D) Facilitate pediatric emergency department continuing education and competency
626 evaluations in pediatrics for emergency department staff.

627
628 (E) Ensure pediatric disaster preparedness.

629
630 (F) Ensure pediatric centered care practices are in place.

631
632 ~~(3)(b) At all times, personnel staffing within the~~ A Comprehensive or Advanced PedRC
633 emergency department personnel staffing shall include, but not be limited to:

634
635 (A)(1) A qualified pediatric specialist pursuant to section 100450.215~~211~~ or a qualified
636 emergency specialist pursuant to section 100450.216~~212~~, who demonstrates
637 competency in resuscitation of pediatric patients of all ages from neonates to
638 adolescents.

639
640 (B)(2) A non-board-certified physician may be recognized as a qualified specialist by the
641 local EMS agency upon substantiation of need by the PedRC if:

642

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- 643 1. ~~(A) The physician provides documentation that meet requirements, which are~~
644 ~~equivalent to those of the Accreditation Council for Graduate Medical Education~~
645 ~~(ACGME) or the Royal College of Physicians and Surgeons of Canada.~~
646
- 647 2. ~~(B) The physician provides documentation of education, training, and experience in~~
648 ~~treating and managing pediatric critically ill or injured patients, which shall be tracked by~~
649 ~~a pediatric performance improvement program.~~
650
- 651 3. ~~(C) The physician has successfully completed a residency program.~~
652
- 653 ~~(C) (3) At minimum, one RN registered nurse or advance practice nurse per shift in the~~
654 ~~emergency department shall have current completion of Pediatric Advanced Life~~
655 ~~Support, Advanced Pediatric Life Support, completion of an Emergency Nursing~~
656 ~~Pediatric Course, or other equivalent pediatric emergency care nursing course, as~~
657 ~~determined by the local EMS agency.~~
658
- 659 ~~(D) (4) Mid-level practitioners Advanced practice providers including Nurse Practitioners~~
660 ~~and/or Physician Assistants regularly assigned to the emergency department who care~~
661 ~~for pediatric patients and who are licensed in California and shall have verified~~
662 ~~competency in resuscitation of pediatric patients of all ages from neonates to~~
663 ~~adolescents.~~
664
- 665 ~~(4) (c) Other All PedRCs shall have other personnel staff that may serve as consultants~~
666 ~~to the emergency department that may include, but is not limited to:~~
667
- 668 ~~(A) (1) A qualified pediatric specialist available for in-house consultation through live~~
669 ~~interactive telehealth or other means determined by the local EMS agency.~~
670
- 671 ~~(B) (2) A pediatric intensivist available for in-house consultation or through live~~
672 ~~interactive telehealth or agreed upon processes outlined within transfer agreements.~~
673
- 674 ~~(5) (d) Support services including respiratory care, laboratory, radiology, and pharmacy~~
675 ~~shall include staff and equipment to care for the pediatric patient.~~
676
- 677 ~~(6) (e) Respiratory care specialists who respond to the emergency department shall~~
678 ~~verify their competence to support oxygenation and ventilation of pediatric patients to~~
679 ~~the Director of Respiratory Services. This verification may include, but is not limited to:~~
680
- 681 ~~(A) (1) Current completion of the American Heart Association Pediatric Advanced Life~~
682 ~~Support Course, or~~
683
- 684 ~~(B) (2) The American Academy of Pediatrics and American College of Emergency~~
685 ~~Physicians sponsored Advanced Pediatric Life Support Course, or~~
686
- 687 ~~(C) The Emergency Nurses Association, Emergency Nursing Pediatric Course, or~~
688

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689 ~~(D)(3) Continuing education courses specific to resuscitation of pediatric patients.~~

690

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

692 ~~Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1799.204, and 1799.205,~~

693 ~~Health and Safety Code.~~

694

695 **~~§ 100450.226~~221. Pediatric Equipment, Supplies and Medication Requirements**

696

697 ~~(a) The pediatric equipment, supplies and medications in all PedRCs, for pediatric~~
698 ~~patients from neonates to adolescents, shall include, but not be limited to:~~

699

700 ~~(1) A size-based resuscitation tape, medical software, or other system available to~~
701 ~~assure proper sizing of resuscitation equipment and proper dosing of medication.~~

702

703 ~~(2) Portable resuscitation supplies, such as a crash cart or bag with a method of~~
704 ~~verification of contents on a regular basis.~~

705

706 ~~(3) Equipment for patient and fluid warming, patient restraint, weight scale (in kilograms)~~
707 ~~and pain scale tools for all ages of pediatric patients.~~

708

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

712

713 ~~(5) Respiratory equipment and supplies appropriate for pediatric patients including, but~~
714 ~~not limited to, clear oxygen masks, bag-mask devices, intubation equipment,~~
715 ~~tracheostomy equipment, supraglottic airways, oral and nasal airways, nasogastric tubes,~~
716 ~~and suction equipment.~~

717

718 ~~(6) Vascular access supplies and equipment for pediatric patients including, but not~~
719 ~~limited to, intravenous catheters, intraosseous needles, umbilical and central venous~~
720 ~~catheters, infusion devices, and Intravenous solutions.~~

721

722 ~~(7) Fracture management devices for pediatric patients including extremity and femur~~
723 ~~splints and spinal stabilization motion restriction devices.~~

724

725 ~~(8) Medications for the care of pediatric patients requiring resuscitation.~~

726

727 ~~(9) Specialized pediatric trays or kits which shall include, but not be limited to:~~

728

729 ~~(A) Lumbar puncture tray including a~~

730

731 ~~(B) Difficult airway kit with laryngeal mask supraglottic airways and other devices to~~
732 ~~provide assisted ventilation.~~

733

734 ~~(B)(C) Tube thoracotomy thoracostomy tray including chest tubes in sizes for pediatric~~
735 ~~patients of all ages.~~

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736
737 ~~(C)~~ (D) Newborn delivery and resuscitation kit including supplies for immediate delivery
738 and resuscitation of the newborn. to include, but not limited to, the following:

- 739
740 (1) towel,
741
742 (2) scissors for cutting the umbilical cord,
743
744 (3) bulb suction,
745
746 (4) warming pad, and
747
748 (5) neonatal bag-mask ventilation device with appropriate sized masks.

749
750 (E) For Comprehensive, Advanced, or General PedRCs, neonatal resuscitation
751 equipment shall also include:

- 752
753 (1) pediatric laryngoscope with Miller 0 and 00 blades,
754
755 (2) size 2.5 and 3.0 endotracheal tubes, and
756
757 (3) umbilical vein catheters.

758
759 ~~(D)~~ (E) Urinary catheter tray including urinary catheters for pediatric patients of all ages.

760
761 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
762 Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1799.204, and 1799.205,
763 Health and Safety Code.

764
765 **§ 100450.218. All PedRC Requirements**

766
767 (a) All PedRCs shall meet the following facility requirements:

- 768
769 (1) All PedRCs shall have an interfacility transfer plan for pediatric patients in
770 accordance with Title 22, Division 9, Chapter 7.
771
772 (2) Establish a process for obtaining and providing consultation via phone, telehealth, or
773 onsite for emergency care and stabilization, transfer, and transport.

774
775 (b) All PedRCs shall meet the following personnel ~~staffing~~ requirements:

- 776
777 (1) All physician PECCs shall be licensed in California and meet all the following
778 minimum requirements:

779
780 (A) Be a qualified emergency specialist, or
781

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- 782 (B) Be a qualified specialist in Pediatrics or Family Medicine, and
783
- 784 (C) Shall have competency in resuscitation of pediatric patients of all ages from
785 neonates to adolescents.
786
- 787 (2) All nurse PECCs shall be licensed in California and meet all the following minimum
788 requirements:
789
- 790 (A) Have at least two (2) years of experience in pediatric or emergency nursing within
791 the previous five (5) years.
792
- 793 (B) Shall have competency in resuscitation of pediatric patients of all ages from
794 neonates to adolescents through American Heart Association Pediatric Advanced Life
795 Support or American College of Emergency Physicians sponsored Advanced Pediatric
796 Life Support.
797
- 798 (3) The designated PECC shall be responsible for all of the following:
799
- 800 (A) Provide oversight of the emergency department pediatric quality improvement
801 program.
802
- 803 (B) Liaison with appropriate hospital-based pediatric care committees.
804
- 805 (C) Liaison with other PedRCs, the local EMS agency, base hospitals, prehospital care
806 providers, and neighboring hospitals.
807
- 808 (D) Facilitate pediatric emergency department continuing education and competency
809 evaluations in pediatrics for emergency department staff.
810
- 811 (E) Coordinate pediatric disaster preparedness.
812
- 813 (F) Ensure ~~pediatric~~ family centered care practices are in place.
814
- 815 (4) All PedRCs shall have personnel ~~staff~~ available for consultation to the emergency
816 department through live interactive telehealth or other means determined by the local
817 EMS agency including, but not limited to:
818
- 819 (A) A qualified pediatric specialist
820
- 821 (B) A pediatric intensivist
822
- 823 (C) Support services including respiratory care, laboratory, radiology, and pharmacy
824 shall include staff and equipment to care for the pediatric patient.
825
- 826 (D) Respiratory care specialists who respond to the emergency department
827

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828 (i) Respiratory care specialists shall verify their competence to support oxygenation and
829 ventilation of pediatric patients to the Director of Respiratory Services. This verification
830 may include, but is not limited to:

831
832 A. Current completion of the American Heart Association Pediatric Advanced Life
833 Support Course, or

834
835 B. The American Academy of Pediatrics and American College of Emergency
836 Physicians sponsored Advanced Pediatric Life Support Course, or

837
838 C. Continuing education courses specific to resuscitation of pediatric patients.

839
840 (c) The pediatric equipment, supplies and medications in all PedRCs, for pediatric
841 patients from neonates to adolescents, shall include, but not be limited to:

842
843 (1) A size/length-based resuscitation tape, medical software, or other system available to
844 assure proper sizing of resuscitation equipment and proper dosing of medication.

845
846 (2) Portable resuscitation supplies, such as a crash cart or bag with a method of
847 verification of contents on a regular basis.

848
849 (3) Equipment for patient and fluid warming, patient restraint, weight scale (in kilograms)
850 and pain scale tools for all ages of pediatric patients.

851
852 (4) Monitoring equipment appropriate for pediatric patients including, but not limited to,
853 blood pressure cuffs, doppler device, electrocardiogram monitor/defibrillator,
854 hypothermia thermometer, pulse oximeter, and end tidal carbon dioxide monitor.

855
856 (5) Respiratory equipment and supplies appropriate for pediatric patients including, but
857 not limited to, clear oxygen masks, bag-mask devices, intubation equipment,
858 supraglottic airways, oral and nasal airways, nasogastric tubes, and suction equipment.

859
860 (6) Vascular access supplies and equipment for pediatric patients including, but not
861 limited to, intravenous catheters, intraosseous needles, infusion devices, and
862 Intravenous solutions.

863
864 (7) Fracture management devices for pediatric patients including extremity splints and
865 spinal motion restriction devices.

866
867 (8) Medications for the care of pediatric patients requiring resuscitation.

868
869 (9) Specialized pediatric trays or kits which shall include, but not be limited to:

870
871 (A) Lumbar puncture tray.

872

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873 (B) Difficult airway kit with supraglottic airways and other devices to provide assisted
874 intubation and ventilation.

875
876 (C) Tube thoracostomy tray including chest tubes in sizes for pediatric patients of all
877 ages.

878
879 (10) Newborn delivery kit to include, but not limited to, the following:

880
881 (A) towel.

882
883 (B) clamps and scissors for cutting the umbilical cord.

884
885 (C) bulb suction.

886
887 (D) warming pad, and

888
889 (E) neonatal bag-mask ventilation device with appropriate sized masks.

890
891 (F) Urinary catheter tray including urinary catheters for pediatric patients of all ages.

892
893 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety
894 Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172,
895 1799.204, and 1799.205, Health and Safety Code.

896
897 **§ 100450.219. Basic PedRC Requirements**

898
899 (a) A hospital may be designated as a Basic PedRC by the local EMS agency upon
900 meeting all the following criteria:

901
902 (1) All designated Basic PedRCs shall be licensed as a general acute care hospital with
903 a basic or standby Emergency Department permit.

904
905 (2) Emergency Department services may include physician staffing 24 hours a day, 7
906 days a week or a physician available for consultation.

907
908 (3) At minimum, one licensed registered nurse or advanced care practitioner per shift in
909 the emergency department shall have current completion American Heart Association of
910 Pediatric Advanced Life Support, Advanced Pediatric Life Support, completion of an
911 Emergency Nursing Pediatric Course, or other equivalent pediatric emergency care
912 nursing course, as determined by the local EMS agency.

913
914 (4) The emergency department in the hospital shall be able to stabilize critically ill or
915 injured infant, children, and adolescents prior to admission to the PICU or transfer to a
916 Comprehensive PedRC facility.

917

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918 ~~(4)~~(5) *Establish agreements with at least one Comprehensive PedRC as approved by*
919 *the local EMS agency, for education, consultation and transfer of critical pediatric*
920 *patients.*

921
922 ~~(5)~~(6) *Establish agreements with an Advanced or General PedRC as approved by the*
923 *local EMS agency, for consultation and transfer of pediatric patients.*

924
925 ~~(6)~~(7) *Establish transfer agreements for pediatric patients needing specialized care, if*
926 *the specialized care is not available at a Comprehensive, Advanced or General PedRC,*
927 *such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health.*

928
929 ~~(7)~~(8) *All Basic PedRCs shall have a physician and/or nurse PECC which may be*
930 *shared with other PedRCs.*

931
932 *(b) Additional requirements may be stipulated by the local EMS agency medical*
933 *director.*

934
935 *Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety*
936 *Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172,*
937 *1799.204, and 1799.205, Health and Safety Code.*

938
939 **§ 100450.220. General PedRC Requirements**

940
941 *(a) A hospital may be designated as a General PedRC by the local EMS agency upon*
942 *meeting all the following criteria:*

943
944 *(1) All designated General PedRCs shall be licensed as a general acute care hospital*
945 *with a basic or comprehensive Emergency Department permit.*

946
947 *(2) Participate with a Comprehensive and/or Advanced PedRC for pediatric emergency*
948 *education for hospital staff and emergency care providers consistent with the local EMS*
949 *agency plan for ongoing pediatric education.*

950
951 *(3) The emergency department in the hospital shall be able to stabilize critically ill or*
952 *injured infant, children, and adolescents prior to admission to the PICU or transfer to a*
953 *Comprehensive PedRC facility.*

954
955 ~~(3)~~(4) *Establish agreements with a Comprehensive and/or Advanced PedRCs as*
956 *approved by the local EMS agency, for education, consultation and transfer.*

957
958 ~~(4)~~(5) *Establish transfer agreements for pediatric patients needing specialized care, if*
959 *the specialized care is not available at a Comprehensive, Advanced or General PedRC,*
960 *such as trauma, burn, spinal cord injury, rehabilitation, and behavioral health.*

961
962 ~~(5)~~(6) *All designated General PedRCs shall have a physician and/or nurse PECC which*
963 *may be shared with other PedRCs.*

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964
965 ~~(6)~~ (7) All designated General PedRCs shall meet the following additional equipment
966 requirements:

967
968 (A) neonatal resuscitation equipment, including:

969
970 (i) pediatric laryngoscope with Miller 0 and 00 blades.

971
972 (ii) size 2.5 and 3.0 endotracheal tubes, and

973
974 (iii) umbilical vein catheters.

975
976 ~~(B) Urinary catheter tray including urinary catheters for pediatric patients of all ages.~~

977
978 (b) Additional requirements may be stipulated by the local EMS agency medical
979 director.

980
981 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety
982 Code. Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172,
983 1799.204 and 1799.205, Health and Safety Code.

984
985 **§ 100450.221. Advanced PedRC Requirements**

986
987 (a) A hospital may be designated as an Advanced PedRC by the local EMS agency
988 upon meeting the following criteria:

989
990 (1) All designated Advanced PedRCs shall be licensed by the Department of Health
991 Services (DHS), Licensing and Certification Division, under California Code of
992 Regulations (CCR), Title 22, Division 5, Chapter 1, as follows:

993
994 (A) As an acute care hospital pursuant to Article 1, sections 70003 and 70005.

995
996 (B) For pediatric service pursuant to Article 6, section 70535 et seq.

997
998 (C) For basic or comprehensive emergency medical services pursuant to ~~a~~ Article 6,
999 section 70411, et seq.

1000
1001 (D) For social services pursuant to Article 6, section 70535 et seq

1002
1003 (E) Community neonatal intensive care unit (NICU) or as an Intermediate NICU if it
1004 meets the following requirements, as per:

1005
1006 (i) Article 6, Section 70545 et seq., for the provision of perinatal services and licensed
1007 by DHS, Licensing and Certification Division as a perinatal service;

1008

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1009 (ii) Article 6, Section 70481 et seq., for the provision of neonatal intensive care services
1010 and licensed by DHS, Licensing and Certification Division as an Intensive Care
1011 Newborn Nursery (ICNN)

1012
1013 (F) If the hospital has a pediatric intensive care unit (PICU) then it shall be licensed by
1014 DHS, Licensing and Certification Division for intensive care services, and meet the
1015 requirements for the provision of intensive care services pursuant to CCR Title 22,
1016 Division 5, Chapter 1, Article 6, Section 70491 et seq.

1017
1018 (G) The emergency department in the hospital shall be able to stabilize critically ill or
1019 injured infant, children, and adolescents prior to admission to the PICU or transfer to a
1020 Comprehensive PedRC facility.

1021
1022 (2) Establish agreements with a minimum of one Comprehensive PedRC as approved
1023 by the local EMS agency, for consultation.

1024
1025 (3) Participate with a Comprehensive PedRC for pediatric emergency education for
1026 emergency care providers consistent with the local EMS agency plan for ongoing
1027 pediatric education.

1028
1029 (4) Establish transfer agreements with a Comprehensive PedRC to transfer pediatric
1030 patients for stabilization, ensuring the highest level of care.

1031
1032 (5) Establish transfer agreements for pediatric patients needing specialized care, if the
1033 specialized care is not available at a Comprehensive, Advanced or General PedRC,
1034 such as trauma, burn, spinal cord injury, and rehabilitation and behavioral health.

1035
1036 (b) All Advanced PedRCs shall meet the following personnel requirements:

1037
1038 (1) Advanced PedRCs shall have a physician and nurse Pediatric Emergency Care
1039 Coordinator (PECC).

1040
1041 (2) Respiratory care service in the pediatric service/department and emergency
1042 department provided by respiratory care practitioners (RCPs) who are licensed in the
1043 state of California and who have completed formal training in pediatric respiratory care
1044 which includes clinical experience in the care of children.

1045
1046 (3) Social work services in the pediatric service/department provided by a medical social
1047 worker (MSW) holding a master's degree in social work who has expertise in the
1048 psychosocial issues affecting the families of seriously ill infants, children, and
1049 adolescents.

1050
1051 (4) Behavioral health specialists with pediatric experience to include but not limited to
1052 psychiatrist, psychologist, and nurse.

1053

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1054 (5) The following specialties shall be on-call, and available for consultation to the NICU
1055 or ED within 30 minutes by telephone and within one hour in-person:

1056
1057 ~~(A) Radiologist – with pediatric experience~~

1058
1059 ~~(B)(A) Neonatologist~~

1060
1061 ~~(C)(B) General Surgeon with pediatric experience~~

1062
1063 ~~(D) Otolaryngologist with pediatric experience~~

1064
1065 ~~(E) Obstetrics/Gynecologist with pediatric experience~~

1066
1067 ~~(F) Mental health professional with pediatric experience~~

1068
1069 (C) Anesthesiologist with pediatric experience

1070
1071 (D) Pediatric Cardiologist

1072
1073 ~~(6) A Pediatric Cardiologist. The following specialties shall be on the hospital staff, on-~~
1074 ~~call, and available to the NICU or ED either in-person, by phone, or by telehealth, in less~~
1075 ~~than one hour within 30 minutes:~~

1076
1077 (A) Radiologist – with pediatric experience

1078
1079 (B) Otolaryngologist with pediatric experience

1080
1081 (C) Mental health professional with pediatric experience

1082
1083 (D) Orthopedist with pediatric experience

1084
1085 (7) The following qualified specialists shall be available twenty-four (24) hours a day, 7
1086 days a week, for consultation which may be met through a transfer agreement or
1087 telehealth:

1088
1089 (A) Pediatric Gastroenterologist

1090
1091 (B) Pediatric Hematologist/Oncologist

1092
1093 (C) Pediatric Infectious Disease

1094
1095 (D) Pediatric Nephrologist

1096
1097 (E) Pediatric Neurologist

1098
1099 (F) Pediatric Surgeon

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- 1100
1101 (G) Cardiac Surgeon with pediatric experience
1102
1103 (H) Neurosurgeon with pediatric experience
1104
1105 (I) Obstetrics/Gynecologist with pediatric experience
1106
1107 (J) Pulmonologist with pediatric experience
1108
1109 Pediatric Endocrinologist
1110
1111 (c) The pediatric equipment, supplies and medications in all Advanced PedRCs, for
1112 pediatric patients from neonates to adolescents, shall include all General PedRC
1113 equipment, but not be limited to and:
1114
1115 (1) Crash carts with pediatric resuscitation equipment that shall be standardized and
1116 available on all units including but not limited to the emergency department, radiology
1117 suite and inpatient pediatric service.
1118
1119 ~~(2) neonatal resuscitation equipment, including:~~
1120
1121 ~~(A) pediatric laryngoscope with Miller 0 and 00 blades,~~
1122
1123 ~~(B) size 2.5 and 3.0 endotracheal tubes, and~~
1124
1125 ~~(C) umbilical vein catheters.~~
1126
1127 ~~(3) Urinary catheter tray including urinary catheters for pediatric patients of all ages.~~
1128
1129 (d) Additional requirements may be stipulated by the local EMS agency medical
1130 director.
1131
1132 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
1133 Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.172, 1799.204, and
1134 1799.205, Health and Safety Code.
1135
1136 **§ 100450.222. Comprehensive PedRC Requirements**
1137
1138 (a) A hospital may be designated as a Comprehensive PedRC by the local EMS agency
1139 upon meeting all criteria of an Advanced PedRC, as well as the following facility
1140 requirements:
1141
1142 (1) All designated Comprehensive PedRCs shall be licensed as a general acute care
1143 hospital with a basic or comprehensive Emergency Department permit and have full,
1144 provisional, or conditional California Children's Services (CCS) approval by the

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1145 Department of Health Care Services as a tertiary hospital, or meet CCS criteria as a
1146 tertiary hospital as approved by the local EMS agency.

1147
1148 (2) Can provide comprehensive specialized pediatric medical and surgical care to any
1149 acutely ill or injured child.

1150
1151 (3) Inpatient resources including a neonatal intensive care unit (NICU) and a pediatric
1152 intensive care unit (PICU).

1153
1154 (4) Provide ongoing outreach and pediatric education for Community, General and
1155 Basic PedRCs, and prehospital care providers, in collaboration with the local EMS
1156 agency.

1157
1158 (5) Establish transfer agreements or serve as a regional referral center for
1159 specialized care, such as trauma, burn, spinal cord injury, and rehabilitation and
1160 behavioral health, of pediatric patients.

1161
1162 (6) Emergency department services include a separate pediatric emergency department
1163 or a designated area for emergency care of pediatric patients within an emergency
1164 department, with physician staff who are qualified specialists in emergency medicine or
1165 pediatric emergency medicine.

1166
1167 (7) All designated Comprehensive PedRCs shall meet the following additional
1168 equipment requirements: of Advanced PedRCs.

1169
1170 (A) neonatal resuscitation equipment, including:

1171
1172 (i) pediatric laryngoscope with Miller 0 and 00 blades,

1173
1174 (ii) size 2.5 and 3.0 endotracheal tubes, and

1175
1176 (iii) umbilical vein catheters.

1177
1178 (b) Additional requirements may be stipulated by the local EMS agency medical
1179 director.

1180
1181 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
1182 Reference: Sections 1797.88, 1797.222, 1798.150, 1798.170, 1798.173, 1799.204, and
1183 1799.205, Health and Safety Code.

1184
1185 **Article 4: Data Management, Quality Improvement and Evaluations**

1186
1187 **§ 100450. ~~227~~ 222223. Data Management Requirements**

1188
1189 (a) The local EMS agency shall implement a standardized data collection and reporting
1190 process for EMSC program.

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ALL MODIFICATIONS TO THE REGULATION TEXT

- 1191
1192 (1) The EMSC program shall include the collection of both prehospital and hospital
1193 patient care data, as determined by the local EMS agency.
1194
1195 (2) The prehospital EMSC patient care elements selected by the local EMS agency
1196 shall be compliant with the most current version of the CEMIS and the NEMIS
1197 databases.
1198
1199 (b) All ~~hospitals that receive pediatric patients~~ PedRCs shall participate in the local EMS
1200 agency data collection process in accordance with local EMS agency policies and
1201 procedures.
1202
1203 (c) Following ~~submission~~ approval of the EMSC program, ~~the~~ PedRCs shall submit data
1204 to the local EMS agency which shall include, but not be limited to:
1205
1206 (1) Baseline data from pediatric ambulance transports, including, but not limited to:
1207
1208 (A) Arrival time/date to the emergency department.
1209
1210 (B) Date of birth.
1211
1212 (C) Mode of arrival.
1213
1214 (D) Gender.
1215
1216 (E) Primary impression.
1217
1218 (2) Basic outcomes for EMS quality improvement activities, including but not limited to:
1219
1220 (A) Admitting hospital name if applicable.
1221
1222 (B) Discharge or transfer diagnosis.
1223
1224 (C) Time and date of discharge or transfer from the ~~e~~Emergency ~~d~~Department.
1225
1226 (D) Disposition from the Emergency Department.
1227
1228 (E) External cause of injury.
1229
1230 (F) Injury location.
1231
1232 (G) Residence zip code.
1233
1234 (d) Pediatric data shall be integrated into the local EMS agency and the EMS Authority
1235 data management system through data submission on no less than a quarterly basis.
1236

ALL MODIFICATIONS TO THE REGULATION TEXT

1237 Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code.
1238 Reference: Sections 1799.204 and 1799.205, Health and Safety Code.

1239

1240 **§ 100450.228~~223224~~. Quality Improvement and Evaluation Process**

1241

1242 (a) Each local EMS agency ~~EMSC program, in collaboration with designated and all~~
1243 ~~PedRCs,~~ shall have a quality improvement program to include structure, process, and
1244 ~~outcome evaluations which focus on improvement efforts to identify root causes of~~
1245 ~~problems, intervene to reduce or eliminate these causes, and take steps to correct the~~
1246 ~~process in collaboration with all PedRCs. This process shall include, at a minimum:~~

1247

1248 (b) All PedRCs shall have a quality improvement program. This process shall include, at
1249 a minimum:

1250

1251 (1) Compliance with the California Evidence Code, Section 1157.7 to ensure
1252 confidentiality, and a disclosure protected review of selected pediatric cases.

1253

1254 (2) A process that integrates emergency department quality improvement activities with
1255 the prehospital, trauma, inpatient pediatrics, pediatric critical care and hospital-wide
1256 quality improvement activities.

1257

1258 ~~(4)~~(3) A process to integrate findings from quality improvement audits and reviews into
1259 education and clinical competency evaluations of staff.

1260

1261 (4) Each PedRC will complete an online or paper assessment of the National Pediatric
1262 Readiness Project self-assessment and share the results with the local EMS agency
1263 every three years at minimum.

1264

1265 ~~(4)~~(5) A multidisciplinary pediatric quality improvement committee to review prehospital,
1266 emergency department, and inpatient ~~pediatric patient~~ care which shall include, but not
1267 be limited to:

1268

1269 (A) Cardiopulmonary or respiratory arrests.

1270

1271 (B) Child maltreatment cases.

1272

1273 (C) Deaths.

1274

1275 (D) Intensive care unit admissions.

1276

1277 (E) Operating room admissions.

1278

1279 (F) Transfers.

1280

1281 (G) Trauma admissions.

1282

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1283 ~~(b)~~(c) The local EMS agency is responsible for:

1284

1285 (1) Ongoing performance evaluations of the local or regional EMSC programs.

1286

1287 ~~(2) The development of a quality improvement program pursuant to this section.~~

1288

1289 ~~(3)~~(2) Ensuring the designated PedRCs, other hospitals that provide care to pediatric
1290 patients, and prehospital providers involved in the EMSC program, participate in the
1291 quality improvement program contained in this section.

1292

1293 Note: Authority cited: Sections 1797.102, 1797.103, 1797.107, 1797.176, 1797.204,
1294 1797.220, 1797.250, 1797.254, 1798.150, and 1798.172. Health and Safety Code.

1295 Reference: Section 1797.104, 1797.176, 1797.204, 1797.220, 1797.222, 1798.170

1296 Health and Safety Code.

Proposed Emergency Medical Services for Children (EMSC) Regulations
 Chapter 14, Division 9, Title 22, California Code of Regulations

Comments Received During 45-day Public Comment Period
 March 16, 2018 Through April 30, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Chapter 14, Div 9, Title 22	San Francisco EMS Agency	No comments regarding proposed EMSC regulations	Comment Acknowledged General Comment
Chapter 14.	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Chapter 14 heading is <i>Emergency Medical Services for Children</i> , yet no content on prehospital pediatric requirements for a LEMSA creating/participating in an EMSC program	Comment Acknowledged No change Pediatric requirements for prehospital personnel are not within the scope of these regulations. Prehospital personnel scope of practice requirements can be found in Title 22, Division 9 Chapters 2, 3, and 4.
Chapter 14.	Rajesh K. Daftary, MD, MPH Assistant Professor Pediatric Emergency Medicine University of California, San Francisco Medical Director Pediatric Emergency Medicine Zuckerberg San Francisco General Hospital	To Whom It May Concern: I am writing in strong support of the proposed rule-making change in which EMS-C standards are to be incorporated into Chapter 14. As children can represent a sizable and somewhat nonuniform proportion across emergency departments in the state, implementing the proposed recommendations can facilitate provision of standard, evidence-based, context-appropriate care. Such recommendations are vital to	Comment Acknowledged General Comment

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		ensuring that all children receive the best possible care, and the highest chance for survival from a life threatening illness. The implementation of ED and prehospital guidelines can also benefit in timely provision of such care, even for the non-critically ill child. Such guidelines, however, do not need to be developed independently by each individual hospital – there is likely great benefit for emergency departments to share evidence-based guidelines on the management of common pediatric presentations. A funding mechanism should be developed so as to support such collaborative work.	
Prehospital assessment & Tx	Sara Watson	12-leads for pediatrics should really be part of pre-hospital assessment, the monitor/ defib be able to obtain & interpret a 12-lead for patients under 18yrs old esp with importance of SCA and that LEMSAs should not be able to change the pediatric age range to 18yo & under. Monitor/ defibrillators need to be able to obtain and interpret 12-leads on pediatrics	Comment Acknowledged No change All paramedics have 12-leads for pediatric patients. Regulations for prehospital personnel do not fall within the scope of these regulations but can be found in Title 22, Division 9, Chapter 2,3, and 4.
100450.206 2 42	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Should EMTALA/Title 22, Division 9, Chapter 7 be also listed and not just local EMS P & P?	Comment Acknowledged No change
100450.206 2 61	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Suggested revision: "...and is accountable for coordinating care for pediatric patients and overseeing the	Comment Acknowledged No change. Addressed in the personnel

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		pediatric QI program.”	section of the regulations.
100450.207 2 67-68	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Do anesthesia or anesthesia critical care need to have any pediatric experience to be designated as a pediatric intensivist?	Comment Acknowledged Language modified
Section 100450.207 Definitions Page 2 Line 68 See submitted track changes for clarification	UC Davis PICU group	Strike out: “Pediatric intensivist” means a physician who is board-certified or board-eligible in pediatric critical care medicine.	Comment Acknowledged Language modified
Article 1. Definitions Section 100450.208 Page 2 Lines 74 – Pediatric Patient	CHA	There is an age discrepancy between the proposed EMS-C regulations of “less than or equal to 14”, and Title 22, “pediatric patient” definition, which states, “Patients beyond the age of 13 shall not be admitted to or cared for in spaces approved for pediatric beds unless approved by the pediatrician in unusual circumstance and the reason documented in the patient’s medical record.” This will cause undue burden on hospitals, and CHA requests the age be changed to 13 to match Title 22 regulations.	Comment Acknowledged No change This definition will be used for reference to these regulations. There does not appear to be consistent age range when referring to pediatric patients. While the comment refers to language in Title 22 Division 5, Chapter 1, California Children’s Services (CCS) refers to pediatric patients as anyone from the age of 1 -21.
Section 100450.208 – Pediatric Patient Page 2 Line 78	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing	Suggest insert a new section for definition of Pediatric Readiness Project score. DRAFT definition: “The Pediatric Readiness Project, supported by the U.S. Department of Health and Human Services Health Resources and Services	Comment Acknowledged No change. Pediatric Readiness Project Score is not used in these regulations. These regulations establish minimum standards.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	<p>Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>	<p>Administration (HRSA) EMS for Children (EMSC) Program, the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association, and referenced on the website of the California Department of Public Health and on the website of the EMSC Innovation and Improvement Center, includes an assessment tool that provides a measure (the PRP "score") to help ensure that emergency departments have the essential guidelines and resources in place to provide quality emergency care to children."</p>	<p>Local EMS Agency's may expand requirements to meet local needs.</p>
<p>Section 100450.208 – Pediatric Patient</p> <p>Page 2</p> <p>Line 78</p>	<p>Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California</p> <p>Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California</p>	<p>Suggest insert a new section for definition of Pediatric Readiness Project score. DRAFT definition: "The Pediatric Readiness Project, supported by the U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) EMS for Children (EMSC) Program, the American Academy of Pediatrics, the American College of Emergency Physicians, and the Emergency Nurses Association, and referenced on the website of the California Department of Public Health and on the website of the EMSC Innovation and Improvement Center, includes an assessment tool that provides a measure (the PRP "score") to help</p>	<p>Comment Acknowledged No change</p> <p>Pediatric Readiness Project Score is not used in these regulations. These regulations establish minimum standards. Local EMS Agency's may expand requirements to meet local needs.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		ensure that emergency departments have the essential guidelines and resources in place to provide quality emergency care to children.”	
Page 3 Lines 93, 102, 115, and 129	Los Angeles County EMS Agency	Requesting clarification of the definition: “CCS approval readily available” (for all PRC Definitions). Does the facility have to have CCS approval? Change wording to “CSS approval <u>or meet local standards and been designated as such by LEMSA</u> ”? Rationale: CCS approval is an additional expense for the hospital and LA County ensures that those hospitals that are not CCS approved, meet the standards.	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
100450.210 Pediatric Receiving Centers Page 3 Lines 93,102,115,129	San Mateo County EMS	Omitted term in definition. Add word conditional . <i>If the hospital has full, provisional or conditional CCS approval readily</i> . This ensures consistency of language used in Article 3/Page 7/Line 289 which utilizes the term conditional to describes one of the three different types of CCS approval that are acceptable. <i>CCS approval readily available</i>	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.209, page 3 Line 80-81	CHA	This PedRC description is not clear. Is it a separate category, or a minimum standard for all four categories? CHA recommends changing the sentence to read “means a licensed general acute care hospital with at minimum, a permit for basic or comprehensive emergency	Comment Acknowledged Language modified The change has been accepted to provide clarity.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>services that has been formally designated as one of four types of PedRCs by the local EMS agency for its role in an EMS system.”</p>	
<p><u>Section</u> – Article 1 – <u>Definitions</u> / <u>Page</u> 3 / <u>Line</u> 86-129</p>	<p>Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency</p>	<p>Given the proposed regulations identify pediatric receiving centers, the <u>levels should reflect pediatric patient transport destination</u> options for pediatric trauma and pediatric critical care. We recommend consideration of the level options below:</p> <p>1. <u>TRAUMA WITH PICU AND/OR ICU - PEDRC</u>:</p> <ul style="list-style-type: none"> • <u>TRAUMA (WITH PICU) PEDRC</u> - (IE. UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND) • <u>TRAUMA (NO PICU) PEDRC- AND WITH GENERAL PEDIATRIC BEDS OR PEDIATRIC CLINIC</u> (IE. HIGHLAND, ALAMEDA HEALTH SYSTEM; AND EDEN) <p>2, <u>PICU/NICU/ICU; NON TRAUMA - PEDRC</u></p> <ul style="list-style-type: none"> • <u>PICU / ICU / NON TRAUMA PEDRC</u>; (IE. KAISER PERMANENTE OAKLAND) • <u>REGIONAL NICU/NO TRAUMA PEDRC</u> (IE. 	<p>Comment Acknowledged Language modified</p> <p>EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.</p> <p>Per Health and Safety Code Sections 1797.200 and 1797.222, the Medical Director has the authority to develop the plans and protocols.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>SUTTER HOSPITALS AND OTHERS).</p> <ul style="list-style-type: none"> • <u>NICU LEVEL II PEDRC</u> (IE.SUTTER HOSPITALS AND OTHERS). • <u>COMMUNITY NICU PEDRC</u> (SUTTER HOSPITALS AND OTHERS). <p>3. ICU/GENERAL PEDIATRIC BEDS; <u>NON TRAUMA; NO PICU/ NO NICU - PEDRC</u></p> <ul style="list-style-type: none"> • <u>IN PATIENT GENERAL PEDIATRIC BEDSPEDRC</u> <p>4. <u>NO PEDIATRIC INPATIENT BEDS - PEDRC</u></p>	
<p>Section 100450.210 Pg. 3 Line 86</p>	<p>Hospital Subcommittee for State Pediatric Surge Plan (Raaz Fares)</p>	<p>Suggest changing "Level I" to "Platinum." Other designations use the terms "Level" and "Tier." This may help differentiate from those designations.</p>	<p>Comment Acknowledged Language Modified</p> <p>EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.</p> <p>Names of the PedRC levels have been changed to Comprehensive, Advanced, General and Basic.</p>
<p>Section 100450.210 Page 3 Line 90 See submitted track changes for clarification</p>	<p>UC Davis PICU group</p>	<p>Add language: ...Intensive care (<u>CCS designated "regional" pediatric intensive care unit specialty care center</u>) ,...</p>	<p>Comment Acknowledged Language Modified</p> <p>EMSA has removed the definitions for each level, and</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
100450.210 Page: 3 Line: 93	County of San Diego EMS	Suggest adding: Provisional or conditional CCS approval. Concur with pg 7 line 290	<p>Comment Acknowledged Language Modified</p> <p>EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.</p>
Section 100450.210 Page 3 Line 93 See submitted track changes for clarification	UC Davis PICU group	Add language: or CCS <u>Tertiary Hospital</u>	<p>Comment Acknowledged Language Modified</p> <p>EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.</p>
Section 100450.211 Pg. 3 Line 99	Hospital Subcommittee for State Pediatric Surge Plan (Raaz Fares)	Suggest changing "Level II" to "Gold." Other designations use the terms "Level" and "Tier." This may help differentiate from those designations.	<p>Comment Acknowledged Language Modified</p> <p>EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.</p> <p>Names of the PedRC levels have been changed to</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			Comprehensive, Advanced, General and Basic.
<p>Section 100450.211 – Pediatric Receiving Center – Level II Page 3 Lines 100-102</p>	<p>Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California</p> <p>Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>	<p>There is an implicit assumption in these proposed regulations that CCS certification, which focuses mostly on inpatient or clinic care, ensures the quality of care in the Emergency Department. CCS certification for inpatient pediatric care is at best an indirect and inaccurate proxy for the quality of clinical pediatric ED care. There are more direct and accurate ways to assess quality of ED pediatric care, such as performance on the Pediatric Readiness Project score, the presence of physician and nurse Pediatric Emergency Care Coordinators, the timeliness of pediatric subspecialty telemedicine assessments, and the rapid availability of specialty pediatric transport. These other indicators could be required for the Level II Pediatric Receiving Center in lieu of CCS certification, and might result in even higher levels of quality than CCS certification. These alternative indicators are easily measured and verified by a LEMSA that seeks to categorize Emergency Departments based on the actual quality of pediatric ED care, and are preferable to the use of CCS certification in the proposed draft regulations. Use of this score would require a definition (a proposal is included above).</p>	<p>Comment Acknowledged Language Modified</p> <p>EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.</p> <p>Pediatric Readiness Project Score is not used in these regulations. These regulations establish minimum standards. Local EMS Agency's may expand requirements to meet local needs.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>Details would need to be added to Section 100.450.222 A few references for the PRP: (see original comment sheet for links)</p> <p>In this light, suggest change to read "Level II pediatric receiving center means a CCS approved pediatric community or general community hospital, or a licensed general hospital with a Basic or Comprehensive ED that has achieved a measure of competency based on performance of the Pediatric Readiness Project score (or similar nationally accepted standard for establishing quality Emergency Department pediatric care), at a score and/or specific category performance as defined by the LEMSA and included in the annual EMSC program as reported to EMSA as per Section 100450.219. Method of determination of the Pediatric Readiness Project score shall be included in the annual LEMSA report."</p> <p>Will also suggest a requirement for telehealth availability and performance for this Level II pediatric receiving hospital in Section 100.450.222</p>	
Section 100450.211 – Pediatric Receiving	Todd R Newton, MD Regional Chief Emergency	There is an implicit assumption in these proposed regulations that CCS	Comment Acknowledged Language Modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
<p>Center – Level II</p> <p>Page 3</p> <p>Lines 100-102</p>	<p>Medicine Kaiser Permanente, Southern California</p> <p>Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California</p>	<p>certification, which focuses mostly on inpatient or clinic care, ensures the quality of care in the Emergency Department. CCS certification for inpatient pediatric care is at best an indirect and inaccurate proxy for the quality of clinical pediatric ED care. There are more direct and accurate ways to assess quality of ED pediatric care, such as performance on the Pediatric Readiness Project score, the presence of physician and nurse Pediatric Emergency Care Coordinators, the timeliness of pediatric subspecialty telemedicine assessments, and the rapid availability of specialty pediatric transport. These other indicators could be required for the Level II Pediatric Receiving Center in lieu of CCS certification, and might result in even higher levels of quality than CCS certification. These alternative indicators are easily measured and verified by a LEMSA that seeks to categorize Emergency Departments based on the actual quality of pediatric ED care, and are preferable to the use of CCS certification in the proposed draft regulations. Use of this score would require a definition (a proposal is included above). Details would need to be added to Section 100.450.222</p> <p>A few references for the PRP: (please see original comment sheet</p>	<p>EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.</p> <p>Pediatric Readiness Project Score is not used in these regulations. These regulations establish minimum standards. Local EMS Agency's may expand requirements to meet local needs.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>for links)</p> <p>In this light, suggest change to read “Level II pediatric receiving center means a CCS approved pediatric community or general community hospital, or a licensed general hospital with a Basic or Comprehensive ED that has achieved a measure of competency based on performance of the Pediatric Readiness Project score (or similar nationally accepted standard for establishing quality Emergency Department pediatric care), at a score and/or specific category performance as defined by the LEMSA and included in the annual EMSC program as reported to EMSA as per Section 100450.219. Method of determination of the Pediatric Readiness Project score shall be included in the annual LEMSA report.”</p> <p>Will also suggest a requirement for telehealth availability and performance for this Level II pediatric receiving hospital in Section 100.450.222</p>	
<p>Section 100450.211 – Pediatric Receiving Center – Level II Page 3 Lines 100-101</p>	<p>Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California</p>	<p>If using CCS certification for inpatient pediatric care as the determinant of quality of care in the ED, a serious error in our opinion (since there are better proxies for</p>	<p>Comment Acknowledged Language Modified</p> <p>EMSA has removed the definitions for each level, and</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	quality ED pediatric care), suggest should be changed to "CCS approved pediatric community or CCS general community hospital"	provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.211 – Pediatric Receiving Center – Level II Page 3 Lines 100-101	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	If using CCS certification for inpatient pediatric care as the determinant of quality of care in the ED, a serious error in our opinion (since there are better proxies for quality ED pediatric care), suggest should be changed to "CCS approved pediatric community or CCS general community hospital"	Comment Acknowledged Language Modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.211 Page 3 Line 101	CHA	Minor edit, Add "II" after PedRC	Comment Acknowledged Language Modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.211 – Pediatric Receiving Center – Level II Page 3 Line 101	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California	What is a "Level II pediatric community hospital"? Where is such an entity defined?	Comment Acknowledged Language Modified EMSA has removed the definitions for each level, and provided requirements for a

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California		Comprehensive, Advanced, General and Basic PedRC under each section. CCS provides standards for and defines Pediatric Community Hospitals.
Section 100450.211 – Pediatric Receiving Center – Level II Page 3 Line 101	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	What is a “Level II pediatric community hospital”? Where is such an entity defined?	Comment Acknowledged Language Modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section. CCS provides standards for and defines Pediatric Community Hospitals.
100450.211 Page: 3 Line: 102	County of San Diego EMS	Suggest adding: Provisional or conditional CCS approval. Concurs with pg 7 line 290	Comment Acknowledged Language Modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.211 Page 3 Lines 102 See submitted track changes for clarification	UC Davis PICU group	Add language: or CCS <u>Pediatric Community Hospital</u>	Comment Acknowledged Language Modified EMSA has removed the definitions for each level, and

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.212 Pg. 3 Line 108	Hospital Subcommittee for State Pediatric Surge Plan (Raaz Fares)	Suggest changing "Level III" to "Silver." Other designations use the terms "Level" and "Tier." This may help differentiate from those designations.	Comment Acknowledged EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section. Names of the PedRC levels have been changed to Comprehensive, Advanced, General and Basic.
100450.212 3 112-114	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Are available diagnostic, operative, therapeutic services, equipment, and selected physician specialists for consultation pediatric-specific?	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.212 - Pediatric Receiving Center- Level III Page 3 Lines 114-116	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan	Suggest delete final sentence in this section, see similar comment to line 101-02 above.	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Quality Kaiser Permanente, Northern California		
Section 100450.212 - Pediatric Receiving Center- Level III Page 3 Lines 114-116	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest delete final sentence in this section, see similar comment to line 101-02 above.	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.212 Page 3 Lines 114 See submitted track changes for clarification	UC Davis PICU group	Add language: available for in-person or telehealth consultation.	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.212 Page 3 Line 115 See submitted track changes for clarification	UC Davis PICU group	Add language: Or CCS <u>General Community Hospital</u>	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
100450.212 Page: 3	County of San Diego EMS	Suggest adding: Provisional or conditional CCS approval. Concur	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Line: 116		with pg 7 line 290	EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
100450.213 3 122-129	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Why would pediatric patients be brought here by EMS with such limited resources?	Comment Acknowledged No change. This is needed by the local EMS agencies as there are many small, rural communities in which Basic PedRC is the only option.
Section 100450.213 Pg. 3 Line 122	Hospital Subcommittee for State Pediatric Surge Plan (Raaz Fares)	Suggest changing "Level IV" to "Bronze." Other designations use the terms "Level" and "Tier." This may help differentiate from those designations.	Comment Acknowledged Language modified EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section. Names of the PedRC levels have been changed to Comprehensive, Advanced, General and Basic.
Section 100450.213 - Pediatric Receiving Center – Level IV Page 3 Lines 127-129	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California	Suggest delete final sentence in this section, see similar comment to line 101-02 above.	Comment Acknowledged EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced,

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California		General and Basic PedRC under each section.
Section 100450.213 - Pediatric Receiving Center – Level IV Page 3 Lines 127-129	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest delete final sentence in this section, see similar comment to line 101-02 above.	Comment Acknowledged EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
100450.213 Page: 3 Line: 129	County of San Diego EMS	Suggest adding: Provisional or conditional CCS approval. Concurs with pg 7 line 290	Comment Acknowledged EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.213 Page 3 Line129 See track changes	UC Davis PICU group	Add language: Or CCS <u>Limited Hospital</u> approval...	Comment Acknowledged EMSA has removed the definitions for each level, and provided requirements for a Comprehensive, Advanced, General and Basic PedRC under each section.
Section 100450.216 Page 4 Lines 156-160	Jay Goldman, MD, FACEP Director of EMS and Ambulance	As written, there is no requirement for the non-pediatric physician in the ED caring for children to be trained in	Comment Acknowledged No Change.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	<p>Kaiser Permanente Northern California</p> <p>Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>	<p>emergency medicine. This seems inadequate in regulations aiming to optimize care for children in the State's Emergency Departments. Suggest change to "Qualified Emergency Specialist". Qualified Emergency Specialist means a qualified California physician who is board certified or board eligible in Emergency Medicine 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.</p> <p>This would require language changes in remainder of regulations that mention "Qualified Specialist".</p>	<p>A "Qualified Emergency Specialist" is defined in section 100450.210.</p>
<p>Section 100450.216</p> <p>Page 4</p> <p>Lines 156-160</p>	<p>Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California</p> <p>Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California</p>	<p>As written, there is no requirement for the non-pediatric physician in the ED caring for children to be trained in emergency medicine. This seems inadequate in regulations aiming to optimize care for children in the State's Emergency Departments.</p> <p>Suggest change to "Qualified Emergency Specialist". Qualified Emergency Specialist means a qualified California physician who is board certified or board eligible in Emergency Medicine by the American Board of Medical Specialties, the Advisory Board for</p>	<p>Comment Acknowledged No Change.</p> <p>A "Qualified Emergency Specialist" is defined in section 100450.210</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties.</p> <p>This would require language changes in remainder of regulations that mention "Qualified Specialist".</p>	
100450.219 5 (3) 204-205	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Is this asking that prehospital providers participating in the system will be required to have pediatric medical control guidelines and field treatment protocols?	Comment Acknowledged Language modified
ARTICLE 2. LOCAL EMS AGENCY EMS-C PROGRAM REQUIREMENTS §100450.219, page 5 line 204-205	CHA	"care rendered to pediatric patients outside the hospital" is an unclear statement, please clarify with an example	Comment Acknowledged Language modified
100450.219 5 (4) 207-207	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Would this be an overview of what PedRCs would be available in the EMSC program once established?	Comment Acknowledged Language modified
100450.219 5 (7) 215	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: What does hospitals with pediatric considerations mean? Pediatric subspecialties instead, maybe?	Comment Acknowledged Language modified
100450.219 5 (8) 218-219	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: "rehabilitation" is not defined. Is this related to addiction or medical rehabilitation?	Comment Acknowledged Language modified
100450.219 Page 6, Lines 235-236	Los Angeles County EMS Agency	Change "Copies of <u>any written agreements for coordination of pediatric transports across county lines, with neighboring local EMS</u>	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>agencies" providing pediatric care readily available</p> <p>Rationale: The statement as it is currently written does not make sense. We designate out-of-county facilities to receive pediatric patients if they are the closest. We are unaware of any written agreements between LEMSAs to provide pediatric care.</p>	
<p><u>Section</u> - Article 2 Local EMS Agency <u>EMSC Program Requirements</u> (f) / <u>Page 6</u> / <u>Line 246, 247, 248,249</u></p>	<p>Cynthia Frankel, EMSC Coordinator Alameda County EMS Agency</p>	<p>Local EMS agencies should not be expected to be compliant with these regulation levels and the other components of this proposed regulation for the 2017 EMS System Plan – (Given we were informed of the new methodology for Pediatric Receiving Centers only now, all the standards would not be sufficiently met). Consider the regulations should state a <u>phased approach</u> for implementation over <u>1 to 3 years</u>.</p>	<p>Comment Acknowledged No change.</p> <p>This language is consistent with language and requirements in other chapters of regulation.</p> <p>In addition, this requirement is for those that are currently operating an EMSC program implemented prior to the effective dates of the regulations and as such would already have the necessary information.</p>
<p><u>Section</u> - Article 2 Local EMS Agency <u>EMSC Program Requirements</u> (f) / <u>Page 6</u> / <u>Line 246, 247, 248,249</u></p>	<p>Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency</p>	<p>Recommend CA EMSA provides an EMSC Program <u>Approval Template</u> for submission. The reference for the template needs to be included or referenced in the regulations.</p>	<p>Comment Acknowledged No change.</p> <p>There are guidelines related to EMSC programs on the EMSA website.</p>
<p><u>Section</u> - Article 2 Local EMS Agency <u>EMSC Program Requirements</u> (f) / <u>Page 6</u> / <u>Line 246, 247, 248,249</u></p>	<p>Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency</p>	<p>Recommend CA EMSA provides an EMSC Program <u>Approval Template</u> for submission. The reference for the template needs to be included or referenced in the regulations.</p>	<p>Comment Acknowledged No change.</p> <p>There are guidelines related to EMSC programs on the EMSA</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			website.
100450.220 6 (2) 262	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Identifying EMSC program goals and objectives are not required in the initial approval process. Would suggest adding this to the program approval process to allow program to develop and grow with goals and objectives from the beginning.	Comment Acknowledged Language modified
100450.221 Page 7, Lines 280-281 Page 8, Lines 322-323 and Lines 354-355 Page 9, Lines 386-387	Los Angeles County EMS Agency	Change "...licensed, pursuant to the Robert W. Crown California Children's Services Act <u>Title XXII, Division 5, California Code of Regulations</u> as a basic Emergency Department" Rationale: Robert W. Crown Act does not mentioned Emergency Department licensure	Comment Acknowledged Language modified
100450.221 Level I PedRC Requirements/Page 7/Line 297	San Mateo County EMS	Suggest rewording - Provide ongoing outreach and pediatric education for level II, III, and IV PedRCs, and prehospital care providers , in collaboration with the local EMS agency. Prehospital care providers have been omitted in this section but are referenced to under Level II (lines 334-5) and Level III (lines 366-7) requirements. Rewording does not change intent.	Comment Acknowledged Language modified
<u>Section</u> - Article 3: Pediatric Receiving Centers § 100450.221. Level I PedRC Requirements	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Given pediatric receiving centers, the <u>levels should reflect pediatric patient transport destination</u> options for pediatric trauma and pediatric critical care Refer to the example below:	Comment Acknowledged Per Health and Safety Code Sections 1797.200 and 1797.222, the Medical Director

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
<u>Page 7 / Line 275-403</u>		<p>1. <u>TRAUMA WITH PICU AND/OR ICU:</u></p> <ul style="list-style-type: none"> • <u>PICU TRAUMA PEDRC</u> - (IE. UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND) • <u>NO PICU TRAUMA PEDRC- AND WITH GENERAL PEDIATRIC BEDS</u> (IE. HIGHLAND, ALAMEDA HEALTH SYSTEM; AND EDEN) <p>2, <u>PICU/NICU/ICU; NONE TRAUMA</u></p> <ul style="list-style-type: none"> • <u>PICU/ICU/NO TRAUMA PEDRC;</u> (IE. KAISER PERMANENTE OAKLAND) • <u>REGIONAL NICU/NO TRAUMA PEDRC</u> (IE. SUTTER HOSPITALS AND OTHERS). • <u>NICU LEVEL II PEDRC</u> (IE.SUTTER HOSPITALS AND OTHERS). • <u>COMMUNITY NICU PEDRC</u> (SUTTER HOSPITALS AND OTHERS). <p>3. <u>ICU/GENERAL BEDS; NON TRAUMA; NO PICU/ NO NICU</u></p> <ul style="list-style-type: none"> • <u>IN PATIENT GENERAL PEDIATRIC BEDSPEDRC</u> • <u>NO PEDIATRIC INPATIENT PEDRC –</u> 	has the authority to develop the plans and protocols.
<u>Section - Article 3: Pediatric Receiving</u>	Cynthia Frankel, EMSC Coordinator,	Once the levels are confirmed, the pediatric readiness <u>benchmarks</u>	Comment Acknowledged No change.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Centers § 100450.221. Level I PedRC Requirements to 100450.224 Level IV/ <u>Page 7 / Line 280-403</u>	Alameda County EMS Agency	<u>need to be required for emergency departments and critical care areas at each level.</u> We recommend each level have minimum personnel competency, policy, and equipment requirements	These regulations provide minimum standards that may be expanded by the LEMSA to meet LEMSA need.
<u>Section - Article 3: Pediatric Receiving Centers § 100450.221. Level I PedRC Requirements Page 7 / Line 280-311</u>	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Patient transport destination decisions are not addressed with the association to pediatric receiving hospitals levels. We recommend inclusion of pediatric destination decisions in an MCI or surge event.	Comment Acknowledged No change. Per Health and Safety Code Sections 1797.200 and 1797.222, the Medical Director has the authority to develop the plans and protocols.
<u>Section - Article 3: Pediatric Receiving Centers § 100450.221. Level I PedRC Requirements Page 7 / Line 280-311</u>	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	<u>Pediatric Receiving Centers - Level 1 PedRC</u> does not include provision for integration of pediatric disaster, MCI, surge planning, pediatric triage, and patient tracking requirement. Recommend adding content in this section (10)	Comment Acknowledged No change. Per Health and Safety Code Sections 1797.200 and 1797.222, the Medical Director has the authority to develop the plans and protocols.
<u>Section Article 3: Pediatric Receiving Centers / Page 7 / Line 310, 311</u>	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Non trauma center with PICU (ie. Kaiser Permanente Oakland) meet all the qualifications of a level 1 pediatric receiving center except pediatric specific patient care areas in ED. The separate pediatric patient care area in ED is ideal but should be recommended only except in tertiary care pediatric level 1 trauma centers	Comment Acknowledged No change Comprehensive PedRC should have separate ED treatment area for pediatrics to provide specialized pediatric-focused care. This is only a designated area, not a separate department.
100450.221 7 (d) 310-311	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Does NICU and PICU have to be CCS full provisional, or conditional approval?	Comment Acknowledged Comprehensive PedRCs requires tertiary hospital CCS

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
			approval and includes PICU and NICU
Section 100450.221 Page 7 Line 289 See submitted track changes for clarification	UC Davis PICU group	Add language: "Have full, provisional, or conditional <u>Tertiary Hospital</u> CCS approval."	Comment Acknowledged Language modified
Section 100450.221 Level I PedRC Requirements Page 7 Lines 293-294	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Suggest adding, to be consistent with page 8 lines 341-343 "Specialized care, such as for trauma, burns, spinal cord injury, and rehabilitation, may be handled via transfer agreements with other pediatric centers that have these capabilities."	Comment Acknowledged Language modified
Section 100450.221 Level I PedRC Requirements Page 7 Lines 293-294	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest adding, to be consistent with page 8 lines 341-343 "Specialized care, such as for trauma, burns, spinal cord injury, and rehabilitation, may be handled via transfer agreements with other pediatric centers that have these capabilities."	Comment Acknowledged Language modified
100450.221 Page: 7 Line: 297	County of San Diego EMS	Suggest adding: Plan and implement ongoing outreach and pediatric education for Level II, III, and IV PedRCs and Pre-Hospital agencies in collaboration with the	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		local EMS agency.	
<p>Section 100450.221 Page 7 Lines 310, 311</p> <p>See submitted track changes for clarification</p>	UC Davis PICU group	<p>Add language: Inpatient resources must include a CCS designated regional neonatal intensive care unit (NICU) and a CCS designated regional pediatric intensive care unit (PICU).</p>	<p>Comment Acknowledged No change</p> <p>Comprehensive PedRCs requires tertiary hospital CCS approval and includes PICU and NICU.</p>
<p><u>Section</u> - Article 3: Pediatric Receiving Centers § 100450.221. Level I PedRC Requirements <u>Page 7-9 / Line 275-402</u></p>	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	<p>Given the proposed regulations identify pediatric receiving centers, the <u>levels should reflect pediatric patient transport destination</u> options for pediatric trauma and pediatric critical care as mentioned above. Refer to the example below:</p> <p>1. <u>TRAUMA WITH PICU AND/OR ICU</u>:</p> <ul style="list-style-type: none"> • <u>PICU TRAUMA PEDRC</u> - (IE. UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND) • <u>NO PICU TRAUMA PEDRC- AND WITH GENERAL PEDIATRIC BEDS</u> (IE. HIGHLAND, ALAMEDA HEALTH SYSTEM; AND EDEN) <p>2, <u>PICU/NICU/ICU; NONE TRAUMA</u></p> <ul style="list-style-type: none"> • <u>PICU/ICU/NO TRAUMA PEDRC</u>; (IE. KAISER PERMANENTE OAKLAND) • <u>REGIONAL NICU/NO TRAUMA PEDRC</u> (IE. SUTTER HOSPITALS AND 	<p>Comment Acknowledged No change.</p> <p>Per Health and Safety Code Sections 1797.200 and 1797.222, the Medical Director has the authority to develop the plans and protocols.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>OTHERS).</p> <ul style="list-style-type: none"> • <u>NICU LEVEL II PEDRC</u> (IE.SUTTER HOSPITALS AND OTHERS). • <u>COMMUNITY NICU PEDRC</u> (SUTTER HOSPITALS AND OTHERS). <p>3. ICU/GENERAL PEDIATRIC BEDS; NON TRAUMA; <u>NO PICU/ NO NICU</u></p> <ul style="list-style-type: none"> • <u>IN PATIENT GENERAL PEDIATRIC BEDSPEDRC</u> <p>4. <u>NO PEDIATRIC INPATIENT BEDS – PEDRC</u></p>	
<p>Section 100450.222 - Level II PedRC Requirements</p> <p>Page 8 Lines 319-347</p> <p>Section 100450.223 - Level III PedRC Requirements</p> <p>Pages 8-9 Lines 351-379</p>	<p>Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California</p> <p>Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>	<p>These sections, as written, are internally inconsistent with the definitions of these levels of PedRC on page 2. In addition, the wording of these two sections is identical, making the requirements of the draft Level II identical to the requirements of the draft Level III, thus eliminating the need to distinguish between these levels. The distinction between Level II and Level III should be in the quality of emergency pediatric care provided in the ED, as determined by PRP score and availability of pediatric specialists. Specific wording change suggestions follow</p>	<p>Comment Acknowledged Language modified</p>
<p>Section 100450.222 - Level II PedRC Requirements</p>	<p>Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern</p>	<p>These sections, as written, are internally inconsistent with the definitions of these levels of PedRC on page 2. In addition, the wording</p>	<p>Comment Acknowledged Language modified</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
<p>Page 8 Lines 319-347</p> <p>Section 100450.223 - Level III PedRC Requirements</p> <p>Pages 8-9 Lines 351-379</p>	<p>California</p> <p>Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California</p>	<p>of these two sections is identical, making the requirements of the draft Level II identical to the requirements of the draft Level III, thus eliminating the need to distinguish between these levels. The distinction between Level II and Level III should be in the quality of emergency pediatric care provided in the ED, as determined by PRP score and availability of pediatric specialists. Specific wording change suggestions follow.</p>	
<p>Section 100450.222 - Level II PedRC Requirements Page 8 Lines 322-323</p>	<p>Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California</p> <p>Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>	<p>Suggest change: "All designated PedRCs shall be licensed as a Basic Emergency Department".</p>	<p>Comment Acknowledged Language modified</p>
<p>Section 100450.222 - Level II PedRC Requirements Page 8 Lines 322-323</p>	<p>Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California</p> <p>Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California</p>	<p>Suggest change: "All designated PedRCs shall be licensed as a Basic Emergency Department".</p>	<p>Comment Acknowledged Language modified</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Section 100450.222 Page 8 Add a line 324 See submitted track changes for clarification	UC Davis PICU group	Add language: "Have full, provisional, or conditional <u>Pediatric Community Hospital CCS approval.</u> "	Comment Acknowledged Language modified
Section 100450.222 - Level II PedRC Requirements Page 8 Line 327	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Suggest addition: "All Level II PedRCs shall have pediatric specialists and subspecialists available promptly and at bedside to the Emergency Department, either in person or by high fidelity video telehealth."	Comment Acknowledged Language modified
Section 100450.222 - Level II PedRC Requirements Page 8 Line 327	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest addition: "All Level II PedRCs shall have pediatric specialists and subspecialists available promptly and at bedside to the Emergency Department, either in person or by high fidelity video telehealth."	Comment Acknowledged Language modified
Section 100450.222 - Level II PedRC Requirements	Jay Goldman, MD, FACEP Director of EMS and Ambulance	Suggest some language requiring performance on the Pediatric Readiness Project score, for	Comment Acknowledged No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Page 8 Line 327	Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	example: "All Level II PedRCs shall have their PRP score measured and submitted to the LEMSA at a frequency to be determined by the LEMSA. The LEMSA will set acceptable minimal performance standards on the Pediatric Readiness Project score required for Level II designation as well as the method of verifying the PRP score, and report the performance standards and verification methods to EMSA as required in Section 100450.219."	Pediatric Readiness Project Score is not used in these regulations. These regulations develop minimum standards.
Section 100450.222 - Level II PedRC Requirements Page 8 Line 327	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest some language requiring performance on the Pediatric Readiness Project score, for example: "All Level II PedRCs shall have their PRP score measured and submitted to the LEMSA at a frequency to be determined by the LEMSA. The LEMSA will set acceptable minimal performance standards on the Pediatric Readiness Project score required for Level II designation as well as the method of verifying the PRP score, and report the performance standards and verification methods to EMSA as required in Section 100450.219."	Comment Acknowledged No change Pediatric Readiness Project Score is not used in these regulations. These regulations develop minimum standards.
100450.222 – 100450.224 PedRC Requirements/Lines 331, 338,341, 363,370,373,395,398,401,	San Mateo County EMS	Please explain the difference between formal agreements, written agreements and transfer agreements. All three terms are used in conjunction with transferring patients. Would recommend using	Comment Acknowledged Comment accepted. The language has been made consistent.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		one term and list what services would be included in the agreements.	
100450.222 Page: 8 Line: 333	County of San Diego EMS	Suggest changing: Establish transfer agreements-keep the language consistent	Comment Acknowledged Language modified
100450.222 Page: 8 Line: 341	County of San Diego EMS	Suggest changing: Establish transfer agreements-keep the language consistent OR:	Comment Acknowledged Language modified
100450.222 Page: 8 Line: 333	County of San Diego EMS	Suggest changing: 4) leave out transfer of ped pts. Use formal agreement for education and consultation.	Comment Acknowledged Language modified
100450.222 Page: 8 Line: 341	County of San Diego EMS	Suggest changing: 4) leave out transfer of ped pts. Use formal agreement for education and consultation.	Comment Acknowledged Language modified
100450.222 8 (7) 342	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Question: Should sentence be written "pediatric patients needing specialized care, not available at a level II PedRC, such as trauma..."?	Comment Acknowledged Language modified The subsection is requiring the establishment of transfer agreement for pediatric patients needing specialized care if that specialized care is not available at the Comprehensive PedRC.
Section 100450.223 - Level III PedRC Requirements Page 8 Lines 354-355	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing	Suggest change: "All designated PedRCs shall be licensed as a Basic Emergency Department."	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Director Hospital and Health Plan Quality Kaiser Permanente, Northern California		
Section 100450.223 - Level III PedRC Requirements Page 8 Lines 354-355	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest change: "All designated PedRCs shall be licensed as a Basic Emergency Department."	Comment Acknowledged Language modified
Section 100450.223 Page 8 Add line 356 See submitted track changes for clarification	UC Davis PICU group	Add language: <u>"Have full, provisional, or conditional General Community Hospital CCS approval."</u>	Comment Acknowledged Language modified
100450.223 Page: 9 Line: 366	County of San Diego EMS	Suggest adding: Establish transfer agreements-keep the language consistent	Comment Acknowledged Language modified
100450.223 Page: 9 Line: 373	County of San Diego EMS	Suggest changing: Establish transfer agreements-keep the language consistent OR:	Comment Acknowledged Language modified
100450.223 Page: 9 Line: 366	County of San Diego EMS	Suggest: 4) leave out transfer pf ped pts. Use formal agreement for education and consultation.	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100450.224 Page: 9 Line: 398	County of San Diego EMS	Suggest changing: Establish transfer agreements-keep the language consistent OR:	Comment Acknowledged Language modified
100450.224 Page: 9 Line: 398	County of San Diego EMS	Suggest: 4) leave out transfer pf ped pts. Use formal agreement for education and consultation.	Comment Acknowledged Language modified
100450.224 Page: 9 Line: 401	County of San Diego EMS	Suggest changing: Establish transfer agreements-keep the language consistent	Comment Acknowledged Language modified
Section 100450.224 Page 9 Add Line 388 See submitted track changes for clarification	UC Davis PICU group	Add language: <u>"Have full, provisional, or conditional Limited Hospital CCS approval."</u>	Comment Acknowledged Language modified
100450.225 10 (a) 410	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: All PedRC (I-IV) as part of their requirements must meet ALL of the qualifications listed. How is a PedRC IV with limited capabilities for care, consultation, physician coverage going to meet these requirements?	Comment Acknowledged Language modified
ARTICLE 3. PEDIATRIC RECEIVING CENTERS §100450.225. page, 10, line 419 (C), line 440 (B)	CHA	Add PALS to both the physician and nurse PECC personnel requirements in line 414 and line 440.	Comment Acknowledged Language modified PALS and APLS was added to the nurse requirement; however the requirement is not needed for a board certified physician.
100450.225 10 (c) 419	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: No definition for how verified competency in resuscitation of pediatric patients is in the document. PALS? APLS?	Comment Acknowledged Language modified PALS and APLS was added to the nurse requirement; however the requirement is not needed for a board certified physician.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100450.225 10 (g) 430	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Suggested revision: Facilitate pediatric emergency care education for emergency department staff and providers.	Comment Acknowledged Language modified
100450.225 10 (h) 432	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: How? Develop pediatric disaster plan, coordinate pediatric drills?	Comment Acknowledged No change These regulations provide minimum standards that may be expanded by the LEMSA to meet LEMSA need. There are guidelines related to EMSC programs on the EMSA website.
100450.225 10 (b) 440	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: No definition for how verified competency in resuscitation of pediatric patients is in the document. PALS? APLS?	Comment Acknowledged Language modified PALS and APLS was added to the nurse requirement; however the requirement is not needed for a board certified physician.
100450.225 10 (c) 443-444	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Pediatric physician coordinator may not exist. Per definition of PECC (100450.206 page 2) the PECC may be a physician or nurse.	Comment Acknowledged Language modified
100450.225 10 (d) 446-447	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: If PECC is a physician, nursing continuing education and pediatric competency evaluation is not needed? Just general pediatric emergency education to staff (and providers) is all that is needed? Regardless of who the PECC is, the	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		requirements for education and competency validation should be the same.	
100450.225 Page: 10 Lines: 412-458	County of San Diego EMS	Suggestion: The requirements should be the same regardless if the position is held by a physician or a nurse. 100450.206 gives states MD or nurse can hold the position of PECC. Suggest-listing requirements and letting the hospitals figure out who takes the responsibility	Comment Acknowledged Language modified
Section 100450.225 - Pediatric Receiving Center Personnel Requirements Pages 10-12 Lines 410-515 Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Pages 12-13 Lines 519-564	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	These two sections establish identical requirements for the PedRC Level II and the PedRC Level III, thus reducing or eliminating the need to distinguish between these levels— unless EMSA adopts suggestions above to mandate more stringent requirements on the Pediatric Readiness Project score and specialist availability at the PedRC Level II. Specific wording change suggestions follow.	Comment Acknowledged Language modified
Section 100450.225 - Pediatric Receiving Center Personnel Requirements Pages 10-12 Lines 410-515 Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Pages 12-13	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	These two sections establish identical requirements for the PedRC Level II and the PedRC Level III, thus reducing or eliminating the need to distinguish between these levels— unless EMSA adopts suggestions above to mandate more stringent requirements on the Pediatric Readiness Project score and specialist availability at the PedRC Level II. Specific wording change suggestions follow.	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Lines 519-564			
100450.225 Pediatric Receiving Center Personnel Requirements/Pages 10-11/Lines 412-455	San Mateo County EMS	General Comment – If a PECC is required and it can be met by either an MD or RN– why then are their job responsibilities different? If an institution chooses to assign both an MD and RN to share the PECC role then their responsibilities can be divided by disciplines.	Comment Acknowledged Language modified Comprehensive and Advanced PedRCs shall have a physician and nurse PECC and will have the same responsibilities. All General and Basic PedRCs shall have a physician and/or nurse PECC
100450.225 Pediatric Receiving Center Personnel Requirements/Pages 10-11/Lines 410 -	San Mateo County EMS	Suggested rewording (a) All PedRCs shall meet the following minimum personnel requirements – <i>not all PedRCs personnel shall meet the following minimum requirements</i>	Comment Acknowledged Language modified
100450.225 Pediatric Receiving Center Personnel Requirements/Pages 10-11/Lines 412- on	San Mateo County EMS	Suggested rewording (1) A designated Pediatric Emergency Care Coordinator (PECC), who may be a physician <u>or</u> nurse and meets the following requirements: (A) A Physician PECC shall be licensed in California and meet the following minimum requirements: 1. Be a qualified emergency specialist or 2. Be a qualified specialist in Pediatrics or Family Medicine and 3. Shall have verified competency in	Comment Acknowledged Language modified Comprehensive and Advanced PedRCs shall have a physician and nurse PECC and will have the same responsibilities. All General and Basic PedRCs shall have a physician and/or nurse PECC

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>resuscitation of pediatric patients of all ages from neonates to adolescents</p> <p>(B) A Nurse PECC shall be a licensed registered nurse (RN) and meet the following minimum requirements:</p> <ol style="list-style-type: none"> 1. Have 2 years of experience in pediatric or emergency nursing within the previous five years 2. Shall have verified competency in resuscitation of pediatric patients of all ages from neonates to adolescents. 	
<p>100450.225 Pediatric Receiving Center Personnel Requirements/Pages 10/Lines 422-432</p>	<p>San Mateo County EMS</p>	<p>D-H are responsibilities of the PECC and should be listed as a separate subsection. These responsibilities would be applicable to the PECC whether it be a physician or nurse holding the position</p>	<p>Comment Acknowledged Language modified</p>
<p>100450.225 Pediatric Receiving Center Personnel Requirements/Pages Pages 10-11/Lines 443-455</p>	<p>San Mateo County EMS</p>	<p>C-G Eliminate. There should be one section listing responsibilities of the PECC. See comments above. There should be no differentiation of responsibilities of the PECC based on the credentials of the person holding the position. It would be up to institution on how coordination of activities among disciplines would be accomplished. As written (C) and (G) require there to be two PECC, a physician and nurse.</p>	<p>Comment Acknowledged Language modified</p>
<p>100450.225 Pediatric Receiving Center Personnel</p>	<p>San Mateo County EMS</p>	<p>Explain the rationale why there is no mention in (A) of a qualified emergency specialist (100450.214)</p>	<p>Comment Acknowledged Language modified</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Requirements/Page 11/ Physician staffing of ED 460-475		as one category to meet minimum ED physician staffing requirements it is only listed in 100450.221 Level 1 PedRC Requirements/ pg 7 /lines 305-308)	
100450.225 11 (g) 454-455	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Pediatric physician coordinator may not exist. Per definition of PECC (100450.206 page 2) the PECC may be a physician or nurse.	Comment Acknowledged Language modified
100450.225 11 (3) 457-458	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: How is this going to happen in a PedRC IV that <u>MAY</u> include physician coverage 24/7 (100450.213 page 3, line 126)	Comment Acknowledged Language modified
Section 100450.225 Page 11 Add language (line 476) See submitted track changes for clarification	UC Davis PICU group	Add language: <u>(C-1) At minimum, one MD per shift in the emergency department shall have current complete of Pediatric Advanced Life Support, Advanced Pediatric Life Support, or other equivalent pediatric emergency care course, as determined by the local EMS agency."</u>	Comment Acknowledged No change The Emergency Medicine Board argues against additional certifications
100450.225 Pediatric Receiving Center Personnel Requirements/Page 11/Line 482	San Mateo County EMS	Omit the term mid-level practitioners as it is no longer the appropriate term to describe NPA and NP. The terms Advanced practice providers or advanced practitioners are more widely acceptable.	Comment Acknowledged Language modified
§100450.225, page 11- line 482-485	CHA	Suggest clarifying this statement. The assumption is minimum staffing for each PedRC is a NP or PA. Recommend: NP/PAs be used in place of the RN or MD requirement under (3)(B) and (3)(C) or in addition to.	No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100450.225 11 (d) 482 - 485	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Suggested revision: "Mid-level practitioners, including Nurse Practitioners and Physician Assistants, regularly assigned to the emergency department who care for pediatric patients and who are licensed in California shall have a current completion of Pediatric Advanced Life Support or Advanced Pediatric Life Support.	Comment Acknowledged Language modified
100450.225 Page 11/485	County of San Diego EMS	Suggest: Change Mid Level to Advance Level Practitioner. Current language	Comment Acknowledged Language modified
100450.225 Page: 12 Line: 512	County of San Diego EMS	FYI: Respiratory therapists don't receive cards for taking ENPC. It is a nursing course	Comment Acknowledged Language modified
100450.225 12 (c) 509	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: ENPC is not an appropriate course for Respiratory Care Specialists	Comment Acknowledged Language modified
100450.225 Pediatric Receiving Center Personnel Requirements/Page 12/Line 509	San Mateo County EMS	Informational – ENA's ENPC may be taken by non-RNs; however they will receive a course completion certificate but not the 4- year provider verification that is offered to RNs, who successfully complete the program.	Comment Acknowledged Language modified
100450.225	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Would make format/language regarding PALS/APLS consistent in this section (for RNs and mid-levels it is in one paragraph and for RCS options are all under separate headings/lines)	Comment Acknowledged Language modified PALS and APLS was added to the nurse requirement; however the requirement is not needed for a board certified physician.
Section 100450.225 Page 12 Add language (line 498)	UC Davis PICU group	Add language: <u>"Child life services, or formalized pediatric centered care practices, are in place."</u>	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
See submitted track changes for clarification			
100450.226 12	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Would it be prudent to list suggested sizes of equipment to have available?	Comment Acknowledged Items listed state they are for pediatric patients. Equipment list is the minimum required.
<u>Section</u> - § 100450.226. Pediatric Equipment, Supplies and Medication Requirements Page 12 / Line 519-520	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Recommend disaster and surge equipment and reference to Pediatric Readiness Projects and disaster surge supplies resources.	Comment Acknowledged No change
100450.226 12 (3) 528	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Scale that weighs in kilograms only	Comment Acknowledged No change
10450.226 12 (3) 529	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Developmentally appropriate pain scale tool for all ages of pediatric patients.	Comment Acknowledged No change
100450.226 12 (4) 533	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Thermometer with hypothermia capability	Comment Acknowledged No change
100450.226 Page 12, Line 537	Los Angeles County EMS Agency	Remove: 'tracheostomy equipment' Rationale: Rarely if ever used and an endotracheal tube is sufficient. If require, should only be for Level I	Comment Acknowledged Language modified
100450.226 Page 13, Line 541	Los Angeles County EMS Agency	Remove: 'umbilical and' Rationale: Rarely if ever used and a 5-French feeding tube can be substituted. If require, should only be for Level I	Comment Acknowledged Language modified
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Lines 541-542	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California	Suggest delete "and central venous". Focus, as in earlier language, should be on intraosseous and peripheral IV.	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California		
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Lines 541-542	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest delete "and central venous". Focus, as in earlier language, should be on intraosseous and peripheral IV.	Comment Acknowledged Language modified
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Line 544	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Suggest delete "and femur". Many pediatric orthopedists avoid use of premade femur splints, and this section would be improved by avoiding any confusion about this.	Comment Acknowledged Language modified
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD	Suggest delete "and femur". Many pediatric orthopedists avoid use of premade femur splints, and this section would be improved by avoiding any confusion about this.	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Line 544	Regional Chief of Pediatrics Kaiser Permanente, Southern California		
100450.226 Page 13, Line 545	Los Angeles County EMS Agency	Change: ' <u>spinal stabilization motion restriction devices</u> ' Rationale: This is updated wording	Comment Acknowledged. Language modified This is consistent with other Chapters of regulation.
100450.226 13 (8) 547	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Comment: Should common/suggested medications be listed?	Comment Acknowledged No change The minimum requirements for personnel, policy and equipment under sections 100450.220 and 100450.221. As these are minimums, they may be expanded upon as needed at the LEMSA level.
100450.226 13 (9) 549	Pediatric Liaison Nurses/LA County Submitted by Robin Goodman	Suggested revision: (A) Lumbar puncture tray (B) Difficult airway kit with pediatric laryngeal mask airways and other devices (?) to provide assisted ventilations (C) Tube thoracotomy tray with chest tubes in sizes for pediatric patients of all ages (D) Newborn delivery and resuscitation kit with supplies for immediate delivery and resuscitation of the newborn (E) Urinary catheter tray with	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		urinary catheters in sizes for pediatric patients of all ages.	
100450.226 Page 13, Line 551-552	Los Angeles County EMS Agency	Change: This should be 2 separate lines: 1) Lumbar puncture and 2) Difficult airway.	Comment Acknowledged Language modified
100450.226. Pediatric Equipment, Supplies and Medication Requirements P 12 Line 551-552	Deede Vultaggio, RN EMS QI Clinical Educator Alameda County Fire Department	<p>“(A) Lumbar puncture tray including a difficult airway kit with laryngeal mask airways and other devices to provide assisted ventilation”</p> <p>Curious why include difficult airway equipment on an LP tray? Suggest two separate stand-alone trays:</p> <ol style="list-style-type: none"> 1. LP to include appropriate sizes & meds/doses, needles, tubes, etc., and 2. Difficult Airway Tray with appropriate pediatric equipment to include suction catheters, BVM, LMA, direct and video laryngoscopy devices, LBRT pack with color-coded divided sections, etc., see prior entry lines 535 - 538 “Respiratory equipment and supplies appropriate for pediatric patients including, but not limited to, clear oxygen masks, bag-mask devices, intubation equipment, tracheostomy equipment, oral and nasal airways, nasogastric tubes, and suction equipment;” 	Comment Acknowledged Language modified
100450.226	Brandon Stinnett	“Lumbar puncture tray including a	Comment Acknowledged

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Page 13 Line 551		<p>difficult airway kit with laryngeal mask airways and other devices to provide assisted ventilation.”</p> <p>Is this a typo? A lumbar puncture and a difficult airway are not related and to have the equipment for both in the same kit does not make sense. Suggest separating the lines i.e. A lumbar puncture tray including devices of appropriate size for neonate through adolescent.</p> <p>A difficult airway tray to include laryngeal mask airways and other devices to provide assisted ventilation.</p>	Language modified
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Line 551	<p>Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California</p> <p>Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>	Is inclusion of “a difficult airway kit” in item about lumbar puncture an error? Should this be a separate item?	Comment Acknowledged Language modified
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Line 551	<p>Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California</p> <p>Joseph J Colli, MD Regional Chief of Pediatrics</p>	Is inclusion of “a difficult airway kit” in item about lumbar puncture an error? Should this be a separate item?	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Kaiser Permanente, Southern California		
Section 100450.226 Page 13 Line 551 See submitted track changes for clarification	UC Davis PICU group	Split up (9)(A) (A) <u>Lumbar puncture tray</u> (B) <u>A difficult airway kit with laryngeal mask airways and other devices to provide assisted ventilation</u>	Comment Acknowledged Language modified
100450.226 Page 13, Line 552	Los Angeles County EMS Agency	Change: 'kit with laryngeal mask <u>supraglottic</u> airways and other devices...' Rationale: Laryngeal mask airways are being replaced in many centers with i-gel	Comment Acknowledged Language modified
100450.226 Page 13, Line 554	Los Angeles County EMS Agency	Change: 'Tube thoracotomy <u>thoracostomy</u> tray Rationale: This is meant to be a chest tube tray <u>not</u> an open-chest tray	Comment Acknowledged Language modified
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Line 554	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	"thoracotomy" should be "thoracostomy".	Comment Acknowledged Language modified
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California	"thoracotomy" should be "thoracostomy".	Comment Acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Page 13 Line 554	Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California		
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Line 557	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Suggest delete "Newborn" (are others delivered?)	Comment Acknowledged No change.
Section 100450.226 - Pediatric Equipment, Supplies and Medication Requirements Page 13 Line 557	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest delete "Newborn" (are others delivered?)	Comment Acknowledged No change
Section 100450.227 - - Data Management Requirements Page 13 Line 577	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director	Suggest change "compliant" to "consistent"	Comment Acknowledged No change Health and Safety Code section 1797.227 (1) states, "Use an electronic health record system that exports data in a format that is <i>compliant</i> with the

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Hospital and Health Plan Quality Kaiser Permanente, Northern California		current version of CEM SIS and NEM SIS.
Section 100450.227 - - Data Management Requirements Page 13 Line 577	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics Kaiser Permanente, Southern California	Suggest change "compliant" to "consistent"	Comment Acknowledged No change Health and Safety Code section 1797.227 (1) states, "Use an electronic health record system that exports data in a format that is <i>compliant</i> with the current version of CEM SIS and NEM SIS.
100450.226 Page 13, Line 557-58	Los Angeles County EMS Agency	The newborn delivery and resuscitation kit is vague – may want to add more specific language such as the following: "Newborn delivery kit to include but not limited to the following: towel, scissors for cutting the umbilical cord, bulb suction, warming pad, and neonatal bag- mask ventilation device with appropriate sized masks. For Level I or II PedRCs neonatal resuscitation equipment may also include pediatric laryngoscope with Miller 0 and 00 blades, size 2.5 and 3.0 endotracheal tubes, and umbilical vein catheters."	Comment Acknowledged Language modified
ARTICLE 4. DATA MANAGEMENT, QUALITY IMPROVEMENT AND EVALUATION.	CHA	"The EMSC program shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency". Recommend: "as	Comment Acknowledged No change LEMSAs cannot receive different data from each facility.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
§100450.227, page 13 line 573-574		determined by the local EMS agency and agreed upon by the PedRC”	
<u>Section</u> – Article 4, Data Management / <u>Page</u> 13 / <u>Line</u> 568-574	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	The requirement for Quality Improvement – data from EMS and hospitals includes pediatric patient disposition and patient care areas (including cardiac / resp. arrest; child maltreatment; ICU admissions; OR admissions, transfers; and trauma). Non-trauma hospitals may not routinely share data with LEMSAs and therefore the requirement should be phased over 1 to 3 years as MOU's and / or contracts may need to be implemented.	Comment Acknowledged No change There is no timeline or deadline for implementation
Section 100450.227 - - Data Management Requirements Pages 13-14 Lines 583-612	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Since Subsections a, a1, a2, and b above establish the general data requirement to be compliant/ consistent with most current CEMSIS and require hospital participation, details in lines 583-612 are unnecessary and prescriptive and potentially limiting. Suggest delete these lines.	Comment Acknowledged No change This is minimal necessary data, many more fields in CEMSIS
Section 100450.227 - - Data Management Requirements Pages 13-14 Lines 583-612	Todd R Newton, MD Regional Chief Emergency Medicine Kaiser Permanente, Southern California Joseph J Colli, MD Regional Chief of Pediatrics	Since Subsections a, a1, a2, and b above establish the general data requirement to be compliant/ consistent with most current CEMSIS and require hospital participation, details in lines 583-612 are unnecessary and prescriptive and potentially limiting. Suggest delete	Comment Acknowledged No change. This is minimal necessary data, many more fields in CEMSIS

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Kaiser Permanente, Southern California	these lines.	
§100450.227, Line 583-612	CHA	Since subsections a. A1.A2 and b. language above these lines establish the general data requirement to be compliant/consistent with the most current CEMIS and requires hospital participation, details in line 583-612 are unnecessary and prescriptive, and potentially limiting. CHA recommends deleting these lines.	Comment Acknowledged No change. This is minimal necessary data, many more fields in CEMIS
100450.227 Data Management Requirements/Page 13/Line 583 (c)	San Mateo County EMS	Unclear what the phrase <i>Following submission of the EMSC program</i> means regarding PedRC submission of data.	Comment Acknowledged Language modified
<u>Section</u> – Article 4, Data Management / <u>Page</u> 13-15/ <u>Line</u> 614-652	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	<u>Mandatory pediatric data exchange requirements at minimum</u> are needed to meet this regulation. MOUs and / or contracts with hospitals for data collection are needed for all of these requirements. This regulation should be <u>phased in over time</u> (ie. 1-3 years)	Comment Acknowledged There is no timeline or deadline for implementation
100450.227 Page 14, Line 606	Los Angeles County EMS Agency	Clarification: Need to specify if ED disposition or final disposition from facility Rationale: ED disposition evaluates initial stability of patient versus final disposition, which determines longer term disability	Comment Acknowledged Language modified
100450.228 Quality	San Mateo County EMS	Point of Clarification – <i>Each EMSC</i>	Comment Acknowledged

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Improvement and Evaluation Process Page 14		program refers to the PedRCs quality improvement programs? LEMSA's quality improvement programs? or both?	Language modified
100450.228, page 14, line 626-627	CHA	Broaden confidentiality and disclosure language. To beginning of line 626, add "Consistent and compliant with all federal and state laws protecting and governing patient safety, quality, and confidentiality including but not limited to"	Comment Acknowledged No change
100450.228 Page 15, Line 637	Los Angeles County EMS Agency	Change: inpatient pediatric patient care Rationale: These are pediatric regulations; therefore this is redundant.	Comment Acknowledged Language modified
100450.228 Page 15, Line 642	Los Angeles County EMS Agency	Change: Remove (,) comma	Comment Acknowledged Language modified
100450.228 Page 15 Lines 647	Los Angeles County EMS Agency	Please clarify intent. Is this all OR cases or just emergent or returns? Is the expectation that all routine/expected cases be reviewed?	Comment Acknowledged No change The number of expected OR/ICU cases is likely small.

Comments on Proposed Emergency Medical Services for Children (EMSC) Regulations
Chapter 14, Division 9, Title 22, California Code of Regulations

Comments Received During the First 15-Day Public Comment Period
July 25, 2018 through August 9, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Los Angeles County EMS Agency	Ensure consistency across regulations for all definitions, for example - Quality improvement is defined for Stroke and STEMI but not EMSC.	Comment acknowledged Definition added.
	Los Angeles County EMS Agency	Remove all reference/requirement for CCS approval or state "meets CCS criteria as approved by the LEMSA" or add the specific requirements wanted; such as "must have a PICU with a minimum of 8 beds" for Comprehensive PRC Rationale: CCS does not regularly survey facilities, in LA County it has been over 10 years, additionally CCS requirements have not been updated since 1999 and may not reflect current needs/practice	Comment acknowledged Language modified
	Los Angeles County EMS Agency	In the QI section for each of the Ped RCs add: Each PedRC will complete an online or paper assessment of their pediatric readiness of the emergency department and share the results with the LEMSA every three years at a minimum. An action plan will be developed by each PedRC in collaboration with the LEMSA.	Comment accepted Language modified
100450.207 Page 2 Lines 81-82	Los Angeles County EMS Agency	Change: definition of the "Pediatric Intensivist" "Pediatric Intensivist" means a physician who is board-certified or board eligible in pediatric critical care medicine as recognized by the American Board of Medical Specialties, the Royal College of Physicians and Surgeons of Canada or the American Osteopathic Board of Medical Specialties.	Comment acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		Rationale: Should have all definitions of physician qualifications using similar language and appropriately reference certifying boards.	
100450.210 Page 4 Lines 151-156	Los Angeles County EMS Agency	Delete section Rationale: Redundant and confusing. Have a definition for qualified specialist, lines 172-176, and when stated within the regs as "qualified emergency specialist" it would mean they met the requirements in emergency medicine	Comment acknowledged No change
100450.210 Page 4 Line 152	County of San Diego	§ 100450.214210. Qualified Emergency Specialist A Physician who is licensed in California, board certified or board eligible in emergency medicine or pediatric emergency medicine by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties.	Comment acknowledged Language modified
100450.211 Page 4 Line 161	County of San Diego	§ 100450.215211. Qualified Pediatric Specialist A physician who is licensed in California board certified or board eligible in a pediatric specialty 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.	Comment acknowledged Language modified
100450.211 Page 4 Lines 161-166	Los Angeles County EMS Agency	Delete section Rationale: Redundant and confusing. Have a definition for qualified specialist, lines 172-176, and when stated within the regs as "qualified	Comment acknowledged No change

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		pediatric specialist" it would mean they met the requirements in pediatrics	
100450.211 Page 4 Line 171	County of San Diego	<p>§ 100450.216212. Qualified Specialist "Qualified specialist" means a physician licensed in California who is board certified or is board eligible in the corresponding specialty 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.</p> <p>Note: Authority cited: Sections 1797.107 and 1799.204, Health and Safety Code. 178 Reference: Section 1799.204, Health and Safety Code.</p>	Comment acknowledged Language modified
100450.212 Page 4 Lines 172-176	Los Angeles County EMS Agency	<p>Change: definition of Qualified Specialist to: "Qualified Specialist" is physician who is board-certified or board eligible in the specified discipline of medicine as recognized by the American Board of Medical Specialties, the Royal College of Physicians and Surgeons of Canada or the American Osteopathic Board of Medical Specialties."</p> <p>Rationale: The Qualified Specialist should be board certified or eligible in the area of medicine appropriate for their service. For the purposes of these regulations a qualified specialist in emergency medicine is board certified as per the above definition in that specialty. Listing separate qualified specialists with the same definition is redundant. The reference currently listed in the regulations is not correct and is misleading.</p>	Comment acknowledged No change
110450.214 Pages 4-5	Los Angeles County EMS Agency	Unclear what this is relating to. Numbering is confusing and are unable to evaluate these	Comment acknowledged

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Lines 220-238		requirements	No change
100450.214 Page 6 Lines 253-258	Los Angeles County EMS Agency	Delete or move to another section Rationale: These are hospital requirements, not EMS Agency based	Comment acknowledged Language modified
100450.214 Page 6 Lines 272-273	Los Angeles County EMS Agency	Strike entire section Rationale: Operationally this does not occur. LEMSAs have a process for designation of specialty care across county lines and patients are directed to the closest appropriate hospital regardless of which LEMSA they are located in. Coordination of pediatric interfacility transports is done at the hospital level not LEMSA	Comment acknowledged Language deleted
100450.215 Page 7 Line 277	Los Angeles County EMS Agency	Change: “..within 60 <u>30</u> days...” Rationale: This is the standards for all other specialty regulations: Stroke, STEMI.	Comment acknowledged Language modified
100450.216 Page 7 Line 347	Los Angeles County EMS Agency	Change: “Establish transfer agreements and <u>or</u> serve...” Rationale: Not all Comprehensive PedRCs have all services required	Comment acknowledged Language modified
100450.216 Page 8 Line 351	Los Angeles County EMS Agency	Change: “may be required at the discretion of <u>stipulated by</u> the local...” Rationale: This is the wording for both the STEMI and stroke regulations- maintain consistency	Comment acknowledged Language modified
100450.217 Page 9 Lines 371-375		Although this section changes the name of the Pediatric RC from “Level II” to “Advanced”, the change is cosmetic and does not include objective details from nationally accepted and federally supported standards (The Pediatric Readiness	Advanced center requirements have been uncoupled from CCS

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
<p data-bbox="128 201 359 488">Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California</p> <p data-bbox="128 529 359 889">Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>		<p data-bbox="396 126 1558 418">Project) that aim to improve emergency pediatric care. This section designates as “Advanced” any CCS Pediatric Community Hospital, without requiring any significant assets, resources, or commitment to quality beyond that required of the “General” Pediatric RC. To the contrary, these regulations allow the Comprehensive and Advanced PedRC to meet their physician needs with non-board-certified physicians, while requiring board certification at General and Basic PedRCs. Other than requiring the CCS approval of 8 or fewer pediatric inpatient beds, the “Advanced” RC is virtually indistinguishable from the “General” RC.</p> <p data-bbox="396 456 1572 818">If the goal of these regulations is specifically to improve children’s access to quality emergency care, the regulations should make use of nationally accepted standards for quality pediatric ED care, such as the Pediatric Readiness Project score. Since approximately 96% of children brought by EMS to non-tertiary centers are discharged from the ED, the focus of these regulations should be on the quality of ED pediatric care, which is the focus of the PRP. There is no evidence to suggest that non-tertiary hospitals that have small, low-intensity inpatient pediatric units provide superior pediatric care in their EDs. That, in fact, is the reason why regulations focusing on pediatric ED care are needed, and why it is important to set the bar for quality a bit higher.</p> <p data-bbox="396 855 1549 1110">If incorporation of the PRP score directly into regulations is not acceptable, EMSA could import more of the components of the PRP into the regulations for Comprehensive and Advanced RCs. Another alternative would be to refer to PRP “or equivalent standard endorsed by the national EMS for Children Program.” In their current state, by not including significant measures of quality of emergency pediatric care, these regulations miss a prime opportunity to improve the foundations of emergency care for children.</p> <p data-bbox="396 1148 1499 1256">These concerns may also apply, although to a lesser degree, to the Comprehensive PedRC. Although by nature of being tertiary pediatric centers, these are less likely to have significant structural gaps in ED quality.</p> <p data-bbox="396 1294 1482 1369">Since EMSA feels strongly about including linkage to CCS approval, suggest adding the following language to permit 3 routes to Advanced PedRC status:</p> <p data-bbox="396 1406 1461 1474">(1) All designated Advanced PedRCs shall be licensed as a general acute care hospital with a basic or comprehensive Emergency</p>	<p data-bbox="1600 126 1871 201">and detailed in the regulations.</p> <p data-bbox="1600 238 1948 347">PRP has been added to the quality improvement section.</p> <p data-bbox="1600 384 1948 784">EMSC regulations are not only concerned with the emergency department, but also with levels/availability of inpatient beds and cannot refer to vague standards. PRP is the CQI tool and we cannot cite a specific score as criteria for designation.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>Department permit. In addition, the Advanced PedRC shall:</p> <p>(A) be approved by the Department of Health Services as a California Children's Services (SSC) Pediatric Community Hospital, or</p> <p>(B) have achieved a measure of competency of emergency pediatric care based on performance of the Pediatric Readiness Project score (or similar national standard endorsed by the National EMS for Children program for establishing quality Emergency Department pediatric care), at a score and/or specific category performance as defined by the LEMSA and included in the annual EMSC program as reported to EMSA as per Section 100450.214 and 100450.215. Method of determination of the Pediatric Readiness Project score shall be included in the annual LEMSA report or,</p> <p>(C) Have promptly available to the Emergency Department required qualified specialists and high-fidelity video telehealth consultation with pediatric subspecialists</p>	
<p>100450.217 Page 9 Lines 383-385</p>	<p>Los Angeles County EMS Agency</p>	<p>Overlap with lines 391-392- very confusing and unclear</p>	<p>Comment acknowledged Language modified</p>
<p>100450.217 Page 9 Line 402</p>	<p>Los Angeles County EMS Agency</p>	<p>Change: "may be required at the discretion of stipulated by the local..."</p> <p>Rationale: This is the wording for both the STEMI and stroke regulations- maintain consistency</p>	<p>Comment acknowledged Language modified</p>
<p>100450.218 Page 10 Line 445</p>	<p>Los Angeles County EMS Agency</p>	<p>Change: "may be required at the discretion of stipulated by the local..."</p> <p>Rationale: This is the wording for both the STEMI and stroke regulations- maintain consistency</p>	<p>Comment acknowledged Language modified</p>
<p>100450.219 Page 11 Lines 462-463</p>	<p>Los Angeles County EMS Agency</p>	<p>Delete section</p> <p>Rationale: Physician staffing is stated based upon the type of ED licensure the hospital has- basic or standby</p>	<p>Comment acknowledged No change</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100450.119 Page 11 Line 466	Los Angeles County EMS Agency	Change: "...shall have current completion of <u>American Heart Association Pediatric Advanced Life...</u> " Rationale: AHA PALS is the standard and is stated as the requirement on Line 618	Comment acknowledged Language modified
100450.219 Page 11 Line 487-488	Shira Schlesinger Director, EMS & Disaster Preparedness Programs Associate EMS Fellowship Director Harbor-UCLA Medical Center	Regulation needs to be cross-walked with <i>Regs 22: 70651 - Standby EMS, Physician on Call</i> . Specifically, that Reg should add Pediatric specialist to the minimum resource call list in standby EDs. The Peds Regs should reference this requirement, likely best placed after 100450.219, Lines 487-488, to state: "Where the Basic PedRC is a standby Emergency Department, contact information for obtaining consultations with Pediatric specialists shall be maintained in the list of referral services available in the emergency service, as referenced in 22 CCR, 70651."	Comment acknowledged No change Consult agreements already established and LEMSAs may establish a roster/resource requirement based upon local need.
100450.219 Page 11 Line 490	Los Angeles County EMS Agency	Change: " may be required at the discretion of <u>stipulated by the local...</u> " Rationale: This is the wording for both the STEMI and stroke regulations- maintain consistency.	Comment acknowledged Language modified
100450.220 Pages 11-13 Lines 499-567	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality	Based on the hierarchical numbering of this section, all the details regarding the PECC requirements apply only to the General and Basic PedRCs. None of the detail lines 506-567 apply to the Comprehensive or Advanced. There are thus no detailed requirements for the PECC at Comprehensive or Advanced PedRCs. This seems to imply that having inpatient pediatric beds ensures the quality of the PECC without further requirements. Suggest changing the	Comment acknowledged Language modified, requirements reorganized

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Kaiser Permanente, Northern California	numbering of these items to clarify that these are requirements for PECC function at all PedRCs.	
100450.220 Page 13 Line 559	Los Angeles County EMS Agency	Change: "...the local EMS agency, base hospitals , prehospital care providers, and neighboring hospitals" Rationale: Redundant. 'Base hospitals' would be included in 'neighboring hospitals'	Comment acknowledged No change
100450.220 Page 13 Line 577	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Suggest adding the following after line 576: (2) Pediatric subspecialists available promptly to the Emergency Department, either in person or by high-fidelity video telehealth.	Comment acknowledged No change
100450.220 Page 13 Line 577	Los Angeles County EMS Agency	Change: "A non -board-certified physician <u>in other than emergency medicine or pediatrics</u> , may be recognized..." Rationale: All physicians functioning as a qualified specialist should be board certified.	Comment acknowledged Language modified
100450.220 Page 13 Lines 577-588	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director	This section permits a non-board-certified physician to be recognized as a qualified specialist at the Comprehensive or Advanced PedRC, but not at the General or Basic. This permits a lower quality of care at the Comprehensive or Advanced PedRC. Existing lines 572-575 sufficiently require qualified pediatric or emergency specialists and should not	Comment acknowledged Definition and criteria modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Hospital and Health Plan Quality Kaiser Permanente, Northern California	be diluted. Suggest deleting lines 577-588.	
100450.220 Page 13 Line 588	Los Angeles County EMS Agency	Delete See above comments for line 577. Should be board certified and therefore would have completed a residency program.	Comment acknowledged Language modified
100450.220 Page 13 Lines 596-597	Los Angeles County EMS Agency	Change: "Advanced practice providers including Nurse Practitioners and/or Physicians Assistants regularly assigned to the emergency department..." Rationale: Redundant. If wish to keep, should be defined in the definition section.	Comment acknowledged Language modified
100450.220 Page 14 Line 605-609	County of San Diego	Number 1 and 2 should match. Line 605- A qualified pediatric specialist available for in-house consultation or through live interactive telehealth or agreed upon processes outlined within transfer agreements.	Comment accepted Language modified for clarity
100450.222 Page 16 Line 712	Los Angeles County EMS Agency	Change: "The prehospital and hospital-EMSC patient care elements..." Rationale: Hospitals do not collect CEMSIS or NEMSIS data elements. If the requirement is that the LEMSA submit data in CEMSIS format that is not what this is stating.	Comment acknowledged Language modified
100450.222 Page 16 Line 716	Los Angeles County EMS Agency	Change: "All hospitals that receive pediatric patients -PedRC's shall..." Rationale: What is the goal? All hospitals receive pediatric patients. Non-PedRC's would not receive EMS pediatric patients and these would be walk-	Comment acknowledged Language modified

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		in patients over which EMS does not have control.	
100450.222 Page 16 Line 721-733	Shira Schlesinger Director, EMS & Disaster Preparedness Programs Associate EMS Fellowship Director Harbor-UCLA Medical Center	Consider adding to prehospital data points: 1) CAD/GIS data for location of patient contact (to enable injury tracking for epidemiological purposes), and 2) Specialty Center designation (i.e. whether patient met specialty center criteria for Trauma/ALS transport	Comment acknowledged No change These elements are captured in the EPRC record.
100450.222 Page 16 Line 734	Shira Schlesinger Director, EMS & Disaster Preparedness Programs Associate EMS Fellowship Director Harbor-UCLA Medical Center	Should be amended to state that Data relevant to "Basic outcomes for EMS quality improvement activities", in addition to being submitted to the local EMSA from the PedRC, should be made available to the EMS/provider agencies to assist in QI activities. This may assist in the communication between provider agencies and hospitals (who are often limited by compliance officers who resist sharing this information as a possible "HIPAA violation")	Comment acknowledged No change Provider agencies should be included in QI. It is a relationship of the LEMSA and providers.
100450.223 Page 17 Line 758	Los Angeles County EMS Agency	Change: "Each local EMS Agency EMSC program, in collaboration with designated PedRCs, shall..." Rationale: The requirements below are specific for the PedRC not the LEMSA. The LEMSA QI requirements start on Line 792.	Comment acknowledged Language modified

Comments on Proposed Emergency Medical Services for Children (EMSC) Regulations
Chapter 14, Division 9, Title 22, California Code of Regulations

Comments Received during the 30-Day Public Comment Period
September 21, 2018 through October 21, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	Pat Frost, Director Emergency Medical Services Contra Costa Health Services	I am passing the concerns expressed by our Kaiser leadership subject matter expert on the pediatric regulations. I believe Dr. Goldman makes important observations. In addition I am equally concerned that the levels are inconsistent with the pediatric surge annex work being supported by CDPH. We should be working to have compatibility in the recognition's in line with the work done at the Western Region level for pediatric surge planning between the states.	Comment acknowledged. No change. The Pediatric Receiving Center levels found in these regulations are compatible and can be functionally aligned with the levels of the pediatric surge annex work being supported by CDPH.
100450.203 Page 1-2 Lines 42-46	Los Angeles County EMS Agency	Delete entire section Rationale: Redundant as QI is defined under 100450.214, page 4. If want a specific definition for EMS QI Program, cannot utilize the same verbiage/abbreviations (QI and quality improvement) as the QI definition	Comment accepted. This definition has been deleted.
100450.204 Page 2 Lines 44-45	Los Angeles County EMS Agency	Change: "...procedures of the local EMS agency for the transfer of pediatric patients between health care facilities" Rationale: The wording is redundant as the definition is for transfer of patients.	Comment accepted. This change has been applied. (this comment is in reference to lines 54-55, "Interfacility Transfer")
100450.207 Page 2	Los Angeles County EMS Agency	Change: "Pediatric emergency care coordinator"...	Comment accepted.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Line 80		Rationale: Missing initial quotation mark.	This change has been applied.
100450.207 Page 2 Line 80	Los Angeles County EMS Agency	Change: "...means a physician or <u>registered nurse</u> " Rationale: Want to ensure higher level of licensure and not a Licensed Vocational Nurse	
100450.209 Page 3 Line 96	BJ Bartelson, Vice President Nursing and Clinical Services California Hospital Association (CHA)	Pediatric Patient means a person who is less than or equal to 14 years of age. Change to 13 years of age. Title 22, section 70537(d) states that patients beyond the age of 13 shall not be admitted to or cared for in spaces approved for pediatric beds unless approved by the pediatrician in unusual circumstances and the reason documented in the patient's medical record" This discrepancy will cause undue burden on hospitals whose patients are 14 or older and placed in pediatric units.	Comment accepted. This definition has been revised in order to be consistent with section 70537(d) of Chapter 1, Division 5, Title 22 of the California Code of Regulations.
100450.214 Page 4 Lines 142-143	Los Angeles County EMS Agency	Change: "Quality improvement" or "QI" means methods of evaluation that are composed <u>comprised</u> of a structure, process, and outcome evaluations that <u>which</u> focus on improvement efforts to identify root causes of problems..." Rationale: Standardize definition across all regulations- this is the definition for both STEMI and Stroke	Comment acknowledged. The language has been revised to improve clarity.
100450.216 Page 4 Line 168	Los Angeles County EMS Agency	Change: "...implementing a new EMSC program shall have the EMSC component of an EMS plan approved... " Rationale: Extraneous wording and not consistent with other regulations	Comment acknowledged. No change.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100450.216 Page 4 Line 171	Los Angeles County EMS Agency	Change: "The EMSC component of an EMS plan submitted to..." Rationale: Extraneous wording and not consistent with other regulations	Comment acknowledged. No change.
100450.216 Page 4 Line 171-228	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Recommend CA EMSA provides an EMSC Program <u>Approval Template</u> for submission. The reference for the template needs to be included or referenced in the regulations.	Comment acknowledged. No change. Similar suggestion addressed in comment during previous comment period(s).
100450.216 Page 4 Line 186	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	<u>Patient transport destination</u> decisions are not addressed with the association to pediatric receiving hospitals levels. We recommend inclusion of pediatric destination decisions in an MCI or surge event based on PedRC designation	Comment acknowledged. No change. Patient transport destination decisions are at the discretion of the LEMSA Medical Director.
100450.216 Page 5 Line 201	Los Angeles County EMS Agency	Change: "A list of <u>facilities providing</u> pediatric critical care and pediatric trauma services" Rationale: Clarify intent of statement	Comment accepted. This change has been applied.
100450.216 Page 5 Lines 206-207	Los Angeles County EMS Agency	Delete section Rationale: These are hospital specific requirements at the Comprehensive PedRC level not LEMSA based	Comment acknowledged. The language has been revised to improve clarity.
100450.216 Page 6 Line 217-219	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	The local EMS agencies should not be expected to be compliant with these regulation levels and the other components of this proposed regulation for the 2018 EMS System Plan – (Given we were informed of the new methodology for Pediatric Receiving Centers only now, all the	Comment acknowledged. No change. Similar suggestion addressed in comment during previous comment period(s).

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		standards would not be sufficiently met). Consider the regulations should state a <u>phased approach</u> for implementation over <u>1 to 3 years</u> .	
100450.216 Page 5 Line 220	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	<u>Pediatric Receiving Centers</u> - PedRC does not include provision for integration of pediatric disaster, MCI, pediatric triage, and patient tracking requirement. Recommend adding content in this section under pediatric surge planning (13)	Comment acknowledged. No change. These regulations seek to establish minimum standards and are not focused on the basis for disaster planning. Additional requirements may be stipulated at the discretion of the LEMSA.
100450.216 Page 5 Line 220 and Article 1, Definitions Page 2 or 3 Line 110	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Pediatric Surge Planning should be defined with minimum requirements. This is too vague. Consider defining in Article 1. Definitions.	Comment acknowledged. No change.
100450.216 Page 6 Line 235	Los Angeles County EMS Agency	Add: <u>“(g) No health care facility shall advertise in any manner or otherwise hold itself out to be affiliated with an EMSC program or a PedRC unless they have been designated by the local EMS agency, in accordance with this Chapter.”</u> Rationale: Maintain consistency with other regulations and to protect the public from false advertising.	Comment accepted. This language has been added.
100450.217 Page 6 Lines 241-242	Los Angeles County EMS Agency	Change: “...submit an annual update to its EMSC program <u>as part of its annual EMS plan submittal</u> , which shall include, but not	Comment accepted. This language has been revised

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		be limited to <u>at a minimum</u> , <u>all</u> the following information: Rationale: Maintain consistency with other regulations	accordingly.
100450.218 Page 7 Line 298	Los Angeles County EMS Agency	Change: "...the local EMS agency, base hospital , prehospital care..." Rationale: Redundant. Base hospitals would be included in neighboring hospitals.	Comment acknowledged. No change.
100450.218 Page 7 Line 306	Los Angeles County EMS Agency	Change: "Ensure pediatric <u>family</u> centered care..." Rationale: We believe this is the intent of this statement.	Comment accepted. This language has been revised accordingly.
100450.218 Page 7 Line 308	Los Angeles County EMS Agency	Keep one of the following words not both: "... <u>personnel staff</u> ..." Rationale: These words mean the same thing.	Comment accepted. This language has been revised accordingly.
100450.220 Page 10-14 Line 325-639	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Once the levels are confirmed, the pediatric readiness disaster and surge <u>benchmarks need to be required for emergency departments and critical care areas at each PedRC</u> . We recommend each PedRC with NICU, PICU have a minimum critical care expansion benchmark with personnel competency, policy, and equipment requirements	Comment acknowledged. No change. LEMSAs may determine additional requirements to ensure the regulations align with future disaster planning.
100450.218 Page 8 Line 336	Los Angeles County EMS Agency	Change: "A size <u>length</u> -based resuscitation tape..." Rationale: Broselow© and similar resuscitation tapes are referred to as length-based not sized-based.	Comment accepted.
100450.218 Page 9	Los Angeles County EMS Agency	Change: "Difficult airway kit with supraglottic airways and other devices	Comment acknowledged.

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Line 366		to <u>assist intubation</u> or to provide assisted ventilation.” Rationale: Supraglottic airways are already specified in line 351.	The language has been revised to improve clarity.
100450.218 Page 9 Line 376	Los Angeles County EMS Agency	Change: “ <u>Clamps and</u> scissors for...” Rationale: Cannot cut the cord without clamping first	Comment accepted.
100450.219 Page 9 Line 393	Los Angeles County EMS Agency	Change: “ All designated Basic PRCs shall be licensed... ” Rationale: Extraneous wording. This section is specific for Basic PedRCs	Comment acknowledged. No change.
100450.220 Page 10 Line 430	Los Angeles County EMS Agency	Change: “ All designated General PRCs shall be licensed... ” Rationale: Extraneous wording. This section is specific for General PedRCs	Comment acknowledged. No change.
100450.220 Page 10 Line 444	Los Angeles County EMS Agency	Change: “All designated General PedRCs <u>shall have...</u> ” Rationale: These regulations are stating the requirements, as worded it is demonstrating what is present	Comment accepted.
100450.220 Page 10 Line 447	Los Angeles County EMS Agency	Change: “...General PedRCs shall meet <u>have the required Basic PedRC equipment and the following additional...</u> ” Rationale: Nowhere does it state that they have to have the Basic PedRC equipment	Comment acknowledged. No change. General PedRCs shall meet the equipment requirements stated in section 100450.218. There are no specific equipment requirements stated for Basic PedRC.
100450.220 Page 11 Line 458	Los Angeles County EMS Agency	Move to Line 371 as a requirement for all PedRCs. Rationale: All PedRCs should have urinary	Comment accepted. This change has been applied to

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		catheterization kits	all PedRC level requirements.
100450.221/page 11/line 458	Mia Fairbanks, MSN, RN, CEN Bay Area Regional Trauma Coordinating Committee	Since the requirements for the Advanced PedRC ED are spelled out in detail, and since there is no evidence that the ED pediatric quality is linked to an inpatient pediatric unit, suggest delete this line	Comment acknowledged. No change.
100450.221 Page 11 Line 472	Los Angeles County EMS Agency	Change: "All designated Advanced PRCs shall be licensed..." Rationale: Extraneous wording. This section is specific for Advanced PedRCs	Comment acknowledged. No change.
100450.211 Page 11 Line 478	BJ Bartelson, Vice President Nursing and Clinical Services California Hospital Association (CHA)	Due to improved outpatient technology and increased outpatient services, pediatric inpatient units are closing, infrequently used or decreasing bed capacity, Many hospitals are combining pediatrics in mixed medical surgical units. The presence of inpatient pediatric services is not significant to ensuring the requirements of an Advanced PedRC delivering emergency care, particularly if transfer agreements are established with Comprehensive PedRC. A hospital who meets all other requirements for an Advanced PedRC should be designated advanced. Therefore CHA suggests removal of line 478.	Comment acknowledged. No change. Similar suggestion addressed in comment during previous comment period(s).
100450.221 Page 11 Line 478	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director	We suggest deleting the line. The detailed requirements in the regulations for the Advanced PedRC are designed to ensure that the Advanced PedRC is prepared and highly qualified to care for pediatric emergencies. These other details are well-considered and set a high bar. However, line	Comment acknowledged. No change. Similar suggestion addressed in comment during previous comment period(s).

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	Hospital and Health Plan Quality Kaiser Permanente, Northern California	478 adds the requirement that the Advanced PedRC have an inpatient pediatric unit (permitted to be very small, infrequently used, and low acuity) despite the absence of evidence that links better quality pediatric ED care, evaluation, or stabilization, to the presence of such an inpatient pediatric unit. A hospital committed to quality pediatric ED care sufficiently to meet all other requirements should be designated Advanced. The presence of a small inpatient pediatric unit does not improve ED pediatric care, and no community should be deprived of an Advanced PedRC that meets all ED requirements but lacks an inpatient unit.	
100450.221 Page 11 Line 480	Los Angeles County EMS Agency	Change: "pursuant to <u>A</u> article 6,..." Rationale: Formatting issue	Comment accepted. The language has been revised accordingly.
100450.221 Page 11 Line 485-498	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	<p>The advanced PedRC should have two separate types of categories listed below.</p> <p><u>ADVANCED</u> <u>TRAUMA WITH NICU and with or without PICU</u></p> <ul style="list-style-type: none"> • <u>TRAUMA (NO PICU; WITH NICU) PedRC- AND WITH GENERAL PEDIATRIC BEDS OR PEDIATRIC CLINIC</u> (IE. HIGHLAND, ALAMEDA HEALTH SYSTEM; AND EDEN) • The types of NICUs should be defined in the regulations as follows: <ul style="list-style-type: none"> o <u>REGIONAL NICU/NO TRAUMA PEDRC</u> 	<p>Comment acknowledged. No change.</p> <p>Similar suggestion addressed in comment during previous comment period(s).</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>(IE. SUTTER HOSPITALS AND OTHERS).</p> <ul style="list-style-type: none"> o <u>NICU LEVEL II PEDRC</u> (IE.SUTTER HOSPITALS AND OTHERS). o <u>COMMUNITY NICU PEDRC</u> (SUTTER HOSPITALS AND OTHERS). <p><u>NON-TRAUMA WITH NICU (with or without PICU)</u></p> <ul style="list-style-type: none"> • <u>NON TRAUMA (with PICU and NICU) PEDRC</u> (IE. KAISER PERMANENTE OAKLAND). <p>The type of NICUs should be included in this section</p> <ul style="list-style-type: none"> o <u>REGIONAL NICU/NO TRAUMA PEDRC</u> (IE. SUTTER HOSPITALS AND OTHERS). o <u>NICU LEVEL II PEDRC</u> (IE.SUTTER HOSPITALS AND OTHERS). o <u>COMMUNITY NICU PEDRC</u> (SUTTER HOSPITALS AND OTHERS). 	
100450.221 Page 11 Line 500	Los Angeles County EMS Agency	Move to Section 100450.218, All PedRC requirements, and change: “The <u>hospital</u> emergency department in the hospital shall be able to stabilize critically ill or injured infant, children, and adolescents prior to admission to the PICU or transfer to a Comprehensive <u>higher level</u> PedRC facility.” Rationale: All PedRCs should be able to stabilize a pediatric patient for either admission or transfer	Comment acknowledged. This requirement has been added to the Basic and General PedRC level requirements.
100450.221 Pages 12-13 Lines, 539-547 and 569-571	Los Angeles County EMS Agency	Please add a definition for “with pediatric experience”. As it is currently written, it would be extremely difficult to evaluate compliance.	Comment accepted. A new definition has been added accordingly.
100450.221	Los Angeles County EMS	Change: “...Cardiologist shall be on the	Comment accepted.

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Page 13 Line 551	Agency	hospital staff, on-call,... Rationale: Extraneous wording. If keep here, need to add to line 536 for all other specialties on-call.	The language has been revised accordingly.
100450.221 Page 13 Lines 551-555 and Line 572	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	Specialists should be available, especially by telehealth, promptly. We suggest adding a one hour maximum to telehealth availability for all consultants, including pediatric cardiology. We suggest deleting lines 551-552 and modifying line 555 to read "met through a transfer agreement or if by telehealth, within one hour". Also suggest adding "(I) Pediatric Cardiologist" after line 572.	Comment acknowledged. This and the other specialty consultation requirements have been revised.
100450.221 Page 13 Line 574	Los Angeles County EMS Agency	Change: "..., shall include, <u>all General PedRC equipment and</u> but not limited to : Rationale: Nowhere does it state that they have to have the Basic PedRC equipment	Comment accepted. The language has been revised accordingly.
100450.221 Page 13 Lines 580-588	Los Angeles County EMS Agency	Delete Rationale: These are required equipment for the General PedRC and if add statement above, do not need to be re-listed	Comment accepted. The language has been deleted accordingly.
100450.221 and 100450.222	Mia Fairbanks, MSN, RN, CEN Bay Area Regional Trauma Coordinating Committee	EMS for Children regulations should specifically and clearly not be in conflict with current medical center trauma designations and EMS triage policies for Pediatric Trauma patients. There is some question between the Advanced and Comprehensive designations that may possibly lead to confusion in EMS Trauma Triage and Trauma Center designation. A thorough review of both sections is required in the	Comment acknowledged. EMSA has determined that these regulations are not in conflict with the.....

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		context of trauma triage.	
100450.222 Page 14 Line 602	Los Angeles County EMS Agency	Change: " All designated Comprehensive PRCs shall be licensed... " Rationale: Extraneous wording. This section is specific for Comprehensive PedRCs	Comment acknowledged. No change.
100450.222 Page 14 Line 602-612	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Given the proposed regulations identify pediatric receiving centers, then each type of PedRC <u>should reflect pediatric patient transport destination</u> options for pediatric trauma and pediatric critical care. We recommend consideration for the options below: The comprehensive PedRC should have two separate types of categories listed below. <u>COMPREHENSIVE</u> <u>TRAUMA WITH PICU AND NICU - PedRC</u> <ul style="list-style-type: none"> • <u>TRAUMA (WITH PICU AND NICU) PedRC</u> (IE. UCSF BENIOFF CHILDREN'S HOSPITAL OAKLAND) <u>NON-TRAUMA WITH PICU AND NICU - PedRC</u> <ul style="list-style-type: none"> • <u>NON TRAUMA (WITH PICU AND NICU) PedRC;</u> (IE. KAISER PERMANENTE OAKLAND) 	Comment acknowledged. No change. Similar suggestion addressed in comment during previous comment period(s).
100450.222 Page 14 Lines 627-628	Los Angeles County EMS Agency	Change: "...Comprehensive PedRCs shall meet the following additional equipment requirements of <u>Advanced PedRCs</u> :" Rationale: No differences in equipment required. Redundant wording	Comment accepted. The language has been deleted accordingly.
100450.222 Page 14	Los Angeles County EMS Agency	Delete Rationale: These are required equipment for	Comment accepted.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Lines 630-636		the Advanced PedRC and if add statement above, do not need to be re-listed	The language has been deleted accordingly.
100450.223 Page 15 Line 652-653	BJ Bartelson, Vice President Nursing and Clinical Services California Hospital Association (CHA)	"The EMSC program shall include the collection of both prehospital and hospital patient care data, as determined by the local EMS agency, and the EMS-C Pediatric RCs. CHA recommends language that includes the PedRC hospitals.	Comment acknowledged. No change.
100450.223 Page 15 Line 659-660	BJ Bartelson, Vice President Nursing and Clinical Services California Hospital Association (CHA)	CHA recommends broadening hospital disclosure protection by including additional language. All PedRCs shall participate in the local EMS agency data collection process in accordance with local EMS agency policies and procedures, and consistent and compliant with all federal and state laws protecting and governing patient safety, quality and confidentiality.	Comment acknowledged. No change. These regulations do not supersede any existing California statutes or federal laws.
100450.224 Page 16 Line 701	Los Angeles County EMS Agency	Change: " Each local EMS agency EMSC program and all PedRCs... " Rationale: This is written as hospital-level QI requirements. Additionally the EMS Agency is not covered under 1157.7, only the hospital is. The intent of the above statement is met under Lines 737-741.	Comment acknowledged. The language has been revised to improve clarity.
100450.224 Page 16 Line 707-721	Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency	Mandatory pediatric data exchange requirement at minimum are needed to meet this regulation. MOUs with hospitals for data collection are needed for all of these requirements. This regulation should be <u>phased in over time</u> (ie. 2 years)	Comment acknowledged. No change.
100459.224 Page 16	Jay Goldman, MD, FACEP Director of EMS and	Rather than simply requiring the PedRC to submit its NPRP self-assessment, each	Comment acknowledged. No change.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
Lines 714-716	<p>Ambulance Kaiser Permanente Northern California</p> <p>Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California</p>	<p>LEMSA should determine minimum requirements on this tool for each level of PedRC. We suggest modifying this section to “The LEMSA shall determine minimum acceptable performance on the National Pediatric Readiness Project level for each level of PedRC. Each PedRC will complete an online or paper assessment of the National Pediatric Readiness Project self-assessment and share the results with the local EMS agency every three years at minimum.”</p>	<p>The Pediatric Readiness Project can be used to assess performance improvement but does not establish a standard. The regulations identify minimum quality improve requirements and do not prohibit LEMSAs from determining a methodology for establishing performance standards.</p>
100450.224 Page 16 Line 718-731	<p>Cynthia Frankel, EMSC Coordinator, Alameda County EMS Agency</p>	<p>The requirement for Quality Improvement – data from EMS and hospitals includes pediatric patient disposition and patient care areas (including cardiac / resp. arrest; child maltreatment; ICU admissions; OR admissions, transfers; and trauma). Given most non-trauma hospitals are not required to share data MOUs and agreements with LEMSA, the requirement should be phased over 1 to 3 years.</p>	<p>Comment acknowledged. No change.</p>

Comments on Proposed Emergency Medical Services for Children (EMSC) Regulations
Chapter 14, Division 9, Title 22, California Code of Regulations

Comments Received during the Second 15-Day Public Comment Period
October 26, 2018 through November 10, 2018

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
	<p>Rajesh K. Daftary, MD, MPH</p> <p>Assistant Professor Pediatric Emergency Medicine University of California, San Francisco</p> <p>Medical Director Pediatric Emergency Medicine Zuckerberg San Francisco General Hospital</p>	<p>I am writing in support of the proposed addition of Chapter 14 to Division 9, Title 22, of the California Code of Regulations.</p> <p>By enumerating the specific requirements of Pediatric Receiving Centers, Chapter 14's addition is likely to enable standardization of supplies, staffing, and leadership. It's worth remembering though that these requirements are at best minimum standards, and that even general pediatric receiving centers would benefit from more than one nurse or advanced practitioner per shift trained in PALS/APLS/ENPC. I welcome this as a starting point for the standardization of pediatric emergency care in our state.</p>	<p>Comment acknowledged. No change.</p>
<p>General comment</p>	<p>Mary Magocsy, RN, MBA San Francisco EMS Agency</p>	<p>My public comment for the proposed EMS for Children regulations relates to the EMS-C regulations as well as the STEMI, stroke and trauma regulations. All of the proposed new or current regulations tier hospitals into various hierarchical categories based on the abilities to treat children, STEMIs, strokes and trauma. Each specialty category came up with their own independent tiering system with varying criteria on how to classify a hospital. This is difficult to implement from my perspective as local EMS Agency. For example, one of our hospitals is a level one trauma center. It currently receives STEMI, stroke and pediatrics – but not critical medical pediatrics. This means in addition to doing trauma re-verification, I will have to engage the STEMI, stroke and pediatrics specialties to independently verify</p>	<p>Comment acknowledged. No change.</p> <p>These regulations authorize LEMSAs to develop and share site review criteria. Guidelines may be developed upon adoption of the regulations.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		<p>their specialty specific level designation. Again, from a local perspective, this is difficult to implement and maintain especially if one has survey and verify multiple hospitals. Is it possible for the children, STEMI, stroke and trauma professionals who developed the regulations can come together to develop common (more or less) standards for the tiered classifications for hospital capabilities?</p>	
<p>100450.206 Page 2 Line 69</p>	<p>Los Angeles County EMS Agency</p>	<p>Change: "...means a physician or <u>registered</u> nurse" Rationale: Want to ensure higher level of licensure and not a Licensed Vocational Nurse</p>	<p>Comment accepted.</p>
<p>100450.209 Page 3 Line 94</p>	<p>Los Angeles County EMS Agency</p>	<p>Pediatric patient definition should read " less than or equal to 14 years of age"</p>	<p>Comment acknowledged. No change.</p>
<p>100450.211 Page 3 Line 112</p>	<p>Los Angeles County EMS Agency</p>	<p>Not sure where the language "Advisory Board for Osteopathic Specialties, a Canadian Board (vague) – came from "American Osteopathic Association Bureau of Osteopathic Specialists (AOABOS) " is like the ABMS osteopathic boards... Also the Canadian board is called "Royal Board of Physicians and Surgeons of Canada" This should be in all the definitions requiring certification</p>	<p>Comment accepted.</p>
<p>100450.214 Page 4 Lines 141-142</p>	<p>Los Angeles County EMS Agency</p>	<p>Change: "... evaluation that are comprised of a structure, process, and outcome evaluations that <u>which</u> focus on improvement efforts to identify root causes of problems..." Rationale: Standardize definition across all regulations- this is the definition for both STEMI and Stroke</p>	<p>Comment acknowledged. No change.</p>

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
100450.216 Page 4 Line 167	Los Angeles County EMS Agency	Change: "...implementing a new EMSC program shall have the EMSC component of an EMS plan approved..." Rationale: Extraneous wording and not consistent with other regulations	Comment acknowledged. No change.
100450.216 Page 4 Line 169	Los Angeles County EMS Agency	Change: "The EMSC component of an EMS plan submitted to..." Rationale: Extraneous wording and not consistent with other regulations	Comment acknowledged. No change.
100450.218 Page 7 Line 289	Los Angeles County EMS Agency	Change: "... through <u>American Heart Association Pediatric Advanced Life Support</u> or <u>American College of Emergency Physicians sponsored Advanced Pediatric Life Support</u> ." Rationale: Maintain consistency with RCP requirements, lines 326 -330	Comment accepted.
100450.218 Page 7 Line 299	Los Angeles County EMS Agency	Change: "...the local EMS agency, base hospital, prehospital care..." Rationale: Redundant. Base hospitals would be included in neighboring hospitals.	Comment acknowledged. No change.
100450.219 Page 9 Line 395	Los Angeles County EMS Agency	Change: " All designated Basic PRCs shall be licensed... " Rationale: Extraneous wording. This section is specific for Basic PedRCs	Comment acknowledged. No change.
100450.220 Page 10 Line 436	Los Angeles County EMS Agency	Change: " All designated General PRCs shall be licensed... "	Comment acknowledged. No change.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		Rationale: Extraneous wording. This section is specific for General PedRCs	
100450.220 Page 10 Line 457	Los Angeles County EMS Agency	Change: "All designated General PedRCs shall meet <u>have...</u> " Rationale: These regulations are stating the requirements, as worded it is demonstrating what is present	Comment acknowledged. No change.
100450.221 Page 11 Line 480	Los Angeles County EMS Agency	Change: " All designated Advanced PRCs shall be licensed... " Rationale: Extraneous wording. This section is specific for Advanced PedRCs	Comment acknowledged. No change.
Section 100450.221 Page 11 Line 486	Jay Goldman, MD, FACEP Director of EMS and Ambulance Kaiser Permanente Northern California Lynn Parkinson, Managing Director Hospital and Health Plan Quality Kaiser Permanente, Northern California	We suggest deleting this line. Prior comments have established that an ED/ hospital that meet requirements for an Advanced PedRC, with the required Intermediate NICU but without a small inpatient pediatric unit, is prepared to provide high quality emergency care to children. In addition, the requirement for an inpatient unit will decrease the number of Advanced PedRCs and will result in decreased pediatric surge capacity, especially in communities with few hospitals committed to the Advanced PedRC level. Hospital licensure provides flexibility to use up to 5% of inpatient beds, in times of unusual need, for children in hospitals without inpatient pediatric units. This flex creates, during times of surge, more pediatric beds than the Advanced PedRC operates. Requiring a dedicated inpatient pediatric unit would result in fewer communities having the option of admitting children to Advanced PedRCs during times of surge or flex. The unintended	Comment acknowledged. No change.

Section/Page/Line	Commenter's Name	Comments/ Suggested Revisions	Response
		consequences of this requirement could thus be worsened access, lower levels of preparedness, and diminished surge capacity.	
100450.221 Page14 Line 600	Los Angeles County EMS Agency	Typo – “available on all units including but not limited to...”	Comment accepted.
100450.222 Page 14 Line 616	Los Angeles County EMS Agency	Change: “ All designated Comprehensive PRCs shall be licensed... ” Rationale: Extraneous wording. This section is specific for Comprehensive PedRCs	Commment acknowledged. No change.

EMERGENCY MEDICAL SERVICES AUTHORITY

10901 GOLD CENTER DR., SUITE 400
RANCHO CORDOVA, CA 95670
(916) 322-4336 FAX (916) 324-2875



DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Leslie Witten-Rood
HIE Manager in EMS Program Manager

SUBJECT: Health Information Exchange and EMS

RECOMMENDED ACTION:

Receive information regarding Health Information Technology for EMS (HITEMS) Project to Achieve Interoperability for Meaningful Use.

FISCAL IMPACT:

On July 2, 2018, The Centers for Medicare and Medicaid Services (CMS) approved the State's Health Information Technology Implementation Advanced Planning Document (HIT IAPD-U), which includes \$36 million of federal funding for the HITEMS project. CMS funding is provided at 90% Federal Financial Participation and requires a 10% non-Federal Match. On August 1, 2018, EMSA received a grant award from the CARESTAR Foundation for \$1 million of the required 10 % match for the HITEMS Project. EMSA continues to seek the additional \$3 million match required that will enable EMSA to access the full \$36 million federal award. The funding will conclude on September 30, 2021.

DISCUSSION:

The Department of Health Care Services (DHCS) partnered with Emergency Medical Services Authority (EMSA) and included the Health Information Technology Project for EMS (HITEMS) in a federal funding request submitted as part of their Advance Planning (HIT IAPD-U) document to the CMS.

As a result of the availability of this funding, EMSA will enter into an Interagency Agreement with The Department of Health Care Services (DHCS) to receive the \$36 million CMS funding. Additionally, EMSA will enter into a grant award agreement with the CARESTAR Foundation for \$1 million. Through the State Budget Process, EMSA has requested from the Department of Finance an increased expenditure authority for

\$10 million through September 30, 2021, to implement Health Information Technology for Emergency Medical Services (HITEMS) using Federal funds from the CMS and matching funds from the CARESTAR Foundation.

The HITEMS funding will allow EMSA to establish connections for HIE between EMS providers (ground and air) and hospitals throughout California. The electronic movement of patient information will result in improved transitions of care from the prehospital to the hospital setting. Information will support better clinical care and the opportunity to obtain outcome measurements for EMS, trauma and disaster response. It is anticipated that each county that implements the + EMS project will continue to maintain the HIE connection established under the HITEMS Project. In October of 2018, EMSA released a draft HIE for EMS Grant Funding Opportunity (GFO) for +EMS Local Assistance Grants. Pending CMS final approval of the GFO, the first round of funding will be available late January of 2019.

The CMS funding award provides for implementation of four use cases:

1. +EMS allows hospitals and eligible professionals to achieve meaningful use objectives, such as transitions of care from the ground and air EMS providers, alerting of trauma, stroke and heart attack teams, and medication reconciliation. In particular, EMS would include health information technology to support Search, Alert, File, and Reconcile (SAFR) functionality for EMS providers.
2. Allow Community Paramedics to receive electronic information about patients that they are treating in a non-emergency situation. Community Paramedic programs are designed to reduce hospital readmissions, assist frequent users of the emergency and trauma system who have social service needs, such as mental health, alcohol or substance abuse, or to transport patients to alternative destinations.
3. Implementation of a specialized registry for end-of-life orders and decisions through the Physician's Order for Life-Sustaining Treatment registry or POLST eRegistry. Building upon the work of the California Health Care Foundation to establish a statewide POLST eREGISTRY following the parameters of SB19, additional onboarding of EMS agencies or providers could be achieved.
4. Design and implement the Patient Unified Look-up System for Emergencies (PULSE) for use by healthcare professionals during a disaster while treating patients in alternate care.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Craig Johnson
Chief, Disaster Medical Services Division

SUBJECT: After-Action Issues from Recent Responses

RECOMMENDED ACTION:

Receive information regarding the After-Action Issues from Recent Responses.

FISCAL IMPACT:

None

DISCUSSION:

Over the past two years there have been numerous State level responses to disasters, including the 2017 and 2018 wildfires. There were many lessons learned that present opportunities for improvement. Following are the key After-Action issues that DMS is addressing in collaboration with stakeholders.

Medical needs in General Population Shelters:

Many general population shelters were activated to support the overwhelming number of evacuees, including victims with medical needs. During the 2017 North Bay Wildfires, 73 shelters were established with a peak population of over 5,300 evacuees. The primary concerns with supporting the shelters were assessing the medical needs of evacuees and ensuring appropriate care was provided. The main after-action discussion points are as follows:

- Need for Emergency Support Function (ESF) 6 and 8 collaboration at all levels to improve planning, resource requesting, and expectations
- Care and management of patients in a “mixed needs” shelter
- Assessment of the clinical capabilities and competencies needed for shelters

- Plans should include establishing Command, Control, and Communications for shelter operations
- Changing roles of American Red Cross shelters and how best to utilize and support their operations
- Difficulties with supporting many small shelters supports consideration of regional mega shelters and
- and/or dedicated medical shelters

To assist with resolving the issues around supporting medical needs in general population shelters, EMSA is engaging with appropriate state partners to enhance ESF 6 & 8 collaboration. EMSA is also participating in the Bay Area Urban Area Security Initiative (UASI) Medical and Health Workgroup Shelter Subcommittee to develop tools to support local shelter operations and planning. The workgroup recently planned and executed a multicounty full-scale shelter exercise as part of the 2018 Yellow Command event. One of the primary exercise objectives was to train and test supporting medical needs in shelters. In addition, EMSA has met and will continue to meet with regional Red Cross representatives to define medical capabilities in their shelters and improve their understanding of the CA Medical and Health System. Finally, CDPH has contracted services to develop a Fire Response Guide for Health Officials which will include tools for Managing Medical Needs in General Population Shelters.

Behavioral Health Support During Disasters:

The 2017-18 wildfires response tested the Medical Health system assessment of the need for Behavioral Health professionals and the ability to acquire the resources. Our understanding of Behavioral Health needs has increased, and better systems need to be in place to ensure timely support during emergencies and disasters. The key improvement actions identified during after-action discussions are as follows:

- Develop Behavioral Health resource typing to improve resource requesting process
- Elevate Behavioral Health education and communication to increase awareness
- Increase Behavioral Health provider enrollment in the DHV system
- Encourage Behavioral Health participation in disaster response planning activities at all levels

To support the need to incorporate Behavioral Health in disaster response, EMSA and CDPH, in collaboration with stakeholders, has revised the Public Health and Medical Emergency Operations Manual (EOM) to include a chapter on Disaster Behavioral Health. In addition, the EOM workgroup, along with Behavioral Health professionals, is developing resource typing. EMSA has also increased Behavioral Health volunteer enrollment in DHV and continues to market the importance of the system.

Coordination of State Missions (State Facilities):

During the 2017 North Bay Wildfires event it became apparent that the medical and health response coordination between local, regional, and state levels needed improvement. Coordination between local and state officials for patient evacuations and appropriate use of resources were identified as key shortcomings. The proposed improvement strategy includes the following:

- State has overall responsibility but works with the local and regional medical/health system personnel for coordination
- State facilities should be integrated with the local response and planning efforts
- Resource needs are met in accordance with system procedures when possible
- Communication and coordination at all response levels is critical

There are numerous other identified improvement opportunities that DMS, along with appropriate partners, will address at a future date.

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Sean Trask, Chief
EMS Personnel Division

SUBJECT: Open Nominations for Election of Officers (March 2019 – March 2020)

RECOMMENDED ACTION:

Open nominations for Commission Officers for 2019 - 2020.

FISCAL IMPACT:

No fiscal impact.

DISCUSSION:

Nominations for Commission Officers are opened at the last Commission meeting of the year, and the election is held at the first meeting of the following year.

Per the Commission on EMS By-Laws, all Commission Officers are eligible for re-election except the immediate past chair who is automatically a member of the Administrative Committee.

Current Commission Officers:

Chair	Eric Rudnick, MD
Vice Chair	Mark Hartwig
Administrative Committee	Dan Burch (Past Chair)
	Lewis Stone
	Richard Johnson, MD

EMERGENCY MEDICAL SERVICES AUTHORITY

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DATE: December 5, 2018

TO: Commission on EMS

FROM: Howard Backer, MD, MPH, FACEP, FAEMS
Director

PREPARED BY: Sean Trask/Sandi Baker
EMS Personnel Division

SUBJECT: Approval of 2020 Meeting Dates

RECOMMENDED ACTION:

Review the approved meeting dates for Calendar Year 2019 and approve the proposed meeting dates for Calendar Year 2020.

FISCAL IMPACT:

The estimated cost of four meetings per year is approximately \$58,000 for a total of approximately \$116,000 for two years.

DISCUSSION:

At the December 6, 2006 Commission on EMS Meeting, the Commission approved scheduling the meetings two years in advance.

The following meeting dates and locations were approved on December 6, 2017 for calendar year 2019:

Calendar Year 2019:

March 20, 2019 in Garden Grove
June 19, 2019 in Sacramento
September 18, 2019 in San Diego
December 4, 2019 in San Francisco

The proposed meeting dates and locations for Calendar Year 2020 are:

Calendar Year 2020:

March 18, 2020 in Garden Grove
June 17, 2020 in Sacramento
September 16, 2020 in San Diego
December 9, 2020 in San Francisco