TITLE 22. SOCIAL SECURITY

DIVISION 9. PREHOSPITAL EMERGENCY MEDICAL SERVICES

EMERGENCY MEDICAL SERVICES AUTHORITY

NOTICE OF MODIFICATION TO TEXT OF PROPOSED ACTION

NOTICE IS HEREBY GIVEN that pursuant to the requirements of Government Code section 11346.8(c) and section 44 of title 1of the California Code of Regulations, the Emergency Medical Services Authority (EMSA) hereby provides a notice of modifications to additional regulatory text.

On February 14, 2025, the Notice of Proposed Action (NOPA) was mailed in compliance with the requirements of Government Code Section 11346.4. The NOPA stated that the changes proposed in the rulemaking action would update critical and specialty care programs. These regulations have not been updated in more than seven years, during which time significant advancements in clinical practices, hospital operations, and prehospital care have transformed the field of critical and specialty care. As a result, the current regulations no longer fully reflect the latest standards, creating potential gaps in care quality, operational inefficiencies, and inconsistencies across the state. To address these challenges and ensure California's specialty care system remains aligned with current evidence-based practices, an update to the chapter is necessary.

Authority and Reference: The Health and Safety Code Section 1797.107 authorizes EMSA to adopt the proposed regulations, which would implement, interpret, clarify, or make specific Section 1797.112 of the Health and Safety Code.

In consideration of the questions and comments received during the **initial 45-day comment period (2/14/25-4/3/25) and second comment period (7/3/25-8/17/25),** significant edits were made to the language of the text as well as the order and overall design of the proposed regulations.

These edits to the proposed regulation text are reflected within the regulation text document in red text with underline and strikethrough. The APA requires that each iteration has a different indicator. Below are the descriptions to each change for a specific section number:

§ 100135.01 – Purpose

Change:
New section added to clearly define the overall purpose of Chapter 6 as establishing minimum statewide standards for the development, implementation, and evaluation of all critical and specialty care systems (trauma, STEMI, stroke, and EMSC).
Necessity:
This section is necessary to articulate the intent and scope of the chapter at the outset and to provide clarity to regulated entities and the public as to why the chapter exists.
Previously, purpose statements were embedded within program-specific trauma language and did not reference other specialty care systems. By consolidating and broadening this section, EMSA ensures consistent statewide interpretation that the chapter applies to all specialty care programs authorized under Division 2.5 of the Health and Safety Code.
This change also aligns with the state's broader EMS modernization efforts and clarifies that these programs form a cohesive component of California's EMS system, ensuring coordinated patient care from prehospital response through definitive hospital treatment.

§ 100135.02 – Scope/Application of Chapter

Change:
New section added to explicitly identify the entities and systems governed by the chapter, including EMSA, local EMS agencies (LEMSAs), and participating hospitals, EMS providers, and dispatch centers.
Necessity:
This section is necessary to comply with the Office of Administrative Law's (OAL) clarity and necessity standards by specifying to whom and to what the regulations apply.
Prior trauma regulations implicitly applied to certain entities but did not explicitly define the chapter's reach or its applicability to programs beyond trauma. The addition of this section eliminates ambiguity about the chapter's applicability and provides LEMSAs and system participants with clear guidance on their responsibilities in establishing and maintaining critical and specialty care systems.
This section also ensures consistency in implementation and evaluation across programs and prevents piecemeal or inconsistent interpretation at the local level.

§ 100135.03 – Severability

Change:
New section added to state that if any provision or application of this chapter is held invalid, the remaining provisions shall continue in effect.
Necessity:
This section is necessary to preserve the validity of the remainder of the chapter in the event that a court or administrative body invalidates any specific provision.

Including a severability clause is a standard administrative law practice and ensures that implementation of other sections can continue uninterrupted. Because Chapter 6 contains multiple interrelated subchapters (trauma, STEMI, stroke, and EMSC), this clause prevents the entire chapter from being rendered inoperative due to a single invalid provision.

§ 100135.04 – Effective Date

Change:

New section added to specify that the chapter becomes effective on January 1, 2026, following filing with the Secretary of State.

Necessity:

This section is necessary to establish a clear and uniform statewide effective date for implementation of the revised chapter.

The previous trauma regulations did not include a defined effective date, resulting in variable interpretations by local EMS agencies as to when new or revised requirements became enforceable. Establishing a single effective date provides clarity for planning, system updates, and compliance alignment among EMSA, LEMSAs, hospitals, and EMS providers.

The reference to the Government Code ensures consistency with state rulemaking timelines and statutory filing requirements.

§ 100135.05 – Relationship to Other Regulations

Change:

New section added to clarify that this chapter does not supersede or conflict with the California Department of Public Health's (CDPH) authority to license and regulate health facilities, and that it complements EMSA's statutory and regulatory authority under Division 2.5 of the Health and Safety Code.

Necessity:

This section is necessary to prevent regulatory overlap and confusion between EMSA's authority over emergency medical services systems and CDPH's authority over hospital licensure and facility operations.

The addition of this provision ensures that specialty care system standards are understood as programmatic and operational requirements within the EMS system, rather than facility licensing mandates.

It also reinforces the requirement for LEMSAs to incorporate specialty care system components into their local EMS plans for EMSA review and approval, promoting alignment between local implementation and state oversight.

Including this clarifying language fulfills the OAL requirement for clarity and ensures inter-agency regulatory consistency.

§ 100135.06 – Authority & Reference

Change:

New section added to provide a consolidated statement of statutory authority and reference for Chapter 6, citing Health and Safety Code Division 2.5.

Necessity:

This section is necessary to meet the administrative law requirement that every regulatory chapter include a clear identification of the statutes that authorize its

adoption and that the regulations implement, interpret, or make specific. Previously, authority and reference citations appeared piecemeal at the end of trauma-specific articles, resulting in inconsistent or incomplete references across subchapters. Consolidating this information at the chapter level enhances readability, eliminates redundancy, and ensures that all subsequent subchapters within Chapter 6 are properly tied to their enabling statutory authority.

§ 100135.07. Advertising Restrictions

Change:

This section prohibits any health care facility or prehospital care provider from advertising or representing itself as being designated or affiliated with a trauma care system, ST-elevation myocardial infarction (STEMI) critical care system, stroke critical care system, pediatric receiving center, or Emergency Medical Services for Children (EMSC) program unless it has been formally designated by the local emergency medical services agency (LEMSA) in accordance with applicable laws and this chapter.

It establishes consistent statewide restrictions to prevent public misrepresentation of designation status, thereby ensuring that patients and EMS providers receive accurate information regarding facility capabilities and system affiliations.

Necessity:

This section is necessary to protect the public from false or misleading claims regarding a facility's or provider's level of care or system designation within the emergency medical services (EMS) system.

Without clear advertising restrictions, facilities could imply official trauma, STEMI, stroke, or pediatric designations without meeting the state's minimum standards, potentially leading patients and EMS personnel to make treatment and transport decisions based on inaccurate information.

Such misrepresentation can delay access to appropriate specialty care, compromise patient outcomes, and undermine public trust in the regulated EMS system.

By requiring that only facilities formally designated by a LEMSA in accordance with approved EMS system plans may advertise or represent themselves as designated centers, this regulation ensures transparency, accountability, and consistency across all jurisdictions.

The inclusion of both hospital-based and prehospital care providers aligns with the integrated systems approach established under Division 2.5 of the Health and Safety Code, recognizing that accurate system representation is essential at every level of patient care—from field response through definitive treatment.

Additionally, this section aligns with Section 1798.165 of the Health and Safety Code, which authorizes EMSA and LEMSAs to regulate designations and prohibit unauthorized claims of specialty system affiliation.

Overall, this regulation maintains the integrity of California's EMS specialty care systems and ensures the public can rely on advertised designations as accurate indicators of verified capability and compliance with state and local standards.

Article 2 — Chapter-Level Definitions

Reflecting revisions and renumbering resulting from the addition of new Article 1 and alignment of terminology across critical and specialty care programs.

§ 100136.01 – Advanced Practice Practitioner

Change:
Added for consistency with terminology used across trauma, stroke, and STEMI systems; replaces older references to "mid-level practitioner" and "advanced practice nurse."
Necessity:
Necessary to align professional terminology with current clinical usage and licensure categories recognized by the Medical Board of California and the Board of Registered Nursing. Updating this term ensures consistency across all specialty care programs and removes outdated language, supporting clear understanding by hospitals and LEMSAs of which practitioners meet qualification requirements for specialty care roles.

§ 100136.02 – Board-Certified (formerly § 100135.01)

Change:
Relocated and revised for clarity; now explicitly references ABMS and AOA pathways and removes inconsistent punctuation.
Necessity:
Necessary to ensure that credentialing standards for physicians are clearly defined and align with recognized national medical certification organizations. Clarifying this definition provides consistency across multiple program-specific sections that reference board-certified specialists.

§ 100136.03 – Board-Eligible (formerly § 100135.02)

Change:
Updated to specify that a physician must have applied and been approved to take the specialty board exam; old text was less specific.
Necessity:
Necessary to ensure consistent interpretation of "board-eligible" across all specialty care programs and to prevent misuse of the term. The revision clarifies that board eligibility requires active application and approval by the specialty board, supporting quality assurance and system integrity.

§ 100136.04 — California Emergency Medical Services Information System (CEMSIS) (former § 100161.01)

Change:
Relocated from the EMSC definitions to Chapter-level Article 2 and standardized wording (no substantive change).
Necessity:
This section is necessary to centralize the definition of CEMSIS so it applies uniformly across all specialty care systems (trauma, STEMI, stroke, EMSC). CEMSIS is the statewide, secure data repository administered by EMSA and is referenced

throughout the specialty program data provisions; moving the definition to Article 2 eliminates duplication and ensures consistent interpretation for all programs. It also aligns the chapter's definitions with the data management requirements that already direct LEMSAs and hospitals to submit prehospital and hospital data compliant with CEMSIS/NEMSIS standards, supporting statewide performance measurement and QI.

§ 100136.05 – Clinical Staff (formerly § 100135.03)

Change:

Consolidated definition now applies across programs, expanding beyond STEMI to "critical or specialty care" patients.

Necessity:

Necessary to standardize the description of clinical personnel involved in specialty care programs and to reflect interdisciplinary team composition. The revision broadens applicability and ensures that terminology remains consistent whether referenced in trauma, stroke, or STEMI system sections.

§ 100136.06 – Critical or Specialty Care Interfacility Transfer (formerly § 100136.04)

Change:

Minor text clarification—updated from "medical acute general care facility" to "general acute care facility" and simplified phrasing for clarity.

Necessity:

Necessary to ensure consistency with statutory terminology and to simplify interpretation for regulated entities. The revision maintains substantive intent but modernizes phrasing for clarity and consistency across system plans.

§ 100136.07 — Emergency Medical Services (EMS)

Change:

Standardized definition that incorporates the statutory meaning of "emergency medical services" by reference to Health and Safety Code § 1797.72; no substantive change in meaning.

Necessity:

This section is necessary to ensure that all uses of "EMS" within Chapter 6 align with the Legislature's definition in Health and Safety Code § 1797.72. Placing the definition in Chapter-level definitions promotes consistency across trauma, STEMI, stroke, and EMSC provisions, prevents conflicting local interpretations, and satisfies OAL clarity expectations by tying the regulatory term directly to its controlling statute.

§ 100136.08 – First Medical Contact (formerly § 100135.05)

Change:

No substantive change in definition; relocated and renumbered to maintain continuity within the chapter's general definitions.

Necessity:

Necessary to preserve the definition of "first medical contact," a key data element used for time-sensitive performance metrics (e.g., STEMI and stroke).

Relocation supports structural consistency following reorganization of the chapter.

§ 100136.09 – Implementation (formerly § 100135.06)

Change:

Definition clarified to specify that "implementation" includes the activation of a specialty care plan and associated operational components.

Necessity:

Necessary to define the term consistently across program types and eliminate ambiguity regarding when a plan is considered operational. Clarification supports EMSA's monitoring and oversight functions.

§ 100136.10 — National Emergency Medical Services Information System (NEMSIS)

Change:

Definition added back with standardized wording. Clarifies that NEMSIS is the national data standard and repository for EMS patient care information.

Necessity:

This section is necessary to align California's specialty-care data requirements with the nationally recognized NEMSIS standard used by EMS agencies across the United States. Defining NEMSIS at the chapter level ensures interoperability with CEMSIS, supports consistent data elements and formats for reporting and analysis, and enables valid benchmarking, research, and quality improvement across trauma, STEMI, stroke, and EMSC programs. Centralizing this definition eliminates duplication across subchapters and provides clear direction to LEMSAs, providers, and hospitals regarding the data standards that underpin statewide performance measurement.

§ 100136.11. Organized Medical Staff

Change:

This section defines the composition and core responsibilities of an organized medical staff within a general acute care hospital participating in the emergency medical services (EMS) system.

It clarifies that the organized medical staff primarily consists of independent practicing physicians—those who are not hospital employees but hold privileges to practice at the facility—and establishes their essential role in promoting patient safety and quality of care within the hospital environment.

Necessity:

This section is necessary to ensure that hospitals participating in EMS specialty care systems maintain a clearly defined and functional organized medical staff structure that supports the delivery of high-quality, safe, and consistent patient care.

By articulating that the organized medical staff consists primarily of independent physicians with practice privileges, this regulation aligns with the statutory framework under the Health and Safety Code and with the hospital licensing requirements established by the California Department of Public Health (CDPH) under Title 22.

The clarification helps ensure that the individuals with the authority and clinical expertise to influence patient outcomes are appropriately identified and empowered to carry out critical oversight functions—such as credentialing, peer review, and quality improvement—within the hospital.
Designating promotion of patient safety and quality of care as the core responsibilities of the organized medical staff ensures alignment with national accreditation standards and the Centers for Medicare and Medicaid Services (CMS) Conditions of Participation, both of which require active physician involvement in hospital governance and quality oversight.
This section therefore provides regulatory consistency across California's trauma, STEMI, and stroke systems of care and establishes a uniform expectation that all designated hospitals, regardless of specialty, operate under a medical staff framework that fosters accountability, clinical excellence, and continuous improvement in patient care outcomes.

§ 100136.12– Patient Care (formerly § 100135.07)

Change:
No substantive text change; relocated for organizational consistency.
Necessity:
Necessary to maintain a unified understanding of patient care continuum from first medical contact through transfer of care. The relocation ensures definitions are logically grouped and accessible to all system types.

§ 100136.13 – Qualified Emergency Specialist (formerly § 100135.08)

Change:
Minor language clarifications—streamlined references to ABMS and AOA, removed redundant phrasing.
Necessity:
Necessary to modernize and standardize terminology related to physician qualifications and to ensure alignment with current medical certification organizations.

§ 100136.14 – Qualified Specialist

Change:
Substantive edits retained flexibility for non-board-certified physicians under trauma plan justification, with slight reorganization for clarity.
Necessity:
Necessary to preserve trauma-system flexibility while improving clarity and ensuring consistent interpretation across all specialty care programs. The updated definition explicitly identifies acceptable certification pathways and requirements for documentation of need.

§ 100136.15 – Quality Improvement (formerly § 100135.10)

Change:
Minor modernization of text to emphasize system-level changes and continuous reassessment.
Necessity:

Necessary to align with current EMS quality improvement frameworks, emphasizing continuous process improvement rather than isolated case reviews. Supports statewide QI data alignment through CEMSIS and NEMSIS.

§ 100136.16 – Telehealth (formerly § 100135.11)

Change:

Carried forward from prior stroke regulations; no substantive edit, but included at chapter level for consistency across all specialty programs.

Necessity:

Necessary to integrate telehealth as a defined term applicable across trauma, stroke, and STEMI systems. This inclusion reflects current clinical practice and supports regulatory consistency with California's telehealth statute (Business and Professions Code §2290.5).

Subchapter 1 – Trauma Care Systems

Article 1 – General Provisions

§ 100137.01 – Purpose and Authority

Change:

New section added to clearly define the purpose of the Trauma Care Systems Subchapter.

Necessity:

This section is necessary to establish the overall intent of the trauma regulations within the broader statewide EMS system. It defines the goal of creating minimum standards for the development, implementation, designation, and evaluation of trauma systems while ensuring coordinated patient care across the full continuum—from prehospital response through rehabilitation.

The previous trauma regulations lacked a clear purpose statement tying the program to its statutory authority under Health and Safety Code § 1798.150 and 1798.160. Adding this section clarifies that the subchapter provides a uniform framework for all LEMSAs while still allowing flexibility for local adaptation to regional needs and resources.

Subchapter 1 – Trauma Care Systems

Article 2 – Trauma Care Systems Definitions

§ 100138.01 – Abbreviated Injury Scale (formerly § 100136.01)

Change:

Renumbered and revised. The previous section referenced the Abbreviated Injury Scale (AIS) but did not specify version or use context. The new section identifies AIS as an anatomic severity scoring system, specifies AIS 15 as the current standard, and distinguishes between its use for data sharing versus performance auditing.

Necessity:

This change is necessary to modernize the regulatory reference to the most current AIS version (AIS 15), which is required by both ACS and NEMSIS national data standards. Clarifying use cases ensures consistency between trauma

registry submissions and system-performance audits. It also prevents discrepancies across LEMSAs using different AIS editions.

§ 100138.02 – Prehospital Trauma Triage Criteria (formerly § 100136.02)

Change:

Renumbered and editorially revised. The phrase "measure or method of assessing the severity of a person's injuries" replaces older terminology. Adds explicit reference to anatomic, physiologic, and mechanism-of-injury factors.

Necessity:

This change clarifies that triage criteria incorporate three evidence-based components consistent with CDC/NHTSA Field Triage Guidelines (2021). Aligning the regulatory language with the federal standard reduces confusion among LEMSAs and ensures statewide consistency in prehospital destination decisions.

§ 100138.03 – Re-Triage (formerly §100136.05)

Change:

Renumbered and revised. Expands description to specify "immediate evaluation, resuscitation, and transport" and clarifies the transfer occurs "direct emergency department to emergency department."

Necessity:

This update reflects modern trauma-system practice emphasizing timely secondary transfer and continuity of emergency care. The clarification eliminates ambiguity with inpatient transfers and conforms to the ACS 2022 verification standard for interfacility transfer.

§ 100138.04 – Service Area (formerly §100135.06)

Change:

Renumbered and slightly reworded for clarity ("defined by the local EMS agency in its trauma care system plan").

Necessity:

The definition is retained with minor modernization. Explicitly linking the service area to the approved trauma plan promotes transparency in trauma-system planning and alignment with local EMS plans submitted under Health and Safety Code §1797.254.

§ 100138.05 – Trauma Care System (formerly § 100136.07)

Change:

Renumbered and simplified to a single clear sentence: "An arrangement under which trauma patients are transported to, and treated by, the appropriate trauma facility."

Necessity:

This revision eliminates redundant phrasing from the prior section while maintaining statutory alignment with §1798.150. The simplified structure aids clarity for regulated entities and harmonizes with other system-level definitions in Chapter 6.

§ 100138.06 – Trauma Center

Change:

Substantively revised. Expands to reference ACS verification levels I–III (adult)

and I–II (pediatric); includes Level IV state-criteria designation; and allows partial trauma-service designation based on system needs.
Necessity:
The change is necessary to align California definitions with the *ACS Resources for Optimal Care of the Injured Patient (2022)* and to recognize Level IV trauma centers authorized by EMSA for rural and remote regions. Including partial-service designations ensures flexibility for local system design while preserving uniform statewide standards.

§ 100138.07 – Trauma Receiving Hospital

Change:
Specifies that trauma receiving hospitals are licensed general acute care hospitals (GACHs) with emergency-service permits that are not ACS-verified but are assigned system roles by the LEMSA. Adds rural-area accessibility clause and replaces outdated "standby" terminology.
Necessity:
This update distinguishes verified trauma centers from non-verified receiving hospitals, codifies rural exceptions, and clarifies that LEMSAs determine destination policies. The change is necessary to reflect how trauma systems operate in practice and to ensure alignment with LEMSA Medical Director authority under §1798.105.

§ 100138.08 – Trauma Service (formerly § 100136.09)

Change:
Renumbered and clarified to specify that a trauma service is established by the organized medical staff and includes administrative and support responsibilities in addition to direct care.
Necessity:
This change is necessary to formalize the organizational accountability of the trauma service consistent with ACS standards. Including administrative and support functions clarifies the multidisciplinary oversight required for comprehensive trauma care.

§ 100138.09 – Trauma Care System Plan (formerly § 100136.10)

Change:
Renumbered and reframed as the "initial implementation plan" summarizing system development and activation.
Necessity:
This clarification is necessary to distinguish initial plan approval from subsequent updates and to tie the definition to Chapter 6's use of "implementation." The updated language provides consistency between statewide and local planning requirements.

§ 100138.10 – Trauma System Status Report (formerly § 100136.11)

Change:
New definition created to replace embedded language previously included in the trauma-plan section. Defines the term as the annual evaluation report included with the LEMSA EMS plan update.

Necessity:
Separating this definition clarifies that annual trauma-system evaluation is distinct from initial implementation. The addition provides consistency across local EMS reporting, enhances performance tracking, and supports EMSA's oversight responsibility under §1797.105.

§ 100138.11 – Trauma Team (formerly § 100135.12)

Change:
Renumbered and rewritten for readability. Specifies multidisciplinary composition (physicians, nurses, allied health personnel) and variability by center level and patient acuity.
Necessity:
This update is necessary to maintain uniform terminology describing trauma-team structure while acknowledging differences across verification levels. It provides a clear regulatory reference for hospital compliance and LEMSA monitoring.

§ 100138.12 – Trauma Team Activation Criteria (formerly § 100136.13)

Change:
Renumbered and condensed; ties activation criteria directly to the general acute care hospital's internal policy.
Necessity:
This change clarifies that activation criteria are facility-specific and must be established by policy under the authority of the organized medical staff. The revision improves clarity, aligns with ACS verification expectations, and strengthens LEMSA oversight of compliance.

§ 100139.01 – Trauma Care System Requirements (Formerly in § 100141.01)

Change:
This section modernizes and restructures the previous § 100141.01 to clarify the plan submission, implementation, and evaluation process for trauma care systems managed by local EMS agencies (LEMSAs). The former text combined LEMSA duties, plan-approval steps, and operational details in a single long section, resulting in overlapping requirements.
The new version:

- Renumbers the provision and standardizes its placement for consistency with the reorganized chapter;
- Clarifies plan timelines by distinguishing between new and previously implemented systems;
- Moves procedural detail on plan submission and EMSA determination into §§ 100141.03 and 100141.04;
- Introduces a data-informed justification requirement that incorporates American College of Surgeons (ACS) performance indicators—replacing outdated volume thresholds—to align with national standards;

- Codifies LEMSA responsibilities (designation, communications, data management, re-triage coordination, and public education) in a clear, itemized format; and
- Updates terminology to reflect modern usage ("general acute care hospital," "prehospital care provider," "data-informed," and "quality improvement process") and removes obsolete cross-references.

Necessity:

This update is necessary to clarify the foundational requirements governing LEMSA development and maintenance of trauma care systems under Health and Safety Code §§ 1797.105 and 1798.150. The prior structure lacked clarity on when and how trauma plans must be submitted or revised, and it relied on outdated system-design metrics.

The revised section:

- Ensures consistent statewide standards while allowing local flexibility;
- Establishes a transparent, performance-based planning framework tied to patient outcomes and system access;
- Provides a clear timeline for LEMSA compliance and EMSA review; and
- Integrates financial-reporting, public-education, and QI expectations within the trauma-system oversight process.

By modernizing and reorganizing § 100141.01 into § 100140.01, the regulation enhances readability, reduces redundancy, and ensures trauma care system plans are current, evidence-based, and aligned with both state statute and national best practices.

§ 100139.02. Trauma Care Committee

Change:

This section requires each local emergency medical services agency (LEMSA) that develops and implements a trauma care system to establish a trauma care committee. The committee must meet at least twice annually and include representation from EMS providers, trauma centers, pediatric trauma receiving hospitals, and trauma receiving hospitals within the LEMSA's jurisdiction.

The section further specifies that the committee will advise the LEMSA on trauma care policies and protocols and participate in trauma care quality improvement (QI) activities.

Necessity:

This section is necessary to ensure collaborative oversight and continuous quality improvement within each local trauma care system. The establishment of a multidisciplinary trauma care committee creates a structured forum for communication, coordination, and shared decision-making among all key stakeholders involved in the delivery of trauma care—from prehospital response through definitive treatment and rehabilitation.

By requiring participation from EMS providers and all levels of trauma-designated hospitals, this provision ensures that operational issues, patient

outcomes, and system-wide performance measures are reviewed collaboratively and consistently.
Regular meetings of the trauma care committee enable the LEMSA to evaluate compliance with state and local standards, identify opportunities for improvement, and implement evidence-based policy or protocol changes.
The inclusion of trauma care QI responsibilities within the committee's scope directly supports the statutory mandate under Health and Safety Code Sections 1797.103 and 1798.150, which charge LEMSAs with monitoring and evaluating the quality of emergency medical services.
This section also aligns with national trauma system best practices, including those outlined by the American College of Surgeons (ACS), which emphasize coordinated multidisciplinary review and stakeholder engagement as essential components of an effective trauma system.
Overall, the trauma care committee requirement strengthens system accountability, promotes data-driven improvements, and ensures ongoing collaboration across the continuum of trauma care.

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

Status: *Section deleted.*
Formerly located in: § 100141.02 of the July 2025 draft regulations (Article 4, "Local EMS Agency Trauma System Requirements and Responsibilities").
Change:
This section has been removed in its entirety. The content formerly contained in § 100141.02—detailed requirements describing specific elements that must be included within a local trauma care system plan—has been relocated to the Trauma Care System Plan Template (Rev. 07/2025), which is incorporated by reference in § 100141.03.
Those elements included data justification, population-based needs assessments, infrastructure standards, system coordination agreements, policy descriptions, personnel training, and financial transparency statements.
Relocating these specifics to the incorporated template eliminates unnecessary redundancy in regulatory text while retaining all substantive requirements through incorporation by reference.
Necessity:
Deletion of this section is necessary to streamline the regulation and avoid duplication between text and incorporated forms. The prior version repeated verbatim the content already required within the plan template, which created a risk of inconsistency when future updates were made.
The trauma plan and status report templates are the official mechanism by which LEMSAs provide the required documentation and data for EMSA review under Health and Safety Code §§ 1797.105 and 1798.150. Moving these requirements into the incorporated forms maintains the same substantive standards while simplifying compliance and ensuring the templates can be updated administratively to reflect evolving data and policy needs.

§ 100139.04 – Trauma Care System Plan Requirements and Determination Process
(Formerly located in: § 100141.03)
Change:
This section has been substantially revised and streamlined to eliminate redundancy and align the plan submission and review process with modern administrative practices.
The following updates were made compared to the prior version (§100141.03):

- Reorganization and Renumbering:

The section was renumbered from §100141.03 to §100140.03 to align with the revised chapter structure. All procedural content previously contained in §§100141.02–100141.03 is now consolidated here for clarity.

- Incorporation by Reference:

The detailed trauma plan content requirements (e.g., policies, maps, MOUs, training assurances, field triage policies, data systems, financial forms) that were previously written directly into the regulatory text have been moved into the incorporated template — the Initial Trauma Care System Plan Template (Rev. 07/2025).
This eliminates extensive lists of required attachments and descriptions, ensuring that form content can be updated administratively without reopening regulation text.

- Streamlined Plan Review Process:
    - Acknowledgment and Determination Timelines: The section clarifies EMSA's 30-day acknowledgment and 60-day determination timelines, which were retained from the prior version but now written in active, consistent language.
    - LEMSA Response to Denial: The revision keeps the six-month resubmission or appeal period but aligns appeal language with §1797.105 and §100000.01 (Commission on EMS process).
    - Implementation Timeline: Explicitly requires implementation of an approved plan within six months of approval.
    - Rescission of Approval: Retains EMSA authority to rescind approval if the LEMSA fails to implement the plan.
    - Plan Modifications: Clarifies what constitutes a "significant change," introduces a notification process for urgent circumstances, and references use of the Annual Trauma System Status Report Template (Rev. 07/2025).
    - Public Posting: Adds a new requirement for LEMSAs to post the approved trauma care system plan on their website to improve transparency.
- Removed Subsections:

Subsections (a)(3) through (11) from the prior §100141.03 — listing specific items to be included in the plan — were removed because

those requirements are now captured in the incorporated template. These included:

- Personnel identification, plan overview, and trauma system design;
- Needs assessment, goals, objectives, and fiscal impact;
- Required policies (e.g., triage, destination, re-triage, advertising);
- Copies of agreements, inter-county MOUs, and data/QI procedures;
- Public education and outreach description; and
- Fee schedules.

§ 100139.04. Trauma System Status Report Requirements and Determination Process. (formally 100141.04)

Change:

This section renumbers and relocates to align with the restructured article sequence. It updates the section title to "Trauma System Status Report Requirements and Determination Process" to more clearly describe both the submission and review procedures.

The revision clarifies that EMSA's review of the trauma system status report occurs as part of the local EMS agency's (LEMSA's) annual EMS plan determination under Health and Safety Code § 1797.105 and 22 CCR § 100000.01. It also strengthens public transparency requirements by specifying that the approved status report must be posted on the LEMSA's website for a minimum of one year, whereas the prior version required only that it be "shared" without a defined duration or condition of approval. The section also incorporates reference to the Annual Trauma System Status Report Template (Rev. 07/2025) to ensure statewide reporting consistency.

Necessity:

This section is necessary to ensure consistent statewide submission, review, and transparency of trauma system performance data. Subsection (a) requires LEMSAs with implemented trauma care systems to use a standardized Annual Trauma System Status Report Template when submitting updates to EMSA as part of their annual EMS plan. This maintains uniform reporting and enables EMSA to evaluate compliance and system evolution against the approved Trauma Care System Plan, consistent with Health and Safety Code §§ 1797.105 and 1797.254.

Subsection (b) is necessary to clarify that EMSA will review the trauma system status report within the established annual EMS plan determination process, providing procedural alignment with § 100000.01 and ensuring timely, coordinated oversight of local trauma systems.

Subsection (c) is necessary to strengthen public accountability by requiring that the approved trauma system status report remain publicly accessible on the LEMSA's website for at least one year. This ensures transparency for hospitals,

providers, and the public and supports statewide consistency in trauma system governance.

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

Change:

This section replaces and consolidates prior language referencing non-designated hospitals within trauma systems to clarify the expectations for general acute care hospitals (GACHs) that are part of a local EMS system with an implemented trauma care system but are not designated as trauma centers, pediatric trauma receiving centers, or trauma receiving hospitals.

The revision explicitly ties the responsibilities of these non-designated hospitals to the re-triage requirements in Section 100144.01, ensuring consistent patient transfer and care coordination within an inclusive trauma system. It also adds language authorizing the LEMSA medical director to establish additional local requirements for non-designated GACHs, providing flexibility to address local needs and resource variations while maintaining statewide baseline standards.

Necessity:

This section is necessary to define the obligations of non-designated hospitals operating within an implemented trauma care system. By linking compliance to Section 100144.01 (re-triage requirements), the regulation ensures that patients initially presenting at non-designated facilities receive timely evaluation, stabilization, and transfer to a designated trauma center when clinically indicated.

Establishing a clear regulatory connection between non-designated facilities and the re-triage process improves system integration, standardizes patient care pathways, and reduces variability in transfer practices across jurisdictions.

§ 100141.01. Level I-III Adult Trauma Centers

Change:

This section replaces and expands prior provisions governing the eligibility and operational requirements for Level I–III adult trauma centers. In the previous version of Chapter 6 (§ 100256 et seq.), trauma-center standards were internally defined by state regulation, referencing outdated or generalized criteria. The new section modernizes the framework by incorporating, by reference, the American College of Surgeons (ACS) *Resources for Optimal Care of the Injured Patient 2022 Standards* (ISBN 978-1-7369212-9-6), thereby aligning California's trauma-center designation process with nationally recognized benchmarks for verification and quality.

The revision introduces several structural and procedural updates:

- (a) Eligibility: Establishes that a licensed GACH must obtain ACS verification to qualify for Level I, II, or III designation, replacing prior state-specific qualification language.
- ACS Verification Grace Period and Exemption: Adds a new 24-month grace period for hospitals actively pursuing ACS verification, and creates an exemption process allowing a LEMSA, with EMSA

approval, to maintain provisional designation for facilities that fail verification but demonstrate substantial compliance and an approved corrective plan. These mechanisms did not exist in the previous text.

- Integration and Cross-References: Adds direct cross-references to § 100144.01 (re-triage) and Article 6 (Data Collection, QI & Evaluation) to integrate trauma-center responsibilities across the chapter.
- LEMSA Discretion: Codifies the authority of a LEMSA medical director to impose additional local requirements beyond ACS standards, providing flexibility to address regional variations while preserving statewide consistency.

Overall, this revision modernizes the designation process, transitions California to a verification-based model, and replaces redundant or obsolete state-specific language.

Necessity:

This section is necessary to ensure that trauma centers designated within California's trauma care system meet nationally recognized standards of structure, process, and performance. Subsection (a) establishes ACS verification as the basis for eligibility, providing an objective and peer-reviewed benchmark that enhances quality and consistency across jurisdictions. The grace-period and exemption provisions are necessary to prevent disruption of trauma-system operations while hospitals complete or remedy the ACS verification process, maintaining patient access in regions where trauma-care resources are limited. Subsection (b) ensures that all designated centers—whether newly verified or provisionally exempt—participate in the statewide trauma-system framework by adhering to requirements for re-triage (§ 100144.01) and continuous data collection, quality improvement, and evaluation (Article 6). These provisions reinforce accountability and allow EMSA to evaluate trauma-system performance based on uniform data and quality metrics.

§ 100141.02. Pediatric Trauma Receiving Centers

Change:

This section introduces a comprehensive framework for the designation of Pediatric Trauma Receiving Centers (PTRCs), consolidating and updating prior pediatric trauma provisions from the previous version of Chapter 6 (formerly scattered across §§ 100257–100259). The revision modernizes eligibility criteria by explicitly requiring American College of Surgeons (ACS) pediatric trauma verification or ACS adult trauma verification with defined pediatric capabilities, referencing the *Resources for Optimal Care of the Injured Patient 2022 Standards* (ISBN 978-1-7369212-9-6).

The new structure distinguishes between two qualifying pathways:

- Direct ACS pediatric verification (Level I or II); and
- ACS adult verification with pediatric capability standards, which must include a pediatric emergency department area, a pediatric intensive care area, and resuscitation equipment consistent with the

pediatric readiness toolkit incorporated by reference from the ACS 2022 Standards.

Additionally, the section introduces:

- A 24-month ACS verification grace period for hospitals actively pursuing verification or upgrading pediatric capabilities.
- A transition clause requiring previously designated PTRCs without ACS verification to achieve compliance within 24 months of the regulations' effective date.
- A prohibition on continued designation beyond the grace period unless an exemption is granted under LEMSA and EMSA oversight (consistent with § 100142.01 structure).
- Integration of cross-references to § 100144.01 (re-triage) and Article 6 (data collection, quality improvement, and evaluation).
- A new provision explicitly empowering LEMSA medical directors to set local requirements for PTRC designation, mirroring the flexibility afforded to adult trauma center designations.

Collectively, these changes align pediatric trauma system standards with ACS verification criteria, replace outdated state-specific requirements, and ensure consistency with national best practices.

Necessity:

This section is necessary to establish clear and uniform statewide standards for pediatric trauma care within California's trauma system. Pediatric trauma patients have unique physiological and clinical needs that differ from adults, and aligning designation standards with the ACS 2022 Standards ensures that designated facilities possess the infrastructure, staffing, and equipment required for optimal outcomes.

Subsection (a) defines eligibility pathways and provides a verification grace period, which is necessary to prevent gaps in pediatric trauma coverage while facilities complete the ACS verification process. The 24-month timeframe aligns with the ACS verification cycle and balances system stability with accountability.

Subsection (b) links PTRCs to the re-triage (§ 100144.01) and quality improvement/data collection (Article 6) requirements to ensure continuous monitoring of patient outcomes and statewide performance integration. These cross-references promote coordinated pediatric trauma care across jurisdictions.

Finally, allowing LEMSA medical directors to impose additional local requirements provides flexibility for counties with unique geographic or resource constraints while maintaining minimum statewide standards. This preserves the integrity of California's inclusive trauma system and ensures pediatric patients receive timely, appropriate, and high-quality care regardless of location.

§ 100141.03. Level IV Trauma Centers (formally § 100137.06)

Change:

Expands and clarifies minimum requirements beyond the earlier baseline (which

focused on initial stabilization, transfer agreements, basic radiology and lab capability, outreach, and continuing education) by adding explicit ED staffing/readiness, trauma-team assembly within 30 minutes, universal alcohol screening per ACS guidance, brain-death protocols, formal re-triage linkage, defined leadership roles (Trauma Program Medical Director; Trauma Nurse Coordinator), structured PIPS elements, peer review cadence, committee/disaster participation, and pediatric competency. (Examples of earlier baseline elements include radiology tech availability and blood bank access.)

Necessity:

Updates and standardizes Level IV criteria to ensure hospitals tasked with initial stabilization and transfer meet consistent statewide expectations. Clear eligibility and detailed operational capabilities are necessary to maintain 24/7 readiness, prompt assessment/resuscitation, and safe transfer, while the defined leadership and PIPS structure establish continuous quality improvement to reduce preventable morbidity and mortality. The transition clause provides a reasonable implementation window for previously designated Level IV centers to meet the updated standards without disrupting regional access to trauma care.

§ 100142.01. Re-Triage of Trauma Patients (formally § 100144.01)

Change:

- Applicability broadened: The regulation now applies to all general acute care hospitals (GACHs) within a trauma care system, not just designated trauma facilities.
- Detailed re-triage requirements: Expands prior language by codifying the identification of eligible patients, partner-center selection, automatic acceptance criteria, standardized communication protocols, patient-consent and documentation transfer, and family-notification procedures.
- Transport considerations: Adds explicit guidance for matching transport mode and personnel scope of practice to patient needs (e.g., allowing 911 transport when speed outweighs specialty staffing).
- Pre-arranged agreements: Retains the concept from the prior version but specifies the minimum elements of these agreements, including pediatric considerations and automatic-acceptance criteria.
- Quality improvement integration: Adds new requirements that re-triage processes be evaluated through trauma center Performance Improvement and Patient Safety (PIPS) programs and incorporated into both facility and LEMSA-level QI systems — a new structural accountability mechanism.
- Terminology modernization: Consolidates terminology (“partner trauma center,” “re-triage”) and eliminates redundancies between transfer and re-triage language for clarity.

Necessity:
This section is necessary to ensure consistent, timely, and clinically appropriate movement of trauma patients between hospitals within the trauma system. Expanding the applicability to all GACHs clarifies that every hospital participating in the trauma care system has defined responsibilities for re-triage, closing gaps identified in prior regulation where only designated trauma centers were referenced.
Subsection (a) establishes the minimum statewide requirements for re-triage policies and procedures, ensuring patients are rapidly identified, accepted, and transferred to the appropriate level of care through standardized communication and documentation. These provisions are essential to improving patient outcomes and reducing preventable delays in definitive trauma treatment.
Subsection (b) codifies that these requirements may be fulfilled through pre-arranged re-triage agreements, which are necessary to streamline coordination, ensure 24/7 readiness, and reduce administrative barriers during emergencies.
Subsection (c) introduces explicit performance-improvement obligations linking re-triage to trauma-center PIPS programs and LEMSA QI processes, creating a feedback mechanism to monitor outcomes and system performance, a critical addition to statewide trauma system accountability.

§ 100143.01. Trauma Data Management Requirements (formally § 100138.01)

Change:
The new section separates and expands data management and reporting requirements from broader QI provisions to provide a clearer regulatory framework for trauma data collection, reporting, and sharing between hospitals, local EMS agencies (LEMSAs), and EMSA.
Major updates include:

- Expanded scope: Broadens requirements beyond trauma centers to include all general acute care hospitals (GACHs) participating in a trauma care system, ensuring that complete trauma-patient data—both prehospital and hospital-level—are captured across the continuum of care.
- Standardization: Requires all trauma data collection and submission processes to align with the California EMS Information System (CEMSIS) and the National EMS Information System (NEMSIS) standards, reflecting national data architecture updates.
- Outcome-data sharing: Introduces a new requirement for LEMSAs, in collaboration with hospitals and ALS providers, to establish a process for sharing outcome data with EMS providers for all transported trauma patients, including those excluded from trauma registries.
- Timeliness requirements: Establishes defined submission intervals (quarterly and within 90 days of discharge) to standardize data timeliness and completeness across local systems.

- LEMSA reporting obligations: Adds new mandates for quarterly trauma system data reports distributed to all system-participating hospitals and for forwarding NTDB (National Trauma Data Bank®) data to EMSA.
- Clarified HIPAA compliance: Specifies that all data transfers—whether to LEMSAs or directly to CEMSIS—must comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

This restructuring replaces fragmented data language from prior sections and integrates hospital, prehospital, and system-level data functions under a single comprehensive framework.

Necessity:

This section is necessary to ensure accurate, timely, and consistent statewide trauma data collection to support EMSA's statutory responsibilities for system oversight, evaluation, and continuous improvement.

Subsection (a) establishes standardized processes for LEMSAs and hospitals to collect, report, and share trauma patient care data. The inclusion of both prehospital and hospital-level data is critical for analyzing patient outcomes, identifying system-level improvement opportunities, and maintaining compliance with Health and Safety Code § 1797.254 regarding local plan submissions.

Requiring LEMSAs to collaborate with trauma centers, pediatric trauma receiving centers, trauma receiving hospitals, and ALS providers ensures an integrated feedback loop for field and facility performance. The outcome-sharing provision promotes data-driven quality improvement and closes long-standing feedback gaps between hospital and prehospital providers.

Quarterly reporting and the 90-day submission deadline are necessary to create timely, actionable datasets for both local and state analysis. These intervals balance operational feasibility with the need for up-to-date information to guide policy and clinical performance decisions.

Subsection (b) specifies the minimum data elements to be collected—anchored to CEMSIS and NEMSIS standards—to ensure interoperability, national comparability, and alignment with federal trauma data initiatives. The defined list of hospital data elements (arrival time, admission/discharge data, ICD-10 codes, AIS severity, etc.) ensures consistent clinical and operational metrics for evaluating trauma system performance.

Collectively, these requirements establish a clear, enforceable structure for trauma data management that supports transparency, accountability, and evidence-based system improvement.

§ 100143.02. Local EMS Agency Trauma Quality Improvement and Evaluation Process (formally § 100138.01)

Change:

The previous section combined statewide trauma quality improvement concepts with facility-level PIPS requirements, resulting in overlapping and inconsistent expectations between EMSA, LEMSAs, and individual trauma

centers. This revision separates LEMSA-level quality improvement (QI) and system evaluation processes into their own section to clarify roles and responsibilities within the trauma system.

Key updates include:

- Defined scope: Clearly identifies that trauma care must be an integral component of each LEMSA's overall QI program and establishes the baseline structure for that process.
- Policy Development: Clarifies that a trauma center physician (surgeon or ED physician) shall assist the LEMSA in developing trauma-related prehospital care policies and protocols—language retained and refined from the prior version (§ 100138.01(b)(2)) to emphasize clinical expertise in policymaking.
- Multidisciplinary QI Committee: Creates a standalone requirement for a trauma or QI committee that specifically addresses multidisciplinary trauma system issues—separating it from facility-level PIPS to reinforce system-wide accountability.
- Expanded participation: Requires participation from prehospital providers, trauma centers, pediatric trauma receiving centers, and trauma receiving hospitals in both (1) the trauma data management requirements (§ 100144.01) and (2) the LEMSA's QI process.
- Regional coordination review: Introduces a new provision requiring LEMSAs to evaluate regional coordination and cross-jurisdictional trauma transfers, reflecting the operational complexity of modern trauma systems.
- System evaluation cadence: Adds a minimum triennial (every 3 years) requirement for trauma system evaluation to ensure ongoing assessment of structure, process, and outcomes.
- Confidentiality protections: Retains reference to Evidence Code § 1157.7 and clarifies that confidentiality protections extend to QI review of trauma cases, ensuring protected peer-review processes.
- Data-driven feedback: Adds explicit language requiring bi-directional information sharing with EMS providers, hospitals, and medical community participants, institutionalizing a transparent evaluation loop between data analysis and system improvement.

These revisions collectively clarify oversight responsibilities, strengthen statewide consistency, and eliminate ambiguity between system-level and facility-level QI functions.

Necessity:

This section is necessary to define and standardize the minimum quality improvement and evaluation functions for local EMS agencies operating a trauma care system.

Subsection (a) delineates the structural elements of a comprehensive trauma QI program. Requiring multidisciplinary participation and clinical physician involvement in policy development ensures that local trauma policies are

evidence-based, field-informed, and clinically sound. Including all trauma-system participants (prehospital, hospital, and specialty centers) creates a closed-loop QI framework for continuous system performance improvement.
Subsection (b) establishes the LEMSA's responsibility for ongoing trauma system evaluation and introduces mandatory data-driven feedback and regional coordination review mechanisms. These provisions ensure trauma system plans are responsive to real-world operational outcomes and interfacility transfer patterns.
The three-year evaluation cycle provides a consistent timeline for formal review while maintaining flexibility for additional interim assessments. Making results available to system participants promotes transparency and encourages collaborative system development.

§ 100143.03. Designated GACH Quality Improvement and Evaluation Requirements

Change:
This section establishes the quality improvement and evaluation requirements for all designated trauma facilities, including trauma centers, pediatric trauma receiving centers, and trauma receiving hospitals.
It requires that each designated general acute care hospital (GACH) maintain a Performance Improvement and Patient Safety (PIPS) program and a trauma care-specific quality improvement (QI) process that is independent from, but reports to, the hospital's general QI program.
Additionally, it requires that each designated facility have a process for reviewing trauma care and providing feedback to both the local emergency medical services agency (LEMSA) and referring providers on triage accuracy, care delivery, outcomes, and opportunities for improvement.
Necessity:
This section is necessary to ensure that trauma-designated hospitals conduct ongoing, structured quality improvement activities that directly address trauma system performance and patient outcomes.
Requiring an independent but connected trauma-specific PIPS process allows facilities to identify, analyze, and address issues unique to trauma care—such as triage accuracy, resuscitation timeliness, surgical intervention, and interfacility transfers—without diluting focus within a broader hospital-wide QI framework.
The PIPS structure mirrors national standards established by the American College of Surgeons (ACS) Committee on Trauma, which mandate continuous performance monitoring and corrective action as core components of trauma center verification.
The feedback mechanisms described in subdivisions (b)(1) and (b)(2) are essential for system-wide learning. Providing structured feedback to the LEMSA supports its statutory responsibility under Health and Safety Code Section 1797.105 to assess and evaluate EMS system effectiveness, while feedback to referring providers strengthens clinical coordination, reinforces proper triage practices, and promotes shared accountability across all levels of care.

Without these requirements, there would be inconsistency in how trauma centers monitor outcomes, communicate findings, and implement performance improvements—potentially leading to avoidable variability in care and poorer patient outcomes.
By formalizing these processes, this section ensures that trauma care across California remains data-driven, coordinated, and continuously improving, in alignment with both state EMS system standards and nationally recognized best practices.

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

§ 100144.01. Purpose and Authority

Change:
This is a new section added to establish the purpose of the ST-Elevation Myocardial Infarction (STEMI) Critical Care System regulations. It parallels §100137.01 (Purpose) of the Trauma Care System regulations and provides a clear statement of intent and scope for the new subchapter.
Necessity:
This section is necessary to articulate the purpose of the STEMI Critical Care System regulations and to define their relationship to the broader Emergency Medical Services (EMS) system. It establishes the framework for statewide minimum standards governing the development, implementation, designation, and evaluation of STEMI Critical Care Systems by local EMS agencies (LEMSAs). By aligning with Division 2.5 of the Health and Safety Code, this section ensures consistent statewide expectations for coordinated and timely care for STEMI patients, while allowing flexibility for LEMSAs to tailor implementation based on regional needs and resources. Including this statement also supports transparency in regulatory intent and provides a foundation for subsequent sections within this subchapter.
Necessity:
This section is necessary to comply with the requirements of the California Administrative Procedure Act (Government Code §11346.2) by clearly identifying the statutory authority under which the regulations are adopted and the specific provisions of law they interpret and implement.
Including this section ensures transparency and legal clarity, confirming that the regulatory framework for STEMI Critical Care Systems is grounded in the EMSA's statutory mandate to coordinate, develop, and oversee specialty care components of the statewide emergency medical services system.

§ 100145.01. Cardiac Catheterization Laboratory

Change:
The definition specifies that such a laboratory is a setting within a licensed general acute care hospital (GACH), or within an expanded area permitted under Title 22, California Code of Regulations § 70438.2, where diagnostic and therapeutic cardiovascular procedures are performed.
Necessity:
This section is necessary to provide a clear and standardized definition of

"cardiac catheterization laboratory," a core component of STEMI receiving center operations. The inclusion of this definition ensures consistency in understanding what qualifies as a Cath lab for purposes of designation, oversight, and compliance within a local STEMI critical care system.
Specifically referencing Title 22 § 70438.2 aligns the STEMI regulations with existing facility licensing and operational standards under the California Department of Public Health (CDPH), ensuring that all designated hospitals operate within the state's established health facility framework.
This clarity supports accurate interpretation by LEMSAs, hospitals, and EMSA when assessing eligibility and compliance under this subchapter.

§ 100145.02. Cardiac Catheterization Team

Change:
This section defines the term "cardiac catheterization team" as the specially trained group of healthcare professionals capable of performing percutaneous coronary intervention (PCI) procedures. The definition establishes a uniform understanding of the personnel and clinical function associated with cardiac catheterization within the statewide STEMI critical care system.
Necessity:
This section is necessary to ensure terminological consistency and clarity of scope in the implementation and oversight of STEMI critical care systems across the state.
Defining the cardiac catheterization team provides a clear framework for identifying the specialized personnel responsible for performing PCI, a time-sensitive and lifesaving procedure that restores blood flow in patients experiencing ST-elevation myocardial infarction (STEMI).
The definition also supports local emergency medical services agencies (LEMSAs) and general acute care hospitals (GACHs) in applying uniform standards when developing, designating, and evaluating STEMI receiving centers.
Without this definition, ambiguity could exist regarding the composition, training, and functional role of cardiac catheterization teams, potentially leading to inconsistency in capability expectations and system performance evaluation.
By explicitly defining the cardiac catheterization team as the group of qualified professionals performing PCI, this section reinforces the critical relationship between staffing competency, timely reperfusion, and improved patient outcomes—consistent with both American Heart Association (AHA) and American College of Cardiology (ACC) standards for STEMI systems of care.
This ensures statewide alignment in terminology, enhances interfacility coordination, and promotes the delivery of high-quality, standardized cardiac care across California's EMS system.

§ 100145.03. Percutaneous Coronary Intervention (PCI)

Change:
It defines "percutaneous coronary intervention" (PCI) as a procedure used to

open or widen a narrowed or blocked coronary artery to restore blood flow to the heart.
Necessity:
This section is necessary to provide a standardized definition for PCI, which is the primary treatment modality for ST-Elevation Myocardial Infarction (STEMI) patients within the STEMI Critical Care System.
Defining PCI establishes a clear and consistent understanding of the procedure referenced throughout this subchapter, ensuring alignment among EMSA, LEMSAs, and hospital providers regarding what constitutes PCI capability.
This definition also ensures consistency with terminology used by the American College of Cardiology (ACC), American Heart Association (AHA), and California Department of Public Health (CDPH) facility standards, thereby supporting uniform statewide application and compliance.

§ 100145.04. ST-Elevation Myocardial Infarction (STEMI)

Change:
This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "ST-Elevation Myocardial Infarction" (STEMI) as a clinical syndrome characterized by symptoms of myocardial infarction accompanied by ST-segment elevation on an electrocardiogram (ECG).
Necessity:
This section is necessary to provide a standardized and clinically accurate definition of STEMI, which forms the foundation of this subchapter.
Including this definition ensures consistent identification and triage of STEMI patients across California's EMS and hospital systems, aligning with national standards from the American College of Cardiology (ACC) and the American Heart Association (AHA).
A clear definition supports proper implementation of field diagnostic protocols, destination policies, and quality improvement benchmarks within local STEMI Critical Care Systems.
This consistency is essential for accurate reporting, outcome measurement, and inter-agency coordination, fulfilling EMSA's mandate to promote uniform statewide emergency medical care standards.

§ 100145.05. STEMI Critical Care

Change:
It defines "STEMI critical care" to encompass all emergency cardiac care related to STEMI patients, as well as broader post-resuscitation and advanced cardiac care services that may be provided by PCI-capable general acute care hospitals (GACHs). This includes treatment policies and specialized protocols such as targeted temperature management, extracorporeal membrane oxygenation (ECMO), decompensated heart failure management, and the use of mechanical circulatory assist devices.
Necessity:
This section is necessary to clarify the scope of services and care that fall within the definition of "STEMI critical care."

By broadening the definition beyond the immediate treatment of STEMI to include advanced post-resuscitation and cardiac support interventions, this section ensures the regulations reflect the modern continuum of cardiac emergency care.
Defining this term enables LEMSAs and EMSA to set appropriate standards for system designation, data collection, and quality improvement across a range of time-sensitive cardiac emergencies.
This inclusion also supports the integration of Return of Spontaneous Circulation (ROSC) and other critical cardiac patient management into the STEMI system framework, promoting comprehensive coordination and improved outcomes for patients with complex cardiac conditions.

§ 100145.06. STEMI Critical Care System

Change:
It defines "STEMI critical care system" as a component of the EMS system developed by a local emergency medical services agency (LEMSA) that links prehospital and hospital care to provide coordinated treatment for patients experiencing ST-Elevation Myocardial Infarction (STEMI).
Necessity:
This section is necessary to formally define the term "STEMI critical care system," establishing the foundation for how LEMSAs organize and integrate cardiac care within their jurisdictions.
By defining the system as a coordinated network connecting EMS field providers and general acute care hospitals (GACHs), this provision ensures alignment with the structure used for trauma and stroke systems, promoting statewide consistency across all time-sensitive specialty care programs.
This definition provides regulatory clarity for implementation, evaluation, and oversight, allowing EMSA to ensure that each local system includes coordinated policies for patient identification, transport, treatment, and data collection in accordance with Division 2.5 of the Health and Safety Code.

§ 100145.07. STEMI Critical Care System Plan

Change:
This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI critical care system plan" as the initial implementation plan prepared by a local emergency medical services agency (LEMSA) summarizing the development and activation of its STEMI critical care system.
Necessity:
This section is necessary to establish a consistent definition for the "STEMI critical care system plan," which serves as the foundational document through which a LEMSA formally proposes and implements a new STEMI system.
Defining this term ensures clarity and uniform expectations across all jurisdictions regarding the content and purpose of the initial plan submitted to the Emergency Medical Services Authority (EMSA) for review and approval.
This definition supports EMSA's oversight responsibilities under Division 2.5 of the

Health and Safety Code by providing a standardized reference for system planning, approval, and future evaluation processes.

§ 100145.08. STEMI Critical Care System Plan Update

Change:

This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI critical care system plan update" as the annual assessment conducted by a local emergency medical services agency (LEMSA) to evaluate the performance, effectiveness, goals, and objectives of its STEMI critical care system.

Necessity:

This section is necessary to clearly distinguish between the initial implementation plan for a STEMI critical care system and the ongoing annual updates that evaluate system operation and performance.

Defining this term ensures statewide consistency in how LEMSAs report and assess their STEMI systems over time and provides EMSA with a standardized framework for reviewing local system effectiveness and compliance.

The definition reinforces EMSA's statutory oversight role under Division 2.5 of the Health and Safety Code by establishing a structured, continuous quality improvement process for system evaluation and approval.

§ 100145.09. STEMI Medical Director

Change:

This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI medical director" as a physician who is board-certified in cardiology by the American Board of Medical Specialties or the American Osteopathic Association, meets the local emergency medical services agency's (LEMSA's) qualification requirements, and is responsible for overseeing the general acute care hospital's STEMI program.

Necessity:

This section is necessary to establish uniform statewide criteria for the professional qualifications and responsibilities of a STEMI medical director.

Defining this role ensures that each designated STEMI receiving center has qualified physician leadership responsible for clinical oversight, quality assurance, and coordination of care for STEMI patients.

This definition promotes consistency across LEMSAs and hospitals, aligning with national standards from the American College of Cardiology (ACC) and the American Heart Association (AHA), while allowing LEMSAs flexibility to set additional local qualifications based on regional needs.

Clear definition of the STEMI medical director role supports accountability, system integrity, and compliance with EMSA's oversight functions under Division 2.5 of the Health and Safety Code.

§ 100145.10. STEMI Patient

Change:

This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI patient" as a patient exhibiting symptoms of

myocardial infarction accompanied by ST-segment elevation on an electrocardiogram (ECG).
Necessity:
This section is necessary to provide a clear and consistent definition of "STEMI patient" for use across all local EMS agencies (LEMSAs) and general acute care hospitals (GACHs) participating in STEMI Critical Care Systems.
By defining this term, the regulation ensures that all stakeholders—prehospital providers, emergency departments, and cardiac catheterization teams—apply consistent clinical criteria when identifying, triaging, and reporting STEMI cases.
A standardized definition aligns with national guidelines from the American College of Cardiology (ACC) and American Heart Association (AHA), supports uniform data reporting into CEMSIS, and facilitates accurate performance evaluation and quality improvement efforts statewide.

§ 100145.11. STEMI Program

Change:
This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI program" as the organizational component of a general acute care hospital (GACH) that specializes in the care of STEMI patients.
Necessity:
This section is necessary to clearly define the "STEMI program" as the internal hospital structure responsible for coordinating all aspects of STEMI patient care, including clinical protocols, staffing, quality improvement, and data reporting.
By establishing this definition, the regulation ensures that every designated STEMI receiving center maintains a formal program framework to oversee patient outcomes and compliance with local EMS agency (LEMSA) and state requirements.
This consistency aligns STEMI programs with the structural expectations already applied to trauma programs and supports EMSA's oversight role in maintaining statewide standards for critical care systems.

§ 100145.12. STEMI Program Manager

Change:
This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI program manager" as a registered nurse or individual with a higher medical degree who is designated by the general acute care hospital (GACH) to monitor and evaluate STEMI patient care and coordinate performance improvement and patient safety activities in collaboration with the STEMI medical director.
Necessity:
This section is necessary to define the professional role responsible for the operational and quality management of STEMI programs within designated hospitals.
Establishing a clear definition of the STEMI program manager ensures that each STEMI receiving center has qualified leadership to oversee program

performance, ensure compliance with local emergency medical services agency (LEMSA) requirements, and support ongoing quality improvement initiatives.
This aligns with the structure used in the trauma and stroke systems, promotes consistent statewide program oversight, and ensures effective coordination between hospital staff and EMS providers.

§ 100145.13. STEMI Receiving Center (SRC)

Change:
This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI receiving center," "SRC," or "STEMI center" as a licensed and verified general acute care hospital (GACH) that meets the minimum standards for STEMI care established in Section 100149.01, possesses percutaneous coronary intervention (PCI) capability, and is formally designated by the local emergency medical services agency (LEMSA).
Necessity:
This section is necessary to provide a clear and consistent definition of what constitutes a STEMI receiving center within California's emergency medical services system.
Defining this term ensures uniform application of designation criteria across LEMSAs and aligns the STEMI system with existing frameworks for trauma and stroke specialty care centers.
By linking the designation to both PCI capability and compliance with the minimum standards in Section 100149.01, the definition ensures that designated centers possess the clinical capacity, infrastructure, and oversight necessary to provide rapid and effective reperfusion therapy for STEMI patients.
This promotes statewide consistency, supports EMSA's statutory oversight responsibilities under Division 2.5 of the Health and Safety Code, and helps ensure that patients experiencing STEMI receive timely access to appropriate facilities capable of delivering definitive care.

§ 100145.14. STEMI Referring Hospital (SRH)

Change:
This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI referring hospital" (SRH) as any licensed general acute care hospital (GACH) within a local EMS system that receives patients transported through the 911 emergency response system but has not been designated as a STEMI receiving center. It also specifies that STEMI referring hospitals must meet the minimum requirements outlined in Section 100149.02 of this subchapter.
Necessity:
This section is necessary to establish a clear and consistent definition for "STEMI referring hospital," distinguishing these facilities from designated STEMI receiving centers within the statewide system.
Defining this term ensures that hospitals without PCI capability but that receive STEMI or suspected STEMI patients through the 911 system understand their

responsibilities for initial stabilization, rapid diagnosis, and timely transfer to designated STEMI receiving centers.
This definition provides regulatory clarity for LEMSAs in developing destination, transfer, and quality improvement policies that ensure continuity of care across all participating hospitals.
By referencing the minimum standards in Section 100149.02, the regulation ensures that all SRHs operate under consistent statewide requirements, thereby promoting timely reperfusion, reducing treatment delays, and improving patient outcomes.

§ 100145.15. STEMI Team

Change:
This is a new section with no prior counterpart in the existing Chapter 6 regulations. It defines "STEMI team" as the clinical personnel, support personnel, and administrative staff who work collectively as part of a general acute care hospital's (GACH's) STEMI program.
Necessity:
This section is necessary to define the composition and collaborative nature of the STEMI team within each designated hospital.
By establishing a clear definition, the regulation ensures that all individuals involved in the management of STEMI patients—from emergency department staff to cardiac catheterization personnel and program administrators—are recognized as integral to coordinated STEMI care.
The definition reinforces the multidisciplinary model that is essential for achieving timely reperfusion, aligning with national standards from the American Heart Association (AHA) and American College of Cardiology (ACC).
It also provides clarity for local emergency medical services agencies (LEMSAs) in evaluating compliance with designation requirements and ensures consistency across all hospitals participating in a STEMI Critical Care System.

§ 100146.01. STEMI Critical Care System Requirements

Change:
This section revises and renumbers prior §§ 100147.01 and 100148.01 to consolidate all local EMS agency (LEMSA) responsibilities for the development, implementation, and oversight of a STEMI Critical Care System. It reorganizes existing requirements for ECG interpretation, field communication, and interfacility transfer into a single, logically sequenced structure, and introduces explicit plan submission and update timelines for new and existing systems.

Necessity:
This section is necessary to ensure consistency and clarity in statewide implementation of STEMI systems. Establishing specific plan submission requirements, ECG interpretation standards, and data reporting expectations provides LEMSAs with a unified regulatory framework that aligns with national best practices (AHA/ACC) and the CEMSIS/NEMSIS data architecture. The reorganization eliminates redundancy between prior sections and improves

regulatory compliance by linking local policy, regional coordination, and performance evaluation into a continuous system of quality improvement.

§ 100146.02. Cardiac Care Committee

Change:

This section renumbers and expands content previously located in § 100147.01(c) of the prior draft, which referenced a "cardiac or STEMI committee." The new section elevates the committee's establishment and responsibilities into a discrete requirement. It specifies that the cardiac care committee must meet at least twice annually and include participation from EMS providers as well as STEMI and cardiac-receiving general acute care hospitals (GACHs). It also clarifies the committee's advisory and quality-improvement functions.

Necessity:

This section is necessary to formalize the multidisciplinary cardiac care committee as a critical governance and quality-improvement structure within every local STEMI critical-care system. Establishing clear membership and meeting-frequency standards promotes regular collaboration among field providers, hospital representatives, and the local EMS agency (LEMSA).

The committee ensures coordination of prehospital and in-hospital cardiac care, facilitates review of system performance, and supports continuous quality improvement consistent with Division 2.5 of the Health and Safety Code. Separating this provision into its own section aligns the STEMI regulations with the trauma system model, enhances transparency, and allows EMSA to more easily evaluate LEMSA compliance during plan review and system audits.

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

Change:

This section renumbers and revises the prior § 100147.02 of the earlier draft, reorganizing the plan submission and approval process for clarity and alignment with the trauma regulatory format. The new section explicitly incorporates the Initial STEMI Critical Care System Plan Template (Rev. 07/2025) by reference, defines EMSA's acknowledgment and determination timelines (30-day and 60-day deadlines), and adds detailed provisions for plan denial, appeal, modification, and rescission of approval. It also introduces requirements for posting the approved plan publicly and clarifies that annual plan updates are required as part of the local EMS plan submission.

Necessity:

This section is necessary to establish a standardized and transparent process for EMSA's review and approval of local STEMI Critical Care System plans.

By defining submission formats, review timelines, and appeal mechanisms, this regulation ensures that all LEMSAs follow consistent procedures for obtaining and maintaining state approval. The inclusion of a plan template improves uniformity and efficiency in EMSA's review process while reducing administrative ambiguity.

The new provisions governing rescission of approval and plan modification reinforce EMSA's oversight authority under Health and Safety Code §§ 1797.105 and 1797.172, ensuring that local systems continue to meet minimum standards and maintain quality care after implementation.
Public posting of approved plans increases transparency and accountability to the communities served.

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

Change:
This section renumbers and revises the previous § 100147.03 (STEMI System Plan Updates) to align with the updated trauma regulatory structure. It formalizes the requirement that local EMS agencies (LEMSAs) submit an annual STEMI Critical Care System Plan Update Template (Rev. 07/2025), incorporated by reference, as part of their annual local EMS plan update to the Emergency Medical Services Authority (EMSA).
The section clarifies that plan updates must describe all substantive changes to the STEMI critical care system since the prior submission and adds a public posting requirement to enhance transparency. EMSA's review process is explicitly tied to the agency's existing statutory authority under Health and Safety Code §§ 1797.105 and 1797.254 and the administrative review process under § 100000.01 of this Division.
Necessity:
This section is necessary to establish a consistent and recurring mechanism for EMSA oversight of implemented STEMI critical care systems. Regular submission and review of plan updates ensure that LEMSAs maintain compliance with current standards, integrate system changes (such as facility designation, data processes, or policy revisions), and demonstrate continued quality and system performance.
The incorporation of a standardized plan update template enhances the efficiency and uniformity of EMSA's review process across all jurisdictions. Linking the review to the annual local EMS plan update streamlines reporting and eliminates duplicative submissions. The requirement for public posting of approved updates promotes transparency and strengthens public confidence in local and statewide STEMI care coordination.

§ 100147.01. STEMI Referring Hospitals

Change:
This section renumbers and separates content previously contained within § 100148.01(b)(2) of the prior draft, which grouped requirements for both STEMI Receiving and Referring Hospitals. The revision clarifies that any licensed general acute care hospital (GACH) receiving 911-transported patients and not designated as a STEMI Receiving Center (SRC) is classified as a STEMI Referring Hospital (SRH).
It establishes minimum eligibility and operational standards, including continuous availability for diagnostic evaluation and thrombolytic therapy, maintenance of

written transfer agreements, and compliance with local EMS agency (LEMSA) policies. The section adds explicit requirements for participation in data collection and quality improvement (QI) programs, collaboration with the LEMSA and SRCs, and periodic compliance reviews every three years.
Necessity:
This section is necessary to define the minimum operational expectations for hospitals that serve as entry points for patients experiencing ST-Elevation Myocardial Infarction (STEMI) but do not provide percutaneous coronary intervention (PCI).
By delineating the requirements for STEMI Referring Hospitals separately from those for STEMI Receiving Centers, the regulation clarifies the role of these facilities in the broader STEMI Critical Care System and ensures consistent care coordination across all tiers of cardiac care.
The inclusion of requirements for QI participation and triannual compliance reviews strengthens system accountability and supports continuous improvement. Requiring written interfacility transfer agreements guarantees timely and efficient transfer to definitive care facilities, reducing treatment delays and improving patient outcomes.
These revisions align STEMI system oversight with the trauma system model and reinforce EMSA's authority to ensure that all hospitals participating in the EMS system meet minimum standards for STEMI care.

§ 100147.02. STEMI Receiving Centers

Change:
This section renumbers and expands the provisions previously contained in §100148.01(b)(1) of the prior version, which outlined minimal requirements for STEMI receiving centers. The revised language separates these requirements into their own section and introduces additional clarifications consistent with national standards and trauma system structure.
Key updates include explicit eligibility criteria for designation, a detailed list of minimum capabilities and operational requirements, and new provisions governing program staffing, QI participation, and system review. The section now specifies that each STEMI receiving center must have a STEMI Medical Director, STEMI Program Manager, and Cardiac Catheterization Team, along with a documented call activation process.
New subsections clarify expectations for PCI availability, written transfer agreements when cardiovascular surgery is not on-site, and coordination with LEMSA-developed diversion and destination policies. The section also adds the requirement for triennial STEMI program reviews and corrects a cross-reference error that previously referred to stroke hospitals.
Necessity:
This section is necessary to define uniform statewide standards for hospitals designated as STEMI Receiving Centers (SRCs). The clear delineation of eligibility, staffing, operational, and quality improvement requirements ensures that SRCs provide timely, coordinated, and high-quality care to patients experiencing ST-

Elevation Myocardial Infarction (STEMI).
Requiring 24/7 availability for PCI, documented call systems, and cath lab activation protocols supports rapid response and reduces treatment delays—key factors in STEMI survival. Mandating policies for diversion, transfer, and triage ensures consistent patient flow management within and across EMS systems.
The addition of periodic reviews and formalized QI participation enhances accountability and continuous improvement. These requirements align with national standards (e.g., AHA Mission: Lifeline, ACC/AHA STEMI guidelines) and mirror the trauma regulatory framework to ensure coherence across all specialty care systems.
The provision allowing LEMSAs to set additional requirements provides necessary flexibility for regional system adaptation while maintaining a consistent statewide baseline.

§ 100148.01. STEMI Data Management Requirements

Change:
This section renumbers and substantially expands upon the prior § 100149.01 (STEMI Data Management and Quality Improvement) by restructuring the data collection and reporting requirements to parallel the trauma data framework in § 100144.01. The updated section explicitly defines responsibilities for both the local EMS agency (LEMSA) and general acute care hospitals (GACHs)—including STEMI Receiving Centers (SRCs) and STEMI Referring Hospitals (SRHs).
New subsections specify:

- the STEMI Critical Care System data collection process and integration with both prehospital and hospital data sources;
- collaboration requirements between LEMSAs, SRCs, SRHs, and ALS providers for outcome data sharing;
- CEMSIS submission timeframes and privacy compliance consistent with HIPAA;
- a detailed list of prehospital and hospital STEMI data elements that align with NEMSIS and CEMSIS standards.

The revisions also remove outdated or duplicative references to stroke data collection that appeared in earlier drafts, ensuring that all provisions are specific to STEMI systems.

Necessity:
This section is necessary to standardize how STEMI patient care data is collected, reported, and evaluated across California's local EMS systems. Consistent data definitions and submission timelines are essential to measure system performance, evaluate time-sensitive outcomes (such as door-to-balloon and first-medical-contact-to-device times), and identify areas for quality improvement.
By requiring both prehospital and hospital participation, the regulation ensures continuity of patient data from field identification through definitive treatment. The detailed data element list aligns state requirements with national reporting standards (NEMSIS/CEMSIS), improving interoperability and benchmarking

capabilities.
The inclusion of quarterly reporting timelines and cross-agency outcome sharing promotes accountability, transparency, and systemwide learning—ultimately improving survival and recovery for STEMI patients. These provisions mirror the trauma data requirements to provide consistent oversight across all specialty care programs while maintaining flexibility for local EMS agencies to include additional fields relevant to their region.

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

Change:

This section renumbers and revises the prior § 100149.02, reorganizing the requirements for local EMS agency (LEMSA) quality improvement (QI) and system evaluation to align with the trauma model in § 100144.02.
The revision clarifies that STEMI care must be integrated into each LEMSA's overall QI program and establishes the minimum required components of a STEMI-specific QI process. It introduces explicit requirements for:

- formation of a multidisciplinary STEMI QI Committee with representation from prehospital providers and general acute care hospitals (GACHs);
- mandatory participation of all relevant system participants (LEMSA, EMS providers, STEMI Receiving Centers, and STEMI Referring Hospitals) in both the STEMI Data Management Process (§ 100150.01) and the broader QI program;
- evaluation of regional coordination and interfacility transfer processes;
- case review of STEMI-related deaths, adverse events, and transfers; and
- ongoing system performance evaluation.

The section also incorporates confidentiality protections consistent with Evidence Code § 1157.7 and provides placeholders for "Evaluation Support Process" and "Periodic Performance Evaluation" to be finalized upon LEMSA program alignment with statewide standards.

Necessity:

This section is necessary to ensure that each local EMS agency systematically monitors, evaluates, and improves the quality of care provided within its STEMI Critical Care System.
A dedicated, multidisciplinary QI process enables identification of performance trends, outcome variations, and opportunities for improvement across the continuum of STEMI care—from prehospital identification to hospital intervention and discharge.
Requiring participation by all key partners ensures shared accountability and coordinated quality improvement efforts. The inclusion of case review and regional coordination analysis strengthens continuity of care across jurisdictional boundaries.

Incorporating confidentiality protections under Evidence Code § 1157.7 allows candid case discussions and peer review, fostering a non-punitive environment for quality improvement.
These revisions mirror the structure and intent of the trauma system QI requirements, providing consistency across specialty care programs while maintaining the flexibility necessary for local implementation and regional collaboration.

§ 100149.01 Purpose and Authority

Change:
This section establishes the purpose of Subchapter 3 by defining its scope and objectives for the development, implementation, designation, and evaluation of Stroke Critical Care Systems as components of California's emergency medical services (EMS) system.
The section aligns with the structure used in the Trauma and STEMI subchapters to ensure consistency across all specialty care systems. The language has been updated for clarity and to reflect current terminology, including the full continuum of stroke patient care from prehospital response through rehabilitation.
Necessity:
This section is necessary to clearly state the intent and framework for the stroke regulations and to establish that Stroke Critical Care Systems are integral to the state's EMS system.
Defining the purpose ensures a uniform statewide understanding of the regulatory objectives and provides direction for local EMS agencies (LEMSAs) to build and operate stroke systems that align with state standards.
This section ensures coordinated patient care, promotes system integration, and supports the consistent delivery of time-critical stroke interventions while maintaining flexibility for regional implementation.
Adoption of this section fulfills the legislative mandate under Health and Safety Code Sections 1798.150 and 1798.160 to provide statewide standards for specialty care systems.

§ 100150.01 Clinical Stroke Team

Change:
This section adds a new definition for "Clinical Stroke Team." The definition establishes the composition and purpose of the group of healthcare professionals responsible for providing coordinated care to stroke patients.
This addition aligns with similar terminology used in other specialty care system subchapters (e.g., the "Cardiac Catheterization Team" in STEMI and "Trauma Team" in Trauma) to maintain consistent structural and definitional clarity across all specialty care system regulations.
The term replaces informal or inconsistent references to "stroke team" found in prior versions and provides a standardized definition for use throughout the Stroke Critical Care Systems subchapter.

Necessity:
This section is necessary to define the term "Clinical Stroke Team" as used throughout the regulations to ensure clarity and consistent interpretation among local EMS agencies (LEMSAs), hospitals, and EMS providers.
A clear definition ensures that the stroke team is understood to include all healthcare professionals who are directly responsible for the care of stroke patients, encompassing physicians, nurses, and allied health personnel involved in acute assessment, stabilization, treatment, and post-acute management.
Standardizing this term promotes uniform statewide implementation of stroke system requirements, supports consistent performance expectations for designated stroke centers, and aligns California's regulations with nationally recognized standards such as those established by The Joint Commission and the American Heart Association/American Stroke Association.

§ 100150.02 Mobile Stroke Program

Change:
This section adds a new definition for "Mobile Stroke Program." The definition identifies a system component that deploys a specialized ambulance meeting the requirements of Section 1797.95 of the Health and Safety Code, capable of responding to 911 scene calls with neurological expertise available either in person or via telehealth.
This definition did not appear in the prior version of the stroke regulations and reflects the evolution of prehospital stroke care models since the original rulemaking. It aligns with current national and state-level innovations in mobile integrated healthcare and stroke systems of care, ensuring that EMSA regulations remain current with modern evidence-based practices.
Necessity:
This section is necessary to define "Mobile Stroke Program" as a recognized component of a local stroke system of care, providing clarity regarding the role and operational expectations of mobile stroke units within the emergency medical services system.
Defining the term establishes a consistent statewide standard for programs that incorporate mobile stroke units (MSUs), ensuring that such programs operate under the oversight of the local emergency medical services agency (LEMSA) and maintain appropriate physician medical control, including neurologist participation.
This definition is critical to integrate emerging prehospital stroke technologies and models into regulated EMS frameworks, support consistent patient triage and destination decision-making, and ensure patient safety through physician-directed care in accordance with Division 2.5 of the Health and Safety Code.

§ 100150.03 Stroke Call Roster

Change:
This section adds a new definition for "Stroke Call Roster." The definition establishes that a stroke call roster is a documented schedule outlining the continuous, year-round availability of licensed healthcare professionals

responsible for providing care to stroke patients.
This term parallels similar definitions used in other specialty care system subchapters, such as the "Trauma Team Call Roster" and "STEMI Team Call Roster," ensuring consistency across California's specialty care system regulations.
The definition standardizes how stroke centers demonstrate and maintain compliance with personnel availability requirements for rapid response to incoming stroke cases.
Necessity:
This section is necessary to define "Stroke Call Roster" to ensure uniform understanding and implementation of staffing and coverage expectations within designated stroke centers.
Establishing this definition clarifies that hospitals participating in a stroke critical care system must maintain 24-hour on-call coverage by qualified personnel, such as neurologists, radiologists, and interventional staff, to ensure timely stroke diagnosis and intervention.
Including this definition promotes consistency in LEMSA oversight and verification of staffing compliance, supports quality patient outcomes through timely response capability, and aligns California's regulatory framework with recognized national standards for comprehensive and primary stroke center designation (e.g., The Joint Commission and DNV standards).

§ 100150.04 Stroke Center

Change:
This section adds a new definition for "Stroke Center." The definition identifies a stroke center as a licensed, certified, and LEMSA-designated general acute care hospital (GACH) that meets the criteria established in this chapter for one of four levels of stroke care: Acute Stroke Ready Hospital (ASRH), Primary Stroke Center (PSC), Thrombectomy Capable Stroke Center (TCSC), or Comprehensive Stroke Center (CSC).
This new definition replaces outdated or inconsistent terminology found in earlier versions of the stroke system regulations and establishes alignment with nationally recognized certification frameworks such as those of The Joint Commission, DNV, and other accrediting organizations.
The inclusion of this section ensures that local EMS agencies apply consistent standards when designating stroke centers within their respective systems.
Necessity:
This section is necessary to clearly define "Stroke Center" as used throughout the subchapter, ensuring consistent interpretation and application among EMSA, LEMSAs, and participating hospitals.
Defining this term provides a regulatory foundation for stroke system designation, certification, and oversight, ensuring hospitals meet the minimum qualifications for providing time-sensitive stroke care.
The differentiation among ASRH, PSC, TCSC, and CSC reflects nationally established tiers of capability and enables LEMSAs to integrate appropriate

levels of care within regional systems based on local resources and patient needs.
This definition promotes statewide uniformity, improves clarity for system planning and evaluation, and supports EMSA's responsibility to maintain consistency with national best practices and Health and Safety Code Division 2.5 requirements.

§ 100150.05 Stroke Certification Entity

Change:
This section adds a new definition for "Stroke Certification Entity." The definition clarifies that a stroke certification entity may be either a nationally recognized hospital certification organization—such as The Joint Commission—or a local emergency medical services agency (LEMSA) that has established a certification process to ensure stroke-designated general acute care hospitals (GACHs) meet all applicable requirements of these regulations.
This is a new section with no counterpart in prior regulation versions. It codifies existing practice by explicitly recognizing both national and LEMSA-led certification processes as valid mechanisms for ensuring stroke center compliance and designation readiness.
Necessity:
This section is necessary to define the term "Stroke Certification Entity" to standardize the authority and scope of organizations responsible for evaluating and certifying stroke centers.
Defining this term clarifies that either nationally recognized accreditation bodies or LEMSAs may perform certification, provided the process ensures hospitals meet all criteria established in this subchapter.
This approach provides flexibility for LEMSAs to adapt to regional needs while maintaining uniform quality standards and accountability.
It also ensures consistent verification of hospital capabilities, reinforces system integrity, and aligns California's stroke system oversight with national best practices and Health and Safety Code Division 2.5 requirements regarding specialty care system designation and evaluation.

§ 100150.06 Stroke Critical Care

Change:
This section adds a new definition for "Stroke Critical Care." The definition establishes the scope of stroke-related emergency and acute care services encompassed within a stroke critical care system, including emergency transport, triage, diagnostic evaluation, and acute interventions for patients requiring immediate medical or surgical treatment.
This section further recognizes that stroke critical care extends beyond acute intervention to include education, prevention, post-acute management, complication prevention, and rehabilitation.
The definition consolidates terminology that was previously undefined in earlier versions of the regulations, aligning it with the parallel "Trauma Care" and "STEMI Critical Care" definitions to promote uniformity across all specialty care system subchapters.

Necessity:
This section is necessary to define "Stroke Critical Care" as the full continuum of time-sensitive medical services provided to stroke patients within the statewide EMS system.
Defining this term establishes clear parameters for what constitutes regulated stroke care activities, ensuring consistency among LEMSAs, designated stroke centers, and EMS providers.
It also emphasizes the importance of a coordinated, system-based approach that includes both prehospital and hospital-based components, in accordance with the integrated specialty care model defined in Division 2.5 of the Health and Safety Code.
Incorporating prevention, acute intervention, and rehabilitation under the definition ensures that stroke system planning and evaluation reflect the complete patient care pathway, supporting improved outcomes and alignment with national standards such as those from the American Stroke Association and The Joint Commission.

§ 100150.07 Stroke Critical Care System

Change:
This section adds a new definition for "Stroke Critical Care System." The definition identifies a stroke critical care system as a subspecialty care component of the local emergency medical services (EMS) system developed and managed by a local EMS agency (LEMSA). It clarifies that this system links prehospital and general acute care hospital services to provide coordinated and timely treatment for patients experiencing stroke.
This is a new definition not previously included in regulation and mirrors the structure and intent of the trauma and STEMI critical care system definitions, promoting consistency across all specialty care subchapters.
Necessity:
This section is necessary to establish a clear definition of "Stroke Critical Care System" as used throughout the subchapter.
Defining this term clarifies the role of the LEMSA in developing, implementing, and overseeing an integrated system that connects prehospital providers and hospital resources to optimize stroke patient outcomes.
It also provides a foundation for statewide consistency in system design, ensuring that each LEMSA's stroke system operates within a common framework while retaining flexibility to address regional needs and available resources.
The inclusion of this definition aligns stroke system terminology with the structure of other regulated specialty care systems—trauma and STEMI—and supports EMSA's statutory authority under Division 2.5 of the Health and Safety Code to set minimum statewide standards for coordinated critical care systems.

§ 100150.08 Stroke Critical Care System Plan

Change:
This section adds a new definition for "Stroke Critical Care System Plan." The definition identifies the plan as an initial implementation document developed

by a local emergency medical services agency (LEMSA) to summarize the development and activation of a stroke critical care system.
This is a new definition that aligns structurally with the trauma and STEMI critical care system plan definitions and serves as a foundational planning document for establishing system components, policies, and operational frameworks before implementation.
Necessity:
This section is necessary to define the term "Stroke Critical Care System Plan" to ensure consistent understanding of the planning process required of LEMSAs when developing a new stroke critical care system.
Establishing this definition provides clarity that each LEMSA must submit an initial plan that describes how its stroke system will be structured, implemented, and evaluated in coordination with EMSA.
The definition supports standardization across local systems by providing a clear reference point for plan submission, review, and approval, ensuring alignment with statewide objectives for time-sensitive care systems.
This section also ensures consistency among the trauma, STEMI, and stroke regulatory frameworks by mirroring equivalent provisions that define initial implementation planning requirements under Division 2.5 of the Health and Safety Code.

§ 100150.09 Stroke Critical Care System Plan Update

Change:
This section adds a new definition for "Stroke Critical Care System Plan Update."
The definition establishes that the plan update is an annual assessment conducted by a local emergency medical services agency (LEMSA) to evaluate the performance, effectiveness, goals, and objectives of its stroke critical care system.
The definition clarifies that this update must be incorporated into the LEMSA's annual EMS plan update submitted to the Emergency Medical Services Authority (EMSA).
This new definition mirrors the format and intent of the corresponding trauma and STEMI plan update provisions, ensuring consistency across all specialty care system regulations.
Necessity:
This section is necessary to define "Stroke Critical Care System Plan Update" to ensure uniform statewide practice for ongoing stroke system evaluation and reporting.
The annual plan update process enables EMSA and LEMSAs to assess system performance, identify gaps, and track progress toward established goals and objectives.
By codifying this definition, the regulation clarifies the expectation for continuous quality improvement and accountability in stroke system operations, ensuring that updates are submitted as part of the regular EMS planning cycle.
The definition also aligns the stroke regulatory framework with existing trauma

and STEMI systems, supporting consistent oversight mechanisms and integration of stroke critical care systems into the broader statewide EMS structure in accordance with Division 2.5 of the Health and Safety Code.

§ 100150.10 Stroke Medical Director

Change:

This section adds a new definition for "Stroke Medical Director." The definition identifies the stroke medical director as a board-certified physician with sufficient experience and expertise in cerebrovascular disease, as determined by the general acute care hospital's credentialing committee, who is responsible for the hospital's stroke program.

This definition did not exist in prior regulation and establishes a clear standard for physician leadership within designated stroke centers, aligning with the equivalent leadership requirements outlined in the trauma and STEMI subchapters.

Necessity:

This section is necessary to define "Stroke Medical Director" to ensure each designated stroke center has qualified physician oversight with the clinical expertise necessary to direct and evaluate stroke care services.

Defining the role provides clarity regarding hospital responsibilities for clinical leadership, program accountability, and quality oversight, ensuring that patient care decisions are guided by a physician experienced in the diagnosis and management of cerebrovascular disease.

The requirement for the hospital credentialing committee to determine sufficient expertise provides flexibility for local implementation while maintaining statewide minimum standards.

Establishing this definition aligns the stroke system's governance and leadership structure with those of trauma and STEMI critical care systems, ensuring a consistent framework for medical oversight and quality assurance across all specialty care programs.

§ 100150.11 Stroke Program

Change:

This section adds a new definition for "Stroke Program." The definition establishes that a stroke program is an organizational component within a general acute care hospital that specializes in the care of stroke patients.

This definition parallels the organizational framework used in trauma and STEMI systems, where defined hospital-based programs ensure the coordination of patient care, quality improvement, and compliance with local emergency medical services agency (LEMSA) requirements.

Necessity:

This section is necessary to define "Stroke Program" to provide clarity and consistency regarding the organizational structure required of hospitals participating in the stroke critical care system.

Defining the stroke program ensures that stroke care is coordinated through a designated structure within the hospital that integrates clinical, administrative,

and quality improvement functions under the oversight of the stroke medical director.
This definition supports consistency among LEMSAs and hospitals by establishing a common understanding of what constitutes a stroke program, ensuring that all designated facilities maintain a dedicated and accountable entity for the management of stroke patients.
The section also aligns with the equivalent program definitions for trauma and STEMI systems, promoting standardized governance and system integration across all specialty care programs under Division 2.5 of the Health and Safety Code.

§ 100150.12 Stroke Program Manager

Change:
This section adds a new definition for "Stroke Program Manager," also referred to as "Stroke Coordinator." The definition identifies this role as a registered nurse or individual with a higher medical degree who is designated by the general acute care hospital to administer the stroke program under the supervision of the Stroke Medical Director.
This definition introduces a standardized leadership role responsible for day-to-day coordination, performance improvement, and administrative oversight of stroke care within designated hospitals.
Necessity:
This section is necessary to define "Stroke Program Manager" to ensure that each designated stroke center maintains an appointed clinical leader responsible for the coordination, management, and evaluation of its stroke program.
Establishing this role provides clarity regarding hospital accountability for stroke program operations and ensures consistent oversight of quality improvement, data collection, education, and compliance with local emergency medical services agency (LEMSA) policies.
The supervision requirement under the Stroke Medical Director reinforces a collaborative leadership structure between clinical and administrative oversight, ensuring that stroke care processes are managed effectively and in alignment with evidence-based standards.
This definition aligns with the leadership roles defined for trauma and STEMI systems, ensuring that all specialty care programs maintain comparable governance and quality management frameworks throughout the statewide emergency medical services system.

§ 100150.13. Stroke Referring Hospital

Change:
This section defines the term "stroke referring hospital" as any licensed general acute care hospital (GACH) within a local emergency medical services (EMS) system that receives patients transported through the 911 emergency response system and that has not been designated as a stroke center. It further specifies

that all stroke referring hospitals must meet the minimum requirements outlined in Section 100152.01 of this subchapter.
Necessity:
This section is necessary to clearly distinguish between designated stroke centers and non-designated general acute care hospitals that nonetheless receive stroke patients through the EMS system.
Defining "stroke referring hospital" establishes a consistent statewide understanding of the role, responsibilities, and baseline standards for hospitals that stabilize or initiate treatment for stroke patients prior to transfer to a higher level of care.
Because these hospitals often serve as the first point of contact in communities without designated stroke centers, their identification and regulation are critical to ensuring continuity of care, timely diagnosis, and appropriate transfer for definitive treatment.
This definition also provides the foundation for regulatory alignment with Section 100152.01, which outlines the operational, data, and quality improvement requirements specific to stroke referring hospitals.
Without this definition, there could be inconsistent classification and oversight of hospitals participating in the stroke care system, potentially leading to delays in patient transfer, variability in pre-transfer treatment, and gaps in data reporting and quality evaluation.
By standardizing the term "stroke referring hospital," this section ensures that all participating facilities are clearly defined, appropriately integrated, and held to consistent minimum performance standards—supporting the broader goal of coordinated, high-quality stroke care throughout California's EMS system.

§ 100150.14 Stroke Team

Change:
This section adds a new definition for "Stroke Team." The definition establishes that the stroke team includes the clinical personnel, support personnel, and administrative staff who function collectively as part of the general acute care hospital's stroke program.
This definition parallels the structure established for trauma and STEMI teams, formalizing the interdisciplinary composition necessary to provide coordinated and effective stroke care.
Necessity:
This section is necessary to define "Stroke Team" to ensure that each designated stroke center identifies and maintains an organized, multidisciplinary team responsible for the delivery of comprehensive stroke care.
Defining the stroke team promotes clarity and consistency regarding the roles and coordination of staff involved in the assessment, diagnosis, treatment, and follow-up of stroke patients.
This structure supports integration across nursing, emergency, neurology, radiology, rehabilitation, and administrative functions to ensure timely interventions and continuous quality improvement within the stroke program.

By formally defining the stroke team, the regulation aligns with the interdisciplinary approach required in trauma and STEMI systems, ensuring that all specialty care programs under Division 2.5 of the Health and Safety Code uphold consistent standards for coordinated, patient-centered care delivery.

§ 100151.01 Stroke Critical Care System Requirements

Change:

This section establishes the minimum requirements and responsibilities of a local emergency medical services agency (LEMSA) that elects to develop and implement a Stroke Critical Care System.

It requires each participating LEMSA to develop a Stroke Critical Care System Plan in compliance with Division 2.5 of the Health and Safety Code and the standards in this chapter, with the option to adopt additional local requirements.

The section outlines responsibilities for planning, coordination, and continuous improvement, including establishment of a Stroke Critical Care System Advisory Committee, designation and oversight of stroke centers, and policies governing prehospital stroke recognition, treatment, and transport.

It also requires interfacility transfer protocols, regional integration agreements, and coordination with other EMS systems. Finally, it mandates public education, data collection, and quality improvement to ensure system performance evaluation.

Necessity:

This section is necessary to define the core responsibilities and structural requirements of local EMS agencies in developing and operating Stroke Critical Care Systems.

By establishing the requirement for a comprehensive Stroke Critical Care System Plan, the regulation ensures that each LEMSA implements an evidence-based, coordinated, and locally adaptable system of stroke care.

The detailed planning requirements—such as prehospital screening protocols, transfer agreements, and cross-jurisdictional coordination—are necessary to reduce treatment delays, improve patient outcomes, and ensure seamless care transitions across the continuum from field response through hospital intervention.

The inclusion of a Stroke Critical Care System Advisory Committee provides multidisciplinary oversight and clinical input to guide local policy and ensure alignment with statewide standards.

Mandating data collection, public education, and ongoing quality improvement ensures continuous evaluation and transparency in system performance.

This structure aligns with the parallel frameworks established in the Trauma and STEMI system regulations, ensuring consistency across all specialty care systems authorized under Division 2.5 of the Health and Safety Code while allowing flexibility to accommodate regional resources and patient needs.

§ 100151.02 Stroke Critical Care System Advisory Committee

Change:
This section requires each local emergency medical services agency (LEMSA) developing and implementing a stroke critical care system to establish a Stroke Critical Care System Advisory Committee.
The committee must meet at least twice per year and include representation from advanced life support (ALS) providers and designated stroke centers.
The section also directs the committee to advise the LEMSA on policies, protocols, and quality improvement (QI) activities related to stroke care.
Additionally, it introduces provisions for LEMSAs that elect to develop a Mobile Stroke Unit (MSU) component, requiring submission of an MSU proposal as part of the annual stroke critical care system plan update or as an addendum, including policies, procedures, and QI plans for MSU operations.
Necessity:
This section is necessary to establish formal multidisciplinary oversight and coordination within each stroke critical care system.
By requiring a Stroke Critical Care System Advisory Committee, the regulation ensures that the development and implementation of stroke care policies are informed by clinical experts and operational partners actively engaged in the EMS and hospital-based components of stroke care.
This collaborative framework strengthens local decision-making, enhances clinical integration, and promotes uniform standards of care across prehospital and hospital settings.
The inclusion of stroke centers and ALS providers ensures that both field and hospital perspectives are represented, improving the continuity of care and the consistency of response protocols.
The requirement for a formalized Mobile Stroke Unit (MSU) proposal process ensures that emerging technologies and advanced care delivery models are implemented safely, with defined operational policies, oversight, and continuous performance monitoring.
Overall, this section aligns with the governance structures used in the trauma and STEMI systems, providing consistency across all specialty care programs under Division 2.5 of the Health and Safety Code, while accommodating innovation and regional flexibility in system design.

§ 100151.03 Stroke Critical Care System Plan Requirements and Determination Process

Change:
This section establishes the requirements and procedures for submission, review, and approval of Stroke Critical Care System Plans by local emergency medical services agencies (LEMSAs).
It specifies that a LEMSA must complete and submit the Initial Stroke Critical Care System Plan Template (Rev. 07/2025) to the Emergency Medical Services Authority (EMSA) for approval prior to implementation of a new stroke system.
The section outlines the determination and notification process, including timelines for EMSA to acknowledge receipt, identify deficiencies, and issue

approval or denial within defined timeframes.
It further establishes procedures for LEMSA responses to denial, including the option to submit a revised plan or appeal to the Commission on EMS.
Additional provisions clarify requirements for implementation timelines, EMSA's authority to rescind approval for noncompliance, the process for modifying approved plans, and requirements for public posting of approved system plans.
Necessity:
This section is necessary to ensure a consistent, transparent, and accountable process for the development, review, and oversight of local Stroke Critical Care System Plans.
Requiring use of a standardized plan template promotes uniformity in the information submitted by LEMSAs and ensures all key components—such as system design, data management, coordination, and quality improvement—are adequately addressed prior to system activation.
The defined timelines for EMSA's review and notification provide clarity to local agencies and prevent delays in system implementation while maintaining necessary state oversight to ensure compliance with statutory and regulatory requirements.
Establishing a formal appeal process protects due process for LEMSAs and maintains consistency with procedures used for other specialty care systems under Section 100000.01 of this Division.
The provisions related to plan modifications and rescission of approval ensure that any significant operational or structural changes to a stroke system remain aligned with statewide standards and that EMSA retains the ability to enforce compliance when systems deviate from approved requirements.
Finally, the public posting requirement promotes transparency and accountability, allowing stakeholders and community members to access information about their local stroke system.
Overall, this section aligns with the equivalent procedures for trauma and STEMI system plans, ensuring consistency across all specialty care system regulations while maintaining the flexibility necessary for local implementation.

§ 100151.04 Stroke Critical Care System Plan Updates

Change:
This section requires each local emergency medical services agency (LEMSA) operating an implemented stroke critical care system to complete and submit the Stroke Critical Care System Plan Update Template (Rev. 07/2025) to the Emergency Medical Services Authority (EMSA) as part of its annual local EMS plan update.
The plan update must include any changes to the stroke critical care system since submission of the prior system plan or annual update, as applicable.
The section also establishes that EMSA will review the plan update in conjunction with its annual review and determination of the LEMSA's local EMS plan, pursuant to Sections 1797.105 and 1797.254 of the Health and Safety Code and Section 100000.01 of this Division.

Finally, it requires LEMSAs to make approved plan updates publicly available on their websites.
Necessity:
This section is necessary to ensure that stroke critical care systems remain current, effective, and in compliance with both state and local requirements following their initial implementation.
Requiring annual submission of a standardized plan update template provides EMSA with a structured and consistent method to evaluate ongoing system performance, identify significant operational or clinical changes, and ensure that system improvements or modifications remain aligned with statewide standards and best practices.
Integrating the stroke system plan update into the annual local EMS plan review streamlines oversight and supports a coordinated, systemwide evaluation of emergency medical services within each jurisdiction.
The provision for public posting of approved updates promotes transparency, enhances stakeholder awareness, and ensures accessibility of information to hospitals, EMS providers, and members of the public.
These requirements mirror those established for trauma and STEMI critical care systems, ensuring statewide consistency and accountability across all specialty care programs while allowing flexibility for regional adaptation and continuous improvement.

§ 100152.01. Stroke Referring Hospital

Change:
This section establishes the minimum operational and coordination requirements for general acute care hospitals (GACHs) functioning as stroke referring hospitals within a local emergency medical services agency (LEMSA)–approved stroke critical care system.
It specifies eligibility criteria for hospitals that receive stroke patients via the 911 emergency response system but are not designated as stroke centers under this subchapter.
The section requires stroke referring hospitals to maintain interfacility transfer (IFT) agreements or protocols, collaborate with the LEMSA on system notification and diversion procedures, and participate in data collection, quality improvement (QI), and evaluation activities in accordance with Article 5.
Necessity:
This section is necessary to ensure that hospitals receiving stroke patients through the EMS system, but not designated as stroke centers, provide a minimum standard of coordinated and timely stroke care prior to transfer to higher-level facilities.
Stroke referring hospitals play a critical stabilizing role in the continuum of stroke care, especially in geographically diverse or resource-limited regions where immediate access to a designated stroke center may not be possible.
By requiring formalized transfer processes and EMS coordination, this section ensures that patients presenting with suspected or confirmed stroke are

promptly stabilized and transferred to appropriate facilities for definitive care without unnecessary delay.
The data collection and QI provisions are essential for maintaining system accountability and performance monitoring, allowing LEMSAs to track stroke patient outcomes and ensure compliance with statewide system standards. Without these requirements, there would be inconsistent practices among non-designated hospitals, resulting in potential delays in treatment, gaps in communication between hospitals and EMS providers, and an inability to evaluate stroke system performance comprehensively.
This section aligns with national best practices outlined by the American Heart Association/American Stroke Association (AHA/ASA) and supports the state's goal of providing seamless, evidence-based care across all phases of stroke management—from prehospital identification through interfacility transfer and definitive treatment.
It ensures that all participating hospitals, regardless of designation level, operate under consistent expectations for coordination, quality improvement, and patient safety within California's stroke critical care systems.

§ 100153.01 Acute Stroke Ready Hospitals

Change:
This section establishes the eligibility criteria and minimum requirements for a licensed general acute care hospital (GACH) to be designated by the local emergency medical services agency (LEMSA) as an Acute Stroke Ready Hospital (ASRH).
It details the clinical and operational capabilities necessary for designation, including 24/7 neuro-imaging services, thrombolytic therapy, and other diagnostic capabilities. It also requires the presence of a qualified stroke program manager and a stroke team with training and expertise in acute stroke care.
The section further requires collaboration with the LEMSA to ensure system-level coordination and notification processes when stroke services are unavailable, written protocols and standardized orders for emergency department stroke care, and participation in continuous data collection and quality improvement (QI) processes.
Additionally, this section mandates a triennial review of hospital stroke programs by the LEMSA or a nationally recognized certification entity and authorizes LEMSAs to establish additional requirements for local designation.
Necessity:
This section is necessary to ensure that Acute Stroke Ready Hospitals—which often serve as the first point of care in rural or resource-limited areas—maintain the capacity to rapidly identify, evaluate, stabilize, and transfer patients experiencing acute stroke to higher-level stroke centers when appropriate.
The specified neuro-imaging, laboratory, and thrombolytic capabilities are critical for timely diagnosis and treatment within evidence-based therapeutic windows, directly affecting morbidity and mortality outcomes.

Requiring a stroke program manager and stroke team with defined qualifications and continuing education ensures consistent clinical oversight, staff competency, and adherence to current best practices in cerebrovascular care.
The provisions regarding transfer protocols and interfacility coordination ensure that patients receive uninterrupted and appropriate care within an integrated regional stroke system, while collaboration with LEMSAs maintains alignment with systemwide policies, diversion procedures, and public safety priorities.
The inclusion of structured data collection and QI participation supports performance measurement, system evaluation, and ongoing improvement across all stroke system components.
Finally, the authorization for LEMSAs to establish additional requirements provides flexibility for local adaptation while preserving statewide consistency and minimum standards.
These requirements parallel the framework established for trauma and STEMI systems, promoting a cohesive, statewide specialty care model that ensures equitable access to high-quality stroke care across California.

§ 100153.02 Primary Stroke Centers

Change:
This section establishes the eligibility criteria and minimum requirements for a licensed general acute care hospital (GACH) to be designated by the local emergency medical services agency (LEMSA) as a Primary Stroke Center (PSC). It specifies that a PSC must first meet all requirements of an Acute Stroke Ready Hospital (ASRH) and then demonstrate additional clinical, operational, and staffing capabilities.
These include defined timelines for neuroimaging and laboratory services, access to neurosurgical and rehabilitation services, and a dedicated team structure that includes a stroke medical director, stroke program manager, and a qualified stroke team with physicians trained in cerebrovascular disease.
The section also requires written policies and standardized emergency department protocols for stroke care, provisions for continuing education for staff and EMS personnel, and a public education component on stroke awareness and prevention.
Designated PSCs must also participate in data collection, quality improvement (QI), and evaluation in accordance with Article 6, conduct program reviews at least every three years, and comply with any additional requirements established by the LEMSA medical director.
Necessity:
This section is necessary to define the standards and operational expectations for Primary Stroke Centers, which serve as regional hubs for the treatment of acute ischemic and hemorrhagic stroke.
By requiring PSCs to meet all ASRH requirements and demonstrate enhanced capabilities—such as rapid neuroimaging, immediate laboratory analysis, and access to neurosurgical services—this section ensures that these hospitals are

capable of delivering timely, evidence-based care to patients with complex or severe stroke presentations.
The specified timeframes for imaging and lab turnaround are consistent with national best practices and clinical guidelines, which emphasize the importance of minimizing "door-to-needle" and "door-to-intervention" times to reduce brain injury and improve patient outcomes.
Requiring dedicated leadership roles (medical director and program manager) and multidisciplinary team composition ensures clinical accountability, coordinated operations, and ongoing staff competency.
The inclusion of continuing education, community outreach, and QI participation promotes a culture of continuous improvement and public engagement in stroke awareness and prevention.
Finally, allowing LEMSAs to impose additional requirements provides flexibility to adapt to local system structures, hospital capabilities, and population needs while maintaining statewide consistency and alignment with the standards of the American Heart Association/American Stroke Association (AHA/ASA) and other nationally recognized certification entities.
Together, these provisions strengthen the statewide stroke system of care, ensuring patients across California have equitable access to high-quality, time-sensitive stroke treatment within an integrated EMS network.

§ 100153.03 Thrombectomy-Capable Stroke Centers

Change:
This section establishes the eligibility criteria and minimum requirements for a licensed general acute care hospital (GACH) to be designated by the local emergency medical services agency (LEMSA) as a Thrombectomy-Capable Stroke Center (TCSC).
It requires that any facility seeking TCSC designation first meet all standards for Primary Stroke Center (PSC) designation and demonstrate additional advanced capabilities related to mechanical thrombectomy, neuro-intensive care, and advanced imaging modalities.
The section outlines staffing qualifications for specialized physicians, including board-certified neuro-interventional radiologists, vascular neurologists, and neuroradiologists, as well as requirements for the 24/7 availability of these specialists and supporting teams.
It also mandates processes for data collection, quality improvement (QI), and evaluation, including adverse event tracking for mechanical thrombectomy procedures and participation in the LEMSA's QI system.
Finally, it requires a triennial review by the LEMSA or a nationally recognized certification entity to ensure continued compliance with state and local standards and authorizes LEMSAs to impose additional designation requirements as needed.
Necessity:
This section is necessary to define the operational, clinical, and staffing standards for Thrombectomy-Capable Stroke Centers, which represent a higher

level of stroke care for patients with large vessel occlusions (LVOs) requiring advanced endovascular intervention.
Mechanical thrombectomy has been demonstrated to significantly improve outcomes when performed rapidly in appropriate patients. Therefore, establishing 24/7 availability for neuro-interventional services, advanced imaging, and neuro-critical care ensures that California's stroke system maintains timely access to this life-saving therapy.
Requiring specific physician qualifications—such as board certification and documented neuro-interventional training—ensures that procedures are performed safely and effectively by clinicians with verified expertise in cerebrovascular intervention.
Mandating the capacity for CTA, MRI/MRA, and perfusion imaging supports accurate diagnosis and patient selection for thrombectomy and related interventions.
The inclusion of data collection, QI, and adverse event monitoring provides a mechanism for continuous oversight, system evaluation, and quality assurance, while the triennial review requirement promotes accountability and ongoing compliance with evolving clinical standards.
Authorizing LEMSAs to impose additional local criteria allows flexibility for regional adaptation and system optimization while maintaining statewide consistency in stroke care delivery.
Overall, these provisions ensure that thrombectomy-capable facilities operate at a level that aligns with national standards (e.g., AHA/ASA and The Joint Commission) and are integrated within California's coordinated stroke critical care system to improve survival and recovery outcomes for patients with severe ischemic stroke.

§ 100153.04 Comprehensive Stroke Centers

Change:
This section establishes the eligibility criteria and minimum requirements for a licensed general acute care hospital (GACH) to be designated by the local emergency medical services agency (LEMSA) as a Comprehensive Stroke Center (CSC).
It specifies that any hospital seeking CSC designation must first meet all requirements for a Thrombectomy-Capable Stroke Center (TCSC) and demonstrate additional advanced capabilities related to complex stroke diagnosis, treatment, and research.
These include the availability of Transcranial Doppler (TCD) services; provision of comprehensive rehabilitation either on-site or through formal transfer agreements; and participation in stroke research programs that contribute to advancing clinical understanding and treatment outcomes.
The section further requires written transfer agreements to ensure the timely acceptance and management of patients requiring neurosurgical intervention or other advanced services.
Staffing requirements include a neurosurgical team capable of treating

hemorrhagic stroke and other neurosurgical emergencies, as well as documented 24/7/365 availability of neurointerventionalists, neurologists, and neurosurgeons.
Comprehensive Stroke Centers must also provide stroke-specific medical education and guidance to other general acute care hospitals (GACHs) within their regional system, participate in data collection and quality improvement (QI) activities in accordance with Article 6, and meet any additional requirements established by the LEMSA medical director.
Necessity:
This section is necessary to define the standards and operational expectations for Comprehensive Stroke Centers (CSCs)—the highest level of stroke care within California's coordinated stroke critical care system.
CSCs serve as regional referral and treatment hubs for the most severe and complex cases, including large vessel occlusions, intracerebral hemorrhages, and other neurosurgical emergencies requiring advanced intervention and continuous neurocritical care.
The requirement for Transcranial Doppler (TCD) services ensures diagnostic capability for cerebral hemodynamic assessment, which is critical in managing both ischemic and hemorrhagic stroke patients.
Mandating comprehensive rehabilitation services and active participation in stroke research promotes long-term patient recovery, innovation, and integration of emerging best practices into clinical care.
The requirement for 24/7/365 coverage by neurointerventional, neurology, and neurosurgery specialists ensures that specialized interventions are available without delay, optimizing outcomes for time-sensitive stroke emergencies.
The inclusion of transfer agreements and system-level education obligations supports a tiered network model in which CSCs act as regional centers of excellence, guiding and supporting other hospitals to enhance system-wide stroke care quality.
Requiring participation in data collection, QI programs, and triennial reviews ensures accountability, transparency, and continuous improvement across the system.
Finally, authorizing LEMSAs to establish additional requirements provides flexibility to tailor the CSC designation process to local and regional system needs while maintaining alignment with national standards, including those of The Joint Commission and the American Heart Association/American Stroke Association (AHA/ASA).
Together, these provisions ensure that Comprehensive Stroke Centers function as integral leaders within California's stroke critical care system, advancing both patient outcomes and statewide performance consistency.

§ 100154.01. Stroke Data Management Requirements

Change:
This section establishes the data management, collection, and reporting requirements for local emergency medical services agencies (LEMSAs),

emergency medical services (EMS) providers, and general acute care hospitals (GACHs) participating in a stroke critical care system.
It defines the standardized process for collecting prehospital and hospital stroke patient care data, sharing outcome information between EMS and hospital providers, and submitting data to the California Emergency Medical Services Information System (CEMSIS).
It also specifies the data elements required for prehospital and in-hospital stroke care, ensuring that all systems use consistent, validated data elements in alignment with national standards.
Necessity:
This section is necessary to establish a uniform, statewide data framework that supports the continuous evaluation, quality improvement, and coordination of California's stroke critical care systems.
Without standardized data definitions, collection intervals, and submission processes, local and state EMS authorities would be unable to measure performance, identify system gaps, or evaluate patient outcomes across regions.
Accurate and complete data are fundamental to improving time-sensitive stroke care. By requiring both prehospital and hospital data—such as stroke recognition times, prearrival alerts, treatment intervals, and outcomes—this section enables comprehensive tracking of the entire stroke care continuum, from 911 call to definitive treatment and discharge.
The section's alignment with the California EMS Information System (CEMSIS) and National EMS Information System (NEMSIS) ensures compatibility with national data reporting standards and facilitates comparative performance evaluation across jurisdictions.
The data-sharing requirements between hospitals and EMS providers are critical to ensure closed-loop communication and performance feedback, particularly for cases where field-identified stroke patients are later found to have alternate diagnoses.
This bidirectional data exchange allows EMS providers and LEMSAs to refine triage, destination, and transport policies, ultimately improving patient outcomes through evidence-based decision-making.
The inclusion of timelines for data submission and specific minimum data elements ensures consistency, timeliness, and accountability in statewide reporting.
This section also provides LEMSAs with the flexibility to expand data collection elements to meet local needs, while maintaining a standardized baseline for statewide quality improvement and regulatory oversight.
By codifying these data management requirements, this section promotes transparency, comparability, and continuous improvement in stroke care delivery, ensuring that every patient in California has access to a high-performing and data-informed stroke critical care system.

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

Change:

This section establishes the minimum quality improvement (QI) and performance evaluation requirements for local emergency medical services agencies (LEMSAs) operating a stroke critical care system.

It outlines the elements that must be incorporated into the LEMSA's QI process, including a multidisciplinary stroke QI committee, participation by prehospital and hospital providers, regional coordination reviews, case reviews, and system-level performance evaluations.

It also requires LEMSAs to implement a bi-directional data-sharing and feedback process to support continuous evaluation and improvement of the stroke system, and mandates performance evaluations at least every three years.

Necessity:

This section is necessary to ensure that local EMS agencies systematically monitor, evaluate, and improve the quality of stroke care provided within their jurisdictions.

Because stroke is a time-critical condition with outcomes heavily dependent on early recognition, rapid intervention, and system coordination, an integrated and data-driven QI process is essential to identifying inefficiencies and improving patient outcomes.

A structured multidisciplinary QI committee is necessary to bring together the full range of system participants—including EMS providers, general acute care hospitals (GACHs), and designated stroke centers—to collaboratively review performance metrics, analyze case data, and recommend system improvements.

This inclusive approach ensures that performance evaluation is comprehensive, transparent, and reflective of the full continuum of care from prehospital assessment through in-hospital treatment.

The requirement for LEMSAs to evaluate regional coordination ensures that stroke destination and interfacility transfer (IFT) policies function effectively, even when patient movement involves facilities outside the LEMSA's jurisdiction. Without this requirement, inconsistencies in regional coordination could lead to delays in care, inappropriate transfers, and missed treatment windows for critical interventions such as thrombolysis or thrombectomy.

The case review and performance evaluation components are necessary to identify adverse events, process delays, or system-level trends that may impact patient outcomes.

Mandating compliance with Evidence Code Section 1157.7 protects the confidentiality of QI reviews, promoting open and constructive case analysis while ensuring compliance with California law.

The bi-directional data-sharing process ensures that performance feedback flows between the LEMSA, EMS providers, and hospitals, creating a continuous learning environment that supports real-time improvement and accountability.

Finally, the requirement for a periodic system evaluation at least every three years ensures that LEMSAs assess the overall effectiveness of their stroke critical care systems, identify resource or policy gaps, and make necessary updates to the system plan.

In total, this section is critical to ensuring that each LEMSA's stroke system operates under a consistent, evidence-based, and continuously improving quality framework, aligned with national best practices and California's statutory intent to deliver timely, coordinated, and high-quality emergency medical services for stroke patients.

§ 100154.03. Designated GACH Quality Improvement and Evaluation Requirements

Change:

This section establishes the requirement that all general acute care hospitals (GACHs) designated as stroke centers under Article 4 of this subchapter undergo regular review and evaluation of their stroke programs at least once every three (3) years.

It specifies two components of this process:

(a) An internal review by the stroke medical director, including assessment and revision of policies and procedures for emergency department stroke services; and

(b) An external review conducted by the local EMS agency (LEMSA) or through a nationally recognized stroke certification program, depending on the hospital's level of designation.

Necessity:

This section is necessary to ensure consistent oversight, accountability, and performance maintenance among all hospitals designated as stroke centers within California's stroke critical care system.

Because stroke care involves rapid diagnosis, timely intervention, and coordination across multiple clinical disciplines, designated stroke centers must demonstrate that they maintain compliance with current standards of practice and system expectations over time.

The three-year review cycle ensures that hospitals regularly evaluate the effectiveness and quality of their stroke programs, update internal protocols to align with evolving evidence-based guidelines, and correct deficiencies identified during review.

Without a defined and recurring evaluation requirement, there would be a risk of program drift, where hospital stroke systems become outdated or inconsistent with local and statewide system goals.

Requiring the stroke medical director to conduct periodic reviews reinforces medical accountability and clinical leadership in maintaining program quality, while also ensuring that hospital policies reflect current best practices for emergency stroke care.

The additional requirement for external review—either by the LEMSA or a nationally recognized stroke certification entity—provides independent

verification of compliance with minimum standards, enhances public confidence in designated centers, and promotes alignment with recognized accreditation frameworks such as those of The Joint Commission or DNV.
This dual-review structure—internal and external—supports continuous quality improvement and provides a standardized mechanism for identifying gaps, sharing best practices, and ensuring that stroke centers remain capable of delivering high-quality, time-sensitive stroke care that meets both state and national performance expectations.
By codifying these requirements, this section ensures that designated stroke centers remain accountable, current, and fully integrated within the local stroke critical care system, thereby improving patient outcomes and supporting California's overall stroke system performance.

Subchapter 4: Emergency Medical Services for Children

§ 100155.01. Purpose and Authority

Change:
This section establishes the purpose of the Emergency Medical Services for Children (EMSC) subchapter, setting forth the overarching framework and intent of the regulations.
It defines the objective to ensure the provision of developmentally appropriate emergency medical services for infants, children, and adolescents across the entire continuum of care, from prehospital response through hospital treatment and rehabilitation.
Necessity:
This section is necessary to clarify the scope, intent, and foundational goals of the EMSC regulations within California's emergency medical services (EMS) system.
Children have unique physiological, developmental, and psychosocial needs that differ significantly from those of adults, requiring specialized training, equipment, and coordinated care systems.
By codifying this purpose, the section provides a clear mandate to establish minimum statewide standards that promote consistency in pediatric emergency care while allowing flexibility for regional adaptation based on local needs and resources.
This section also ensures alignment with the state's statutory authority under Division 2.5 of the Health and Safety Code, which directs the EMS Authority to provide leadership and coordination in emergency medical systems planning and implementation, including care for pediatric populations.

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

Changes:

- Updated integration reference from "including the prehospital and GACH pediatric care components" to explicitly state incorporation *into the LEMSA's EMS Plan*.
- Removed prior redundant descriptive phrases ("which provides…").

- Adjusted punctuation and capitalization for consistency with other specialty system definitions.

Necessity:
Clarifies that the EMSC program is a regulated, integrated component of the LEMSA's EMS Plan rather than a stand-alone program. The revision promotes consistency in structure and scope among all specialty care systems regulated by EMSA.

§100156.02. National Pediatric Readiness Project

Changes:

- Newly added section introducing the National Pediatric Readiness Project (NPRP).
- References to national partners (AAP, ACEP, ENA) were added.
- Added phrase "also known as being 'pediatric ready'" to define terminology consistency.

Necessity:
Adds the National Pediatric Readiness Project as a formally recognized framework for pediatric emergency preparedness. Establishing this definition aligns California's regulatory standards with nationally validated benchmarks used in pediatric emergency medicine.

§100156.03. Pediatric Emergency Care Coordinator (PECC)

Changes:

- Expanded definition to include EMS provider agencies as well as emergency departments.
- Added new clause specifying responsibilities: "familiarizing colleagues with pediatric-specific policies and protocols, promoting pediatric quality improvement efforts, and managing pediatric equipment and supplies."
- Replaced vague phrase "responsible individual" with "individual(s) who is qualified in the emergency care of pediatric patients."

Necessity:
Clarifies qualifications and duties of the PECC and extends applicability to prehospital agencies. These additions ensure standardized implementation of pediatric readiness coordination across the continuum of care.

§100156.04. Pediatric Experience

Changes:

- Added definition of "pediatric experience" (new section).
- Establishes competency-based verification through hospital credentialing rather than prescriptive minimum hour requirements.

Necessity:
Defines pediatric experience in measurable but flexible terms that align with facility credentialing processes. The change ensures consistent qualification of pediatric care personnel statewide.

§100156.05. Pediatric Critical Care Physician

Changes:

- Added phrase "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."
- Updated language from older reference to "approved boards" to specify recognized national certifying bodies.
- Minor grammatical corrections for clarity.

Necessity:
Standardizes qualifications for pediatric critical care physicians and harmonizes board references with current professional recognition standards. Ensures uniformity across hospitals and improves accountability for clinical expertise in pediatric critical care services.

§ 100156.06. Pediatric Patient

Changes:

- Number updated from prior placeholder format to § 100156.06 for consistency.
- Added explicit reference that a pediatric patient is "less than 15 years of age," aligning the definition with Title 22 standards and statewide pediatric trauma and EMSC policies.
- Deleted prior flexible age-range language ("child or adolescent") to standardize.

Necessity:
This revision ensures statewide uniformity in determining who qualifies as a pediatric patient for triage, destination, and reporting. Aligning with Title 22 definitions eliminates ambiguity between EMS and hospital data sets.

§ 100156.07. Pediatric Readiness

Changes:

- Newly added section to define "Pediatric Readiness."
- Added reference to "Pediatric Readiness Assessment of the Pediatric Readiness Project."
- Introduced the phrase "capacity … to meet the unique needs of children" for alignment with the National Pediatric Readiness Project terminology.

Necessity:
Adds a measurable, nationally recognized benchmark for assessing pediatric capability across EMS and hospitals. Establishing this term codifies California's participation in the national pediatric readiness framework and provides a regulatory basis for ongoing quality improvement.

§ 100156.08. Pediatric Receiving Center (PedRC)

Changes:

- Section relocated and renumbered for alignment with other specialty system articles.
- Updated description to specify that the hospital must hold a standby, basic, or comprehensive emergency-services permit.

- Added reference to formal LEMSA designation levels: basic, general, advanced, or comprehensive.
- Corrected cross-reference to Article 5 for designation requirements.

Necessity:
Clarifies the structural and operational requirements for pediatric receiving centers to ensure alignment with LEMSA designation processes. The update brings consistency across trauma, STEMI, stroke, and EMSC systems.

§ 100156.09. Pediatric Recognition Program

Changes:

- New section added to codify the process by which LEMSAs recognize pediatric readiness in hospitals and prehospital providers.
- Language "designate pediatric receiving GACHs and prehospital providers" replaced earlier informal "recognition of readiness" phrasing.
- Added reference to alignment with EMSC performance measures.

Necessity:
Creates a regulatory mechanism for LEMSAs to formally recognize pediatric-ready entities. This change standardizes the recognition process statewide and ensures compliance with national EMSC program expectations and grant-reporting requirements.

§ 100156.10. Qualified Pediatric Specialist

Changes:

- Updated certification pathways to explicitly include both ABMS and AOA Bureau of Osteopathic Specialties.
- Replaced the outdated phrase "approved specialty board" with current board designations.
- Corrected minor typographical and reference errors (e.g., section renumbering, punctuation).

Necessity:
Ensures qualifications for pediatric specialists reflect current national certification standards. The revision promotes consistency in credentialing expectations and confirms that pediatric care oversight is provided by properly certified professionals.

§ 100157.01. EMSC Program Requirements

Changes:

- Newly structured section modeled after other specialty system frameworks (Trauma § 100139.01, Stroke § 100154.01).
- Added (b) Plan Requirement: Specifies development and submission of an EMSC program plan prior to implementation, including annual updates.
- Cross-references updated: Refers to § 100155.01 (Purpose and Application) and § 100155.02 (Application) for consistency in plan-submission procedure.
- Expanded (c) Planning Responsibilities:

- Added requirement to establish an EMSC Committee (§ 100157.02).
- Added new subsections on Pediatric Readiness Recognition Program, System Coordination Agreements, and Disaster Preparedness, none of which were previously delineated.
- Updated language under "Policies" to explicitly include pediatric-specific personnel training, ambulance equipment, and level-of-service categories (first response, transport, IFT, critical care).
- Added requirement for public education and data-driven QI processes under paragraph (9).

- Terminology and formatting standardization: Changed "Designate and Oversight" → "Designation and Oversight"; corrected subparagraph sequence; normalized punctuation and indentation.
- Authority and Reference citations expanded to include §§ 1797.250, 1797.254 (LEMSA plans) and § 1798.150 (system oversight).

Necessity:
This section establishes the foundational framework for local EMS agencies to develop, implement, and maintain Emergency Medical Services for Children (EMSC) programs in alignment with statewide EMS planning requirements.
The revisions are necessary to:

1. Create consistency with other specialty-care systems (Trauma, STEMI, Stroke) by defining equivalent plan, approval, and evaluation expectations.
2. Clarify LEMSA responsibilities for pediatric system design, policy development, and performance oversight, ensuring pediatric-specific elements (training, equipment, transfer, and destination policies) are standardized statewide.
3. Integrate national pediatric readiness principles by establishing a local recognition program and formal disaster-preparedness planning for pediatric surge.
4. Ensure transparency and accountability through defined public-education, data-collection, and QI requirements.

§ 100157.02. EMSC Committee
Changes:

- New section introduced to codify LEMSA committee structure for pediatric system oversight, mirroring trauma (§ 100139.02) and stroke (§ 100154.01) committees.
- Added explicit meeting frequency requirement ("at least twice a year").
- Expanded required membership composition to include:
  - Public and private EMS providers;
  - 911-receiving general acute care hospitals (GACHs);

    - Regional pediatric trauma receiving centers that receive pediatric interfacility transfers (IFTs); and
    - "Other relevant stakeholders" for flexibility in regional participation.
- Added new subsection (b) defining committee functions—advising on EMSC policies and participating in pediatric care QI work.
- Updated Authority and Reference citations to include §§ 1797.250, 1797.254, and 1798.150 for plan submission and system oversight alignment.

Necessity:
This section establishes the EMSC Committee as the formal advisory and quality-improvement body for pediatric emergency care within each LEMSA.
It is necessary to:

1. Ensure stakeholder representation across the full continuum of pediatric emergency care, including prehospital and hospital providers.
2. Create consistency with existing trauma and stroke committee structures to support uniform statewide governance of specialty systems.
3. Provide a mechanism for data-driven, multidisciplinary input into pediatric system design, policy, and performance improvement.
4. Support compliance with state and federal EMSC program grant requirements mandating stakeholder involvement and continuous quality review.

§ 100157.03. EMSC Program Plan Requirements and Determination Process
Changes:

- New section introduced to mirror the plan-approval process used in the trauma (§ 100139.03) and stroke (§ 100154.03) frameworks, ensuring procedural uniformity across specialty systems.
- Added detailed submission, review, and approval timelines:
    - 30-day acknowledgment of receipt;
    - 60-day determination for approval or denial.
- Standardized EMSA oversight procedures, including the addition of:
    - (c) LEMSA response period of six months after denial;
    - (d) Implementation deadline of six months after plan approval;
    - (e) Rescission language linking failure to implement to revocation of the local EMS plan.
- Added new (g) Plan Modifications paragraph defining "significant changes," such as closure of a pediatric receiving center (PedRC), changes in pediatric service level, or pediatric destination policy changes.
- Added new (h) Public Notice requirement for transparency by requiring posting of the approved plan on the LEMSA website.

- Corrected prior drafting error referencing "stroke critical care system plan" to "EMSC program plan."
- Introduced and incorporated by reference two new templates:
  - Initial EMSC Plan Template (Rev. 07/2025);
  - Annual EMSC Program Plan Update Template (Rev. 07/2025).
- Updated Authority and Reference citations to include §§ 1797.103, 1797.105, 1797.107, 1797.250, 1797.254, 1798.150, and 1799.204 to reflect both LEMSA planning requirements and pediatric program jurisdiction.

Necessity:
This section is necessary to provide a clear, standardized, and transparent process for the development, submission, approval, and modification of local EMSC program plans.
Specifically, the updates:

1. Align EMSC with existing specialty-care plan procedures for trauma and stroke, establishing consistent timelines and responsibilities statewide.
2. Ensure accountability by defining EMSA's review process, LEMSA response timelines, and consequences for failure to implement.
3. Increase flexibility by permitting expedited implementation when delays could affect pediatric patient care, while still requiring prompt EMSA notification.
4. Enhance public transparency through mandated online posting of approved EMSC plans.
5. Support ongoing system oversight by linking plan modifications and updates to data-driven pediatric readiness and QI requirements.

§ 100157.04. EMSC Program Plan Update
Changes:

- New standalone section created to delineate the process for annual submission and review of EMSC program plan updates, modeled after the equivalent sections in the trauma (§ 100139.04) and stroke (§ 100154.04) systems.
- Clarified that all implemented EMSC programs must annually complete and submit the Annual EMSC Program Plan Update Template (Rev. 07/25), incorporated by reference.
- Added explicit cross-references to § 100157.03 (Plan Requirements and Determination Process) to maintain procedural continuity.
- Added review and approval process language in subdivision (b), confirming that EMSA will evaluate EMSC updates as part of its annual local EMS plan review under § 1797.105, ensuring statewide consistency.
- Added (c) Public Notice requirement to ensure local transparency by requiring online posting of approved updates.

- Expanded Authority and Reference citations to include §§ 1797.103, 1797.105, 1797.176, 1797.254, 1798.150, and 1799.204 to align with state oversight and pediatric system authority.

Necessity:
This section is necessary to establish a standardized annual process for maintaining current and accurate Emergency Medical Services for Children (EMSC) program information within the statewide EMS planning framework.
The revisions:

1. Ensure continuity and accountability by requiring annual updates from each LEMSA, allowing EMSA to verify ongoing compliance with pediatric readiness standards.
2. Provide consistency with other specialty system update requirements, allowing coordinated oversight of trauma, STEMI, stroke, and EMSC programs under the same procedural model.
3. Promote system transparency by requiring approved plan updates to be made publicly available.
4. Facilitate statewide quality improvement by ensuring that pediatric system changes—such as hospital designation updates, pediatric readiness status, and interfacility transfer policies—are captured annually.

§ 100158.01. EMS Provider EMSC Requirements
Changes:

- New section added to formally establish minimum EMSC participation and pediatric readiness standards for EMS provider agencies.
- Introduced requirement that each EMS provider agency designate a prehospital Pediatric Emergency Care Coordinator (PECC), aligning with federal EMSC program performance measures.
- Added subsection (a) clarifying that:
  - The PECC role is mandatory for all 911 response providers within a LEMSA operating an approved EMSC program.
  - The role may be assigned in combination with other duties, providing flexibility for smaller or rural agencies.
  - The role must be filled by an EMS clinician, ensuring appropriate clinical expertise.
- Added subsection (b) outlining core PECC duties, including:
  - Training and Competency – ensuring all field personnel maintain pediatric-specific knowledge and skills aligned with LEMSA policies and protocols.
  - Equipment and Supplies – confirming that all 911 response vehicles carry and maintain required pediatric equipment.
  - Quality Improvement – integrating pediatric metrics into the agency's QI program.

- Added cross-reference to Section 100156.05 (PECC Definition) for consistency across EMSC regulatory sections.
- Updated authority and reference to include §§ 1797.107 and 1799.204, aligning with EMSA's statutory role in system development and pediatric emergency care standards.

Necessity:
This section is necessary to ensure pediatric readiness and accountability among EMS provider agencies participating in local EMSC programs.
The inclusion of PECC designation and defined responsibilities:

1. Operationalizes national EMSC standards by requiring a designated pediatric care lead within each EMS provider agency.
2. Improves clinical competence by ensuring regular pediatric training, equipment maintenance, and skills verification.
3. Supports quality assurance by mandating pediatric-specific oversight within agency QI processes.
4. Promotes system integration by aligning field-level readiness with LEMSA and hospital-level pediatric initiatives.
5. Provides flexibility for agencies of varying size and resource capacity while maintaining a statewide minimum standard.

These provisions collectively strengthen pediatric preparedness and performance across California's EMS system, ensuring that all EMS provider agencies delivering 911 response are capable of delivering high-quality, developmentally appropriate care to children.

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

Changes:

- New section created to formally identify requirements for general acute care hospitals (GACHs) that are *not* designated as Pediatric Receiving Centers (PedRCs) but that operate within a jurisdiction with an approved EMSC program.
- Added new IFT-specific requirements to ensure uniform safety, communication, and accountability in pediatric interfacility transfers (IFTs).
- Subsection (a) establishes that non-designated GACHs must comply with the LEMSA's pediatric IFT policy and defines detailed minimum IFT policy components, including:
    - (i) Identification of patients eligible for transfer;
    - (ii) Partner PedRC selection process;
    - (iii) Automatic acceptance criteria;
    - (iv) Continuous 24/7/365 communication access between hospitals;
    - (v) Standardized communication language and minimum patient information exchange;
    - (vi) Guidance on selecting transport resources based on patient acuity and provider scope;

- (vii) Processes for transferring consent forms, records, and belongings;
- (viii) Requirements for providing family or guardian information about receiving facility location and logistics.

- Added new subparagraph (B) allowing LEMSAs to support compliance through pre-established IFT agreements between hospitals, consistent with local policy and designed to enhance coordination and patient safety.
- Added subsection (b) to clarify that non-designated GACHs remain subject to the data management, QI, and evaluation provisions under Article 6 of the subchapter.
- Added subsection (c) authorizing the LEMSA medical director to impose additional local requirements beyond the statewide minimums.
- Introduced uniform cross-references to PedRC sections for consistency across Articles 5 and 6.
- Authority and Reference to include §§ 1797.103, 1797.105, 1797.107, 1797.250, 1798.150, and 1799.204, aligning with EMSA oversight of system planning, interfacility coordination, and pediatric emergency standards.

Necessity:
This section is necessary to ensure that pediatric patients treated at hospitals *not* designated as Pediatric Receiving Centers receive safe, coordinated, and timely interfacility transfer to an appropriate higher level of pediatric care. Specifically, the regulation:

1. Addresses a critical systems gap by establishing minimum IFT standards for non-designated hospitals, where many pediatric patients may initially present.
2. Standardizes pediatric transfer practices statewide, promoting equity and continuity of care regardless of hospital designation.
3. Improves clinical outcomes by requiring prearranged communication pathways, defined criteria for automatic acceptance, and timely access to specialized pediatric resources.
4. Enhances operational clarity for both hospitals and EMS agencies by codifying transfer expectations and documentation requirements.
5. Maintains local flexibility, allowing LEMSAs to impose additional or region-specific requirements while preserving a consistent statewide baseline.

These provisions are essential to ensure that pediatric interfacility transfers occur efficiently and safely, reducing avoidable delays and improving outcomes for critically ill or injured children across California's EMS system.

§ 100160.01. Requirements for all PedRCs

Changes:

- New comprehensive section added to consolidate and define minimum statewide standards for all Pediatric Receiving Centers (PedRCs) within local EMS systems.
- This section mirrors the structure of trauma, STEMI, and stroke system standards but is specific to pediatric emergency and critical care readiness.
- Establishes five key regulatory domains: Capabilities, Program Staffing, System Participation, Continuing Education, and Data/QI Compliance.

(a) Capabilities

- Added detailed list of minimum clinical and operational capabilities required for all PedRC-designated GACHs.
- Introduced 24/7/365 consultation requirement (telephone or telehealth) to ensure access to pediatric expertise at all times.
- Added specific consultant categories including pediatric specialists, pediatric critical care physicians, and respiratory care specialists with verified pediatric competencies.
- Added structured list of equipment, supplies, and medication standards scaled for neonates through adolescents, including:
    - Resuscitation tools (tape, carts, and verification systems),
    - Warming and monitoring devices,
    - Airway, vascular, and fracture management supplies,
    - Medication requirements, and
    - Specialized kits and newborn delivery supplies.
- Added rapid transfer requirement, mandating formal written protocols and prearranged EMS and hospital agreements for interfacility transfers (IFTs).

(b) Program Staffing

- Introduced mandatory PECC staffing requirement for all PedRCs, specifying minimum qualifications and numbers based on PedRC designation level (Basic, General, Advanced, Comprehensive).
- Added distinct qualification standards for nursing/NP/PA PECCs (licensure, experience, CE requirements) and for physician PECCs (licensure, board certification, resuscitation competency).
- Added defined PECC responsibilities, including:
    - Family-centered care oversight,
    - Liaison functions with EMS, GACHs, and LEMSA,
    - Coordination of continuing education,
    - Pediatric disaster preparedness, and
    - Oversight of QI activities involving pediatric emergency care.

(c) System Participation and Coordination

- Added requirement that PedRCs collaborate with LEMSA and EMS providers on policy development related to pediatric transfers.

- Requires PedRCs to adhere to LEMSA IFT policies and develop detailed IFT protocols mirroring those required for non-designated hospitals.

(d) Pediatric IFT Requirements & Agreements

- Incorporated IFT policy details from § 100159.01 to maintain alignment and consistency between designated and non-designated hospitals.
- Added optional prearranged IFT agreements to enhance efficiency and patient safety, allowing LEMSAs to operationalize regional pediatric transport systems.

(d/e) Continuing Education

- Added mandatory continuing education requirement for all categories of personnel involved in pediatric emergency care, including hospital staff, EMS personnel, and community providers.

(e) Data Collection, QI, and Evaluation

- Added requirement for all PedRCs to comply with Article 6 of this subchapter, ensuring participation in pediatric data collection, quality improvement, and system evaluation processes.

Technical and Structural Changes

- Introduced clear subsection hierarchy and reordered paragraphs to align with parallel specialty care regulations (Trauma, STEMI, Stroke).
- Eliminated redundancy between subsections by cross-referencing existing sections (e.g., IFT policy requirements).
- Added standardized use of "twenty-four (24) hours per day, seven (7) days per week, 365 days per year" to align with EMSA regulatory style.
- Updated numbering to match statewide convention for major system standards articles.

Necessity:

This section is necessary to ensure statewide consistency, readiness, and quality in pediatric emergency and critical care within designated Pediatric Receiving Centers (PedRCs).

The detailed capability, staffing, and operational requirements:

1. Establish a consistent statewide baseline for pediatric emergency readiness across all designated facilities, ensuring equitable access to high-quality pediatric care.
2. Strengthen pediatric clinical competency and system integration by requiring on-site or consultative access to pediatric specialists, defined PECC oversight, and 24/7 communication capabilities.
3. Promote interfacility coordination and efficiency through standardized IFT processes and prearranged agreements, reducing transfer delays and improving outcomes for critically ill or injured children.

4. Ensure continuous quality improvement through mandatory participation in data collection, education, and performance evaluation under Article 6.
5. Align with national EMSC standards and Pediatric Readiness Project recommendations, integrating evidence-based best practices into California's EMS regulatory framework.
6. Allow local flexibility by permitting LEMSAs to define designation levels (Basic, General, Advanced, Comprehensive) while maintaining uniform minimum standards statewide.

By codifying these requirements, EMSA ensures that all designated PedRCs operate at a consistent level of pediatric readiness, clinical capability, and coordination — improving outcomes for children throughout the state.

§ 100160.02. Basic PedRCs

Changes:

- New section added to define eligibility criteria and minimum designation standards for Basic Pediatric Receiving Centers (PedRCs) within the EMSC system.
- Establishes the lowest-level designation tier in the pediatric care continuum, providing a regulatory foundation for smaller or rural hospitals to participate in pediatric emergency care under LEMSA oversight.
- Aligns with the tiered system model used for trauma and STEMI designations (basic → general → advanced → comprehensive), promoting consistency across all specialty care systems.

(a) Eligibility

- Added clear eligibility criteria allowing licensed GACHs to apply for Basic PedRC designation through the LEMSA, provided they meet requirements under this section.
- Clarifies that EMSA oversight occurs through LEMSA program plan approval, preserving local flexibility.

(b) Requirements

- Subparagraph (1): ED Permit.
  - Specifies that Basic PedRCs must have at least a basic or standby emergency department permit, ensuring minimum facility readiness.
- Subparagraph (2): Capabilities.
  - Introduces minimum staffing and operational capability standards, including:
    - (A) Physician Availability: Requires 24/7/365 physician coverage or consultation capability to support continuous pediatric access.
    - (B) Staff Qualification: Adds new requirement for at least one licensed RN or advanced practice clinician per

shift to have current pediatric emergency training (e.g., PALS, APLS, or ENPC).
        - (C) Initial Stabilization: Establishes requirement that Basic PedRCs be capable of initial stabilization of critically ill or injured pediatric patients before transfer to a higher level of care.
- Subparagraph (3): Program Staffing.
    - Requires designation of at least one Pediatric Emergency Care Coordinator (PECC), consistent with § 100160.01(b).
    - Allows shared PECC staffing between facilities to increase feasibility for small or rural hospitals.
- Subparagraph (4): Agreements with Higher-Level PedRCs.
    - Adds requirement for formal agreements with at least one comprehensive PedRC (for transfer and education support) and one advanced or general PedRC (for consultation and transfer coordination).
    - Ensures structured escalation of pediatric care through a defined referral network.
- Subparagraph (5): Transfer Agreements.
    - Adds requirement for written transfer agreements for specialty pediatric services (e.g., trauma, burn, behavioral health, rehabilitation), establishing a complete transfer network for specialized care.
- Subparagraph (6): Additional Requirements.
    - Provides authority for the LEMSA medical director to impose additional local standards, preserving flexibility for regional adaptation and innovation.
- Overall, the section parallels the organizational structure of other specialty care programs while emphasizing scalability for community hospitals.

Necessity:

This section is necessary to define and standardize the minimum capabilities and requirements for Basic Pediatric Receiving Centers, ensuring that hospitals with limited pediatric resources can safely stabilize and transfer children while maintaining alignment with the statewide EMSC program.

Specifically, these requirements:

1. Create a defined entry point for hospitals to participate in pediatric emergency care within the EMSC system, expanding geographic access to initial stabilization and treatment.
2. Establish minimum safety and competency thresholds for physician and nursing coverage, ensuring that children receive appropriate care regardless of location.

3. Support regional integration through mandatory transfer and consultation agreements, enabling efficient movement of patients to higher levels of care.
4. Enhance workforce competency by requiring pediatric-specific training for emergency department personnel.
5. Increase statewide consistency by defining a clear, baseline standard for Basic PedRC designation across all LEMSAs.
6. Preserve local flexibility through medical director authority, enabling LEMSAs to tailor additional requirements based on regional needs and hospital capabilities.

These provisions ensure that even hospitals with limited pediatric infrastructure contribute safely and effectively to the EMSC network, promoting equitable access to time-sensitive pediatric emergency care throughout California.

§ 100160.03. General PedRCs

Changes:

- New section establishing statewide standards for General Pediatric Receiving Centers (PedRCs) as the second tier in the pediatric care designation hierarchy (above Basic, below Advanced and Comprehensive).
- The section expands requirements for equipment, staffing, and coordination compared with Basic PedRCs while preserving alignment with § 100160.01 (core standards applicable to all PedRCs).
- Adds new subsections to define eligibility, operational requirements, and transfer responsibilities.

(a) Eligibility

- Introduces clear eligibility language specifying that any licensed GACH meeting the requirements of this section may be designated as a General PedRC by the local EMS agency (LEMSA).
- Reinforces that designation authority rests with the LEMSA, consistent with the structure used for trauma and STEMI systems.

(b) Requirements

- Subparagraph (1): ED Permit.
    - Requires General PedRCs to hold at least a basic or comprehensive emergency department (ED) permit, increasing operational readiness expectations beyond those of Basic PedRCs.
- Subparagraph (2): Capabilities.
    - (A) Initial Stabilization: Retains requirement from Basic PedRCs but emphasizes readiness to stabilize critically ill or injured pediatric patients prior to transfer or admission.
    - (B) Neonatal Resuscitation: Adds a new and specific list of minimum neonatal resuscitation equipment, including pediatric laryngoscope blades, small endotracheal tubes, and umbilical vein catheters.

        - This aligns with national Pediatric Readiness Project recommendations and American Academy of Pediatrics standards.
- Subparagraph (3): Program Staffing.
    - Expands the PECC requirement to explicitly mandate two PECCs—one physician and one nurse/NP/PA—consistent with higher-level expectations.
    - Allows for shared PECC staffing arrangements across PedRCs to maintain feasibility for mid-size hospitals.
- Subparagraph (4): Continuing Education.
    - Adds new requirement for formal participation in pediatric emergency education through partnerships with comprehensive or advanced PedRCs, ensuring ongoing staff training and knowledge retention.
- Subparagraph (5): Agreements with Higher Level PedRCs.
    - Requires formal agreements for consultation, education, and patient transfer with advanced and/or comprehensive PedRCs, supporting regional integration and escalation pathways.
- Subparagraph (6): Transfer Agreements.
    - Retains and expands requirement for written transfer agreements with specialized centers (e.g., trauma, burn, spinal cord injury, rehabilitation, behavioral health), ensuring comprehensive access to specialty pediatric services.
- Subparagraph (7): Additional Requirements.
    - Preserves LEMSA Medical Director authority to establish additional local criteria as appropriate for the system's needs.

Technical and Structural Adjustments

- Introduced cross-references to § 100160.01 for consistency and to prevent duplication of general PedRC standards.
- Adopted parallel numbering and phrasing conventions used in Trauma (§ 100139 et seq.) and Stroke (§ 100152 et seq.) systems for readability and consistency.
- Clarified minor typographical elements ("and;" → "and," etc.) for grammatical alignment.

Necessity:

This section is necessary to define clear statewide standards for General PedRC designation, establishing an intermediate level of pediatric readiness between Basic and Advanced centers.

Specifically, the requirements:

1. Create a standardized framework for mid-level hospitals to deliver consistent, high-quality pediatric emergency stabilization and coordination prior to transfer.

2. Ensure essential neonatal resuscitation capability, addressing a critical clinical need for infants who present to emergency departments not equipped as specialized pediatric centers.
3. Strengthen clinical competency and preparedness through required PECC staffing, continuing education, and defined training standards for nurses and physicians.
4. Promote systemwide coordination through required consultation and transfer agreements with higher-level PedRCs, ensuring seamless patient movement and reducing care delays.
5. Enhance alignment with national pediatric readiness benchmarks, ensuring California's EMSC program reflects evidence-based national best practices.
6. Preserve flexibility for LEMSAs to set additional local requirements while maintaining a statewide baseline for designation consistency.

These provisions ensure that General PedRCs serve as reliable regional pediatric resources capable of providing safe stabilization, initial management, and effective coordination with advanced centers, thereby improving outcomes for critically ill or injured children.

§ 100160.04. Advanced PedRCs

Changes:

- New section added to establish statewide minimum standards and eligibility for Advanced Pediatric Receiving Centers (PedRCs) — representing the third tier of pediatric emergency designation, above General PedRCs and below Comprehensive PedRCs.
- Expands on § 100160.01 and § 100160.03 by introducing advanced-level licensing, staffing, and subspecialty consultation requirements.
- Adds cross-references to relevant California Code of Regulations (Title 22) and clarifies integration with CDPH licensing criteria.

(a) Eligibility

- Introduces eligibility language consistent with the other designation tiers, authorizing LEMSAs to designate a GACH as an Advanced PedRC if the hospital meets the requirements of this section.
- Aligns eligibility terminology with trauma and STEMI system designations ("may be designated by the local EMS agency").

(b) Requirements

- Establishes broad compliance obligations with § 100160.01 (systemwide PedRC requirements) plus additional advanced-level specifications.

(1) Licensing

- New detailed licensing subsection specifying all regulatory categories and CDPH licensure articles required for Advanced PedRC designation.
- Introduces explicit references to:
    - Article 1 (sections 70003 & 70005) for GACH licensure.

- Article 6, Section 70535 et seq. for pediatric service licensing.
- Article 6, Sections 70411 et seq. and 70451 et seq. for emergency medical services.
- Article 6, Section 70629 et seq. for social service requirements.
- Adds optional NICU licensure specifications (Community NICU or Intermediate NICU) under Articles 70545 and 70481, reinforcing continuity of perinatal-to-pediatric critical care.
- Adds explicit PICU licensure requirements under Article 70491 et seq. for hospitals maintaining a pediatric intensive care unit.

- Aligns regulatory cross-references with existing Title 22 language to ensure clarity and prevent interpretation conflicts between CDPH and EMSA oversight.

(2) Capabilities

- Expands upon General PedRC stabilization requirements by requiring the ability to stabilize critically ill pediatric patients for admission to a PICU or transfer to a Comprehensive PedRC.
- Introduces standardized pediatric crash cart requirements:
  - All general PedRC equipment plus pediatric resuscitation carts available in all patient care areas (ED, radiology, inpatient units).
- This ensures consistent readiness for pediatric emergencies throughout the hospital environment, not just in the emergency department.

(f) Staffing Requirements and Qualifications

- Completely new section defining 24/7 availability of essential clinical staff:
  - Respiratory Care Practitioners (RCPs) with pediatric-specific clinical training.
  - Medical Social Workers (MSWs) with pediatric/family psychosocial expertise.
  - Behavioral Health Specialists (psychiatrists, psychologists, or nurses with pediatric experience).
- These additions elevate the care environment by ensuring comprehensive medical and psychosocial support for children and families.

(g) On-Call Specialties Requirements and Qualifications

- Adds new and specific lists of pediatric subspecialties with mandated response times and modalities (in-person, phone, telehealth).
- Establishes three consultation tiers:
  1. Within 30 minutes by telephone / 60 minutes in-person:

        - Neonatologist, general surgeon with pediatric experience, anesthesiologist or nurse anesthetist with pediatric experience.
    2. Within 30 minutes (in-person, phone, or telehealth):
        - Radiologist, otolaryngologist, mental health professional, orthopedist, and pediatric cardiologist.
    3. Available 24/7/365 for consultation (transfer or telehealth acceptable):
        - Pediatric gastroenterologist, hematologist/oncologist, infectious disease specialist, nephrologist, neurologist, pediatric surgeon, cardiac surgeon, neurosurgeon, obstetrician/gynecologist, pulmonologist, and endocrinologist.
- This subsection represents a major expansion of defined pediatric specialty access, ensuring higher-acuity care continuity at the advanced tier.

(3) Agreements with Higher-Level PedRCs

- Expands interfacility coordination requirements:
    - Formal consultation and transfer agreements with at least one Comprehensive PedRC.
    - Explicit inclusion of specialty transfer agreements for trauma, burn, spinal cord injury, rehabilitation, and behavioral health.
- Strengthens alignment between local and regional pediatric systems, ensuring escalation of care when needed.

(4) Continuing Education

- Requires ongoing collaboration with a Comprehensive PedRC for pediatric emergency training and continuing education for staff.
- Aligns continuing education expectations with LEMSA pediatric education plans to ensure systemwide uniformity and competency.

(iv) Program Staffing

- Maintains requirement for dual PECCs (physician + nurse/NP/PA), consistent with the higher-acuity expectations of advanced centers.
- Reinforces professional accountability for pediatric QI, training, and system coordination.

(5) Additional Requirements

- Preserves LEMSA Medical Director discretion to establish additional regional criteria, maintaining flexibility for local adaptation.

Necessity:

This section is necessary to codify advanced-level pediatric hospital designation standards that bridge community-level pediatric care and the highest level of comprehensive pediatric centers.

Specifically, the section:

1. Ensures alignment with CDPH licensing to avoid duplication and clarify the interface between EMSA's designation authority and hospital licensure requirements.
2. Creates a statewide minimum standard for advanced-level pediatric capability, ensuring consistent care quality across regions.
3. Improves pediatric readiness and outcomes by requiring continuous access to pediatric subspecialists, trained staff, and essential equipment.
4. Enhances coordination of pediatric transfers through standardized agreements and clear communication expectations.
5. Supports comprehensive care delivery through mandated respiratory therapy, social work, and behavioral health staffing — recognizing the unique physical and psychosocial needs of children.
6. Aligns California EMSC standards with national benchmarks, including the *American Academy of Pediatrics Policy Statement on Pediatric Readiness in the Emergency Department (2023)* and the *National Pediatric Readiness Project (NPRP)*.
7. Provides flexibility for LEMSAs to adapt implementation to regional resources while maintaining statewide consistency.

By codifying these standards, EMSA ensures that Advanced PedRCs are equipped to manage critically ill or injured children, provide specialized consultation, and maintain coordinated referral pathways that collectively elevate the quality and consistency of pediatric emergency care statewide.

§ 100160.05. Comprehensive PedRCs

Changes:

- New section defining the highest designation tier for Pediatric Receiving Centers — the Comprehensive PedRC, equivalent in scope and function to Level I trauma centers or Comprehensive Stroke Centers.
- Consolidates and elevates standards from § 100160.01 (general requirements) and § 100160.04 (advanced PedRCs) to ensure the highest level of pediatric emergency, surgical, and critical care capability.
- Establishes the criteria for tertiary pediatric care facilities serving as regional referral and education hubs within the statewide EMSC system.

(a) Eligibility

- Introduces standard eligibility language authorizing LEMSAs to designate a licensed GACH as a Comprehensive PedRC when all requirements of this section are met.
- Clarifies that eligibility is contingent upon meeting both advanced-level requirements (§ 100160.04) and additional comprehensive-level provisions.

- Reinforces that designation authority rests with the local EMS agency, consistent with the trauma, STEMI, and stroke system structure.

(b) Requirements

- Builds upon prior PedRC levels by requiring the hospital to meet all advanced PedRC criteria plus additional specialized care, inpatient resource, and educational outreach standards.

(1) Licensing

- Adds new requirement that Comprehensive PedRCs must be approved by the Department of Health Care Services (DHCS) as a California Children's Services (CCS) Program tertiary hospital.
- This ensures statewide consistency in tertiary pediatric care qualifications and aligns EMSC standards with DHCS pediatric system designations.
- Provides a clear linkage between EMS designation and existing state-level hospital certification processes to prevent overlap or inconsistency.

(2) Capabilities

- Expands upon § 100160.04(b)(2) to define specific operational and clinical requirements:
    - (A) Level of Care.
        - Requires the ability to provide comprehensive specialized pediatric medical and surgical care to all acutely ill or injured children — establishing the highest threshold of pediatric capability in the system.
        - Positions Comprehensive PedRCs as regional pediatric hubs for consultation, care delivery, and referral.
    - (B) Pediatric-Specific Emergency Services.
        - Adds requirement for a dedicated pediatric emergency department or a designated pediatric care area within a general ED.
        - Specifies that emergency physicians must be qualified specialists in emergency medicine or pediatric emergency medicine, elevating professional competency expectations.
    - (C) Inpatient Resources.
        - Adds requirement for both a Neonatal Intensive Care Unit (NICU) and a Pediatric Intensive Care Unit (PICU) — ensuring the full continuum of inpatient pediatric critical care.
        - Reinforces the requirement for continuous pediatric coverage across multiple hospital departments.

(4) Continuing Education

- Introduces explicit requirement for ongoing outreach and education programs directed at lower-tier PedRCs (basic, general) and prehospital providers.
- Positions Comprehensive PedRCs as educational leaders responsible for disseminating pediatric emergency training and readiness best practices in coordination with the LEMSA.
- Promotes a structured statewide network of continuous quality improvement and knowledge transfer.

(5) Transfer Agreements

- Requires Comprehensive PedRCs to either:
  - Serve as regional referral centers for specialty pediatric care (e.g., trauma, burn, spinal cord injury, rehab, behavioral health); or
  - Maintain written transfer agreements with other specialized facilities when services are not available in-house.
- Clarifies the role of Comprehensive PedRCs in regional system coordination and patient flow optimization.

(6) Additional Requirements

- Retains standard clause allowing the LEMSA Medical Director to establish additional local or regional criteria as needed, maintaining flexibility for system-specific adaptations.

Technical and Structural Adjustments

- Introduced cross-reference to § 100160.04(b) to avoid redundant text and ensure clear hierarchical structure between designation tiers.
- Standardized terminology (e.g., "GACH," "LEMSA," "PedRC") for consistency across subchapter.
- Minor numbering and format adjustments to maintain uniformity with other specialty care systems (e.g., Stroke § 100156.04, Trauma § 100139.03).

Necessity:

This section is necessary to define and codify the statewide standards for the highest level of pediatric care within California's Emergency Medical Services for Children (EMSC) program.

Specifically, these requirements:

1. Ensure comprehensive, tertiary-level readiness by mandating NICU and PICU services, pediatric emergency medicine-trained physicians, and full-spectrum pediatric surgical and subspecialty capabilities.
2. Align EMSC hospital designations with DHCS California Children's Services (CCS) standards, reducing regulatory fragmentation and ensuring consistent oversight across state agencies.
3. Establish regional leadership roles for Comprehensive PedRCs, requiring them to provide outreach education, consultation, and referral support to lower-level PedRCs and EMS providers.

4. Enhance pediatric patient outcomes through streamlined regional coordination, ensuring critically ill or injured children have access to facilities capable of providing the highest level of care.
5. Promote statewide consistency in pediatric system design, mirroring the tiered structure of trauma and stroke systems for clarity and interoperability.
6. Preserve LEMSA flexibility to tailor additional requirements based on local resources, geography, and pediatric population needs.

By defining Comprehensive PedRC requirements, this section completes the tiered pediatric care framework envisioned in the EMSC regulations — establishing a coordinated, standards-based system that ensures timely access to expert care for every child in California, regardless of location.

§ 100161.01. EMSC Data Management Requirements

Changes:

- New section establishing statewide minimum data collection, reporting, and sharing standards for the Emergency Medical Services for Children (EMSC) program.
- Introduces parallel data infrastructure and reporting expectations consistent with those in the Trauma (§ 100143.01), STEMI (§ 100151.05), and Stroke (§ 100154.01) subchapters, but adapted for pediatric-specific measures and system participation.
- Expands LEMSA and hospital data coordination responsibilities to ensure continuous pediatric system evaluation and quality improvement.

(a) Data Collection and Reporting Process Requirements

(1) LEMSA Responsibilities

- Adds explicit requirement that each local EMS agency (LEMSA) must develop and implement a standardized EMSC data collection and reporting process.
- Aligns structure and intent with data sections in other specialty system subchapters (Trauma, STEMI, Stroke).
- Requires that the LEMSA's process cover both prehospital and hospital-level pediatric data, ensuring complete patient care tracking across the continuum.
- New language mandating collaboration between the LEMSA, Pediatric Receiving Centers (PedRCs), and EMS providers to share outcome data — promoting closed-loop communication and accountability for system performance.
- Adds emphasis on inclusion of all transported pediatric patients, not only those treated at designated PedRCs, ensuring comprehensive data coverage and accurate outcome evaluation.

(2) GACH Responsibilities

- Introduces two new requirements for hospitals within EMSC systems:

- (A) PedRCs must collaborate with the LEMSA and EMS providers to provide pediatric outcome data for use in prehospital quality improvement (QI). This ensures that field personnel receive case-level follow-up to improve care practices.
- (B) All GACHs receiving pediatric patients via EMS—whether designated or not—must participate in the LEMSA's data collection process per local policy. This expands accountability beyond designated centers and increases dataset completeness.

(3) Timing of Submission

- Establishes a clear reporting timeline:
  - Quarterly data submissions to EMSA, either directly or via the LEMSA.
  - Within 90 days of patient discharge, ensuring timely inclusion of both hospital and prehospital data in CEMSIS (California EMS Information System).
- Mirrors timelines in other system subchapters for consistency and to support statewide data synchronization.

(b) EMSC Patient Care Data Requirements

(1) Prehospital EMSC Patient Care Data Elements

- New subsection specifying that all prehospital pediatric care data collected under EMSC must conform to the most current CEMSIS and NEMSIS (National EMS Information System) standards.
- Ensures data compatibility with national reporting standards and allows California to benchmark its pediatric outcomes nationally.
- Provides flexibility for LEMSAs to select locally relevant subsets of pediatric elements while maintaining baseline conformity with CEMSIS/NEMSIS.

(2) GACH EMSC Patient Care Data Elements

- New provision granting LEMSAs authority to select hospital-level pediatric data elements for inclusion in the EMSC reporting process.
- Recognizes that pediatric care systems vary in maturity and data capacity, allowing for regional customization while maintaining a statewide data structure.
- Balances statewide standardization with local flexibility to account for resource disparities among GACHs.

Technical and Structural Adjustments

- Introduces consistent terminology ("EMSC patient care data," "PedRCs," "LEMSA") for clarity and alignment with other subchapters.
- Adds standardized quarterly submission language consistent with §§ 100143.02, 100151.05, and 100154.01 to support integrated data governance.

- Corrects capitalization and formatting to follow EMSA's regulatory drafting conventions (e.g., "Emergency Medical Services Authority (EMSA)" on first reference).

Necessity:

This section is necessary to establish a consistent, statewide pediatric data infrastructure that enables effective system oversight, quality improvement, and outcome evaluation across prehospital and hospital settings.

Specifically, these requirements:

1. Ensure comprehensive data collection by mandating standardized processes for both EMS and hospital providers, allowing complete patient tracking across the pediatric care continuum.
2. Enable statewide benchmarking by aligning pediatric data elements with CEMSIS and NEMSIS, ensuring California's participation in national EMSC and pediatric readiness reporting initiatives.
3. Promote collaboration and transparency between prehospital and hospital providers through structured outcome data sharing — a key component of pediatric quality improvement.
4. Enhance accountability and timeliness by requiring quarterly submission within 90 days of discharge, supporting rapid performance feedback and system monitoring.
5. Support evidence-based decision-making by generating reliable pediatric datasets for trend analysis, regional gap identification, and statewide policy evaluation.
6. Maintain flexibility for LEMSAs to define additional local elements and procedures based on regional needs and resource capacity while adhering to a standardized framework.

By codifying these data management standards, EMSA strengthens the integrity and comparability of pediatric emergency care data statewide, enabling improved patient outcomes and system performance measurement consistent with national best practices under the National Pediatric Readiness Project.

§ 100161.02. Local EMS Agency EMSC Quality Improvement and Evaluation Process

Changes:

- New section created to establish statewide minimum standards for quality improvement (QI) and evaluation specific to the Emergency Medical Services for Children (EMSC) program.
- Modeled after equivalent QI provisions in other specialty care systems (Trauma § 100143.03, STEMI § 100151.06, Stroke § 100154.02) while adapting the framework to pediatric system needs.
- Clarifies LEMSA's leadership responsibility for pediatric QI integration into the broader EMS QI program.
- Introduces consistent expectations for multidisciplinary review, participation, data use, and periodic system evaluation.

(a) Pediatric Care Integration into LEMSA QI Program

- Adds clear direction that pediatric care must be embedded within each LEMSA's existing QI infrastructure — not a stand-alone process — ensuring full system accountability.
- Establishes that any LEMSA operating an approved EMSC program must maintain a formal, structured QI process inclusive of pediatric performance indicators.

(1) Policy Development

- New placeholder subsection recognizing the need for LEMSAs to create written QI policies governing pediatric data use, confidentiality, case selection, and corrective-action protocols.
- Provides regulatory flexibility — allowing EMSA to retain, revise, or delete depending on broader QI rule harmonization.

(2) Multidisciplinary QI Committee

- Expands prior informal pediatric QI expectations into a formal requirement for an EMSC-specific or multidisciplinary QI committee.
- Ensures inclusion of diverse system participants (prehospital, hospital, nursing, medical direction, and administrative representatives).
- Clarifies that pediatric QI may be housed within an existing LEMSA QI body, avoiding redundancy while maintaining pediatric visibility.

(3) System Participation

- Requires participation from all relevant EMS providers and designated PedRCs in both:
    - (i) Data collection activities defined in § 100161.01 (data management); and
    - (ii) The LEMSA's ongoing pediatric QI review.
- New subparagraph (B) expands participation to include all GACHs that send or receive pediatric patients, not just designated centers — closing prior data and accountability gaps for transferred patients.
- This provision ensures that interfacility transfer outcomes and coordination are part of QI review regardless of facility designation level.

(4) Regional Coordination Review

- Introduces requirement for regular evaluation of regional pediatric patient movement and destination policies, including inter-LEMSA pediatric IFTs.
- Mirrors trauma and stroke coordination review standards to strengthen statewide pediatric system integration.
- Corrects prior system fragmentation by explicitly calling for review of cross-jurisdictional transfers and destination compliance.

(5) Case Review

- Adds structured review of:
    - Pediatric deaths,
    - Locally defined adverse events, and
    - Transfers (especially delayed or complex IFTs).

- Aligns pediatric QI expectations with trauma/stroke review protocols emphasizing continuous performance feedback loops.

(6) System Performance Evaluation

- Establishes that QI must include evaluation of structure, process, and outcomes, reinforcing comprehensive system assessment consistent with EMSA's statewide QI model.
- Provides framework for performance metrics tied to data collected under § 100161.01.

(7) Confidentiality Protections

- Retains statutory citation to Evidence Code § 1157.7 ensuring confidentiality of QI reviews and protection of participants.
- Updates language from "stroke cases" (carryover from prior template) to apply to pediatric cases — a technical correction necessary for accuracy and applicability.

(b) LEMSA Responsibility for Ongoing Evaluation

- Establishes LEMSA accountability for continuous monitoring and feedback within its EMSC system.
- Clarifies that pediatric QI results and data trends must inform future plan revisions and local policy decisions.

(1) Evaluation Support Process

- Adds requirement for a bi-directional feedback mechanism using committee work and regular data reporting to:
    - Share results with EMS providers, PedRCs, GACHs, and the broader medical community.
    - Support iterative evaluation of the EMSC program plan and its responsiveness to local system needs.
- Emphasizes collaboration and transparency while maintaining confidentiality protections.

(2) Periodic Performance Evaluation

- Introduces minimum triennial (every 3 years) evaluation cycle consistent with other specialty systems.
- Requires dissemination of evaluation results to system participants, ensuring visibility and promoting shared accountability for pediatric performance improvement.
- Corrects typographical header to "Periodic" (previously "Period") to align with EMSA formatting standards.

Technical and Structural Adjustments

- Aligns all cross-references to § 100161.01 (data management) and Article 6 numbering.
- Corrects terminology: "pediatric IFTs" (replacing typographical "pedistric IFTs").
- Clarifies use of "LEMSA Medical Director" where applicable.
- Ensures structural parallelism with QI provisions across Trauma, STEMI, and Stroke subchapters.

Necessity:
This section is necessary to ensure consistent, data-driven evaluation and quality improvement across California's EMSC programs, establishing parity with existing trauma, STEMI, and stroke systems.
Specifically, these standards:

1. Formalize pediatric QI integration into LEMSA operations, ensuring children's emergency care is continuously monitored and improved within all EMS systems.
2. Promote multidisciplinary collaboration across prehospital, hospital, and interfacility settings to identify trends, reduce variability, and improve outcomes.
3. Close gaps in transfer and outcome review by including all GACHs, not only designated PedRCs, in system performance assessments.
4. Strengthen regional coordination by mandating review of pediatric transfers that cross LEMSA boundaries and by assessing destination policy compliance.
5. Safeguard QI confidentiality while maintaining transparency through required feedback loops and triennial performance evaluations.
6. Align pediatric QI expectations with national models endorsed by the *Health Resources and Services Administration (HRSA) EMSC Program* and the *National Pediatric Readiness Project*.
7. Enable data-informed decision-making by linking the QI process directly to the standardized data management system in § 100161.01.

By codifying these requirements, EMSA ensures every LEMSA implements a continuous, structured pediatric quality improvement system that drives measurable enhancements in the care and outcomes of California's children.

§ 100161.03. Designated GACH Quality Improvement and Evaluation Requirements

Changes:

- New section created to define standardized quality improvement (QI) and evaluation requirements for all designated Pediatric Receiving Centers (PedRCs) participating in an Emergency Medical Services for Children (EMSC) system.
- Mirrors and adapts similar QI provisions from other specialty care systems (e.g., Trauma § 100143.03, Stroke § 100154.03) while integrating pediatric-specific system performance and case review expectations.
- Establishes a uniform statewide framework to align hospital-level pediatric QI efforts with LEMSA and EMSA system-level oversight.

(a) QI Program Requirement

- Adds new requirement that all designated PedRCs must maintain an internal QI program specific to pediatric care.

- Clarifies that the QI program must integrate emergency, prehospital, inpatient, trauma, and hospital-wide quality activities, ensuring a holistic approach to pediatric system evaluation.
- The provision unifies fragmented hospital pediatric QI efforts into a single, coordinated process aligned with LEMSA QI expectations.

(1) System Performance Evaluation

- Introduces requirement for a comprehensive performance evaluation process that bridges prehospital, emergency department, inpatient pediatrics, and hospital-wide quality programs.
- (A) Integrates emergency department QI activities with trauma, pediatric critical care, and hospital-wide processes—ensuring communication and consistency across disciplines.
- (B) Adds requirement to incorporate findings from QI audits into staff education and competency evaluations, institutionalizing continuous learning from system review findings.
- Represents a shift from siloed review models to an integrated quality management system consistent with national pediatric readiness standards.

(2) Multidisciplinary QI Committee

- New subsection requiring participation in a multidisciplinary pediatric QI committee to review both prehospital and hospital-level care.
- Ensures representation across all phases of pediatric patient care — from EMS response through inpatient admission.
- Lists key review categories that reflect high-acuity or high-risk pediatric events requiring system learning:
    - (A) Cardiopulmonary/respiratory arrests
    - (B) Child maltreatment cases
    - (C) Deaths
    - (D) ICU admissions and length of stay
    - (E) OR admissions and surgery type
    - (F) Transfers and ED boarding
    - (G) Trauma admissions
- This codifies case types for mandatory review, promoting statewide consistency and alignment with the National Pediatric Readiness Project (NPRP) and HRSA EMSC Performance Measures.

(3) National Pediatric Readiness Project Self-Assessment

- New requirement mandating completion of the National Pediatric Readiness Project (NPRP) Self-Assessment at least every three (3) years.
- Requires results to be shared with the LEMSA, integrating national benchmarking into local and state QI efforts.
- Encourages continuous improvement and alignment with national pediatric readiness standards through cyclical reassessment.

(6) Pediatric Interfacility Transfer (IFT)

- New subsection focused on improving pediatric IFT processes — a previously under-regulated but critical element of pediatric systems of care.
- (A) Requires each PedRC to include IFT process improvement as part of its QI activities and provide feedback to referring GACHs and the LEMSA to close the loop on transfer quality and timeliness.
- (B) Extends QI participation to all sending and receiving GACHs for pediatric transfers, ensuring that all facilities share accountability for safe and timely IFTs.
- Aligns with provisions in § 100160.01(d) and § 100159.01(a)(1)(A), integrating IFT oversight into overall system performance evaluation.

(4) Confidentiality Protections

- Retains consistent confidentiality language referencing California Evidence Code § 1157.7, ensuring all QI activities, including case reviews and committee discussions, are protected from disclosure.
- Corrects reference scope to apply to pediatric cases rather than stroke or trauma, harmonizing with EMSC subject matter.

Technical and Structural Adjustments

- Standardized references to "PedRCs," "LEMSA," and "GACHs" for clarity and consistency across Articles 5 and 6.
- Added numbering continuity to align with related subsections (e.g., replacing misnumbered "(6)" after (3) with proper sequencing).
- Ensured section titles, cross-references, and formatting match EMSA's regulatory drafting conventions used in other specialty care program articles.
- Typographical correction of "quality QI activities" (redundant phrasing).

Necessity:

This section is necessary to ensure that all designated Pediatric Receiving Centers maintain a structured, standardized quality improvement program that aligns with statewide and national pediatric emergency care objectives. Specifically, these provisions:

1. Establish consistent statewide QI expectations for all PedRCs, closing variability among local systems and ensuring alignment with EMSA oversight and national pediatric readiness standards.
2. Promote multidisciplinary system learning by integrating prehospital, emergency, trauma, inpatient, and administrative perspectives into coordinated QI review processes.
3. Drive continuous improvement through required incorporation of QI findings into staff education, skill maintenance, and clinical competency evaluations.
4. Support statewide benchmarking via mandatory completion of the National Pediatric Readiness Project Self-Assessment, providing data to guide readiness and capacity improvements.

5. Enhance interfacility transfer safety and efficiency by requiring formal QI evaluation of pediatric IFTs and feedback loops between sending and receiving facilities.
6. Protect sensitive quality review processes under Evidence Code § 1157.7 to encourage open participation and thorough case analysis.
7. Promote accountability and transparency between LEMSAs, hospitals, and EMS providers through standardized data sharing and evaluation processes.

By codifying these QI and evaluation standards, EMSA ensures that designated pediatric facilities operate under a uniform, evidence-based performance framework that supports safe, coordinated, and continuously improving care for California's children.

Incorporated by Reference Forms

The forms are being incorporated by reference to streamline the submission process and ensure that all required information is consistently and accurately provided

- Initial Trauma Care System Plan Template (Rev. 11/2025)
- Annual Trauma System Status Report Template (Rev. 11/2025)
- American College of Surgeons Resource for Optimal Care of the Injured Patient 2022 Standards, ISBN 978-1-7369212-9-6 (Rev. 03/2022)
- Initial STEMI Critical Care System Plan Template (Rev. 11/2025)
- Annual STEMI Critical Care System Plan Update Template (Rev. 11/2025)
- STEMI Patient Care Data Dictionary (Rev. 11/2025)
- Initial Stroke Critical Care System Plan Template (Rev. 11/2025)
- Annual Stroke Critical Care System Plan Update Template (Rev. 11/2025)
- Stroke Patient Care Data Dictionary (Rev. 11/2025)
- Initial EMSC Plan Template (Rev. 11/2025)
- Annual EMSC Program Plan Update Template (Rev. 11/2025)

Comments will be accepted between November 12, 2025 and November 26, 2025. When commenting, please indicate the proposed rulemaking action to which your comment refers. The original OAL action number is Z2025-0205-03 (Critical and Specialty Care Programs – Update of Chapter 6 of Division 9 of Title 22).

All written comments received by November 26, 2025, which pertain to the indicated changes will be considered by EMSA and will be summarized and responded to in the Final Statement of Reasons.

AVAILABILITY OF DOCUMENTS ON THE INTERNET

Copies of the Notice of Proposed Action, the Initial Statement of Reasons, and the proposed text are available on the EMSA website at https://emsa.ca.gov/public_comment/

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