



Health Services
LOS ANGELES COUNTY

Los Angeles County
Board of Supervisors

Hilda L. Solis
First District

Mark Ridley-Thomas
Second District

Sheila Kuehl
Third District

Don Knabe
Fourth District

Michael D. Antonovich
Fifth District

Mitchell H. Katz, M.D.
Director

Hal F. Yee, Jr., M.D., Ph.D.
Chief Medical Officer

Christina R. Ghaly, M.D.
Chief Operations Officer

313 N. Figueroa Street, Suite 912
Los Angeles, CA 90012

Tel: (213) 240-8101
Fax: (213) 481-0503

www.dhs.lacounty.gov

*To ensure access to high-quality,
patient-centered, cost-effective
health care to Los Angeles County
residents through direct services at
DHS facilities and through
collaboration with community and
university partners.*



www.dhs.lacounty.gov

November 15, 2016

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, California 90012

Dear Supervisors:

**APPROVAL TO DESIGNATE POMONA VALLEY HOSPITAL MEDICAL
CENTER AS A LEVEL II TRAUMA CENTER AND EXECUTE A TRAUMA
CENTER
SERVICE AGREEMENT
(SUPERVISORIAL DISTRICT 1)
(3 VOTES)**

SUBJECT

Approval to designate Pomona Valley Hospital Medical Center as a Level II Trauma Center and execute a Trauma Center Service Agreement.

IT IS RECOMMENDED THAT THE BOARD:

Delegate authority to the Director of Health Services (Director), or his designee, to designate Pomona Valley Hospital Medical Center (Pomona Valley) as a Level II Trauma Center and execute a Trauma Center Service Agreement (TCSA) with Pomona Valley, with no payment provisions, at such time as Pomona Valley is fully capable and qualified to function as a designated Trauma Center (TC) through June 30, 2017.

ADOPTED

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

25 November 15, 2016

LORI GLASGOW
EXECUTIVE OFFICER

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTION

Trauma care is vital to public health and safety. TCs can save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries. In communities with access to TCs, mortality and morbidity rates from traumatic injuries are significantly reduced.

Approval of the recommendation will allow the Director to execute an agreement, substantially similar to Exhibit I, that officially designates Pomona Valley as a TC when the hospital is fully capable and qualified to function in that capacity, which is expected to occur in early 2017. The delegated authority will afford the Department of Health Services' (DHS) the ability to execute the TCSA Agreement with Pomona Valley as soon as it is ready for TC designation and thereby avoid the typically eight to ten week timeline to process a Board letter and obtain Board approval.

During the Pre-Trauma Center Designation Agreement period, DHS Emergency Medical Services (EMS) Agency has been and continues to work collaboratively with Pomona Valley to ensure the hospital completes the necessary pre-designation activities, including but not limited to: completing building infrastructure improvements, construction of a permanent helipad, development of required policies, acquiring necessary staff and equipment, and implementing data collection and trauma specific performance improvement programs. As part of the assessment of Pomona Valley's readiness to become a TC, the EMS Agency arranged for the American College of Surgeons (ACS) to conduct a Consultative Review of Pomona Valley's trauma program which included evaluating the quality of care provided to "walk-in" patients who met trauma center criteria, as well as equipment, and policies and processes specific to the care of trauma patients implemented by Pomona Valley.

On August 10 and 11, 2016, a Consultative Review of Pomona Valley for its readiness for designation as a TC was conducted by the ACS and the EMS Agency. The evaluation determined that Pomona Valley does not currently meet all of the requirements to be designated a TC. The surveyors noted that the targeted time frame of trauma designation in the first quarter of 2017 seemed too ambitious given the remaining unresolved construction and personnel issues. Delays in construction that were beyond Pomona Valley's control have resulted in delays in other program-related activities, such as the hiring of specific staff that needs to coincide more closely with the TC designation. Once Pomona Valley meets the outstanding requirements identified by ACS and County, the EMS Agency will move forward with the TC designation and DHS will execute a TCSA with Pomona Valley. The expiration date of June 30, 2017 is co-terminus with the other TCs' TCSAs. When DHS returns to the Board for authority to either extend the current TCSAs or execute superseding TCSAs, Pomona Valley will be included in the request for either of those actions.

Implementation of Strategic Plan Goals

The recommended action supports Goal 3, Integrated Services Delivery, of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

No fiscal impact.

DHS will continue to evaluate if there is a need to increase the level of funding for the TCSA if Pomona Valley becomes a designated trauma center.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

Pursuant to the authority granted under California Health and Safety (H&S) Code Section 1798.160, the County maintains trauma facilities as part of the regional trauma care system for treatment of potentially seriously injured persons. Division 2.5 of the H&S Code authorizes the local Emergency Medical Services (EMS) Agency to designate TCs as part of the regional trauma care system. There are currently 12 non-County and two County-operated TCs in the County.

The Board approved the first TCSAs on October 11, 1983, under the Los Angeles County Trauma Program to provide funding for otherwise unreimbursed trauma care, to help ensure the availability of trauma care within Los Angeles County.

On July 7, 2015, the Board approved the execution of a pre-trauma center designation Agreement with Pomona Valley in order to reduce transport times for patients that met trauma triage criteria, as well as to augment the critical care services available to the residents of the East San Gabriel Valley area.

The EMS Agency has worked in collaboration with Pomona Valley to ensure successful completion of designation requirements, and continues to assess the hospital's readiness to function as a Trauma Center.

In September, 2016, following the ACS Consultative Review on August 10 and 11, 2016, the EMS Agency was notified by Pomona Valley that it was unable to meet the deadlines for several contractual requirements before the original expiration date of its Pre-Trauma Center Designation Agreement due to the aforementioned construction delays and, therefore, would be unable to begin functioning as a TC within the originally anticipated timeframe. DHS utilized the delegated authority provided by the Board on July 7, 2015 to extend the aforementioned Agreement for six months until April 30, 2017. DHS will continue to monitor and work collaboratively with Pomona Valley to ensure that Pomona Valley meets all TC requirements. When these requirements have been met, the EMS Agency can officially designate Pomona Valley a TC.

County Counsel has approved Exhibit I as to form.

CONTRACTING PROCESS

Pomona Valley was the selected applicant for pre-trauma center designation services in the East San Gabriel Valley from the Request for Applications solicitation process that was completed in fiscal year 2014-15.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Following successful completion of the pre-designation TC requirements, execution of a TCSA with Pomona Valley will allow the provision of trauma services by a designated TC for the East San Gabriel Valley area.

The Honorable Board of Supervisors

11/15/2016

Page 4

Respectfully submitted,

A handwritten signature in black ink that reads "Mitchell Katz". The signature is written in a cursive style with a large, sweeping "K" at the end.

Mitchell H. Katz, M.D.

Director

MHK:CC

Enclosures

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors
Emergency Medical Services Commission
Hospital Association of Southern California

DEPARTMENT OF HEALTH SERVICES



TRAUMA CENTER SERVICE AGREEMENT

BY AND BETWEEN

COUNTY OF LOS ANGELES

AND

POMONA VALLEY HOSPITAL MEDICAL CENTER

EFFECTIVE

UPON EXECUTION – JUNE 30, 2017

TRAUMA CENTER SERVICE AGREEMENT

TABLE OF CONTENTS

EXHIBIT I (BODY OF THE AGREEMENT)

ATTACHMENTS:

ADDITIONAL PROVISIONS

ATTACHMENT AP-1 Safely Surrender Notice (English)

ATTACHMENT AP-2 Safely Surrender Notice (Spanish)

EXHIBIT A.I LEVEL I TRAUMA CENTER REQUIREMENTS

EXHIBIT A.II LEVEL II TRAUMA CENTER REQUIREMENTS

EXHIBIT A.III LEVEL I PEDIATRIC TRAUMA CENTER REQUIREMENTS

EXHIBIT A.IV LEVEL II PEDIATRIC TRAUMA CENTER REQUIREMENTS

ATTACHMENT A-1 Emergency Department Approved for
Pediatrics (EDAP) Standards

EXHIBIT B.2 PROVISIONS FOR REIMBURSEMENT OF ELIGIBLE PATIENTS

ATTACHMENT B-1 Trauma Service County Eligibility Protocol

Attachment U-1 Trauma Service County Eligibility (TSCE)
Agreement

Attachment U-2 Hospital Certification of Inability to
Cooperate

ATTACHMENT B-2 Notice (English)

ATTACHMENT B-3 Notice (Spanish)

ATTACHMENT B-4 Instructions for Submission of Claims &
Data Collection

ATTACHMENT B-5 Trauma Physician Services Program Packet

ATTACHMENT B-6 Trauma Center Payment Refund Form

EXHIBIT C PATIENT INCLUSION IN THE TRAUMA CENTER DATA SYSTEM

EXHIBIT D TRAUMA CENTER DATA COLLECTION SYSTEM

ATTACHMENT D-1 TEMIS Hospital Hardware & Software Specifications

ATTACHMENT D-2 Trauma Patient Summary (TPS) Form Pages 1 & 2

ATTACHMENT D-3 Hospital Employee Acknowledgment & Confidentiality Agreement

EXHIBIT E DATA ADVISORY COMMITTEE MEMBERSHIP

EXHIBIT F Intentionally Omitted

EXHIBIT G Intentionally Omitted

EXHIBIT H Intentionally Omitted

EXHIBIT I Intentionally Omitted

EXHIBIT J Intentionally Omitted

EXHIBIT K Intentionally Omitted

EXHIBIT L PARAMEDIC BASE HOSPITAL AGREEMENT

TRAUMA CENTER SERVICE AGREEMENT

TABLE OF CONTENTS

<u>PARAGRAPH</u>	<u>PAGE #</u>
1. <u>TERM</u> :.....	- 2 -
2. <u>ADDITIONAL PROVISIONS</u> :.....	- 5 -
3. <u>SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY)</u> :.....	- 5 -
4. <u>SPECIFIC RESPONSIBILITIES OF CONTRACTOR</u> :.....	- 11 -
5. <u>INDEMNIFICATION</u> :.....	- 13 -
6. <u>GENERAL INSURANCE REQUIREMENTS</u> :.....	- 14 -
7. <u>SPECIFIC INSURANCE COVERAGE REQUIREMENTS</u> :.....	- 19 -
8. <u>WAIVERS</u> :.....	- 21 -
9. <u>STANDARDS OF CARE</u> :.....	- 23 -
10. <u>NUMBER OF PATIENTS TO BE TREATED</u> :.....	- 24 -
11. <u>PATIENT TRANSFERS</u> :.....	- 24 -
12. <u>TRAUMA CENTER SIGNS</u> :.....	- 26 -
13. <u>TRAUMA TEAM</u> :.....	- 26 -
14. <u>TRAUMA CENTER FEES</u> :.....	- 27 -
15. <u>QUALITY IMPROVEMENT</u> :.....	- 29 -
16. <u>DUE PROCESS</u> :.....	- 31 -
17. <u>RESPONSIBILITY FOR INDIGENT PATIENTS</u> :.....	- 36 -
18. <u>STATUS OF CONTRACTOR</u> :.....	- 37 -
19. <u>INTERPRETERS</u> :.....	- 37 -

20. CONSUMER COMPLAINTS: - 38 -

21. NOTICES: - 39 -

TRAUMA CENTER SERVICE AGREEMENT

THIS AGREEMENT is made and entered into this _____ day
of _____, 2016,

by and between

COUNTY OF LOS ANGELES
(hereafter "County"),

and

POMONA VALLEY HOSPITAL
MEDICAL CENTER
(hereafter "Contractor").

WHEREAS, various general acute care hospitals located within Los Angeles County have been identified by County as hospitals which are uniquely staffed and equipped to provide appropriate care to emergency patients who suffer major trauma; and

WHEREAS, Contractor is willing to accept and care for trauma patients at hospital under County's advanced trauma system and in accordance with the terms and conditions which follow herein; and

WHEREAS, Contractor, by virtue of the parties' execution of this Agreement, is a County designated Trauma Center; and

WHEREAS, this Agreement establishes funding available to Contractor for certain services performed during the term of this Agreement for services to be performed by Contractor described herein in accordance with the terms and conditions under this Agreement; and

WHEREAS, Contractor has agreed to use its best efforts to maintain continuous participation as a County-designated Trauma

Center and Paramedic Base Hospital during the term of this Agreement; and

WHEREAS, the Agreement is authorized by Health and Safety Code Sections 1797.204, 1797.252, and 1798.170, Government Code Section 26227, as well as by provisions of Welfare and Institutions Code Section 16946.

NOW, THEREFORE, the parties agree as follows:

1. TERM:

A. The term of this Agreement shall commence and be effective upon execution with such date reflected on page 1 of this Agreement, and shall remain in full force and effect through and including June 30, 2017, or upon execution of superseding replacement Trauma Center Services Agreement, whichever occurs first. In any event, County may terminate this Agreement in accordance with the Termination Paragraphs of the Additional Provisions hereunder.

B. Notwithstanding any other provision of this Agreement, Director of County's Department of Health Services or his duly authorized designee (jointly hereafter referred to as "Director") may immediately suspend this Agreement at

any time if Contractor's license to operate basic or comprehensive emergency services is revoked or suspended.

If such licensure, suspension, or revocation remains in effect for a period of at least sixty (60) days, Director may terminate this Agreement upon giving at least thirty (30) days prior written notice to Contractor.

- C. Notwithstanding any other provision hereof, Director may suspend this Agreement immediately upon giving written notice to Contractor, if Contractor, its agents, subcontractors, or employees at Contractor may be engaging in a continuing course of conduct which poses an imminent danger to the life or health of patients receiving or requesting medical care and services at Contractor. Any such action by Director shall be subject to the "due process" procedures established in Paragraph 16 hereinbelow.
- D. Notwithstanding any other provision of this Agreement, in the event the County makes a final decision to implement a central hospital base station concept, Director may withdraw the requirement that Contractor maintain

designation as a base hospital, furnish base hospital services, and meet all requirements set forth in Exhibit L, Paramedic Base Hospital Requirements, attached hereto and incorporated herein by reference by giving Contractor at least one-hundred eighty (180) days prior written notice thereof. This provision shall not affect County's right to terminate this Agreement for cause under Paragraph 37 of the Additional Provisions of the Agreement.

E. Notwithstanding any other provision of this Agreement, either party may terminate this Agreement with or without cause by giving the other party at least sixty (60) days prior written notice thereof. This provision shall not affect County's right to terminate this Agreement for cause under Paragraph 37 of the Additional Provisions of the Agreement.

F. If the State EMS Authority and the State EMS Commission disapprove for any reason the County's trauma system plan, County may terminate this Agreement by providing written notice to Contractor of the State's action, and

by setting forth in the notice an effective date of termination which is no less than thirty (30) days from the date of the County's receipt of notification of the State's action, but which is no more than sixty (60) days from said date.

G. In accordance with this Agreement, Contractor may, during the term of this Agreement, submit claims for services provided to eligible indigent patients. In consideration for services to be performed by Contractor under this Agreement, these claims will be reimbursed at the all-inclusive rates set forth in Exhibit B-2, Provisions For Reimbursement.

2. ADDITIONAL PROVISIONS: Attached hereto and incorporated herein by reference, is a document labeled "ADDITIONAL PROVISIONS". The terms and conditions therein contained are part of this Agreement.

3. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY):

- A. The Department of Health Services ("Department") shall develop and monitor compliance with triage protocols and procedures for County's trauma system.
- B. The Department shall be responsible for the development and ongoing evaluation and Performance Improvement of the trauma system.
- C. The Department shall be responsible for periodic performance evaluations of the trauma system, which shall be conducted at least every three (3) years in conjunction with the American College of Surgeons review.

The evaluation shall be based, in part, on requirements described in Exhibit A.I, Level I Trauma Center Requirements, Exhibit A.II, Level II Trauma Center Requirements, Exhibit A.III, Level I Pediatric Trauma Center Requirements, and Exhibit A.IV, Level II Pediatric Trauma Center Requirements, attached hereto and incorporated herein by reference. Results of the trauma evaluation shall be made available to individual participants.

- D. The Department shall implement policies and procedures for quality improvement in order to monitor the appropriateness and quality of care rendered to trauma patients in Los Angeles County as described under Paragraph 15 hereinbelow.
- E. The Department shall be responsible for maintaining a source of reimbursement for eligible indigent patients described in Exhibit B-2, Provisions For Reimbursement, attached hereto and incorporated herein by reference.
- F. One or more individuals within the Department shall be designated by Director to liaise with all Los Angeles County designated Trauma Centers with respect to matters affecting County's advanced trauma system.
- G. The Department shall be responsible for ensuring that Trauma Centers and other hospitals that treat trauma patients participate in the data and quality improvement process.
- H. The Department shall be responsible for ensuring that patient inclusion in the data collection system is based on Exhibit C, Patient Inclusion in the Trauma Center Data

System, attached hereto and incorporated herein by reference.

- I. The Trauma Center data collection system requirements are described and set forth in Exhibit D, Trauma Center Data Collection System, attached hereto and incorporated herein by reference. The Department shall comply with all Department responsibilities for the Trauma Center data collection system in Exhibit D, Trauma Center Data Collection System.
- J. The Department, after consultation with and advice from the Emergency Medical Services Commission ("EMSC"), EMS Data Advisory Committee shall maintain a comprehensive Trauma Center data collection system. The composition of the EMS Data Advisory Committee, is described in Exhibit E, Data Advisory Committee Membership, attached hereto and incorporated herein by reference.
- K. The Department shall monitor the trauma patient catchment area defined for Contractor to ensure that trauma patients are triaged appropriately to Contractor. Contractor acknowledges receipt of a map defining its

catchment area as of the date of execution of this Agreement.

- L. The Department may modify trauma patient catchment areas from time to time to meet the needs of the advanced trauma system. In the event that a catchment area is to be changed, then sixty (60) days prior to the effective date of the change, the Department shall give written notice to all designated Trauma Centers. All impacted Trauma Centers which are not County operated, including Contractor, shall be afforded the opportunity to provide written statements regarding the proposed change. If Contractor is adversely affected by the change of the catchment areas, Contractor shall be provided with "due process" as specified in Paragraph 16 hereinbelow prior to the change in the catchment areas.
- M. In the event that an existing Trauma Center ceases to participate in the advanced trauma system, the Department shall first attempt to reconfigure the trauma patient catchment areas so as to provide coverage for the area no longer served by such hospital by utilizing existing

Trauma Centers. If coverage cannot be provided by the use of existing Trauma Centers, the Director shall give written notice to Contractor and to all concerned designated Trauma Centers of any Department intention to seek a new hospital to provide the coverage. Contractor and all other concerned designated Trauma Centers shall have the opportunity to provide written statements to Director within ten (10) days of receipt of such notification regarding the proposed change. If Contractor believes it would be adversely affected by the addition of a new Trauma Center in such circumstances, Contractor may present its complaint in accordance with the "due Process" provisions specified in Paragraph 16 hereinbelow prior to County designation of the new Trauma Center.

- N. Interim System Re-Configuration. The Department may, on an interim basis, restructure the trauma system as it deems necessary, in those instances when a Contractor gives notice that it is withdrawing from the system or when a Contractor is suspended or terminated from the

prehospital care system. In the event that an interim restructuring occurs, any affected Contractor shall be given the opportunity to provide written and oral statements regarding the restructuring to the local EMS agency. The affected existing Contractors shall be provided with the "due process" procedures as specified in Paragraph 16 hereinbelow.

- O. The Department shall follow the trauma system policy which addresses the coordination with all health care organizations within the trauma system to facilitate the transfer of an organization member in accordance with the criteria set forth in Paragraph 11 hereinbelow.

4. SPECIFIC RESPONSIBILITIES OF CONTRACTOR:

- A. Contractor shall furnish Trauma Center services to patients in need thereof who are delivered, or present themselves, to Contractor. In the provision of such services, Contractor shall comply at all times during the term of this Agreement with the staffing criteria and other requirements of applicable Exhibits A.I - A.IV.

- B. The Contractor shall comply with the reimbursement process for eligible indigent patients described in Exhibit B-2, Provisions For Reimbursement, attached hereto and incorporated herein by reference.
- C. The Contractor shall include only those patients that meet inclusion in the data collection system based on Exhibit C, Patient Inclusion in the Trauma Center Data System, attached hereto and incorporated herein by reference.
- D. The Contractor shall comply with all Contractor responsibilities for the Trauma Center data collection system in Exhibit D, Trauma Center Data Collection System, attached hereto and incorporated herein by reference.
- E. It is understood and agreed that medical care furnished to patients pursuant to this Agreement shall be provided by physicians duly licensed to practice medicine in the State of California, and the agreement by Contractor to arrange for the furnishing of such treatment at hospital is not to be construed as Contractor entering into the

practice of medicine. This provision shall not limit the right of practitioners or nursing personnel affiliated with or employed by Contractor at hospital to render any and all services within the scope of their professional licensure or certification, as permitted by Contractor's rules, regulations, and policies with respect thereto.

F. Contractor shall maintain designation as a base hospital, furnish base hospital services, and meet all requirements set forth in Exhibit L, Paramedic Base Hospital Requirements, attached hereto and incorporated herein by reference. The foregoing base hospital requirement shall not apply to Childrens Hospital Los Angeles or to a Contractor that has lost its designation as a base hospital in accordance with Paragraph 1(D) of this Agreement.

5. INDEMNIFICATION: Contractor shall indemnify, defend, and hold harmless County, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and

expenses (including attorney and expert witness fees), arising from or connected with Contractor's acts and/or omissions arising from and/or relating to this Agreement.

County shall indemnify, defend, and hold harmless Contractor and its officers, employees and agents, from and against any and all liability, including but not limited to demands, claims, actions, fees, costs and expenses (including attorney and expert witness fees), arising from or connected with County's acts and/or omissions arising from and/or relating to this Agreement.

6. GENERAL INSURANCE REQUIREMENTS: Without limiting Contractor's indemnification of County, and during the term of this Agreement, Contractor shall provide and maintain, and shall require all of its subcontractors to maintain, the following programs of insurance specified in this Agreement. Such insurance shall be primary to and not contributing with any other insurance or self-insurance programs maintained by County, and such coverage shall be provided and maintained at Contractor's own expense.

A. Evidence of Insurance: Certificate(s) or other evidence of coverage satisfactory to County shall be delivered to County's Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor-East, Los Angeles, California 90012, prior to commencing services under this Agreement. Such certificates or other evidence shall:

- (1) Specifically identify this Agreement.
- (2) Clearly evidence all coverages required in this Agreement.
- (3) Contain the express condition that Contractor will use best efforts to give County written notice by mail at least thirty (30) calendar days in advance of cancellation for all policies evidenced on the certificate of insurance. Should Contractor receive notice from insurer of a cancellation to take effect earlier than thirty (30) calendar days from such notice, Contractor shall use best efforts to notify County in writing of such cancellation on the next business day.

(4) Include copies of the additional insured endorsement to the commercial general liability policy, adding County of Los Angeles, its Special Districts, its officials, officers, and employees as insured for all activities arising from this Agreement.

(5) Identify any deductibles or self-insured retentions for County's approval. Contractor shall be responsible for all deductibles as they apply to any insurance coverage with respect to this Agreement.

B. Insurer Financial Ratings: Insurance is to be provided by an insurance company acceptable to County with an A.M. Best rating of not less than A: VII, unless otherwise approved by County.

C. Failure to Maintain Coverage: Failure by Contractor to maintain the required insurance, or to provide evidence of insurance coverage acceptable to County, shall constitute a material breach of contract upon which County may immediately terminate or suspend this

Agreement. County, at its sole option, may obtain damages from Contractor resulting from said breach.

D. Notification of Incidents, Claims, or Suits: Contractor shall report to County:

- (1) Any third party claim or lawsuit filed against Contractor arising from or related to services performed by Contractor under this Agreement.
- (2) Any loss, disappearance, destruction, misuse, or theft of any kind whatsoever of County property, monies or securities entrusted to Contractor under the terms of this Agreement.
- (3) Simultaneously, any injury, death or treatment of a patient provided services covered in this Agreement for which Contractor provides any report/notice to the Joint Commission on Accreditation of Hospital Organization (JCAHO), or any report/notice as required under Title 22, C.C.R.70737 (e.g., unusual occurrence). Such report to County shall only include the patient name, date, and treatment.

E. Insurance Coverage Requirements for Subcontractors:

Except as set forth below, Contractor shall ensure that any and all non-physician subcontractors (e.g. pump technicians) performing medical care and treatment services under this Agreement shall meet the professional liability insurance requirements of this Agreement by either:

- (1) Contractor providing evidence of insurance covering the activities of subcontractors, or
- (2) Contractor providing evidence submitted by subcontractors evidencing that subcontractors maintain the required insurance coverage. County retains the right to obtain copies of evidence of subcontractor insurance coverage at any time.

The amount of professional liability insurance required in this Agreement for non-physician subcontractors would be an amount equal to that which the County routinely requires in its agreements with non-physician contractors providing similar medical care and treatment services to the County.

F. Insurance Coverage Requirements for Affiliate Physicians:

Contractor shall ensure that any and all physicians, either individually, or by or through a related medical group, physician group, or independent physician association where appropriate, with privileges to perform or otherwise performing any services covered under this Agreement on premises of or used by Contractor maintain professional liability insurance covering liability arising from any error, omission, negligent, or wrongful act of such physician(s) with limits of not less than One Million Dollars (\$1,000,000) per occurrence and Three Million Dollars (\$3,000,000) aggregate. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement, only if such coverage is consistent with the industry standard in California.

7. SPECIFIC INSURANCE COVERAGE REQUIREMENTS:

A. General Liability Insurance: (written on ISO policy form CG 00 01 or its equivalent) with limits of not less than the following:

General Aggregate: \$2 Million
Personal and Advertising Injury: \$1 Million
Each Occurrence: \$1 Million

B. Automobile Liability Insurance: (written on ISO policy form CA 00 01 or its equivalent) with a limit of liability of not less than One Million Dollars (\$1,000,000) for each accident. Such insurance shall include coverage for all "owned", "hired", and "non-owned" vehicles, or coverage for "any auto".

C. Workers' Compensation and Employers' Liability: Insurance providing workers' compensation benefits, as required by the Labor Code of the State of California or by any other state, and for which Contractor is responsible. If Contractor's employees will be engaged in maritime employment, coverage shall provide workers' compensation benefits as required by the U.S. Longshore and Harbor Worker's Compensation Act, Jones Act, or any other Federal law for which Contractor is responsible.

In all cases, the above insurance also shall include Employers' Liability coverage with limits of not less than the following:

Each Accident: \$1 Million

Disease - Policy Limit: \$1 Million

Disease - Each Employee \$1 Million

D. Professional Liability: Insurance maintained by Contractor covering liability arising from any error, omission, negligent or wrongful act of Contractor, its officers, or employees with limits of not less than Three Million Dollars (\$3,000,000) per occurrence. The coverage also shall provide an extended two (2) year reporting period commencing upon the termination or cancellation of this Agreement.

8. WAIVERS: Director may waive trauma center criteria contained in Exhibits A.I - A.IV, when it is determined that the conditions necessitating the waiver request will be in effect less than seventy-two (72) hours for any one occurrence and that procedures exist to ensure that patient care is not

jeopardized. Waivers may, upon discretion of Director, include but not be limited to, the following instances:

- A. Temporary inability of Contractor to meet staffing requirements with regard to trauma team or any in-house or on-call or second call physicians whose absence, as determined by Director, would not jeopardize the welfare of trauma patients.
- B. Temporary loss of function or restricted capacity of any of the special facilities, resources or capabilities of Contractor, if such loss or restriction would not jeopardize the welfare of trauma patients. County recognizes that routine servicing and subsequent temporary inoperability ("down time") of the Computerized Tomography (CT) scanner does not require invocation of a waiver.

Contractor shall direct its waiver request to Director's office. If a waiver is given, Contractor shall re-contact Director as soon as the temporary staffing or the equipment deficiency for which the waiver was given has been resolved. If a deficiency has not

been corrected within the time deemed appropriate by Director, Director may temporarily suspend Contractor's designation as a Trauma Center. In this event, Contractor shall notify surrounding base hospitals and Trauma Centers, and paramedic provider agencies serving Contractor's area that it is on temporary bypass status.

When the deficiency necessitating bypass status has been corrected, Director may lift the suspension, and Contractor shall immediately notify such surrounding hospitals.

9. STANDARDS OF CARE:

A. Contractor shall provide for supervision and monitoring of care rendered under the terms of this Agreement in accordance with the recognized standards thereof through regular review of patient medical records by Contractor's appropriately designated medical staff committee(s) at hospital. In addition, Contractor shall provide for specific quality improvement activities as described in the QUALITY IMPROVEMENT Paragraph 15, hereinbelow.

B. Contractor shall:

(1) maintain Contractor's accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and be in conformance at hospital with the standards of the JCAHO which apply to the provision of emergency medical services.

(2) not subject trauma patients to avoidable delay in receiving necessary medical care at Contractor pending financial arrangements.

10. NUMBER OF PATIENTS TO BE TREATED: While the parties contemplate that persons suffering major trauma at locations near Contractor will normally be delivered to Contractor for care, the parties recognize that County can make no guarantee in this regard and further that County is unable to assure that any minimum number of trauma patients will be delivered to Contractor during the term of this Agreement.

11. PATIENT TRANSFERS:

A. Patients to whom service is being provided hereunder may be transferred between and from trauma centers to other

medical facilities, including County-operated facilities, in compliance with JCAHO standards, Title 22 of the California Administrative Code, Emergency Medical Treatment and Active Labor Act (EMTALA), and other laws and protocols governing such transfers, providing that:

- (1) any transfer shall be, as determined by the trauma center surgeon of record, medically prudent; and
- (2) in accordance with local EMS agency interfacility transfer policies; and
- (3) the transfer may not be refused if the receiving facility has the capacity to accept.

- B. Contractor agrees to continue to provide services hereunder until a patient is transferred.
- C. Contractor shall have written transfer agreements with trauma centers. Contractor shall develop written criteria for consultation and transfer of patients needing a higher level of care.
- D. To the extent that it is not contrary to, or inconsistent with, any Federal or State law, regulation or policy, the County shall take the necessary steps to ensure that

preference is given to Contractor seeking to effectuate a medically prudent transfer of a patient to a County owned facility.

E. Contractor or other responsible party shall be financially liable for transportation of patients for whom services are rendered hereunder and who are being transferred from Contractor to any other facility. Nothing herein shall prevent Contractor from billing the patient or other financially responsible party for such services.

12. TRAUMA CENTER SIGNS: Contractor may, at its own expense, identify itself as a Trauma Center by placing signs to that effect on Contractor's grounds. Such signs shall exclude any reference to the level of its County designation and shall otherwise conform to local government regulations.

13. TRAUMA TEAM: Contractor agrees to designate trauma teams, whose members must include the general surgeon, and other team members as appropriate to respond to all trauma codes called either from the field or from the hospital. Upon activation of the trauma code, appropriate team members shall be

available as defined in regulations and shall assemble in the trauma resuscitation area.

14. TRAUMA CENTER FEES: By payment as set forth in this paragraph, Contractor agrees to offset a portion of the cost of the data collection effort excluding new hardware, the data management system, and a portion of the County's administrative costs for the trauma system and base hospital operation. The annual Trauma Center/Base Hospital fee for Fiscal Years (FYs) 2008-09 2009-10, and 2010-11 shall be Fifty-One Thousand Two Hundred Twenty-Seven Dollars (\$51,227) and Fifty-Two Thousand Seven Hundred and Eighty-Two Dollars (\$52,782), and Eighty-Three Thousand Eight Hundred Eighty Dollars (\$83,880) respectively; FYs 2012-13 and 2013-14 shall be Eighty-Six Thousand Five Hundred Seventy-Seven Dollars (\$86,577), and Eighty-Eight Thousand Eight Hundred Thirty-One Dollars (\$88,831), respectively, and each year thereafter, for each Contractor and is due on or before August 31 of the fiscal year. Since the base hospital requirement does not apply to Children's Hospital Los Angeles, as noted in Paragraph 4.F SPECIFIC RESPONSIBILITIES OF CONTRACTOR, the

annual Trauma Center fee for Children's Hospital Los Angeles for FYs 2008-09, 2009-10 and 2010-11 shall be Thirty-Nine Thousand Six Hundred Seventy Dollars (\$39,670), Forty-One Thousand Twenty-Eight Dollars (\$41,028), and Seventy-One Thousand Nine Hundred Twenty-Two Dollars (\$71,922), respectively; FYs 2012-13 and 2013-14 shall be Seventy-One Thousand Five Hundred Twenty Dollars (\$71,520), and Seventy-Three Thousand Three Hundred Eighty Two Dollars (\$73,382) respectively, and each year thereafter, and is due on or before August 31 of the fiscal year.

If this Agreement is revoked, cancelled, or otherwise terminated on a date other than June 30, the amount reflected herein above for such term shall be prorated, and a reduced amount, based upon the actual number of days of such term that the Agreement is in effect, shall be due County hereunder. If the greater sum has already been paid by Contractor, County shall refund the difference between that payment and the prorated amount.

If this Agreement is revoked, cancelled, or terminated because of Contractor's failure to maintain the trauma system

criteria as described in applicable Exhibits A.I - A.IV, or failure to maintain an acceptable level of trauma care as determined by community standards, Contractor shall not be eligible for any such refund.

In any event, County shall refund to Contractor its prorated share of remaining funds contributed by designated County Trauma Centers to the data collection system, if the total cost of such programs, as determined by the County's Auditor Controller and Director in accordance with standard auditing and accounting practices, is found to be less than the total amount contributed by designated Trauma Centers.

Notwithstanding any other provision in this Agreement, payment of the Trauma Center Fees due on August 31, 2015, shall be suspended until such time as a superseding replacement Trauma Center Services Agreement is executed.

15. QUALITY IMPROVEMENT:

A. Specific rights of the Department:

- (1) Director may from time to time review Contractor's policies and procedures regarding quality

improvement as they pertain to care rendered under this Agreement.

- (2) Director may request Contractor to verify that internal follow up is occurring by Contractor on a particular case under review by the Department. Contractor shall respond in writing within fifteen (15) days of Director's written request.

B. Specific responsibilities of Contractor:

- (1) Contractor shall conduct a detailed audit of:
 - (a) all trauma related deaths;
 - (b) all trauma patient transfers;
 - (c) all major complications.
- (2) Contractor shall abide by the following requirements concerning case audit:
 - (a) Audit attendances must be documented by signature and rosters retained by Contractor;
 - (b) Audit minutes must be recorded and retained by Contractor.
- (3) All such records shall be available to designees duly authorized by Director during the term of this

Agreement and for a period of seven (7) years thereafter upon request of Director.

(4) Contractor shall further advise Director, upon request, what corrective action was taken on specific cases.

16. DUE PROCESS:

A. Notice of Proposed Adverse Action: In all cases in which the Director has the authority to, and pursuant to this authority, has taken any of the actions constituting grounds for hearing as hereafter set forth in Subparagraph 16.B., Contractor shall promptly be given written notice of the specific charges and factual basis upon which the Director's action is based. With the exception of summary suspensions or summary suspension with intent to terminate, Contractor shall be afforded a right to request a hearing before implementation of any of the actions which constitute grounds for a hearing. Contractor shall have thirty (30) days following the receipt of such notice within which to file with Director a request for hearing before the EMSC.

B. Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing: summary suspension of Contractor as a Trauma Center; summary suspension with intent to terminate Agreement; Trauma Center operational and programmatic changes wherein Contractor has been given specific rights herein to request a hearing; modifications to Contractor's trauma patient catchment area; and the proposed addition of a new hospital as a Trauma Center when Contractor believes it would be adversely affected by such addition. Nothing in this paragraph 16 shall affect County's right to terminate Agreement under subparagraph 1.D.

C. Summary Suspension or Summary Suspension with Intent To Terminate: In the case of summary suspensions or summary suspension with intent to terminate this Agreement, Contractor, at its election, shall have the right to request in writing that Director reconsider the summary suspension action. Director shall act on this request for reconsideration within ten (10) days after the receipt of the reconsideration request. Contractor

representatives shall be given an opportunity to meet with Director to discuss the alleged basis for the summary action.

Within ten (10) days following the meeting with Director, or within ten (10) days following the summary suspension action, Director shall issue a written decision to Contractor regarding the summary suspension.

This decision may be that the suspension be continued for a particular time or upon particular condition, that the summary suspension be terminated, that Agreement be terminated, that other conditions be imposed on Contractor, or such other action as may seem warranted. If Director takes any action other than full and immediate termination of the summary suspension, Contractor may request a hearing on the summary suspension before the EMSC, as provided in this Paragraph. Such request shall be in writing and addressed to Director. Such request shall be delivered to Director within five (5) days of Director's delivery to Contractor of his/her written decision.

D. Time and Place of Hearing: Director shall, within fifteen (15) days of receipt of a request for hearing, file a request for the hearing with the EMSC. The EMSC shall give notice to Contractor of the time, place, and date of the hearing in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) days, nor more than ninety (90) days from the filing of the request for a hearing, subject to the convenience and approval of the EMSC; however, if the request is received from Contractor when Contractor is under a summary suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible.

E. Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Contractor is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who will appear on behalf of the other, then each party, within

ten (10) days of such request, shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.

- F. Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.
- G. Memorandum of Points and Authorities: Subject to the rules of the EMSC, each party shall have the right to submit a memorandum of points and authorities to the EMSC.
- H. Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:
- (1) oral testimony of the parties' representatives;
 - (2) documentary evidence introduced at the hearing;

- (3) briefs or memorandum of points and authorities presented in connection with the hearing;
- (4) policies and procedures of the Department;
- (5) all officially noticed matters.

I. Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, a tape or disc recording, or by its clerk's minutes of the proceedings.

If a shorthand reporter is specifically requested in writing by Contractor or by Director, the cost of same shall be borne by such party.

J. Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent permitted and prescribed in County Code Section 3.20.070B.

17. RESPONSIBILITY FOR INDIGENT PATIENTS: Nothing contained in this Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

18. STATUS OF CONTRACTOR: The parties hereto agree that Contractor, its officers, agents, and employees, including its professional and nonprofessional personnel, shall act in an independent capacity and not as officers, agents, or employees of County and shall not have the benefits of County employees.

Except as may otherwise expressly be provided hereunder, Contractor shall furnish all personnel, supplies, equipment, space, furniture, insurance, utilities, and telephone necessary for performance of Contractor's responsibilities set forth in this Agreement. This Paragraph shall not preclude or limit Contractor from seeking reimbursement, contributions, tuition, or other payments from the public or from non-County provider agencies for services provided by Contractor hereunder where entitlement thereto is permitted by law or by separate contract.

19. INTERPRETERS: If Contractor is located in an area where communication problems may exist because of a high concentration of non-English-speaking residents, Contractor shall provide interpreters in accordance with the requirements

for such services established under Section 70721, Title 22 of the California Administrative Code.

20. CONSUMER COMPLAINTS:

- A. Contractor agrees to comply with all responsibilities and related requirements applicable under Section 70707, Title 22 of the California Administrative Code, to ensure that each patient receiving services hereunder at Contractor is made aware of the following information prior to discharge: the name, location, and telephone number of Contractor's representative responsible for handling patient complaints; means, including forms, for submitting complaints in writing to that representative; a "Bill of Rights" defining patient prerogatives relative to matters on care, services, communication, and registry of complaints.
- B. Contractor shall, on request, furnish to Director, copies of all trauma patient complaints, and the results of Contractor's investigation and action taken. All of Contractor's administrative files maintained on such complaints shall be open to inspection by Director. Such

inspection rights shall not extend to reports of medical staff committees, nor to incident reports or other attorney-client communication or materials qualifying for the attorney-client privilege.

21. NOTICES: Any and all notices required, permitted, or desired to be given hereunder by one party to the other shall be in writing and shall be delivered to the other party personally or by United States mail, certified or registered postage prepaid return receipt requested, to the parties at the following addresses and to the attention of the persons named.

County's Director shall have the authority to issue all notices which are required or permitted by County hereunder. Addresses and persons to be notified may be changed by a party by giving at least ten (10) calendar days prior written notice thereof to the other.

A. Notices to County shall be addressed as follows:

- (1) Department of Health Services
Emergency Medical Services Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, California 90670
Attention: Director
- (2) Department of Health Services
Contracts and Grants Division

313 North Figueroa Street
Sixth Floor - East
Los Angeles, California 90012
Attention: Director

B. Notice to Contractor shall be addressed as follows:

Attention: Chief Executive Officer

/

/

/

/

/

/

/

/

/

/

/

/

/

/

IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Agreement to be subscribed by its Director of Health Services and Contractor has caused this Agreement to be subscribed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By _____
Mitchell H. Katz, M.D.
Director of Health Services

Contractor

By _____
Signature

Printed Name

Title

APPROVED AS TO FORM:

MARY C. WICKHAM
County Counsel

By _____
Brian T. Chu, Principal Deputy County Counsel

TRAUMA CENTER SERVICE AGREEMENT

ADDITIONAL PROVISIONS

TABLE OF CONTENTS

<u>PARAGRAPH</u>	<u>PAGE #</u>
1. <u>ADMINISTRATION AND MONITORING</u> :	<u>- 1 -</u>
2. <u>CONTRACT COMPLIANCE</u> :	<u>- 2 -</u>
3. <u>LICENSES</u> :	<u>- 3 -</u>
4. <u>CONFIDENTIALITY</u> :	<u>- 3 -</u>
5. <u>RECORDS AND AUDITS</u> :	<u>- 4 -</u>
6. <u>COUNTY'S QUALITY ASSURANCE PLAN</u> :	<u>- 8 -</u>
7. <u>CONTRACTOR'S PERFORMANCE DURING CIVIL UNREST OR DISASTER</u> :	<u>-8 -</u>
8. <u>INDEPENDENT CONTRACTOR STATUS</u> :	<u>- 9 -</u>
9. <u>NONDISCRIMINATION IN SERVICES</u> :	<u>- 10 -</u>
10. <u>NONDISCRIMINATION IN EMPLOYMENT</u> :	<u>- 10 -</u>
11. <u>FAIR LABOR STANDARDS ACT</u> :	<u>- 10 -</u>
12. <u>EMPLOYMENT ELIGIBILITY VERIFICATION</u> :	<u>- 11 -</u>
13. <u>STAFF PERFORMANCE WHILE UNDER THE INFLUENCE</u> :	<u>- 11 -</u>
14. <u>CONTRACTOR'S WILLINGNESS TO CONSIDER COUNTY'S EMPLOYEES FOR EMPLOYMENT</u> :	<u>- 12 -</u>
15. <u>CONSIDERATION OF GREATER AVENUES FOR INDEPENDENCE ("GAIN") PROGRAM OR GENERAL RELIEF OPPORTUNITY FOR WORK ("GROW") PARTICIPANTS FOR EMPLOYMENT</u> :	<u>- 13 -</u>

16. TERMINATION FOR IMPROPER CONSIDERATION: - 13 -

17. RESTRICTIONS ON LOBBYING: - 15 -

18. COUNTY LOBBYISTS: - 15 -

19. UNLAWFUL SOLICITATION: - 16 -

20. CONFLICT OF INTEREST: - 16 -

21. PROHIBITION AGAINST ASSIGNMENT AND DELEGATION: - 17 -

22. SERVICE DELIVERY SITE - MAINTENANCE STANDARDS: - 19 -

23. CONFLICT OF TERMS: - 20 -

24. MERGER PROVISION: - 20 -

25. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: - 21 -

26. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: - 22 -

27. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM: - 22 -

28. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT: - 24 -

29. CONTRACTOR RESPONSIBILITY AND DEBARMENT: - 24 -

30. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION: - 27 -

31. SEVERABILITY: - 28 -

32. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996: - 28 -

33. COMPLIANCE WITH APPLICABLE LAWS: - 30 -

34. COMPLIANCE WITH CIVIL RIGHTS LAWS: - 31 -

35. GOVERNING LAWS, JURISDICTION, AND VENUE: - 31 -

36. SUBCONTRACTING: - 32 -

37. TERMINATION FOR MATERIAL BREACH AND/OR ANTICIPATORY BREACH:
..... - 34 -

38. NO PAYMENT FOR SERVICES PROVIDED FOLLOWING EXPIRATION /
TERMINATION OF AGREEMENT: - 38 -

39. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY
LAW: - 39 -

40. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO THE
SAFELY SURRENDERED BABY LAW: - 39 -

41. RECYCLED BOND PAPER: - 40 -

TRAUMA CENTER SERVICE AGREEMENT

ADDITIONAL PROVISIONS

1. ADMINISTRATION AND MONITORING:

A. Director or his authorized designee shall have the authority to administer this Agreement on behalf of County.

B. Contractor extends to Director the right to review and monitor Contractor's trauma program policies and procedures pertinent to this Agreement and to inspect Contractor's facility and records for contractual compliance with State and local EMS Agency policies and regulations.

Inspection by County staff shall be conducted during County's normal business hours and only after giving Contractors at least three (3) working days prior written notice thereof. In computing the three working days, a Saturday, Sunday, or legal holiday shall not be included.

Said notice need not be given in cases where Director determines that the health and welfare of trauma system patients would be jeopardized by waiting three (3) days.

ADDITIONAL PROVISIONS

Nothing herein shall preclude County staff authorized by Director from making unannounced visits to determine compliance with criteria contained in Exhibits "A.I"- "A.IV", attached hereto and incorporated herein by reference.

2. CONTRACT COMPLIANCE: Should Contractor, as initially determined by Director, fail to comply with any provision set forth hereunder as a Contractor responsibility or obligation, Director may do any or all of the following in addition to other rights which Director of County may have hereunder or at law:
 - A. Send Contractor a written warning itemizing the area(s) of concern and requesting or specifying a plan for remedial action.
 - B. Send Contractor a written itemized listing of the area(s) of concern and permit Contractor to voluntarily request temporary suspension of Contractor for a period of thirty (30) days or less to allow for remedial action to be taken.

ADDITIONAL PROVISIONS

- C. Send Contractor a written itemized listing of the area(s) of concern and summarily suspend, or summarily suspend with intent to terminate, Contractor. Any such action by County shall be subject to the "due process" procedures established in Paragraph 16 of the body of the Agreement.
3. LICENSES: Contractor shall obtain and maintain, during the term of this Agreement, all appropriate licenses, permits, certifications, accreditations, or other authorizations required by law for operation at its facility and for the provision of services hereunder. Contractor, in its operation, shall also comply with all applicable local, state, and Federal statutes, ordinances, and regulations.
4. CONFIDENTIALITY: Contractor agrees to maintain the confidentiality of its records, including billings, in accordance with all applicable State, Federal, and local laws, ordinances, rules, regulations, and directives relating to confidentiality. Contractor shall inform all of its officers, employees, and agents, and others providing services hereunder of said confidentiality provisions. County shall maintain the

ADDITIONAL PROVISIONS

confidentiality of patient medical records made available hereunder in accordance with the customary standards and practices of governmental third party payers.

5. RECORDS AND AUDITS:

- A. Records of Services Rendered: Contractor shall maintain books and records of services rendered to all patients provided trauma service at Contractor hereunder, including discharge dispositions, in accordance with Contractor's customary record-keeping requirements. All patient records must comply with general acute care hospital licensure requirements and JCAHO standards applicable to books and records of services rendered. Such books and records shall be retained by Contractor for a minimum period of seven (7) years following the discharge of a patient. Patient records for minors shall be retained either for seven (7) years following the discharge of the patient or until the minor's 19th birthday, whichever is later. During such seven (7) year period, all such records, as well as other records and

ADDITIONAL PROVISIONS

reports maintained by Contractor pertaining to this Agreement, shall be retained by Contractor at a location in Los Angeles County, and shall be available during Contractor's normal business hours to duly authorized representatives of Director upon request for review and copying.

In the event County staff desire to conduct any review of Contractor's records authorized under this Paragraph, Contractor shall be given written notice at least ten (10) days in advance of any such review. Said notice need not be given in cases where Director determines that the health and welfare of trauma system patients would be jeopardized by waiting ten (10) days.

Contractor's Director of Utilization Review and its Director of Medical Records shall be permitted to participate in the review and Contractor shall fully cooperate with County's representatives. Contractor shall allow County's representatives access to all medical records and reports, and other records pertaining

ADDITIONAL PROVISIONS

to this Agreement, and shall allow photocopies to be made of these documents utilizing Contractor's photocopier, for which County shall reimburse Contractors at County's customary rate for record copying services. Such inspection rights shall not extend to the proceedings or records of Contractor's organized committees or its medical staff, having as their responsibility the evaluation and improvement of the quality of care rendered in the hospital, which are protected by Evidence Code, Section 1157. An exit conference shall be held following the performance of such review activities at which time the results of the review shall be discussed with Contractor representatives prior to the generation of any final written report or action by Director based on such audit or review. The exit conference shall be held on site prior to the departure of the reviewers and Contractor representatives shall be provided with an oral or written list of preliminary findings at the exit conference.

ADDITIONAL PROVISIONS

B. Federal Access to Records: If, and to the extent that, Section 1861 (v) (1) (I) of the Social Security Act [42 U.S.C. Section 1395x (v) (1) (I)] is applicable, Contractor agrees that for a period of four years following the furnishing of trauma services to a patient by Contractor, Contractor shall maintain and make available, upon written request, to the Secretary of the United States Department of Health and Human Services or to the Comptroller General of the United States, or to any of their duly authorized representatives, the contract, books, documents, and records of Contractors which are necessary to verify the nature and extent of the cost of such services. Furthermore, if Contractor carries out any of the services provided hereunder through a subcontract with a value or cost of Ten Thousand Dollars (\$10,000) or more over a twelve-month period with a related organization (as that term is defined under Federal law), Contractor agrees that each such subcontract shall provide for such access to the

ADDITIONAL PROVISIONS

subcontract, books, documents, and records of the subcontractor.

6. COUNTY'S QUALITY ASSURANCE PLAN: County or its Agents will evaluate Contractor's performance under this Agreement at least every three (3) years. Such evaluation will include assessing Contractor's compliance with all contract terms and performance standards. Contractor deficiencies which County determines are severe or continuing and that may place performance of this Agreement in jeopardy if not corrected will be reported to the Board of Supervisors. The report will include improvement/corrective action measures taken by County and Contractor. If improvement does not occur consistent with the corrective action measures, County may terminate this Agreement or impose other penalties as specified in this Agreement.

7. CONTRACTOR'S PERFORMANCE DURING CIVIL UNREST OR DISASTER: Contractor recognizes that health care facilities maintained by County provide care essential to the residents of the communities they serve, and that these services are of particular importance at the time of riot, insurrection, civil

ADDITIONAL PROVISIONS

unrest, natural disaster, or similar event. Notwithstanding any other provision of this Agreement, full performance by Contractor during any riot, insurrection, civil unrest, natural disaster, or similar event is not excused if such performance remains physically possible. Failure to comply with this requirement shall be considered a material breach by Contractor for which Director may suspend or County may immediately terminate this Agreement.

8. INDEPENDENT CONTRACTOR STATUS: This Agreement is by and between the County of Los Angeles and Contractor and it is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between County and Contractor.

Contractor understands and agrees that all Contractor employees furnishing services pursuant to this Agreement are, for purposes of Workers' Compensation liability, employees solely of Contractor and not of County.

Contractor shall bear the sole responsibility and liability for furnishing workers' compensation benefits, if

ADDITIONAL PROVISIONS

applicable, to any person for injuries arising from, or connected with, services performed on behalf of Contractor pursuant to this Agreement.

9. NONDISCRIMINATION IN SERVICES: Contractor shall not discriminate in the provision of services hereunder because of race, color, religion, national origin, ancestry, sex, age, or physical or mental disability, or medical condition, in accordance with applicable requirements of State and Federal law.
10. NONDISCRIMINATION IN EMPLOYMENT: Contractor's employment practices and policies shall also meet all applicable State and Federal nondiscrimination requirements.
11. FAIR LABOR STANDARDS ACT: Contractor shall comply with all applicable provisions of the Federal Fair Labor Standards Act, and shall indemnify, defend, and hold harmless County, its agents, officers, and employees from and against any and all liability including, but not limited to wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law including, but not limited

ADDITIONAL PROVISIONS

to, the Federal Fair Labor Standards Act for services performed by Contractor's employees for which County may be found jointly or solely liable.

12. EMPLOYMENT ELIGIBILITY VERIFICATION: Contractor warrants that it fully complies with all Federal statutes and regulations regarding employment of aliens and others, and that all its employees performing services hereunder meet the citizenship or alien status requirements contained in Federal statutes and regulations. Contractor shall retain such documentation for all covered employees for the period prescribed by law. Contractor shall indemnify, defend, and hold harmless, the County, its officers, and employees from employer sanctions and any other liability which may be assessed against Contractor or County in connection with any alleged violation of Federal statutes or regulations pertaining to the eligibility for employment of persons performing services under this Agreement.
13. STAFF PERFORMANCE WHILE UNDER THE INFLUENCE: Contractor shall use reasonable efforts to ensure that no employee or physician will perform services hereunder while under the influence of

ADDITIONAL PROVISIONS

any alcoholic beverage, medication, narcotic, or other substance that might impair his/her physical or mental performance.

14. CONTRACTOR'S WILLINGNESS TO CONSIDER COUNTY'S EMPLOYEES FOR EMPLOYMENT: Contractor agrees to receive referrals from County's Department of Human Resources of qualified permanent employees who are targeted for layoff or qualified former employees who have been laid off and are on a re-employment list during the life of this Agreement. Such referred permanent or former County employees shall be given consideration of employment as Contractor vacancies occur after the implementation and throughout the term of this Agreement; subject to the following: (i) Contractor's collective bargaining agreement(s); (ii) Contractor's personnel policies and procedures; (iii) Contractor's own employees targeted for layoffs or who have been laid off; and (iv) the most qualified applicant.

Notwithstanding any other provision of this Agreement, the parties do not in any way intend that any person shall acquire

ADDITIONAL PROVISIONS

any rights as a third party beneficiary of this Agreement.

15. CONSIDERATION OF GREATER AVENUES FOR INDEPENDENCE ("GAIN") PROGRAM OR GENERAL RELIEF OPPORTUNITY FOR WORK ("GROW") PARTICIPANTS FOR EMPLOYMENT: Should Contractor require additional or replacement personnel after the effective date of this Agreement, Contractor shall give consideration for any such employment openings to participants in the County's Department of Public Social Services' Greater Avenues for Independence ("GAIN") or General Relief Opportunity for Work ("GROW") Programs, who meet Contractor's minimum qualification for the open position. For this purpose, consideration shall mean that Contractor will interview qualified candidates. The County will refer GAIN/GROW participants by job category to the Contractor. In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, County employees shall be given first priority.
16. TERMINATION FOR IMPROPER CONSIDERATION: County may, by written notice to Contractor, immediately terminate the right of Contractor to proceed under this Agreement if it is found that

ADDITIONAL PROVISIONS

consideration, in any form, was offered or given by Contractor, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing the Agreement or securing favorable treatment with respect to the award, amendment, or extension of the Agreement or the making of any determination with respect to the Contractor's performance pursuant to the Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Contractor as it could pursue in the event of default by the Contractor.

Contractor shall immediately report any attempt by a County officer, or employee, or agent to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (213) 974-0914 or (800) 544-6861.

Among other items, such improper consideration may take the form of cash, discounts, services, the provision of travel or entertainment, or tangible gifts.

ADDITIONAL PROVISIONS

17. RESTRICTIONS ON LOBBYING: If any Federal monies are to be used to pay for Contractor's services under this Agreement, Contractor shall comply with all certification and disclosure requirements prescribed by Section 319, Public Law 101-121 (Title 31, United States Code, Section 1352) and any implementing regulations, and shall ensure that each of its subcontractors receiving funds provided under this Agreement also fully comply with all such certification and disclosure requirements.
18. COUNTY LOBBYISTS: Contractor and each County lobbyist or County lobbying firm as defined in Los Angeles County Code Section 2.160.010, retained by Contractor, shall fully comply with the County Lobbyist Ordinance, Los Angeles County Code Chapter 2.160. Failure on the part of Contractor or any County lobbyist or County lobbying firm retained by Contractor to fully comply with the County Lobbyist Ordinance shall constitute a material breach of this Agreement upon which County may immediately terminate or suspend this Agreement.

ADDITIONAL PROVISIONS

19. UNLAWFUL SOLICITATION: Contractor shall inform all of its employees of the provision of Article 9 of Chapter 4 of Division 3 (commencing with Section 6150) of the Business and Professions Code of the State of California (i.e., State Bar Act provisions regarding unlawful solicitation as a runner or capper for attorneys) and shall take positive and affirmative steps in its performance hereunder to ensure that there is no violation of said provision by its employees. Contractor agrees that if a patient requests assistance in obtaining the services of any attorney, it will refer the patient to the attorney referral service of those bar associations within Los Angeles County that have such a service.
20. CONFLICT OF INTEREST: No County officer or employee whose position in County enables him or her to influence the award or County administration of this Agreement or any competing agreement shall participate in the negotiation of this Agreement. No County employee with a spouse or economic dependent employed in any capacity by Contractor herein, shall

ADDITIONAL PROVISIONS

participate in the negotiation of this Agreement, or have a direct or indirect financial interest in this Agreement.

No officer, subcontractor, agent, or employee of Contractor who may financially benefit from the provision of services hereunder shall in any way participate in County's approval, or ongoing evaluation, of such services, or in any way attempt to unlawfully influence County's approval or ongoing evaluation of such services.

21. PROHIBITION AGAINST ASSIGNMENT AND DELEGATION:

- A. Assignment of Delegation to Subcontractor: Contractor shall not assign its rights or delegate its duties under this Agreement by subcontract, or both, whether in whole or in part, without the prior written consent of County where such assignment or delegation materially changes the operation of the trauma center in performing services under this Agreement. Any assignment or delegation which does not have such prior County consent shall be null and void. For purposes of this Paragraph, such County consent shall require a written amendment to this

ADDITIONAL PROVISIONS

Agreement which is formally approved and executed by the parties. Any billings to County by any delegatee or assignee on any claim under this Agreement, absent such County consent, shall not be paid by County. Any payments by County to any delegatee or assignee on any claim under this Agreement, in consequences of any such County consent, shall reduce dollar for dollar any claims which Contractor may have against County and shall be subject to set-off, recoupment, or other reduction for any claims which County may have against Contractor, whether under this Agreement or otherwise.

- B. Shareholders or partners, or both, of Contractor may sell, exchange, assign, divest, or otherwise transfer any interest they may have therein. However, in the event any such sale, exchange, assignment, divestment, or other transfer is effected in such a way as to give majority control of Contractor to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of

ADDITIONAL PROVISIONS

this Agreement, then prior written notice thereof by County's Board of Supervisors shall be required. Any payments by County to Contractor on any claim under this Agreement shall not waive or constitute such County consent. Consent to any such sale, exchange, assignment, divestment, or other transfer shall be refused only if County, in its sole judgement, determines that the transferee(s) is (are) lacking in experience, capability, or financial ability to perform all Agreement services and other work. This in no way limits any County right found elsewhere in this Agreement, including, but not limited to, any right to terminate this Agreement.

22. SERVICE DELIVERY SITE - MAINTENANCE STANDARDS: Contractor shall assure that the locations where services are provided under provisions of this Agreement are operated at all times in accordance with County community standards with regard to property maintenance and repair, graffiti abatement, refuse removal, fire safety, landscaping, and in full compliance with all applicable local laws, ordinances, and regulation relating

ADDITIONAL PROVISIONS

to the property. County's periodic monitoring visits to Contractor's facilities shall include a review of compliance with the provisions of this Paragraph.

23. CONFLICT OF TERMS: To the extent that any conflict exists between the language of the body of this Agreement and of the language of the exhibits attached hereto, the former shall govern and prevail.
24. MERGER PROVISION: The body of this Agreement, together with the exhibits attached hereto, fully expresses all understandings of the parties concerning all matters covered and shall constitute the total Agreement. No addition to, or alteration of the terms of this Agreement, whether by written or verbal understanding of the parties, their officers, agents, or employees, shall be valid and effective unless made in the form of a written amendment to this Agreement which is formally adopted and executed by the parties in the same manner as this Agreement.
25. CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Contractor acknowledges that County has

ADDITIONAL PROVISIONS

established a goal of ensuring that all individuals who benefit financially from County through County contracts are in compliance with their court-ordered child, family, and spousal support obligations in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

As required by County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting Contractor's duty under this Agreement to comply with all applicable provisions of law, Contractor warrants that it is now in compliance and shall during the terms of this Agreement maintain compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 U.S.C. Section 653a) and California Unemployment Insurance Code (Section 1088.55), and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department (CSSD) Notices of Wage and Earnings Assignment for Child, Family, or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246 (b).

ADDITIONAL PROVISIONS

26. TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM: Failure of Contractor to maintain compliance with the requirements set forth in the CONTRACTOR'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM Paragraph immediately above, shall constitute a default by Contractor under this Agreement.
- Without limiting the rights and remedies available to County under any other provision of this Agreement, failure to cure such defaults within ninety (90) calendar days of written notice shall be grounds upon which County may terminate this contract pursuant to the "Termination for Default" Paragraph of this Agreement (or "Term and Termination" Paragraph of this Agreement, whichever is applicable) and pursue debarment of Contractor, pursuant to County Code Chapter 2.202.
27. CONTRACTOR'S EXCLUSION FROM PARTICIPATION IN A FEDERALLY FUNDED PROGRAM: Contractor hereby warrants that neither it nor any of its staff members is restricted or excluded from providing services under any health care program funded by the Federal government, directly or indirectly, in whole or in part, and

ADDITIONAL PROVISIONS

that Contractor will notify Director within thirty (30) calendar days in writing of: (1) any event that would require Contractor or a staff member's mandatory exclusion from participation in a Federally funded health care program; and (2) any exclusionary action taken by any agency of the Federal government against Contractor or one or more staff members barring it or the staff members from participation in a Federally funded health care program, whether such bar is direct or indirect, or whether such bar is in whole or in part.

Contractor shall indemnify and hold County harmless against any and all loss or damage County may suffer arising from any Federal exclusion of Contractor or its staff members from such participation in a Federally funded health care program.

Failure by Contractor to meet the requirements of this Paragraph shall constitute a material breach of contract upon which County may immediately terminate or suspend this Agreement.

ADDITIONAL PROVISIONS

28. NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT:

Contractor shall notify its employees that they may be eligible for the Federal Earned Income Credit under the Federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice 1015.

29. CONTRACTOR RESPONSIBILITY AND DEBARMENT:

A. A responsible contractor is a contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity, and experience to satisfactorily perform the contract. It is County's policy to conduct business only with responsible contractors.

B. Contractor is hereby notified that, in accordance with Chapter 2.202 of the County Code, if County acquires information concerning the performance of Contractor under this Agreement or other contracts, which indicates that Contractor is not responsible, County may or otherwise in addition to other remedies provided under

ADDITIONAL PROVISIONS

this Agreement, debar Contractor from bidding on County contacts for a specified period of time not to exceed three (3) years, and terminate this Agreement and any or all existing contracts Contractor may have with County.

- C. County may debar Contractor if the Board of Supervisors finds, in its discretion, that Contractor has done any of the following: (1) violated any terms of this Agreement or other contract with County or a nonprofit corporation created by the County, (2) committed any act or omission which negatively reflects on Contractor's quality, fitness, or capacity to perform a contract with County or any other public entity, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against County or any other public entity.
- D. If there is evidence that Contractor may be subject to debarment, Director will notify Contractor in writing of the evidence which is the basis for the proposed

ADDITIONAL PROVISIONS

debarment and will advise Contractor of the scheduled date for a debarment hearing before County's Contractor Hearing Board.

- E. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. Contractor or Contractor's representative, or both, shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a proposed decision, which shall contain a recommendation regarding whether Contractor should be debarred, and, if so, the appropriate length of time of the debarment. If Contractor fails to avail itself of the opportunity to submit evidence to the Contractor Hearing Board, Contractor shall be deemed to have waived all rights of appeal.

- F. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendations of the Contractor Hearing Board shall be presented to the Board

ADDITIONAL PROVISIONS

of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

G. These terms shall also apply to any subcontractors of Contractor, vendor, or principal owner of Contractor, as defined in Chapter 2.202 of the County Code.

30. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, INELIGIBILITY AND VOLUNTARY EXCLUSION: Contractor hereby acknowledges that the County is prohibited from contracting with and making sub-awards to parties that are suspended, debarred, ineligible, or excluded or whose principals are suspended, debarred, ineligible, or excluded from securing federally funded contracts. By executing this Agreement, Contractor certifies that neither it nor any of its owners, officers, partners, directors, or other principals is currently suspended, debarred, ineligible, or excluded from securing federally funded contacts. Further, by executing this Agreement, Contractor certifies that, to its knowledge, none its subcontractors, at any tier, or any owner, officer, partner,

ADDITIONAL PROVISIONS

director, or other principal of any subcontractor is currently suspended, debarred, ineligible, or excluded from securing federally funded contracts. Contractor shall immediately notify County in writing, during the term of this Agreement, should it or any of its subcontractors or any principals of either be suspended, debarred, ineligible, or excluded from securing federally funded contracts. Failure of Contractor to comply with this provision shall constitute a material breach of this Agreement upon which the County may immediately terminate or suspend this Agreement.

31. SEVERABILITY: If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

32. COMPLIANCE WITH HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996: The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (HIPAA). Contractor understands

ADDITIONAL PROVISIONS

and agrees that, as a provider of medical treatment services, it is a "covered entity" under HIPAA and, as such, has obligations with respect to the confidentiality, privacy and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, and the use of appropriate consents and authorizations specified under HIPAA. The parties acknowledge their separate and independent obligations with respect to HIPAA, and that such obligations relate to transactions and code sets, privacy, and security. Contractor understands and agrees that it is separately and independently responsible for compliance with HIPAA in all these areas and that it is separately and independently responsible for compliance with HIPAA in all these areas and that County has not undertaken any responsibility for compliance on Contractor's behalf. Contractor has not relied, and will not in any way rely, on County for legal advice or

ADDITIONAL PROVISIONS

other representations with respect to Contractor's obligations under HIPAA, but will independently seek its own counsel and take the necessary measures to comply with the law and its implementing regulations.

CONTRACTOR AND COUNTY UNDERSTAND AND AGREE THAT EACH IS INDEPENDENTLY RESPONSIBLE FOR HIPAA COMPLIANCE AND AGREE TO TAKE ALL NECESSARY AND REASONABLE ACTIONS TO COMPLY WITH THE REQUIREMENTS OF THE HIPAA LAW AND IMPLEMENTING REGULATIONS RELATED TO TRANSACTIONS AND CODE SET, PRIVACY, AND SECURITY. EACH PARTY FURTHER AGREES TO INDEMNIFY AND HOLD HARMLESS THE OTHER PARTY (INCLUDING THEIR OFFICERS, EMPLOYEES, AND AGENTS), FOR ITS FAILURE TO COMPLY WITH HIPAA.

33. COMPLIANCE WITH APPLICABLE LAWS: Contractor shall comply with all applicable Federal, State, and local laws, rules, regulations, ordinances, and directives, and all provisions required thereby to be included in this Agreement are hereby incorporated herein by reference.

Contractor shall indemnify and hold harmless the County from and against any and all liability, damages, costs, and

ADDITIONAL PROVISIONS

expenses, including, but not limited to, defense costs and attorneys' fees, arising from or related to any violation on the part of the Contractor or its employees, agents, or subcontractors of any such laws, rules, regulations, ordinances, or directives.

34. COMPLIANCE WITH CIVIL RIGHTS LAWS: Contractor hereby assures that it will comply with all applicable provisions of the Civil Rights Act of 1964, 42 U.S.C. Sections 2000 (e) (1) through 2000 (e) (17), to the end that no person shall, on the grounds of race, creed, color, sex, religion, ancestry, age, condition of physical handicap, marital status, political affiliation, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement or under any project, program, or activity supported by this Agreement.

35. GOVERNING LAWS, JURISDICTION, AND VENUE: This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. The Agreement agrees and consents to the exclusive jurisdiction of the courts of the State of

ADDITIONAL PROVISIONS

California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles.

36. SUBCONTRACTING:

- A. The overall provisions of trauma services may not be subcontracted by the Contractor without the advance approval of the County. Any attempt by Contractor to subcontract without prior consent of the County may be deemed a material breach of this Agreement.
- B. If Contractor desires to subcontract, Contractor shall provide the following information promptly at the County's request:
 - (1) A description of the work to be performed by the subcontractor.
 - (2) A draft copy of the proposed subcontract; and
 - (3) Other pertinent information and/or certifications requested by the County.
- C. Contractor shall indemnify and hold the County harmless with respect to the activities of each and every

ADDITIONAL PROVISIONS

subcontractor in the same manner and to the same degree as if such subcontractor(s) were Contractor employees.

- D. Contractor shall remain fully responsible for all performances required of it under this Agreement, including those that Contractor has determined to subcontract, notwithstanding the County's approval of Contractor's proposed subcontract.
- E. The County's consent to subcontract shall not waive the County's right to prior and continuing approval of any and all personnel, including subcontractor employees, providing services under this Agreement. Contractor is responsible to notify its subcontractors of this County right.
- F. The County's Project Director is authorized to act for and on behalf of the County with respect to approval of any subcontract and subcontractor employees.
- G. Contractor shall be solely liable and responsible for all payments or other compensation to all subcontractors and their officers, employees, agents, and successors in

ADDITIONAL PROVISIONS

interest arising through services performed hereunder, notwithstanding the County's consent to subcontract.

- H. Contractor shall obtain certificates of insurance, which establish that the subcontractor maintains all the programs of insurance required by the County from each approved subcontractor. Contractor shall ensure delivery of all such document to: County of Los Angeles, Department of Health Services, Contracts and Grants Division, 313 North Figueroa Street, Sixth Floor East, Los Angeles, California 90012, before any subcontractor employee may perform any work hereunder.

37. TERMINATION FOR MATERIAL BREACH AND/OR ANTICIPATORY BREACH:

- A. The County may, by written notice to Contractor, terminate the whole or any part of this Agreement, if, in the judgment of County's Project Director.
- (1) Contractor has materially breached this Agreement;
 - (2) Contractor expressly repudiates this Agreement by an unequivocal refusal to perform; or

ADDITIONAL PROVISIONS

(3) In the event the County intends to terminate this Agreement in accordance with Paragraph 37, it shall give thirty (30) days written notice to the Contractor that it is in material breach and/or anticipatory breach of this Agreement. In this notice of intended termination, the Director shall set forth the facts underlying its claim that the Contractor is in material breach and/or anticipatory breach. Remedy of the breach or convincing progress towards a cure within twenty (20) days (or such longer period as the County may authorize in writing) of receipt of said notice shall revive the Agreement in effect for the remaining term.

B. In the event that the County terminates this Agreement in whole or in part as provided in Sub-paragraph 37A above, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so terminated. Contractor shall be liable to the County for any and all excess

ADDITIONAL PROVISIONS

costs incurred by the County, as determined by the County, for such similar goods and services. Contractor shall continue the performance of this Agreement to the extent not terminated under the provisions of this subparagraph. The parties agree that this particular damage provision (i.e., that the Contractor shall be liable to the County for all excess costs incurred by the County) shall be limited to a time period of twelve months or the remaining period of this Agreement upon breach, whichever is less.

- C. Except with respect to material breach of any subcontractor, Contractor shall not be liable for any such excess costs of the type identified in the subparagraph above if its failure to perform this Agreement arises out of causes beyond the control and without the fault or negligence of Contractor. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or contractual capacity, acts of Federal or

ADDITIONAL PROVISIONS

State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather, but in every case, the failure to perform must be beyond the control and without the fault or negligence of Contractor. If the failure to perform is caused by the default of a subcontractor, and if such default arises out of causes beyond the control of both Contractor and subcontractor, and without the fault or negligence of either of them, Contractor shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit Contractor to meet the required performance schedule. As used in this Subparagraph 37C, the terms "subcontractor" and "subcontractors" mean subcontractor(s) at any tier.

- D. If, after the County has given notice of material breach and/or anticipatory breach under the provisions of this

ADDITIONAL PROVISIONS

Sub-paragraph 37C, it is determined by the County that Contractor was not in material breach and/or anticipatory breach under the provisions of this Sub-paragraph 37C, or that the material breach and/or anticipatory breach was excusable under the provisions of Sub-paragraph 37C, the rights and obligations of the parties shall be the same as if the notice of termination had been issued pursuant to Sub-paragraph 37A.

E. The rights and remedies of the County provided in this Sub-paragraph 37 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

38. NO PAYMENT FOR SERVICES PROVIDED FOLLOWING EXPIRATION / TERMINATION OF AGREEMENT: Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by Contractor after the expiration or other termination of this Agreement. Should Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to

ADDITIONAL PROVISIONS

County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from Contractor. This provisions shall survive the expiration or other termination of this Agreement.

39. NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW:

The Contractor shall notify and provide to its employees, and shall require each subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in English as Attachment "1" and in Spanish as Attachment "2" of the Additional Provisions Exhibit of this Agreement and is also available on the Internet at www.babysafela.org for printing purposes.

40. CONTRACTOR'S ACKNOWLEDGMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW:

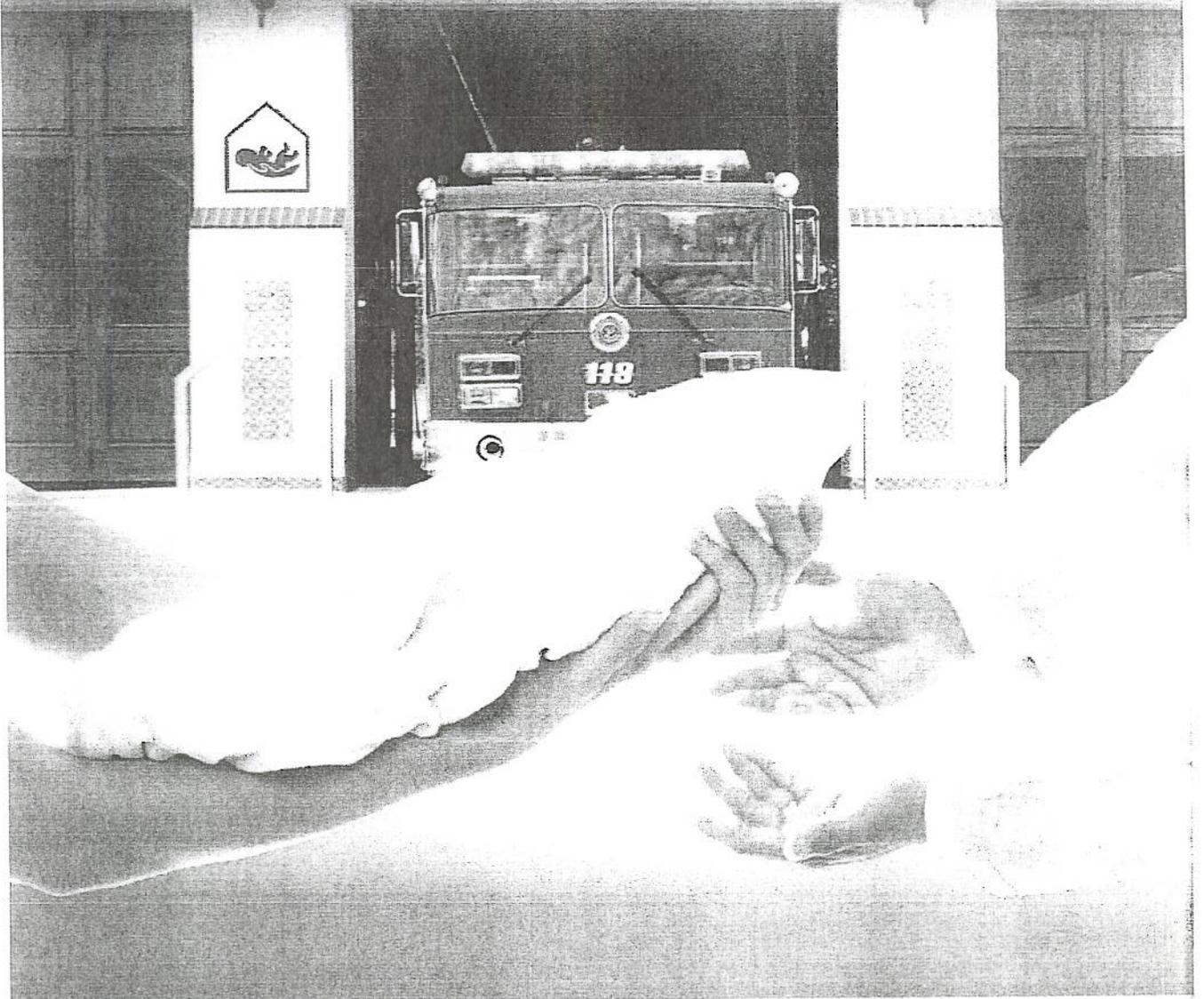
The Contractor acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Contractor understands that

ADDITIONAL PROVISIONS

it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Contractor's place of business. The Contractor will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. The County's Department of Children and Family Services will supply the Contractor with the poster to be used.

41. RECYCLED BOND PAPER: Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at County landfills, Contractor agrees to use recycled-content paper to the maximum extent possible in connection with services to be performed by Contractor under this Agreement.

Safely Surrendered



No charges. No blame. No shame.

In Los Angeles, you can call 1-800-477-2727 for help.

For more information, visit www.18004772727.org



In Los Angeles County: 1 877 BABY SAFE 1 877 222 9723

www.babysafela.org

Safely Surrendered Baby Law

What is the Safely Surrendered Baby Law?

California's Safely Surrendered Baby Law allows parents or other persons, with lawful custody, which means anyone to whom the parent has given permission to confidentially surrender a baby. As long as the baby is three days (72 hours) of age or younger and has not been abused or neglected, the baby may be surrendered without fear of arrest or prosecution.

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially, and safely surrender a baby within three days (72 hours) of birth. The baby must be handed to an employee at a hospital or fire station in Los Angeles County. As long as the baby shows no sign of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, staff will use bracelets to help connect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent or other surrendering adult.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their baby within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at 1-800-540-4000.

Can only a parent bring in the baby?

No. While in most cases a parent will bring in the baby, the Law allows other people to bring in the baby if they have lawful custody.

Does the parent or surrendering adult have to call before bringing in the baby?

No. A parent or surrendering adult can bring in a baby anytime, 24 hours a day, 7 days a week, as long as the parent or surrendering adult surrenders the baby to someone who works at the hospital or fire station.

Does the parent or surrendering adult have to tell anything to the people taking the baby?

No. However, hospital or fire station personnel will ask the surrendering party to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the baby. The questionnaire includes a stamped return envelope and can be sent in at a later time.

What happens to the baby?

The baby will be examined and given medical treatment. Upon release from the hospital, social workers immediately place the baby in a safe and loving home and begin the adoption process.

What happens to the parent or surrendering adult?

Once the parent or surrendering adult surrenders the baby to hospital or fire station personnel, they may leave at any time.

Why is California doing this?

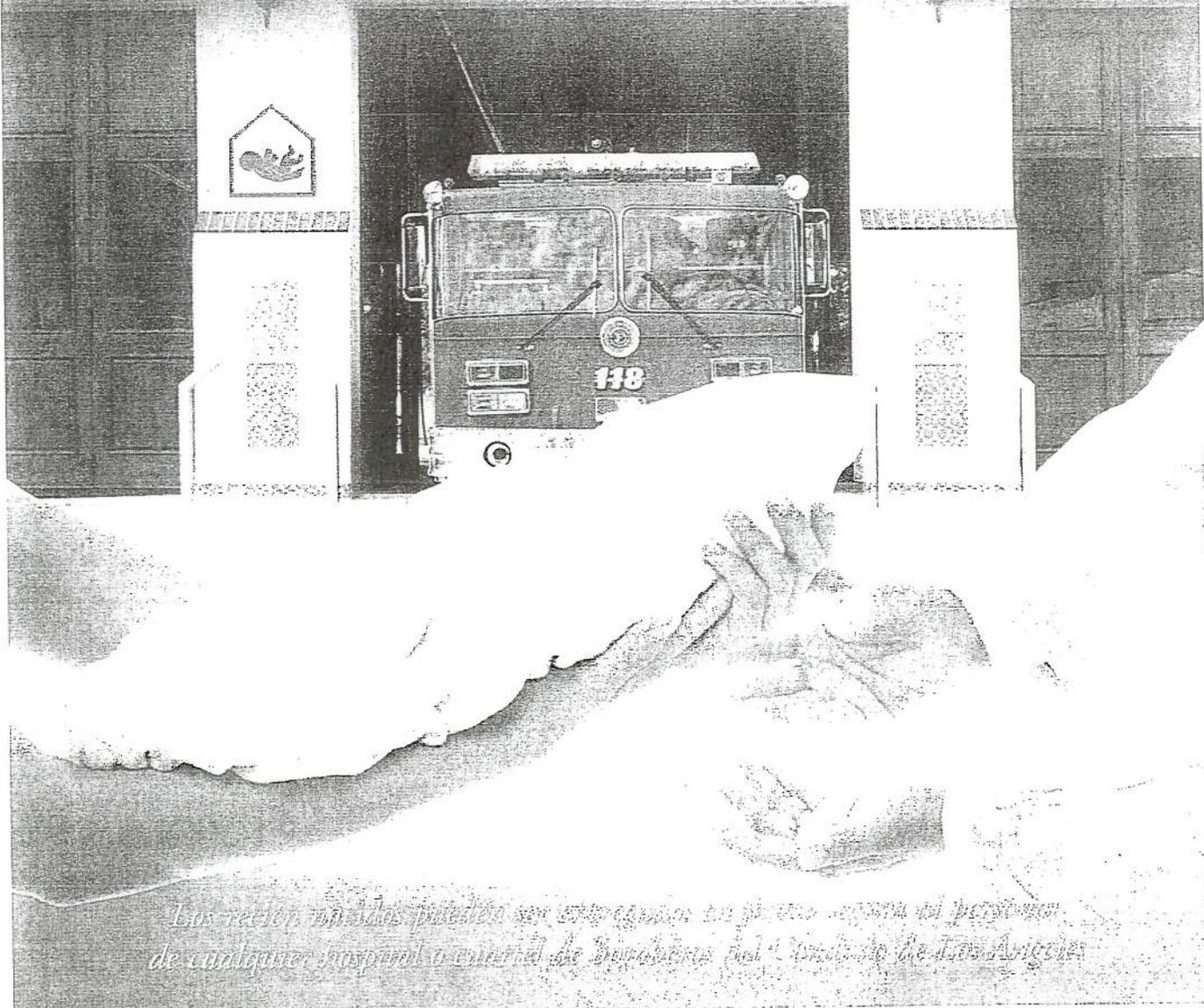
The purpose of the Safely Surrendered Baby Law is to protect babies from being abandoned, hurt or killed by their parents. You may have heard tragic stories of babies left in dumpsters or public bathrooms. Their parents may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had no one or nowhere to turn for help, they abandoned their babies. Abandoning a baby is illegal and places the baby in extreme danger. Too often, it results in the baby's death. The Safely Surrendered Baby Law prevents this tragedy from ever happening again in California.

A baby's story

Early in the morning on April 9, 2005, a healthy baby boy was safely surrendered to nurses at Harbor-UCLA Medical Center. The woman who brought the baby to the hospital identified herself as the baby's aunt and stated the baby's mother had asked her to bring the baby to the hospital on her behalf. The aunt was given a bracelet with a number matching the anklet placed on the baby; this would provide some identification in the event the mother changed her mind about surrendering the baby and wished to reclaim the baby in the 14-day period allowed by the Law. The aunt was also provided with a medical questionnaire and said she would have the mother complete and mail back in the stamped return envelope provided. The baby was examined by medical staff and pronounced healthy and full-term. He was placed with a loving family that had been approved to adopt him by the Department of Children and Family Services.



Ley de Entrega de Bebés Sin Peligro



Los recién nacidos pueden ser entregados en perfecto estado al personal de cualquier hospital o central de bomberos del Condado de Los Angeles.

Este artículo de la ley...

Ley de Entrega de Bebés Sin Peligro

¿Qué es la Ley de Entrega de Bebés Sin Peligro?

La Ley de Entrega de Bebés sin Peligro de California permite la entrega confidencial de un recién nacido por parte de sus padres u otras personas con custodia legal, es decir cualquier persona a quien los padres le hayan dado permiso. Siempre que el bebé tenga tres días (72 horas) de vida o menos, y no haya sufrido abuso ni negligencia, pueden entregar al recién nacido sin temor de ser arrestados o procesados.

Cada recién nacido se merece la oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele que tiene otras opciones. Hasta tres días (72 horas) después del nacimiento, se puede entregar un recién nacido al personal de cualquier hospital o cuartel de bomberos del condado de Los Angeles.

¿Cómo funciona?

El padre/madre con dificultades que no pueda o no quiera cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura dentro de los tres días (72 horas) del nacimiento. El bebé debe ser entregado a un empleado de cualquier hospital o cuartel de bomberos del Condado de Los Angeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazalete y el padre/madre o el adulto que lo entregue recibirá un brazalete igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden comenzar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Angeles al 1-800-540-4000.

¿Sólo los padres podrán llevar al recién nacido?

No. Si bien en la mayoría de los casos son los padres los que llevan al bebé, la ley permite que otras personas lo hagan si tienen custodia legal.

¿Los padres o el adulto que entrega al bebé deben llamar antes de llevar al bebé?

No. El padre/madre o adulto puede llevar al bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, siempre y cuando entreguen a su bebé a un empleado del hospital o cuartel de bomberos.

¿Es necesario que el padre/madre o adulto diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital o cuartel de bomberos le pedirá a la persona que entregue al bebé que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que resultan de gran utilidad para cuidar bien del bebé. El cuestionario incluye un sobre con el sello postal pagado para enviarlo en otro momento.

¿Qué pasará con el bebé?

El bebé será examinado y le brindarán atención médica. Cuando le den el alta del hospital, los trabajadores sociales inmediatamente ubicarán al bebé en un hogar seguro donde estará bien atendido, y se comenzará el proceso de adopción.

¿Qué pasará con el padre/madre o adulto que entregue al bebé?

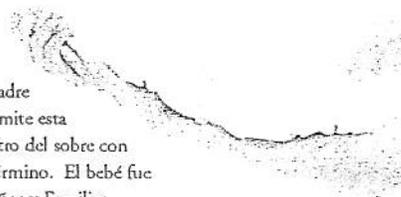
Una vez que los padres o adulto hayan entregado al bebé al personal del hospital o cuartel de bomberos, pueden irse en cualquier momento.

¿Por qué se está haciendo esto en California?

La finalidad de la Ley de Entrega de Bebés sin Peligro es proteger a los bebés para que no sean abandonados, lastimados o muertos por sus padres. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Los padres de esos bebés probablemente hayan estado pasando por dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si sus familias se enteraran. Abandonaron a sus bebés porque tenían miedo y no tenían nadie a quien pedir ayuda. El abandono de un recién nacido es ilegal y pone al bebé en una situación de peligro extremo. Muy a menudo el abandono provoca la muerte del bebé. La Ley de Entrega de Bebés sin Peligro impide que vuelva a suceder esta tragedia en California.

Historia de un bebé

A la mañana temprano del día 9 de abril de 2005, se entregó un recién nacido saludable a las enfermeras del Harbor-UCLA Medical Center. La mujer que llevó el recién nacido al hospital se dio a conocer como la tía del bebé, y dijo que la madre le había pedido que llevara al bebé al hospital en su nombre. Le entregaron a la tía un brazalete con un número que coincidía con la pulsera del bebé; esto serviría como identificación en caso de que la madre cambiara de opinión con respecto a la entrega del bebé y decidiera recuperarlo dentro del período de 14 días que permite esta ley. También le dieron a la tía un cuestionario médico, y ella dijo que la madre lo llenaría y lo enviaría de vuelta dentro del sobre con franqueo pagado que le habían dado. El personal médico examinó al bebé y se determinó que estaba saludable y a término. El bebé fue ubicado con una buena familia que ya había sido aprobada para adoptarlo por el Departamento de Servicios para Niños y Familias.



TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.I
LEVEL I TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

<u>PARAGRAPH</u>	<u>PAGE</u>
DEFINITIONS:.....	- 1 -
Abbreviated Injury Scale:.....	- 1 -
Dedicated:.....	- 1 -
on-call physicians.....	- 1 -
in-house physicians.....	- 1 -
Emergency Department Approved for Pediatrics:.....	- 1 -
General Surgeon:.....	- 1 -
In-house:.....	- 1 -
Injury Severity Score:.....	- 2 -
Immediately Available:.....	- 2 -
On-Call:.....	- 2 -
Promptly Available:.....	- 2 -
Qualified Specialist:.....	- 3 -
Residency Program:.....	- 4 -
Senior Resident:.....	- 4 -
Trauma Center:.....	- 4 -
Trauma Resuscitation Area:.....	- 4 -
Trauma Service:.....	- 4 -
Trauma Team:.....	- 5 -
GENERAL REQUIREMENTS:.....	- 5 -
PROFESSIONAL STAFF REQUIREMENTS:.....	- 8 -
SURGICAL:.....	- 8 -
Immediately Available:.....	- 8 -
Promptly Available:.....	- 8 -
Available for Consultation:.....	- 10 -
NON-SURGICAL:.....	- 10 -
Immediately Available:.....	- 10 -
Promptly Available:.....	- 11 -
Available for Consultation:.....	- 11 -
ADDITIONAL SERVICE CAPABILITIES:.....	- 12 -
Emergency Service:.....	- 12 -
Surgical Service:.....	- 12 -
Intensive Care Service:.....	- 13 -
Radiological Service:.....	- 13 -

Clinical Laboratory Service:.....	<u>- 13 -</u>
SUPPLEMENTAL SERVICES:.....	<u>- 14 -</u>
QUALITY IMPROVEMENT PROCESS:.....	<u>- 15 -</u>
VOLUME STANDARDS:.....	<u>- 16 -</u>
CLINICAL EDUCATION AND RESEARCH:.....	<u>- 16 -</u>

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.I TRAUMA CENTER REQUIREMENTS LEVEL I

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Dedicated:

- a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
- b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

3. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

4. General Surgeon:

"General Surgeon" for the purposes of this trauma system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

5. In-house:

"In-house" means being within the actual confines of the Trauma Center.

6. Injury Severity Score:

Exhibit A.I

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

7. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

8. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

9. Promptly Available:

"Promptly available" means:

- a. responding without delay when notified and requested to respond to the Trauma Center;
- b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the Trauma Center) within a period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and
- c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the Trauma Center the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

10. Qualified Specialist:

Exhibit A.I

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

- a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a Trauma Center if:
 - (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;
 - (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
 - (3) the physician has successfully completed a residency program.

11. Residency Program:

"Residency program" means a residency program of the Trauma Center or a residency program formally affiliated with a Trauma Center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

12. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center.

Exhibit A.I

Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

13. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

14. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a Trauma Center where trauma patients are evaluated upon arrival.

15. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a Trauma Center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

16. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to Trauma Center designation level and the patient=s severity of injury, but must include the trauma surgeon.

B. GENERAL REQUIREMENTS:

1. A licensed hospital which has been designated as a Level I Trauma Center by the EMS Agency.
2. Appropriate pediatric equipment and supplies and the

Exhibit A.I

capability of initial evaluation and treatment of pediatric trauma patients.

3. Establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care when the Trauma Center is without a pediatric intensive care unit.
4. ReddiNet System where geographically available.
5. A trauma program medical director who is a board certified surgeon whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
 - a. recommending trauma team physician privileges;
 - b. working with nursing and administration to support the needs of trauma patients;
 - c. developing trauma treatment protocols;
 - d. determining appropriate equipment and supplies for trauma care;
 - e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
 - f. having authority and accountability for the quality improvement peer review process;
 - g. correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;
 - h. coordinating pediatric trauma care with other hospital and professional services;
 - i. coordinating with local and State EMS agencies;
 - j. assisting in the coordination of the budgetary process for the trauma program; and
 - k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.
6. A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administrative ability, and responsibilities that include but are not limited to:
 - a. organizing services and systems necessary for the

Exhibit A.I

- multi-disciplinary approach to the care of the injured patient;
- b. coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel;
 - c. collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program; and
 - d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.
7. A trauma service or multi-disciplinary trauma committee included in their organization which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.
 8. A trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the trauma patient.
 9. Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists:
 - a. General Surgery
 - b. Neurologic
 - c. Obstetric/Gynecologic
 - d. Ophthalmologic
 - e. Oral or Maxillofacial or Head/Neck
 - f. Orthopaedic
 - g. Plastic
 - h. Urologic
 10. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists:
 - a. Anesthesiology
 - b. Emergency Medicine
 - c. Internal Medicine
 - d. Pathology
 - e. Psychiatry
 - f. Radiology
 11. Commitment by the hospital and its medical staff to treat and care for any patient presenting.

Exhibit A.I

12. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

- a. Immediately Available:

- (1) General Surgery:

A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for trauma patients twenty-four (24) hours per day. A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be promptly available for consultation.

(Requirement may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who is capable of assessing emergent situations. When a senior resident is the responsible surgeon:

- (a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
 - (b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and
 - (c) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

- b. On-call and Promptly Available:

- (1) Cardiothoracic
 - (2) General Surgeon (*Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism*

Exhibit A.I

- exists for a second general surgeon.)*
- (3) Hand
 - (4) Neurologic (Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.)
 - (5) Obstetric/Gynecologic
 - (6) Ophthalmic
 - (7) Oral or Maxillofacial or Head/Neck
 - (8) Orthopedic
 - (9) Pediatric
 - (10) Plastic
 - (11) Reimplantation/Microsurgery (*This surgical service may be provided through a written transfer agreement at Level I and Level II Trauma Centers.*)
 - (12) Urologic
 - (13) Vascular (Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.)

The on-call general surgeon, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

- (a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
- (b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and
- (c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative

Exhibit A.I

procedures.)

- c. Available for Consultation:
Available for consultation or consultation and transfer agreements for adult and pediatric trauma patients requiring the following surgical services:
 - (1) Burns
 - (2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

- a. Immediately Available:
 - (1) Emergency Medicine:
Emergency medicine, in-house and immediately available at all times.

(This requirement may be fulfilled by supervised senior residents, as defined in Section A-12 of this Exhibit, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.)

- (2) Anesthesiologist:
Anesthesiology, in-house and immediately available at all times.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing emergent situations in trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call

Exhibit A.I

shall be advised about the patient, be promptly available at all times, and present for all operations.)

- b. Promptly Available:
- (1) Anesthesiologist (Second physician on call.)
 - (2) Emergency Medicine (Second physician on call.)
 - (3) Radiologist

The on-call anesthesiologist, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

- c. Available for Consultation:
- (1) Cardiologist
 - (2) Gastroenterologist
 - (3) Hematologist
 - (4) Infectious Disease Specialist
 - (5) Internist
 - (6) Nephrologist
 - (7) Neurologist
 - (8) Pathologist
 - (9) Pediatrician
 - (10) Pulmonary Disease Specialist

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**
- Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:
- a. designate a Medical Director;
 - b. maintain an Emergency Medicine Physician in the Emergency Department twenty-four (24) hours per day;
 - c. designate an emergency physician to be a member of the trauma team;
 - d. provide emergency medical services to adult and pediatric patients;
 - e. have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
 - f. designate a trauma resuscitation area of adequate size to accommodate multi-system injured patient and equipment; and
 - g. comply with current Emergency Department Approved for

Exhibit A.I

Pediatrics (EDAP) requirements (Attachment A-1).

2. **Surgical Service:**

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

- a. operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available;
- b. cardiopulmonary bypass equipment;
- c. operating microscope;
- d. appropriate surgical equipment and supplies as determined by the trauma program medical director; and
- e. Post Anesthetic Recovery Room (PAR) which meets the requirements of California Administrative Code. (A Surgical Intensive Care Unit is acceptable.)

3. **Intensive Care Service:**

In addition to the special permit licensing services, a Trauma Center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, an approved Intensive Care Unit (ICU). The ICU shall:

- a. for trauma patients, the ICU=s may be separate specialty units;
- b. have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
- c. have a qualified specialist in house and immediately available to care for the trauma patients in the intensive care unit. (*The qualified specialist may be a resident with two (2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making.*); and
- d. have the qualified specialist in (3) above be a member of the trauma team.

4. **Radiological Service:**

- a. The radiological service shall have immediately available a radiological technician capable of performing:
 - (1) plain films; and
 - (2) computed tomography imaging (CT).
- b. A radiological service shall have the following additional services promptly available:

Exhibit A.I

- (1) angiography; and
- (2) ultrasound.

5. **Clinical Laboratory Service:**

A clinical laboratory service shall have:

- a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
- b. capability of collecting and storing blood for emergency care; and
- c. clinical laboratory services immediately available.

E. SUPPLEMENTAL SERVICES:

1. In addition to the special permit licensing services, a Trauma Center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:

- a. Burn Center.
(This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)
- b. The following services shall have personnel trained and equipped for acute care of the critically injured patient:
 - (1) Physical Therapy Service
 - (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
 - (3) Respiratory Care Service
 - (4) Hemodialysis capabilities (with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours per day)
 - (5) Occupational Therapy Service Speech Therapy Service
 - (6) Social Service

2. A Trauma Center shall have the following services or programs that do not require a license or special permit:

- a. Pediatric Service. In addition to the requirements in

Exhibit A.I

Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:

- (1) a pediatric intensive care unit (PICU) approved by the State Department of Health Services= California Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
 - (2) a multidisciplinary team to manage child abuse and neglect.
- b. Acute spinal cord injury management capability. (*This service may be provided through a written transfer agreement with a Rehabilitation Center.*)
 - c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
 - d. An outreach program, to include:
 - (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
 - (2) trauma prevention for the general public.
 - e. Written inter-facility transfer agreements with referring and specialty hospitals.

F. QUALITY IMPROVEMENT PROCESS:

Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);
2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;
3. Participation in the trauma system data management system;
4. Participation in the local EMS agency trauma quality improvement committee as outlined in the Prehospital Care

Exhibit A.I

Policy Manual Reference No. 615, Trauma Quality Improvement Subcommittee-Trauma Hospital Advisory Committee (THAC-QI) and Reference No. 616 Trauma Hospital Regional Quality Improvement Program;

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and
6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. VOLUME STANDARDS:

A Level I Trauma Center shall have one of the following patient volumes annually:

1. a minimum of 1200 trauma program center admissions, or
2. a minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is greater than 15, or
3. an average of 35 trauma patients, with an ISS greater than 15, per trauma program surgeon per year.

H. CLINICAL EDUCATION AND RESEARCH:

A Level I Trauma Center shall include the following:

1. Trauma research program with ongoing clinical research in trauma.
2. Accreditation Council on Graduate Medical Education (ACGME) approved surgical, internal medicine and anesthesiology residency programs. A mechanism shall be in place to ensure residents= participation in the acute care of the trauma patient.
3. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.
4. Formal continuing education in trauma care. Continuing education in trauma care shall be provided for:

Exhibit A.I

- a. staff physicians;
- b. staff nurses;
- c. staff allied health personnel;
- d. EMS personnel; and
- e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.II
LEVEL II TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

<u>PARAGRAPH</u>	<u>PAGE</u>
DEFINITIONS:.....	- 1 -
Abbreviated Injury Scale:.....	- 1 -
Dedicated:.....	- 1 -
on-call physicians.....	- 1 -
in-house physicians.....	- 1 -
Emergency Department Approved for Pediatrics:.....	- 1 -
General Surgeon:.....	- 1 -
In-house:.....	- 1 -
Injury Severity Score:.....	- 2 -
Immediately Available:.....	- 2 -
On-Call:.....	- 2 -
Promptly Available:.....	- 2 -
Qualified Specialist:.....	- 3 -
Residency Program:.....	- 4 -
Senior Resident:.....	- 4 -
Trauma Center:.....	- 4 -
Trauma Resuscitation Area:.....	- 4 -
Trauma Service:.....	- 4 -
Trauma Team:.....	- 5 -
GENERAL REQUIREMENTS:.....	- 5 -
PROFESSIONAL STAFF REQUIREMENTS:.....	- 8 -
SURGICAL:.....	- 8 -
Immediately Available:.....	- 8 -
Promptly Available:.....	- 8 -
Available for Consultation:.....	- 10 -
NON-SURGICAL:.....	- 10 -
Immediately Available:.....	- 10 -
Promptly Available:.....	- 11 -
Available for Consultation:.....	- 11 -
ADDITIONAL SERVICE CAPABILITIES:.....	- 11 -
Emergency Service:.....	- 12 -
Surgical Service:.....	- 12 -
Intensive Care Service:.....	- 12 -
Radiological Service:.....	- 13 -

Clinical Laboratory Service:.....	<u>- 13 -</u>
SUPPLEMENTAL SERVICES:.....	<u>- 13 -</u>
QUALITY IMPROVEMENT PROCESS:.....	<u>- 15 -</u>
VOLUME STANDARDS:.....	<u>- 16 -</u>
CLINICAL EDUCATION:.....	<u>- 16 -</u>

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.II TRAUMA CENTER REQUIREMENTS LEVEL II

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Dedicated:

- a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
- b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

3. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

4. General Surgeon:

"General Surgeon" for the purposes of this trauma system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

5. In-house:

"In-house" means being within the actual confines of the Trauma Center.

6. Injury Severity Score:

Exhibit A.II

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

7. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

8. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

9. Promptly Available:

"Promptly available" means:

- a. responding without delay when notified and requested to respond to the hospital;
- b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a period of time that is medically prudent and in accordance with local EMS agency policies and procedures; and
- c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

10. Qualified Specialist:

Exhibit A.II

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

- a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:
 - (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;
 - (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
 - (3) the physician has successfully completed a residency program.

11. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

12. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center.

Exhibit A.II

Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

13. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

14. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

15. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

16. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient=s severity of injury, but must include the trauma surgeon.

B. GENERAL REQUIREMENTS:

1. A licensed hospital which has been designated as a Level II Trauma Center by the EMS Agency.
2. Appropriate pediatric equipment and supplies and the

Exhibit A.II

capability of initial evaluation and treatment of pediatric trauma patients.

3. Establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care when the Trauma Center is without a pediatric intensive care unit.
4. ReddiNet System where geographically available.
5. A trauma program medical director who is a board certified surgeon whose responsibilities include, but are not limited to, factors that affect all aspects of trauma care such as:
 - a. recommending trauma team physician privileges;
 - b. working with nursing and administration to support the needs of trauma patients;
 - c. developing trauma treatment protocols;
 - d. determining appropriate equipment and supplies for trauma care;
 - e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
 - f. having authority and accountability for the quality improvement peer review process;
 - g. correcting deficiencies in trauma care or excluding from trauma call those trauma team members who no longer meet standards;
 - h. coordinating pediatric trauma care with other hospital and professional services;
 - i. coordinating with local and State EMS agencies;
 - j. assisting in the coordination of the budgetary process for the trauma program; and
 - k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program.
6. A trauma nurse coordinator/manager who is a registered nurse with qualifications including evidence of educational preparation and clinical experience in the care of the adult and/or pediatric trauma patient, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to:
 - a. organizing services and systems necessary for the

Exhibit A.II

- multi-disciplinary approach to the care of the injured patient;
- b. coordinating day-to-day clinical process and performance improvement as it pertains to nursing and ancillary personnel;
 - c. collaborating with the trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the trauma program; and
 - d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.
7. A trauma service or multi-disciplinary trauma committee included in their organization which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.
 8. A trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the trauma patient.
 9. Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists:
 - a. General Surgery
 - b. Neurologic
 - c. Obstetric/Gynecologic
 - d. Ophthalmologic
 - e. Oral or Maxillofacial or Head/Neck
 - f. Orthopaedic
 - g. Plastic
 - h. Urologic
 10. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists:
 - a. Anesthesiology
 - b. Emergency Medicine
 - c. Internal Medicine
 - d. Pathology
 - e. Psychiatry
 - f. Radiology
 11. Commitment by the hospital and its medical staff to treat and care for any patient presenting.

Exhibit A.II

12. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

- a. Immediately Available:

- (1) General surgery:

A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for trauma patients twenty-four (24) hours per day. A general surgeon capable of evaluating and treating adult and pediatric trauma patients shall be promptly available for consultation.

(Requirement may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who is capable of assessing emergent situations. When a senior resident is the responsible surgeon:

- (a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
 - (b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and
 - (c) a staff trauma surgeon on a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

- b. On-call and Promptly Available:

- (1) Cardiothoracic
 - (2) General Surgeon (Trauma Centers, Level I and

Exhibit A.II

Level II, shall ensure that a back-up mechanism exists for a second general surgeon.)

- (3) Hand
- (4) Neurologic (*Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.*)
- (5) Obstetric/Gynecologic
- (6) Ophthalmic
- (7) Oral or Maxillofacial or Head/Neck
- (8) Orthopedic
- (9) Plastic
- (10) Reimplantation/Microsurgery (*This surgical service may be provided through a written transfer agreement at Level I and Level II Trauma Centers.*)
- (11) Urologic
- (12) Vascular (*Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.*)

The on-call general surgeon, while on-call to the Trauma Center, is dedicated to that facility and must be promptly available at the hospital.

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-12 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

- (a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
- (b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-9 of this Exhibit; and
- (c) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative

Exhibit A.II

procedures.)

- c. Available for Consultation:
Available for consultation or consultation and transfer agreements for adult and pediatric trauma patients requiring the following surgical services:
- (1) Burns
 - (2) Pediatric
 - (3) Spinal cord injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

- a. Immediately Available:
- (1) Emergency Medicine:
Emergency medicine, in-house and immediately available at all times.

(This requirement may be fulfilled by supervised senior residents, as defined in Section A-12 of this Exhibit, in emergency medicine, who are assigned to the emergency department and are serving in the same capacity. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine.)

- b. Promptly Available:
- (1) Anesthesiologist

(Shall be Promptly Available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives. This requirement may be fulfilled by senior residents or certified registered nurse anesthetists who are capable of assessing

Exhibit A.II

emergent situations in trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

- (2) Emergency Medicine (Second physician on call.)
- (3) Radiologist

c. Available for Consultation:

- (1) Cardiologist
- (2) Gastroenterologist
- (3) Hematologist
- (4) Infectious Disease Specialist
- (5) Internist
- (6) Nephrologist
- (7) Neurologist
- (8) Pathologist
- (9) Pediatrician
- (10) Pulmonary Disease Specialist

D. ADDITIONAL SERVICE CAPABILITIES:

1. **Emergency Service:**

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title

22. The emergency service shall:

- a. designate a Medical Director;
- b. maintain an Emergency Medicine Physician in the Emergency Department twenty-four (24) hours per day;
- c. designate an emergency physician to be a member of the trauma team;
- d. provide emergency medical services to adult and pediatric patients;
- e. have appropriate adult and pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
- f. designate a trauma resuscitation area of adequate size to accommodate multi-system injured patient and equipment; and
- g. comply with current Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

Exhibit A.II

2. Surgical Service:

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

- a. operating staff who are promptly available unless operating on trauma patients and back-up personnel who are promptly available;
- b. appropriate surgical equipment and supplies as determined by the trauma program medical director; and
- c. Post Anesthetic Recovery Room (PAR) which meets the requirements of California Administrative Code. (A Surgical Intensive Care Unit is acceptable.)

3. Intensive Care Service:

In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, an approved Intensive Care Unit (ICU). The ICU shall:

- a. for trauma patients, the ICU=s may be separate specialty units;
- b. have appropriate equipment and supplies as determined by the physician responsible for the intensive care service and the trauma program medical director;
- c. have a qualified specialist promptly available to care for the trauma patients in the intensive care unit. *(The qualified specialist may be a resident with two (2) years of training who is supervised by the staff intensivist or attending surgeon who participates in all critical decision making.);* and
- d. the qualified specialist in (3) above shall be a member of the trauma team.

4. Radiological Service:

- a. The radiological service shall have immediately available a radiological technician capable of performing:
 - (1) plain films; and
 - (2) computed tomography imaging (CT).
- b. A radiological service shall have the following additional services promptly available:
 - (1) angiography; and
 - (2) ultrasound.

5. Clinical Laboratory Service:

A clinical laboratory service shall have:

Exhibit A.II

- a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
- b. capability of collecting and storing blood for emergency care; and
- c. clinical laboratory services immediately available.

E. SUPPLEMENTAL SERVICES:

- 1. In addition to the special permit licensing services, a trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
 - a. Burn Center.
(This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)
 - b. The following services shall have personnel trained and equipped for acute care of the critically injured patient:
 - (1) Physical Therapy Service
 - (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
 - (3) Respiratory Care Service
 - (4) Hemodialysis capabilities (with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours per day)
 - (5) Occupational Therapy Service Speech Therapy Service
 - (6) Social Service
- 2. A trauma center shall have the following services or programs that do not require a license or special permit:
 - a. Pediatric Service. In addition to the requirements in Division 5 of Title 22 of the California Code of Regulations, the pediatric service providing in-house pediatric trauma care shall have:
 - (1) a pediatric intensive care unit approved by the State Department of Health Services= California

Exhibit A.II

- Children Services (CCS); or a written transfer agreement with an approved pediatric intensive care unit. Hospitals without pediatric intensive care units shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care; and
- (2) a multidisciplinary team to manage child abuse and neglect.
- b. Acute spinal cord injury management capability. (*This service may be provided through a written transfer agreement with a Rehabilitation Center.*)
 - c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
 - d. An outreach program, to include:
 - (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
 - (2) trauma prevention for the general public.
 - e. Written inter-facility transfer agreements with referring and specialty hospitals.

F. QUALITY IMPROVEMENT PROCESS:

Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);
2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;
3. Participation in the trauma system data management system;
4. Participation in the local EMS agency trauma quality improvement committee as outlined in the Prehospital Care Policy Manual Reference No. 615, Trauma Quality Improvement Subcommittee-Trauma Hospital Advisory Committee (THAC-QI) and Reference No. 616 Trauma Hospital Regional Quality Improvement Program;

Exhibit A.II

5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and
6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. VOLUME STANDARDS:

A Level II Trauma Center shall demonstrate the capacity and ability to care for 350 trauma patients annually, including surgical and intensive care unit capacities/capabilities.

H. CLINICAL EDUCATION:

A Level II Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.
2. Formal continuing education in trauma care. Continuing education in trauma care shall be provided for:
 - a. staff physicians;
 - b. staff nurses;
 - c. staff allied health personnel;
 - d. EMS personnel; and
 - e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.III
PEDIATRIC LEVEL I TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

<u>PARAGRAPH</u>	<u>PAGE</u>
DEFINITIONS:.....	- 1 -
Abbreviated Injury Scale:.....	- 1 -
Available for Consultation:.....	- 1 -
Dedicated:.....	- 1 -
on-call physicians.....	- 1 -
in-house physicians.....	- 1 -
Emergency Department Approved for Pediatrics:.....	- 1 -
General Surgeon:.....	- 2 -
In-house:.....	- 2 -
Injury Severity Score:.....	- 2 -
Immediately Available:.....	- 2 -
On-Call:.....	- 2 -
Pediatric Experience:.....	- 2 -
Promptly Available:.....	- 2 -
Qualified Specialist:.....	- 3 -
Residency Program:.....	- 4 -
Senior Resident:.....	- 4 -
Trauma Center:.....	- 4 -
Trauma Resuscitation Area:.....	- 5 -
Trauma Service:.....	- 5 -
Trauma Team:.....	- 5 -
GENERAL REQUIREMENTS:.....	- 5 -
PROFESSIONAL STAFF REQUIREMENTS:.....	- 9 -
SURGICAL:.....	- 9 -
Immediately Available:.....	- 9 -
Promptly Available.....	- 10 -
Available for Consultation:.....	- 11 -
NON-SURGICAL:.....	- 11 -
Immediately Available:.....	- 11 -
Promptly Available.....	- 14 -
Available for Consultation.....	- 14 -
ADDITIONAL SERVICE CAPABILITIES:.....	- 15 -
Emergency Service:.....	- 15 -
Surgical Service:.....	- 15 -

Pediatric Intensive Care Unit (PICU):.....	<u>- 15 -</u>
Radiological Service:.....	<u>- 16 -</u>
Clinical Laboratory Service:.....	<u>- 16 -</u>
SUPPLEMENTAL SERVICES:.....	<u>- 16 -</u>
QUALITY IMPROVEMENT PROCESS:.....	<u>- 18 -</u>
CLINICAL EDUCATION AND RESEARCH:.....	<u>- 19 -</u>

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.III TRAUMA CENTER REQUIREMENTS PEDIATRIC LEVEL I

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Available for Consultation:

"Available for Consultation" means being physically available to the specified area of the Trauma Center within a period of time that is medically prudent, but not in excess of twenty-four (24) hours unless documented in the medical record that the consult does not need to respond in person.

3. Dedicated:

- a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
- b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

4. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

5. General Surgeon:

"General Surgeon" for the purposes of this trauma

Exhibit A.III

system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

6. In-house:

"In-house" means being within the actual confines of the Trauma Center.

7. Injury Severity Score:

"Injury Severity Score" or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

8. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

9. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

10. Pediatric Experience:

"Pediatric Experience" means a surgical or non-surgical physician specialty that has been approved to provide care to the pediatric trauma patient as defined by the Pediatric Trauma Director.

11. Promptly Available:

"Promptly available" means:

- a. responding without delay when notified and requested to respond to the hospital;
- b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a period of time that is medically prudent and in accordance with local EMS

Exhibit A.III

- agency policies and procedures; and
- c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

12. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

- a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:
- (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;
 - (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
 - (3) the physician has successfully completed a

Exhibit A.III

residency program.

13. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

14. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

15. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

16. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

17. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has

Exhibit A.III

oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

18. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient=s severity of injury, but must include the trauma surgeon.

B. GENERAL REQUIREMENTS:

1. A licensed hospital which has been designated as a Level I pediatric Trauma Center by the EMS Agency.
2. ReddiNet System where geographically available.
3. A pediatric trauma program medical director who is a board certified pediatric surgeon (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
 - a. recommending pediatric trauma team physician privileges;
 - b. working with nursing and administration to support the needs of pediatric trauma patients;
 - c. developing pediatric trauma treatment protocols;
 - d. determining appropriate equipment and supplies for pediatric trauma care;
 - e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
 - f. having authority and accountability for the pediatric trauma quality improvement peer review process;
 - g. correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;
 - h. coordinating pediatric trauma care with other hospital and professional services;

Exhibit A.III

- i. coordinating with local and State EMS agencies;
 - j. assisting in the coordination of the budgetary process for the trauma program; and
 - k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.
4. A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
- a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured child;
 - b. coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel;
 - c. collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program; and
 - d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.
5. A pediatric trauma service which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.
6. A pediatric trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
- a. The pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director; and
 - b. the remainder of the team shall include physician, nursing, and support personnel in sufficient numbers to evaluate, resuscitate, treat, and stabilize

Exhibit A.III

pediatric trauma patients.

7. Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists with pediatric experience:
 - a. Microsurgery/Reimplantation (*may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service*)
 - b. Neurologic
 - c. Obstetric/Gynecologic (*may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service*)
 - d. Ophthalmologic
 - e. Oral or Maxillofacial or Head/Neck
 - f. Orthopaedic
 - g. Pediatric
 - h. Plastic
 - i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists with pediatric experience:
 - a. Anesthesiology
 - b. Cardiology
 - c. Critical Care
 - d. Emergency Medicine
 - e. Gastroenterology
 - f. General Pediatrics
 - g. Hematology/Oncology
 - h. Infectious Disease
 - i. Neonatology
 - j. Nephrology
 - k. Neurology
 - l. Pathology
 - m. Psychiatry
 - n. Pulmonology
 - o. Radiology
 - p. Rehabilitation/Physical Medicine. (*This requirement may be provided through a written agreement with a pediatric rehabilitation center.*)

9. Commitment by the hospital and its medical staff to treat

Exhibit A.III

and care for any pediatric patient presenting.

10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.
11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:

(1) Pediatric Surgeon:

A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for consultation.

(This requirement may be fulfilled by:

- (a) a staff pediatric surgeon with experience in pediatric trauma care; or
- (b) a staff trauma surgeon with experience in pediatric trauma care; or
- (c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
 - (i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
 - (ii) a staff pediatric trauma surgeon with experience in pediatric trauma care or a staff surgeon with experience in pediatric trauma care shall be on-call and promptly

Exhibit A.III

- available; and*
- (iii) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

- b. On-call and Promptly Available with pediatric experience:
- (1) Cardiothoracic
 - (2) Pediatric Surgeon (*Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.*)
 - (3) Hand
 - (4) Pediatric Neurologic (*Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.*)
 - (5) Obstetric/Gynecologic (*This surgical service may be provided through a written transfer agreement.*)
 - (6) Pediatric Ophthalmic
 - (7) Pediatric Oral or Maxillofacial or Head/Neck
 - (8) Pediatric Orthopedic
 - (9) Plastic Surgeon
 - (10) Reimplantation/Microsurgery (*This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.*)
 - (11) Urologic
 - (12) Vascular (*Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.*)

(The above requirements may be fulfilled by a supervised senior resident as defined in Section A-14 of this Exhibit who are capable of assessing emergent situations in their respective

Exhibit A.III

specialties. When a senior resident is the responsible surgeon:

- (a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
- (b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and
- (c) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:

Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:

- (1) Burns
- (2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:

(1) Emergency Medicine:

Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:

- (a) a qualified specialist in pediatric emergency medicine; or
- (b) a qualified specialist in emergency medicine with pediatric experience; or
- (c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education in

Exhibit A.III

pediatric emergency medicine with pediatric experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:

- (i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and
- (ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.)

- (2) Pediatric Anesthesiologist:
Pediatric Anesthesiology, Level I shall be immediately available, with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists with pediatric experience who are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

- (3) Pediatric Critical Care:

Exhibit A.III

Pediatric Critical Care, in-house and immediately available.

(The in-house requirement may be fulfilled by:

- (a) a qualified specialist in pediatric critical care medicine; or
- (b) a qualified specialist in anesthesiology with experience in pediatric critical care; or
- (c) a qualified surgeon with expertise in pediatric critical care; or
- (d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible pediatric critical care physician then:
 - (i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and
 - (ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:

- (1) Pediatric Anesthesiology (second call)
- (2) Pediatric Emergency Medicine (second call)
- (3) Pediatric Gastroenterology
- (4) Pediatric Infectious Disease
- (5) Pediatric Nephrology
- (6) Pediatric Neurology
- (7) Pediatric Pulmonology
- (8) Pediatric Radiology

c. Available for Consultation:

- (1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:
 - (a) General Pediatrics
 - (b) Mental Health
 - (c) Neonatology

Exhibit A.III

- (d) Pathology
- (e) Pediatric Cardiology
- (f) Pediatric Hematology/Oncology
- (g) Pediatric Infectious Disease

(2) The following qualified specialist with pediatric experience shall be Available for Consultation **or provided through transfer agreement:**

- (a) Adolescent Medicine
- (b) Child Development
- (c) Genetics/Dysmorphology
- (d) Neuroradiology
- (e) Obstetrics
- (f) Pediatric Allergy and Immunology
- (g) Pediatric Dentistry
- (h) Pediatric Endocrinology
- (i) Pediatric Pulmonology
- (j) Rehabilitation/Physical Medicine.

D. ADDITIONAL SERVICE CAPABILITIES:

1. Emergency Service:

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:

- a. designate an emergency physician to be a member of the pediatric trauma team;
- b. provide emergency medical services to pediatric patients;
- c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
- d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
- e. comply with the Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. Surgical Service:

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

- a. operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available;

Exhibit A.III

- b. appropriate surgical equipment and supplies as determined by the trauma program medical director;
 - c. cardiopulmonary bypass equipment; and
 - d. operating microscope.
3. **Pediatric Intensive Care Unit (PICU):**
- a. The PICU shall be approved by the State Department of Health Services= California Children Services (CCS);
 - b. The PICU shall have appropriate equipment and supplies as determined by the physician responsible for the pediatric intensive care service and the pediatric trauma program medical director;
 - c. The pediatric intensive care specialist shall be **immediately available**, advised about all patients who may require admission to the PICU, and shall participate in all major therapeutic decisions and interventions; and
 - d. The qualified specialist in (c) above shall be a member of the trauma team.
4. **Radiological Service:**
- a. The radiological service shall have in-house and immediately available a radiological technician capable of performing:
 - (1) plain films; and
 - (2) computed tomography imaging (CT).
 - b. A radiological service shall have the following additional services promptly available for children:
 - (1) angiography; and
 - (2) ultrasound.
5. **Clinical Laboratory Service:** A clinical laboratory service shall have:
- a. a comprehensive blood bank or access to a community central blood bank with adequate hospital storage facilities;
 - b. capability of collecting and storing blood for emergency care; and
 - c. clinical laboratory services immediately available with micro sampling capability.
6. **Nursing Services:** Nursing services that are staffed by qualified licensed nurses with education, experience, and demonstrated clinical competence in the care of critically ill and injured children.

Exhibit A.III

E. SUPPLEMENTAL SERVICES:

1. In addition to the special permit licensing services, a pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:
 - a. Burn Center.
(This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)
 - b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
 - (1) Physical Therapy Service
 - (2) Rehabilitation Center *(This service may be provided through a written transfer agreement with a rehabilitation center.)*
 - (3) Respiratory Care Service
 - (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
 - (5) Occupational Therapy Service
 - (6) Speech Therapy Service
 - (7) Social Service
2. A trauma center shall have the following services or programs that do not require a license or special permit:
 - a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code. *(Surgical Intensive Care Unit is acceptable.)*
 - b. Acute spinal cord injury management capability. *(This service may be provided through a written transfer agreement with a Rehabilitation Center.)*
 - c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
 - d. An outreach program, to include:
 - (1) capability to provide both telephone and on-site consultations with physicians in the community

Exhibit A.III

- and outlying areas; and
- (2) trauma prevention for the general public; and
- (3) public education and illness/injury prevention education.
- e. Written inter-facility transfer agreements with referring and specialty hospitals.
- f. Suspected child abuse and neglect team (SCAN).
- g. Aeromedical transport plan.
- h. Child Life Program.
- i. Pediatric Trauma research program.
- j. Maintain an educational rotation with an Accreditation Council on Graduate Medical Education (ACGME) approved and affiliated surgical residency program.

F. QUALITY IMPROVEMENT PROCESS:

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);
2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;
3. Participation in the trauma system data management system;
4. Participation in the local EMS agency trauma quality improvement committee as outlined in the Prehospital Care Policy Manual Reference No. 615, Trauma Quality Improvement Subcommittee-Trauma Hospital Advisory Committee (THAC-QI) and Reference No. 616 Trauma Hospital Regional Quality Improvement Program;
5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and
6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. CLINICAL EDUCATION AND RESEARCH:

A Level I Pediatric Trauma Center shall include the following:

1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.
2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:
 - a. staff physicians;
 - b. staff nurses;
 - c. staff allied health personnel;
 - d. EMS personnel; and
 - e. other community physicians and health care personnel.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
PEDIATRIC LEVEL II TRAUMA CENTER REQUIREMENTS

TABLE OF CONTENTS

<u>PARAGRAPH</u>	<u>PAGE</u>
DEFINITIONS:.....	- 1 -
Abbreviated Injury Scale:.....	- 1 -
Available for Consultation:.....	- 1 -
Dedicated:.....	- 1 -
on-call physicians.....	- 1 -
in-house physicians.....	- 1 -
Emergency Department Approved for Pediatrics:.....	- 1 -
General Surgeon:.....	- 2 -
In-house:.....	- 2 -
Injury Severity Score:.....	- 2 -
Immediately Available:.....	- 2 -
On-Call:.....	- 2 -
Pediatric Experience:.....	- 2 -
Promptly Available:.....	- 3 -
Qualified Specialist:.....	- 3 -
Residency Program:.....	- 4 -
Senior Resident:.....	- 5 -
Trauma Center:.....	- 5 -
Trauma Resuscitation Area:.....	- 5 -
Trauma Service:.....	- 5 -
Trauma Team:.....	- 6 -
GENERAL REQUIREMENTS:.....	- 6 -
PROFESSIONAL STAFF REQUIREMENTS:.....	- 9 -
SURGICAL:.....	- 9 -
Immediately Available:.....	- 10 -
Promptly Available.....	- 11 -
Available for Consultation:.....	- 12 -
NON-SURGICAL:.....	- 12 -
Immediately Available:.....	- 12 -
Promptly Available.....	- 15 -
Available for Consultation.....	- 16 -
ADDITIONAL SERVICE CAPABILITIES:.....	- 16 -
Emergency Service:.....	- 16 -

Surgical Service:.....	- 17 -
Pediatric Intensive Care Unit (PICU):.....	- 17 -
Radiological Service:.....	- 17 -
Clinical Laboratory Service:.....	- 18 -
SUPPLEMENTAL SERVICES:.....	- 18 -
QUALITY IMPROVEMENT PROCESS:.....	- 19 -
CLINICAL EDUCATION AND RESEARCH:.....	- 20 -

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT A.IV
TRAUMA CENTER REQUIREMENTS
PEDIATRIC LEVEL II

A. DEFINITIONS:

1. Abbreviated Injury Scale:

"Abbreviated Injury Scale" or "AIS" is an anatomic severity scoring system. For the purposes of data sharing, the standard to be followed is AIS 90. For the purposes of volume performance measurement auditing, the standard to be followed is AIS 90, using AIS code derived or computer derived scoring.

2. Available for Consultation:

"Available for Consultation" means being physically available to the specified area of the Trauma Center within a period of time that is medically prudent, but not in excess of twenty-four (24) hours unless documented in the medical record that the consult does not need to respond in person.

3. Dedicated:

- a. For on-call physicians, "Dedicated", means taking call at only one facility during the same time frame.
- b. For in-house physicians, "Dedicated", means that their main responsibility is trauma.

4. Emergency Department Approved for Pediatrics:

"Emergency Department Approved for Pediatrics (EDAP)" means a licensed basic emergency department that has been confirmed by the Department of Health Services (DHS), and the American Academy of Pediatrics Chapter II, and the Los Angeles Pediatric Society as meeting specific service criteria to provide optimal emergency pediatric care.

5. General Surgeon:

"General Surgeon" for the purposes of this trauma

Exhibit A.IV

system, is a surgeon, credentialed by the facility and experienced in cardiovascular and organ repair.

6. In-house:

"In-house" means being within the actual confines of the Trauma Center.

7. Injury Severity Score:

"Injury Severity Score " or "ISS" means the sum of the square of the Abbreviated Injury Scale ("AIS") score of the three most severely injured body regions.

8. Immediately Available:

"Immediately available" means unencumbered by conflicting duties or responsibilities; responding without delay when notified; and being physically available to the specified area of the Trauma Center when the patient is delivered in accordance with local EMS Agency's policies and procedures.

9. On-Call:

"On-call" means agreeing to be available, according to a predetermined schedule, to respond to the Trauma Center in order to provide a defined service.

10. Pediatric Experience:

"Pediatric Experience" means a surgical or non-surgical physician specialty that has been approved to provide care to the pediatric trauma patient as defined by the Pediatric Trauma Director.

11. Promptly Available:

"Promptly available" means:

- a. responding without delay when notified and requested to respond to the hospital;
- b. being physically available to the specified area of the Trauma Center (trauma receiving area, emergency department, operating room, or other specified area of the trauma center) within a period of time that is medically prudent and in accordance with local EMS

Exhibit A.IV

- agency policies and procedures; and
- c. the interval between the delivery of the patient at the Trauma Center and the arrival of the respondent should not have a measurable harmful effect on the course of the patient's management or outcome.

When the term "promptly available" is used it is presumptively met if upon notification and request to respond to the hospital the physician is in-house within thirty (30) minutes of the request. Responses in excess of thirty (30) minutes will be reviewed on a case by case basis to determine whether the response was medically prudent and proportionate to the patient's clinical condition and whether the failure to respond within thirty (30) minutes had a measurable harmful effect on the course of the patient's management or outcome.

12. Qualified Specialist:

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means:

- a. A physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian Board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.
- b. A non-board certified physician may be recognized as a "qualified specialist" by the local EMS agency upon substantiation of need by a trauma center if:
- (1) the physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Education ("ACGME") or the Royal College of Physicians and Surgeons of Canada;
 - (2) the physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
 - (3) the physician has successfully completed a

Exhibit A.IV

residency program.

13. Residency Program:

"Residency program" means a residency program of the trauma center or a residency program formally affiliated with a trauma center where senior residents can participate in educational rotations, which has been approved by the appropriate Residency Review Committee of the Accreditation Council on Graduate Medical Education.

14. Senior Resident:

"Senior resident" or "senior level resident" means a physician, licensed in the State of California, who has completed at least three (3) years of the residency or is in their last year of residency training and has the capability of initiating treatment and who is in training as a member of a residency program at the designated Trauma Center. Residents in general surgery shall have completed three (3) years of residency in order to be considered a senior resident.

15. Trauma Center:

"Trauma Center" or "designated Trauma Center" means a licensed general acute care hospital, accredited by the Joint Commission of Accreditation of Healthcare Organizations, which has been designated as a Level I, II, III, or IV Trauma Center and/or Level I or II Pediatric Trauma Center by the local EMS agency and the Los Angeles County Board of Supervisors in accordance with Title 22.

16. Trauma Resuscitation Area:

"Trauma resuscitation area" means a designated area within a trauma center where trauma patients are evaluated upon arrival.

17. Trauma Service:

A "trauma service" is a clinical service established by the organized medical staff of a trauma center that has

Exhibit A.IV

oversight and responsibility of the care of the trauma patient. It includes, but is not limited to, direct patient care services, administration, and as needed, support functions to provide medical care to injured patients.

18. Trauma Team:

"Trauma team" means the multi-disciplinary group of personnel who have been designated to collectively render care for trauma patients at a designated Trauma Center. The trauma team consists of physicians, nurses, and allied health personnel. The composition of the trauma team may vary in relationship to trauma center designation level and the patient=s severity of injury, but must include the trauma surgeon.

B. **GENERAL REQUIREMENTS:**

1. A licensed hospital which has been designated as a Level II pediatric Trauma Center by the EMS Agency.
2. ReddiNet System where geographically available.
3. A pediatric trauma program medical director who is a board certified surgeon with experience in pediatric trauma care (may also be trauma program medical director for adult trauma services), whose responsibilities include, but are not limited to, factors that affect all aspects of pediatric trauma care such as:
 - a. recommending pediatric trauma team physician privileges;
 - b. working with nursing and administration to support the needs of pediatric trauma patients;
 - c. developing pediatric trauma treatment protocols;
 - d. determining appropriate equipment and supplies for pediatric trauma care;
 - e. ensuring the development of policies and procedures to manage domestic violence, elder and child abuse and neglect;
 - f. having authority and accountability for the pediatric trauma quality improvement peer review process;
 - g. correcting deficiencies in pediatric trauma care or excluding from trauma call those trauma team members who no longer meet standards;

Exhibit A.IV

- h. coordinating pediatric trauma care with other hospital and professional services;
 - i. coordinating with local and State EMS agencies;
 - j. assisting in the coordination of the budgetary process for the trauma program; and
 - k. identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who have pediatric trauma care experience and who are qualified to be members of the pediatric trauma program.
4. A pediatric trauma nurse coordinator/manager who is a registered nurse with qualifications (may also be trauma nurse coordinator/manager for adult trauma services) including evidence of educational preparation and clinical experience in the care of pediatric trauma patients, knowledge of Trauma Center operations and local EMS Agency policies and regulations, administration ability, and responsibilities that include but are not limited to factors that affect all aspects of pediatric trauma care, including:
- a. organizing services and systems necessary for the multi-disciplinary approach to the care of the injured child;
 - b. coordinating day-to-day clinical process and performance improvement as it pertains to pediatric trauma nursing and ancillary personnel;
 - c. collaborating with the pediatric trauma program medical director in carrying out the educational, clinical, research, administrative and outreach activities of the pediatric trauma program; and
 - d. ensuring compliance with policies, procedures, and protocols established by the EMS Agency.
5. A pediatric trauma service which can provide for the implementation of the requirements specified in this Agreement and provide for coordination with the local EMS Agency.
6. A pediatric trauma team, which is a multi-disciplinary team responsible for the initial resuscitation and management of the pediatric trauma patient.
- a. The pediatric trauma team leader shall be a surgeon with pediatric trauma experience as defined by the trauma program medical director; and
 - b. the remainder of the team shall include physician,

Exhibit A.IV

nursing, and support personnel in sufficient numbers to evaluate, resuscitate, treat, and stabilize pediatric trauma patients.

7. Department(s), division(s), service(s) or section(s) that include at least the following surgical specialties, which are staffed by qualified specialists with pediatric experience:
 - a. Microsurgery/Reimplantation (*may be provided through a written transfer agreement with a hospital that has a department division service, or section that provides this service*)
 - b. Neurologic
 - c. Obstetric/Gynecologic (*may be provided through a written transfer agreement with a hospital that has a department, division, service, or section that provides this service*)
 - d. Ophthalmologic
 - e. Oral or Maxillofacial or Head/Neck
 - f. Orthopaedic
 - g. Pediatric
 - h. Plastic
 - i. Urologic

8. Department(s), division(s), service(s) or section(s) that include at least the following non-surgical specialties, which are staffed by qualified specialists with pediatric experience:
 - a. Anesthesiology
 - b. Cardiology
 - c. Critical Care
 - d. Emergency Medicine
 - e. Gastroenterology
 - f. General Pediatrics
 - g. Hematology/Oncology
 - h. Infectious Disease
 - i. Neonatology
 - j. Nephrology
 - k. Neurology
 - l. Pathology
 - m. Psychiatry
 - n. Pulmonology
 - o. Radiology
 - p. Rehabilitation/Physical Medicine (*This requirement may be provided through a written agreement with a pediatric rehabilitation center.*)

Exhibit A.IV

9. Commitment by the hospital and its medical staff to treat and care for any pediatric patient presenting.
10. Demonstrated capacity and ability to care for pediatric trauma patients fourteen (14) years and younger, including surgical and intensive care unit capacities/capabilities.
11. Helipad with a permit issued by the State of California, Department of Transportation, Division of Aeronautics.

C. PROFESSIONAL STAFF REQUIREMENTS:

1. **SURGICAL:** Qualified surgical specialist(s) or specialty availability, which shall be available as follows:

a. Immediately Available:

(1) Pediatric Surgeon:

A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be in-house, immediately available, and dedicated to the facility for pediatric trauma patients twenty-four (24) hours per day. A pediatric surgeon capable of evaluating and treating pediatric trauma patients shall be promptly available for consultation.

(This requirement may be fulfilled by:

- (a) a staff pediatric surgeon with experience in pediatric trauma care; or
- (b) a staff trauma surgeon with experience in pediatric trauma care; or
- (c) a senior general surgical resident who has completed at least three clinical years of surgical residency training and is capable of assessing emergent situations. When a senior resident is the responsible surgeon:
 - (i) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the pediatric patient, including initiating surgical care; and
 - (ii) a staff pediatric trauma surgeon with experience in pediatric trauma care or a staff surgeon with

Exhibit A.IV

experience in pediatric trauma care shall be on-call and promptly available; and

- (iii) a staff pediatric trauma surgeon or a staff surgeon with experience in pediatric trauma care shall be advised of all trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

b. On-call and Promptly Available with pediatric experience:

- (1) Cardiothoracic
- (2) Pediatric Surgeon (*Pediatric Trauma Centers, Level I and Level II, shall ensure that a backup mechanism exists for a second pediatric surgeon.*)
- (3) Neurologic (*Pediatric Trauma Centers, Level I and Level II, shall ensure that a back-up mechanism exists for a second neurological surgeon.*)
- (4) Obstetric/Gynecologic (*This surgical service may be provided through a written transfer agreement.*)
- (5) Ophthalmic
- (6) Oral or Maxillofacial or Head/Neck
- (7) Orthopedic
- (8) Plastic
- (9) Reimplantation/Microsurgery (*This surgical service may be provided through a written transfer agreement at Pediatric Level I and Level II Trauma Centers.*)
- (10) Urologic
- (11) Vascular (*Pediatric Trauma Centers, Level I and Level II, shall ensure the availability of a surgeon credentialed by the Trauma Center to perform vascular surgery.*)

(The above requirements may be fulfilled by a supervised senior resident as defined in Section

Exhibit A.IV

A-14 of this Exhibit who are capable of assessing emergent situations in their respective specialties. When a senior resident is the responsible surgeon:

- (a) the senior resident shall be able to provide the overall control and surgical leadership necessary for the care of the patient, including initiating surgical care;
- (b) a staff trauma surgeon or a staff surgeon with experience in trauma care shall be on-call and promptly available as defined in Section A-11 of this Exhibit; and
- (c) a staff pediatric trauma surgeon on a staff surgeon with experience in pediatric trauma care shall be advised of all pediatric trauma patient admissions, participate in major therapeutic decisions, and be present in the emergency department for major resuscitations and in the operating room for all trauma operative procedures.)

c. Available for Consultation:

Available for consultation or consultation and transfer agreements for pediatric trauma patients requiring the following surgical services:

- (1) Burns
- (2) Spinal Cord Injury

2. **NON-SURGICAL:** Qualified non-surgical specialist(s) or specialty availability, which shall be as follows:

a. Immediately Available:

- (1) Emergency Medicine:
Emergency medicine, staffed with qualified specialist in emergency medicine with pediatric experience, who are in-house and immediately available at all times with a second physician on call.

(This requirement may be fulfilled by:

- (a) a qualified specialist in pediatric emergency medicine; or
- (b) a qualified specialist in emergency medicine with pediatric experience; or

Exhibit A.IV

- (c) a subspecialty resident in emergency medicine who has completed at least one year of subspecialty residency education in pediatric emergency medicine with pediatric experience. In such cases, the senior resident(s) shall be capable of assessing emergency situations in trauma patients and of providing for initial resuscitation. Emergency medicine physicians who are qualified specialist in emergency medicine and are board certified in emergency medicine or pediatric emergency medicine shall not be required by the local EMS agency to complete an Advanced Trauma Life Support (ATLS) course. Current ATLS verification is required for all emergency medicine physicians who provide emergency trauma care and are qualified specialists in a specialty other than emergency medicine. When a senior resident is the responsible emergency physician in house:
- (i) a qualified specialist in pediatric emergency medicine or emergency medicine with pediatric experience shall be promptly available; and
 - (ii) the qualified specialist on-call shall be notified of all patients who require resuscitation, operative surgical intervention, or intensive care unit admission.)

- (2) Pediatric Critical Care:
Pediatric Critical Care, in-house and immediately available.

(The in-house requirement may be fulfilled by:

- (a) a qualified specialist in pediatric critical care medicine; or
- (b) a qualified specialist in anesthesiology with experience in pediatric critical care; or
- (c) a qualified surgeon with expertise in pediatric critical care; or
- (d) a physician who has completed a least two years of residency in pediatrics. When a senior resident is the responsible

Exhibit A.IV

pediatric critical care physician then:

- (i) a qualified specialist in pediatric critical care medicine, or a qualified specialist in anesthesiology with experience in pediatric critical care, shall be on-call and promptly available; and
- (ii) the qualified specialist on-call shall be advised about all patients who may require admission to the pediatric intensive care unit and shall participate in all major therapeutic decisions and interventions.

b. Promptly Available:

(1) Anesthesiologist:

Anesthesiology, Level II shall be promptly available with a mechanism established to ensure that the anesthesiologist is in the operating room when the patient arrives with a second physician on call and dedicated to the facility.

(This requirement may be fulfilled by senior residents or certified registered nurse anesthetists with pediatric experience who are capable of assessing emergent situations in pediatric trauma patients and of providing any indicated treatment and are supervised by the staff anesthesiologist. In such cases, the staff anesthesiologist with pediatric experience on-call shall be advised about the patient, be promptly available at all times, and present for all operations.)

(2) Radiologist

c. Available for Consultation:

(1) The following qualified specialist with pediatric experience **shall be on the hospital staff** and Available for Consultation:

- (a) General Pediatrics
- (b) Mental Health
- (c) Neonatology
- (d) Pathology
- (e) Pediatric Cardiology

Exhibit A.IV

- (f) Pediatric Gastroenterology
- (g) Pediatric Hematology/Oncology
- (h) Pediatric Infectious Disease
- (i) Pediatric Neurology
- (j) Pediatric Radiology

(2) The following qualified specialist with pediatric experience shall be Available for Consultation **or provided through transfer agreement:**

- (a) Adolescent Medicine
- (b) Child Development
- (c) Genetics/Dysmorphology
- (d) Neuroradiology
- (e) Obstetrics;
- (f) Pediatric Allergy and Immunology
- (g) Pediatric Dentistry
- (h) Pediatric Endocrinology
- (i) Pediatric Pulmonology
- (j) Rehabilitation/Physical Medicine.**

D. ADDITIONAL SERVICE CAPABILITIES:

1. Emergency Service:

Basic or comprehensive emergency service which has special permits issued pursuant to Chapter 1, Division 5 of Title 22. The emergency service shall:

- a. designate an emergency physician to be a member of the pediatric trauma team;
- b. provide emergency medical services to pediatric patients;
- c. have appropriate pediatric equipment and supplies as approved by the director of emergency medicine in collaboration with the trauma program medical director;
- d. designate a trauma resuscitation area of adequate size to accommodate multi-system injured pediatric trauma patients and equipment; and
- e. comply with Emergency Department Approved for Pediatrics (EDAP) requirements (Attachment A-1).

2. Surgical Service:

A surgical service shall have an operating suite that is available or being utilized for trauma patients and that has:

- a. operating staff who are promptly available unless operating on trauma patients and back-up personnel who

Exhibit A.IV

pediatric trauma center shall have, pursuant to Section 70301 of Chapter 1, Division 5 of Title 22 of the California Code of Regulations, the following approved supplemental services:

- a. Burn Center.
(This service may be provided through written transfer agreement with a Burn Center. Patients requiring burn care may be presented to the County's Medical Alert Center for transfer to a burn center within Los Angeles County. Patients may be placed outside the Los Angeles County if resources within the County are unavailable. The Medical Alert Center will assist in facilitating the transfer of burn patients to appropriate facilities.)
 - b. The following services shall have personnel trained in pediatrics and equipped for acute care of the critically injured child:
 - (1) Physical Therapy Service
 - (2) Rehabilitation Center (*(This service may be provided through a written transfer agreement with a rehabilitation center.)*)
 - (3) Respiratory Care Service
 - (4) Hemodialysis capabilities, with qualified personnel able to acutely hemodialyze trauma patients twenty-four (24) hours/day
 - (5) Occupational Therapy Service
 - (6) Speech Therapy Service
 - (7) Social Service
2. A trauma center shall have the following services or programs that do not require a license or special permit:
- a. Post Anesthetic Recovery Room (PAR) shall meet the requirements of California Administrative Code. (Surgical Intensive Care Unit is acceptable.)
 - b. Acute spinal cord injury management capability. (*This service may be provided through a written transfer agreement with a Rehabilitation Center.*)
 - c. Protocol to identify potential organ donors as described in Division 7, Chapter 3.5 of the California Health and Safety Code.
 - d. An outreach program, to include:
 - (1) capability to provide both telephone and on-site consultations with physicians in the community and outlying areas; and
 - (2) trauma prevention for the general public; and
 - (3) public education and illness/injury prevention

Exhibit A.IV

education.

- e. Written inter-facility transfer agreements with referring and specialty hospitals.
- f. Suspected child abuse and neglect team (SCAN).
- g. An aeromedical transport plan.
- h. A Child Life Program.

F. QUALITY IMPROVEMENT PROCESS:

Pediatric Trauma Centers shall have a quality improvement process to include structure, process, and outcome evaluations which focus on improvement efforts to identify root causes of problems, intervene to reduce or eliminate these causes, and take steps to correct the process. In addition the process shall include:

- 1. A detailed audit of all trauma related deaths, major complications, and transfers (including interfacility transfers);
- 2. A multidisciplinary trauma peer review committee that includes all members of the trauma team;
- 3. Participation in the trauma system data management system;
- 4. Participation in the local EMS agency trauma evaluation committee;
- 5. Written system in place for patients, parents of minor children who are patients, legal guardians(s) of children who are patients, and/or primary caretaker(s) of children who are patients to provide input and feedback to hospital staff regarding the care provided to the child; and
- 6. Following of applicable provisions of Evidence Code Section 1157.7 to ensure confidentiality.

G. CLINICAL EDUCATION AND RESEARCH:

A Level II Pediatric Trauma Center shall include the following:

- 1. Multidisciplinary trauma conference including, but not limited to, the trauma team; held at least once a month to critique selected trauma cases.
- 2. Formal continuing education in pediatric trauma care. Continuing education in pediatric trauma care shall be provided for:

Exhibit A.IV

- a. staff physicians;
- b. staff nurses;
- c. staff allied health personnel;
- d. EMS personnel; and
- e. other community physicians and health care personnel.

**EMERGENCY DEPARTMENT APPROVED
FOR PEDIATRICS (EDAP) STANDARDS
2005**

INTRODUCTION:

Emergency Department Approved for Pediatrics (EDAP) Standards were developed as a concerted effort by the Committee on Pediatric Emergency Medicine, which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians, National EMSC Resource Alliance, California Chapter 2 of the American Academy of Pediatrics, Emergency Nurses Association, American College of Surgeons, and Los Angeles County Department of Health Services Emergency Medical Services Agency.

The Standards have been approved by The Hospital Association of Southern California and meet or exceed the standards established by the Emergency Medical Services for Children (EMSC) administration, personnel, and policy guidelines for the care of pediatric patients in the emergency department set forth by the California Emergency Medical Services Authority in 1995.

DEFINITIONS:

Board certified: Completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in that specialty.

Board prepared: Successful completion of a Board approved emergency medicine or pediatric residency training program and demonstrate active progression in the certifying process.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic emergency department that is approved by the County of Los Angeles to receive pediatric patients from the 9-1-1 system. These emergency departments provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies, procedures, and protocols.

Medical Pediatric Critical Care Center (MPCCC): A licensed acute care hospital that is approved by the County of Los Angeles to receive critically ill non-trauma pediatric patients from the 9-1-1 system.

ATTACHMENT A-1

Pediatric Trauma Center (PTC): A licensed acute care hospital that is designated by the County of Los Angeles to receive critically **injured** pediatric trauma patients from the 9-1-1 system.

Promptly available: Being in the emergency department within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, that the interval between the arrival of the patient to the emergency department and the arrival of the respondent should not have a measurably harmful effect on the course of patient management or outcome.

Qualified specialist: A physician licensed in the State of California who has: 1) taken special postgraduate medical training, or has met other specified requirements; and 2) active progression towards board certification in the corresponding specialty for those specialties that have board certification and are recognized by the American Board of Medical Specialties.

Senior resident: A physician licensed in the State of California who has completed at least two years of the residency under consideration and has the capability of initiating treatment when the clinical situation demands, and who is in training as a member of the residency program at the designated hospital.

I. ADMINISTRATION/COORDINATION

A. EDAP Medical Director

1. Qualifications:

- a. Qualified specialist in Emergency Medicine or Pediatrics.
- b. Completion of eight hours of CME in topics related to pediatrics every two years.
- c. Current Pediatric Advanced Life Support Course (PALS) or American Academy of Pediatrics - American College of Emergency Physicians Advanced Pediatric Life Support Course (APLS) provider or instructor.

2. Responsibilities:

- a. Oversight of EDAP quality improvement (QI) program.
- b. Member of hospital emergency department committee and pediatric committee.

ATTACHMENT A-1

- c. Liaison with medical pediatric critical care centers (MPCCC), pediatric trauma centers (PTC), base hospitals, community hospitals, prehospital care providers, and the EMS Agency.
 - d. Identify needs and facilitate pediatric education for emergency department physicians.
 - e. Review, approve, and assist in the development of all pediatric policies and procedures.
- B. Designated Pediatric Consultant *
- 1. Qualifications:
 - a. Qualified specialist in pediatrics or subspecialty in pediatric emergency medicine.
 - 2. Responsibilities:
 - a. Member of hospital emergency department committee and pediatric committee.
 - b. Participation with EDAP staff in developing and monitoring pediatric QI program, protocols, policies and procedures.
 - c. Consult with EDAP Medical Director and Pediatric Liaison Nurse as needed.
- * Pediatric Consultant may also be the EDAP Medical Director.
- C. Pediatric Liaison Nurse (PdLN)
- 1. Qualifications:
 - a. At least two years experience in pediatrics or in an emergency department that sees pediatric patients, within the previous five years.
 - b. Experience with QI programs is recommended.
 - c. Current PALS or APLS provider /instructor.
 - d. Completion of a two day pediatric emergency nursing course or ENPC course. *
 - e. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education units (CEU) in pediatric topics every two years.
- * A two day pediatric emergency nursing course should include but not limited to a broad spectrum of topics including: injury prevention, resuscitation, surgical emergencies, apparent life

ATTACHMENT A-1

threatening event (ALTE), death of a child to include sudden infant death syndrome (SIDS), trauma, medical conditions, submersions, respiratory emergencies, airway management, ingestion, child abuse and neglect, fever to include bacterial and viral infections, seizures, and neonatal emergencies.

2. Responsibilities:
 - a. Attend monthly meetings of the Pediatric Liaison Nurses of Los Angeles County.
 - b. Participate in the development and maintenance of a pediatric QI program.
 - c. Liaison with MPCCCs, PTCs, base hospitals, community hospitals, prehospital care providers, and the EMS Agency.
 - d. Member of selected hospital based emergency department and/or pediatric committees.
 - e. Notify the EMS Agency in writing of any change in status of the EDAP Medical Director, Pediatric Consultant, and Pediatric Liaison Nurse.

II. PERSONNEL

A. Physicians-Qualifications/Education

1. Twenty four hour emergency department coverage shall be provided or directly supervised by physicians functioning as emergency physicians or pediatricians experienced in emergency care. This includes senior residents practicing at their respective hospitals only.
2. At least 75% of the emergency department coverage shall be provided by physicians who are Board certified or demonstrate active progression in the certifying process towards emergency medicine or pediatrics.
3. Those emergency department physicians who are not board certified or board prepared shall be a current PALS or APLS provider or instructor.

B. Nurses-Qualifications/Education

1. At least 75% of the total RN staff and at least one RN per shift in the emergency department shall be a current PALS or APLS provider or instructor.
2. At least one RN per shift shall have completed a two day pediatric emergency nursing course (within the last 4 years).

ATTACHMENT A-1

NOTE: It is highly recommended that all nurses regularly assigned to the emergency department meet the above requirements.

3. All nurses assigned to the emergency department shall attend at a minimum; eight hours of pediatric BRN approved education every two years, which may include the two day pediatric emergency nursing course.

C. Pediatric physicians/Specialty services

1. There shall be a pediatric on call panel that allows for telephone consultation and a promptly available pediatrician to the emergency department twenty four hours per day. This pediatrician shall be board certified or board prepared.
2. A plan shall exist whereby other pediatric specialists may be consulted and available in at least the following specialties: surgery, orthopedics, anesthesia and neurosurgery. This requirement may be met by a written agreement with a MPCCC.
3. A plan shall exist whereby a second emergency physician or pediatrician will be available within thirty minutes to serve as back-up for the emergency department in critical situations.

D. Physician Assistant-Qualifications/Education

1. Physician Assistant (PA) licensed by the State of California.
2. PA working in the emergency department shall be a current PALS or APLS provider or instructor.

III. POLICIES, PROCEDURES, AND PROTOCOLS

- A. Establish procedures and protocols for pediatric emergency patients to include but not limited to:
 1. Triage and initial evaluation
 2. Patient safety
 3. Suspected child abuse and neglect
 4. Transfers
 5. Consents
 6. Sedation/analgesia
 7. Do-not-resuscitate (DNR)/Advanced Health Care Directives
 8. Death to include SIDS and the care of the grieving family

ATTACHMENT A-1

9. Aeromedical transport to include landing procedure.
 10. Daily verification of proper location and functioning of equipment and supplies of the pediatric code cart.
 11. Immunizations.
 12. Child abandonment to include a recent (within 72 hours) postpartum woman without evidence of a newborn.
 13. Family presence.
- B. Establish a written interfacility consult and transfer agreement with a MPCCC and PTC to facilitate transfers of critically ill and injured pediatric patients. The consult shall be available twenty four hour a day for telephone consultation.
- C. Establish a written interfacility consult and transfer agreement with a California Children Services (CCS) approved Level II or Level III Neonatal Intensive Care Unit (NICU).

IV. QUALITY IMPROVEMENT (QI)

- A. A pediatric QI program shall be developed and monitored by the EDAP Medical Director and Pediatric Liaison Nurse with input from the Designated Pediatric Consultant as needed.
- B. The program should include an interface with prehospital care, emergency department, trauma, pediatric critical care, pediatric in-patient, and hospital wide QI activities.
- C. A mechanism shall be established to easily identify pediatric (14 years & under) visits to the emergency department.
- D. The pediatric QI program should include identification of the indicators, methods to collect data, results and conclusions, recognition of improvement, action(s) taken, assessment of effectiveness of actions, and communication process for participants.
- E. The pediatric QI program should include review of the following pediatric patients seen in the emergency department:
1. Deaths
 2. Cardiopulmonary and/or respiratory arrests, including all pediatric intubations
 3. Suspected child abuse or neglect
 4. Transfers to and/or from another facility
 5. Admissions from the ED to an adult ward or ICU

6. Selected return visits to the ED
 7. Pediatric transports within the 9-1-1 system
- F. A mechanism to document and monitor pediatric education of EDAP staff shall be established.

V. SUPPORT SERVICES

- A. Respiratory Therapy
1. At least one respiratory therapist shall be in house twenty four hours per day.
 2. Current PALS provider or instructor.
- B. Radiology
1. Radiologist on call and promptly available twenty four hours per day.
 2. Radiology technician in house twenty four hours per day with a back-up technician on call and promptly available.
 3. CT scan technician on call and promptly available.
- C. Laboratory
1. Technician in house twenty four hours per day and a back-up technician on call and promptly available.
 2. Clinical Laboratory capabilities in house:
 - a. Chemistry
 - b. Hematology
 - c. Blood bank
 - d. Arterial blood gas
 - e. Microbiology
 - f. Toxicology
 - g. Drug levels

NOTE: Toxicology and drug levels may be done offsite if routine tests are available within two hours.

VI. EQUIPMENT, SUPPLIES, AND MEDICATIONS

Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. EDAP staff shall be appropriately educated as to the locations of all items. Each EDAP shall have a method of daily verification of proper location and function of equipment and supplies. It is highly recommended that each EDAP have a mobile pediatric crash cart.

The following are requirements for equipment, supplies, and medications for an EDAP:

GENERAL EQUIPMENT

Foley catheters (8-22fr)

IV blood/fluid warmer

Length and weight tape for determining pediatric resuscitation drug dosages

Meconium Aspirator

OB Kit

Posted or readily available pediatric drug dosage reference material calculated on a dose per kilogram basis.

Restraint device

Weight scale in kilograms

Warming device

MONITORING EQUIPMENT

Blood pressure cuffs (infant, child, adult, and thigh)

Doppler

ECG monitor/defibrillator (0-400 Joules) with pediatric and adult paddles

End tidal CO₂ monitor or detector, (adult and pediatric sizes)

Hypothermia thermometer

Pulse oximeter

RESPIRATORY EQUIPMENT

Bag-valve-mask device, self inflating (pediatric size: 450-900ml and adult size: 1000-2000ml)

Bag-valve, with clear masks (neonate, infant, child, and adult sizes)

Endotracheal tubes (uncuffed: 2.5-5.5 and cuffed: 6.0-9.0)

Laryngoscope (curved and straight: 0-3)

ATTACHMENT A-1

Magill forceps (pediatric and adult)
Nasal cannulae (infant, child, and adult)
Nasopharyngeal airways (infant, child, adult)
Nasogastric tubes (including 5 and 8fr feeding tubes)
Oral airways (sizes 0-5)
Clear oxygen masks (standard and non-rebreathing) for infant, child, and adult
Stylets for endotracheal tubes
Suction catheters (sizes 6-12fr)
Tracheostomy tubes (sizes 0-6)
Yankauer suction tips

VASCULAR ACCESS EQUIPMENT

Arm boards (infant, child, and adult)
Infusion devices to regulate rate and volume
Intraosseous needles
IV administration sets with calibrated chambers
IV catheters (14-26ga)
IV solutions (D5.2NS, D5.45NS, D5NS, D10W, and NS)
Stopcocks (3 way)
Umbilical vein catheters

FRACTURE MANAGEMENT DEVICES

Pediatric cervical spine immobilization devices
Pediatric femur splint
Spine board (long and short)

SPECIALIZED TRAYS OR KITS

Cricothyrotomy tray
Pediatric lumbar puncture tray
Pediatric tracheostomy tray
Thoracostomy tray

ATTACHMENT A-1

Chest tube (sizes 10-28fr)

Venous cutdown tray

PEDIATRIC SPECIFIC RESUSCITATION MEDICATIONS

Albuterol

Dobutamine

Amiodarone

Epinephrine (1:1,000 & 1:10,000)

Atropine

Lidocaine

Adenosine

Naloxone

Calcium chloride

Procainamide

Dextrose (25% & 50%)

Racemic epinephrine (inhalation)

Dopamine

Sodium Bicarbonate

NOTE: It is suggested that these drugs be immediately available in the resuscitation room and not locked in a computerized system.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B-2

PROVISIONS FOR REIMBURSEMENT

TABLE OF CONTENTS

<u>PARAGRAPH</u>	<u>PAGE #</u>
I. ELIGIBLE INDIGENT CARE CLAIMS.....	- 1 -
A. GENERAL CONDITIONS.....	- 1 -
B. PATIENT ELIGIBILITY:	- 4 -
C. CLAIMS SUBMISSION.....	- 7 -
D. AUDITING RECORDS.....	- 11 -

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT B-2

I. ELIGIBLE INDIGENT CARE CLAIMS

A. GENERAL CONDITIONS: The terms described in this Exhibit is only applicable to non-County trauma hospitals. County has allocated certain monies to be used to pay Contractor for trauma care provided to eligible indigent patients during the term of this Agreement. For the term of this Agreement, funds and Hospital Services Account funds shall be deposited to the County administered Special Revenue Funds. These deposits, together with other funds, which County may at its sole discretion allocate to the account from time to time, shall be used in any payments made to the Contractor for trauma patient care.

A component of any payment made to the Contractor shall be provided from the Special Revenue Funds by County for the hospital component of treatment of trauma patients hereunder who are unable to pay for the treatment and for whom payment for such services has not been made and will not be made through private coverage or by any program funded in whole or in part by the federal and/or State government. Contractor will determine and document persons

who are eligible for services covered hereunder. Only eligible patients [i.e., (1) those unable to pay for services, and (2) for whom there is no third-party coverage in part or in whole for trauma services provided], qualify under this funding program. A claim shall not be submitted to the County for any patient if: (a) the patient has the ability to pay for the service, but refuses or fails to pay for same or (b) the Contractor has failed to submit to any known third-party payer(s) for the patient, an accurate, complete, and timely billing, and for that reason has been denied payment by such payer(s) or (c) for any patient care which is covered in, or the subject of reimbursement in, any other contract between Contractor and County.

County funding is limited to trauma patients without the ability to pay for the services and for whom Contractor has made a reasonable, good faith effort to determine if there is a responsible private or public third-party source of payment, and it is determined that there is no source of payment.

During the term of this Agreement, as required by Section 16818 of the Welfare and Institutions Code, (W&IC) Contractor shall continue to provide, at the time treatment is sought by a patient at its facility, individual notice

of the availability of reduced cost hospital care. Additionally, Contractor shall post, in conspicuous places in its emergency department and patient waiting rooms, notices of the procedures for applying for reduced cost hospital care. The approved "Notice" language is reflected in English in Attachment "B-2" and in Spanish in Attachment "B-3".

B. PATIENT ELIGIBILITY: For a patient to be eligible and the Contractor to submit a claim to County, Contractor must at a minimum document that it has made reasonable efforts to secure payment from the patient by billing after discharge and on at least a monthly basis after the date of discharge for a minimum of three (3) billings. Financial notes must clearly indicate that the patient was billed at least three (3) times. Contractor must document that the person cannot afford to pay for the services provided by the Contractor. This documentation must show that the patient's annual income places them at or below 200% of the current year Federal Poverty Level. Contractor must also document that payment for the services will not be covered by third-party coverage or by any program funded in whole or in part by the federal

government; and, that Contractor has not received payment for any portion of the amount billed.

Contractor will determine and document persons who are eligible for trauma care coverage hereunder in accordance with the procedures set forth in Attachment "B-1", Trauma Service County Eligibility ("TSCE") Protocol, attached hereto and incorporated herein by reference.

Attachment "U-1", *Trauma Service County Eligibility ("TSCE") Agreement* form shall be utilized by Contractor as the sole means for determining whether the patient is at or below the 200% of the current year Federal Poverty Level and therefore meets patient's eligibility criteria for trauma care coverage during the term of this Agreement. The TSCE Agreement form must be completed and signed by the patient or the patient's responsible relative(s) at the time it is determined there is not a responsible private or public third-party source of payment and that the patient meets the eligibility requirements. The completed form must be signed and dated by a hospital representative who obtained the information verifying that the information was obtained from the patient or the patient's responsible relative(s). If a TSCE Agreement form cannot be secured because the patient or the patient's responsible relative(s)

is (are) unable to cooperate in providing the necessary financial information, then Attachment "U-2", *Hospital Certification of Inability to Cooperate* form must be completed. If the Inability to Cooperate form is used it should be completed at the initial interaction with the patient or the patient's responsible relative(s). A hospital representative will complete the form, sign and date it and a second hospital representative will verify the information by also signing and dating the form. The original (or electronic scan) of either the *TSCE* or *Inability to Cooperate* form must be maintained by Contractor as part of its financial records. Contractor shall submit a copy of the applicable form to the County Emergency Medical Services (EMS) Agency when submitting a claim to be included in the indigent claims total as stated in Attachment "B-4", *Instructions for Submission of Claims and Data Collection*.

Documentation to establish that Contractor has complied with the aforementioned patient eligibility requirements must be maintained by Contractor and made available upon request, pursuant to Paragraph 5, of the Additional Provisions Exhibit of this Agreement, to

authorized County or State representatives for inspection, audit, and photocopying.

C. CLAIMS SUBMISSION TO COUNTY: Contractor shall submit all claims that meet the eligibility requirements to the County, for the period of July 1, through June 30, of the applicable fiscal year. Only the claims submitted, meeting the above eligibility requirements, will be used in determining the total indigent claims under the program and will be used in allocating a portion of the next year's annual Trauma Center funding.

a. A valid claim shall be limited to trauma services provided to eligible indigent patients for whom Contractor is required to complete a Trauma Patient Summary ("TPS") form, Attachment "D-2", of Agreement.

b. Contractor shall submit required reports as set forth in Attachment "B-4", *Instructions for Submission of Claims and Data Collection*, attached hereto and incorporated herein by reference to County's Emergency Medical Services Agency, 10100 Pioneer Boulevard, Suite 200, Santa Fe Springs, California 90670, for

trauma care provided under the terms of this Agreement, and this claim shall be used in determining a portion of the next year's trauma center overall funding from the County.

c. Claims submitted to the County shall be limited to the hospital component of trauma services provided to eligible indigent patients during the term of this Agreement. Inclusion of the claim shall be limited to the claims for which all required data is in the Trauma and Emergency Medicine Information System (TEMIS) and which has been submitted as required by reporting procedures reflected in Attachment "B-4".

d. All Contractor claims for services provided during the County Fiscal Year (FY) (July 1 - June 30) must be received by County within six (6) months after the close of this contract period (June 30), no later than the last working day of December. Only claims that have not been paid and Trauma Hospital has ascertained that no payment will be received should be submitted.

e. Upon submission of claim by Contractor to County for a trauma patient's care, Contractor

assigns and subrogates to County any and all rights to collection as set forth herein, Contractor shall cease all current and waive all future collection efforts, by itself and by its contractors/agents, to obtain any payment from the patient. At its sole discretion, County and/or County's Contractor may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement up to the full amount of usual and customary fees, (including, for example, billed charges) for patient care and services regardless of any amount the Contractor has received under the TCSA. In the event Contractor is contacted by other third party's representative (e.g., insurance claim adjuster) or a patient's attorney regarding pending litigation, Contractor shall indicate that the claim for services provided to their client is assigned and subrogated to the County and refer such representative to the designated

County contact. Contractor shall reasonably cooperate with County in its collection efforts.

f. Contractor shall notify the County if they become aware of any third party coverage such as Medi-Cal, Medicare, other government programs, or other health insurance for any claim they submitted to be included in the indigent funding calculation. The County has all rights to work with the identified third party payor to recoup any payment due.

g. Any and all payments received by Contractor from a trauma patient or from third-party payers, including a legal settlement, for claims previously submitted to the County, must be immediately reported to the County and the payment amount shall be surrendered to the County since Contractor assigned and subrogated their rights to said claim. The payment received by the Contractor must be provided to the County within sixty (60) days of receipt of the payment and a *TRAUMA HOSPITAL PAYMENT SURRENDER FORM* (Attachment B-6) must be completed and submitted with each payment the hospital is surrendering.

All claim payments surrendered by the Contractor will be deposited to the Special Revenue Funds.

h. For trauma patients admitted to Contractor's facility prior to or on the last day during the term of this Agreement, and remaining in the hospital after that date, reports and claim submission to County shall be submitted only after patient has been discharged, (no partial billings).

i. All reports and claims shall be completed in such detail and with such attachments in accordance with procedures prescribed in writing in Attachment "B-4". Contractor hereby acknowledges receipt of such forms, attachments, and procedures.

j. Claims shall be submitted to County's EMS Agency on an on-going basis once all eligibility requirements have been met and the Contractor has all reason to believe that no other source of funding is available, but no later than six (6) months after the close of this contract period (the last working day of December) during which services were provided.

D. AUDITING OF RECORDS: Contractor shall maintain and upon request make available to State or County representatives records of all of the financial information referenced in this Paragraph, including records of patient and third-party payer payments, all in accordance with Paragraph 5, of the Additional Provisions Exhibit of this Agreement.

a. County may periodically conduct an audit of the Contractor's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a statistically random sample of submitted claims for a fiscal year. The scope of the audit shall include an examination of patient medical and financial records, patient/insurance billing records, and collection agency reports associated with the sampled claims.

b. Audited submitted claims that do not comply with program requirements shall result in an adjustment being made to the Contractor's subsequent indigent allocation being reduced by the percentage of audited claims that were not in compliance (for example, if twenty (20) indigent

patient claims are audited and two (2) claims are do not meet the program requirements the subsequent year's indigent allocation would incur a 10% reduction. Audit results may be appealed to the EMS Agency Director, or his/her designee.

TRAUMA CENTER SERVICE AGREEMENT

TRAUMA SERVICE COUNTY ELIGIBILITY PROTOCOL

- I. PURPOSE: The Trauma Service County Eligibility (TSCE) Protocol is to be used by the County of Los Angeles (County) and by County Contract Trauma Service Hospitals (Contractor) in connection with the Trauma Service Hospital Agreement between the County and Contractor for the purposes of adjusting hospital and other health care charges to Trauma Service Patients for Authorized Services according to the financial conditions of the patient and the patient's responsible relatives.

TSCE shall not in any way diminish or defeat the County's right, under California Government Code Sections 23004.1 and 23004.2 to recover from third-party tort-feasors the reasonable cost of health care services provided to the patients involved.

II. DEFINITIONS:

- A. "County Hospital(s)" means any hospital or other health care facility which is owned and operated by the County of Los Angeles.
- B. "General Relief recipient(s)" means any person who has been determined eligible for the County's General Relief program as administered by the County Department of Public Social Services (DPSS).

ATTACHMENT B-1

- C. "Inpatient service(s)" means any preventive, diagnostic, or treatment service(s) provided by Contractor to a patient who is a registered inpatient therein.
- D. "Inpatient stay of admission " means an uninterrupted term of inpatient services and shall constitute an occurrence of inpatient services.
- E. "Emergency Department visit" means any health care services, other than inpatient services, provided in the emergency department by Contractor.
- F. "Responsible relative(s)" means the patient's spouse, or parent(s), or legal guardian(s) if the patient is a minor child, or other legal representatives if known.
- G. "Special medical payment program(s)" means any program such as Medi-Cal, Medicare, CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), California Children Services, and Victims of Crime, which is governed by particular statute, ordinance, or regulation.
- H. "Third-party coverage" means any health care benefits payable on behalf of the patient from other than the financial resources of the patient and the patient's responsible relatives, if any. Generally, third-party coverage includes special medical payment programs, prepaid health plans, and private health insurance.

ATTACHMENT B-1

- I. "Trauma Hospital Authorized Service(s)" means any emergency department visits and inpatient services: (1) which have been specifically authorized by the County pursuant to a Trauma Service Hospital Agreement between the County and Contractor, and (2) for which such Contractor may receive reimbursement from the County under such Agreement.
 - J. "Trauma Patient" means any patient who receives Trauma Hospital Authorized Service.
 - K. "Trauma Service Hospital(s)" means any hospital or other health facility which is not a County Hospital and which has formally executed a Trauma Service Hospital Agreement with the County under which such hospital or other health care facility may receive reimbursement from the County for Trauma Hospital Authorized Services provided to trauma patients.
- III. SERVICES COVERED: TSCE shall cover any occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit) at any Trauma Service Hospital except for any such occurrence of service for which there is third-party coverage that will fully pay for the particular occurrence of service.
- IV. ELIGIBILITY: In order to be eligible for TSCE for inpatient services or for emergency department visits, the patient and the

ATTACHMENT B-1

patient's responsible relatives, if any, must cooperate with the County and Contractor in terms of financial data acquisition and otherwise in accordance with TSCE, including, but not necessarily limited to, the following requirements:

- A. provide the names and addresses of the patient and the patient's responsible relatives.
- B. provide acceptable address verification.
- C. complete and sign, under penalty of perjury, the TSCE Agreement, which shall be substantially similar to Attachment U-1, attached hereto and incorporated herein by reference, setting forth, among other things, the income and family size of the patient and the patient's responsible relatives, and the patient's third party coverage, including, but not limited to, prepaid health plan status (member or not). A separate TSCE Agreement shall be completed and signed for each inpatient stay of admission and for each emergency department visit.
- D. complete and sign authorization(s) as requested by the County and the Contractor to allow the County and the Contractor to verify any information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.
- E. provide the County or the Contractor with any documentation

requested by the County or the Contractor for any information disclosed by the patient and the patient's responsible relatives on or in connection with the TSCE Agreement.

- V. ELIGIBILITY DETERMINATIONS WHEN PATIENT UNABLE TO COOPERATE: The parties recognize that there may be situations when the patient and/or patient's responsible relatives, if any, are unable to cooperate with the County and the Contractor in terms of providing the financial information necessary to make a TSCE determination. Examples of these situations include, but are not necessarily limited to, situations where the patient has expired, or is comatose or otherwise mentally incompetent.

Under these circumstances, the Contractor may certify, under penalty of perjury, that it has endeavored to:

- A. obtain the names and addresses of the patient and the patient's responsible relatives;
- B. obtain acceptable address verification; and
- C. obtain all of the information needed to complete the TSCE Agreement, including information regarding the income and family size of the patient and the patient's responsible relatives, and the patient's third-party coverage.

This certification by the Contractor which shall be substantially similar to Attachment U-2, attached hereto and

incorporated by reference, shall be accepted by the County in lieu of a TSCE Agreement completed by the patient or patient's responsible relatives.

VI. FREQUENCY OF TSCE DETERMINATIONS: TSCE determination, as to the patient's eligibility for TSCE, shall be subject to the TSCE Agreement (Attachment U-1) and shall establish eligibility for all inpatient services received at a Trauma Service Hospital during an inpatient stay of admission or for health care services received at the said hospital during an emergency department visit.

VII. TSCE ELIGIBILITY COMPUTATION: The patient's TSCE eligibility shall be established by comparing the gross monthly and annual income of the patient and patient's responsible relatives, if any, and the patient's family size to 200 per cent of the Poverty Income Guidelines as published annually in the Federal Register. If the gross monthly and annual income of the patient and the patient's responsible relatives is less than or equal to 200 per cent of the Poverty Guidelines for the patient's family size, then the patient shall be eligible for TSCE and shall not be liable for the inpatient services received during the particular inpatient stay of admission or for health care services received during the particular emergency department visit.

Any patient who is a verified County General Relief

ATTACHMENT B-1

recipient shall automatically be granted TSCE eligibility. Once TSCE eligibility has been established for an occurrence of Trauma Hospital Authorized Service (i.e., an inpatient stay of admission or an emergency department visit), it shall not be re-determined retroactively for any reason except where:

- A. The patient and/or the patient's responsible relatives have intentionally failed to fully disclose or have intentionally misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the liability of the patient and the patient's responsible relatives shall, at the election of the Director, revert to the full charge for such occurrence of Trauma Hospital Authorized Service; or
- B. Clerical error has occurred or the patient and/or the patient's responsible relatives have negligently failed to fully disclose or have negligently misrepresented their income, family size, third-party coverage, and/or other requested information, in which case the TSCE eligibility shall be re-determined.
- C. The patient is determined by the Director not to be eligible as a Trauma Patient for such occurrence of Trauma Hospital Authorized Service, in which case: (1) the patient and the patient's responsible relatives shall not be eligible for

ATTACHMENT B-1

TSCE for such occurrence of service, and (2) any funds received by the particular Contractor from the County for such occurrence of service must be repaid to the County. When a patient and/or patient's responsible relatives, if any, previously unable to cooperate with the County and the Contractor in terms of providing the financial information necessary to make TSCE determination, agrees to cooperate, TSCE eligibility shall be re-determined.



NOTICE

MEDICAL CARE FOR THOSE WHO CANNOT AFFORD TO PAY

THIS HEALTH CARE FACILITY PROVIDES SERVICES FREE OF CHARGE OR AT A REDUCED CHARGE TO PERSONS WHO CANNOT AFFORD TO PAY FOR MEDICAL CARE.

IF YOU ARE UNABLE TO PAY FOR ALL OR PART OF THE CARE YOU NEED, YOU MAY CONTACT THE ADMISSIONS OR BUSINESS OFFICE OF THIS FACILITY AND ASK ABOUT THE AVAILABILITY OF SUCH CARE. IF YOU WOULD LIKE FURTHER INFORMATION, YOU MAY CALL THE COUNTY OF LOS ANGELES, PRIVATE SECTOR COORDINATOR'S OFFICE AT (562) 347-1590.



NOTICIA

SERVICIO MEDICO PARA QUIENES NO PUEDEN AFRONTAR PAGARLO

ESTE HOSPITAL PROVEE SERVICIOS GRATIS O A COSTO REDUCIDO A PERSONAS QUE NO PUEDEN PAGAR POR SERVICIOS MEDICOS.

SI USTED NO PUEDE PAGAR POR TODO O PARTE DEL CUIDADO QUE NECESITA, USTED DEBE COMUNICARSE CON LA OFICINA DE ADMISIONES O NEGOCIOS DE ESTE HOSPITAL Y PREGUNTAR ACERCA DE ESTE PROGRAMA. SI DESEA MAS INFORMACION, PUEDE LLAMAR AL CONDADO DE LOS ANGELES, OFICINA DEL COORDINADOR DEL SECTOR PRIVADO, AL (562) 347-1590.

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES
TRAUMA CENTER SERVICE AGREEMENT
NON-COUNTY HOSPITALS
INSTRUCTIONS FOR SUBMISSION OF CLAIMS



GENERAL INFORMATION

Hospitals must submit a **UB-04 Form** and a copy of the **Trauma Service County Eligibility Agreement (TSCE) Form** or a **Hospital Certification of Inability to Cooperate Form** for each eligible patient's care if they want an indigent patient claim to be considered in the formula for Trauma Center funds. Additionally, Hospitals must submit an electronic file of the UB-04 with the paper copy of the claim packet. If Hospital is unable to submit an electronic file of the UB-04, they must submit the required UB-04 data in an Excel or CSV electronic file when claims are submitted.

In addition to the following requirements for completion of the UB-04 Form, the Trauma Hospital must ensure that all like data elements in the Trauma and Emergency Information System (TEMIS) data system match the UB-04 data for trauma patients. Only patients identified in TEMIS as "County Indigent" will be considered eligible for inclusion in the County's payment methodology to Trauma Centers.

PATIENT INFORMATION: Hospitals are required to make reasonable efforts to collect all information as required on the TSCE Form. If, after reasonable efforts are made, some data elements cannot be obtained for services provided as EMERGENCY DEPARTMENT, indicate "N/A" (not available) in the space for the data element which was not obtainable. **Claims for services provided to patients shall not be accepted without completion of all data elements unless a reasonable justification is provided, e.g., "comatose on arrival and expired with no family or identification"**. In these cases a **Hospital Certification of Inability to Cooperate Form** should be submitted.

HOSPITALS SUBMIT CLAIMS TO:

Department of Health Services
Emergency Medical Services (EMS) Agency
10100 Pioneer Blvd., Suite 200
Santa Fe Springs, California 90670
Attention: HOSPITAL CLAIMS
Contact: Hospital Reimbursement Coordinator - (562) 347-1590

COMPLETION OF UB-04 FORM

The following Field Locations on the UB-04 Form **must be completed**:

INPATIENT

1. Hospital Name
- 3a. Patient Control Number (Unique Patient Identification)
- 3b. Medical Record Number
6. Statement Cover Period
- 8a. Patient ID (if hospital uses this field to enter the patient ID)
- 8b. Patient's Name (last, first, middle initial)
- 9a-d. Patient's Address (street address, city, state, and zip code)
10. Birthdate
11. Sex
12. Admission Date
42. Revenue Code
46. Service Units
56. National Provider Identifier
57. Facility ID Number (unique facility number assigned by OSHPD)
66. Diagnoses (primary and two other applicable ICD code)
- 74 a-e. Principal and Other Procedures Descriptions, if applicable

OUTPATIENT

1. Hospital Name
- 3a. Patient Control Number (Unique Patient Identification)
- 3b. Medical Record Number
6. Statement Cover Period
- 8a. Patient ID (if hospital uses this field to enter the patient ID)

- 8b. Patient's Name (last, first, middle initial)
- 9a-d. Patient's Address (street address, city, state, and zipcode)
- 10. Birthdate
- 11. Sex
- 42. Revenue Code
- 44. HCPCS Code (or CPT Code, if applicable)
- 45. Service Date
- 56. National Provider Identifier
- 57. Facility ID Number (unique facility number assigned by OSHPD)
- 66. Diagnoses (primary and two other applicable ICD code)
- 74 a-e. Principal and Other Procedures Descriptions, if applicable

COUNTY OF LOS ANGELES ● DEPARTMENT OF HEALTH SERVICES

TRAUMA PHYSICIAN SERVICES PROGRAM

BILLING PROCEDURES

JULY 1, 2016 TO JUNE 30, 2019

I. INTRODUCTION

Pursuant to provisions of the State of California Welfare and Institutions Code, Sections 16950 et seq., and Health and Safety Code ("HSC"), Sections 1797.98a, et seq., a Physician Services Account has been established by the County of Los Angeles ("County") to pay for contracts with private physicians ("Physician") to provide reimbursement for certain professional services they have rendered to eligible indigent patients. County has determined that a portion of the Physician Services Account should be allocated to a special County sub-account which will serve as a source of reimbursement for otherwise uncompensated physician services rendered to trauma patients in hospitals designated by County contract as trauma hospitals.

This document defines the procedures which must be followed by a Physician in seeking reimbursement from this trauma services sub-account. Reimbursement is also limited to the policy parameters set forth herein and incorporated in the attached "Department of Health Services' Physician Reimbursement Policies." The County may revise such policies from time to time as deemed necessary or appropriate and if approved by the Board of Supervisors.

Submission of a claim for trauma services by a Physician under these procedures establishes (1) a contractual relationship between the County and the Physician covering the services provided and (2) signifies the Physician's acceptance of all terms and conditions herein.

This claiming process is effective immediately; is only valid for trauma services to the extent that monies are available therefore; and are subject to revisions as required by State laws and regulations and County requirements.

In no event may this claiming process be used by a Physician if his/her services are included as part of the trauma hospital services claimed for reimbursement by the hospital under County's contract with the hospital.

This claiming process may not be used by a Physician for services for which a billing has previously been submitted or could be submitted to the County under any other County contract or claiming process.

This claiming process may not be used by a physician if he or she is an employee of a County trauma hospital.

II. PHYSICIAN ELIGIBILITY

- A. Physician must possess a valid and current license to practice medicine in the State of California during the enrollment period when the trauma services are provided. Proof of licensure must be submitted with enrollment and updated whenever licensure renewed.
- B. Physician must complete a Trauma Physician Services Program "Conditions of Participation Agreement" and "Program Enrollment Provider Form" and provide them to the County's Office of Emergency Medical Services ("EMS") Agency in care of the contracted Claims Adjudicator (see address on page 4). Physician claims will not be accepted if said Agreement and form are not on file with the EMS Agency.
- C. Any Physician, **including an emergency department Physician**, who responds as part of an organized system of trauma care to eligible patients in a hospital designated by formal County contract as a "trauma hospital" may submit a claim hereunder. (Physician employees of a County trauma hospital are not, however, eligible for reimbursement under this claiming process.)
- D. Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California.

III. PATIENT ELIGIBILITY/BILLING EFFORTS

Patients covered by this claiming process are only those for whom the trauma hospital is required to complete a trauma patient summary ("TPS") form, and who do not have health insurance coverage for emergency services and care, and who cannot afford to pay for services rendered, and for whom payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, including Medi-Cal, but with the exception of claims submitted for reimbursement through Section 1011 of the Federal Medicare Prescription Drug, Improvement and Modernization Act of 2003.

During the time prior to submission of the bill to the County, the Physician must have made reasonable efforts to obtain reimbursement and not received payment for any portion of the amount billed. For purposes of this claim process, reimbursement for unpaid Physician billings shall be limited to the following:

- (a) patients for whom a Physician has conducted reasonable inquiry to determine if there is a responsible private or public third-party source of payment; and

- (b) patients for whom a Physician has billed all possible payment sources, but has not received reimbursement for any portion of the amount billed; and
- (c) either of the following has occurred:
 - 1. A period of not less than three (3) months has passed from the date the Physician billed the patient or responsible third party, during which time the Physician has made two attempts to obtain reimbursement and has not received payment for any portion of the amount billed.
 - 2. The Physician has received actual notification from the patient or responsible third party that no payment will be made for the services rendered.
 - 3. Physician has attempted to settle by offering to bill patients a reduced amount, i.e., a percentage of total charges.

Upon receipt of payment from the County under this claiming process, Physician must cease any current, and waive any future, collection efforts to obtain reimbursement from the patient or responsible third party. During the period after a claim has been submitted and prior to receipt of payment, the Physician can continue attempts to collect from a patient. However, once the Physician receives payment from the County, further collection efforts shall cease.

Examples of when these County collection efforts might occur would include, but not necessarily be limited to, situations where there are third-party tortfeasors responsible for a patient's medical expenses. If, after receiving payment from the County hereunder, Physician is reimbursed by a patient or a responsible third party, Physician shall notify the County within 60 days of receipt of payment (see address below) in writing of the payment, and reimburse the County the amount received from the County.

MAKE REFUND CHECK PAYABLE TO:

County of Los Angeles/Department of Health Services

Refund checks should be accompanied by:

- a copy of the Remittance Advice, and
- a specific explanation for the refund, e.g., received payment for services from Medi-Cal, etc.

SUBMIT NOTIFICATION AND/OR REFUND TO:

County of Los Angeles/Department of Health Services

Special Funds Unit

313 North Figueroa Street, Room 505

Los Angeles, CA 90012

ATTN: PHYSICIAN SERVICES FOR INDIGENTS PROGRAM

IV. CONDITIONS OF REIMBURSEMENT

Payment is contingent upon adherence to State law and County requirements regarding eligible claims, and provision of data as specified in these Billing Procedures.

V. CLAIM PERIOD

Claims may only be submitted for eligible services provided. All claims for services provided during a fiscal year (July 1 through June 30) must be received by County's Claim Adjudicator no later than October 31st of the following fiscal year. Claims received after this deadline has passed will not be paid.

VI. REIMBURSEMENT

Reimbursement of a valid claim hereunder will be paid at the applicable approved percentage of the Official County Fee Schedule (OCFS), not to exceed 100% of Physician charges. The OCFS, which establishes rates of reimbursement deemed appropriate by the County, utilizes the most current Physicians' Current Procedural Terminology (CPT-4) codes in conjunction with the Resource Based Relative Value Scale (RBRVS) unit values and a County determined weighted average conversion factor. The conversion factor for all medical procedures other than anesthesiology is \$79.49 per relative unit value. The conversion factor for anesthesiology procedures is \$48.77 per relative unit value.

VII. COMPLETION OF FORMS

- A. Complete "Conditions of Participation Agreement" for Trauma Physician Services Program (sample attached). Submit one original signed Agreement to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340

- B. Complete one CMS-1500 Form per patient.
- C. Complete one Physician Services for Indigents Program (PSIP) Demographic Data Form per patient (sample attached). Physicians are required to provide patient data for services provided in a hospital to the extent the information is available from the hospital. Additional requirements for data submission have been established. Refer to the attached Instructions for Submission of Claims and Data Collection.

VIII. ELECTRONIC BILLING

As an option, the County's Claims Adjudicator can receive claims electronically. The record layout necessary for electronic submission shall be obtained directly from the County Claims Adjudicator at (800) 303-5242 Ext. 518.

IX. SUBMIT CLAIM(S) TO COUNTY'S CONTRACTED CLAIMS ADJUDICATOR

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: TRAUMA CLAIMS

X. CLAIM REJECTION AND APPEALS

- A. Revised claims previously rejected for incomplete information must be received by the contracted Claims Adjudicator within 20 calendar days from the date of the rejection letter; however, in no case shall claims be resubmitted later than February 15 of the following fiscal year.
- B. The Physician must submit an appeal of any denied claim within thirty (30) calendar days from the date of the denied Remittance Advice. A denied claim can be appealed once; however, after the appeal is dispositioned, a further appeal will not be considered. All resubmissions or appeals must be received by Claims Adjudicator within seven (7) months after the close of the fiscal year during which services were provided, no later than February 15 of the following fiscal year. All appeals shall be prepared and sent in accordance with the directions set forth in Exhibit "A".

XI. INFORMATION CONTACTS

For Status of Claims, call:
AIA Physician Hotline - (800) 303-5242

XII. COUNTY LIABILITY/PAYMENT/SUBROGATION

Payment of any claim under this claiming process is expressly contingent upon the availability of monies allocated therefor by the State and by the County of Los Angeles Board of Supervisors. To the extent such monies are available for expenditure, valid claims may be paid. Valid claims will be paid in the order of receipt; that is, if a complete and correct claim is received by County, it will have priority over claims subsequently received.

Physician agrees to assign and subrogate all rights that s/he may have against any patient, his/her responsible relative, any third party tortfeasor or any other party for

reimbursement as a result of care and services provided by Physician, and/or his/her staff, for which a claim has been submitted to County under the PSIP. At its sole discretion, County, and/or its contractor, may proceed independently against such parties for reimbursement to the extent permitted by law. The rights hereby assigned and subrogated to County under this provision include reimbursement for the full amount of any customary or actually billed charges of Physician, and his/her staff, for patient care and services regardless of the amount the Physician has received under the Trauma Services for Indigents Program. Physician agrees to cooperate with County and/or its contractors in the exercise of the rights assigned and subrogated to County under this provision.

XIII. GENERAL OBLIGATION OF PHYSICIANS SUBMITTING CLAIMS

In addition to any Physician duties specified previously herein, Physicians using this claiming process are obligated as follows:

A. Records/Audit Adjustment

1. Physician shall immediately prepare, and thereafter maintain, complete and accurate records sufficient to fully and accurately reflect the services provided, the costs thereof, all collection attempts from the patient and third-party payers, and revenue collected, if any, for which claim has been made under this claiming process.
2. All such records shall be retained by Physician for a minimum of three (3) years following the last date of the Physician services to the patient.
3. Such records shall be made available during normal County working hours to representatives of the County and/or State, upon request, at all reasonable times during such three year period for the purposes of inspection, audit, and copying. Photocopying capability must be made available to County representatives during an on-site audit.
4. County may periodically conduct an audit of the Physician's records. Audits shall be performed in accordance with generally accepted auditing standards. The audit may be conducted on a single claim, a group of claims, or a statistically random sample of claims from the adjudicated universe for a fiscal year. The scope of the audit shall include an examination of patient financial records, patient/insurance billing records, and collections agency reports associated with the sampled claims. Medical records may also be requested.

Audited claims that do not comply with program requirements shall result in a refund to the County of the claim amount plus an assessment of twenty-five percent (25%) of the amount paid for each claim. Audit results may be appealed to the EMS Agency Director, or his/her designee

If an audit of Physician or hospital records conducted by County and/or State representatives relating to the services for which claim was made and paid hereunder finds that (1) the records are incomplete or do not support the medical necessity for all or a portion of the services provided, or (2) no records exist to evidence the provision of all or a portion of the claimed services, or (3) Physician failed either to report or remit payments received from patients or third parties as required herein, or (4) the patient was ineligible for services hereunder, or (5) Physician did not otherwise qualify for reimbursement hereunder, Physician shall reimburse the County as stated above.

County also reserves the right to exclude Physician from reimbursement of future claims for any failure to satisfy conditions of this claiming process.

B. Indemnification/Insurance

By utilizing this claiming process, the Physician certifies that the services rendered by him/her, and for which claim is made, are covered under a program of professional liability insurance with a combined single-limit of not less than one million dollars (\$1,000,000) per occurrence and three million dollars (\$3,000,000) aggregate.

By utilizing this claiming process, the Physician further certifies that his/her workers' compensation coverage is in an amount and form to meet all applicable requirements of the California Labor Code, and that it specifically covers all persons providing services on behalf of the Physician and all risks to such persons.

C. Non-discrimination

In utilizing this claiming process, the Physician signifies that he/she has not discriminated in the provision of services for which claim is made because of race, color, religion, national origin, ancestry, sex, age, physical or mental disability, or medical condition and has complied in this respect with all applicable non-discrimination requirements of Federal and State law.

COUNTY OF LOS ANGELES DEPARTMENT OF HEALTH SERVICES

PHYSICIAN REIMBURSEMENT PROGRAMS

PHYSICIAN REIMBURSEMENT POLICIES

JULY 1, 2016 TO JUNE 30, 2019

I. POLICY STATEMENT

THE PURPOSE OF THIS POLICY IS TO ENSURE THE COUNTY'S CONFORMANCE WITH STATUTORY AND REGULATORY REQUIREMENTS, AND TO ADDRESS PRIORITIES OF THE HEALTH CARE SYSTEM WHICH ARE CRITICAL TO PROVIDING FOR THE MEDICAL NEEDS OF THE INDIGENT POPULATION, WITHIN THE LEVEL OF AVAILABLE FUNDS.

II. GENERAL RULES

A. Official County Fee Schedule: The Official County Fee Schedule is used to determine reimbursement rates for eligible physician claims. The Official County Fee Schedule, which establishes rates of reimbursement deemed appropriate by the County utilizes the most current Physicians' Current Procedural Terminology ("CPT-4") codes which coincides with the current Resource Based Relative Values Scale ("RBRVS") unit values and a County-determined weighted average conversion factor. The conversion factor for all medical procedures except anesthesiology is \$79.49 per relative unit value. The conversion factor for anesthesiology procedures is \$48.77 per relative unit value. Reimbursement is also limited to the policy parameters contained herein.

B. Eligible Period: Reimbursement shall be for emergency medical services provided on the calendar day on which emergency services are first provided and on the immediately following two calendar days.

EXCEPTION: Trauma physicians providing trauma services at County contract trauma hospitals may bill for trauma physician services provided beyond this period.

C. Medi-Cal/Medicare Exclusions:

1. Procedures which are not covered in the Medi-Cal Program's Schedule of Maximum Allowances ("SMA") are excluded from reimbursement.

2. Procedures which are covered in Medi-Cal's SMA but require a Treatment Authorization Request ("TAR") are excluded from reimbursement; however, will be considered upon appeal and/or provision of applicable operative and/or pathology reports.

- D. Screening Exams: Payment will be made for emergency department medical screening examinations required by law to determine whether an emergency condition exists.
- E. Assistant Surgeons: Reimbursement for assistant surgeons will be at a rate of 16% of the primary surgeon's fee.
- F. Multiple Surgery Procedure Codes: Adjudication of claims involving multiple surgery procedure codes performed in an inpatient operating room requires submission of operative reports. No more than five (5) Procedure Codes shall be paid as follows: 100% for 1st Procedure and 50% for the 2nd through 5th Procedures.
- G. Nurse Practitioner and Physician's Assistant Services: Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician's assistants in California.

III. INELIGIBLE CLAIMS

- A. Duplicate Procedures: Claims which include duplicate procedures provided to the same patient for the same episode of care are generally excluded from reimbursement. This does not apply for Evaluation & Management codes billed by separate physicians.
- B. Unlisted Procedures: Procedures which are not listed in the Official County Fee Schedule are excluded from reimbursement.
- C. Non-physician Procedures: Procedures commonly not performed by a physician will be denied (e.g., venipuncture). Claims will be reviewed and considered on appeal only.
- D. Insurance Rejections: Claims for patients with potential insurance or other third-party payer coverage will be denied unless a notice of rejection from the insurance company or other third-party payer is provided to the County. The rejection notice should indicate either (1) the patient is not a covered beneficiary or (2) the term of coverage expired prior to the date of the claimed service. If insurance or other third-party coverage has been denied for other reasons, e.g., the deductible has not been met, the type or scope of service has been classified as a nonemergency, or other similar issues denying insurance coverage, the claim will be denied. Where limited insurance policies have been exhausted by hospital billings, physician claims will be reviewed and considered on appeal.

IV. EXCLUSIONS

- A. Radiology/Nuclear Medicine (Codes 70002 - 79499): Reimbursement for radiology codes will be limited to readings performed while the patient is in the emergency department or other eligible site. Additionally, payment will only be made for the first radiology claim received by the County per patient per episode of care. Subsequent radiology claims for the same patient/episode will be denied.
- B. EKG (Code 93010): Reimbursement for EKG codes will only be made for the first EKG claim received by the County per patient per episode of care. Subsequent EKG claims for the same patient/episode will be denied.
- C. Pathology (Codes 80104 - 89999): Reimbursement for pathology codes will be limited to codes 86077, 86078, and 86079. Additionally, codes 88329, 88331, and 88332 will be reimbursed only if the pathologist is on site and pathology services are requested by the surgeon.
- D. Surgery (Codes 10000 - 69979): There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).
- E. Anesthesia: There are no exclusions as long as the procedure is covered in Medi-Cal's SMA and does not require a TAR (see Medi-Cal Exclusions in section A. above).
- F. Modifiers: Reimbursement is excluded for all modifiers except radiology.
- G. Prior Dx Codes: Reimbursement will no longer be made for wound checks and suture removal.
- H. Critical Care (Codes 99291 and 99292): Reimbursement will not be made on critical care codes after the first 24 hours of service.
- I. Newborn Care (Inpatient Code 99431 and Emergency Department Code 99283): Reimbursement will only be made once for the same recipient by any provider and only if accompanied by a Medi-Cal denial. V30 through V30.2 codes are reimbursable only if a copy of Medi-Cal denial is provided.

V. ADDITIONAL EXCLUSIONS

Upon approval of the Board of Supervisors, the County may revise the Physician Reimbursement Policies from time to time as necessary or appropriate.

VI. APPEALS

Appeals for claims rejected or denied may be submitted to the Physician Reimbursement Advisory Committee ("PRAC"), a committee of physicians selected by Hospital Council of Southern California and by the Los Angeles County Medical Association. Appeals shall include the PSIP Demographic Data Form, CMS-1500, operative reports, if applicable, and supporting documents as needed. Appeals shall be mailed to the contracted Claims Adjudicator:

American Insurance Administrators (AIA)
P.O. BOX 2340
Bassett, CA 91746-0340
ATTN: APPEALS UNIT

**PHYSICIAN
REIMBURSEMENT
PROGRAM**

**PROGRAM ENROLLMENT PROVIDER FORM
JULY 1, 2016 TO JUNE 30, 2019**

Completion of Enrollment Form is required by each physician

Physician Name: _____
 (Last Name) (First Name) (M.I.)

Address: _____ City: _____ Zip Code: _____

Telephone No.: (____) _____ Contact Person: _____

E-mail Address: _____ NPI #: _____

Primary Specialty: _____ State License Number: _____ (attach a copy/proof of current licensure)

U.P.I.N.: _____ Payee Tax I.D.#: _____

Payee Address: _____ City: _____ State: _____ Zip Code _____

Physician/Group name must match IRS Tax ID Number

IF PAYEE IS A PHYSICIAN GROUP, COMPLETE GROUP INFORMATION BELOW:

Group Name: _____

IF USING A BILLING COMPANY, COMPLETE BILLING COMPANY INFORMATION BELOW:

Company Name: _____ E Mail Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Telephone Number: (____) _____ Contact Person: _____

LIST ALL HOSPITAL WHERE MEDICAL SERVICES ARE PROVIDED WITHIN LOS ANGELES COUNTY

Hospital Name: _____ Address: _____

If information on this form changes in any way, a new provider application must be submitted with the corrected information. This application must be completed by each physician providing services claimed under this program.

As a condition of claiming reimbursement under the Physician Services for Indigents Program and/or the Trauma Physician Services Program, I certify that the above information is true, and complete to the best of my knowledge.

 SIGNATURE OF PHYSICIAN

 DATE

IMPORTANT: For prompt processing, return this form as soon as possible to:
AMERICAN INSURANCE ADMINISTRATORS
P.O. BOX 2340
Bassett, CA 91746-0340

COUNTY OF LOS ANGELES / DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY

TRAUMA CENTER PAYMENT SURRENDER FORM

FACILITY: _____

PATIENT NAME: _____

DATE OF SERVICE: _____ TPS#: _____

DATE CLAIM SUBMITTED TO EMS AGENCY: _____

AMOUNT OF PAYMENT BEING SURRENDERED: \$_____

PAYMENT RECEIVED FROM

DATE COVERAGE IDENTIFIED

- INSURANCE (Health Plan/HMO) ____/____/____
- MEDI-CAL ____/____/____
- MEDICARE ____/____/____
- PATIENT ____/____/____
- THIRD PARTY TORTFEASORS ____/____/____
- OTHER _____ ____/____/____

(Specify)

SUBMITTED BY: _____ **DATE:** ____/____/____

(THIS FORM MUST BE ATTACHED TO EACH PAYMENT SURRENDER CHECK)

Mail to: SPECIAL REVENUE FUNDS SECTION
313 N. Figueroa St., Room 505
Los Angeles, CA 90012

Attention: Section Head

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT C

PATIENT INCLUSION IN THE TRAUMA DATA SYSTEM

EXCLUSIONS:

Patients with the following injuries are to be EXCLUDED from the registry, unless an additional injury that meets criteria/guidelines exists:

GROUND LEVEL FALLS:

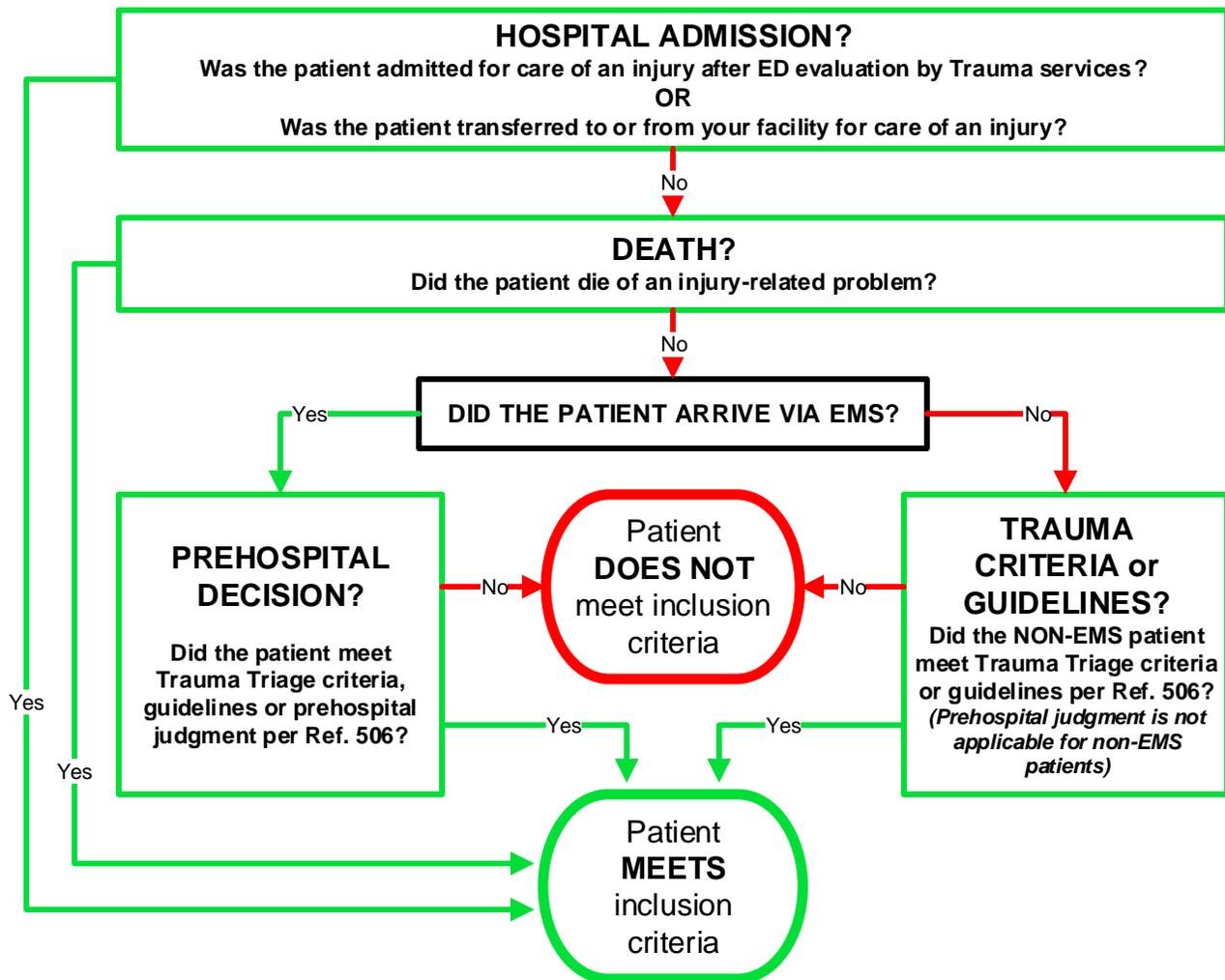
resulting in isolated closed hip fractures in patients > 50 years of age; or fractures of or distal to the knee or elbow in patients of any age

OR

burns; drownings; hangings; poisonings; late effect of injuries; foreign bodies; superficial injuries (S00, S10, S20, S30, S40, S50, S60, S70, S80, & S90); and insect bites

INCLUSIONS:

Patient has at least one ICD-10 injury diagnostic code within the range of S00-S99, T07, T14, T20-T28, T30-T32, & T79.A1-T79.A9



CASES ENTERED INTO THE REGISTRY THAT DO NOT MEET "EXHIBIT C" CRITERIA MUST BE IDENTIFIED AS "DHS=NO", AND HAVE THE TPS RATIONALE OF "DHS=NO" INDICATED.

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT D

TRAUMA CENTER DATA COLLECTION SYSTEM

1. SPECIFIC RESPONSIBILITIES OF COUNTY'S DEPARTMENT OF HEALTH SERVICES (COUNTY'S LOCAL EMERGENCY MEDICAL SERVICES (EMS) AGENCY) INCLUDE THE FOLLOWING:

- A. The local EMS agency shall develop and implement a standardized data collection instrument and implement a data management system for trauma care.
- (1) The system shall include the collection of both prehospital and hospital patient care data, as recommended by the Trauma Hospital Advisory Committee (THAC) to the local EMS agency.
 - (2) Trauma data shall be integrated into the local EMS agency data management system.
 - (3) County commits to pursue the participation, in the local EMS agency data collection system efforts, of all hospitals receiving trauma patients in accordance with local EMS agencies policies and procedures which are based on Title 22.
 - (4) County shall generate and distribute periodic reports to all designated Trauma Centers participating in the trauma system on a quarterly basis, to include but not limited to:
 - (a) system volume report on the total number of

Exhibit D

- patients by trauma center; and
 - (b) system volume report on the number of pediatric patients versus the number of adult patients by trauma center; and
 - (c) system volume report on the number of blunt injuries versus the number of penetrating injuries by trauma center; and
 - (d) system volume report on the mechanism of injury by trauma center.
- (5) County shall generate and distribute for the purposes of benchmarking to Contractor quarterly reports on system aggregate data on the following:
- (a) Intensive Care Unit (ICU) Length of Stay (LOS); and
 - (b) Payer Source distribution; and
 - (c) Injury Severity Score (ISS) distribution with the patient's outcome, lived versus died.
- (6) County agrees to honor special request for reports by Contractor to compare hospital specific data elements to the system aggregate data elements within a reasonable agreed upon time period.
- B. The Department agrees to provide the following to the Contractor:

Exhibit D

- (1) A current Trauma Center Trauma and Emergency Medicine Information System (TEMIS) software training/procedure manual.
- (2) Annually a minimum of sixteen (16) hours TEMIS basic software training and twenty-four (24) hours of intermediate/advanced training will be offered, for all necessary persons identified by Contractor, to enable Contractor personnel to perform data entry, database maintenance, and basic and advanced report generation functions. Contractor's need for basic training of new employees will be met without regard to the minimum number of participants within two (2) weeks of Contractor's request. Intermediate/advanced training classes to be scheduled monthly, with a specific agenda for standardized education, with a minimum number of two (2) participants, in no less than four (4) hour increments. Additional training hours will be made available as needed. A nonexclusive, nontransferable license to Contractor to use current software and

Exhibit D

documentation and any software updates, or until Agreement is terminated as set forth herein. Such license also includes the right of Contractor to copy TEMIS software and documentation for back-up or archive purposes, but such license further gives Contractors no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software or documentation to any other person or entity.

In the event that Agreement is terminated for any reason, the Department shall promptly remove all TEMIS software and Contractor shall return to County all TEMIS documentation (and all copies thereof made by Contractor hereunder) provided by County to Contractor.

Unlimited technical support for the TEMIS system provided during normal business hours.

C. County does not warrant that operation of the software will be error-free. In the event of errors in software the Department, on behalf of County, shall use reasonable efforts to promptly rectify the software. Whenever possible, the Department shall correct a problem in twenty-four (24) hours or less. County shall have no such obligation if the problem(s) is (are) a

Exhibit D

direct or indirect result of software modifications made without written approval from Director. County's inability to resolve above issues will result in temporary suspension of Contractor's data obligations.

The foregoing including responsibilities for resolving software problems are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information and the like), arising out of the use or inability to use the software, even if County has been advised of the possibility of such damages.

County does not assume and shall have no liability under this Agreement for failure to replace defective software, or the corresponding data due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not limited to, acts of God, acts of public enemy, acts of

Exhibit D

the United States, any state, or other political subdivision, fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

2. SPECIFIC RESPONSIBILITIES OF CONTRACTOR INCLUDE THE FOLLOWING:

- A. Contractor agrees to replace County provided TEMIS hospital hardware and return such equipment to the County by December 31, 2010. Contractor shall maintain their new equipment in fully functioning order until Agreement is terminated.
- B. Contractor's data collection requirements for patient inclusion in the trauma database are defined and set forth in Exhibit "C", attached hereto and incorporated herein by reference.

Contractor shall enter into the TEMIS database within fifteen (15) days of hospital admission, the data elements found in the Initial Patient Information Section (to include patient name, admit date, mode of entry, and sequence number) of the Trauma Patient Summary - Page 1 (TPS1). The remainder of TPS1 shall be entered into the TEMIS database within thirty (30) days of hospital admission. Data elements found in the

Exhibit D

Trauma Patient Summary - Page 2 (TPS2) shall be entered into the TEMIS database within sixty (60) days of hospital discharge.

- C. Contractor acknowledges receipt of the County Department of Health Services Trauma Patient Summary Form, Attachment "D-2", attached hereto and incorporated herein by reference. Contractor agrees to provide all mandatory data elements from Attachment "D-2" in reporting trauma patient information to the Department, to assist the Department in its data collection effort. In the event that Director determines that the Department's Trauma Patient Summary Form should be modified or that additional data must be collected by Contractor based on recommendations from the Trauma Hospital Advisory Committee (THAC), said request for additional data must first be referred to the EMSC Data Advisory Committee by Director for review and advice. The Department shall estimate the cost impact on Trauma Centers of the request for the modification and shall advise the EMSC. If the request for additional data results in increased costs to Contractor, Contractor may terminate this Agreement upon giving at least sixty (60) days prior written

Exhibit D

notice to County.

- D. Contractor shall utilize TEMIS application programs and provide their own equipment in accordance with the specifications shown in Attachment "D-1", TEMIS Hospital Hardware and Software Specifications, attached hereto and incorporated herein by reference, in a reasonably secure area of the hospital provided by the Contractor. Contractor shall in no way modify the structure or function of the software without prior written approval of Director. The hardware and software configuration provided shall be used exclusively for the purposes intended herein.
- E. Contractor shall provide DSL or T1 internet connection for the submission of Contractor's TEMIS data to County.
- F. Should County remove all or any portion of TEMIS software required to submit Contractor's data to County via County defined media, or fail to correct any software errors that prevent Contractor from being able to perform data entry, Contractor's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software error.

Exhibit D

- G. Contractor shall seek telephone assistance from Director, whenever TEMIS operation failure occurs, to obtain County TEMIS maintenance services as described herein.
- H. Contractor shall assign qualified back-up personnel to operate TEMIS, as reasonably appropriate for Contractor to meet Contractor's data collection responsibilities described herein. Furthermore, Contractor shall permit adequate time for complete training of such personnel.
- I. All software application modules, all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are "proprietary" or "confidential". Contractor shall use reasonable means to insure that these confidential products are safeguarded and held in confidence. Such means shall include, but not be limited to: requiring each Contractor employee or agent given access thereto to enter into a written agreement in the same form identified as Attachment "D-3", Hospital Employee Acknowledgement and Confidentiality Agreement Regarding Trauma Center Data Collection Obligations, attached

Exhibit D

hereto and incorporated herein by reference; disclosing confidential County products only to employees with a need to know of such confidential County products in order for Contractor to exercise its rights and perform its obligation as a Trauma Center; and refraining from reproducing, adapting, modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

- J. Contractor shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse of the software license.

3. RELEASE AND/OR SALE OF TEMIS DATA:

- A. The parties acknowledge that the data collection effort was undertaken for the purpose of improving the Los Angeles Trauma System and that the County and

Exhibit D

participating hospitals have expended significant amounts of time, effort and money to develop data collection systems and data. Accordingly, it is hereby acknowledged and agreed that County will not release or sell any identifiable data to any entity for publication or for any other use whatsoever without first receiving written permission from Contractor, if it is identified, except as otherwise provided by law.

- B. Only non-hospital identifiable information resulting from the TEMIS may be sold by County without permission of the hospitals.
- C. Seventy-five percent (75%) of the proceeds of the sale of any TEMIS Trauma Center information shall be distributed to the participating hospitals in equal amounts. Said distribution shall be effected by reducing the annual fee by an amount equal to Contractor's share of the sale of proceeds from the previous year.

**Trauma and Emergency Medicine Information System (TEMIS)
Hospital Hardware and Software Specifications**

Workstation requirements are dependent on the workstation's intended use.

Minimum Workstation Recommendations

- Intel® Pentium E5200 (2.5 GHz)
- Microsoft Windows XP Professional SP3
- 1 GB of RAM
- 2 GB of Available Disk Space
- Display Adapter and Monitor Capable of Displaying 1024 X 768
- 100 Mbps NIC Adapter or faster
- Mouse
- Keyboard

Recommended Workstation Specifications

- Intel® Core i7 Processor - 940
- Microsoft Windows 7 Professional 64-bit
- 4 GB of RAM
- 100 GB of Available Disk Space
- Display Adapter and Monitor Capable of Displaying 1440 X 900
- Graphics accelerator with 512MB RAM and Monitor Capable of Displaying 1440 X 900
- DirectX 9 graphics device with WDDM 1.0 or higher driver
- 1 Gbps NIC Adapter or faster
- Mouse
- Keyboard

GENERAL INFO	LAST NAME		FIRST NAME		INIT.	ARRIVAL DATE / /	
	SEX: M F	AGE:	RACE/ETHNICITY: <input type="checkbox"/> Asian <input type="checkbox"/> Black <input type="checkbox"/> Hispanic <input type="checkbox"/> White <input type="checkbox"/> Other <input type="checkbox"/> Filipino <input type="checkbox"/> Pacific Islander (oth)/Hawaiian <input type="checkbox"/> Native American <input type="checkbox"/> Unknown			SEQ #	
	D.O.B. / /	<input type="checkbox"/> YR <input type="checkbox"/> MO <input type="checkbox"/> DAY <input type="checkbox"/> HR <input type="checkbox"/> ESTIMATE	ENTRY MODE EMS: <input type="checkbox"/> Ground <input type="checkbox"/> Air EMS Form avail? <input type="checkbox"/> Y <input type="checkbox"/> N NON-EMS: <input type="checkbox"/> Vehicle / Walk-in <input type="checkbox"/> Police <input type="checkbox"/> Other			MR #	
	WT.		TRANSFERRED: <input type="checkbox"/> ED to ED <input type="checkbox"/> Direct Admit FROM: ___ ___ ___			OTH #	

PREHOSPITAL / WALK-INS	INJURY DATE / /	INJURY DESCRIPTION <input type="checkbox"/> Blunt	PRIMARY E-CODE:
	INJURY TIME : : :	MECHANISM OF INJURY <input type="checkbox"/> Penetrating	OTHER E/V-CODES:
	PROVIDER	PROTECTIVE DEVICES <input type="checkbox"/> None Airbag deployed? <input type="checkbox"/> N <input type="checkbox"/> Y(Front)	LOCATION E-CODE:
	RA/ SQUAD	<input type="checkbox"/> Helmet <input type="checkbox"/> Protective clothing <input type="checkbox"/> Side <input type="checkbox"/> Other (curtain, knee, etc.)	INJ. ZIP CODE: <i>If unknown, must complete all other known Address fields</i>
	DISPATCH DATE / /	<input type="checkbox"/> Non-clothing gear <input type="checkbox"/> Eye protection <input type="checkbox"/> Shoulder belt <input type="checkbox"/> Lap belt	WORK RELATED? N Y:
	DISPATCH TIME : : :	<input type="checkbox"/> Personal Flotation Device <input type="checkbox"/> Infant seat <input type="checkbox"/> Child car seat <input type="checkbox"/> Other: <input type="checkbox"/> Booster seat	OCCUPATION:
1 ST ON SCENE : : :	1st FIELD GCS: EYE___ MOTOR___ VERBAL___ TOTAL___	FIELD INTUB? Y N	INDUSTRY:
TRANSPORT ARR. : : :	1st FIELD VS: BP___/___ HR___ RR___ O2 SAT___%		
TRANSPORT LEFT : : :			

EMERGENCY DEPARTMENT	ARRIVAL TIME : : :	1st ED VS: TIME : : : GCS: E___ M___ V___ TOTAL___	ED NOTIFIED? N Y
	EXIT ED DATE / /	TEMP:___ F C @ : : : <input type="checkbox"/> Sedated <input type="checkbox"/> Eye obstruction <input type="checkbox"/> Intubated	MET CRITERIA? N Y:
	EXIT ED TIME : : :	BP___/___ HR___ RR___ ASST? Y N O2 Sat ___% on O2? Y N	<input type="checkbox"/> GSW trunk <input type="checkbox"/> Btwn Midclv <input type="checkbox"/> PH <input type="checkbox"/> PN <input type="checkbox"/> Low BP <input type="checkbox"/> SCI <input type="checkbox"/> PSI <input type="checkbox"/> BH,GCS<15 <input type="checkbox"/> Flail Chest <input type="checkbox"/> Fall >15' <input type="checkbox"/> Diffuse Abd Tenderness <input type="checkbox"/> Neuro Comp <input type="checkbox"/> PT Arrest
	ACTIVATION? Y N	TPS RATIONALE: <input type="checkbox"/> Admission <input type="checkbox"/> Transferred to TRAUMA service <input type="checkbox"/> Died <input type="checkbox"/> Prehosp decision <input type="checkbox"/> NON-EMS Criteria/Guidelines <input type="checkbox"/> DHS=No	GUIDELINES MET:
	TIME: : : :	ADMITTING MD:	<input type="checkbox"/> Pedestrian/Bike vs auto <input type="checkbox"/> Ejected <input type="checkbox"/> Extricated <input type="checkbox"/> Med Hx <input type="checkbox"/> Very old/young <input type="checkbox"/> Survivor Fatal Accident <input type="checkbox"/> Prehosp JUDGMENT only
	LEVEL:	ADMITTING SERVICE:	ED FLUID TOTALS:
	<u>MD SERVICE</u>	<u>MD CODE</u>	IV FLUIDS _____ml BLOOD PROD. _____ml AUTOTRANS. _____ml
	EMERGENCY PHYS.	REQ TIME	NEXT PHASE AFTER ED:
	TRAUMA SURGEON	STAT? Y N	<input type="checkbox"/> <24hr Obs. <input type="checkbox"/> OR <input type="checkbox"/> ICU <input type="checkbox"/> Ward <input type="checkbox"/> Telemetry/Step. <input type="checkbox"/> Peds Ward <input type="checkbox"/> Peds ICU <input type="checkbox"/> Posthospital (complete TPS 2 info)
	TRAUMA RESIDENT	ARR TIME	
NEUROSURGEON			
ORTHOPEDIST			
ANESTHESIOLOGIST			

RADIOLOGY / LAB	BODY REGION	X-RAYS:				CT:				LABS:		
		ICD-9	DATE	TIME	Nml/Abn	ICD-9	DATE	TIME	Nml/Abn	TIME	GRP/PANEL	Result/Tested?
	HEAD	87.17	/	:	N A	87.03	/	:	N A	:	HGB / HCT	Nml Abn
	NECK	87.22	/	:	N A	88.38	/	:	N A	:	TOX (BLOOD)	T NT F NF
	CHEST	87.44	/	:	N A	87.41	/	:	N A	:	TOX (URINE)	T NT F NF
	ABD	88.19	/	:	N A	88.01	/	:	N A	:	ETOH	T NT F NF
	PELVIS	88.19	/	:	N A	88.38	/	:	N A	:		
F.A.S.T	88.79	/	:	N A		/	:		:			
Comments / Results:												

ENTER ALL THAT APPLY DURING HOSPITAL STAY											
PROCEDURES	PHASE BEGUN	START DATE	START TIME	END TIME	PROCEDURE	PHASE BEGUN	START DATE	START TIME	END TIME	PROCEDURE	
		/	:	:	<input type="checkbox"/> ETT 96.04 <input type="checkbox"/> CRIC 31.1		/	:	:	<input type="checkbox"/> CENTRAL LINE 38.93	
		/	:	:	<input type="checkbox"/> (L) CHEST TUBE 34.04		/	:	:	<input type="checkbox"/> ICP 01.18	
		/	:	:	<input type="checkbox"/> (R) CHEST TUBE 34.04		/	:	:		
		/	:	:	<input type="checkbox"/> THORACOTOMY 34.02		/	:	:		
	/	:	:	<input type="checkbox"/> DPA / DPL 54.25		/	:	:		<input type="checkbox"/> VENTILATOR 96.7	

TOTAL VENTILATOR DAYS: (MUST INCLUDE ALL EPISODES)	
---	--

NAME	ARRIVAL DATE: / /	MR#	SEQ#	OTH#
------	----------------------	-----	------	------

OPERATIONS / PROCEDURES	DATE	CUT TIME	END TIME	OPERATION	PROC. ICD-9	SURG TYPE	MD CODE
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				
	/	:	:				

ICU	ARRIVAL	EXIT	CONSULTS	DATE	SERVICE	MD CODE	PHASE AFTER OR: 1 ST VISIT _____ 2 ND VISIT _____ 3 RD VISIT _____ 4 TH VISIT _____ 5 TH VISIT _____	
	/	/		/				
	/	/		/				
	/	/		/				
	/	/		/				

D/C DATE	/	TRANSFER'D / D/C TO	<input type="checkbox"/> Home w/o services <input type="checkbox"/> Home w/Home Health <input type="checkbox"/> Morgue <input type="checkbox"/> Acute Care Facility <input type="checkbox"/> SNF <input type="checkbox"/> Subacute Care <input type="checkbox"/> Rehab <input type="checkbox"/> Hospice <input type="checkbox"/> AMA/Eloped/LWBS <input type="checkbox"/> Jail <input type="checkbox"/> Other:						
D/C TIME	:	RATIONALE	<input type="checkbox"/> Health Plan <input type="checkbox"/> Financial <input type="checkbox"/> Higher Level / Specialized Care <input type="checkbox"/> Rehab <input type="checkbox"/> Extended Care <input type="checkbox"/> In Custody <input type="checkbox"/> Other:			FACILITY:			
PRIOR PHASE		D/C CAPACITY	<input type="checkbox"/> Pre-Injury Capacity (D/C'd from ED with minimum or no injuries) <input type="checkbox"/> Temporary Handicap (Admitted for injuries) <input type="checkbox"/> Permanent Handicap, >1yr limitations (excludes splenectomy)						
<input type="checkbox"/> LIVED <input type="checkbox"/> DIED:		ORGAN DONOR?	Y	N	AUTOPSY UPDATE?	Y	N	CORONER #	<input type="checkbox"/> N/A

DISCHARGE DIAGNOSES		ICD-9	AIS	BODY REG	DISCHARGE DIAGNOSES		ICD-9	AIS	BODY REG

HAND-CALCULATED ISS:	1) HEAD/NECK	2) FACE	3) CHEST	4) ABD/PELVIS	5) EXTREMITIES	6) EXTERNAL	TOTAL:
----------------------	--------------	---------	----------	---------------	----------------	-------------	--------

NTDS CO-MORBID CONDITIONS No NTDS co-morbidities Alcoholism Angina within 30 days Ascites within 30 days
 Bleeding disorder Chemo within 30 days CHF Congenital Anomalies Current smoker CVA/Residual Neuro Deficit
 Diabetes Dialysis (needs/is on) Disseminated Cancer DNR status Esophageal varices Functional Dependent Hlth Status
 HTN req'g meds Impaired sensorium MI within 6 months Obesity Prematurity Respiratory Disease Steroid use
 Revascularization/Amputation for PVD Other:

NTDS COMPLICATIONS No NTDS comp. Abd Compartment Synd AMI Abd fascia left open Acute renal failure ARDS
 Anastomotic leak Base Deficit Bleeding Coagulopathy Coma CPR CVA Decub ulcer Drug/ETOH withdrawal
 DVT/thrombophleb. Extremity Compartment Syndrome Graft/prosthesis/flap failure ICP elevation Jaundice/hepatic failure
 Pancr. fistula PE Pneumonia Surg site infection (superficial) Surg site infection (deep) Surg site infection (organ/space)
 Sepsis Unanticipated intubation Unplanned readmit Wound disruption Wound infection Other:

Pvt/Commercial Insurance: <input type="checkbox"/> Blue Cross/Blue Shield <input type="checkbox"/> HMO <input type="checkbox"/> Medi-Cal HMO <input type="checkbox"/> Auto Insurance <input type="checkbox"/> Worker's Comp. <input type="checkbox"/> Organ Donor Subsidy <input type="checkbox"/> Other private carrier:	Government: <input type="checkbox"/> CCS (California Children's Services) <input type="checkbox"/> CHIP eligible <input type="checkbox"/> CHP (Comm. Hlth Plan)/Healthy Fam. <input type="checkbox"/> Custody Funds <input type="checkbox"/> Military Insurance <input type="checkbox"/> VOC (Victims of Crime) <input type="checkbox"/> Other Government:	Self: <input type="checkbox"/> Cash <input type="checkbox"/> ATP w/liability <input type="checkbox"/> Pre-pay Not billed: <input type="checkbox"/> Charity <input type="checkbox"/> ATP w/o liability	Medicaid: <input type="checkbox"/> Medi-Cal <input type="checkbox"/> Medi-Cal pending <input type="checkbox"/> Medicare
			TOTAL CHARGES: \$

TRAUMA CENTER SERVICE AGREEMENT

**HOSPITAL EMPLOYEE
ACKNOWLEDGMENT AND CONFIDENTIALITY AGREEMENT
REGARDING BASE/TRAUMA HOSPITAL DATA COLLECTION OBLIGATION**

HOSPITAL: _____

I hereby agree that I will not divulge to any unauthorized person any data or information obtained while performing work associated with my employer's base/trauma hospital data obligations. I agree to forward all requests of the release of any data or information received by me to my employer's Trauma and Emergency Medicine Information System (TEMIS) supervisor.

I agree to keep all hospital, patient, and/or agency identifiable TEMIS data confidential and (unless authorized by the patient or the appropriate agency/hospital CEO) to protect these confidential materials against disclosure to other than my employer or County authorized employees who have a need to know the information.

I agree that all TEMIS software application modules, and all modifications, enhancements, and revisions thereof and thereto, and all materials, documents, software programs and documentation, written training documentation, aids, and other items provided to hospital by County for the purposes of the TEMIS data collection shall be considered confidential. As such, I will refrain from reproducing, distributing, or disclosing any such confidential County products except as necessary to perform the Hospital's base/trauma hospital data collection obligation.

I agree to report to my immediate supervisor any and all violations of this agreement by myself and/or by any other person of which I become aware. I agree to return all confidential materials to my immediate supervisor upon completion of my employer's data collection obligation or termination of my employment with my employer, whichever occurs first.

I acknowledge that violation of this agreement may subject me to civil and/or criminal action and that the County of Los Angeles may seek all possible legal redress.

NAME: _____
(Signature)

DATE: _____

NAME: _____ POSITION: _____
(Print)

TRAUMA CENTER SERVICE AGREEMENT

EXHIBIT E

EMERGENCY MEDICAL SERVICES COMMISSION (EMSC) DATA ADVISORY COMMITTEE MEMBERSHIP & BY-LAWS

This committee is responsible for all matters regarding quality of prehospital data, report generation, prehospital research, and policy development impacting the Trauma & Emergency Medicine Information System (TEMIS).

- Committee to be Chaired by an EMSC Commissioner.
- Two or more EMSC Commissioners appointed to the Committee.
- A base hospital administrator or assistant administrator, or a non administrator duly authorized to represent a base hospital administrator/assistant administrator, selection facilitated by Healthcare Association of Southern California.
- A trauma center administrator or assistant administrator, or a non administrator duly authorized to represent a trauma center administrator/assistant administrator, selection facilitated by Healthcare Association of Southern California.
- A 9-1-1 receiving hospital (non-base/non-trauma) representative, selection facilitated by Healthcare Association of Southern California.
- A public sector paramedic provider representative selected by the Provider Agency Advisory Committee.
- A public sector paramedic provider representative from the Los Angeles County Fire Department.

Exhibit E

- A public sector paramedic provider representative from the Los Angeles City Fire Department.
- A private sector paramedic provider representative, selection facilitated by the Ambulance Advisory Board.
- A prehospital care coordinator selected by the Base Hospital Advisory Committee.
- A trauma program manager and one physician selected by the Trauma Hospital Advisory Committee.
- A base hospital medical director selected by the Medical Council.
- A trauma center program director, selection facilitated by the Trauma Committee of the Southern California Chapter of the American College of Surgeons.
- A fire chief, selection facilitated by the Los Angeles County Chapter of the California Fire Chief's Association.

EXHIBIT F
Intentionally Omitted

EXHIBIT G
Intentionally Omitted

EXHIBIT H
Intentionally Omitted

EXHIBIT I
Intentionally Omitted

EXHIBIT J
Intentionally Omitted

EXHIBIT K
Intentionally Omitted



AGREEMENT

BY AND BETWEEN

COUNTY OF LOS ANGELES

AND

POMONA VALLEY HOSPITAL MEDICAL CENTER

FOR

PARAMEDIC BASE HOSPITAL SERVICES

TABLE OF CONTENTS

PARAGRAPH	TITLE	PAGE
RECITALS		1
1.0	APPLICABLE DOCUMENTS.....	4
2.0	DEFINITIONS.....	5
3.0	WORK	6
4.0	TERM OF AGREEMENT.....	6
5.0	AGREEMENT SUM.....	7
6.0	ADMINISTRATION OF AGREEMENT- COUNTY	7
6.1	COUNTY'S PROJECT DIRECTOR	8
6.2	COUNTY'S PROJECT MANAGER.....	8
6.3	COUNTY'S AGREEMENT PROJECT MONITOR	8
7.0	ADMINISTRATION OF AGREEMENT – HOSPITAL.....	8
7.1	HOSPITAL'S PROJECT MANAGER	8
7.2	HOSPITAL'S AUTHORIZED OFFICIAL.....	8
7.3	Intentionally Omitted	9
7.4	HOSPITAL'S STAFF IDENTIFICATION	9
7.5	BACKGROUND AND SECURITY INVESTIGATIONS.....	9
7.6	CONFIDENTIALITY	9
7.7	STAFF PERFORMANCE UNDER THE INFLUENCE.....	10
8.0	STANDARD TERMS AND CONDITIONS.....	10
8.1	AMENDMENTS	10
8.2	ASSIGNMENT AND DELEGATION.....	11
8.3	AUTHORIZATION WARRANTY	11
8.4	BUDGET REDUCTIONS	12
8.5	COMPLAINTS	12
8.6	COMPLIANCE WITH APPLICABLE LAW	12
8.7	COMPLIANCE WITH CIVIL RIGHTS LAWS – ANTI DISCRIMINATION AND AFFIRMATIVE ACTION	13
8.8	Intentionally Omitted	15
8.9	CONFLICT OF INTEREST	15
8.10	CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST	15

TABLE OF CONTENTS

8.11	CONSIDERATION OF HIRING GAIN/GROW PROGRAM PARTICIPANTS.....	16
8.12	HOSPITAL RESPONSIBILITY AND DEBARMENT.....	16
8.13	HOSPITAL'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW	19
8.14	HOSPITAL'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM.....	19
8.15	COUNTY'S QUALITY ASSURANCE PLAN.....	19
8.16	Intentionally Omitted	20
8.17	EMPLOYMENT ELIGIBILITY VERIFICATION.....	20
8.18	FACSIMILE REPRESENTATIONS.....	20
8.19	FAIR LABOR STANDARDS	21
8.20	FORCE MAJEURE	21
8.21	GOVERNING LAW, JURISDICTION, AND VENUE	21
8.22	INDEPENDENT CONTRACTOR STATUS.....	22
8.23	INDEMNIFICATION.....	22
8.24	GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE	23
8.25	INSURANCE COVERAGE	27
8.26	LIQUIDATED DAMAGES	28
8.27	Intentionally Omitted	29
8.28	Intentionally Omitted	29
8.29	Intentionally Omitted	29
8.30	Intentionally Omitted	29
8.31	Intentionally Omitted	29
8.32	NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT	29
8.33	NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW.....	29
8.34	NOTICES.....	29
8.35	PROHIBITION AGAINST INDUCEMENT OR PERSUASION	30
8.36	Intentionally Omitted	30
8.37	PUBLICITY	30
8.38	RECORD RETENTION AND INSPECTION/AUDIT SETTLEMENT	30
8.39	RECYCLED BOND PAPER.....	32

TABLE OF CONTENTS

8.40	SUBCONTRACTING	32
8.41	TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM.....	33
8.42	TERMINATION FOR CONVENIENCE	33
8.43	TERMINATION FOR DEFAULT	33
8.44	TERMINATION FOR IMPROPER CONSIDERATION.....	35
8.45	TERMINATION FOR INSOLVENCY.....	36
8.46	TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE	36
8.47	Intentionally Omitted	37
8.48	SEVERABILITY	37
8.49	WAIVER.....	37
8.50	WARRANTY AGAINST CONTINGENT FEES.....	37
8.51	WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM	37
8.52	TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM	38
9.0	UNIQUE TERMS AND CONDITIONS.....	38
9.1	Intentionally Omitted	38
9.2	HOSPITAL'S OBLIGATIONS AS A "COVERED ENTITY" UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT of 1996 (HIPAA) AND THE HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH).....	38
9.3	DUE PROCESS.....	39
9.4	RESPONSIBILITY FOR INDIGENT PATIENTS	42
9.5	STATUS OF HOSPITAL.....	42
	SIGNATURES	43

TABLE OF CONTENTS

STANDARD EXHIBITS

- A STATEMENT OF WORK
- B Intentionally Omitted
- C Intentionally Omitted
- D Intentionally Omitted
- E COUNTY'S ADMINISTRATION
- F HOSPITAL'S ADMINISTRATION
- G FORM(S) REQUIRED AT THE TIME OF AGREEMENT EXECUTION
- H Intentionally Omitted
- I SAFELY SURRENDERED BABY LAW

UNIQUE EXHIBITS

- J COMMUNICATIONS MANAGEMENT COMMITTEE (Ad Hoc)
- K BASE HOSPITAL COMMUNICATIONS EQUIPMENT
- L COMMUNICATIONS EQUIPMENT MAINTENANCE STANDARDS
- M PARAMEDIC SYSTEM TROUBLE CONTROL PROCEDURES
- N Intentionally Omitted
- O Intentionally Omitted
- P REMOTE BASE STATION RADIO SITES (Referenced in Exhibit M)
- Q CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS
- R BASE HOSPITAL FORM
- R-1 BASE HOSPITAL FORM (PAGE 2)
- R-2 MCI BASE HOSPITAL FORM
- S BASE HOSPITAL FORM INSTRUCTION MANUAL
- T Intentionally Omitted
- U PREHOSPITAL CARE POLICY REFERENCE NO. 214, BASE HOSPITAL AND PROVIDER AGENCY REPORTING RESPONSIBILITIES
- V EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP) STANDARDS

**AGREEMENT BETWEEN
COUNTY OF LOS ANGELES
AND
POMONA VALLEY HOSPITAL MEDICAL CENTER
FOR
PARAMEDIC BASE HOSPITAL SERVICES**

This Agreement and Exhibits made and entered into this 1ST day of January, 2013 by and between the County of Los Angeles, hereinafter referred to as County and Pomona Valley Hospital Medical Center, hereinafter referred to as Hospital. Pomona Valley Hospital Medical Center is located at 1798 North Garey Avenue, Pomona, California 91767.

RECITALS

WHEREAS, the County may contract with private businesses for Paramedic Base Hospital Services when certain requirements are met; and

WHEREAS, the Hospital is a private firm specializing in providing Paramedic Base Hospital Services; and

WHEREAS, pursuant to the authority granted under the Emergency Medical Services and Prehospital Emergency Medical Care Personnel Act ("Act") (Health and Safety Code, Sections 1797, et seq.), County maintains an Advanced Life Support ("ALS") system providing services utilizing Emergency Medical Technicians-Paramedics (hereafter "paramedics") for the delivery of emergency medical care to the sick and injured at the scene of an emergency, during transport to a general acute care Hospital, during interfacility transfer, while in the emergency department of a general acute care Hospital, until care responsibility is assumed by the regular staff of that Hospital, and during training within the facilities of a participating general acute care Hospital; and

WHEREAS, County has designated its Department of Health Services as the local Emergency Medical Services Agency (hereafter "EMS Agency"); and

WHEREAS, the EMS Agency approves and designates selected paramedic base hospital(s) as the Agency deems necessary to provide immediate medical direction and supervision of paramedics within Los Angeles County in accordance with policies and procedures established by the Agency and State EMS Authority; and

WHEREAS, various general acute care Hospitals, both public and private, in Los Angeles County have been designated by the EMS Agency to serve as paramedic base hospitals pursuant to a selection procedure developed and implemented with the assistance of health services provider agencies and other qualified agencies and organizations; and

WHEREAS, Hospital, by virtue of its qualifications pursuant to such selection process and its execution of this Agreement, is a County designated paramedic base hospital (hereafter "base hospital"); and

WHEREAS, a County-designated 911 receiving facility which is also a base hospital shall provide medical direction for all ill and injured patients meeting base hospital contact criteria or guidelines within its area, in addition to other base contacts normally handled; and

WHEREAS, in the event a Hospital is approved as a County-designated trauma center during the term of this Agreement, this Agreement will be incorporated as Exhibit L into Hospital's new Trauma Center Service Agreement (hereafter "TCSA"); and

WHEREAS, "Director" as used herein, refers to County's Director of the Department of Health Services or his or her duly authorized designee; and

WHEREAS, the Act and related implementing regulations require commitment of hospital administration, emergency department, and medical staff to meet requirements for program participation as specified by law and by EMS Agency policies and procedures; and

WHEREAS, the parties wish to cooperate with each other and with paramedic provider agencies in the joint development and operation of an ALS system in Los Angeles County in order to efficiently and appropriately meet the needs of Los Angeles County residents for high quality paramedic services; and

WHEREAS, a physician in the base hospital's emergency department, under the direction of a base hospital medical director and with the assistance of registered nurses who are specially trained and certified as authorized mobile intensive care nurses (hereafter "MICNs") by the EMS Agency, exercises control over the delivery by paramedics of certain emergency care services in the field by issuance to them of verbal medical instructions over a radio or commercial telephone; and

WHEREAS, a base hospital supervises prehospital triage, treatment, patient destination, and advanced life support, and monitors personnel program compliance by providing medical direction; and

WHEREAS, a base hospital provides, or causes to be provided, emergency medical services, and prehospital personnel training and continuing education in accordance with EMS Agency policies and procedures; and

WHEREAS, a base hospital collects prehospital and emergency department data specified in the Base Hospital Form; and

WHEREAS, a base hospital utilizes and maintains two-way telecommunications equipment, as part of the County's Paramedic Communications System (hereafter "PCS"), as specified by the EMS Agency, capable of direct two-way voice communication with the paramedic advanced life support units (hereafter "ALS unit") assigned to a base hospital; and

WHEREAS, the PCS is composed of discrete radio subsystems licensed individually by the Federal Communications Commission (hereafter "FCC") with Hospital holding title to the PCS subsystem(s) used to link to a County facility and County holding title to the PCS subsystem(s) used to link the County facilities with the EMS Agency; and

WHEREAS, Hospital's commitment to provide and operate PCS equipment, and to otherwise establish and maintain a base hospital and to provide the professional and hospital services associated therewith represents a substantial and continuing commitment of financial, physical, professional, and personnel resources by Hospital and its professional staff; and

WHEREAS, the parties desire to carry out their respective obligations under this Agreement in an efficient cost-effective manner; and

WHEREAS, Hospital agrees to share in a portion of costs required to implement and maintain a countywide computerized data collection and information management system (costs specified in body); and

WHEREAS, in exchange, County agrees to provide countywide standardized prehospital management reports and to make available countywide statistical data; and

WHEREAS, this Agreement is authorized by Health and Safety Code Sections 1797.58 and 1798.100 and Title 22 California Code of Regulations, Section 100168.

NOW THEREFORE, in consideration of the mutual covenants contained herein, and for good and valuable consideration, the parties agree to the following:

1.0 APPLICABLE DOCUMENTS

Exhibits A, E, F, G, I, J, K L, M, O, P, Q, R, R1, R2, S, T, U, and V are attached to and form a part of this Agreement. In the event of any conflict or inconsistency in the definition or interpretation of any word, responsibility, schedule, or the contents or description of any task, deliverable, goods, service, or other work, or otherwise between the base Agreement and the Exhibits, or between Exhibits, such conflict or inconsistency shall be resolved by giving precedence first to the Agreement and then to the Exhibits according to the following priority.

Standard Exhibits:

- 1.1 EXHIBIT A – Statement of Work
- 1.2 EXHIBIT B – Intentionally Omitted
- 1.3 EXHIBIT C – Intentionally Omitted
- 1.4 EXHIBIT D – Intentionally Omitted
- 1.5 EXHIBIT E – County's Administration
- 1.6 EXHIBIT F – Hospital's Administration
- 1.7 EXHIBIT G – Forms Required at the Time of Agreement Execution
- 1.8 EXHIBIT H – Intentionally Omitted
- 1.9 EXHIBIT I – Safely Surrendered Baby Law

Unique Exhibits:

- 1.10 EXHIBIT J – Communications Management Committee (Ad Hoc)
- 1.11 EXHIBIT K – Base Hospital Communications Equipment
- 1.12 EXHIBIT L – Communications Equipment Maintenance Standards
- 1.13 EXHIBIT M – Paramedic System Trouble Control Procedures
- 1.14 EXHIBIT N – Intentionally Omitted
- 1.15 EXHIBIT O – Charitable Contributions Certification
- 1.16 EXHIBIT P – Remote Base Station Radio Sites
- 1.17 EXHIBIT Q – Current Temis Hospital Hardware And Software Specifications

- 1.18 EXHIBIT R – Base Hospital Form
- 1.19 EXHIBIT R1 – Base Hospital Form (Page 2)
- 1.20 EXHIBIT R2 – MCI Base Hospital Form
- 1.21 EXHIBIT S – Receiving Hospital Outcome Data
- 1.22 EXHIBIT T – Base Hospital Radio Channel, Assignment/Paramedic Telephone Numbers
- 1.23 EXHIBIT U – Prehospital Care Policy Reference No. 214, Base Hospital and Provider Agency Reporting Responsibilities
- 1.24 EXHIBIT V – Emergency Department Approved for Pediatrics (EDAP) Standards. This Agreement and the Exhibits hereto constitute the complete and exclusive statement of understanding between the parties, and supersedes all previous Agreements, written and oral, and all communications between the parties relating to the subject matter of this Agreement. No change to this Agreement shall be valid unless prepared pursuant to sub-paragraph 8.1 - Amendments and signed by both parties.

2.0 DEFINITIONS

The headings herein contained are for convenience and reference only and are not intended to define the scope of any provision thereof. The following words as used herein shall be construed to have the following meaning, unless otherwise apparent from the context in which they are used.

- 2.1 **Agreement:** Agreement executed between County and Hospital. It sets forth the terms and conditions for the issuance and performance of the Statement of Work, Exhibit A.
- 2.2 **Hospital:** The sole proprietor, partnership, or corporation that has entered into an agreement with the County to perform or execute the work covered by the Statement of Work.
- 2.3 **Hospital Project Manager:** The individual designated by the Hospital to administer the Agreement operations after the Agreement award.
- 2.4 **County Agreement Project Monitor:** Person with responsibility to oversee the day to day activities of this Agreement. Responsibility for inspections of any and all tasks, deliverables, goods, services and other work provided by Hospital.

- 2.5 **County Project Director:** Person designated by County with authority for County on contractual or administrative matters relating to this Agreement that cannot be resolved by the County's Project Manager.
- 2.6 **County Project Manager:** Person designated by County's Project Director to manage the operations under this Agreement.
- 2.7 **Day(s):** Calendar day(s) unless otherwise specified.
- 2.8 **Fiscal Year:** The twelve (12) month period beginning July 1st and ending the following June 30th.
- 2.9 **DHS:** Department of Health Services
- 2.10 **Director:** Director of Health Services or his/her authorized designee

3.0 WORK

- 3.1 Pursuant to the provisions of this Agreement, Hospital shall fully perform, complete and deliver on time, all tasks, deliverables, services and other work as set forth herein.
- 3.2 If Hospital provides any tasks, deliverables, goods, services, or other work, other than as specified in this Agreement, the same shall be deemed to be a gratuitous effort on the part of the Hospital, and Hospital shall have no claim whatsoever against the County.

4.0 TERM OF AGREEMENT

- 4.1 The term of this Agreement shall be four (4) years six (6) months commencing January 1, 2013 through June 30, 2017 after execution by the Director or his designee, unless sooner terminated or extended, in whole or in part, as provided in this Agreement.
- 4.2 The County shall have the sole option to extend this Agreement term for up to two (2) additional one-year periods for a maximum total Agreement term of six (6) years six (6) months. Each such option and extension shall be exercised at the sole discretion of the Director or his designee as authorized by the Board of Supervisors and must be agreed to and executed in writing by both parties.
- 4.3 The County maintains databases that track/monitor Hospital performance history and compliance with Title 22, California Code of Regulations, Section 100168. Information entered into such databases may be used for a variety of purposes, including determining whether the County will exercise an agreement term extension option.

- 4.4 Notwithstanding any other provision of this Agreement, Director may suspend this Agreement immediately upon giving written notice to Hospital if Hospital's license to operate as a general acute care Hospital or its permit to operate basic or comprehensive emergency service is revoked or suspended. Any such action by the EMS Agency shall be subject to the review procedures for suspensions established in Paragraph 9.8, Due Process, herein below. If such a suspension order has been issued and remains in effect for a period of at least sixty (60) calendar days, Director may terminate this Agreement upon giving at least thirty (30) calendar days prior written notice thereof to Hospital.

5.0 AGREEMENT SUM

- 5.1 To provide ongoing financial support to County for data collection, monitoring, and evaluation of the ALS programs, all of which benefit Hospital in the provision of base hospital services, Hospital agrees to offset the portion of the cost outlined in Paragraph 6.20 of Exhibit A, Statement of Work.
- 5.2 Hospital shall not be entitled to payment or reimbursement for any tasks or services performed, nor for any incidental or administrative expenses whatsoever incurred in or incidental to performance hereunder, except as specified herein. Assumption or takeover of any of Hospital's duties, responsibilities, or obligations, or performance of same by any entity other than Hospital, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever, shall occur only with the County's express prior written approval.

6.0 ADMINISTRATION OF AGREEMENT - COUNTY

COUNTY ADMINISTRATION

The Director shall have the authority to administer this Agreement on behalf of the County. Director retains professional and administrative responsibility for the services rendered under this Agreement. A listing of all County Administration referenced in the following sub-paragraphs are designated in Exhibit E - County's Administration. The County shall notify Hospital in writing of any change in the names or addresses shown.

6.1 County's Project Director

Responsibilities of the County's Project Director include:

- ensuring that the objectives of this Agreement are met; and
- providing direction to Hospital in the areas relating to County policy, information requirements, and procedural requirements.

6.2 County's Project Manager

The responsibilities of the County's Project Manager include:

- meeting with Hospital's Project Manager on a regular basis; and
- inspecting any and all tasks, deliverables, goods, services, or other work provided by or on behalf of Hospital.

The County's Project Manager is not authorized to make any changes in any of the terms and conditions of this Agreement and is not authorized to further obligate County in any respect whatsoever.

6.3 County's Agreement Project Monitor

The County's Project Monitor is responsible for overseeing the day-to-day administration of this Agreement. The Project Monitor reports to the County's Project Manager.

7.0 ADMINISTRATION OF AGREEMENT - HOSPITAL

7.1 Hospital's Project Manager

7.1.1 The Hospital's Project Manager is designated in Exhibit F - Hospital's Administration. The Hospital shall notify the County in writing of any change in the name or address of the Hospital's Project Manager.

7.1.2 The Hospital's Project Manager shall be responsible for the Hospital's day-to-day activities as related to this Agreement and shall coordinate with County's Project Manager and County's Agreement Project Monitor on a regular basis.

7.2 Hospital's Authorized Official (s)

7.2.1 Hospital's Authorized Official(s) are designated in Exhibit F. Hospital shall promptly notify County in writing of any change in the name(s) or address(es) of Hospital's Authorized Official(s).

7.2.2 Hospital represents and warrants that all requirements of Hospital have been fulfilled to provide actual authority to such officials to execute documents under this Agreement on behalf of Hospital.

7.3 Intentionally Omitted

7.4 Hospital's Staff Identification

Hospital shall provide, at Hospital's expense, all staff providing services under this Agreement with a photo identification badge.

7.5 Background and Security Investigations

Mobile Intensive Care Nurses (MICN) performing services under this Agreement have undergone and passed a background investigation through the Board of Registered Nursing and Department of Justice as required by their license as Registered Nurses (RN).

7.6 Confidentiality

7.6.1 Hospital shall maintain the confidentiality of all records and information, including, but not limited to, billings, County records, and patient records, in accordance with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures relating to confidentiality, including, without limitation, County policies concerning information technology security and the protection of confidential records and information.

7.6.2 Hospital shall indemnify, defend, and hold harmless County, its Special Districts, elected and appointed officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, costs and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting, or professional fees, arising from, connected with, or related to any failure by Hospital, its officers, employees, agents, or subcontractors, to comply with this Paragraph 7.6, as determined by County in its sole judgment. Any legal defense pursuant to Hospital's indemnification obligations under this Paragraph 7.6 shall be conducted by Hospital and performed by counsel selected by Hospital and approved by County. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Hospital fails to provide County with a full and adequate defense, as determined by County in its sole judgment, County shall be entitled to retain its own counsel, including, without limitation,

County Counsel, and reimbursement from Hospital for all such costs and expenses incurred by County in doing so. Hospital shall not have the right to enter into any settlement, agree to any injunction, or make any admission, in each case, on behalf of County without County's prior written approval.

7.6.3 Hospital shall inform all of its officers, employees, agents and subcontractors providing services hereunder of the confidentiality provisions of this Agreement.

7.6.4 Hospital shall sign and adhere to the provisions of the "Contractor Acknowledgement and Confidentiality Agreement", Exhibit G1.

7.7 Staff Performance under the Influence

Hospital shall not knowingly permit any employee to perform services under this Agreement while under the influence of any alcoholic beverage, medication, narcotic, or other substance which might impair their physical or mental performance.

8.0 STANDARD TERMS AND CONDITIONS

8.1 AMENDMENTS

8.1.1 For any change which affects the scope of work, term, Agreement Sum, payments, or any term or condition included under this Agreement, an Amendment shall be prepared, mutually agreed to in writing, and executed by the Hospital and by Director.

8.1.2 The County's Board of Supervisors or Chief Executive Officer or designee may require the addition and/or change of certain terms and conditions in the Agreement during the term of this Agreement. The County reserves the right to add and/or change such provisions as required by the County's Board of Supervisors or Chief Executive Officer. To implement such changes, an Amendment to the Agreement shall be prepared and executed by the Hospital and by Director.

8.1.3 The Director, may at his/her sole discretion, authorize extensions of time as defined in Paragraph 4.0 - Term of Agreement. The Hospital agrees that such extensions of time shall not change any other term or condition of this Agreement during the period of such extensions. To implement an extension of time, an Amendment to the Agreement shall be prepared, mutually agreed to in writing, and executed by the Hospital and by Director.

8.2 ASSIGNMENT AND DELEGATION

- 8.2.1 The Hospital shall not assign its rights or delegate its duties under this Agreement, or both, whether in whole or in part, without timely written notice to and consent of County, in its discretion, and any attempted assignment or delegation without such consent shall be null and void. For purposes of this sub-paragraph, County consent shall require a written amendment to the Agreement, which is formally approved and executed by the parties. Any payments by the County to any approved delegate or assignee on any claim under this Agreement shall be deductible, at County's sole discretion, against the claims, which the Hospital may have against the County.
- 8.2.2 Shareholders, partners, members, or other equity holders of Hospital may transfer, sell, exchange, assign, or divest themselves of any interest they may have therein. However, in the event any such sale, transfer, exchange, assignment, or divestment is effected in such a way as to give majority control of Hospital to any person(s), corporation, partnership, or legal entity other than the majority controlling interest therein at the time of execution of the Agreement, such disposition is an assignment requiring the written consent of County in accordance with applicable provisions of this Agreement.
- 8.2.3 Any assumption, assignment, delegation, or takeover of any of the duties, responsibilities, obligations, or performance of same by any entity other than the Hospital, whether through assignment, subcontract, delegation, merger, buyout, or any other mechanism, with or without consideration for any reason whatsoever without timely written notice to the County, shall be a material breach of the Agreement which may result in the termination of this Agreement. In the event of such termination, County shall be entitled to pursue the same remedies against Hospital as it could pursue in the event of default by Hospital. If County does not consent to such assignment and delegation, County may terminate this Agreement with 30 days written notice to Hospital.

8.3 AUTHORIZATION WARRANTY

The Hospital represents and warrants that the person executing this Agreement for the Hospital is an authorized agent who has actual authority to bind the Hospital to each and every term, condition, and obligation of this Agreement and that all requirements of the Hospital have been fulfilled to provide such actual authority.

8.4 BUDGET REDUCTIONS

In the event that the County's Board of Supervisors adopts, in any fiscal year, a County Budget which provides for reductions in the salaries and benefits paid to the majority of County employees and imposes similar reductions with respect to County Contracts, the County reserves the right to reduce its payment obligation under this Agreement correspondingly for that fiscal year and any subsequent fiscal year during the term of this Agreement (including any extensions), and the services to be provided by the Hospital under this Agreement shall also be reduced correspondingly. The County's notice to the Hospital regarding said reduction in payment obligation shall be provided within thirty (30) calendar days of the Board's approval of such actions. Except as set forth in the preceding sentence, the Hospital shall continue to provide all of the services set forth in this Agreement unless it chooses to exercise its rights under Paragraph 8.42, Termination for Convenience.

8.5 COMPLAINTS

The Hospital shall develop, maintain and operate procedures to comply with Exhibit V, Prehospital Care Policy Reference No. 214, Base Hospital and Provider Agency Reporting Responsibilities.

8.6 COMPLIANCE WITH APPLICABLE LAW

8.6.1 In the performance of this Agreement, Hospital shall comply with all applicable Federal, State and local laws, rules, regulations, ordinances, directives, guidelines, policies and procedures. All provisions required thereby to be included in this Agreement are incorporated herein by reference.

8.6.2 Hospital and County shall indemnify, defend, and hold harmless each party, its officers, employees, and agents, from and against any and all claims, demands, damages, liabilities, losses, costs, and expenses, including, without limitation, defense costs and legal, accounting and other expert, consulting or professional fees, arising from, connected with, or related to any failure by Hospital, its officers, employees, agents, or subcontractors, to comply with any such laws, rules, regulations, ordinances, directives, guidelines, policies, or procedures. Any legal defense pursuant to Hospital's indemnification obligations under this Paragraph 8.6 shall be conducted by Hospital and performed by counsel selected by Hospital. Notwithstanding the preceding sentence, County shall have the right to participate in any such defense at its sole cost and expense, except that in the event Hospital fails to provide County

with a full and adequate defense. County shall be entitled to retain its own counsel, including, without limitation, County Counsel, and reimbursement from Hospital for all such costs and expenses incurred by County in doing so. Hospital shall not have the right to enter into any settlement, agree to any injunction or other equitable relief, or make any admission, in each case, on behalf of County without County's prior written approval.

8.7 COMPLIANCE WITH CIVIL RIGHTS LAWS – ANTI-DISCRIMINATION AND AFFIRMATIVE ACTION

- 8.7.1 The Hospital hereby assures that it will comply with Subchapter VI of the Civil Rights Act of 1964, 42 USC Sections 2000 (e) (1) through 2000 (e) (17), the Fair Employment & Housing Act, Government Code Section 12920-12922; and Affirmative Action in County Agreements, Chapter 4.32 of the Los Angeles County Code, to the end that no person shall, on the grounds of race, creed, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement or under any project, program, or activity supported by this Agreement.
- 8.7.2 Hospital certifies and agrees that all persons employed by it, its affiliates, subsidiaries, or holding companies are and shall be treated equally without regard to or because of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations.
- 8.7.3 Hospital shall ensure that applicants are employed, and that employees are treated during employment, without regard to race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, in compliance with all applicable Federal and State anti-discrimination laws and regulations. Such action shall include, but is not limited to: employment, upgrading, demotion, transfer, recruitment or recruitment advertising, layoff or termination, rates of pay or other forms of compensation, and selection for training, including apprenticeship.
- 8.7.4 Hospital certifies and agrees that it will deal with its subcontractors, bidders, or vendors without regard to or because of race, color,

religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation.

- 8.7.5 Hospital certifies and agrees that it, its affiliates, subsidiaries, or holding companies shall comply with all applicable Federal and State laws and regulations to the end that no person shall, on the grounds of race, color, religious creed, ancestry, national origin, sex, sexual orientation, age, physical or mental disability, medical condition, marital status, or political affiliation, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement or under any project, program, or activity supported by this Agreement.
- 8.7.6 Hospital shall allow County representatives access to the Hospital's employment records during regular business hours to verify compliance with the provisions of this sub-paragraph 8.7 when so requested by the County.
- 8.7.7 If the County finds that any provisions of this sub-paragraph 8.7 have been violated, such violation shall constitute a material breach of this Agreement upon which the County may terminate or suspend this Agreement. While the County reserves the right to determine independently that the anti-discrimination provisions of this Agreement have been violated, in addition, a determination by the California Fair Employment Practices Commission or the Federal Equal Employment Opportunity Commission that the Hospital has violated Federal or State anti-discrimination laws or regulations shall constitute a finding by the County that the Hospital has violated the anti-discrimination provisions of this Agreement.
- 8.7.8 The parties agree that in the event the Hospital violates any of the anti-discrimination provisions of this Agreement, the County shall, at its sole option, be entitled to the sum of Five Hundred Dollars (\$500) for each such violation pursuant to California Civil Code Section 1671 as liquidated damages in lieu of terminating or suspending this Agreement.

The parties agree that in the event the Hospital violates any of the anti-discrimination provisions of this Agreement, the County shall, at its sole option after considering any written evidence in mitigation or explanation of the violation presented by the Hospital, be entitled to the sum of Five Hundred Dollars (\$500) for each such violation or a maximum of One Thousand Five Hundred Dollars (\$1,500) for any continuing course of violations, pursuant to California Civil Code

Section 1671 as liquidated damages in lieu of terminating or suspending this Agreement.

8.8 Intentionally Omitted

8.9 CONFLICT OF INTEREST

8.9.1 No County employee whose position with the County enables such employee to influence the award of this Agreement or any competing Agreement shall participate in the negotiation of this Agreement. No County employee with a spouse or economic dependent employed in any capacity by Hospital herein shall participate in the negotiation of this Agreement, or have a direct or indirect interest in this Agreement. No officer or employee of the Hospital who may financially benefit from the performance of work hereunder shall in any way participate in the County's approval, or ongoing evaluation, of such work, or in any way attempt to unlawfully influence the County's approval or ongoing evaluation of such work.

8.9.2 The Hospital shall comply with all conflict of interest laws, ordinances, and regulations now in effect or hereafter to be enacted during the term of this Agreement. The Hospital warrants that it is not now aware of any facts that create a conflict of interest. If the Hospital hereafter becomes aware of any facts that might reasonably be expected to create a conflict of interest, it shall immediately make full written disclosure of such facts to the County. Full written disclosure shall include, but is not limited to, identification of all persons implicated and a complete description of all relevant circumstances. Failure to comply with the provisions of this sub-paragraph shall be a material breach of this Agreement.

8.10 CONSIDERATION OF HIRING COUNTY EMPLOYEES TARGETED FOR LAYOFF/OR RE-EMPLOYMENT LIST

Should the Hospital require additional or replacement personnel after the effective date of this Agreement to perform the services set forth herein, the Hospital shall give consideration for such employment openings to qualified, permanent County employees who are targeted for layoff or qualified, former County employees who are on a re-employment list during the life of this Agreement.

8.11 CONSIDERATION OF HIRING GAIN/GROW PROGRAM PARTICIPANTS

- 8.11.1 Should the Hospital require additional or replacement personnel after the effective date of this Agreement, the Hospital shall give consideration for any such employment openings to participants in the County's Department of Public Social Services Greater Avenues for Independence (GAIN) Program or General Relief Opportunity for Work (GROW) Program who meet the Hospital's minimum qualifications for the open position. If the Hospital decides to pursue consideration of GAIN/GROW participants for hiring, the Hospital shall provide information regarding job openings and job requirements to DPSS' GAIN/GROW staff at GAINGROW@dpss.lacounty.gov. The County will refer GAIN/GROW participants by job category to the Hospital.
- 8.11.2 In the event that both laid-off County employees and GAIN/GROW participants are available for hiring, referred County employees shall be given first priority.

8.12 CONTRACTOR RESPONSIBILITY AND DEBARMENT

8.12.1 Responsible Contractor

A responsible Contractor is a Contractor who has demonstrated the attribute of trustworthiness, as well as quality, fitness, capacity and experience to satisfactorily perform the agreement. It is the County's policy to conduct business only with responsible Contractors.

8.12.2 Chapter 2.202 of the County Code

The Hospital is hereby notified that, in accordance with Chapter 2.202 of the County Code, if the County acquires information concerning the performance of the Hospital on this or other contracts which indicates that the Hospital is not responsible, the County may, in addition to other remedies provided in the Agreement, debar the Hospital from bidding or proposing on, or being awarded, and/or performing work on County contracts for a specified period of time, which generally will not exceed five years but may exceed five years or be permanent if warranted by the circumstances, and terminate any or all existing Contracts the Hospital may have with the County.

8.12.3 Non-responsible Contractor

The County may debar a Contractor if the Board of Supervisors finds, in its discretion, that the Contractor has done any of the following: (1) violated a term of an agreement with the County or a nonprofit corporation created by the County, (2) committed an act or omission which negatively reflects on the Contractor's quality, fitness or capacity to perform an agreement with the County, any other public entity, or a nonprofit corporation created by the County, or engaged in a pattern or practice which negatively reflects on same, (3) committed an act or offense which indicates a lack of business integrity or business honesty, or (4) made or submitted a false claim against the County or any other public entity.

8.12.4 Contractor Hearing Board

1. If there is evidence that the Hospital may be subject to debarment, the EMS Agency will notify the Hospital in writing of the evidence which is the basis for the proposed debarment and will advise the Hospital of the scheduled date for a debarment hearing before the Contractor Hearing Board.
2. The Contractor Hearing Board will conduct a hearing where evidence on the proposed debarment is presented. The Hospital and/or the Hospital's representative shall be given an opportunity to submit evidence at that hearing. After the hearing, the Contractor Hearing Board shall prepare a tentative proposed decision, which shall contain a recommendation regarding whether the Hospital should be debarred, and, if so, the appropriate length of time of the debarment. The Hospital and the EMS Agency shall be provided an opportunity to object to the tentative proposed decision prior to its presentation to the Board of Supervisors.
3. After consideration of any objections, or if no objections are submitted, a record of the hearing, the proposed decision, and any other recommendation of the Contractor Hearing Board shall be presented to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

4. If a Hospital has been debarred for a period longer than five (5) years, that Hospital may after the debarment has been in effect for at least five (5) years, submit a written request for review of the debarment determination to reduce the period of debarment or terminate the debarment. The County may, in its discretion, reduce the period of debarment or terminate the debarment if it finds that the Hospital has adequately demonstrated one or more of the following: (1) elimination of the grounds for which the debarment was imposed; (2) a bona fide change in ownership or management; (3) material evidence discovered after debarment was imposed; or (4) any other reason that is in the best interests of the County.
5. The Contractor Hearing Board will consider a request for review of a debarment determination only where (1) the Hospital has been debarred for a period longer than five (5) years; (2) the debarment has been in effect for at least five (5) years; and (3) the request is in writing, states one or more of the grounds for reduction of the debarment period or termination of the debarment, and includes supporting documentation. Upon receiving an appropriate request, the Contractor Hearing Board will provide notice of the hearing on the request. At the hearing, the Contractor Hearing Board shall conduct a hearing where evidence on the proposed reduction of debarment period or termination of debarment is presented. This hearing shall be conducted and the request for review decided by the Contractor Hearing Board pursuant to the same procedures as for a debarment hearing.
6. The Contractor Hearing Board's proposed decision shall contain a recommendation on the request to reduce the period of debarment or terminate the debarment. The Contractor Hearing Board shall present its proposed decision and recommendation to the Board of Supervisors. The Board of Supervisors shall have the right to modify, deny, or adopt the proposed decision and recommendation of the Contractor Hearing Board.

8.12.5 Subcontractors of Hospital

These terms shall also apply to Subcontractors of County Hospitals.

8.13 HOSPITAL'S ACKNOWLEDGEMENT OF COUNTY'S COMMITMENT TO THE SAFELY SURRENDERED BABY LAW

The Hospital acknowledges that the County places a high priority on the implementation of the Safely Surrendered Baby Law. The Hospital understands that it is the County's policy to encourage all County Contractors to voluntarily post the County's "Safely Surrendered Baby Law" poster in a prominent position at the Hospital's place of business. The Hospital will also encourage its Subcontractors, if any, to post this poster in a prominent position in the Subcontractor's place of business. The County's Department of Children and Family Services will supply the Hospital with the poster to be used. Information on how to receive the poster can be found on the Internet at www.babysafela.org.

8.14 HOSPITAL'S WARRANTY OF ADHERENCE TO COUNTY'S CHILD SUPPORT COMPLIANCE PROGRAM

8.14.1 The Hospital acknowledges that the County has established a goal of ensuring that all individuals who benefit financially from the County through Agreement are in compliance with their court-ordered child, family and spousal support obligations in order to mitigate the economic burden otherwise imposed upon the County and its taxpayers.

8.14.2 As required by the County's Child Support Compliance Program (County Code Chapter 2.200) and without limiting the Hospital's duty under this Agreement to comply with all applicable provisions of law, the Hospital warrants that it is now in compliance and shall during the term of this Agreement maintain in compliance with employment and wage reporting requirements as required by the Federal Social Security Act (42 USC Section 653a) and California Unemployment Insurance Code Section 1088.5, and shall implement all lawfully served Wage and Earnings Withholding Orders or Child Support Services Department Notices of Wage and Earnings Assignment for Child, Family or Spousal Support, pursuant to Code of Civil Procedure Section 706.031 and Family Code Section 5246(b).

8.15 COUNTY'S QUALITY ASSURANCE PLAN

8.15.1 The County or its agent will evaluate the Hospital's performance under this Agreement on not less than a three year basis. Such

evaluation will include assessing the Hospital's compliance with all Agreement terms and conditions and performance standards identified in the Statement of Work. Hospital deficiencies which the County determines are severe or continuing and that may place performance of the Agreement in jeopardy if not corrected will be reported to the Board of Supervisors.

8.15.2 The report will include improvement/corrective action measures taken by the County and the Hospital. If improvement does not occur consistent with the corrective action measures, the County may terminate this Agreement or in accordance with Paragraph 8.43

8.16 Intentionally Omitted

8.17 EMPLOYMENT ELIGIBILITY VERIFICATION

8.17.1 The Hospital warrants that it fully complies with all Federal and State statutes and regulations regarding the employment of aliens and others and that all its employees performing work under this Agreement meet the citizenship or alien status requirements set forth in Federal and State statutes and regulations. The Hospital shall retain all such documentation for all covered employees for the period prescribed by law.

8.17.2 The Hospital shall indemnify, defend, and hold harmless, the County, its agents, officers, and employees from employer sanctions and any other liability which may be assessed against the Hospital or the County or both in connection with any alleged violation of any Federal or State statutes or regulations pertaining to the eligibility for employment of any persons performing work under this Agreement.

8.18 FACSIMILE, SCANNED REPRESENTATIONS

The County and the Hospital hereby agree to regard facsimile and or scanned (sent via electronic mail) representations of original signatures of authorized officers of each party, when appearing in appropriate places on the Amendments prepared pursuant to sub-paragraph 8.1, and received via communications facilities, as legally sufficient evidence that such original signatures have been affixed to Amendments to this Agreement, such that the parties need not follow up facsimile or scanned transmissions of such documents with subsequent (non-facsimile or non-scanned) transmission of "original" versions of such documents.

8.19 FAIR LABOR STANDARDS

The Hospital shall comply with all applicable provisions of the Federal Fair Labor Standards Act and shall indemnify, defend, and hold harmless the County and its agents, officers, and employees from any and all liability, including, but not limited to, wages, overtime pay, liquidated damages, penalties, court costs, and attorneys' fees arising under any wage and hour law, including, but not limited to, the Federal Fair Labor Standards Act, for work performed by the Hospital's employees for which the County may be found jointly or solely liable.

8.20 FORCE MAJEURE

8.20.1 Neither party shall be liable for such party's failure to perform its obligations under and in accordance with this Agreement, if such failure arises out of fires, floods, epidemics, quarantine restrictions, other natural occurrences, strikes, lockouts (other than a lockout by such party or any of such party's subcontractors), freight embargoes, or other similar events to those described above, but in every such case the failure to perform must be totally beyond the control and without any fault or negligence of such party (such events are referred to in this sub-paragraph as "force majeure events").

8.20.2 Notwithstanding the foregoing, a default by a subcontractor of Hospital shall not constitute a force majeure event, unless such default arises out of causes beyond the control of both Hospital and such subcontractor, and without any fault or negligence of either of them. In such case, Hospital shall not be liable for failure to perform, unless the goods or services to be furnished by the subcontractor were obtainable from other sources in sufficient time to permit Hospital to meet the required performance schedule. As used in this sub-paragraph, the term "subcontractor" and "subcontractors" mean subcontractors at any tier.

8.20.3 In the event Hospital's failure to perform arises out of a force majeure event, Hospital agrees to use commercially reasonable best efforts to obtain goods or services from other sources, if applicable, and to otherwise mitigate the damages and reduce the delay caused by such force majeure event.

8.21 GOVERNING LAW, JURISDICTION, AND VENUE

This Agreement shall be governed by, and construed in accordance with, the laws of the State of California. The Hospital agrees and consents to the

exclusive jurisdiction of the courts of the State of California for all purposes regarding this Agreement and further agrees and consents that venue of any action brought hereunder shall be exclusively in the County of Los Angeles.

8.22 INDEPENDENT CONTRACTOR STATUS

8.22.1 This Agreement is by and between the County and the Hospital and is not intended, and shall not be construed, to create the relationship of agent, servant, employee, partnership, joint venture, or association, as between the County and the Hospital. The employees and agents of one party shall not be, or be construed to be, the employees or agents of the other party for any purpose whatsoever.

8.22.2 The Hospital shall be solely liable and responsible for providing to, or on behalf of, all persons performing work pursuant to this Agreement all compensation and benefits. The County shall have no liability or responsibility for the payment of any salaries, wages, unemployment benefits, disability benefits, Federal, State, or local taxes, or other compensation, benefits, or taxes for any personnel provided by or on behalf of the Hospital.

8.22.3 The Hospital understands and agrees that all persons performing work pursuant to this Agreement are, for purposes of Workers' Compensation liability, solely employees of the Hospital and not employees of the County. The Hospital shall be solely liable and responsible for furnishing any and all Workers' Compensation benefits to any person as a result of any injuries arising from or connected with any work performed by or on behalf of the Hospital pursuant to this Agreement.

8.23 INDEMNIFICATION

The Hospital shall indemnify, defend and hold harmless the County, its Special Districts, elected and appointed officers, employees, and agents from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected with the Hospital's acts and/or omissions arising from and/or relating to this Agreement.

The County shall indemnify, defend and hold harmless Hospital, and its agents and employees from and against any and all liability, including but not limited to demands, claims, actions, fees, costs, and expenses (including attorney and expert witness fees), arising from or connected

with the County's acts and/or omissions arising from and/or relating to this Agreement.

8.24 GENERAL PROVISIONS FOR ALL INSURANCE COVERAGE

Without limiting Hospital's indemnification of County, and in the performance of this Agreement and until all of its obligations pursuant to this Agreement have been met, Hospital shall provide and maintain at its own expense insurance coverage satisfying the requirements specified in Sections 8.24 and 8.25 of this Agreement. These minimum insurance coverage terms, types and limits (the "Required Insurance") also are in addition to and separate from any other contractual obligation imposed upon Hospital pursuant to this Agreement. The County in no way warrants that the Required Insurance is sufficient to protect the Hospital for liabilities which may arise from or relate to this Agreement.

8.24.1 Evidence of Coverage and Notice to County

- Certificate(s) of insurance coverage (Certificate) or other evidence of coverage satisfactory to County, and a copy of an Additional Insured endorsement confirming County and its Agents (defined below) has been given Insured status under the Hospital's General Liability policy, shall be delivered to County at the address shown below and provided prior to commencing services under this Agreement.
- Renewal Certificates shall be provided to County prior to Hospital's policy expiration dates. The County reserves the right to obtain complete, certified copies of any required Hospital and/or Sub-Contractor insurance policies at any time.
- Certificates shall identify all Required Insurance coverage types and limits specified herein, reference this Agreement by name or number, and be signed by an authorized representative of the insurer(s). The Insured party named on the Certificate shall match the name of the Hospital identified as the contracting party in this Agreement. Certificates shall provide the full name of each insurer providing coverage, its NAIC (National Association of Insurance Commissioners) identification number if applicable, its financial rating, the amounts of any policy deductibles or self-insured retentions exceeding fifty thousand (\$50,000.00) dollars, and list any County required endorsement forms.
- Neither the County's failure to obtain, nor the County's receipt of, or failure to object to a non-complying insurance certificate

or endorsement, or any other insurance documentation or information provided by the Hospital, its insurance broker(s) and/or insurer(s), shall be construed as a waiver of any of the Required Insurance provisions.

Certificates and copies of any required endorsements shall be sent to:

County of Los Angeles
Department of Health Services
Contracts and Grants Division
313 N. Figueroa Street, 6E
Los Angeles, CA 90012
Attention: Kathy K. Hanks, C.P.M.
Director, Contracts and Grants

And

County of Los Angeles
Department of Health Services
Centralized Contract Monitoring Division
5555 Ferguson Drive, Suite 210
Commerce, CA 90022

And

County of Los Angeles-DHS
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attention: Administrative Services

Hospital also shall promptly report to County any injury or property damage accident or incident, including any injury to a Hospital employee occurring on County property, and any loss, disappearance, destruction, misuse, or theft of County property, monies or securities entrusted to Hospital. Hospital also shall promptly notify County of any third party claim or suit filed against Hospital or any of its Sub-Contractors which arises from or relates to this Agreement, and could result in the filing of a claim or lawsuit against Hospital and/or County.

8.24.2 Additional Insured Status and Scope of Coverage

The County of Los Angeles, its Special Districts, Elected Officials, Officers, Agents, Employees and Volunteers (collectively County and its Agents) shall be provided additional insured status under Hospital's General Liability policy with respect to liability arising out of Hospital's ongoing and completed operations performed on behalf of the County. Use of a blanket additional insured endorsement form is acceptable providing it satisfies the Required Insurance provisions herein.

8.24.3 Cancellation of or Changes in Insurance

Hospital shall provide County with, or Hospital's insurance policies shall contain a provision that County shall receive, written notice of cancellation or any change in Required Insurance, including insurer, limits of coverage, term of coverage or policy period. The written notice shall be provided to County at least ten (10) days in advance of cancellation for non-payment of premium and thirty (30) days in advance for any other cancellation or policy change. Failure to provide written notice of cancellation or any change in Required Insurance may constitute a material breach of the Agreement, in the sole discretion of the County, upon which the County may suspend or terminate this Agreement.

8.24.4 Failure to Maintain Insurance

Hospital's failure to maintain or to provide acceptable evidence that it maintains the Required Insurance shall constitute a material breach of the Agreement, upon which County immediately may withhold payments due to Hospital, and/or suspend or terminate this Agreement.

8.24.5 Insurer Financial Ratings

Coverage shall be placed with insurers acceptable to the County with A.M. Best ratings of not less than A:VII unless otherwise approved by County.

8.24.6 Hospital's Insurance Shall Be Primary

Hospital's insurance policies, with respect to any claims related to this Agreement, shall be primary with respect to all other sources of coverage available to Hospital. Any County maintained insurance or self-insurance coverage shall be in excess of and not contribute to any Hospital coverage.

8.24.7 Waivers of Subrogation

To the fullest extent permitted by law, the Hospital hereby waives its rights and its insurer(s)' rights of recovery against County under all the Required Insurance for any loss arising from or relating to this Agreement. The Hospital shall require its insurers to execute any waiver of subrogation endorsements which may be necessary to effect such waiver.

8.24.8 Sub-Contractor Insurance Coverage Requirements

INTENTIONALLY OMITTED

8.24.9 Deductibles and Self-Insured Retentions (SIRs)

Hospital's policies shall not obligate the County to pay any portion of any Hospital deductible or SIR. The Hospital agrees to carry at all times insurance of the kinds and in the amounts listed below with a deductible or self-insured retention that does not exceed \$50,000, provided it is commercially available, and provide notice to the County if any deductibles or self-insured retentions (SIR) with respect to the insurance coverages described below exceed \$50,000. Hospital's policies shall not obligate the County to pay any portion of any Hospital deductible or SIR.

8.24.10 Claims Made Coverage

If any part of the Required Insurance is written on a claims made basis, any policy retroactive date shall precede the effective date of this Agreement. Hospital understands and agrees it shall maintain such coverage for a period of not less than three (3) years following Agreement expiration, termination or cancellation.

8.24.11 Application of Excess Liability Coverage

Hospitals may use a combination of primary, and excess insurance policies which provide coverage as broad as the underlying primary policies, to satisfy the Required Insurance provisions.

8.24.12 Separation of Insureds

With the exception of D&O liability insurance coverage, all liability policies shall provide cross-liability coverage as would be afforded by the standard ISO (Insurance Services Office, Inc.) separation

of insureds provision with no insured versus insured exclusions or limitations.

8.24.13 Alternative Risk Financing Programs

The County reserves the right to review, and then approve, Hospital use of self-insurance, risk retention groups, risk purchasing groups, pooling arrangements and captive insurance to satisfy the Required Insurance provisions. The County and its Agents shall be designated as an Additional Covered Party under any approved program.

8.24.14 County Review and Approval of Insurance Requirements

The County reserves the right to review and adjust the Required Insurance provisions, conditioned upon County's determination of changes in risk exposures. Before adjusting any of the Required Insurance provision, the County must consult with the Hospital. If the Required Insurance provisions are increased, the Hospital may immediately terminate this Agreement.

8.25 INSURANCE COVERAGE

8.25.1 **Commercial General Liability** insurance (providing scope of coverage equivalent to ISO policy form CG 00 01), naming County and its Agents as an additional insured, with limits of not less than:

General Aggregate:	\$2 million
Products/Completed Operations Aggregate:	\$1 million
Personal and Advertising Injury:	\$1 million
Each Occurrence:	\$1 million

8.25.2 **Automobile Liability** insurance (providing scope of coverage equivalent to ISO policy form CA 00 01) with limits of not less than \$1 million for bodily injury and property damage, in combined or equivalent split limits, for each single accident. Insurance shall cover liability arising out of Hospital's use of autos pursuant to this Agreement, including owned, leased, hired, and/or non-owned autos, as each may be applicable.

8.25.3 **Workers Compensation and Employers' Liability** insurance or qualified self-insurance satisfying statutory requirements, which includes Employers' Liability coverage with limits of not less than \$1

million per accident. If Hospital will provide leased employees, or, is an employee leasing or temporary staffing firm or a professional employer organization (PEO), coverage also shall include an Alternate Employer Endorsement (providing scope of coverage equivalent to ISO policy form WC 00 03 01 A) naming the County as the Alternate Employer, and the endorsement form shall be modified to provide that County will receive not less than thirty (30) days advance written notice of cancellation of this coverage provision. If applicable to Hospital's operations, coverage also shall be arranged to satisfy the requirements of any federal workers or workmen's compensation law or any federal occupational disease law.

8.25.4 Unique Insurance Coverage

- **Intentionally Omitted**
- **Professional Liability/Errors and Omissions**

Insurance covering Hospital's liability arising from or related to this Agreement, with limits of not less than \$1 million per claim and \$3 million aggregate. Further, Hospital understands and agrees it shall maintain such coverage for a period of not less than three (3) years following this Agreement's expiration, termination or cancellation.

- **Intentionally Omitted**
- **Intentionally Omitted**

8.26 LIQUIDATED DAMAGES

8.26.1 If the Director, or his/her designee, determines that there are deficiencies in the performance of this Agreement that the Director, or his/her designee, deems are correctable by the Hospital over a certain time span, the Director, or his/her designee, will provide a written notice to the Hospital to correct the deficiency within specified time frames. Should the Hospital fail to correct deficiencies within said time frame, the Director, or his/her designee, may impose penalties outlined in Exhibit 3, Statement of Work Exhibits.

8.26.2 This sub-paragraph shall not, in any manner, restrict or limit the County's right to damages for any breach of this Agreement provided by law or as specified in the Procedure for Non-Compliance with Data Collection Requirements or sub-paragraph

8.26.1, and shall not, in any manner, restrict or limit the County's right to terminate this Agreement as agreed to herein.

8.27 Intentionally Omitted

8.28 Intentionally Omitted

a. 8.29 Intentionally Omitted

8.30 Intentionally Omitted

8.31 Intentionally Omitted

8.32 NOTICE TO EMPLOYEES REGARDING THE FEDERAL EARNED INCOME CREDIT

The Hospital shall notify its employees, and shall require each Subcontractor to notify its employees, that they may be eligible for the Federal Earned Income Credit under the federal income tax laws. Such notice shall be provided in accordance with the requirements set forth in Internal Revenue Service Notice No. 1015.

8.33 NOTICE TO EMPLOYEES REGARDING THE SAFELY SURRENDERED BABY LAW

The Hospital shall notify and provide to its employees, and shall require each Subcontractor to notify and provide to its employees, a fact sheet regarding the Safely Surrendered Baby Law, its implementation in Los Angeles County, and where and how to safely surrender a baby. The fact sheet is set forth in Exhibit I of this Agreement and is also available on the Internet at www.babysafela.org for printing purposes.

8.34 NOTICES

8.34.1 All notices or demands required or permitted to be given or made under this Agreement shall be in writing and shall be hand delivered with signed receipt or mailed by first-class registered or certified mail, postage prepaid, addressed to the parties as identified in Exhibits E - County's Administration and F - Hospital's Administration. Addresses may be changed by either party giving ten (10) days' prior written notice thereof to the other party. The Director or his /her designee shall have the authority to issue all notices or demands required or permitted by the County under this Agreement.

8.34.2 **Electronic Notice:** In addition, and in lieu of written notification, the Director, or his/her designee, shall have the authority to issue any

notice to Hospital electronically via e-mail at the designated email address as identified in Exhibit F – Hospital’s Administration. This includes all notices or demands required or permitted by the County under this Agreement.

8.35 PROHIBITION AGAINST INDUCEMENT OR PERSUASION

Notwithstanding the above, the Hospital and the County agree that, during the term of this Agreement and for a period of one year thereafter, neither party shall in any way intentionally induce or persuade any employee of one party to become an employee or agent of the other party. No bar exists against any hiring action initiated through a public announcement.

8.36 Intentionally Omitted

8.37 PUBLICITY

8.37.1 The Hospital shall not disclose any details in connection with this Agreement to any person or entity except as may be otherwise provided hereunder or required by law. However, in recognizing the Hospital’s need to identify its services and related clients to sustain itself, the County shall not inhibit the Hospital from publishing its role under this Agreement within the following conditions:

- The Hospital shall develop all publicity material in a professional manner; and
- During the term of this Agreement, the Hospital shall not, and shall not authorize another to, publish or disseminate any commercial advertisements, press releases, feature articles, or other materials using the name of the County without the prior written consent of the County’s Project Director. The County shall not unreasonably withhold written consent.

8.37.2 The Hospital may, without the prior written consent of County, indicate in its proposals and sales materials and signs that it has been awarded this Agreement with the County of Los Angeles.

8.38 RECORD RETENTION AND INSPECTION/AUDIT SETTLEMENT

Hospital shall submit copies of all records, audio recordings, and logs pertaining to prehospital care of patients and personnel involved in the prehospital care system at the request of representatives of the EMS Agency. Records obtained from Hospital may be used for, but are not

limited to, audit, investigation, statistical analysis or education. Representatives of the EMS Agency shall comply with all applicable State and federal laws relating to confidentiality and shall maintain the confidentiality of all records, audio recordings and logs submitted in compliance with this subparagraph.

Hospital shall retain the receiving Hospital copy of the EMS Report Form for a minimum of seven (7) years and include such reports with patient charts for patients brought to Hospital as part of the EMS system. Such records, if for a minor, shall be retained for a minimum of seven (7) years, or one (1) year past the age of majority, whichever is greater.

Hospital shall retain all records related to suspected or pending litigation in any way related to this Agreement until completion and resolution of all issues arising therefrom.

The Hospital shall maintain and provide upon request by County accurate and complete financial records of its activities and operations relating to this Agreement in accordance with generally accepted accounting principles. The Hospital shall also maintain accurate and complete employment and other records relating to its performance of this Agreement. The Hospital agrees that the County, or its authorized representatives, shall have access to and the right to examine, audit, excerpt, copy, or transcribe any pertinent transaction, activity, or record relating to this Agreement. All such material, including, but not limited to, all financial records, bank statements, cancelled checks or other proof of payment, timecards, sign-in/sign-out sheets and other time and employment records, and proprietary data and information, shall be kept and maintained by the Hospital and shall be made available to the County during the term of this Agreement and for a period of five (5) years thereafter unless the County's written permission is given to dispose of any such material prior to such time. All such material shall be maintained by the Hospital at a location in Los Angeles County, provided that if any such material is located outside Los Angeles County, then, at the County's option, the Hospital shall pay the County for travel, per diem, and other costs incurred by the County to examine, audit, excerpt, copy, or transcribe such material at such other location.

8.38.1 In the event that an audit of the Hospital is conducted specifically regarding this Agreement by any Federal or State auditor, then the Hospital shall file a copy of such audit report, with the County's Auditor-Controller within thirty (30) days of the Hospital's receipt thereof, unless otherwise provided by applicable Federal or State law or under this Agreement. Subject to applicable law, the County shall make a reasonable effort to maintain the confidentiality of such audit report(s).

8.38.2 Failure on the part of the Hospital to comply with any of the provisions of this sub-paragraph 8.38 shall constitute a material breach of this Agreement upon which the County may terminate or suspend this Agreement.

8.39 RECYCLED BOND PAPER

Consistent with the Board of Supervisors' policy to reduce the amount of solid waste deposited at the County landfills, the Hospital agrees to use recycled-content paper to the maximum extent possible on this Agreement.

8.40 SUBCONTRACTING

8.40.1 The requirements of this Agreement may not be subcontracted by the Hospital without the advance approval of the County. Any attempt by the Hospital to subcontract without the prior consent of the County may be deemed a material breach of this Agreement.

8.40.2 If the Hospital desires to subcontract, the Hospital shall provide the following information promptly at the County's request:

- A description of the work to be performed by the Subcontractor;
- A draft copy of the proposed subcontract; and
- Other pertinent information and/or certifications requested by the County.

8.40.3 The Hospital shall remain fully responsible for all performances required of it under this Agreement, including those that the Hospital has determined to subcontract, notwithstanding the County's approval of the Hospital's proposed subcontract.

8.40.4 The County's consent to subcontract shall not waive the County's right to prior and continuing approval of any and all personnel, including Subcontractor employees, providing services under this Agreement. The Hospital is responsible to notify its Subcontractors of this County right.

8.40.5 The County's Project Director is authorized to act for and on behalf of the County with respect to approval of any subcontract and Subcontractor employees. After approval of the subcontract by the County, Hospital shall forward a fully executed subcontract to the County for their files.

- 8.40.6 The Hospital shall be solely liable and responsible for all payments or other compensation to all Subcontractors and their officers, employees, agents, and successors in interest arising through services performed hereunder, notwithstanding the County's consent to subcontract.
- 8.40.7 The Hospital shall obtain certificates of insurance, which establish that the Subcontractor maintains all the programs of insurance required by the County from each approved Subcontractor. The Hospital shall ensure delivery of all such documents to:

County of Los Angeles
Department of Health Services
Contracts and Grants Division
313 N. Figueroa Street, 6E
Los Angeles, CA 90012
Attention: Kathy K. Hanks, C.P.M.
Director, Contracts and Grants

And

County of Los Angeles-DHS
Emergency Medical Services Agency
10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Attention: Administrative Services

before any subcontractor employee may perform any work hereunder.

**8.41 TERMINATION FOR BREACH OF WARRANTY TO
MAINTAIN COMPLIANCE WITH COUNTY'S CHILD SUPPORT
COMPLIANCE PROGRAM**

Failure of the Hospital to maintain compliance with the requirements set forth in sub-paragraph 8.14 - Hospital's Warranty of Adherence to County's Child Support Compliance Program, shall constitute default under this Agreement. Without limiting the rights and remedies available to the County under any other provision of this Agreement, failure of the Hospital to cure such default within ninety (90) calendar days of written notice shall be grounds upon which the County may terminate this Agreement pursuant to sub-paragraph 8.43 - Termination for Default and pursue debarment of the Hospital, pursuant to County Code Chapter 2.202.

8.42 TERMINATION FOR CONVENIENCE

The EMS Agency may elect to restructure the prehospital care system as it deems necessary in accordance with paragraph 6.4 and 6.5 of Exhibit A, Statement of Work

8.43 TERMINATION FOR DEFAULT

8.43.1 The County may, by written notice to the Hospital, terminate the whole or any part of this Agreement, if, in the judgment of County's Project Director:

- Hospital has materially breached this Agreement; or
- Hospital fails to timely provide and/or satisfactorily perform any task, deliverable, service, or other work required either under this Agreement; or
- Hospital fails to demonstrate a high probability of timely fulfillment of performance requirements under this Agreement, or of any obligations of this Agreement and in either case, fails to demonstrate convincing progress toward a cure within five (5) working days (or such longer period as the County may authorize in writing) after receipt of written notice from the County specifying such failure.
- Hospital expressly repudiates this Agreement by an unequivocal refusal to perform
- In the event the County intends to terminate this Agreement in accordance with Paragraph 8.43, it shall give thirty (30) days' notice to the Hospital that it is in material breach and/or anticipatory breach of the Agreement. In the notice of intended termination, the Director shall set forth the facts underlying its claim that the Hospital is in material breach and/or anticipatory breach. Remedy of the breach or convincing progress towards a cure within twenty (20) days (or such longer period as the County may authorize in writing) of receipt of said notice shall revive the Agreement in effect for the remaining term.

8.43.2 In the event that the County terminates this Agreement in whole or in part as provided in sub-paragraph 8.43.1, the County may procure, upon such terms and in such manner as the County may deem appropriate, goods and services similar to those so

terminated. The Hospital shall be liable to the County for any and all excess costs incurred by the County, as determined by the County, for such similar goods and services. The Hospital shall continue the performance of this Agreement to the extent not terminated under the provisions of this sub-paragraph. The parties agree that this particular damage provision (i.e., that the costs incurred by the County) shall be limited to a time period of twelve (12) months or the remaining period this Agreement after breach or whichever time period is less.

8.43.3 Except with respect to defaults of any Subcontractor, the Hospital shall not be liable for any such excess costs of the type identified in sub-paragraph 8.43.2 if its failure to perform this Agreement arises out of causes beyond the control and without the fault or negligence of the Hospital. Such causes may include, but are not limited to: acts of God or of the public enemy, acts of the County in either its sovereign or contractual capacity, acts of Federal or State governments in their sovereign capacities, fires, floods, epidemics, quarantine restrictions, strikes, freight embargoes, and unusually severe weather; but in every case, the failure to perform must be beyond the control and without the fault or negligence of the Hospital. If the failure to perform is caused by the default of a Subcontractor, and if such default arises out of causes beyond the control of both the Hospital and Subcontractor, and without the fault or negligence of either of them, the Hospital shall not be liable for any such excess costs for failure to perform, unless the goods or services to be furnished by the Subcontractor were obtainable from other sources in sufficient time to permit the Hospital to meet the required performance schedule. As used in this sub-paragraph, the term "Subcontractor(s)" means Subcontractor(s) at any tier.

8.43.2 The rights and remedies of the County provided in this sub-paragraph 8.43 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

8.44 TERMINATION FOR IMPROPER CONSIDERATION

8.44.1 The County may, by written notice to the Hospital, immediately terminate the right of the Hospital to proceed under this Agreement if it is found that consideration, in any form, was offered or given by the Hospital, either directly or through an intermediary, to any County officer, employee, or agent with the intent of securing this Agreement or securing favorable treatment with respect to the award, amendment, or extension of this Agreement or the making

of any determinations with respect to the Hospital's performance pursuant to this Agreement. In the event of such termination, the County shall be entitled to pursue the same remedies against the Hospital as it could pursue in the event of default by the Hospital.

8.44.2 The Hospital shall immediately report any attempt by a County officer or employee to solicit such improper consideration. The report shall be made either to the County manager charged with the supervision of the employee or to the County Auditor-Controller's Employee Fraud Hotline at (800) 544-6861.

8.44.3 Among other items, such improper consideration may take the form of cash, discounts, service, the provision of travel or entertainment, or tangible gifts.

8.45 TERMINATION FOR INSOLVENCY

8.45.1 The County may terminate this Agreement forthwith in the event of the occurrence of any of the following:

- The filing of a voluntary or involuntary petition regarding the Hospital under the Federal Bankruptcy Code;
- The appointment of a Receiver or Trustee for the Hospital; or
- The execution by the Hospital of a general assignment for the benefit of creditors.

8.45.2 The rights and remedies of the County provided in this subparagraph 8.45 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

8.46 TERMINATION FOR NON-ADHERENCE OF COUNTY LOBBYIST ORDINANCE

The Hospital, and each County Lobbyist or County Lobbying firm as defined in County Code Section 2.160.010 retained by the Hospital, shall fully comply with the County's Lobbyist Ordinance, County Code Chapter 2.160. Failure on the part of the Hospital or any County Lobbyist or County Lobbying firm retained by the Hospital to fully comply with the County's Lobbyist Ordinance shall constitute a material breach of this Agreement, upon which the County may in its sole discretion, immediately terminate or suspend this Agreement.

8.47 Intentionally Omitted

8.48 SEVERABILITY

If any provision of this Agreement or the application thereof to any person or circumstance is held invalid, the remainder of this Agreement and the application of such provision to other persons or circumstances shall not be affected thereby.

8.49 WAIVER

No waiver by the County of any breach of any provision of this Agreement shall constitute a waiver of any other breach or of such provision. Failure of the County to enforce at any time, or from time to time, any provision of this Agreement shall not be construed as a waiver thereof. The rights and remedies set forth in this sub-paragraph 8.49 shall not be exclusive and are in addition to any other rights and remedies provided by law or under this Agreement.

8.50 WARRANTY AGAINST CONTINGENT FEES

8.50.1 The Hospital warrants that no person or selling agency has been employed or retained to solicit or secure this Agreement upon any Agreement or understanding for a commission, percentage, brokerage, or contingent fee, excepting bona fide employees or bona fide established commercial or selling agencies maintained by the Hospital for the purpose of securing business.

8.50.2 For breach of this warranty, the County shall have the right to terminate this Agreement and, at its sole discretion, deduct from the Agreement price or consideration, or otherwise recover, the full amount of such commission, percentage, brokerage, or contingent fee.

8.51 WARRANTY OF COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

Hospital acknowledges that County has established a goal of ensuring that all individuals and businesses that benefit financially from County through agreement are current in paying their property tax obligations (secured and unsecured roll) in order to mitigate the economic burden otherwise imposed upon County and its taxpayers.

Unless Hospital qualifies for an exemption or exclusion, Hospital warrants and certifies that to the best of its knowledge it is now in compliance, and

during the term of this agreement will maintain compliance, with Los Angeles County Code Chapter 2.206.

8.52 TERMINATION FOR BREACH OF WARRANTY TO MAINTAIN COMPLIANCE WITH COUNTY'S DEFAULTED PROPERTY TAX REDUCTION PROGRAM

Failure of Hospital to maintain compliance with the requirements set forth in Paragraph 8.51 "Warranty of Compliance with County's Defaulted Property Tax Reduction Program" shall constitute default under this agreement. Without limiting the rights and remedies available to County under any other provision of this agreement, failure of Hospital to cure such default within 10 days of notice shall be grounds upon which County may terminate this agreement and/or pursue debarment of Hospital, pursuant to County Code Chapter 2.206.

9.0 UNIQUE TERMS AND CONDITIONS

9.1 Intentionally Omitted

9.2 HOSPITAL'S OBLIGATIONS AS A "COVERED ENTITY" UNDER HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA) AND THE HEALTH INFORMATION TECHNOLOGY FOR ECONOMIC AND CLINICAL HEALTH ACT (HITECH)

9.2.1 The parties acknowledge the existence of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH) and their implementing regulations. Hospital understands and agrees that, as a provider of medical services, it is a "covered entity" under HIPAA/HITECH and, as such, has obligations with respect to the confidentiality, privacy, and security of patients' medical information, and must take certain steps to preserve the confidentiality of this information, both internally and externally, including the training of its staff and the establishment of proper procedures for the release of such information, including the use of appropriate consents and authorizations specified under HIPAA/HITECH.

9.2.2 The parties acknowledge their separate and independent obligations with respect to HIPAA/HITECH, and that such obligations relate to transactions and code sets, privacy, and security. Hospital understands and agrees that it is separately and independently responsible for compliance with HIPAA/HITECH in all these areas and that County has not

undertaken any responsibility for compliance on Hospital's behalf. Hospital has not relied, and will not in any way rely, on County for legal advice or other representations with respect to Hospital's obligations under HIPAA/HITECH, but will independently seek its own counsel and take necessary measures to comply with the law and its implementing regulations.

- 9.2.3 Hospital and County understand and agree that each is independently responsible for HIPAA/HITECH compliance and agree to take all necessary and reasonable actions to comply with the requirements of the HIPAA/HITECH laws and implementing regulations related to transactions and code sets, privacy, and security.
- 9.2.4 Each party further agrees that, should it fail to comply with its obligations under HIPAA/HITECH, it shall indemnify and hold harmless the other party (including the other party's officers, employees, and agents), for damages to the other party that are attributable to such failure.

9.3 DUE PROCESS

- 9.3.1 Notice of Proposed Adverse Action: In all cases in which the EMS Agency has the authority to, and pursuant to this authority, has taken any of the actions constituting grounds for hearing as set forth in Paragraph 9.8.2 herein below, Hospital shall promptly be given written notice of the specific charges and factual basis upon which the EMS Agency action is based. With the exception of summary suspensions, summary suspensions with intent to terminate Agreement, or interim system re-configuration, Hospital shall be afforded its due process right to a hearing before implementation of any of the actions which constitute grounds for a hearing. Hospital shall have thirty (30) calendar days following the receipt of such notice within which to file with Director a written request for hearing before the EMSC.
- 9.3.2 Grounds for Hearing: Any one or more of the following actions constitute grounds for a hearing:

REMEDIAL HEARING:

- 1) Summary Suspension
- 2) Summary Suspension with intent to terminate
- 3) Suspension

4) Suspension with intent to terminate

5) Termination for cause

OTHER:

6) Substantial operational changes in the ALS program (interim system re-configuration and system re-configuration).

7) Restructuring, including deletions, additions, or substitution of base hospitals in the system.

8) Agency requests to modify existing forms, logs, and documentation or Agency's request for additional data as specified in Exhibit A, Paragraph 6.20.

9.3.3 Summary Suspension or Summary Suspension with Intent to Terminate: In the case of summary suspensions or summary suspensions with intent to terminate, Hospital, at its election, shall have the right to request Director in writing to reconsider the summary suspension action. Director shall act on this request for reconsideration within ten (10) calendar days after the receipt of the reconsideration request. Hospital shall be given an opportunity to meet with Director. The meeting shall not be a full hearing but is intended to identify the alleged basis for the summary action.

Within ten (10) calendar days following the meeting with Director, Director shall issue to Hospital a written recommendation regarding the summary suspension. This recommendation may be that the suspension be continued for a particular time or upon particular conditions, that the summary suspension be terminated, that Hospital's agreement be terminated, that other conditions be imposed on Hospital, or such other action as may seem warranted. If Director recommends any action other than immediate return of Hospital to full base hospital status, Hospital may request a hearing on the summary suspension before the EMSC, as provided in this Paragraph. Such request shall be in writing and addressed to Director. Any such request shall be delivered within five (5) calendar days of Director's delivery to Hospital of their written decisions.

9.3.4 Time and Place of Hearing: Director shall, within fifteen (15) calendar days of receipt of a Hospital request for hearing as set forth above, apply to the EMSC for such hearing. Director shall give notice to Hospital of the time, place, and date of the hearing

in accordance with EMSC rules and procedures. The date of commencement of the hearing shall be not less than thirty (30) calendar days, nor more than ninety (90) calendar days from the receipt of the request for hearing, subject to the convenience and approval, however, of the EMSC. However, if the request is received from Hospital when under a summary suspension then in effect, Director shall attempt to arrange a hearing before the EMSC as soon as possible. In situations involving a summary suspension, Director shall use his/her best efforts to schedule a hearing within forty-five (45) calendar days of receipt of a request for hearing.

- 9.3.5 Notice of Charges: As part of, or together with the notice of hearing, Director shall state in writing, in concise language, the acts or omissions with which Hospital is charged or reasons for substantial operational change or restructuring. If either party, by written notice, requests a list of individuals who will appear on behalf of the other, then each party within ten (10) calendar days of such request shall furnish to the other a list, in writing, of the names and addresses of the individuals, so far as is then reasonably known, who will give testimony or evidence in support of that party at the hearing.
- 9.3.6 Hearing Procedure: At the hearing, subject to the rules of the EMSC, both sides shall have the following rights: to call and examine witnesses, to introduce exhibits, and to rebut any evidence. The EMSC may question witnesses.
- 9.3.7 Memorandum of Points and Authorities: Subject to the rules of EMSC, each party shall have the right to submit to the EMSC a memorandum of points and authorities.
- 9.3.8 Basis of Decision: Subject to the rules of the EMSC, the EMSC decision on a hearing under this Agreement shall be based upon the evidence produced at the hearing. The evidence may consist of the following:
- 1) Oral testimony of the parties' representatives;
 - 2) Documentary evidence introduced at the hearing;
 - 3) Briefs or memoranda of points and authorities presented in connection with the hearing;
 - 4) Policies and procedures of the EMS Agency; and

5) All officially noticed matters.

9.3.9 Record of Hearing: The parties understand that the EMSC maintains a record of hearings by one or more of the following methods: a shorthand reporter, an audio or disc recording, or by its clerk's minutes of the proceedings. If a shorthand reporter is specifically requested in writing by Hospital or by Director, the costs of same shall be borne by such party. The parties understand that the EMSC may, but shall not be required to, order that oral evidence shall be taken only by oath or affirmation administered by any person designated by such body and entitled to notarize documents in the State of California.

9.3.10 Decision of the EMSC: The decision of the EMSC shall be effective and binding on the parties to the extent permitted and prescribed in County Code Section 3.20.070 B.

9.4 RESPONSIBILITY FOR INDIGENT PATIENTS

Nothing contained in this Agreement is intended nor shall it be construed to affect either party's existing rights, obligations, and responsibilities with respect to care required by or provided to indigent patients.

9.5 STATUS OF HOSPITAL

The parties hereto agree that Hospital, its officers, agents, and employees, including its professional and non-professional personnel, shall act in an independent capacity and not as officers, agents, or employees of County and shall not have the benefit of County employees. Except as may otherwise expressly be provided hereunder, Hospital shall employ all personnel (excluding physicians), assure physicians availability, provide supplies, equipment, equipment space, furniture, insurance, utilities, and telephones necessary for performance of Hospital's responsibilities as set forth in this Agreement. This Paragraph shall not preclude or limit Hospital from seeking reimbursement, contributions, tuition, or other payment from public or private paramedic provider agencies for services provided by Hospital. However, this Paragraph shall not be interpreted to mean that any such reimbursement, contributions, or payment is required or mandated.

IN WITNESS WHEREOF, Hospital has executed this Agreement, or caused it to be duly executed and the County of Los Angeles, by order of its Board of Supervisors has caused this Agreement to be executed on its behalf by the Chair of said Board and attested by the Executive Officer-Clerk of the Board of Supervisors thereof, the day and year first above written.

COUNTY OF LOS ANGELES

By *Mitchell H. Katz*
Mitchell H. Katz, M.D.
Director of Health Services

HOSPITAL

Pomona Valley Hospital Medical Center

By *[Signature]*
Signature

Richard E. Yocum
Printed Name

PRESIDENT/CEO
Title

APPROVED AS TO FORM
BY THE OFFICE OF THE
COUNTY COUNSEL

STATEMENT OF WORK

STATEMENT OF WORK

TABLE OF CONTENTS

SECTION	TITLE	PAGE
1.0	SCOPE OF WORK	1
2.0	ADDITION/DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS	1
3.0	QUALITY CONTROL.....	1
4.0	QUALITY ASSURANCE PLAN.....	1
5.0	DEFINITIONS	2
6.0	RESPONSIBILITIES.....	2
	<u>COUNTY</u>	
6.1	Personnel.....	2
6.2	Intentionally Omitted	2
6.3	Policies and Procedures	3
6.4	Interim System Re-Configuration.....	3
6.5	System Configuration.....	3
6.6	Data Management	4
6.7	Staff Designation	5
6.8	Assignment of ALS Units	5
6.9	Paramedic Communication System Management.....	5
6.10	Responsibilities of County through ISD	6
6.11	Agreement Compliance	6
	<u>HOSPITAL</u>	
6.12	Project Manager.....	7
6.13	Personnel.....	7
6.14	Uniforms/Identification Badges	7
6.15	Materials and Equipment	7
6.16	Training	7
6.17	Intentionally Omitted	7
6.18	General Requirements.....	8
6.19	Standards and Protocols.....	8
6.20	Data Collection.....	8

6.21	Program Monitoring	11
6.22	Communication between Base Hospital and Receiving Hospital.....	12
6.23	Reimbursement for ALS Direction	12
6.24	Base Hospital Assignment for ALS Units.....	12
6.25	Continuing Education (CE) Provider Program	13
6.26	Hospital Minutes/Attendance Rosters.....	13
6.27	Base Hospital Medical Director.....	14
6.28	Base Hospital Physicians.....	15
6.29	MICNs	15
6.30	Prehospital Care Coordinator (PCC).....	16
6.31	EMS Agency Notification of Hiring/Termination of MICNs	16
6.32	Quality Improvement.....	16
6.33	Paramedic Communication System (PCS)	17
6.34	County Provided TEMIS Hardware	18
7.0	Intentionally Omitted.....	18
8.0	Intentionally Omitted.....	18
9.0	Intentionally Omitted.....	18
10.0	Intentionally Omitted.....	18
11.0	GREEN INITIATIVES	19
12.0	BASE HOSPITAL PROGRAM REVIEW CHECKLIST	19
13.0	PROCEDURE FOR NON-COMPLIANCE AND PENALTIES.....	19

EXHIBIT A

STATEMENT OF WORK (SOW)

1.0 SCOPE OF WORK

The basis of this Agreement is the desire and intention of the parties to cooperate in the operation of each party's component of the paramedic delivery system, consistent with each party's other health services activities and fiscal requirements and the duties and responsibilities of the County. Its purposes are to establish, in a manner reflective of that cooperative basis, the specific duties and responsibilities of the parties with respect to the matters addressed herein and to provide mechanisms and procedures for (a) resolution of disputes, (b) communications regarding the operation of the system, (c) consideration of future development of the system in response to change in circumstances, (d) interaction with other system participants, and (e) quality improvement.

2.0 ADDITION AND/OR DELETION OF FACILITIES, SPECIFIC TASKS AND/OR WORK HOURS

- 2.1 The EMS Agency may elect to restructure the prehospital care system as it deems necessary in accordance with paragraph 6.4 and 6.5 of this Exhibit A, Statement of Work.
- 2.2 All changes must be made in accordance with sub-paragraph 8.1 Amendments of the Agreement.

3.0 QUALITY CONTROL

The Hospital shall establish and utilize a comprehensive Quality Control Plan to assure the County a consistently high level of service throughout the term of the Agreement. The Plan shall be submitted to the County Contract Project Monitor for review. The plan shall include, but may not be limited to the following:

- 3.1 Method of monitoring to ensure that Agreement requirements are being met;
- 3.2 A record of all inspections conducted by the Hospital, any corrective action taken, the time a problem was first identified, a clear description of the problem, and the time elapsed between identification and completed corrective action, shall be provided to the County upon request.

4.0 QUALITY ASSURANCE PLAN

The County will evaluate the Hospital's performance under this Agreement using the quality assurance procedures as defined in this Agreement, Paragraph 8, Standard Terms and Conditions, Sub-paragraph 8.15, County's Quality Assurance Plan.

4.1 Contract Discrepancy Report (SOW Exhibit 1)

Verbal notification of a Contract discrepancy will be made to the Project Monitor as soon as possible whenever a Contract discrepancy is identified. The problem shall be resolved within a time period mutually agreed upon by the County and the Hospital.

The County Project Monitor will determine whether a formal Contract Discrepancy Report shall be issued. Upon receipt of this document, the Hospital is required to respond in writing to the County Project Monitor within thirty (30) workdays, acknowledging the reported discrepancies or presenting contrary evidence. A plan for correction of all deficiencies identified in the Contract Discrepancy Report shall be submitted to the County Project Monitor within thirty (30) workdays.

4.2 County Observations

In addition to departmental contracting staff, other County personnel may observe performance, activities, and review documents relevant to this Agreement at any time during normal business hours. However, these personnel may not unreasonably interfere with the Hospital's performance.

5.0 DEFINITIONS

For convenience, specific terms and definitions can be found in the Agreement, Paragraph 2.0 Definitions.

6.0 RESPONSIBILITIES

The County's and the Hospital's responsibilities are as follows:

COUNTY

6.1 Personnel

The County will administer the Agreement according to the Agreement, Paragraph 6.0, Administration of Agreement - County. Specific duties will include:

- 6.1.1 Monitoring the Hospital's performance in the daily operation of this Agreement.
- 6.1.2 Providing direction to the Hospital in areas relating to policy, information and procedural requirements.
- 6.1.3 Preparing Amendments in accordance with the Agreement, Paragraph 8.0, Standard Terms and Conditions, Sub-paragraph 8.1 Amendments.

6.2 Intentionally Omitted

6.3 Policies and Procedures

- 6.3.1 Establish policies and procedures consistent with State and County laws, regulations, and standards to assure medical control of ALS personnel.
- 6.3.2 Review and revise policies every three years or as needed.
- 6.3.3 Make available to Hospital upon execution of this Agreement a complete manual containing all protocols and policies which the EMS Agency currently considers to be applicable to participants in the ALS system.
- 6.3.4 Establish policies and procedures that ensure a mechanism exists for replacing medical supplies and equipment used by advanced life support personnel during treatment of patients. Such policies and procedures shall not require hospital to provide or replace such medical supplies and equipment.
- 6.3.5 Establish policies and procedures that ensure a mechanism exists for replacing controlled drugs and narcotics used by advanced life support personnel during treatment of patients. Such policies and procedures shall not require hospital to provide or replace such medical supplies and equipment.

6.4 Interim System Re-Configuration

DHS may, on an interim basis, restructure the prehospital care system as it deems necessary, including reassignment of ALS Units to or from Hospital as the primary directing base hospital, in those instances when a designated base hospital gives notice that it is withdrawing from the system or when a designated base hospital is suspended or terminated from the prehospital care system. In the event that an interim restructuring occurs, Hospital, if affected by the restructuring, shall be given the immediate opportunity to provide written and oral statements to Director regarding the restructuring to the EMS Agency and shall be provided with the "due process" procedures specified in Paragraph 9.8, Due Process of the Agreement. Nothing herein, however, is intended to prevent implementation by Director on an emergency basis of such changes as he/she may find measurably necessary to preserve the integrity of the prehospital care system and to protect the health and safety of County residents.

6.5 System Configuration

Director shall notify Hospital of proposals for substantial operational or structural changes in the components of the ALS system or in the overall operation or configuration of such system. This shall include, but not be limited to, increasing or decreasing the number of base hospitals in the event that a restructuring of the prehospital care system is deemed necessary. In the event the number of base hospitals is increased or decreased, and unless otherwise agreed upon by the parties, written notice shall be given to Hospital at least one-hundred and twenty (120) calendar days prior to the effective date of any resulting substantial operational or structural changes to the EMS Agency. If the need for Hospital to

serve as a base hospital can no longer be substantiated, or if Hospital is adversely affected by the addition of a new base hospital, Hospital, upon request, shall be provided with "due process" as specified in Paragraph 9.8, Due Process of the Agreement.

6.6 Data Management

6.6.1 DHS, after consultation with and advice from the Emergency Medical Services Commission ("EMSC") Data Advisory Committee, as defined by the EMS Commission bylaws, if duly constituted, shall continue maintenance of a comprehensive Base Hospital Forms Completion Manual.

The DHS base hospital data collection system includes:

1. A base hospital manual.
2. A minimum of sixteen (16) hours Trauma and Emergency Medicine Information System ("TEMIS") basic software training up to twenty-four (24) hours of intermediate/advanced training for all necessary persons identified by Hospital, and as agreed upon by County, to enable Hospital personnel to perform data entry, database maintenance, and basic report generation functions.
3. A nonexclusive, nontransferable license to Hospital to use TEMIS software and documentation and any software updates for as long as County maintains its software license contract with Lancet Technology, Inc., or until Agreement is terminated as set forth herein. Such license also includes the right of Hospital to copy TEMIS software, data, and documentation for back-up or archive purposes, but such license further gives Hospital no right to sell, lease, sublease, donate, assign, distribute, or otherwise transfer any right in TEMIS software, data, or documentation to any other person or entity.
4. Software meeting specifications shown in Exhibit Q, CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS, attached hereto and incorporated herein by reference, for the purpose of base hospital data entry and/or data manipulation. In the event that Agreement is terminated for any reason, DHS shall promptly remove all TEMIS software provided by County/County's TEMIS-related contractor and Hospital shall return to County all TEMIS data and documentation (and all copies thereof made by Hospital hereunder) provided by County to Hospital.

6.6.2 DHS, on behalf of County, in the event of errors in software, shall use reasonable efforts to promptly rectify the software. Whenever possible, DHS shall correct a problem in twenty-four (24) hours or less (excluding Saturday, Sunday, and Holidays). County shall have no such obligation if

the problem(s) is (are) a direct or indirect result of software modifications, made without the prior written approval from Director.

- 6.6.3 The foregoing are the only warranties of any kind, either expressed or implied, that are made by County, and County disclaims all other warranties including, but not limited to, the implied warranties of fitness for a particular purpose. In no event shall County be liable for any direct, indirect, incidental, or consequential damages of any nature whatsoever (including, without limitation, damages for loss of business profits, business interruption, loss of information, and the like), arising out of the use or inability to use the software (including without limitation any claim of patent infringement or other similar claim), even if County has been advised of the possibility of such damages.
- 6.6.4 County does not warrant that operation of the software will be uninterrupted or error-free or that all errors will be corrected.
- 6.6.5 County does not assume and shall have no liability under this Agreement for failure to repair or replace defective software, the related data or documentation due directly or indirectly to causes beyond the control of, and without the fault or negligence of County, including, but not limited to, acts of God, acts of public enemy, acts of the United States, any state, or other political subdivision, fires, floods, epidemics, quarantine, restrictions, strikes, freight embargoes, or similar or other conditions beyond the control of County.

6.7 Staff Designation

Director shall designate staff within the EMS Agency to review, monitor, communicate and coordinate matters affecting the EMS delivery system under the jurisdiction of the EMS Agency. EMS staff shall periodically attend Hospital's continuing education programs, field care audits, and meetings related to the EMS system and shall perform contract compliance reviews as specified in this Agreement.

6.8 Assignment of ALS Units

After consultation with Hospital and provider agencies, Director shall assign designated ALS units to operate under Hospital's primary control as base hospital. These assignments may be changed from time to time by Director after consultation with Hospital. Director shall take into consideration the number of base hospital contacts handled by each base hospital within a Base Hospital Region, the receiving hospital for the majority of patients handled by the ALS unit being assigned, whether the ALS unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit, and the provider agency's desire to affiliate with a particular base hospital.

6.9 Paramedic Communication System Management

- 6.9.1 Designate one individual within DHS as the PCS manager to provide administration and direction of the PCS.
- 6.9.2 Utilize County's Internal Services Department ("ISD") for ongoing design, installation, maintenance, and technical consultation.
- 6.9.3 Assign Hospital frequencies and private line ("PL") tones in consultation with ISD.
- 6.9.4 Notify Hospital of any proposals for operational or structural changes in the components of the PCS. No non-emergent substantial operational or structural change in the components of the PCS will be made without prior notification of Hospital, and until Hospital, if it wishes, has appropriately exhausted administrative due process remedies under the Agreement.
- 6.9.5 Promulgate PCS communications operations procedures and maintenance standards in cooperation with ISD prior to the execution of this Agreement. Any changes made during the term of this Agreement shall be reviewed and approved by the Communications Management Committee, described in Exhibit J, attached hereto and incorporated herein by reference.
- 6.9.6 Notify the Hospital Association of Southern California ("HASC") of any proposals for changes in policies and procedures.

6.10 Responsibilities of County through ISD

- 6.10.1 Assume ongoing responsibility for the design, development, timely implementation, and technical integrity of the PCS. To the extent feasible, ISD shall consult with the DHS PCS Manager and solicit input in the areas of design development, implementation, and technical integrity of the PCS.
- 6.10.2 Maintain and repair County-owned equipment.
- 6.10.3 Prepare PCS communications operating procedures and maintenance standards in cooperation with the EMS Agency

6.11 Agreement Compliance

Should DHS, as determined by Hospital, fail to comply with any provision set forth hereunder as a DHS responsibility or obligation, Hospital may do any or all of the following in addition to other rights which Hospital may have hereunder or at law:

- 1) Send Director a written statement itemizing the areas of concern and request or specify a plan for remedial action.

- 2) Send Director a written itemized listing of the area(s) of concern and notification of intent to terminate Agreement.
- 3) Institute the review procedures outlined in Paragraph 9.8, DUE PROCESS of the Agreement.

HOSPITAL

6.12 Project Manager

6.12.1 Hospital shall provide a full-time Project Manager or designated alternate.

6.12.2 Project Manager shall act as a central point of contact with the County.

6.12.3 Project Manager/alternate shall have full authority to act for Hospital on all matters relating to the daily operation of the Agreement. Project Manager/alternate shall be able to effectively communicate, in English, both orally and in writing.

6.13 Personnel

6.13.1 Hospital shall assign a sufficient number of employees to perform the required work. At least one employee on site shall be authorized to act for Hospital in every detail and must speak and understand English.

6.13.2 Hospital shall be required to background check their employees as set forth in sub-paragraph 7.5 – Background & Security Investigations, of the Agreement.

6.14 Uniforms/Identification Badges

6.14.1 Hospital shall ensure their employees are appropriately identified as set forth in sub-paragraph 7.4 – Hospital's Staff Identification, of the Agreement.

6.15 Materials and Equipment

The purchase of all materials/equipment to provide the needed services is the responsibility of the Hospital. Hospital shall use materials and equipment that are safe for the environment and safe for use by the employee.

6.16 Training

6.16.1 Hospital shall provide training programs for all new employees and continuing in-service training for all employees.

6.16.2 All employees shall be trained in their assigned tasks and in the safe handling of equipment. All equipment shall be checked daily for safety. All employees must wear safety and protective gear according to OSHA standards.

6.17 Intentionally Omitted

6.18 General Requirements

- 6.18.1 Hospital must be licensed by the State Department of Health Services as a general acute care hospital.
- 6.18.2 Hospital must be accredited by the Joint Commission or any accreditation deemed acceptable by the Centers for Medicare and Medicaid Services (CMS).
- 6.18.3 Hospital must have a special permit for Basic or Comprehensive Emergency Medical Service pursuant to the provisions of Title 22, Division 5, California Code of Regulations.
- 6.18.4 Hospital must meet or exceed standards for Emergency Departments Approved for Pediatrics (Exhibit V).
- 6.18.5 Hospital must satisfy the requirements of Title 22, California Code of Regulations, Section 100168.
- 6.18.6 Hospital must participate in the ReddiNet® communication system.
- 6.18.7 Hospital administration, medical staff and emergency room staff shall meet the requirements under applicable State regulations and the EMS Agency's policies and procedures for the provision of services under this Agreement.

6.19 Standards and Protocols

Hospital shall implement and monitor the policies and procedures of the EMS Agency related to the services performed by Hospital under this Agreement.

6.20 Data Collection

Hospital shall complete and submit the following documents to Director, the completion and submission of which shall be according to DHS procedure and formats previously provided to Hospital:

- 1) Base Hospital Form: The MICN or emergency department physician, or both, shall complete at least one current EMS Agency approved and provided Base Hospital Form for every base hospital paramedic contact involving a patient. Samples of the EMS Agency approved Base Hospital Form are attached as Exhibit R, (Base Hospital Form), R-1 (Page 2), R-2 (MCI Form), attached hereto and incorporated herein by reference. Hospital shall submit the Base Hospital Form within sixty (60) calendar days of the incident. Upon approval of Director, Hospital may discontinue transmittal of a "hard copy" of the form when Director determines that the computer data Base Hospital Form information which is transmitted to the EMS Agency is of high quality and timely, and reflects all documentation. Base Hospital Form should be completed in accordance with the current

Base Hospital Form Instruction Manual (Exhibit S) as posted in the EMS Agency's website.

- 2) Receiving Hospital Outcome Data: Hospital shall complete emergency department outcome data for all patients where Hospital provided base hospital medical direction to prehospital care personnel and patients were delivered to its emergency department via the County's prehospital care system. Hospital personnel shall enter the appropriate information as defined in Exhibit S, attached hereto and incorporated herein by reference, onto the Base Hospital Form and into the County's automated data collection system (TEMIS).
- 3) Required Data Elements: Hospital shall enter data elements as defined in Exhibit S.
- 4) In the event the EMS Agency determines that existing forms, logs, and documents should be modified or that additional data should be collected from Hospital, said modification or request for additional data must first be reviewed by the EMSC Data Advisory Committee, if constituted. The EMS Agency shall estimate the cost impact on Hospital of the proposed modification or request for additional data, and, if a dispute concerning same arises, the matter may be submitted to the EMSC for arbitration in accordance with County Code Section 3.20.070.
- 5) Hospital shall submit required data under County's automated data collection system to the EMS Agency via EMS Agency defined media within forty-five (45) calendar days following an "incident". Data format must meet specifications defined by the EMS Agency. Should County remove all or any portion of TEMIS software required to submit Hospital's data to County via County defined media, or fail to correct any software errors that prevent Hospital from being able to perform data entry, Hospital's obligation to submit data electronically shall cease, until County has reinstalled the necessary software or corrected the software errors.
- 6) Hospital shall utilize TEMIS application programs and provide hardware which meets the requirements listed under Current TEMIS Hospital Hardware and Software Specifications described in Exhibit Q. Hospital shall in no way modify the structure or function of the software as set forth in the Agreement without the prior written approval of Director. The software provided shall be used exclusively for the purposes intended herein and shall be maintained by Hospital in a secure location.
- 7) To provide ongoing financial support to County for data collection, monitoring, and evaluation of the ALS programs, all of which benefit Hospital in the provision of base hospital services, Hospital agrees to offset a portion of the costs attributed thereto. The amount payable to County by Hospital for the first one (1)-year period of Agreement shall be Fifteen Thousand Dollars (\$15,000) for the first year of the Agreement

(which shall be prorated if the first term is less than twelve months), and each subsequent year the amount shall be as follows:

-Year two: Fifteen Thousand Five Hundred Dollars (\$15,500)

Base fees are used to cover the cost of the Trauma and Emergency Medicine Information System Application Software and Support Services Agreement with Lancet Technology, Inc. This agreement is effective through June 2014. The Base fees for years three through five will be updated based on the new agreement with Lancet Technology, Inc.

If a Hospital chooses to upgrade from a single-user copy to a multi-user copy of the Lancet software under this agreement, an additional Three Thousand Dollars (\$3,000) will be added to the Base fees.

For any hospital that is a designated Trauma Center, the base hospital fee is included as part of the Trauma Center fee. In the event Hospital is approved as a County-designated trauma center before the end of any base Agreement year, the base fees paid for that Agreement year shall be applied to the prorated trauma center fees due at the time the TCSA is executed. The amount due for each consecutive year of the Agreement shall be paid on or before July 31 of the period. If this Agreement is canceled or terminated on a date other than June 30 of any one (1) year period (July 1 through June 30) of the Agreement term, the amount due by Hospital for that period shall be reduced by proration. If Hospital has already paid the annual amount, County shall return to Hospital that portion of the payment allocable to the period following the termination or cancellation date.

- 8) Hospital shall provide all supplies necessary for the ongoing use of their equipment (e.g., printer cartridges, printer paper, compact discs, DVDs, flash drives, etc.).
- 9) Hospital shall seek telephone assistance from County's Project Manager or their designee, whenever TEMIS operation failure occurs, to obtain County TEMIS maintenance services as described herein.
- 10) Hospital shall assign qualified back-up personnel, excluding PCC, to enter data into TEMIS, as reasonably appropriate for Hospital to meet Hospital's data collection responsibilities described herein. Furthermore, Hospital shall permit adequate time for complete training of such personnel. Arrangements for training of new or replacement Hospital personnel shall be the primary responsibility of Hospital.
- 11) All software application modules, all modifications, enhancements, and revisions thereto, and all materials, documents, software programs and documentation, written training documentation and aids, and other items provided by County or its agents, are "proprietary" or "confidential". Hospital shall use reasonable means to ensure that these confidential data system products are safeguarded and held in confidence. Such

means shall include, but not be limited to: disclosing confidential County data system products only to employees with a need to know of such confidential County data system products in order for Hospital to exercise its rights and perform its obligation as a base hospital; and not reproducing, adapting, modifying, disassembling, decompiling, reverse engineering, distributing, or disclosing any confidential County data system products except as expressly permitted hereunder. Copies of software, application modules, and data may be made for the sole purpose of backup only.

- 12) Hospital shall indemnify, hold harmless, and defend County from and against any and all liability, damages, costs, and expenses, including, but not limited to, defense costs and attorneys' fees, for or by reason of any actual or alleged infringement of any United States patent, copyright, or any actual or alleged trade secret disclosure, arising from or related to the misuse of the software license by hospital or hospital personnel.
- 13) Nothing in this Agreement shall prohibit Hospital from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Hospital costs associated with providing ALS services, including data collection. Nothing herein, however, requires reimbursement or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray such costs.

6.21 Program Monitoring

6.21.1 Hospital extends to Director, or his designee and to authorized representatives of the State, the right to review and monitor Hospital's programs and procedures with respect to this Agreement, and to inspect its facilities for contractual compliance with State and EMS Agency policies and regulations.

Inspections by DHS staff shall be conducted during County's normal business hours and only after Director has given Hospital at least three (3) working days prior written notice thereof. In computing the three (3) working days, a Saturday, Sunday, or legal holiday shall not be included. Entry and exit conferences shall be held with Hospital's Administrator or his or her designee. Said notice need not be given where Director determines that the health and welfare of patients may be jeopardized by waiting the three day period.

6.21.2 Program Review: At minimum, audits shall be conducted every three (3) years to ensure compliance with State and EMS Agency policies and regulations. Hospital shall be given no less than thirty (30) calendar days notice in advance of said review. Hospital's director of utilization review and director of medical records shall be permitted to participate in the review and Hospital and its staff shall fully cooperate with County representatives. In the conduct of such audit and review, Hospital shall allow such representatives access to all reports, audio recordings, medical

records, and other reports pertaining to this Agreement, and shall allow photocopies to be made of these documents, utilizing Hospital's photocopier.

An exit conference shall be held following the performance of such an on-site compliance review by Director and results of the compliance review shall be discussed with Hospital's Administrator or his or her authorized designee prior to the generation of any final written report or action by Director or other DHS representatives based on such review. The exit conference shall be held on site prior to the departure of the reviewers and Hospital shall be provided with an oral or written list of preliminary findings at the exit conference. If a written report of the program review shall be prepared and provided to Hospital. Hospital shall permit periodic unscheduled site visits by EMS Agency representatives for monitoring ED diversion status, continuing education programs and prehospital care meetings.

6.22 Communication between Base Hospital and Receiving Hospital

6.22.1 Hospital shall communicate all appropriate ALS patient management information to the receiving hospital to which a patient is directed as result of a radio or telephone communications response. Such notification shall be by telephone or ReddiNet and conveyed by a physician or MICN familiar with the treatment given, as soon as the patient destination is determined, or as soon as is practically possible.

6.22.2 Hospital shall assist newly approved SFTP paramedic providers to utilize SFTPs in determining patient destination and in notifying the receiving hospital, for up to two (2) years after SFTP implementation or until such time paramedic providers are capable of so notifying the receiving hospital, whichever is less.

6.23 Reimbursement for ALS Direction

Nothing in this Agreement shall prohibit Hospital from seeking reimbursement, contributions or other payments from municipalities, paramedic provider agencies, or receiving hospitals to defray costs associated with providing ALS services, including supply and resupply of ALS units. Except as expressly noted, nothing herein, however, requires reimbursement or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray such Hospital costs.

6.24 Base Hospital Assignment of ALS units

Except as otherwise may be noted herein, the number of ALS units assigned to Hospital on a primary basis shall be based upon the number of base hospital contacts handled by each base hospital within a geographic area; the receiving hospital for the majority of patients handled by the ALS Units being assigned; whether a Base Hospital within the geographic area can reasonably accept an/any additional unit/s; whether the ALS Unit being assigned is primarily a 9-1-1 response unit or private interfacility transport unit; and the provider agency's desire

to affiliate with a particular base hospital. Subject to Paragraph 9.8, DUE PROCESS of the Agreement, nothing herein, however, shall be deemed to restrict Director and County's Board of Supervisors in the exercise of their authority under applicable laws and regulations to designate additional base hospitals for the geographic area served by Hospital hereunder.

6.25 Continuing Education (CE) Provider Program

6.25.1 Hospital shall establish and maintain an EMS continuing education provider program in accordance with policies established in the Prehospital Care Manual and CE Manual by Director. County requirements for such programs shall be a minimum of twelve (12) hours of education per year, of which a minimum of six (6) hours per year are field care audits. A base hospital may require additional field care audits to maintain MICN sponsorship.

6.25.2 Hospital shall facilitate scheduling structured field observation for MICN certification.

6.25.3 In addition, Hospital shall provide special and mandatory training programs deemed necessary in writing by Director. A minimum of three (3) classes, per mandatory training program, shall be offered.

6.25.4 Hospital shall provide supervised clinical experience for paramedic interns in accordance with State and EMS Agency policies and procedures, upon request of a Los Angeles County approved training school that has a signed Clinical Agreement with Hospital.

6.25.5 Hospital shall coordinate a prehospital orientation program for new base hospital physician and nursing staff to the prehospital program.

6.25.6 Hospital shall facilitate the education of new MICNs by providing instructor(s) to lecture, perform radio simulations, or assist as needed at any County-sponsored MICN Development Course to which Hospital sends MICN candidates.

6.25.7 To the extent Hospital is required to provide mandatory formal education programs over and above those set forth in subparagraphs (1) and (2) immediately above, Hospital may seek reimbursement, contributions, or other payment to defray its costs from municipalities, paramedic provider agencies, or receiving hospitals. However, nothing herein shall be deemed to require any such reimbursement, contribution, or payment.

6.26 Hospital Minutes/Attendance Rosters/Newsletters and Other Communication Related Materials

Hospital shall routinely record minutes of all base hospital meetings, and maintain attendance records of all such meetings, and continuing education classes. Hospital shall forward copies of base hospital meeting minutes to the EMS Agency's Hospital Programs Section on a regular basis, but no less than quarterly.

Hospital may also submit Newsletters and Other Communication Related Materials in lieu of meeting minutes if Hospital deems that such communication method is more effective. Hospital shall forward the following to the EMS Agency:

- 1) Copies of base hospital meeting minutes to the EMS Agency's Hospital Programs Section.
- 2) Monthly continuing education schedules to the Office of Program Approvals prior to scheduled date of course.
- 3) Yearly summaries of EMS CE classes including the date, course title, instructor or non-instructor based, and number of EMS continuing education hours to the Office of Program Approvals by January 31 of the following year.
- 4) Course rosters for Los Angeles County mandated training programs to the Office of Prehospital Certification no later than fifteen (15) calendar days after the class concludes, but not to exceed established deadline of course.

6.27 Base Hospital Medical Director

Hospital shall designate an emergency physician to direct and coordinate the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Hospital (including without limitation, the quality improvement program for the services provided herewithin), and to ensure compliance with policies, procedures, and protocols established by the EMS Agency. This physician, who shall have the title of "Base Hospital Medical Director", shall:

- 1) Be board certified in emergency medicine:
- 2) Be engaged at Hospital in the field of emergency medicine as a full-time emergency physician, as defined by spending an average of at least ninety-six (96) hours per month in the practice of emergency medicine, and have experience and knowledge of base hospital radio operations and EMS Agency policies and procedures. The number of prescribed hours may include administrative and or educational hours spent in meeting Base Hospital Medical Director responsibilities.
- 3) Comply with the provisions set forth in the Prehospital Care Manual.
- 4) Satisfactorily complete orientation to Hospital's prehospital care program.
- 5) Attend a mandatory EMS orientation course as provided by the EMS Agency within six (6) months of assuming base hospital medical director responsibilities.
- 6) Reimbursement for Medical Director: Nothing in this Agreement shall prohibit Hospital from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving

hospitals to defray Hospital's costs associated with providing ALS services, including the base hospital medical director's salary. However, nothing in this Agreement shall be deemed to require any such reimbursement, contribution, or other payment.

6.28 Base Hospital Physicians

Hospital shall have at least one (1) full-time emergency department physician on duty at all times. Such emergency department physician shall be responsible for prehospital management of patient care and patient destination. If a paramedic run is not handled directly by the base hospital physician, such physician shall be immediately available for consultation by an MICN directing a paramedic run. All of Hospital's emergency department physicians participating in Hospital's activities as a base hospital shall:

- 1) Satisfactorily complete Hospital's base hospital orientation program. Such a program shall include: base hospital protocols, base hospital treatment guidelines, base hospital radio operations, and prehospital medicine approved by the Medical Director of the EMS Agency, within thirty (30) days of assuming base physician responsibilities.
- 2) Be board certified in emergency medicine or have satisfied the requirements to take the emergency medical board examination, or have completed the Advanced Cardiac Life Support provider training program.
- 3) Comply with policies and procedures of the EMS Agency.
- 4) Be under the direction of the base hospital medical director.

6.29 MICNs

Hospital shall have at least one (1) MICN on duty at all times. MICNs shall:

- 1) Be currently certified as an MICN in Los Angeles County.
- 2) Be currently certified as an Advanced Cardiac Life Support provider or instructor.
- 3) Comply with policies and procedures of the EMS Agency.
- 4) Be under the direction of the base hospital physician on duty.
- 5) Be employed by one of the following agencies approved to employ and utilize MICNs in Los Angeles County:
 - a) Base Hospital
 - b) EMS Agency
 - c) Paramedic training program

d) Paramedic provider agency

6.30 Prehospital Care Coordinator (PCC)

Hospital shall designate a dedicated MICN with experience and knowledge of base hospital radio operations and EMS Agency policies and regulations to serve as the Hospital's PCC and as a liaison to the EMS Agency, paramedic provider agencies, and the local receiving facilities. Under the direction of, and in conjunction with the Hospital's base hospital medical director, the PCC shall assist in directing and coordinating the medical aspects of field care and related activities of medical and emergency medical services personnel assigned to Hospital and shall ensure compliance with policies, procedures, and protocols established by the EMS Agency. The PCC shall:

- 1) Be currently certified as an MICN in Los Angeles County.
- 2) Have experience in, and knowledge of, base hospital radio operations and EMS Agency policies, procedures, and protocols.
- 3) Be sufficiently available during normal County business hours to meet the responsibilities set forth in this subparagraph.
- 4) Comply with the provisions set forth in the Prehospital Care Manual.
- 5) Attend a mandatory EMS orientation course as provided for by the EMS Agency within six (6) months of assuming base hospital PCC responsibilities.

Nothing in this Agreement shall prohibit Hospital from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Hospital's costs associated with providing ALS services, including the PCC's salary. Nothing, however, in this Agreement shall be deemed to require any such reimbursement, contributions, or other payments.

6.31 EMS Agency Notification of Hiring/Termination of MICNs

Hospital shall notify the EMS Agency's Office of Prehospital Certification within fifteen (15) working days of the hiring or termination of any MICN as well as failure of the MICN to meet established guidelines set by the EMS Agency in maintaining current certification.

Failure of an MICN to meet current certification requirements established by the EMS Agency and EMS Agency mandated courses shall result in immediate suspension of their MICN certification.

6.32 Quality Improvement (QI)

Hospital shall have a current prehospital care QI plan approved by the EMS Agency and ensure participation in the EMS Agency's systemwide QI program by designating a representative for the meetings.

Hospital shall have a process developed, with input from the base hospital medical director, base hospital physician, the PCC, MICNs, paramedics, and Hospital administration to:

- 1) Identify important aspects of prehospital care issues.
- 2) Identify indicators for those important aspects.
- 3) Evaluate the prehospital care and service, including trends, to identify opportunities for improvement.
- 4) Take action to improve care and service, or to solve problems, and evaluate the effectiveness of those actions.

Hospital shall also participate in the EMS Agency's Quality Improvement Program, with records provided by Hospital in accordance with the terms of this Agreement.

6.33 Paramedic Communication System (PCS)

- 6.35.1 Provide the specific PCS base hospital communications equipment listed in Exhibit K, attached hereto and incorporated herein by reference, meeting the operational requirements and standards as determined by the County through the Director of the ISD. Any changes in required communications equipment shall be mutually agreed upon between the parties. These changes shall be made in consultation with the EMS Agency's PCS manager.
- 6.35.2 Acquire and maintain in effect throughout the term of this Agreement FCC licenses for such communications equipment in accordance with California Public Safety Radio Association ("CPSRA") procedures.
- 6.35.3 Operate, maintain, and repair Hospital-owned PCS equipment in accordance with standards promulgated hereunder.
- 6.35.4 Obtain leased lines to current or new remote control stations or to a closer termination point on new or current stations or lines jointly determined by Hospital, Director, and ISD, if Hospital is afforded capability of remote control radio stations located at a County site or other remotely located site. If the remote radio stations are located at a non-County site and are owned by Hospital, then Hospital shall also pay for all costs associated with the maintenance and repair of such stations, and for all costs of the A.C. power required for operating the equipment.
- 6.35.5 Comply with the operating and maintenance standards for communications equipment as set forth in Exhibit L, attached hereto and incorporated herein by reference. Hospital further agrees to operate its PCS equipment in accordance with the transmitter power output and antenna specifications as shown in Exhibit K.

- 6.35.6 Comply with channel assignments made by the EMS Agency for communication with paramedics.
- 6.35.7 Provide training of Hospital personnel assigned to Hospital's PCS operation on the use of communications equipment listed in Exhibit K.
- 6.35.8 Comply with Paramedic System Trouble Control Procedures established by the EMS Agency PCS manager listed in Exhibit M.
- 6.35.9 Have the capability of emergency maintenance and repair of PCS equipment, as well as periodic preventive maintenance, either by its own personnel or through a communications service company which has a service contract with Hospital and which has a demonstrated capability of providing the required services.
- 6.35.10 Nothing in this Agreement shall prohibit Hospital from seeking reimbursement, contributions, or other payment from municipalities, paramedic provider agencies, or receiving hospitals to defray Hospital's costs associated with providing ALS services. However, nothing in this Agreement shall be deemed to require any such reimbursement, contributions, or payment.

6.34 County Provided TEMIS Hardware

Hospital agrees to replace County provided TEMIS hospital hardware and return such equipment to the County by March 30, 2013. Hospital shall maintain their new equipment in fully functioning order until Agreement is terminated.

Hospital shall utilize TEMIS application programs and provide their own equipment in accordance with the specifications shown in Attachment Q, Current TEMIS Hospital Hardware and Software Specifications, attached hereto and incorporated herein by reference, in a reasonably secure area of the hospital provided by the Hospital.

7.0 Intentionally Omitted

8.0 Intentionally Omitted

9.0 Intentionally Omitted

10.0 Intentionally Omitted

11.0 GREEN INITIATIVES

- 11.1 Hospital shall use reasonable efforts to initiate "green" practices for environmental and energy conservation benefits.
- 11.2 Hospital shall notify County's Project Manager of Hospital's new green initiatives prior to the agreement commencement.

12.0 BASE HOSPITAL PROGRAM REVIEW CHECKLIST

A Base Hospital Program Review Checklist, Exhibit 2, listing required services that will be monitored by the County during the term of this Agreement is an important monitoring tool for the County.

All listings of services used in the Base Hospital Program Review Checklist are intended to be completely consistent with the Agreement and the SOW, and are not meant in any case to create, extend, revise, or expand any obligation of Hospital beyond that defined in the Agreement and the SOW. In any case of apparent inconsistency between services as stated in the Agreement and the SOW and this PRS, the meaning apparent in the Agreement and the SOW will prevail. If any service seems to be created in this PRS which is not clearly and forthrightly set forth in the Agreement and the SOW, that apparent service will be null and void and place no requirement on Hospital.

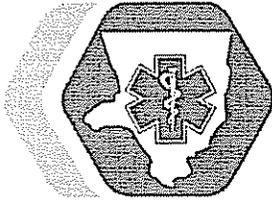
13.0 PROCEDURE FOR NON-COMPLIANCE AND PENALTIES

Hospital's failure to meet data collection requirements for base hospital data elements shall be addressed by the County in accordance with Exhibit 3, Procedure for Non-Compliance with Data Collection Requirements.

STATEMENT OF WORK EXHIBITS

TABLE OF CONTENTS

<u>Exhibits</u>	<u>Page</u>
1 CONTRACT DISCREPANCY REPORT	1
2 BASE HOSPITAL PROGRAM REVIEW CHECKLIST	2
3 PROCEDURE FOR NON-COMPLIANCE WITH DATA COLLECTION REQUIREMENTS	5



EMERGENCY MEDICAL SERVICES AGENCY

LOS ANGELES COUNTY

BASE HOSPITAL PROGRAM REVIEW CHECKLIST

The purpose of the Base Hospital Review is to verify compliance with contractual requirements. Assessments of hospital documents, personnel credentials, the quality improvement program, data base maintenance, and prehospital continuing education programs are integrated into the review process.

ADMINISTRATIVE REQUIREMENTS

A. License/Permit/Accreditation

Base Hospital (BH) meets all of the following:

1. Licensed by the State Department of Health Services as a general acute care hospital.
2. Above license indicates a special permit for Basic or Comprehensive Emergency Medicine Service.
3. Accredited by the Joint Commission or any accreditation deemed acceptable by the Centers for Medicare and Medicaid Services (CMS).
4. Has a current FCC license for paramedic communications equipment.
5. Approved as an Emergency Department Approved for Pediatrics (EDAP).

B. Insurance

BH insurance is current and specifically covers the facility, and meets all requirements in the Agreement.

SERVICE REQUIREMENTS

A. Personnel

1. BH has designated a Medical Director who meets the following:
 - a. Board certified in emergency medicine or has met the Requirements to take the emergency medicine board examination; and,
 - b. Has completed the BH orientation program; and,

- c. BHMD is a full-time emergency physician as defined by working an average of at least 96 hours per month; and,
 - d. Has attended the Los Angeles County EMS Agency orientation program.
 - 2. BH has at least one full-time physician on duty at all times who meets the following:
 - a. Each BH physician is board certified in emergency medicine; or has met the requirements to take the emergency medicine board examination; or has completed the ACLS provider or instructor training program.
 - b. Each BH physician has completed a base hospital orientation within 30 days of assuming BH physician responsibilities.
 - 3. BH has designated a Prehospital Care Coordinator who meets the following requirements:
 - a. Certified Mobile Intensive Care Nurse (MICN) in Los Angeles County; and,
 - b. Has successfully completed the CLAS provider or instructor training program; and,
 - c. Has attended the Los Angeles County EMS Agency orientation program.
 - 4. BH Mobile Intensive Care Nurses are:
 - a. Currently certified in Los Angeles County; and,
 - b. Currently certified as an ACLS provider or instructor.
 - 5. Ancillary Personnel
 - a. BH has qualified back-up personnel who are trained in TEMIS data collection.
 - b. BH has personnel for maintenance and repair of radio and system equipment 24 hours/day and 7 days/week.
 - 6. General

All BH personnel are informed of contract required information on Confidentiality requirements.
- B. Quality Improvement (QI)
 - 1. BH implements a QI Plan that includes objectives, integration into the organization, scope and mechanisms to oversee the effectiveness of the program.
 - 2. BH designates a representative to participate in the system wide EMS QI Committee.
- C. Data Collection

1. The MICN and/or BH physician completes one DHS approved BH Form for every patient on whom base contact is made.
 2. The BH captures electronically all required fields from the BH Form.
 3. BH Forms and electronic data requirements:
 - a. The BH Forms are submitted within 60 calendar days following an incident.
 - b. Data is submitted electronically within 45 calendar days following an incident.
 4. The original "Base Hospital" copy is retained for seven years, or if the patient is a minor, one year past the age of majority, whichever is greater.
 5. BH maintains a chronological log/mechanism to track each paramedic radio contact.
 6. Copies of the requested BH field care audio recordings were submitted for compliance review of Treatment Protocols.
- D. Base Hospital Meeting Minutes
- BH meeting minutes are submitted to the EMS Agency on a regular basis, but no less than quarterly.
- E. Prehospital Continuing Education (CE) Provider
- BH meets all requirements outlined in Prehospital Care Manual Reference No. 1013.

FISCAL REQUIREMENTS

BH pays the annual fee within the time frame specified in the Agreement.

PROCEDURE FOR NON-COMPLIANCE WITH DATA COLLECTION REQUIREMENTS

Month	Action 1	Audit Result	Action 2
1 st	Hospital starts Base Hospital Form submission and electronic data entry of paramedic base hospital contacts occurring in the 1 st month.		
2 nd	Hospital starts Base Hospital Form submission and electronic data entry of paramedic base hospital contacts occurring in the 2 nd month.		
3 rd	EMS Agency reviews Hospital's 1 st month data compliance	<p>Hospital does not meet 90% compliance in:</p> <ol style="list-style-type: none"> 1. Submitting Base Hospital Forms within sixty (60) calendar days of incident, or 2. Submitting required data under County's automated data collection system within forty-five (45) calendar days following an incident, or 3. Submitting accurate and valid data on all mandatory data fields. 	EMS Agency notifies Hospital's Prehospital Care Coordinator, via email or telephone, of audit results, requests corrective action plan and assists in determining solutions.
4 th	EMS Agency reviews Hospital's 2 nd month data compliance	<p>No significant improvement</p> <p>Significant Improvement</p>	<p>EMS Agency sends a written notice to Hospital notifying of audit results and continued non-compliance.</p> <p>Monitor</p>
5 th	EMS Agency reviews Hospital's 3 rd month data compliance	<p>No significant improvement</p> <p>Significant Improvement</p>	<p>EMS Agency notifies Hospital's Prehospital Care Coordinator in writing of audit results and request to submit within 15 calendar days a plan to correct deficiency.</p> <p>Monitor</p>

Month	Action 1	Audit Result	Action 2
6 th	EMS Agency reviews Hospital's 4 th month data compliance	No significant improvement Significant improvement	Within 15 days of County's receipt of Hospital's plan, the County will provide Hospital a written approval or request additional modifications to Hospital's plan. Monitor
7 th	EMS Agency reviews Hospital's 5 th month data compliance	No significant improvement Significant improvement	County will notify Hospital CEO in writing of continued non-compliance and advise that a penalty will be assessed if compliance is not improved. Monitor
8 th	EMS Agency reviews Hospital's 6 th month data compliance	No significant improvement Improvement based on approved corrective action plan	County will assess \$2,600 penalty for non-compliance Monitor
9 th	EMS Agency reviews Hospital's 7 th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
10 th	EMS Agency reviews Hospital's 8 th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
11 th	EMS Agency reviews Hospital's 9 th month data compliance	No significant improvement Improvement based on approved corrective action plan	County will assess additional \$1,300 penalty for non-compliance Monitor
12 th	EMS Agency reviews Hospital's 10 th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
13 th	EMS Agency reviews Hospital's 11 th month data compliance	No significant improvement Improvement based on approved corrective action plan	Still non-compliant Monitor
14 th	EMS Agency reviews Hospital's 12 th month data compliance	No significant improvement Improvement based on approved corrective action plan	County will assess additional \$1,300 penalty for non-compliance Monitor two additional months of data ¹

¹ If two additional months of data show that Hospital remains non-compliant, Hospital will be evaluated for agreement termination.

COUNTY'S ADMINISTRATION

CONTRACT NO. _____

COUNTY PROJECT DIRECTOR:

Name: Cathy Chidester
Title: Director, Emergency Medical Services Agency
Address: 10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Telephone: (562) 347-1604 Facsimile: (562) 941-5835
E-Mail Address: cchidester@dhs.lacounty.gov

COUNTY PROJECT MANAGER:

Name: Richard Tadeo
Title: Assistant Director, Emergency Medical Services Agency
Address: 10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Telephone: (562) 347-1610 Facsimile: (562) 941-2306
E-Mail Address: rtadeo@dhs.lacounty.gov

COUNTY CONTRACT PROJECT MONITOR:

Name: Deidre Gorospe
Title: Senior Emergency Medical Systems Program Head
Address: 10100 Pioneer Boulevard, Suite 200
Santa Fe Springs, CA 90670
Telephone: (562) 324-1661 Facsimile: (562) 946-6701
E-Mail Address: dgorospe@dhs.lacounty.gov

HOSPITAL'S ADMINISTRATION

HOSPITAL'S NAME: Pomona Valley Hospital Medical Center

CONTRACT NO: _____

HOSPITAL'S PROJECT MANAGER:

Name: Angela Besiant
 Title: Director, Emergency Services
 Address: 1798 N. Garey Avenue
Pomona, Ca 91767
 Telephone: 909 865. 9644
 Facsimile: 909 865. 9671
 E-Mail Address: Angela.Besiant@pvhmc.org

HOSPITAL'S AUTHORIZED OFFICIAL(S)

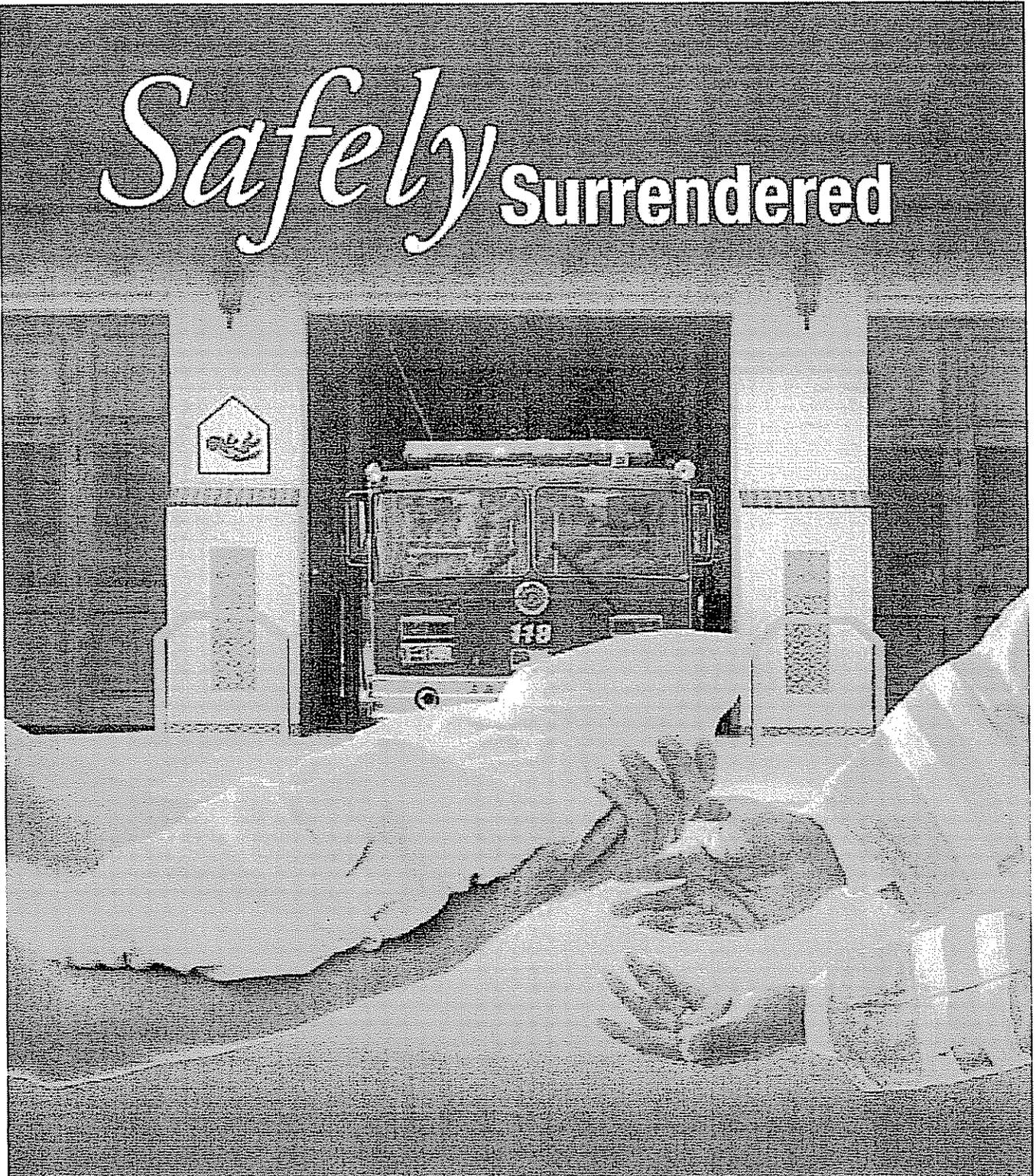
Name: Richard E. Yochum
 Title: President / CEO
 Address: 1798 N. Garey Avenue
Pomona Ca. 91767
 Telephone: 909-865. 9885
 Facsimile: 909-865. 9796
 E-Mail Address: Richard.Yochum@pvhmc.org

Name: Darlene Scafiddi
 Title: Vice President, Patient Care Services
 Address: 1798 N. Garey Avenue
Pomona, Ca. 91767
 Telephone: 909 865. 9879
 Facsimile: 909 623. 6167
 E-Mail Address: Darlene.Scafiddi@pvhmc.org

Notices to Contractor shall be sent to the following:

Name: Richard E. Yochum
 Title: President / CEO
 Address: 1798 N. Garey Avenue
Pomona, Ca. 91767
 Telephone: 909 865. 9885
 Facsimile: 909 865. 9796
 E-Mail Address: Richard.Yochum@pvhmc.org

Safely Surrendered



No shame. No blame. No names.

In Los Angeles County: 1-877-BABY SAFE • 1-877-922-9723

www.babysafe.org



In Los Angeles County: 1-877-BABY SAFE 1-877-222-9728

www.babysafe.ca.org

Safely Surrendered Baby Law

What is the Safely Surrendered Baby Law?

California's Safely Surrendered Baby Law allows parents or other persons, with lawful custody, which means anyone to whom the parent has given permission to confidentially surrender a baby. As long as the baby is three days (72 hours) of age or younger and has not been abused or neglected, the baby may be surrendered without fear of arrest or prosecution.

How does it work?

A distressed parent who is unable or unwilling to care for a baby can legally, confidentially, and safely surrender a baby within three days (72 hours) of birth. The baby must be handed to an employee at a hospital or fire station in Los Angeles County. As long as the baby shows no sign of abuse or neglect, no name or other information is required. In case the parent changes his or her mind at a later date and wants the baby back, staff will use bracelets to help connect them to each other. One bracelet will be placed on the baby, and a matching bracelet will be given to the parent or other surrendering adult.

What if a parent wants the baby back?

Parents who change their minds can begin the process of reclaiming their baby within 14 days. These parents should call the Los Angeles County Department of Children and Family Services at 1-800-540-4000.

Can only a parent bring in the baby?

No. While in most cases a parent will bring in the baby, the Law allows other people to bring in the baby if they have lawful custody.

Does the parent or surrendering adult have to call before bringing in the baby?

No. A parent or surrendering adult can bring in a baby anytime, 24 hours a day, 7 days a week, as long as the parent or surrendering adult surrenders the baby to someone who works at the hospital or fire station.

Does the parent or surrendering adult have to tell anything to the people taking the baby?

No. However, hospital or fire station personnel will ask the surrendering party to fill out a questionnaire designed to gather important medical history information, which is very useful in caring for the baby. The questionnaire includes a stamped return envelope and can be sent in at a later time.

What happens to the baby?

The baby will be examined and given medical treatment. Upon release from the hospital, social workers immediately place the baby in a safe and loving home and begin the adoption process.

What happens to the parent or surrendering adult?

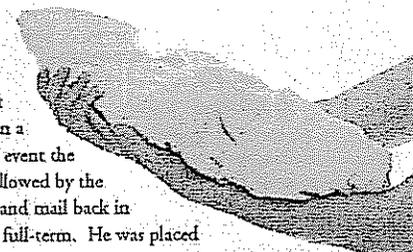
Once the parent or surrendering adult surrenders the baby to hospital or fire station personnel, they may leave at any time.

Why is California doing this?

The purpose of the Safely Surrendered Baby Law is to protect babies from being abandoned, hurt or killed by their parents. You may have heard tragic stories of babies left in dumpsters or public bathrooms. Their parents may have been under severe emotional distress. The mothers may have hidden their pregnancies, fearful of what would happen if their families found out. Because they were afraid and had no one or nowhere to turn for help, they abandoned their babies. Abandoning a baby is illegal and places the baby in extreme danger. Too often, it results in the baby's death. The Safely Surrendered Baby Law prevents this tragedy from ever happening again in California.

A baby's story

Early in the morning on April 9, 2005, a healthy baby boy was safely surrendered to nurses at Harbor-UCLA Medical Center. The woman who brought the baby to the hospital identified herself as the baby's aunt and stated the baby's mother had asked her to bring the baby to the hospital on her behalf. The aunt was given a bracelet with a number matching the anklet placed on the baby; this would provide some identification in the event the mother changed her mind about surrendering the baby and wished to reclaim the baby in the 14-day period allowed by the Law. The aunt was also provided with a medical questionnaire and said she would have the mother complete and mail back in the stamped return envelope provided. The baby was examined by medical staff and pronounced healthy and full-term. He was placed with a loving family that had been approved to adopt him by the Department of Children and Family Services.



Ley de Entrega de Bebés *Sin Peligro*



Los recién nacidos pueden ser entregados en forma segura al personal de cualquier hospital o cuartel de bomberos del Condado de Los Angeles.

Sin pena. Sin culpa. Sin nombres.

En el Condado de Los Angeles: 1-877-BABY SAFE • 1-877-222-9723

www.lacounty.org



Oficina Comunitaria de Los Angeles 1-877-838-8111 FAX 1-877-222-0725

www.babysafe.org

Ley de Entrega de Bebés Sin Peligro

¿Qué es la Ley de Entrega de Bebés sin Peligro?

La Ley de Entrega de Bebés sin Peligro de California permite la entrega confidencial de un recién nacido por parte de sus padres u otras personas con custodia legal, es decir cualquier persona a quien los padres le hayan dado permiso. Siempre que el bebé tenga tres días (72 horas) de vida o menos, y no haya sufrido abuso ni negligencia, pueden entregar al recién nacido sin temor de ser arrestados o procesados.

Cada recién nacido se merece la oportunidad de tener una vida saludable. Si alguien que usted conoce está pensando en abandonar a un recién nacido, infórmele que tiene otras opciones. Hasta tres días (72 horas) después del nacimiento, se puede entregar un recién nacido al personal de cualquier hospital o cuartel de bomberos del condado de Los Angeles.

¿Cómo funciona?

El padre/madre con dificultades que no pueda o no quiera cuidar de su recién nacido puede entregarlo en forma legal, confidencial y segura dentro de los tres días (72 horas) del nacimiento. El bebé debe ser entregado a un empleado de cualquier hospital o cuartel de bomberos del Condado de Los Angeles. Siempre que el bebé no presente signos de abuso o negligencia, no será necesario suministrar nombres ni información alguna. Si el padre/madre cambia de opinión posteriormente y desea recuperar a su bebé, los trabajadores utilizarán brazaletes para poder vincularlos. El bebé llevará un brazaletes y el padre/madre o el adulto que lo entregue recibirá un brazaletes igual.

¿Qué pasa si el padre/madre desea recuperar a su bebé?

Los padres que cambien de opinión pueden comenzar el proceso de reclamar a su recién nacido dentro de los 14 días. Estos padres deberán llamar al Departamento de Servicios para Niños y Familias (Department of Children and Family Services) del Condado de Los Angeles al 1-800-540-4000.

¿Sólo los padres podrán llevar al recién nacido?

No. Si bien en la mayoría de los casos son los padres los que llevan al bebé, la ley permite que otras personas lo hagan si tienen custodia legal.

¿Los padres o el adulto que entrega al bebé deben llamar antes de llevar al bebé?

No. El padre/madre o adulto puede llevar al bebé en cualquier momento, las 24 horas del día, los 7 días de la semana, siempre y cuando entreguen a su bebé a un empleado del hospital o cuartel de bomberos.

¿Es necesario que el padre/madre o adulto diga algo a las personas que reciben al bebé?

No. Sin embargo, el personal del hospital o cuartel de bomberos le pedirá a la persona que entregue al bebé que llene un cuestionario con la finalidad de recabar antecedentes médicos importantes, que resultan de gran utilidad para cuidar bien del bebé. El cuestionario incluye un sobre con el sello postal pagado para enviarlo en otro momento.

¿Qué pasará con el bebé?

El bebé será examinado y le brindarán atención médica. Cuando le den el alta del hospital, los trabajadores sociales inmediatamente ubicarán al bebé en un hogar seguro donde estará bien atendido, y se comenzará el proceso de adopción.

¿Qué pasará con el padre/madre o adulto que entregue al bebé?

Una vez que los padres o adulto hayan entregado al bebé al personal del hospital o cuartel de bomberos, pueden irse en cualquier momento.

¿Por qué se está haciendo esto en California?

La finalidad de la Ley de Entrega de Bebés sin Peligro es proteger a los bebés para que no sean abandonados, lastimados o muertos por sus padres. Usted probablemente haya escuchado historias trágicas sobre bebés abandonados en basureros o en baños públicos. Los padres de esos bebés probablemente hayan estado pasando por dificultades emocionales graves. Las madres pueden haber ocultado su embarazo, por temor a lo que pasaría si sus familias se enteraran. Abandonaron a sus bebés porque tenían miedo y no tenían nadie a quien pedir ayuda. El abandono de un recién nacido es ilegal y pone al bebé en una situación de peligro extremo. Muy a menudo el abandono provoca la muerte del bebé. La Ley de Entrega de Bebés sin Peligro impide que vuelva a suceder esta tragedia en California.

Historia de un bebé

A la mañana temprano del día 9 de abril de 2005, se entregó un recién nacido saludable a las enfermeras del Harbor-UCLA Medical Center. La mujer que llevó el recién nacido al hospital se dio a conocer como la tía del bebé, y dijo que la madre le había pedido que llevara al bebé al hospital en su nombre. Le entregaron a la tía un brazaletes con un número que coincidía con la pulsera del bebé; esto serviría como identificación en caso de que la madre cambiara de opinión con respecto a la entrega del bebé y decidiera recuperarlo dentro del período de 14 días que permite esta ley. También le dieron a la tía un cuestionario médico, y ella dijo que la madre lo llenaría y lo enviaría de vuelta dentro del sobre con franqueo pagado que le habían dado. El personal médico examinó al bebé y se determinó que estaba saludable y a término. El bebé fue ubicado con una buena familia que ya había sido aprobada para adoptarlo por el Departamento de Servicios para Niños y Familias.

COMMUNICATIONS MANAGEMENT COMMITTEE (Ad Hoc)

1. PURPOSE: The Communications Management Committee ("CMC") is organized to provide technical and administrative assistance in the design, maintenance, and operation of the PCS to the PCS Manager.
 2. ORGANIZATION: The CMC shall be composed of the following representatives or their designees:
 - A. PCS Manager, appointed by the Director of the Department of Health Services;
 - B. Chief Deputy Director, Internal Services Department;
 - C. Executive Director, Hospital Association of Southern California;
 - D. Consultant, nominated by the EMSC;
 - E. Representative, nominated by the Los Angeles County Ambulance Association;
 - F. Representative, nominated by the Los Angeles County Chapter of the Southern California Fire Chiefs Association.
 - G. Representative, nominated by the Base Hospital Advisory Committee.
- Failure of the listed non-County agencies to appoint representatives to the CMC shall not invalidate the formation of the CMC. Alternative arrangements which fulfill the purposes of this committee may also be utilized with the approval of the local EMS Agency.

3. RESPONSIBILITIES:

- A. Assess current operations of PCS;
- B. Identify current and on-going problems;
- C. Develop solutions and schedules for resolving problems;
- D. Report status to participants of PCS on a regular basis; and
- E. Bring major problems to the attention of the directors of the local EMS Agency and the Internal Services Department.

4. MEETINGS: The CMC shall meet on an "as needed" basis as determined by the PCS Manager.

BASE HOSPITAL COMMUNICATIONS EQUIPMENT

The following list describes the minimum equipment requirements involved in the Hospital's portion of the Emergency Medical Services Communications System (EMSCS).

1. MED 1-8 RADIO STATIONS

A. Radio Equipment

- (1) 2 each - Transceiver, 4-channel, transmitter output adjustable between 20-45 watts, with CTCSS and "AND" squelch
- (2) 2 - Duplexer
- (3) 2 each - Antenna, Omni-directional, vertically polarized, typically 5.0 dB gain
- (4) 2 each - Hardware Kit, Antenna Mounting
- (5) 2 each - Coaxial cable, (5/8 hardline type) low-loss at UHF, including connectors, etc. (maximum length - approx. 100 ft.)

- B. Radio Transmitter Power - Power output of each MED 1-8 transmitter shall be adjusted for 20 watts to appear at the base of the antenna.

Base hospital agrees to upgrade EMSCS equipment as described in Radio Specifications 1927 and 1928 as revised by County of Los Angeles Internal Services, to meet the State Emergency Medical Services Authority EMSA. Future FCC mandates to operate on Digital Modes and Narrow Band Frequency standards, when adopted by public safety Radio Communications organizations, such as APCO, must be kept in

mind if replacing the State Emergency Medical Services Authority's EMSA Narrow Band Frequency Standard when adopted.

2. MED 9 RADIO STATION

A. Radio Equipment

- (1) 1 each - Transceiver, Single-Channel, transmitter output adjustable between 20-45 watts, with CTCSS and "AND" squelch.
- (2) 1 each - Duplexer
- (3) 1 each - Coaxial cables (5/8 hardline type) low-loss at UHF, including connectors, etc. (maximum length - approx. 100 ft.)
- (4) 1 each Antenna, Omni-directional, vertically polarized, typically 5.0 dB gain.
- (5) 1 lot Hardware Kit, Antenna Mounting.

B. Radio Transmitter Power

Power output of the MED 9 transmitter shall be adjusted for 20 watts to appear at base of antenna.

Base hospital agrees to upgrade Paramedic Communication System (PCS) equipment as described in Radio Specifications 1927 and 1928 to meet the State Emergency Medical Services Authority's EMSA Narrow Band Frequency Standard when adopted.

COMMUNICATIONS EQUIPMENT MAINTENANCE STANDARDS

- I. Radio station room, antenna structure and control lines
 - A. Radio Station Room
 - (1) Radio equipment shelter (with sufficient space to install three (3) radio stations). Not required if the Hospital has suitable existing facility to house radio station equipment on roof or top floor of Hospital's tallest building.
 - (2) One (1) each Power Distribution Panel (wired to hospital's emergency A.C. power as well as commercial power)
 - (3) Five (5) each A.C. Power Outlets near radio stations and connected to Item No. 2 above

One (1) lot - Hardware Kit, Antenna Mounting
 - B. Antenna Structure
 - (1) One (1) each Tower, antenna, up to sixty (60) ft. or other structure suitable for antenna mounting (installed near radio station room)
 - C. Radio Control Lines

At least four (4) sets of 4 wire circuits - one (1) set per transceiver and one (1) spare set must be installed by hospital from terminal block(s) in the radio station room termination points close to the control consoles.
 - D. Control Consoles and Paramedic Telephones
 - (1) Location in the Emergency Department
 - (2) Console Equipment
 - a. One (1) each - Hospital Coordination Console (HCC) per

Specification No. 1928, or other suitable tone/remote control console with DTMF decoder

- b. Two (2) each - Medical Communications Console per Revised. Specification No. 1927

Above item can be a single equipment instead of two (2), if provision is made for control of both MED 1-8 transceivers from the single console. Provision must also be made for connection of both paramedic emergency telephones to the single console. The Console must provide means to log all traffic via radio channels and telephone calls to the console. The recording medium must be of archival quality. It is recommended that, unless space considerations for the consoles are the Hospital's primary concern, two MCTC's be installed.

E. Power Outlets

At least eight (8) A.C. power outlets shall be provided. Outlets must be connected to Hospital's emergency power system as well as commercial power.

F. Paramedic Emergency Telephones

Two (2) telephones with telephone lines shall be dedicated for paramedic/hospital communications.

G. Maintenance and Trouble Call Reporting

- (1) Purpose: To provide preventive and ongoing maintenance and/or repair for PCS Equipment.
- (2) Responsibilities of Hospital:
 - a. Provide the local EMS Agency with evidence of twenty-four

(24) hours per day, seven (7) days per week maintenance and repair service for radio and system equipment.

- b. Report problems to the Internal Services Department.
- c. Perform or cause to be performed the following preventive maintenance:

(1) Quarterly:

Systems check to include:

- a. console functions and operation;
- b. transmit and receive test of all frequencies.
- c. Clean and service base hospital recording system.

(2) Annually:

- a. FCC frequency and deviation test for all radios;
- b. Visual inspection of the antenna structures;
- c. Solicit report from assigned field provider units about any chronic communication problems to include but not be limited to field equipment, dead space, radio failure and co-channel interference, and submit a written report to the local EMS Agency about such problems.

PARAMEDIC SYSTEM TROUBLE CONTROL PROCEDURES

1. The Paramedic System

- A. The paramedic system, as it exists now, consists of the following items requiring Internal Services Department (ISD) maintenance.
- LAC+USC Medical Center, Harbor-UCLA Medical Center: each of the two (2) County hospitals has three (3) base stations, MED 1-4, MED 5-8, MED 9, two (2) hot line telephones for incoming paramedic calls; one (1) H.E.A.R. radio, sometimes used by paramedics.
- B. The non-County hospital or its consultant is responsible for maintenance of leased lines between the hospital and the base station location or the entry to the County microwave system unless noted. ISD involvement on leased lines is to provide access to County sites and work with the TELCO concerned as necessary to resolve the problem. When the Service Provider/Consultant determines that the fault is at the County site or equipment past their control, the fault will be reported to the Dispatcher (See Exhibit P).

2. Maintenance Control: Maintenance control revolves on the County ISD Dispatcher, who will act as the single point of contact between the entity requesting repair or maintenance and the maintenance personnel. After normal business hours, the Dispatcher may be reached at Emergency after hours (213) 974-1234 or Dispatch (562) 401-9349. Maintenance itself will be accomplished by personnel of the Microwave Maintenance Division, Radio Field Services,

Antelope Valley Shop, and may require the involvement of third party Maintenance Service or other disciplines within ISD. Maintenance personnel may call the person requesting the repair for clarification of information provided by the Dispatcher, or if joint effort is required, to arrange for the parties to meet or communicate.

A. Routine Procedures – County Hospitals: The following procedures are guidelines to be used for controlling and resolving trouble reports:

- (1) The Dispatcher will be notified of a problem by either hospital personnel or maintenance shop personnel.
- (2) The Dispatcher requires the following information:
 - (a) description of the problem;
 - (b) classification of the problem: e.g., phone line, microwave circuit, console, logging recorder or radio;
 - (c) caller's name;
 - (d) caller's telephone number;
 - (e) the address and room number where the problem exists;
and
 - (f) if the problem was reported outside normal working hours, or late in the business day, ask whether or not work may be delayed until the next normal business day. (Normal County maintenance working days are from 7:30 A.M. to 4:00 P.M.,

Monday through Friday.)

- (3) The Dispatcher will assign a number to the trouble call.
- (4) The Dispatcher will log the call and prepare a trouble ticket by entering the trouble number and will time stamp the trouble ticket.
- (5) The Dispatcher will notify the appropriate maintenance personnel immediately, providing the trouble number and available details.

When it cannot be determined which shop may be responsible for non-County hospital problems, the Field Services shop will be notified. During regular working hours, trouble calls will be provided to the maintenance shop concerned. When the shop is closed or after normal working hours, appropriate maintenance personnel will be called at their homes, unless it has been determined by the calling party that work may be held in abeyance until the next regular business day.
- (6) The Dispatcher will log the time and to whom the call was given on the daily log.
- (7) The Dispatcher will time stamp the trouble ticket and write the name of the person who took the call in the maintenance shop.
- (8) When repair has been completed, the technician will contact the person who reported the problem and ask them to test the system.

If that person informs the technician that the problem has been

cleared, the technician will notify the Dispatcher of that fact.

- (9) When the Dispatcher is notified that the trouble has been resolved, the dispatcher will so note on the log along with who reported the trouble resolved.
- (10) The Dispatcher will then time stamp the trouble ticket.
- (11) The Dispatcher will call the person reporting the trouble to confirm that the trouble has been cleared.
- (12) If maintenance has determined that the problem at a County hospital is a leased line problem, this shall be reported to the Dispatcher with circuit information. The Dispatcher will take action with the appropriate TELCO.
- (13) When TELCO reports the problem has been cleared, the Dispatcher will so notify the person making the trouble report.

B. Non-County Hospitals: The following procedures are guidelines to be used for controlling and resolving trouble reports:

- (1) The Dispatcher will be notified of a problem by either a consultant or if at a hospital, hospital personnel or maintenance shop personnel, as designated by their agreement with the consultant.
- (2) The ISD Dispatcher requires the following information:
 - (a) description of the problem;
 - (b) classification of the problem: e.g., definitely a remote

County site problem, no radio control, noisy receiver;

- (c) caller's name;
 - (d) caller's telephone number;
 - (e) the address and room number where the problem exists;
and
 - (f) if the problem was reported outside normal working hours, or
if late in the business day, ask whether or not work may be
delayed until the next normal business day.
- (3) The Dispatcher will assign a number to the trouble call.
- (4) The Dispatcher will log the call and prepare a trouble ticket by
entering the trouble number and will time stamp the trouble ticket.
- (5) The Dispatcher will notify the appropriate maintenance personnel
immediately, providing the trouble number and available details.
- When it cannot be determined which shop may be responsible for
non-County hospital problems, the Field Services shop will be
notified. During regular working hours, trouble calls will be provided
to the maintenance shop concerned. When the shop is closed or
after normal working hours, appropriate maintenance personnel will
be called at their homes, unless it has been determined by the
calling party that work may be held in abeyance until the next
regular business day. In such case, the call will be made to the

shop at 7:30 A.M. on the next business day.

- (6) The Dispatcher will log the time and to whom the call was given, on the daily log.
- (7) The Dispatcher will time stamp the trouble ticket and write the name of the person who took the call in the maintenance shop.
- (8) When repair has been completed, the technician will contact the person who reported the problem and ask them to test the system. If that person informs the technician that the problem has been cleared, the technician will notify the Dispatcher of that fact.
- (9) When the Dispatcher is notified that the trouble has been resolved, the Dispatcher will so note on the log along with who reported the trouble resolved.
- (10) The Dispatcher will then time stamp the trouble ticket.
- (11) The Dispatcher will call the person reporting the trouble to confirm that the trouble has been cleared.
- (12) If maintenance has determined that the problem is a leased line problem, this shall be reported to the Dispatcher (with circuit information). The Dispatcher will so inform the person reporting the problem and request that the person report back.
- (13) If the private agency calls back indicating that the trouble was a leased line problem, and that it has been cleared, the Dispatcher

will note that on the trouble ticket, time stamp it and close it.

- (14) If the private agency calls back indicating that the trouble is not a leased line problem, the Dispatcher will reopen the trouble ticket and reinitiate the maintenance procedure. See Paragraph 2 above.

Escalation Procedure

- C. Dispatch Actions: In the event that the trouble has not been cleared up by 3:00 P.M., on normal business days, the Dispatcher shall do the following:
 - (1) Call the appropriate maintenance shop for a follow-up report on the trouble.
 - (2) If the trouble will be carried over to the next business day, note that fact, the time and the name of the supervisor authorizing the carry over on the trouble ticket. These tickets will be placed in the carry-over slot.
 - (3) If work will continue until resolution of the problem, note the name of the technician assigned on the trouble ticket. These tickets will be passed on to each succeeding shift until closed out.
 - (4) If work in progress has not been resolved by 7:30 A.M. the next working day, the appropriate maintenance shop will be called requesting new completion times on these trouble calls.
 - (5) After logging the time, name of shop contact and status of actions taken, call the person reporting the trouble and provide a status

report.

D. Escalation:

- (1) After 24 hours have elapsed with no report of problem resolution, the Dispatcher will call the section head of the maintenance shop involved and report that fact. This information, the section head's response and the time will be logged and entered on the trouble ticket. The person reporting the problem will be called and apprised of the status of work on their problem.
- (2) After 48 hours have elapsed with no report of problem resolution, the Dispatcher will call the maintenance Division Chief concerned, requesting problem resolution. The person reporting the trouble and the Department of Health Services, EMS Division, will be called and given the status of actions taken, including the fact that the problem has escalated to the Division Chief. The DHS representative will be given the name and telephone number of the Division Chief.
- (3) After 72 hours have elapsed with report of problem resolution, the Dispatcher will call the Branch Manager notifying them of the problem and the fact that 72 hours have elapsed since the problem was first reported. This information will be logged by the Dispatcher. The person reporting the problem and the Department

of Health Services, EMS Division, will be called and given the status if action taken, including the fact that the problem has been escalated to the Branch Manager. When the Division Chief or Branch Manager provides the Dispatcher with the status of the delayed repair action, the Dispatcher will note the status, who called, and the time in the log and will inform the person reporting the problem and DHS of the status of actions.

ISD TELEPHONE NUMBERS FOR MAINTENANCE SUPPORT

ISD DISPATCH 24/7 (562) 940-3305

REMOTE BASE STATION RADIO SITES

	REMOTE POINT	ASSIGNMENT	FROM	BASE HOSPITAL	SOURCE	SUBSCRIBER	ACTIVE
1	POINT VICENTE	MED 1-4	SAN PEDRO & PENINSULA	TORRANCE MEMORIAL MEDICAL CENTER	LEASED LINE	LEASED LINE TORRANCE MEMORIAL MEDICAL CENTER	YES
2	RIO HONDO MICROWAVE	MED 1-4	SAN DIMAS SHERIFF	POMONA VALLEY HOSPITAL MEDICAL CENTER	LACO MICROWAVE	LEASED LINE POMONA VALLEY HOSPITAL MEDICAL CENTER	YES
		MED 5-8	SAN DIMAS SHERIFF	POMONA VALLEY HOSPITAL MEDICAL CENTER	LACO MICROWAVE	LEASED LINE POMONA VALLEY HOSPITAL MEDICAL CENTER	YES
		MED 9	SAN DIMAS SHERIFF	POMONA VALLEY HOSPITAL MEDICAL CENTER	LACO MICROWAVE	LEASED LINE POMONA VALLEY HOSPITAL MEDICAL CENTER	
3	THE COUNTRY	MED 5-8	POINT	POMONA VALLEY HOSPITAL MEDICAL CENTER	LEASED LINE	LEASED LINE	YES
4	WALKER DRIVE	MED 1-4	POINT	UCLA MEDICAL CENTER	LEASED LINE	LEASED LINE	NO
		MED 5-8	POINT	UCLA MEDICAL CENTER	LEASED LINE	LEASED LINE	NO
		MED 9	POINT	UCLA MEDICAL CENTER	LEASED LINE	LEASED LINE	NO
5	HAUSER PEAK	MED 9 #970 MED 7a		HENRY MAYO NEWHALL			
6	OAT MOUNTAIN	MED 4a MED 5A		HENRY MAYO NEWHALL			

	REMOTE POINT	ASSIGNMENT	FROM	TO	SOURCE	SUBSCRIBER	ACTIVE
7	BALD MOUNTAIN	MED 4A #810		HENRY MAYO NEWHALL			
8	VERDUGO HILLS HOSPITAL	MED2A #92		HUNTINGTON MEMORIAL			
9	PASADENA CITY COLLEGE	MED 9v, MED 5v		HUNTINGTON MEMORIAL			
10	BEACH CITIES, HARBOR MASTER	MED 9 #860 MED-1Dv		LITTLE COMPANY OF MARY			
11	BLACKJACK MOUNTAIN	MED 6D #160		LITTLE COMPANY OF MARY			
12	LITTLE COMPANY OF MARY - SAN PEDRO	MED 9#190 MED 4E MED 8E		LITTLE COMPANY OF MARY			
13	SAN PEDRO HILL	MED 9#960 MED 8E		LITTLE COMPANY OF MARY			
14	VAN NUYS COURT	MED 8A		NORTH RIDGE HOSPITAL MEDICAL CENTER			
15	DIAMOND BAR	MED5A #250 OR #680		POMONA VALLEY HOSPITAL MEDICAL CENTER			
16	JOHNSTONE	MED 5A #250		POMONA VALLEY HOSPITAL MEDICAL CENTER			
17	LONG BEACH COMMUNITY HOSPITAL	MED 7Ev		ST MARY MEDICAL CENTER			
18	LAKELWOOD REGIONAL	MED 7Ev		ST MARY MEDICAL CENTER			
19	SIGNAL HILL	MED 7Ev		ST MARY MEDICAL CENTER			
20	QUEEN OF ANGELS/HOLLYPRES	MED 9 #750 MED 7C #750		LAC+USC MEDICAL CENTER			

EXHIBIT Q

CURRENT TEMIS HOSPITAL HARDWARE AND SOFTWARE SPECIFICATIONS

Minimum Workstation Recommendations

- Intel® Pentium E5200 (2.5 GHz)
- Microsoft Windows XP Professional SP3
- 1 GB of RAM
- 2 GB of Available Disk Space*
- Display Adapter and Monitor Capable of Displaying 1024 X 768
- 100 Mbps NIC Adapter or faster*
- Mouse
- Keyboard
- LA Base Software

Recommended Workstation Specification

- Intel® Core i5 Processor
- Microsoft Windows 7 Professional 64-bit
- 4 GB of RAM
- 100 GB of Available Disk Space*
- Display Adapter and Monitor Capable of Displaying 1024 X 768
- Graphics accelerator with 512MB RAM and Monitor Capable of Displaying 1024 X 768
- DirectX 9 graphics device with WDDM 1.0 or higher driver
- 1 Gbps NIC Adapter or faster*
- Mouse
- Keyboard
- LA Base Software

BASE HOSPITAL FORM

BASE HOSPITAL FORM

Log # _____ SEQ. # _____ Pa2

GENERAL
 Date: _____ Pt. # _____ of _____ Hospital Code: _____
 Time: _____ Unit: _____ Age: _____ Sex: M F
 Location: _____ Weight: _____ Kg lbs. Est. Too Tall
 Peds Weight Color Code: _____

ASSESSMENT
 Chief Complaint Code: _____ SEVERITY: None Mild Mod. Severe
 O/D/DISTRESS: _____
 Protocol: _____ O/P: _____
 Medical HX: _____ Q: _____
 Medications: _____ R: _____
 NKA Allergies: _____ S: _____
 Suspected Drugs/ETOH: _____ T: _____

PHYSICAL
LOC
 CONSCIOUS (check one below each col)
 Alert Oriented x 3
 NoT Alert Disoriented
 Combative NorMal for Pt.
 UNCONSCIOUS (check only one box)
 Responds Verbal Pain
 Purposeful Nonpurposeful
 No Response
 m LAPSS met Y N
 Last known well: _____
 Date: _____
 Time: _____

PHYSICAL
PUPILS
 PERL
 Unequal
 Pinpoint
 Fixed & Dil
 Sluggish
BREATHING
 Rate/Effort: Norm Abnormal
 Labored Snoring
 Acc. Mus. Use Apnea
 TV ↑ N ↓
 Clear Rales
 Wheeze RHonchi
 Stridor Unequal
 BS after ET/KING
 CO2 Detect. + -
 Capno. # _____
 Waveform Y N
SKIN
 Normal
 Warm
 Hot
 Cool
 Pale
 Diaphoretic
 Cyanotic
 Flushed
 Jaundiced
 Capillary Refill
 NoRmal
 DELayed

ECG
 Init. Rhyth: _____
 12 Lead _____ (time)
 NL AbN STEMI
 Artifact Paced Rhythm
 Wavy Baseline
ARRREST
 Witnessed By: _____
 Citizen EMS None
 CPR by: _____
 Citizen EMS
 Est. Down Time: _____
 Pulses w/ CPR
 Restoration Pulse (ROSC)
 Time: _____

TREATMENTS
 O₂ _____ L/Min. via NC Mask BVM BioW by EXist. Trach ET KING CPAP
 IV None Ordered IV Unable Refused SL IO Preexist TKO WO FC
 T.G.P.: MA _____ Rate _____ Capture: Y N Needle Thoracostomy
 Spinal Immob. Refuse Glucometer
 CMS Intact Before #1
 After #2
 Clear by Algorithm

Time	B/P	P	R	O ₂ Sat	Pain 0-10	Drug	SED's in the past 48 hrs <input type="checkbox"/> Y <input type="checkbox"/> N	Dose	Route	Treatment/Results

TRAUMA
 No Apparent Injuries BUrns/Shock Spinal Cord Inj.
 B P < 5 yr BP < 70 > 7 yr BP < 90
 Minor Lac/ Head Abdomen
 Flail Chest GCS = 14 Genital/Buttocks
 T. Pneumo Facial/Dental Extremities
 Trauma Neck FRactures
 Arrest Chest Amputations
 Back Bet Mid Clav Neuro/Vasc Comp

MECHANISM
 Enc. Veh. S Belt A Bag Assault
 Pass Space Intrusion With Blunt Instr
 Surv. of Fatal Acc. STabbing
 Ejected from Vehicle GSW
 Extrication Required Trunk
 Pect/Bike vs Vehicle SI Accidental Sports
 Motorcycle/Moped SI Intentional Wk Related
 Vs Vehicle ANimal Bite UNKnown
 HeLmet CRush OTher _____

TRAUMA
 FALL > 15 ft
 Electric Shock
 Hazmat Expos.
 Thermal Burn
 Wk Related
 UNKnown
 OTher _____

TRANSPORT
 MAR: _____ ETA: _____ EDAP: _____ ETA: _____
 REC: _____ ETA: _____
 Destination:
 MAR
 EDAP (< 14 yrs)
 PERINATAL (> 20 wks pregnancy)
 TC
 PTC (< 14 yrs trauma)
 PMC (< 14 yrs medical)
 SRC (12 Lead ECG = STEMI or ROSC)
 ASC Other _____
 Indicate rationale below:
 ED SAT
 Int Disaster
 CT
 Request
 SART
 SC Rag
 Extremis
 No SC Access (w/ 30 mins)
 Other _____

DISPO
 Time Clear _____
 Time Receiving Hosp. Notified _____
 Person Notified _____
 If Base is = Receiving hospital: Cath Lab Ward OB Expired Discharged
 Adm. To Rm # _____ ICU/CCU OR Stepdown Inter. Rad
 Other _____ Transferred from E.D. to _____
 E.D. Diagnosis _____

COMMON
 MICN/Cert. # _____ Physician _____ Patient Name/Number _____

MCI BASE HOSPITAL FORM

MCI BASE HOSPITAL FORM

of Patients Transported

DATE | TIME | PROVIDER CODE | HOSP CODE

LOCATION | UNIT | RADIO | FULL CALL

MICN | TOTAL PATIENTS | PHONE | SFTP

PHYSICIAN | TIME CLEAR | HEAR | JOINT

Comb R/P/H | Info Only

	Delayed	Minor	Major

BASE HOSPITAL FORM

PR# | M Seq #

Age | F Log #

Wt. _____ Kg/lbs

GCS	Vital Signs	Peds Weight Color Code
E _____	BP/ _____	<input type="checkbox"/> Immediate
M _____	Cap Refill _____	<input type="checkbox"/> Delayed
V _____	Pulse _____	<input type="checkbox"/> Minor
	Resp _____	

Chief Complaint _____

Field Decontamination

Treatment: O2 IV Sp. Immob. Meds AMA

Trans By: _____ Rec. Facil. _____

No Transport | ETA _____

Trans To: MAR PeriNat EDAP PMC TC/PTC Other

Admit: ICU/CCU OR Ward Triage OB Other

Transferred: Discharged Expired

ED Diagnosis _____

Name: _____

BASE HOSPITAL

BASE HOSPITAL FORM

PR# | M Seq #

Age | F Log #

Wt. _____ Kg/lbs

GCS	Vital Signs	Peds Weight Color Code
E _____	BP/ _____	<input type="checkbox"/> Immediate
M _____	Cap Refill _____	<input type="checkbox"/> Delayed
V _____	Pulse _____	<input type="checkbox"/> Minor
	Resp _____	

Chief Complaint _____

Field Decontamination

Treatment: O2 IV Sp. Immob. Meds AMA

Trans By: _____ Rec. Facil. _____

No Transport | ETA _____

Trans To: MAR PeriNat EDAP PMC TC/PTC Other

Admit: ICU/CCU OR Ward Triage OB Other

Transferred: Discharged Expired

ED Diagnosis _____

Name: _____

BASE HOSPITAL

BASE HOSPITAL FORM

PR# | M Seq #

Age | F Log #

Wt. _____ Kg/lbs

GCS	Vital Signs	Peds Weight Color Code
E _____	BP/ _____	<input type="checkbox"/> Immediate
M _____	Cap Refill _____	<input type="checkbox"/> Delayed
V _____	Pulse _____	<input type="checkbox"/> Minor
	Resp _____	

Chief Complaint _____

Field Decontamination

Treatment: O2 IV Sp. Immob. Meds AMA

Trans By: _____ Rec. Facil. _____

No Transport | ETA _____

Trans To: MAR PeriNat EDAP PMC TC/PTC Other

Admit: ICU/CCU OR Ward Triage OB Other

Transferred: Discharged Expired

ED Diagnosis _____

Name: _____

BASE HOSPITAL

BASE HOSPITAL FORM

PR# | M Seq #

Age | F Log #

Wt. _____ Kg/lbs

GCS	Vital Signs	Peds Weight Color Code
E _____	BP/ _____	<input type="checkbox"/> Immediate
M _____	Cap Refill _____	<input type="checkbox"/> Delayed
V _____	Pulse _____	<input type="checkbox"/> Minor
	Resp _____	

Chief Complaint _____

Field Decontamination

Treatment: O2 IV Sp. Immob. Meds AMA

Trans By: _____ Rec. Facil. _____

No Transport | ETA _____

Trans To: MAR PeriNat EDAP PMC TC/PTC Other

Admit: ICU/CCU OR Ward Triage OB Other

Transferred: Discharged Expired

ED Diagnosis _____

Name: _____

BASE HOSPITAL

TABLE OF CONTENTS

INTRODUCTION – READ ME FIRST!.....	2
REGULAR RUNS.....	4
SFTP RUNS.....	5
REPORT COMPLETION AND FORM DISTRIBUTION.....	6
HOW TO USE THIS MANUAL.....	7
GENERAL GUIDELINES.....	7
FORM LAYOUT.....	8
A NOTE TO PHYSICIANS AND MICN'S.....	9
Section 1: GENERAL INFORMATION.....	10
Section 2: ASSESSMENT.....	15
Section 3. PHYSICAL.....	24
Section 4. TREATMENTS.....	36
Section 6. TRANSPORT.....	49
Section 7. DISPOSITION.....	57
Section 8. COMMENTS.....	60
Section 9. SIGNATURE.....	61
Section 10. MULTIPLE CASUALTY INCIDENT FORM (MCI).....	62
Section 11. STANDING FIELD TREATMENT PROTOCOLS (SFTP'S).....	68
GLOSSARY.....	74

INTRODUCTION – READ ME FIRST!

The nation and the world look to the Los Angeles County EMS program for answers to many basic prehospital care questions. Ours is one of the oldest systems and, in terms of number of personnel and population served, the largest EMS system in existence. What a gold mine of information!

However, complexity runs hand in hand with size, and in Los Angeles this is certainly true. Nowhere in the world is there such a diverse mix of providers, rescue vehicle types and operating procedures. Within this vast system, the Base Hospital Form is a vital component of emergency medical care.

THE PURPOSE OF THE BASE HOSPITAL FORM

The Base Hospital Form is a one-page form utilized by all of the base hospitals in the Los Angeles County EMS system. The Base Hospital Form provides:

1. A clear summary of the patient's condition which the MICN or physician can use to order treatments.

2. A medical-legal record documenting the patient's signs, symptoms and the treatments ordered.

3. A means of capturing prehospital data for research and management purposes for the base hospital, receiving hospital and the Department of Health Services.

DATA COLLECTION AND "TEMIS"

TEMIS stands for the Trauma and Emergency Medicine Information System. To examine prehospital medical issues for research and management purposes effectively, all providers must collect the same basic medical data in a consistent fashion and the data must be computable. TEMIS is a centralized database managed by the Los Angeles County Emergency Medical Services Agency, which is a division of the Department of Health Services. By standardizing and centralizing data analysis, TEMIS can maximize the benefits of prehospital data collection.

In addition, TEMIS integrates information from every base hospital within the County of Los Angeles with information from the trauma centers and paramedic providers. To accomplish its goals, TEMIS uses a computer system developed by Lancet Technology, a private firm that has implemented emergency medical computer systems worldwide.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

WHAT REALLY IS THE POINT OF ALL THIS PAPERWORK?

TEMIS has the same essential goal as all emergency medical services agencies: **to save lives.**

How does TEMIS save lives? Information obtained from the TEMIS database can enhance prehospital care research, assist with quality improvement, and help to provide a sound basis for the development of policies and procedures in order to maintain a quality EMS system throughout the County.

TEMIS data has recently been utilized for the following:

- System impact assessments relative to hospital closures
- Evaluation of trauma transport rationale
- Evaluation of patients transported by helicopter
- Evaluation of impact of pediatric color coding on pediatric medication orders
- Reassignment of ALS Units
- Needs assessment for proposed implementation of ALS services

DATA ENTRY ELEMENTS

Data from the Base Hospital Form must be entered into the TEMIS (Trauma and Emergency Medicine Information System) database within 45 days of the incident date. To maintain a quality database, documentation on the Base Hospital Form must be complete and accurate. For the most part, only the person who originally filled out the form should modify the document.

The following fields are mandatory for data entry into TEMIS:

BASE HOSPITAL FORM INSTRUCTION MANUAL

REGULAR RUNS

SECTION	FIELDS		
GENERAL INFO	Sequence Number and Log Number	Date/Time	Hospital Code
	Provider Code/Unit	Age	Sex
	Location	Pediatric Weight/Color Code	Communication Type and Call Type
ASSESSMENT	Chief Complaint	Severity of Illness	Prior to Base Contact Medication and Treatment
PHYSICAL	LOC	GCS/mLAPSS	EKG and Arrest 12-Lead time and Electronic Intrepretation
TREATMENTS	Intravenous Access	Medications Ordered	Glucometer
	Spinal Immobilization	Transcutaneous Pacing (if applicable)	
TRAUMA	Trauma Complaint	Mechanism of Injury	
TRANSPORT	Transport Options (MAR, Trauma/ PTC, PMC, etc.)	Actual Transport Destination (if transported)	Method of Transport (if transported)
	Trauma/Peds Rationale (all injured and all pediatric patients)	Not Transported Rationale (if applicable)	Rationale for Transport to Other (if applicable)
DISPO	Time Clear	Time Receiving Hospital Notified (if applicable)	ED Diagnosis and Patient Disposition (if Base is Receiving Facility)
SIGNATURE	MICN Certification# (if handled call)	Physician# (if handled call or was consulted by MICN)	

BASE HOSPITAL FORM INSTRUCTION MANUAL

SFTP RUNS

SECTION	FIELDS		
INFO	Sequence Number and Log Number	Date/Time	Hospital Code
	Provider Code/Unit	Age	Sex
	Communication Type and Call Type		
ASSESSMENT	Chief Complaint	Severity of Illness	Protocol Used
PHYSICAL	EKG/Arrest: STEMI Pts. 12-Lead time and Electronic Interpretation		
TREATMENTS			
TRAUMA	Trauma Complaint	Mechanism of Injury	
TRANSPORT	Actual Transport Destination (if transported)	Rationale for Transport to Other (if applicable)	Not Transported Rationale (if applicable)
	Method of Transport (if transported)	Trauma/Peds Rationale (all injured and all pediatric patients)	
DISPO	Time Clear	Time Receiving Hospital Notified (if applicable)	ED Diagnosis and Patient Disposition (if Base is Receiving Facility)
SIGNATURE	MICN Certification# (if handled call)	Physician# (if handled call or was consulted by MICN)	

REPORT COMPLETION AND FORM DISTRIBUTION

BY WHOM

One Base Hospital Form must be completed for each base hospital contact involving a patient (one form per patient). The MICN or physician handling the voice contact between the paramedic and base hospital is responsible for thorough and accurate completion of the form.

WHEN

To ensure accuracy, the Base Hospital Form should be fully completed at the time of the run.

Tight hospital schedules rarely allow personnel to return to complete these forms after-the-fact. Clerks entering the data have neither the expertise nor authority to revise forms.

DISTRIBUTION OF COPIES

The original copy of the Base Hospital Form is retained by the base hospital as part of the record for each patient run. Prehospital Care records must be stored in accordance with Los Angeles County Department of Health Services, Prehospital Care Manual, Reference No. 610: Retention of Prehospital Care Records.

The second page (labeled "EMS Agency") should be mailed to the Emergency Medical Services Agency. These forms should be received by the EMS Agency no later than sixty (60) days after the incident date. Generally, they are batched in chronological order and sent to the EMS Agency on a monthly (or more frequent) basis.

The third and page (labeled "Complimentary Copy") is for discretionary use by the base hospital.

HOW TO USE THIS MANUAL

Each item on the Base Hospital Form constitutes a "data element." This manual provides a detailed explanation regarding the proper completion of each data element. The explanations in this manual are grouped in sections, each representing a section on the form. Each section contains a description of the data elements contained in that section and a brief explanation for completing the form. Additional information or clarifications often follow. Occasionally, clarifications are boxed to highlight their importance.

GENERAL GUIDELINES

When completing the Base Hospital Form, be sure to do the following:

1. **Write or print legibly.**
2. **Use only a hard tipped, ink pen. Press firmly.** You are making three copies.
3. **Avoid stray marks.** Mark boxes carefully, placing a bold "X" in the center of the desired check box. Keep codes and numeric responses within the space provided. Accidental marks on the original top sheet may appear on subsequent copies and may look like entries.
4. **Correct errors properly.** Make corrections by drawing a single line through the incorrect item or narrative (the writing underneath the single line must remain readable). Make the changes on the original, noting the date and time the changes were made, with the signature of the individual making the changes, adjacent to the correction. Ideally, changes should be made by the individual who initially completed the form. Under no circumstances should changes to either patient assessment or patient treatment documentation be made by an individual who did not participate in the response.
(Los Angeles County Department of Health Services, Prehospital Care Manual, Reference No. 606: Documentation of Prehospital Care).

Any person who alters or modifies the medical record of any person with fraudulent intent, or who, with fraudulent intent, creates any false medical record, is guilty of a misdemeanor (Section 471.5 of the California Penal Code).

5. **Use military time.** Use the same clock for the entire run to obtain consistent times.

FORM LAYOUT

The Base Hospital Form is divided into nine sections. Some of the sections that contain crucial bits of information are color-coded.

- The **GREY SHADED** portions are mandatory and must be completed in their entirety for all responses.
- Sections with **BLACK HEADINGS** must have at least one entry.
- The **RED LETTERED** items represent the trauma criteria and identify patients who meet the qualifications for mandatory transport to a trauma center.
- The **BLUE LETTERED** items represent the trauma guidelines and identify patients who meet the guidelines for transport to a trauma center.
- **CODES** are required for certain items. The codes for the following are on the back of the Base Hospital Form.
 - Paramedic Provider Agency Codes
 - ECG Codes
 - Drug/Defib Codes
 - Drug Route Codes
- Contact Codes
- Medical Chief Complaint Codes
- Location Codes
- Basic Receiving Hospital Codes

A NOTE TO PHYSICIANS AND MICN'S

Your care in filling out these reports is essential to their usefulness.

Hospitals are often chronically understaffed, and runs often occur at inconvenient times. You may be pulled away from performing other equally important tasks in the Emergency Department. Nevertheless, please take a couple of extra seconds to ensure the following:

- **COMPLETENESS**
- **ACCURACY**

Remember:

- These forms are medical-legal documents!
- The staff entering your information into the computer may not be able to recognize your mistakes. As a result, reports containing incorrect information may be generated.

BASE HOSPITAL FORM INSTRUCTION MANUAL

Section 1: GENERAL INFORMATION

BASE HOSPITAL FORM

Log #	SEQ. #	Pt. # _____ of _____	Hospital Code	<input type="checkbox"/> Pg2
Date	Prov. Code	Age _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Radio	<input type="checkbox"/> Full Call
Time	Unit	<input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> H <input type="checkbox"/> Est	<input type="checkbox"/> Phone	<input type="checkbox"/> SFT Protocol
Location	Weight _____ <input type="checkbox"/> Kg <input type="checkbox"/> lbs. <input type="checkbox"/> Est	Peds. Weight Color Code	<input type="checkbox"/> HEAR Radio	<input type="checkbox"/> Joint Run
		<input type="checkbox"/> Too Tall	<input type="checkbox"/> Info Only	

This section, located at the top of the form contains general run information and must be completed in its entirety.

DATA ELEMENTS:

The first two items in this section are medical record numbers used to identify and track patients from the prehospital phase of care through hospitalization. These two numbers both must be completed accurately.

Log#:

Enter the number assigned to the patient by your hospital.

- This number is from the base hospital log and is specific for each patient.

SEQ.#:

Enter the Sequence number the paramedic gives you to identify each patient. The paramedic will find this Sequence number preprinted in the "Patient Information" section of the EMS Report Form or prepopulated for those providers utilizing electronic patient care devices.

- A sequence number **must be entered correctly** for every patient. Each sequence is unique and contains 2 letters and 6 numbers for providers using paper EMS Report forms and contains 2 letters (which are the provider's code eg. CI=Los Angeles City Fire, MP=Monterey Park Fire; PF=Pasadena Fire) and 10 numbers. The electronic providers 2 letters will always be the same. A sequence number cannot be made up or altered in any way by the base hospital.
- Occasionally, the TEMIS database will not accept a Sequence number that has been correctly transmitted to the base hospital from a paramedic unit. If this occurs, contact the EMS Agency Base Hospital Data Coordinator.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

- If the physician or MICN did not obtain a Sequence number at the time of the run, every effort **must** be made to contact the provider prior to requesting a replacement (“dummy”) number from the EMS Agency.

Pg2:

- A supplemental page to the Base Hospital Form when extra space is needed for documentation.

Date:

Enter the date the run is called into the base hospital.

- Enter the month first, then the day and year.
- Use leading zeros when necessary.
- Use the (MM,DD,YYYY) format.

Time:

Enter the time the run is called into the base hospital.

- Use military time.

Location:

Enter the code that describes the environment of the incident: e.g., street, home, canyon, etc.

Location codes are listed on the back of the form.

- Additional details can be written on the adjacent line: e.g., the precise address, the name of a retirement home, or any other information that may need to be tracked.

Prov. Code (Provider Code):

Enter the two-letter provider code of the provider agency calling in the run.

Provider codes are listed on the back of the form. Letters correspond to the name of the agency.

BASE HOSPITAL FORM INSTRUCTION MANUAL

Unit:

Enter the number that identifies the specific unit that calls in the run.

- This number is preceded by a letter designating the type of apparatus:
 "E" for engine
 "R" for rescue ambulance
 "S" for squad
 "T" for truck
 "A" for private ambulance
 "H" for helicopter
 "AE" for Assessment Engine
 "AT" for Assessment Truck
 "PE" for Paramedic Engine

Pt.# ____ of ____:

Enter the number identifying the patient amongst the total number of patients involved in an incident.

- If there is only one patient write **PT.# 1 of 1**
- If there are multiple patients (for example, four patients), and the patient is identified by the paramedics as the third patient, then write **Pt.# 3 of 4**

Age:

Pt. # _____ of _____
Age _____ Sex: <input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> H <input type="checkbox"/> Est
Weight _____ <input type="checkbox"/> Kg <input type="checkbox"/> lbs. <input type="checkbox"/> Est

Enter the age of the patient in years. If the age is estimated, place an "X" in the checkbox in front of Est.

- Age units are as follows: Hours (H): newborn to 24 hours Days (D): 1day to 1 month. Months (M): 1 month to 2 years (24 months). Years (Y): over 2 years. These units of age are consistent with the California and National EMS databases.

BASE HOSPITAL FORM INSTRUCTION MANUAL

Sex:

Mark the appropriate box to identify the patient's gender.

- M Male
 F Female

Weight: _____ kg/lbs.:

Enter the weight of the patient. Indicate kilograms or pounds by circling the appropriate modifier. If the weight is estimated, place an "X" in the checkbox in front of Est.

- Patient weight should be entered for all pediatric patients and all patients for whom medications are ordered.

Peds Weight Color Code:

Document the color that corresponds to the length of the child or infant as measured on a pediatric resuscitation measuring tape. Place an "X" in the checkbox in front of Too Tall if the child is taller than the measuring tape.

Hospital Code:

Enter the three-letter code of the base hospital.

Base hospital codes are listed on the back of the form.

Communication Type:

For **regular runs** where medical direction is provided, mark only one of the following:

- Radio** The base station radio console transmits and records the run.
- Phone** The run is called in via telephone and is automatically recorded.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Hear Radio** The run comes over the Hospital Emergency Administrative Radio.

Run Type:

Mark only one of the following:

- Full Call** The paramedics give the base hospital a full report and medical direction is provided by the base hospital (AMA) calls are considered "Full Calls" even though medical direction may not be given).
- SFT Protocol** Paramedics working for an approved SFTP Provider agency make base hospital contact to receive destination information (no medical direction is provided by the base hospital).
- Joint Run** The paramedics initially make base hospital contact with a SFTP run. The base hospital or paramedics decide that medical direction or consultation is required. A full report is then given by the paramedics and medical direction is provided by the base hospital.
- Info Only** Mark this box if the run is called in for the purpose of documenting information only and no treatments or interventions were ordered.

NOTE: Against Medical Advise (AMA) calls are **not** considered "Information Only" calls. Los Angeles County Prehospital Care Manual, Reference No. 808: Base Hospital Contact and Transport Criteria, requires base hospital contact when a patient who meets base contact criteria, as specified in Section 1, refuses treatment or transport. Base contact should be made before the paramedics leave the scene. The MICN/Base Hospital MD should attempt to discuss the situation with the patient and continue the paramedics' efforts to convince the patient of their need to seek medical attention. (A patient's refusal of treatment/transportation is considered a "high-risk" situation and careful documentation of all of the run's details are essential.)

BASE HOSPITAL FORM INSTRUCTION MANUAL

Section 2: ASSESSMENT

ASSESSMENT	Chief Complaint Code	<input type="text"/>	<input type="text"/>	<input type="text"/>	SEVERITY OF DISTRESS	<input type="checkbox"/> None <input type="checkbox"/> MILD <input type="checkbox"/> Mod. <input type="checkbox"/> Severe	PRIORITY BASE	PTBC (Meds)	PTBC (Treatments)
	Protocol				O/P	<input type="checkbox"/> ASA <input type="checkbox"/> ATR <input type="checkbox"/> ALB <input type="checkbox"/> D50/D25 <input type="checkbox"/> OND <input type="checkbox"/> EPI <input type="checkbox"/> GLU <input type="checkbox"/> GLP <input type="checkbox"/> MID <input type="checkbox"/> NAR <input type="checkbox"/> NTG <input type="checkbox"/> Morphine		<input type="checkbox"/> O2 _____ M/NC <input type="checkbox"/> BVM <input type="checkbox"/> CPAP <input type="checkbox"/> ET <input type="checkbox"/> KING <input type="checkbox"/> IV <input type="checkbox"/> IO <input type="checkbox"/> Monitor <input type="checkbox"/> 12 Lead <input type="checkbox"/> Glucometer <input type="checkbox"/> Defib X _____ <input type="checkbox"/> CAR <input type="checkbox"/> TCP <input type="checkbox"/> AED-Defib <input type="checkbox"/> N. Thor <input type="checkbox"/> Spinal Immob.	
	Medical HX				Q				
	Medications				R				
	<input type="checkbox"/> NKA Allergies:				S	<input type="checkbox"/> Suspected Drugs/ETOH			

This section identifies the patient's chief complaint, severity of illness, any related medical history, and provides space for written comments.

DATA ELEMENTS:

Chief Complaint Code:

Enter the two-letter code that best identifies the patient's problem. If the patient has more than one problem, list the **most significant** problem first. Up to three codes can be entered.

Trauma Complaint Codes:

Chief complaint codes for **injuries** are in the trauma section on the front of the form. They are the two bold letters of the items listed in the "Trauma" portion of the Trauma/Mechanism of Injury Section. Trauma injury codes are "Blunt" or "Penetrating", with the exception of NA (No Apparent Injuries), IT (Inpatient Trauma), BU (Burns/Shock), and SC (Spinal Cord Inj.).

- Enter the two-letter code identifying the type of injury, "B" for blunt force vs. "P" for penetrating and the location of the injury (head, chest, etc.).
- If the patient has more than one injury, enter the most significant injury code first, followed by the less significant injury codes. **Indented injury codes (subcategory) are always more significant than the injury code (primary) they follow and therefore should be used instead of the complaint (primary).**

○ For example:

- Enter the subcategory "BR" for blunt fracture rather than the primary category "BE" for Blunt Extremities. It is redundant to enter "BE" as well as "BR" because there cannot be a fracture unless there is an extremity injury.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Enter the subcategory "14" for a blunt head trauma with a GCS < 15 rather than the primary category "BH" for Blunt Head. It is redundant to enter "BH" since there cannot be a "14" unless there is blunt head trauma.

Medical Complaint Codes:

Chief complaint codes for **medical** problems are listed on the back of the form.

The **medical** codes and their definitions are as follows:

AD	Agitated	Behavioral emergency where patient exhibits an acute onset of extreme agitation, combative and bizarre behavior that may be accompanied by paranoid delusions, hallucinations, aggression with an unusual increase in human strength, and hyperthermia.
AP	Abd/Pelvic Pain	Pain or discomfort in the abdomen or pelvic region not associated with trauma.
AR	Allergic Reaction	Hives, itching, redness of the skin, runny nose or shortness of breath that have occurred suddenly. The patient may have been in contact with a known allergen (shellfish, milk products, medication, etc.).
AL	Altered LOC (Level of Consciousness)	Characterized by an abnormal response to environment (e.g. disorientation, no spontaneous eye opening, etc.)
AE	Apnea Episode	One or more episodes where respiration has ceased for a brief time. This should not be confused with "Respiratory Arrest", which is marked when the patient has stopped breathing and shows no sign of regaining spontaneous respirations.
TE	Apparent Life Threatening Event(ALTE) (<12 mo.)	An episode that is frightening to the observer and characterized by a combination of transient apnea, color change (usually cyanosis, but occasionally erythema or plethoric), marked change in muscle tone (usually limpness), and choking and/or gagging. The infant (12 months or younger) may appear normal by the time rescuers arrive.
EH	Behavioral	Abnormal behavior of mental or emotional origin. Do not mark this box for psychiatric patients unless their bizarre

BASE HOSPITAL FORM INSTRUCTION MANUAL

		behavior is the cause of, or related to, their current complaint.
OS	Bleeding Other Site	Bleeding (not related to trauma) from a site not elsewhere listed in the medical complaint section.
CA	Cardiac Arrest	Cardiac arrest is defined as a sudden cessation of cardiac output and effective circulation, usually precipitated by ventricular fibrillation, and in some instances, ventricular asystole. This code should not be used when the arrest was caused by a traumatic injury.
CP	Chest Pain	Pain in the chest occurring anywhere from the clavicles to the lower costal margins.
CH	Choking/Airway Obstruction	Characterized by apnea, choking and/or difficulty breathing of rapid onset, which appears to be due to an obstruction of the airway.
CC	Cough/Congestion	Cough and/or congestion in the chest, nasal passages, or throat.
DC	Device(Medical) Complaint	Any complaint with a medical device (e.g. G-tube dislodged or clogged, ventilator malfunction, etc.)
DI	Dizzy	The patient complains of feeling dizzy. If the patient is weak and dizzy – use both codes (WE and DI).
DO	DOA	Patient is dead upon EMS arrival and is determined dead per Los Angeles County <u>Prehospital Care Manual</u> : Reference No.814 Determination/Pronouncement of Death in the Field.
DY	Dysrhythmia	The cardiac monitor indicates a rhythm abnormality that may require medical attention (SVT, VT, etc.).
FE	Fever	The patient exhibits or complains of an elevated body temperature.
FB	Foreign Body	A foreign body within any orifice of the body.
GI	GI Bleed	Gastrointestinal Bleed. Bleeding from the upper or lower GI tract. The patient has coffee ground emesis, bloody stool or vomitus, and/or black tarry stool.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

HP	Head Pain	“Headache” or any other type of head pain not associated with trauma.
HY	Hypoglycemia	Patient exhibits signs/symptoms of hypoglycemia and the documented blood glucose is below normal.
IM	Inpatient Medical	Interfacility transfer of a patient with a medical chief complaint from a medical ward or ICU. Do not use this complaint for patients transferred from the Emergency Department.
MI	Myocardial Infarction	Patient has an acute myocardial infarction according to the electronic 12-Lead EKG interpretation.
LA	Labor	An obstetric patient late in her pregnancy experiencing regular uterine contractions.
LN	Local Neuro Signs	The patient exhibits or experiences weakness and/or numbness of a specific part of the body (slurred speech, facial droop, etc.) or expressive aphasia.
NV	Nausea/Vomiting	The patient is experiencing nausea and/or vomiting.
ND	Near Drowning	History of submersion causing signs/symptoms to include difficulty breathing. This category includes patients who die from drowning.
NB	Neck/Back Pain	Pain in the neck and/or the back from the shoulders to the buttocks not associated with trauma.
NW	Newborn	Use this as the chief complaint for a newborn infant delivered in the field. A separate Base Hospital Form and EMS Report Form are required for mother and newborn.
NC	No Medical Complaint	No physical or medical complaint. A patient without signs or symptoms of illness. This should not be marked if the patient has a trauma complaint.
NO	Nose Bleed	A type of external bleeding from the nose that occurs spontaneously and is not associated with trauma.
OB	Obstetrics/GYN	A patient who is known to be pregnant shows signs or symptoms related to the pregnancy. These signs and symptoms may include high blood pressure, convulsions, severe headaches, edema, vaginal

BASE HOSPITAL FORM INSTRUCTION MANUAL

		bleeding, abdominal pain and/or cramping.
OP	Other Pain	Complaint of pain in a site not listed in the medical complaint section and not associated with trauma.
OD	Overdose	Overdose of drugs by a purposeful act.
PO	Poisoning	Accidental ingestion of medication or chemical substance.
PS	Palpitations	Sensation of heartbeat that is irregular or fast.
RA	Respiratory Arrest	Absence of breathing.
SE	Seizure	Active convulsions or current incident that suggests the patient has had a recent seizure.
SB	Short of Breath	The patient states he is short of breath and/or breathing is characterized by gasping, rapid respirations, cyanosis, use of accessory muscles, retractions, etc.
SY	Syncope	Transient loss of consciousness. "Near syncope" may be coded SY unless there are other associated symptoms such as weakness/dizziness, which would be more descriptive.
VA	Vaginal Bleed	Abnormal vaginal bleeding.
WE	Weak	The patient is experiencing weakness. If the patient is weak and dizzy – use both codes (WE and DI).
OT	Other	Signs or symptoms that do not fit into any of the categories mentioned in this section.

ASSESSMENT	Chief Complaint Code	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Mod <input type="checkbox"/> Severe	PRIOR TO BASE	PTBC (Meds)	PTBC (Treatments)
	Protocol	O/P		<input type="checkbox"/> ADE <input type="checkbox"/> ASA <input type="checkbox"/> ATR <input type="checkbox"/> ALB <input type="checkbox"/> DSO/D25 <input type="checkbox"/> OND <input type="checkbox"/> EPI <input type="checkbox"/> GLU <input type="checkbox"/> GLP <input type="checkbox"/> MID <input type="checkbox"/> NAR <input type="checkbox"/> NTG <input type="checkbox"/> Morphine	<input type="checkbox"/> O2 <input type="checkbox"/> M/NC <input type="checkbox"/> BVM <input type="checkbox"/> CPAP <input type="checkbox"/> ET <input type="checkbox"/> KING <input type="checkbox"/> IV <input type="checkbox"/> IO <input type="checkbox"/> Monitor <input type="checkbox"/> 12 Lead <input type="checkbox"/> Glucometer <input type="checkbox"/> Defib X <input type="checkbox"/> CAR <input type="checkbox"/> TCP <input type="checkbox"/> AED-Defib <input type="checkbox"/> N. Thor <input type="checkbox"/> Spinal Immob.
	Medical HX	S			
	Medications	T			
	<input type="checkbox"/> NKA Allergies:	<input type="checkbox"/> Suspected Drugs/ETOH			

Severity Of Distress:

BASE HOSPITAL FORM INSTRUCTION MANUAL

The objective assessment by EMS personnel of the patient's presentation of signs and symptoms related to the chief complaint.

- None** Exhibits no outward signs of distress and shows no adverse reaction related to the chief complaint.

- Mild** Exhibits a low level of distress. Shows few external cues indicating a low level of distress related to the chief complaint. The patient can easily divert attention from signs and symptoms related to the chief complaint.

- Mod**
(moderate) Exhibits an increasing level of distress. The patient is not easily distracted and remains more focused on chief complaint/signs and symptoms. For example, signs and symptoms of a patient in moderate distress with a chief complaint of shortness of breath may include one or more of the following:
 - Speaks in short sentences
 - Accessory muscle use
 - Costal retractions
 - Moist or cool skin signs

- Severe** Exhibits a great level of distress. The patient is completely focused on the chief complaint/signs and symptoms. Nothing can distract the patient from the serious signs and symptoms that he/she is experiencing. For example, signs and symptoms of a patient in severe distress with a chief complaint of shortness of breath may include one or more of the following:
 - Speaks in one or two word sentences
 - Not able to speak
 - Diaphoresis
 - Costal/sternal retractions
 - Skin discoloration
 - Abnormal breath sounds
 - Breath sounds audible without a stethoscope
 - Tripod position

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Chief Complaint Code <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	SEVERITY OF DISTRESS <input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Mod. <input type="checkbox"/> Severe	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; vertical-align: top;"> PTBC (Meds) <input type="checkbox"/> ADE <input type="checkbox"/> ASA <input type="checkbox"/> ATR <input type="checkbox"/> ALB <input type="checkbox"/> D50/D25 <input type="checkbox"/> OND <input type="checkbox"/> EPI <input type="checkbox"/> GLU <input type="checkbox"/> GLP <input type="checkbox"/> MID <input type="checkbox"/> NAR <input type="checkbox"/> NTG <input type="checkbox"/> Morphine </td> <td style="width: 50%; vertical-align: top;"> PTBC (Treatments) <input type="checkbox"/> O2 _____ M/NC <input type="checkbox"/> BVM <input type="checkbox"/> CPAP <input type="checkbox"/> ET <input type="checkbox"/> KING <input type="checkbox"/> IV <input type="checkbox"/> IO <input type="checkbox"/> MonitorR <input type="checkbox"/> 12 Lead <input type="checkbox"/> Glucometer <input type="checkbox"/> Defib X _____ <input type="checkbox"/> CAR <input type="checkbox"/> TCP <input type="checkbox"/> AED-Defib <input type="checkbox"/> N. THor <input type="checkbox"/> Spinal Immob. </td> </tr> </table>	PTBC (Meds) <input type="checkbox"/> ADE <input type="checkbox"/> ASA <input type="checkbox"/> ATR <input type="checkbox"/> ALB <input type="checkbox"/> D50/D25 <input type="checkbox"/> OND <input type="checkbox"/> EPI <input type="checkbox"/> GLU <input type="checkbox"/> GLP <input type="checkbox"/> MID <input type="checkbox"/> NAR <input type="checkbox"/> NTG <input type="checkbox"/> Morphine	PTBC (Treatments) <input type="checkbox"/> O2 _____ M/NC <input type="checkbox"/> BVM <input type="checkbox"/> CPAP <input type="checkbox"/> ET <input type="checkbox"/> KING <input type="checkbox"/> IV <input type="checkbox"/> IO <input type="checkbox"/> MonitorR <input type="checkbox"/> 12 Lead <input type="checkbox"/> Glucometer <input type="checkbox"/> Defib X _____ <input type="checkbox"/> CAR <input type="checkbox"/> TCP <input type="checkbox"/> AED-Defib <input type="checkbox"/> N. THor <input type="checkbox"/> Spinal Immob.
PTBC (Meds) <input type="checkbox"/> ADE <input type="checkbox"/> ASA <input type="checkbox"/> ATR <input type="checkbox"/> ALB <input type="checkbox"/> D50/D25 <input type="checkbox"/> OND <input type="checkbox"/> EPI <input type="checkbox"/> GLU <input type="checkbox"/> GLP <input type="checkbox"/> MID <input type="checkbox"/> NAR <input type="checkbox"/> NTG <input type="checkbox"/> Morphine	PTBC (Treatments) <input type="checkbox"/> O2 _____ M/NC <input type="checkbox"/> BVM <input type="checkbox"/> CPAP <input type="checkbox"/> ET <input type="checkbox"/> KING <input type="checkbox"/> IV <input type="checkbox"/> IO <input type="checkbox"/> MonitorR <input type="checkbox"/> 12 Lead <input type="checkbox"/> Glucometer <input type="checkbox"/> Defib X _____ <input type="checkbox"/> CAR <input type="checkbox"/> TCP <input type="checkbox"/> AED-Defib <input type="checkbox"/> N. THor <input type="checkbox"/> Spinal Immob.			
Protocol <input type="text"/>	O/P <input type="text"/>	Q <input type="text"/>		
Medical HX <input type="text"/>	S <input type="text"/>	R <input type="text"/>		
Medications <input type="checkbox"/> NKA Allergies:	T <input type="text"/>	<input type="checkbox"/> Suspected Drugs/ETOH		

Protocol:

Indicate the Standing Field Treatment Protocol (SFTP) used for the run (e.g. 1244, 1247) that is reported by the paramedic making base contact (more than one protocol may be used). The required data elements to be documented can be found on the table in "The Introduction Section" of the Base Hospital Form Training Manual.

O/P,Q,R,S,T:

Use the letters of the acronym to document pain. **O**nset, **P**rovocation, **Q**uality, **R**egion/Radiation/Relief, **S**everity, and **T**ime.

For Example: "Sudden onset, unprovoked crushing chest pain that radiates to the left arm and jaw began one (1) hour ago. The patient rates the pain as an "8" on the 1-10 scale and it is not affected by movement or respiration".

Medical HX:

Medical History. Enter any significant medical history that has or might have an effect on the patient's problem.

- Medical history may include heart disease, diabetes, hypertension, pregnancy, etc.
- If a patient states that she is pregnant, or you suspect she is pregnant, write the estimated length of pregnancy in months followed by "mo".

Medications:

- List the patient's current medications.
- This includes nonprescription drugs and herbal supplements.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- List the prescribed medications and indicate whether it has been taken recently.
 - For Example: Has a seizure patient been taking his/her anticonvulsant medication regularly?

- If the patient is not currently taking medication, draw a circle with a line through it.
 - For Example: Medications \emptyset

12 M E S S A G E	Chief Complaint Code	<input type="checkbox"/> None <input type="checkbox"/> MID	P T B C (M e d s)	P T B C (T r e a t m e n t s)		
		<input type="checkbox"/> Mod. <input type="checkbox"/> Severe			<input type="checkbox"/> ADE	<input type="checkbox"/> O2 <input type="checkbox"/> M/NC
	Protocol	O/P			<input type="checkbox"/> ASA	<input type="checkbox"/> BVM <input type="checkbox"/> CPAP
		Q			<input type="checkbox"/> ATR	<input type="checkbox"/> ET <input type="checkbox"/> KING
		R			<input type="checkbox"/> ALB	<input type="checkbox"/> IV <input type="checkbox"/> IO
Medical HX	S	<input type="checkbox"/> D50/D25	<input type="checkbox"/> Monitor <input type="checkbox"/> 12 Lead			
Medications	T	<input type="checkbox"/> OND	<input type="checkbox"/> Glucometer			
<input type="checkbox"/> NKA Allergies:	<input type="checkbox"/> Suspected Drugs/ETOH	<input type="checkbox"/> EPI	<input type="checkbox"/> Defib X			
		<input type="checkbox"/> GLU	<input type="checkbox"/> CAR			
		<input type="checkbox"/> GLP	<input type="checkbox"/> TCP			
		<input type="checkbox"/> MID	<input type="checkbox"/> AED-Defib			
		<input type="checkbox"/> NAR	<input type="checkbox"/> N. THor			
		<input type="checkbox"/> NTG	<input type="checkbox"/> Spinal Immob.			
		<input type="checkbox"/> Morphine				

PTBC (Prior To Base Contact) Meds:

Mark the box beside each medication that was administered by the paramedic prior to base hospital contact.

PTBC (Prior To Base Contact) Treatments:

Mark the box beside each treatment that was performed by the paramedics prior to base hospital contact.

NKA:

No known allergies. Mark this box if the patient denies having any allergies to medication.

- If the patient is unconscious or cannot answer, leave this box blank.

Allergies:

If the patient is allergic to certain medications, list them on this line.

- Allergies to food, dust, bee stings, hay fever, etc., are not of importance unless they are responsible for the current problem.

Suspected Drugs/ETOH:

BASE HOSPITAL FORM INSTRUCTION MANUAL

Mark this box if the situation, statements by the patient, family members or bystanders and/or patient behavior cause the paramedics to suspect that the patient has ingested alcoholic beverages or mind altering drugs.

- If the paramedic provides relevant information, note the reasons for checking this box in the Assessment section. Citing objective evidence concerning the patient's suspected alcohol/drug consumption is particularly important; (e.g., slurred speech, staggered gait, glassy eyes, odor of alcohol, fresh track marks, etc.).

ASSESSMENT	Chief Complaint Code	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Mod. <input type="checkbox"/> Severe	PROBABLE	PTBC (Meds)	PTBC (Treatments)
	Protocol	O/P		<input type="checkbox"/> ADE	<input type="checkbox"/> O2 <input type="checkbox"/> M/NC
	Medical HX	S		<input type="checkbox"/> ASA	<input type="checkbox"/> BVM <input type="checkbox"/> CPAP
	Medications	T		<input type="checkbox"/> ATR	<input type="checkbox"/> ET <input type="checkbox"/> KING
	<input type="checkbox"/> NKA Allergies:	<input type="checkbox"/> Suspected Drugs: ETOH		<input type="checkbox"/> ALB	<input type="checkbox"/> IV <input type="checkbox"/> IO
		<input type="checkbox"/> D50/D25	<input type="checkbox"/> Monitor <input type="checkbox"/> 12 Lead		
		<input type="checkbox"/> OND	<input type="checkbox"/> Glucometer		
		<input type="checkbox"/> EPI	<input type="checkbox"/> Defib X		
		<input type="checkbox"/> GLU	<input type="checkbox"/> CAR		
		<input type="checkbox"/> GLP	<input type="checkbox"/> TCP		
		<input type="checkbox"/> MID	<input type="checkbox"/> AED-Defib		
		<input type="checkbox"/> NAR	<input type="checkbox"/> N. Thor		
		<input type="checkbox"/> NTG	<input type="checkbox"/> Spinal Immob.		
		<input type="checkbox"/> Morphine			

Assessment:

General Comments/Narrative:

- On the lines provided, comment on crucial assessment information or information that is not covered elsewhere on the Base Hospital Form. Additional information may be written on a "Page 2".

Remember:

- Write legibly.
- Written comments must be professional and list only medically pertinent facts and observations.
- Include pertinent negative findings relative to chief complaint.
- Document barriers to care (communication difficulties, combative patient, hostile environment, etc.).
- Explain deviations from usual standard of care (unable to obtain blood glucose on combative patient, blood pressure cuff too large/small to obtain complete vital signs, etc.).

The Base Hospital Form is a *legal* document!

BASE HOSPITAL FORM INSTRUCTION MANUAL

Section 3. PHYSICAL

PHYSICAL	LOC	CONSCIOUS (check one box/each col) <input type="checkbox"/> Alert <input type="checkbox"/> Oriented x 3 <input type="checkbox"/> Not Alert <input type="checkbox"/> Disoriented <input type="checkbox"/> Combative <input type="checkbox"/> NorMal for Pt.	PUPILS	<input type="checkbox"/> PERL <input type="checkbox"/> Unequal <input type="checkbox"/> Pinpoint <input type="checkbox"/> Fixed & Dil <input type="checkbox"/> Sluggish	BREATHING	Rate/Effort: <input type="checkbox"/> Norm <input type="checkbox"/> Abnormal <input type="checkbox"/> Labored <input type="checkbox"/> Snoring <input type="checkbox"/> Acc. Mus. Use <input type="checkbox"/> Apnea T.V. <input type="checkbox"/> ↑ <input type="checkbox"/> N <input type="checkbox"/> ↓	SKIN	<input type="checkbox"/> Normal <input type="checkbox"/> Warm <input type="checkbox"/> Hot <input type="checkbox"/> Cool <input type="checkbox"/> Pale <input type="checkbox"/> Diaphoretic <input type="checkbox"/> Cyanotic <input type="checkbox"/> Flushed <input type="checkbox"/> Jaundiced Capillary Refill <input type="checkbox"/> NoRmal <input type="checkbox"/> DELayed	Init. Rhyth: _____ E <input type="checkbox"/> 12 Lead _____ (time) C <input type="checkbox"/> NL <input type="checkbox"/> ABnl <input type="checkbox"/> STEMI G <input type="checkbox"/> Artifact <input type="checkbox"/> Paced Rhythm <input type="checkbox"/> Wavy Baseline
	mLAPSS	UNCONSCIOUS (check only one box) Responds <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Purposeful <input type="checkbox"/> Nonpurposeful <input type="checkbox"/> No Response		GCS		<input type="checkbox"/> Clear <input type="checkbox"/> Rales <input type="checkbox"/> Wheeze <input type="checkbox"/> RHonchi <input type="checkbox"/> Stridor <input type="checkbox"/> Unequal <input type="checkbox"/> BS after ET/KING CO2 Detect. <input type="checkbox"/> + <input type="checkbox"/> - <input type="checkbox"/> Capno. # _____ Waveform <input type="checkbox"/> Y <input type="checkbox"/> N		Witnessed By: A <input type="checkbox"/> Citizen <input type="checkbox"/> EMS <input type="checkbox"/> NonA R CPR by: R <input type="checkbox"/> Citizen <input type="checkbox"/> EMS E Est. Down Time: _____ S <input type="checkbox"/> PUIses w/ CPR T <input type="checkbox"/> Restoration Pulse (ROSC) Time: _____	
	APSS	mLAPSS met <input type="checkbox"/> Y <input type="checkbox"/> N	Eye _____ Motor _____ Verbal _____						
	S	Last known well: Date: _____ Time: _____							

This section identifies the findings on **initial** assessment by EMS personnel. As the patient's condition improves/deteriorates with EMS intervention, the results should be documented in the Treatment Section. Additional information may be documented on a "Page 2".

The Physical Section is separated into eight subsections:

- A. LOC
- B. mLAPSS
- C. Pupils
- D. GCS
- E. Breathing
- F. Skin
- G. ECG
- H. Arrest

BASE HOSPITAL FORM INSTRUCTION MANUAL

DATA ELEMENTS:

LOC and mLAPSS:

P H Y S I C A L	L	CONSCIOUS (check one box/each col)
	O	<input type="checkbox"/> Alert <input type="checkbox"/> Oriented x 3 <input type="checkbox"/> Not Alert <input type="checkbox"/> Disoriented <input type="checkbox"/> Combative <input type="checkbox"/> Normal for Pt.
	C	UNCONSCIOUS (check only one box)
		Responds <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Purposeful <input type="checkbox"/> Nonpurposeful <input type="checkbox"/> No Response
	A	mLAPSS met
	L	<input type="checkbox"/> Y <input type="checkbox"/> N
	A	Last known well:
	S	Date: _____
	S	Time: _____

This section describes the patient's level of consciousness. Items within this section are divided into two categories: the upper group for patients who are conscious, and the lower for patients who are unconscious. **Select only one category to mark.**

CONSCIOUS: (Mark one box in each column)

NOTE: Do not mark oriented or disoriented for patients who are non-communicative; do not speak English, or are too young to communicate.

For the patient who is awake, mark whichever upper box is appropriate:

- Alert** The patient is awake and responsive to the environment.
- Not Alert** The patient is awake, but is drowsy or lethargic. This includes intoxicated patients.
- Combative** The patient physically resists treatment.
- Oriented x 3** The patient is oriented to person, place, and time.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Disoriented** The patient is not oriented to person, place, and/or time. If the patient is lacking orientation to **any** of these elements, this box is marked.

- Normal for Pt.** The patient's behavior, although not typical of most patients, is the same as it was before the incident. Mark this box to describe patients who suffer from mental illness, dementia, developmental delays, etc. It can also be used for infants and children who are age appropriate.

If this box is marked, further documentation should follow in the Narrative Section. Documentation should include who is stating that the patient is acting "normal" (family member, caregiver, etc.).

UNCONSCIOUS:

For patients who are unconscious, mark **only one** of the lower boxes. These items are in order which represent a decreasing level of responsiveness. Mark the box that represents the patient's highest level of responsiveness.

- Responds to Verbal** The patient is unconscious but does respond to verbal stimuli. For instance, in response to a voice the patient turns his head and moans.

- Responds to Pain** The patient is unconscious but does respond to Painful stimuli.
 - **Purposeful** The patient responds to painful stimuli by attempting to avoid the painful source (e.g. flinching or pushing it away).

 - **Non-purposeful** The patient responds to pain in a non-purposeful fashion. This includes decorticate and decerebrate rigidity.

 - **No response** The patient does not respond to any stimuli.

BASE HOSPITAL FORM INSTRUCTION MANUAL

mLAPSS

P H Y S I C A L	L	CONSCIOUS (check one box/each col)
	O	<input type="checkbox"/> Alert <input type="checkbox"/> Oriented x 3 <input type="checkbox"/> Not Alert <input type="checkbox"/> Disoriented <input type="checkbox"/> Combative <input type="checkbox"/> Normal for Pt.
	C	UNCONSCIOUS (check only one box)
		Responds <input type="checkbox"/> Verbal <input type="checkbox"/> Pain <input type="checkbox"/> Purposeful <input type="checkbox"/> Nonpurposeful <input type="checkbox"/> No Response
	A	mLAPSS met
	L	<input type="checkbox"/> Y <input type="checkbox"/> N
	A	Last known well:
	P	Date: _____
	S	Time: _____
	S	

mLAPSS Modified Los Angeles Prehospital Stroke Screen Criteria (mLAPSS)

1. Symptoms less than 2 hours duration
2. No history of seizures or epilepsy
3. Age equal to or greater than 40 years
4. At baseline, not wheelchair bound or bedridden
5. Blood glucose between 60 and 400 mg/dl
6. Motor Exam: Examine for obvious asymmetry (positive if one or more of the following is met)
 - a. Facial Smile/Grimace
 - b. Grip
 - c. Arm Strength

BASE HOSPITAL FORM INSTRUCTION MANUAL

mLAPSS**Modified Los Angeles Prehospital Stroke Screen**

Must be documented on all patients exhibiting local neurological signs and/or patients showing signs/symptoms of a possible stroke.

Mark:

- "Met"
- "Not Met"

Document:

Last Known Well: Completed for all patients exhibiting acute stroke symptoms, neurological deficits or whenever a mLAPSS exam is performed.

Date The date the patient was last seen at their baseline neurological status.

Time The time the patient was last seen at their baseline neurological status. If the patient awakes with symptoms, then the time they were last known to be at baseline should be recorded.

BASE HOSPITAL FORM INSTRUCTION MANUAL

PUPILS

P U P I L S	<input type="checkbox"/> PERL
	<input type="checkbox"/> Unequal
	<input type="checkbox"/> Pinpoint
	<input type="checkbox"/> Fixed & Dil
	<input type="checkbox"/> Sluggish
G C S	Eye
	Motor
	Verbal

This section describes the patient's pupillary status. Mark **one** box in this section.

- PERL** Pupils equal and reactive to light. Mark this box if the pupils are completely normal
- Unequal** Mark if the pupils are unequal in size.
- Pinpoint** Mark this box if the pupils are extremely constricted.
- Fixed & Dil** Fixed and dilated. Mark this box if pupils are dilated and not reacting to light.
- Sluggish** Pupils react slower to light than expected.

 BASE HOSPITAL FORM INSTRUCTION MANUAL

GCS

The Glasgow Coma Scale must be used on all patients age one year and older per Los Angeles County EMS Agency Medical Control Guidelines, Altered Level of Consciousness, 2003. The Glasgow Coma Scale is a numerical system for describing a patient's level of consciousness. The three GCS fields describe the level of patient response to stimuli. The Glasgow Coma Scale numeric values are used for the following items:

GLASGOW COMA SCALE**EYE OPENING**

Spontaneously	4
To Voice	3
To Pain	2
None	1

BEST MOTOR RESPONSE

Obedient	6
Purposeful	5
Withdrawal	4
Flexion	3
Extension	2
None	1

BEST VERBAL RESPONSE

Oriented	5
Confused	4
Inappropriate	3
Incomprehensible	2
None	1

BASE HOSPITAL FORM INSTRUCTION MANUAL

BREATHING

B R E A T H I N G	Rate/Effort: <input type="checkbox"/> Norm <input type="checkbox"/> Abnormal
	<input type="checkbox"/> Labored <input type="checkbox"/> Snoring
	<input type="checkbox"/> Acc. Mus. Use <input type="checkbox"/> Apnea
	T.V <input type="checkbox"/> ↑ <input type="checkbox"/> N <input type="checkbox"/> ↓
	<input type="checkbox"/> Clear <input type="checkbox"/> Rales
	<input type="checkbox"/> Wheeze <input type="checkbox"/> RHonchi
	<input type="checkbox"/> Stridor <input type="checkbox"/> Unequal
	<input type="checkbox"/> BS after ET/KING
	CO2 Detect. <input type="checkbox"/> + <input type="checkbox"/> —
	<input type="checkbox"/> Capno. # _____
Waveform <input type="checkbox"/> Y <input type="checkbox"/> N	

This section describes the patient's breathing.

Rate/Effort

- Normal** Mark this box if the patient's breathing appears normal in all respects, including rate, rhythm and depth.
 - If this box is marked, the tidal volume must also be marked as normal.

- Abnormal** Mark this box if any or all respects of the patients breathing are not normal.

- Labored** Mark this box if the patient's breathing appears labored.

- Snoring** Mark this box if the patient has a rough, hoarse type of breathing which can be caused by relaxation of the soft palate or some type of obstruction in the patients airway. Snoring is usually heard in a sleeping or unconscious patient ,an unconscious patient cannot clear their throat of mucus.

- Acc. Mus. Use** Mark this box if the patient is using accessory muscles to breathe.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Apnea** Mark this box if the patient is not breathing or has periods of apnea.

T.V. (Tidal Volume)

Tidal Volume is the depth of the patient's respirations. Mark as increased, normal or decreased.

- ↑** Increased
- N** Normal
- ↓** Decreased

Breath Sounds

- Clear** Mark if the patient's lungs are clear bilaterally upon auscultation.
- Wheeze** Mark this box if the patient is wheezing.
- Stridor** Mark this box if the patient has stridor.
- Rales** Mark this box if the patient has rales.
- Rhonchi** Mark this box if the patient has rhonchi.
- Unequal** Mark this box if the patient has unequal breath sounds.

Airway Interventions:

- BS after ET/KING** Breath sounds are heard bilaterally after insertion of an endotracheal tube or a King LTs-D.
- CO2 Detector** Mark if Co2 is present (+) or absent (-).
- Capno #** Mark the numerical CO2 measurement from the capnometry.
- Waveform** Mark **Y** Yes or **N** No to indicate if there is good waveform noted on the capnography tracing.

BASE HOSPITAL FORM INSTRUCTION MANUAL

SKIN

S K I N	<input type="checkbox"/> Normal
	<input type="checkbox"/> Warm
	<input type="checkbox"/> Hot
	<input type="checkbox"/> Cool
	<input type="checkbox"/> Pale
	<input type="checkbox"/> Diaphoretic
	<input type="checkbox"/> Cyanotic
	<input type="checkbox"/> Flushed
	<input type="checkbox"/> Jaundiced
	Capillary Refill
	<input type="checkbox"/> Normal
	<input type="checkbox"/> DELayed

The skin subsection requires at least one entry.

- Normal** Skin is normal in **all** respects (color, temperature, moisture, appearance).
- Warm** Skin feels warm to the touch.
- Hot** Skin feels warmer than normal and patient appears to have a fever.
- Cool** Skin feels cool to the touch.
- Pale** Skin appears abnormally pale, ashen, or gray.
- Diaphoretic** Skin is sweaty or moist to the touch.
- Cyanotic** Skin or lips appear blue.
- Flushed** Skin appears abnormally red.
- Jaundiced** Skin and/or sclera appear yellow.
- Other** Any skin abnormality not previously listed.

Capillary Refill

- Normal** Capillary refill is less than or equal to 2 seconds.
- Delayed** Capillary refill is greater than 2 seconds.

BASE HOSPITAL FORM INSTRUCTION MANUAL

ECG and Arrest

	Init. Rhyth:
E C G	<input type="checkbox"/> 12 Lead _____ (time)
	<input type="checkbox"/> NL <input type="checkbox"/> ABnl <input type="checkbox"/> STEMI
	<input type="checkbox"/> Artifact <input type="checkbox"/> Paced Rhythm
	<input type="checkbox"/> Wavy Baseline
A R R E S T	Witnessed By:
	<input type="checkbox"/> Citizen <input type="checkbox"/> EMS <input type="checkbox"/> None
	CPR by:
	<input type="checkbox"/> Citizen <input type="checkbox"/> EMS
	Est. Down Time: _____
	<input type="checkbox"/> Pulses w/ CPR
<input type="checkbox"/> Restoration Pulse (ROSC)	
	Time: _____

Initial Rhythm

This section identifies an EKG (electrocardiogram) found on **initial** assessment. Write the three-letter code in the space provided. EKG Codes are located on the back of the Base Hospital Form. Additional information about the rhythm, such as the presence of PVC's, should be described in the Assessment Section of the form.

12 Lead EKG

Write the time that the 12 Lead EKG was done on the line to the right of 12 Lead. This information is critical and allows tracking of the time of EMS contact to the time the patient receives definitive treatment.

- Normal (NL)** Electronic interpretation indicates a normal 12 Lead.
- Abnormal (ABNL)** Electronic interpretation indicates an abnormal 12 Lead but does not show an acute MI.
- STEMI** Electronic interpretation indicates an acute MI. Patient should be transported to a STEMI Receiving Facility (SRC), if possible.
- Artifact** Mark if there is artifact that may give a false

BASE HOSPITAL FORM INSTRUCTION MANUAL

positive STEMI.

- Wavy Baseline** Mark if the baseline is wavy on the 12 Lead ECG.
- Paced Rhythm** Mark if the underlying rhythm is paced.

Arrest Details

Witnessed By:

- Citizen** Mark this box if the arrest was witnessed by a non-medical person (law enforcement are considered citizens).
- EMS** Mark this box if the arrest was witnessed by EMS personnel.
- None** Mark this box if the arrest was not witnessed.

CPR By:

- Citizen** Mark this box if CPR was initiated by a non-medical person prior to EMS arrival (law enforcement are considered citizens).
- EMS** Mark this box if CPR was initiated by EMS.

Est. Down Time: Indicate the approximate down time if known. The estimated time in minutes from the time of witnessed cardiac arrest/collapse to the initiation of CPR. (If unwitnessed arrest this would be UNK [unknown]).

- Pulses With CPR** Mark if pulses are palpated with CPR during compressions.
- Restoration of Pulse (ROSC)** Mark this box if the reason CPR was discontinued was because the patient's pulse was restored. Mark on any patient who was in full arrest and had pulses restored at any time during the prehospital phase, even if the pulses were lost prior to arrival at the receiving facility.

Time Note the time (use military time) that pulses were restored.

Section 4. TREATMENTS

T R E A T M E N T S	O ₂ _____ L/Min. via <input type="checkbox"/> NC <input type="checkbox"/> Mask <input type="checkbox"/> BVM <input type="checkbox"/> BlOw by <input type="checkbox"/> Exist. Trach <input type="checkbox"/> ET <input type="checkbox"/> KING <input type="checkbox"/> CPAP										<input type="checkbox"/> Spinal Immob. <input type="checkbox"/> Refuse		<input type="checkbox"/> Glucometer	
	IV <input type="checkbox"/> None Ordered <input type="checkbox"/> IV Unable <input type="checkbox"/> Refused <input type="checkbox"/> SL <input type="checkbox"/> IO <input type="checkbox"/> Preexist <input type="checkbox"/> TKO <input type="checkbox"/> WO <input type="checkbox"/> FC										CMS Intact <input type="checkbox"/> Before		#1 _____	
	T.C.P.: MA _____ Rate _____ Capture: <input type="checkbox"/> Y <input type="checkbox"/> N										<input type="checkbox"/> Needle Thoracosomy		<input type="checkbox"/> Clear by Algorithm	
	Time	B/P	P	R	O ₂ Sat	Pain 0-10	SED's in the past 48 hrs <input type="checkbox"/> Y <input type="checkbox"/> N	Drug	Dose	Route	Treatment/Results			
							<input type="checkbox"/> PRN							
							<input type="checkbox"/> PRN							
							<input type="checkbox"/> PRN							
							<input type="checkbox"/> PRN							
							<input type="checkbox"/> PRN							

This section documents the treatments (including medication) ordered by the Base Hospital for paramedic personnel to perform in the field. If treatments ordered are **not carried out**, indicate the reason in the results section.

DATA ELEMENTS:

O₂ _____ L/M.:

If oxygen is ordered, enter the amount of oxygen in liters per minute to be administered.

- If an amount of O₂ is entered, the device used must also be indicated in the "via" section to the right on the form.

VIA:

If oxygen is administered, indicate the device used. If an amount of oxygen is entered for the previous data element, one of the following must be marked:

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> N/C | Nasal cannula. |
| <input type="checkbox"/> Mask | Oxygen mask. |
| <input type="checkbox"/> BVM | Bag/valve/mask. |
| <input type="checkbox"/> Blow by | Oxygen delivery device held near the patient's face. |
| <input type="checkbox"/> Exist. Trach | Patient is being oxygenated/ventilated via an existing tracheotomy tube. |
| <input type="checkbox"/> ET | Endotracheal tube. |
| <input type="checkbox"/> KING | King LTs-D (Laryngeal Tube (suction) – Device |
| <input type="checkbox"/> CPAP | Continuous Positive Airway Pressure |

BASE HOSPITAL FORM INSTRUCTION MANUAL

Spinal Immobilization:

Mark this box if spinal immobilization is ordered. Mark the pre and post immobilization circulation/motor/sensation (CMS).

- Refused:** Mark if patient refused to be placed in Spinal immobilization.
- CMS Intact Before:** Mark if CMS is reported intact before immobilization.
- CMS Intact After:** Mark if CMS is reported intact after Immobilization
- Clear by algorithm:** Mark this box if spinal immobilization was not performed in the field based on the spinal immobilization algorithm, Los Angeles County EMS Agency, Medical Control Guidelines, Spinal Immobilization, 2002.

Glucometer

- #1** Enter the glucose level reported by the paramedics for the initial glucometer reading.
- #2** Enter the glucose level reported by the Paramedics for the second glucometer reading (if applicable).

IV:

This is a **required** item for all regular runs (not required for SFTPs). One of the boxes will pertain to every patient.

- None Ordered** No IV Ordered
- IV Unable** Paramedics are not able to successfully establish an IV.
- Refused** Patient refused to allow EMS personnel to establish IV access.
- SL** Saline Lock. An IV line is established using a catheter and a flush or normal saline to keep the vein open.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- IO** An intraosseous devise was established.
- Preexist** Upon arrival of EMS personnel, patient already had IV access established. Usually by a clinic, urgent care, doctor's office, etc.
- TKO** To Keep Vein Open (IV rate)
- WO** Wide Open (IV rate)
- FC _____cc** Fluid Challenge (IV rate). The administration of a specific amount of IV fluids given over a specified amount of time.
 - On the line provided, enter the amount in cc's of IV fluid ordered for the fluid challenge

T.C.P.

On the lines provided, enter the MA and Rate ordered for Transcutaneous pacing; Check appropriate box for capture Y or N.

Needle Thoracostomy

Mark this box if a needle thoracostomy was attempted or performed.

Time: Enter the time the patient's vital signs are reported or the times drugs/treatments are ordered. If initial vital signs are prior to contact, you may enter PTC and will be entered into the computer as F7. Use military time.

B/P: Blood Pressure. Enter the patient's blood pressure in the space provided. A systolic **and** diastolic reading should be recorded.

If the B/P is palpated, mark "P" for the diastolic. If the diastolic B/P is not recorded, the data entry personnel should enter it with the F6 key to indicate that it was not documented.

P: Pulse. Enter the patient's heart rate per minute in the space provided.

R: Respiratory rate. Enter the patient's respiratory rate per minute in the space provided.

O₂ SAT: Enter the numeric value for pulse oximetry.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Pain 0-10: Indicate the pain level using the 0-10 scale, when applicable. Ongoing pain assessment should be recorded when medications to relieve the pain are administered.

Drug:

SED's in the past 48 hrs Y N

Document whether the patient has used any sexually enhancing medications in the past 48 hours.

In the space provided, indicate: drugs ordered, EKG codes, and treatments rendered.

- Write each drug/treatment ordered on a separate line. Even if multiple drugs are ordered at the same time, write them on separate lines so the dose and results can be clearly documented. Use a Pg 2 continuation form if needed.
- Medication and ECG codes are listed on the back of the Base Hospital Form. Recent JCAHO surveys have penalized hospitals for using abbreviations that are not listed in the hospital approved abbreviation list. Follow guidelines established by your facility. It may be advisable to write the complete name of each medication, rather than utilizing an abbreviation.
- If a drug has been administered and an ECG Rhythm noted within a two-minute period, they can both be documented on the same line.

PRN: Mark this box if the medication is ordered as a "PRN" medication.

Dose:

- Enter the dose of the medication order. For example: Epinephrine 1:10,000 1 mg IVP.
- Enter the joules delivered for defibrillation or synchronized cardioversion.

Route:

- Enter the route of administration for each medication (rate/route of administration). Drug routes are listed on the back of the Base Hospital Report Form. For example: Epinephrine 1:10,000 1mg IVP.

Treatment/Results:

Enter the results of the administered drug/treatment.

Symbols can be used to indicate the patient's condition after administration.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- ↑ Or + Improved
- N No Change
- ↓ Or - Deteriorated

BASE HOSPITAL FORM INSTRUCTION MANUAL

Section 5. TRAUMA

T R A U M A	<input type="checkbox"/> No Apparent Injuries	<input type="checkbox"/> BUrns/Shock	<input type="checkbox"/> Spinal Cord Inj.	M E C H O F I N J	<input type="checkbox"/> Enc. Veh.	<input type="checkbox"/> S Belt	<input type="checkbox"/> A Bag	<input type="checkbox"/> ASSault	<input type="checkbox"/> Fall	<input type="checkbox"/> > 15 ft	<input type="checkbox"/> Injury
	<input type="checkbox"/> ≤6 yr BP < 70	<input type="checkbox"/> ≥7 yr BP < 90	B P		<input type="checkbox"/> Pass Space Intrusion	<input type="checkbox"/> With Blunt Instr	<input type="checkbox"/> STabbing	<input type="checkbox"/> Electric Shock			
	B P	B P	<input type="checkbox"/> Abdomen		<input type="checkbox"/> Surv. of Fatal Acc.	<input type="checkbox"/> GSW	<input type="checkbox"/> Hazmat Expos.				
	<input type="checkbox"/> Minor Lac/	<input type="checkbox"/> Head	<input type="checkbox"/> Diffuse Tend		<input type="checkbox"/> Ejected from Vehicle	<input type="checkbox"/> TRunk	<input type="checkbox"/> Thermal Burn				
	<input type="checkbox"/> Flail Chest	<input type="checkbox"/> GCS ≤14	<input type="checkbox"/> Genital/ButtoCKs		<input type="checkbox"/> EXtrication Required	<input type="checkbox"/> SI Accidental	<input type="checkbox"/> SPorts				
	<input type="checkbox"/> T. Pneumo	<input type="checkbox"/> Facial/Dental	<input type="checkbox"/> Extremities		<input type="checkbox"/> Ped/Bike vs Vehicle	<input type="checkbox"/> SI Intentional	<input type="checkbox"/> WK Related				
	<input type="checkbox"/> Trauma	<input type="checkbox"/> Neck	<input type="checkbox"/> FRactures		<input type="checkbox"/> Motorcycle/Moped	<input type="checkbox"/> ANimal Bite	<input type="checkbox"/> UNKnown				
	<input type="checkbox"/> Arrest	<input type="checkbox"/> Chest	<input type="checkbox"/> AmputatIons		<input type="checkbox"/> Vs Vehicle	<input type="checkbox"/> CRush	<input type="checkbox"/> OTher				
	<input type="checkbox"/> Back	<input type="checkbox"/> Bet Mid Clav	<input type="checkbox"/> Neuro/Vasc Como		<input type="checkbox"/> HeLmet						

The Trauma section describes complaints caused by injury. This section is divided into two parts:

- Trauma Complaint: Describes the location of the injury
- Mechanism of Injury: Describes how the injury occurred.

AT LEAST ONE BOX MUST BE MARKED IN EACH PART
(if the patient has sustained an injury)

Trauma Criteria are in RED ink and some of the Trauma Guidelines are in BLUE ink.

A patient who meets one of these criteria is automatically transported to the nearest trauma center. An exception occurs when the patient's problem is so severe that it cannot be controlled in the field. If this uncontrollable condition makes transportation to the nearest trauma center impossible, the patient is transported to the most accessible receiving hospital.

TRAUMA

T R A U M A	<input type="checkbox"/> No Apparent Injuries	<input type="checkbox"/> BUrns/Shock	<input type="checkbox"/> Spinal Cord Inj.
	<input type="checkbox"/> ≤6 yr BP < 70	<input type="checkbox"/> ≥7 yr BP < 90	B P
	B P	B P	<input type="checkbox"/> Abdomen
	<input type="checkbox"/> Minor Lac/	<input type="checkbox"/> Head	<input type="checkbox"/> Diffuse Tend
	<input type="checkbox"/> Flail Chest	<input type="checkbox"/> GCS ≤14	<input type="checkbox"/> Genital/ButtoCKs
	<input type="checkbox"/> T. Pneumo	<input type="checkbox"/> Facial/Dental	<input type="checkbox"/> Extremities
	<input type="checkbox"/> Trauma	<input type="checkbox"/> Neck	<input type="checkbox"/> FRactures
	<input type="checkbox"/> Arrest	<input type="checkbox"/> Chest	<input type="checkbox"/> AmputatIons
	<input type="checkbox"/> Back	<input type="checkbox"/> Bet Mid Clav	<input type="checkbox"/> Neuro/Vasc Comp

This section identifies the type, general severity and location of the patient's injuries. Each mark should represent a separate injury. Mark all items that describe the patient's problem(s).

No Apparent Injuries No complaints, signs or symptoms of injury

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

following a traumatic event. Use this code **ONLY** if there is a traumatic mechanism of injury but the patient has no complaints – **DO NOT MARK FOR MEDICAL COMPLAINTS.**

- Burns/Shock** Thermal/chemical burn or electric shock.

- Spinal Cord Inj.** Spinal cord injury is suspected, or weakness/paralysis/paresthesia are presented after a traumatic injury.

- ≤6 yr BP < 70**
≥7 yr BP < 90 Systolic blood pressure below 70 in a patient who is six years of age or under meets trauma criteria. Systolic blood pressure below 90 in a patient who is seven years of age or older meets trauma criteria.

Below are the majority of injuries that are associated with excessive blunt force or penetration beyond the skin and subcutaneous tissue. These injuries are marked as either blunt or penetrating in the boxes adjacent to the portion of the body that is affected.

Blunt injuries occur from a force that has not actually penetrated the skin, although a laceration may have been caused by the tearing/crushing force of a blunt object such as a boxing glove or striking one's head against the windshield.

Penetrating injuries may be inflicted by dull objects traveling at high velocity or a sharp object with a relatively low velocity (e.g., broken glass, knives, etc.). Penetrating injuries may occur from a slashing or puncturing force.

B P (Blunt or Penetrating)

- Minor Lac** Minor laceration/contusion/abrasion. An insignificant laceration, abrasion, or contusion involving the skin or subcutaneous tissue.

- Flail Chest** **Blunt** injury to the chest resulting in an unstable chest wall, identified by paradoxical chest wall movement.

- Tension Pneumo.** A life-threatening collection of air under increased pressure in the pleural cavity. Signs may include those of a pneumothorax (shortness of breath, tachypnea, decreased or absent lung sounds on one side) plus shock, neck vein distension and tracheal deviation (late sign).

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Trauma Arrest** A cessation of cardiac output and effective circulation due to a traumatic injury. Indicate blunt or penetrating.
NOTE:
 Do not mark the "Cardiac Arrest" box when the arrest occurs as a result of trauma.
- Back** All injuries from the shoulders to the buttocks. Does not include the buttocks.
- Head** Any injury to the head or skull from above the eyebrows and behind the ears.
NOTE:
 An open skull fracture caused by blunt force is marked "blunt" not "penetrating". "Head" should also be marked in association with facial injuries when it is likely that the brain was involved. The following subcategory should be marked if applicable:
- GCS≤14** **Blunt** head injuries when the GCS is less than or equal to 14. This code may be used when a strong index of suspicion for a blunt head injury is suspected by mechanism of injury (windshield spidered, etc.)
- Facial/Dental** Injury to the face. Face is defined as the area from the eyebrows down to and including the angle of the jaw, and the ears.
NOTE:
 Circle one or both items (facial and/or dental). Often an injury caused by excessive blunt force to the face will result in head and/or neck injuries. It may be necessary to mark the blunt head and/or blunt neck boxes.
- Neck** Any injury or pain occurring between the angle of the jaw and clavicle, including probably cervical spine injuries.
- Chest** Any injury to the chest occurring below the

BASE HOSPITAL FORM INSTRUCTION MANUAL

- clavicle to the sixth rib, bordered on either side by the posterior axillary line.
- Bet Mid Clav.** Penetrating injury between the mid-clavicular lines. Refers to anterior penetrating injuries that occur above the sixth rib between the mid-clavicular lines.
 - Abdomen** Includes the flank and pelvis as well as the four abdominal quadrants. The following subcategory should be marked if indicated:
 - Diffuse Tend** The abdomen is tender in response to palpation in two or more of the four abdominal quadrants.
 - Genital/Buttocks** An injury to the buttocks or external reproductive structure. **NOTE:** Circle genitals and/or buttocks.
 - Extremities** Any injury, strain or sprain to the shoulders, arms, hands, legs, or feet. One or more of the following boxes should be marked when appropriate:
 - Fractures** Fracture of an extremity, hip, or clavicle.
 - Amputations** Amputation of any digit or extremity.
 - Neuro/Vas Comp** Extremity injury with neurological and/or vascular compromise.

MECHANISM OF INJURY

M E C H O F I N J	<input type="checkbox"/> Enc. Veh.	<input type="checkbox"/> S Belt	<input type="checkbox"/> A Bag	<input type="checkbox"/> ASSault	<input type="checkbox"/> FAIL		
	<input type="checkbox"/> Pass Space Intrusion	<input type="checkbox"/> With Blunt Instr	<input type="checkbox"/> > 15 ft			MOI 1	MOI 2
	<input type="checkbox"/> Surv. of Fatal Acc.	<input type="checkbox"/> STabbing	<input type="checkbox"/> Electric Shock				
	<input type="checkbox"/> Ejected from Vehicle	<input type="checkbox"/> GSW	<input type="checkbox"/> Hazmat Expos.				
	<input type="checkbox"/> EXtrication Required	<input type="checkbox"/> TRunk	<input type="checkbox"/> Thermal Burn				
	<input type="checkbox"/> Ped/Bike vs Vehicle	<input type="checkbox"/> SI Accidental	<input type="checkbox"/> SPorts				
	<input type="checkbox"/> Motorcycle/Moped	<input type="checkbox"/> SI Intentional	<input type="checkbox"/> Wk Related				
	<input type="checkbox"/> Vs Vehicle	<input type="checkbox"/> ANimal Bite	<input type="checkbox"/> UNknown				
<input type="checkbox"/> HeLmet	<input type="checkbox"/> CRush	<input type="checkbox"/> OTher _____					

The Mechanism of Injury subsection identifies how an injury was sustained. Whenever a patient suffers from a traumatic injury, at least one box in this section must be marked. Mark as many boxes as apply. Red lettered items within this

BASE HOSPITAL FORM INSTRUCTION MANUAL

section are trauma criteria. **Blue lettered items** within this section are trauma guidelines.

DATA ELEMENTS

- Enclosed Vehicle** Patient was riding in an enclosed vehicle. Automobile, truck (including the back of a pick-up), jeep, convertible, bus, tractor or other motorized vehicle.

Mark the subcategories (under enclosed vehicle) below, if applicable:

- Seat Belt** Patient was wearing a seat belt at the time of impact.
- Air Bag** Air bag inflated at the time of impact and directly protected the patient.
- Passenger Space Intrusion** The space in which the passenger was sitting prior to the accident is so damaged that it is impossible for the patient to sit comfortably in the same location.
- Survivor of Fatal Accident** The patient survived a collision where another person **in the same vehicle** was fatally injured.
- Ejected From Vehicle** Patient was thrown from an enclosed vehicle. Convertibles and pick-up trucks are considered enclosed vehicles; however, motorcycles are not.
- Extrication Required** Special equipment such as the jaws of life were required to remove the injured person from the vehicle. Popping a window or removing a door is not considered extrication.
- Ped/Bike vs Vehicle** The patient is a bicyclist or pedestrian who hit or was hit by a motorized vehicle.
- Motorcycle/Moped** The patient was riding on an unenclosed motorized vehicle at the time of the accident. Unenclosed vehicles include mopeds, ATV's, motorcycles, etc.

BASE HOSPITAL FORM INSTRUCTION MANUAL

If the patient was involved in an unenclosed vehicle accident, the following additional boxes should be marked when applicable.

- Vs Vehicle** The patient riding on an unenclosed vehicle struck, or was struck by another vehicle.
- Helmet** The patient riding on an unenclosed motorized vehicle was wearing a helmet at the time of impact.
NOTE: If a motorcycle/moped patient was not wearing a helmet, draw a circle with a line over the word "helmet" to show that an assessment for safety devices was performed.
- Assault** Patient was assaulted (punched, kicked, strangled, etc.) without a blunt instrument.
- With Blunt Instr** A blunt instrument (bat, belt, fists, etc.) was used during the assault.
- Stabbing** A sharp or piercing instrument (e.g., knife broken glass, ice pick, etc.) caused the injury, which penetrated the skin during the attack.
- GSW** Injury was caused by a gunshot (accidental or intentional).
- Trunk** The GSW is located in the trunk. Trunk refers to the chest, shoulder, back, abdomen, pelvis and/or buttocks.
- S.I. Accidental** Self-inflicted, accidental. The injury appears to have been accidentally caused by the patient.
- S.I. Intentional** Self-inflicted, intentional. The injury appears to have been intentionally caused by the patient.

NOTE:

EMS personnel should base their opinions on objective evidence whenever possible. Statements by the patient or witnesses can also

BASE HOSPITAL FORM INSTRUCTION MANUAL

be of help. Important factors in the decision should be noted in the Assessment Section. Do not use as the chief MOI when other mechanisms would be more appropriate (i.e., GSW, fall/jump, etc.)

- Animal Bite** The teeth of a human, reptile, dog, cat, or other animal inflicted the injury. This box can be marked whether the skin was punctured or not. Insect bites and bee stings are **not** considered animal bites.
- Crush** The injuries sustained were a result of external pressure being placed on body parts between two opposing forces.
- Fall** An injury resulting from a fall from any height. This category includes slipping in a bathtub, falling off a bicycle, jumping from a ledge, falling from a horse, etc.
- >15 ft.** Greater than (>) 15 feet – A subcategory of Fall. A **vertical uninterrupted** fall of greater than 15 feet. This does not include falling down stairs or rolling down a sloping cliff.
- Electric Shock** Passage of an electrical current through body tissue as a result of contact with an electrical source.
- Hazmat Expos** Hazardous Material Exposure. The patient was exposed to any toxic or poisonous agents. Agents included are liquids, gases, powders, foams or radioactive material.
NOTE:
 For pepper spray incidents or brief exposures to other minor irritants use the **medical** code "OT" unless another more appropriate major chief complaint exists.
- Thermal Burn** Burn was caused by excessive heat.
- Sports** Any injury that occurs during a sporting or

BASE HOSPITAL FORM INSTRUCTION MANUAL

recreational athletic activity. This includes such activities as aerobics and jogging.

Work Related

An injury occurred on the job and would likely be covered by Worker's Compensation.

Unknown

The cause or mechanism of injury is unknown.

Other

A mechanism of injury that does not fall into any of the existing categories.

NOTE:

On the line provided, write in the mechanism of injury.

MOI 1, MOI 2:

Enter the two-letter code of the most **general** mechanism of injury first. Enter the subcategory of injury in the MOI 2 box or an additional MOI if one exists. This field is **required** for all patients whose chief complaint is a result of injury.

- Mark all boxes that apply; however, the "MOI 1" is the **MAIN CATEGORY** (not the sub-category). Main categories include **EV, PB, MM, AS, GS, OT, FA, ES, HE, TB, SP, UN.**

BASE HOSPITAL FORM INSTRUCTION MANUAL

Section 6. TRANSPORT

TRANSPORT	MAR: _____	ETA: _____	EDAP: _____	ETA: _____	VIA	<input type="checkbox"/> ALS	NO TRANSPORT	<input type="checkbox"/> BLS	Destination	<input type="checkbox"/> Heli ETA _____	Other
	REC: _____	ETA: _____				<input type="checkbox"/> Other _____		<input type="checkbox"/> Pronounced			
Destination		Indicate rationale below									
<input type="checkbox"/> MAR <input type="checkbox"/> EDAP (≤14 yrs) <input type="checkbox"/> PERINATAL (≤ 20 wks pregnancy) <input type="checkbox"/> TC <input type="checkbox"/> PTC (≤14 yrs trauma) <input type="checkbox"/> PMC (≤14 yrs medical) <input type="checkbox"/> SRC (12 Lead ECG = STEMI or ROSC) <input type="checkbox"/> ASC <input type="checkbox"/> Other _____		<input type="checkbox"/> Criteria <input type="checkbox"/> Guidelines <input type="checkbox"/> Judgment <input type="checkbox"/> IFT		<input type="checkbox"/> ED SAT <input type="checkbox"/> Int Disaster <input type="checkbox"/> CT <input type="checkbox"/> Request <input type="checkbox"/> SART <input type="checkbox"/> SC Req <input type="checkbox"/> Extremis <input type="checkbox"/> No SC Access (w/ 30 mins) <input type="checkbox"/> Other _____		<input type="checkbox"/> AMA <input type="checkbox"/> DOA <input type="checkbox"/> Unwarranted <input type="checkbox"/> Other _____		<input type="checkbox"/> Pronounced By _____ MD Resus D/C @ _____ (rhythm) Total min EMS CPR _____ <input type="checkbox"/> DNR/AHCD/POLST			

This section identifies if and where a patient is transported, the mode of transportation, ETA's and the rationale for transporting to a facility.

This section is divided into four sections:

Section 1

The transport codes section:

T	MAR: _____	ETA: _____	EDAP: _____	ETA: _____
	REC: _____	ETA: _____		

Document the three letter code of the Most Accessible Receiving (MAR) and the actual Receiving (REC) facility on all patients.

Document the EDAP on all pediatric patients.

The estimated time of arrival (ETA) must be documented on the corresponding line.

Section 2

The Destination section:

R A N S P O R T	Destination		Indicate rationale below
	<input type="checkbox"/> MAR <input type="checkbox"/> EDAP (≤14 yrs) <input type="checkbox"/> PERINATAL (≤ 20 wks pregnancy) <input type="checkbox"/> TC <input type="checkbox"/> PTC (≤14 yrs trauma) <input type="checkbox"/> PMC (≤14 yrs medical) <input type="checkbox"/> SRC (12 Lead ECG = STEMI or ROSC) <input type="checkbox"/> ASC <input type="checkbox"/> Other _____	<input type="checkbox"/> Criteria <input type="checkbox"/> Guidelines <input type="checkbox"/> Judgment <input type="checkbox"/> IFT	

BASE HOSPITAL FORM INSTRUCTION MANUAL

The destination section is broken down to explain why the patient went to a certain receiving facility and if the patient met any criteria or guidelines requiring transport to a specialty center (e.g. trauma center, pediatric trauma center or pediatric medical center).

DATA ELEMENTS:

MAR	Most Accessible Receiving Hospital. The licensed, basic emergency hospital that can be reached in the shortest possible time. Depending on traffic or geography, this hospital may not necessarily be the closest facility. The paramedics determine the MAR.
EDAP	Emergency Department Approved for Pediatrics. The most accessible licensed, basic emergency department that has been confirmed as meeting specific service criteria to provide basic emergency pediatric care. Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 510, Pediatric Patient Destination.
Perinatal	Perinatal Center. A hospital with a licensed, basic emergency department and an obstetrical department. Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 511, Perinatal Patient Destination.
TC	Trauma Center. The trauma center assigned to receive patients from the area in which the patient is located. Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 504, Trauma Patient Destination.
PTC (≤14yrs trauma)	Pediatric Trauma Center. A designated acute care hospital approved to receive critically injured pediatric patients. For information regarding which pediatric patients require PTC care, refer to the Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 510, Pediatric Patient Destination.
PMC (≤14yrs medical)	Pediatric Medical Care. A designated acute care hospital approved to receive critically ill pediatric patients. For information regarding which pediatric patients require PMC care, refer to the Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 510, Pediatric Patient Destination.
SRC(12 Lead ECG	ST Elevation Myocardial Infarction (STEMI) Receiving

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

= STEMI or
ROSC

Center (SRC) is a facility that has been approved to receive STEMI patients. Los Angeles County Prehospital Care Manual, Reference No. 513, STEMI Patient Destination.

ASC

Approved Stroke Center (ASC) is a facility that has been approved to receive suspected stroke patients. Los Angeles County Prehospital Care Manual, Reference No. 521 Stroke Patient Destination.

Other

A licensed, basic emergency department that may receive the patient in place of one of the categories of hospitals listed above. This item is used most frequently to designate the receiving hospital was unavailable for some reason (on diversion). The reason must be documented by indicating the rationale in the section designated for rationale.

When a patient is transported to a TC/PTC or PMC a box needs to be checked in this section:

<input type="checkbox"/> Criteria
<input type="checkbox"/> Guidelines
<input type="checkbox"/> Judgment
<input type="checkbox"/> IFT

DATA ELEMENTS:

Criteria

Mark this box if the patient meets TC/PTC criteria and is transported to a TC/PTC. Los Angeles County Prehospital Care Manual, Reference No. 506: Trauma Triage.

Guidelines

Mark this box if the patient meets TC/PTC/PMC guidelines and is transported to a TC/PTC/PMC. Los Angeles County Prehospital Care Manual, Reference No. 506: Trauma Triage.

Judgment

Mark this box if the patient does not meet

BASE HOSPITAL FORM INSTRUCTION MANUAL

TC/PTC/PMC criteria/guidelines but is transported to a TC/PTC/PMC because the MICN/BHMD feels that the patient would benefit from a higher level of care.

- IFT** Interfacility Transfer/Transport. Mark this box if the patient is being transferred to from one facility to another.

If the "Other" box is marked in the "destination section", one of the following reasons must be marked. As stated in the previous section, the "Other" box will be marked for all diversions. Refer to Los Angeles County Prehospital Care Manual, Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Units for additional information regarding diversion categories.

<p>Indicate rationale below</p> <ul style="list-style-type: none"> <input type="checkbox"/> ED SAT <input type="checkbox"/> Int Disaster <input type="checkbox"/> CT <input type="checkbox"/> Request <input type="checkbox"/> SART <input type="checkbox"/> SC Req <input type="checkbox"/> Extremis <input type="checkbox"/> No SC Access (w/i 30 mins) <input type="checkbox"/> Other _____

- ED Sat.** The desired hospital is closed due to emergency department saturation.
- Int. Disaster** The desired hospital is closed due to internal disaster, e.g., fire, flood, bomb threat, etc.
- CT** The patient may require a CT scan for diagnosis and the CT scanner at the desired hospital is non-functioning.
- Request** The patient, family member, private medical doctor (PMD), or other authorized party requests transport to an alternate facility.
- SART** A licensed general acute care hospital, a licensed basic emergency department or a hospital sponsored program clinic that has met specific requirements approved by the County of

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Los Angeles to receive patients who are victims of sexual assault/abuse.

Every effort should be made to transport sexual assault patients to the most accessible receiving (MAR) facility that has an affiliated designated SART Center. If EMS personnel determine that such a transport would unreasonably remove unit from its primary response area, the patient should be transported to the MAR facility.

In **all** cases the health and well-being of the patient is the overriding consideration in determining hospital destination.

SC Req

The patient met the criteria/guidelines for transport to a specialty center (TC/PTC/PMC/SRC/ASC/Perinatal) however the designated specialty center was closed d/t one of the above reasons. (ED sat; Internal Disaster., etc). Patient is transported to the next closest Specialty Center that is open.

Extremis

The patient is transported to the most accessible facility because the severity of the injury/illness precludes transportation to a specialty center. Extremis patients include patients with an obstructed airway; patients in cardiopulmonary arrest (excluding traumatic penetrating torso injuries); and other patients as determined by the base hospital personnel whose lives would be jeopardized by transportation to any but the most accessible receiving(MAR).

**No SC
Access
(w/i 30mins)**

The patient meets criteria/ guidelines for transport to a specialty center however is transported to a non-specialty center due to time constraints or geography. Refer to Los Angeles County Prehospital Care Manual, Reference No. 506, Trauma Triage; Reference No. 510, Pediatric Patient Destination; Reference No. 511, Perinatal Patient Destination; Reference No. 513, STEMI Patient Destination; Reference No. 521, Stroke Patient Destination.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Other** Mark this box and document reason the line Adjacent if the patient is not transported to the MAR or designated Specialty Center for any reason other than those previously listed above.

Section 3:

VIA

V I A	<input type="checkbox"/> ALS
	<input type="checkbox"/> BLS
	<input type="checkbox"/> Heli ETA _____
	<input type="checkbox"/> Other _____

Method of Transport

- ALS** ALS unit accompanied by at least one paramedic.
- BLS** BLS without paramedics.
- Heli ETA** Helicopter. The ETA designates when the helicopter is expected to arrive on scene.
- Other** If marked, indicate type of transport used.

Section 4

N O T R A N S P O R T	<input type="checkbox"/> AMA	<input type="checkbox"/> Pronounced
	<input type="checkbox"/> DOA	By _____ MD
	<input type="checkbox"/> Unwarranted	Resus D/C @ _____
	<input type="checkbox"/> Other	_____ (rhythm)
		Total min EMS CPR _____
		<input type="checkbox"/> DNR/AHCD/POLST

If the patient is not transported mark one of the following boxes:

- AMA** Mark if a competent patient refuses treatment and/or transport to a hospital as recommended by EMS personnel.
- Refer to Los Angeles County Prehospital Care Manual, Reference No. 834, Patient Refusal of Treatment or Transport.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Base hospital contact is required when a patient, who meets base contact criteria, as specified in Los Angeles County Prehospital Care Manual, Reference No. 808, Base Hospital Contact and Transport Criteria, Section 1, refuses treatment and/or transport. Base contact must be made while the patient is still on scene and available to speak with the MICN.
- Physical/mental impairment, drugs, alcohol intoxication, etc. may significantly impair a patient's ability to make competent decisions.
- If the patient refuses medical attention, the patient (or for minors, a parent or guardian) must sign a release. Two witnesses must also sign. EMT's may sign as witnesses if no others can be found. This release should not be signed if the patient's condition does not warrant treatment or transport.

When possible, direct communication between the patient and the MICN/BHMD should be established. Base hospital personnel should reiterate the necessity of medical treatment and thoroughly document the explanation of the risks and consequences of refusal of treatment and/or transport.

DOA

Base hospital contact is **not required** for patients who are determined to be dead based on specific criteria (decapitation, incineration, decomposition, evisceration of major organ, etc.) set forth in Los Angeles County Prehospital Care Manual, Reference No. 814. Determination/Pronouncement of Death in the Field. **For patients who have the signs and symptoms of death but do not meet the above criteria**, EMS personnel should begin resuscitative measures and contact the base hospital. Resuscitative measures may be discontinued if a base hospital physician, on the basis of a complete description of the circumstances and the findings, determines that resuscitative intervention is futile. The "Pronounced" box should be marked. **If there is any objection or disagreement by family members or caretakers** about withholding resuscitation, or if prehospital personnel have any reservations about the validity of the DNR/AHCD/POLST order, resuscitation

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

should begin immediately and paramedics should contact the base hospital for further direction.

Unwarranted

The patient's condition does not require transportation by paramedics.

Pronounced

Mark for patients who have received resuscitative efforts in the field and have subsequently been pronounced by a physician. Enter the name of the physician who pronounced the patient.

Resus D/C @

Write in the time that CPR and other lifesaving therapies are terminated by decision of the base hospital physician. The time should be documented using military time. Document the code of the rhythm the patient was in when pronounced in the boxes provided.

Total min EMS CPR

The total elapsed time in minutes from the beginning of EMS CPR to time of pronouncement by base hospital physician.

DNR/AHCD/POLST

Do-Not-Resuscitate/Advance Health Care Directive/Physician Order for Life Sustaining Treatment. The patient has a valid DNR or Advance Healthcare Directive (AHCD) or Physician Order for Life Sustaining Treatment (POLST) form. Refer to Los Angeles County Prehospital Care Manual, Reference No. 815, Honoring Prehospital Do-Not-Resuscitate Orders and Physician Orders For Life Sustaining Treatment.

Section 7. DISPOSITION

DISP	Time Clear		If Base is = Receiving hospital: <input type="checkbox"/> Cath Lab <input type="checkbox"/> Ward <input type="checkbox"/> OB <input type="checkbox"/> Expired <input type="checkbox"/> Discharged
	Time Receiving Hosp. Notified		Adm. To Rm # _____ <input type="checkbox"/> ICU/CCU <input type="checkbox"/> OR <input type="checkbox"/> Stepdown <input type="checkbox"/> Inter. Rad
	Person Notified _____		<input type="checkbox"/> Other _____ Transferred from E.D. to _____ HOSP. CODE
			E.D. Diagnosis _____

This section identifies specific information regarding the disposition of the patient.

DATA ELEMENTS:

Time Clear:

Enter the military time when the MICN or Physician hangs up or signs off the radio with the provider. This time may be after the time the receiving hospital was notified, if the receiving hospital was notified while the base was still in contact with the provider.

- Use leading zeros when necessary.
- Use the same clock during the run for accurate time recordings.

Time Receiving Hosp. Notified:

If the patient is transported to a facility other than the base hospital, enter the time the receiving hospital was notified of the run.

If the receiving hospital is different than the base hospital, the following must also be filled out:

Person Notified:

Enter the name of the person at the receiving hospital notified of the incoming patient.

If Base is also the Receiving Hospital:

If Base is = Receiving hospital: <input type="checkbox"/> Cath Lab <input type="checkbox"/> Ward <input type="checkbox"/> OB <input type="checkbox"/> Expired <input type="checkbox"/> Discharged
Adm. To Rm # _____ <input type="checkbox"/> ICU/CCU <input type="checkbox"/> OR <input type="checkbox"/> Stepdown <input type="checkbox"/> Inter. Rad
<input type="checkbox"/> Other _____ Transferred from E.D. to _____ HOSP. CODE
E.D. Diagnosis _____

BASE HOSPITAL FORM INSTRUCTION MANUAL

This subsection deals with the disposition of a patient from the base hospital emergency department. This section is filled out when a patient is admitted to the hospital, transferred, or discharged from the emergency department or has expired within the emergency department. This section may be completed at a later time by personnel other than the MICN/MD who handled the run.

Mark the appropriate disposition for the patient:

- | | |
|--|--|
| <input type="checkbox"/> Cath Lab | Went to the Cardiac Catheterization Lab. This information is used to cross reference patient in the STEMI database. |
| <input type="checkbox"/> Ward | Admitted to a medical-surgical area. Although most facilities have private or semi-private rooms – the term “ward” is used for data collection purposes. |
| <input type="checkbox"/> OB | Admitted to the obstetrics ward. |
| <input type="checkbox"/> Expired | The patient died in the emergency department. |
| <input type="checkbox"/> Discharged | The patient was discharged home from the emergency department. |
| <input type="checkbox"/> ICU/CCU | Admitted to the Intensive Care Unit or the Cardiac Care Unit |
| <input type="checkbox"/> OR | Transferred directly from the emergency department to the operating room. |
| <input type="checkbox"/> Stepdown | Transferred to the Direct Observation Unit (DOU) or Stepdown Unit. This includes the Telemetry Unit. |
| <input type="checkbox"/> Inter. Rad | Transferred directly from the emergency department to Interventional Radiology for embolization, angiography, etc. |
| <input type="checkbox"/> Other | Write a comment on the line provided. |

Adm. To Rm.# _____:

- Enter the room number that the patient was admitted to.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Transferred from E.D. to _____

- If the patient is transferred from the emergency department to another health care facility, write the name of the facility on the line provided.

E.D. Diagnosis _____

- On the line provided, enter the emergency department diagnosis documented on the emergency department chart by the physician.

The E.D. diagnosis is entered into TEMIS as an ICD-9 code.

Section 8. COMMENTS

C O M M	
------------------	--

Any additional information regarding the disposition of the patient at the base hospital can be added here. Comments regarding crucial run information not noted elsewhere should be written on the available lines in the "Assessment" section. Additional documentation can be continued on the Base Hospital Form Page 2, if needed.

Section 9. SIGNATURE

S G	MICN/Cert. #	Physician	Patient Name/Number

This section identifies the nurse and base hospital physician responsible for the run, and the patient's medical record number, if known.

DATA ELEMENTS:

MICN/Cert. #:

If an MICN handles the run, his/her signature and certification number is written here. Writing a first initial and last name is sufficient for the signature.

Enter the letter "N" in the first space, followed by the certification number. If the physician on duty handles the run, this box will be left blank.

Physician:

If a physician **handles** the run, his/her signature and identification number is written here. Writing a first initial and last name is sufficient for the signature.

If **both** an MICN and a physician **handle** the call or if the physician is **consulted** during the run, both names and numbers should appear.

Patient Name/Number:

Enter the patient's name and medical record number (when the base is the receiving facility).

- This item is optional

Section 10. MULTIPLE CASUALTY INCIDENT FORM (MCI)

INTRODUCTION

The Multiple Casualty Incident Form (MCI) has been developed by the Los Angeles County EMS Agency as a replacement form for use by base hospitals in situations where multiple patients are encountered on scene and reported to the base hospital. The form is a "shortened" version of the Los Angeles County Base Hospital Form that encompasses the essential data for the incident while providing a valuable tool to MICN's and Physician's for multi-patient incidents. The MCI Base Hospital Form may be used in place of the standard Base Hospital Form for incident involving 3 or more patients.

WHO COMPLETES THE FORM

The MICN or Physician handling the voice contact between the paramedic and base hospital is responsible for thorough and accurate completion of the form.

WHEN TO USE THE FORM

A standard Base Hospital Form (one per patient) or an EMS Agency approved MCI Base Hospital Form (up to four patients per form) may be used.

ALS Patients: Pertinent information must be documented for each ALS patient.

BLS Patients: If the incident involves only BLS patients on whom no medical direction has been given, only one form (for one patient) needs to be initiated in order to document the Sequence number for the incident.

ALS and BLS Patients: Pertinent information must be documented for each ALS patient. BLS patients on whom no medical direction has been given do not require a Base Hospital Form. The number and disposition of BLS patients may be documented in the Comments Section of the Base Hospital Report Form on an ALS patient.

See Los Angeles County, Prehospital Care Manual, Reference No. 606, Documentation of Prehospital Care.

BASE HOSPITAL FORM INSTRUCTION MANUAL

DISTRIBUTION OF COPIES

Distribution of the copies of the MCI Base Hospital Form is identical to the distribution of the normal Base Hospital Form.

INCIDENT INFORMATION SECTION

MCI BASE HOSPITAL FORM						# of Patients Transported			
DATE	TIME	PROVIDER CODE	HOSP CODE			Immediate	Delayed	Minor	Death/Minor
_____	_____	_____	_____	<input type="checkbox"/> RADIO	<input type="checkbox"/> FULL CALL				
LOCATION _____	UNIT _____	<input type="checkbox"/> PHONE	<input type="checkbox"/> SFTP						
MICN _____	TOTAL PATIENTS _____	<input type="checkbox"/> HEAR	<input type="checkbox"/> JOINT						
PHYSICIAN _____	TIME CLEAR _____	<input type="checkbox"/> Comb R/P/H	<input type="checkbox"/> Info Only						

The top of the form contains Incident Information. The information in this area is similar to the Base Hospital Form in an abbreviated version. In addition, the right side of this area contains a section that can be used as a quick worksheet listing *Triage Categories* and patient destination (Hospital code). See Section 1 of this manual for more information regarding Incident Information.

PATIENT ASSESSMENT/GCS/TRIAGE CATEGORIES

Pt #	<input type="checkbox"/> M Seq # _____
Age _____	<input type="checkbox"/> F Log # _____
Wt. _____	Kg/lbs
GCS	Vital Signs
E _____	BP/ _____
M _____	Cap Refill _____
V _____	Pulse _____
	Resp _____
Chief Complaint _____	Peds Weight Color Code
	Immediate
	Delayed
	Minor
<input type="checkbox"/> Field Decontamination	Complaint
	Mech of Inj

BASE HOSPITAL FORM INSTRUCTION MANUAL

Sequence Number/Patient Number

Each of the four (4) sections on the Base MCI form has a space for a separate Sequence Number (one for each patient). This alleviates the need to fill out a full Base Hospital Form on each patient. In the top left portion of the section is the patient number for the incident. For example there are three (3) patients on the incident; the patients would be numbered 1 through 3.

Triage Categories

Immediate
Delayed
Minor

There are three (3) categories (Immediate, Delayed, and Minor) which correspond to Triage Tags commonly used in Los Angeles County. Mark the box that corresponds to the Triage Category reported by the provider. There is a fourth category (DOA); however, the base hospital will not need to document the DOA patient in an MCI.

Age/Gender/Name/Weight

M Seq # _____

Age F Log # _____

Wt. _____ Kg/lbs

Peds Weight Color Code

To the left of the Sequence Number is the Age and Gender of the patient. Write in the Age and Age units of the patient and mark the gender that corresponds to the patient. Below the Sequence Number is a space for the Pediatric Color Code and weight of the patient if indicated.

GCS/Vital Signs

GCS	Vital Signs
E _____	BP/ Cap Refill _____
M _____	Pulse _____
V _____	Resp _____

This section contains the Glasgow Coma Scale (GCS). Refer to Section 3 of this manual for definitions regarding GCS. The vital signs consist of the Blood Pressure (BP) or Cap Refill if using the START system, Pulse and Respirations.

BASE HOSPITAL FORM INSTRUCTION MANUAL

CHIEF COMPLAINT/COMPLAINT CODES/MECHANISM OF INJURY/FIELD DECONTAMINATION

Chief Complaint _____ _____ _____	<table border="1"> <tr> <td style="background-color: black; color: white; padding: 2px;">Complaint</td> </tr> <tr> <td style="text-align: center;"> </td> </tr> <tr> <td style="background-color: black; color: white; padding: 2px;">Mech of Inj</td> </tr> <tr> <td style="text-align: center;"> </td> </tr> </table>	Complaint		Mech of Inj	
Complaint					
Mech of Inj					
<input type="checkbox"/> Field Decontamination					

Chief Complaint

The Chief Complaint section is a short narrative summary of the complaints of the patient.

Complaint Codes

Complaint

This area contains two (2) spaces for complaints. Each complaint code is a unique two-letter code. The Chief Complaint (most significant) should be placed first (left) followed by the less significant complaint. See Sections 2 and 6 of this manual for more information on Complaint codes.

Mechanism of Injury

Mech of Inj

This area contains two (2) spaces for mechanism of injury. The primary Mechanism of Injury should be placed first (left) followed by the less significant mechanism of injury. See Section 6 of this manual for more information on Mechanism of Injury codes.

Field Decontamination

This section is used to signify that some form of field decontamination such as showering has occurred. Mark box if any type of field decontamination has been performed.

BASE HOSPITAL FORM INSTRUCTION MANUAL

TREATMENT/AMA

Treatment: <input type="checkbox"/> O2 <input type="checkbox"/> IV <input type="checkbox"/> Sp. Immob. <input type="checkbox"/> Meds
--

Treatment

This section contains common Treatments performed on patients as well as a section to write in other Treatments. When indicated, a mark should be placed in the box to the left of the corresponding Treatment performed on a patient.

AMA

AMA

When a patient signs out *Against Medical Advice*, place a check mark in the box to the left of **AMA**. See Section 7 of this manual for more information on AMA.

TRANSPORT SECTION

Transported By: <input type="checkbox"/> No Transport	Rec Facility	Trans To	
		<input type="checkbox"/> MAR <input type="checkbox"/> EDAP <input type="checkbox"/> Trauma	<input type="checkbox"/> PeriNat <input type="checkbox"/> PCCC <input type="checkbox"/> Other

Transported By:

Transported By:
<input type="checkbox"/> No Transport

This section contains the information about the EMS unit transporting the patient. Space is provided to write the Provider/Unit and the time the patient was transported. The bottom section provides a box to designate a patient that was not transported.

Receiving Facility

BASE HOSPITAL FORM INSTRUCTION MANUAL

Rec Facility

Write in the three-letter Hospital Code that corresponds to the facility the patient is being transported.

Trans To

Trans To	
<input type="checkbox"/> MAR	<input type="checkbox"/> PeriNat
<input type="checkbox"/> EDAP	<input type="checkbox"/> PMC
<input type="checkbox"/> TC/PTC	<input type="checkbox"/> Other

Transport To.

Place mark on the box that corresponds to the designated type of facility to which the patient is transported.

See Section 7 of this manual for more information on patient transport.

DISPOSITION

Admit:	<input type="checkbox"/> ICU/CCU	<input type="checkbox"/> OR	<input type="checkbox"/> Ward	<input type="checkbox"/> Tele	<input type="checkbox"/> OB	<input type="checkbox"/> Other
Transferred:	<input type="checkbox"/> Discharged	<input type="checkbox"/> Expired				
ED Diagnosis:						
Name:						

This section is utilized in the same way as the Base Hospital Form (see Section 8 of this manual for more information on Disposition).

Section 11. STANDING FIELD TREATMENT PROTOCOLS (SFTP'S)

The following is required information for all runs on which SFTPs have been utilized.

DOCUMENT ALL INFORMATION PROVIDED TO YOU!

1. GENERAL INFORMATION

Log #	SEC. SEQ #	Pt. #	IF APPLICABLE	SEQ. #	Hospital Code
Date	Prov. Code	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Too Tall	<input type="checkbox"/> Radio <input type="checkbox"/> Full Call
Time	Unit	<input type="checkbox"/> Y <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> H	Paeds Weight	<input type="checkbox"/> HEAR Radio	<input type="checkbox"/> SFT Protocol
Location	Weight	Kg lbs.	Color Code	<input type="checkbox"/> Comb R/P/H	<input type="checkbox"/> Joint Run
					<input type="checkbox"/> Info Only

This section located at the top of the form, contains general run information and must be completed for all calls.

The first two items in this section are medical record numbers used to identify and track patients from the prehospital care phase through hospitalization. Both of these numbers (Log# and SEQ. #) must be completed accurately.

- Log #: Enter the Base Hospital Log Number.
- SEQ. #: Enter the sequence number the paramedic gives you to identify each patient.
- Date: Enter the date the run is called into the base hospital.
- Time: Enter the time the run is called into the base hospital.
- Prov. Code: Enter the two-letter provider code of the provider agency calling in the run.
- Unit: Enter the number that identifies the specific unit of the provider agency that calls in the run.
- Age: Enter the age of the patient in years. If the age is estimated, write the age followed by "est".
- Sex: Mark the appropriate box to identify the patient's gender.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Communication Type For regular runs where medical direction is provided, mark only one of the following: Radio, Phone, Hear Radio, Combination (R/P/H).

SFT Protocol: Mark this box for SFTP runs in which the base is contacted for destination information ONLY.

Joint Run: Mark this box when the base hospital provides medical direction during a run that began as a Standard Field Treatment Protocol run.

2. ASSESSMENT:

ASSESSMENT	Chief Complaint Code <input type="text"/> <input type="text"/> <input type="text"/>	SEVERITY C-Distress	<input type="checkbox"/> None <input type="checkbox"/> Mild <input type="checkbox"/> Mod. <input type="checkbox"/> Severe	P T B C	PTBC (Meds) <input type="checkbox"/> ADE _____ <input type="checkbox"/> ASA _____ <input type="checkbox"/> ATR _____ <input type="checkbox"/> ALB _____ <input type="checkbox"/> D50 _____ <input type="checkbox"/> D25 _____ <input type="checkbox"/> EPI _____ <input type="checkbox"/> GLU _____ <input type="checkbox"/> GLP _____ <input type="checkbox"/> MID _____ <input type="checkbox"/> NAR _____ <input type="checkbox"/> NTG _____ <input type="checkbox"/> Other _____	PTBC (Treatments) <input type="checkbox"/> O2 _____ MNC <input type="checkbox"/> BVM <input type="checkbox"/> ET <input type="checkbox"/> ETC/KING <input type="checkbox"/> IV <input type="checkbox"/> IO <input type="checkbox"/> Monitor <input type="checkbox"/> 12 Lead <input type="checkbox"/> Glucometer <input type="checkbox"/> Defib X _____ <input type="checkbox"/> CAR <input type="checkbox"/> AED-Analyzed <input type="checkbox"/> AED-Defib <input type="checkbox"/> N, THor Spinal Immob. <input type="checkbox"/> Y <input type="checkbox"/> N
	Protocol <input type="text"/>	C/P				
	Medical HX <input type="text"/>	Q				
	Medications <input type="text"/>	R				
	<input type="checkbox"/> NKA Allergies: <input type="text"/>	S				
	T	<input type="checkbox"/> Suspected Drugs/ETOH				

This section identifies the patient's chief complaint, its severity, and the protocol utilized.

Chief Complaint Code:

Enter the two-letter code of the patient's problem. If the patient has more than one problem, list the most significant problem first. Up to three codes can be entered.

- Chief complaint codes of the patient's problems are listed on the backside of the Base Hospital Form.
- Chief complaint codes for trauma are on the front of the form. They consist of two bold letters from the items listed in the "Trauma" portion of the Trauma/Mech of Injury Section.

Whenever a trauma subcategory has been marked, enter the subcategory code rather than the major category.

Severity of Distress:

Mark one of the following which best describes the severity of the chief complaint:

- None** Exhibits no outward signs of distress and shows no adverse reaction related to the chief complaint.
- Mild** Exhibits a low level of distress. Shows few external cues indicating a low level of distress related to the chief complaint. The patient can

BASE HOSPITAL FORM INSTRUCTION MANUAL

- easily divert attention from signs and symptoms related to the chief complaint.
- Mod Exhibits an increasing level of distress. The patient is not easily distracted and remains more focused on chief complaint/signs and symptoms. For example, signs and symptoms of a patient in moderate distress with a chief complaint of shortness of breath may include one or more of the following:
 - Speaks in short sentences
 - Accessory muscle use
 - Costal retractions
 - Moist or cool skin signs
 - Severe Exhibits a great level of distress. The patient is completely focused on the chief complaint/signs and symptoms. Nothing can distract the patient from the serious signs and symptoms of a patient in severe distress with a chief complaint of shortness of breath. For example, signs and symptoms of severe shortness of breath may include one or more of the following:
 - Speaks in one or two word sentences
 - Not able to speak
 - Diaphoresis
 - Costal/sternal retractions
 - Cool skin
 - Skin discoloration
 - Abnormal breath sounds
 - Breath sounds audible without a stethoscope
 - Tripod position

Protocol:

Indicate which protocol was used:

General ALS:

- ALS General ALS
- CA Cardiac Arrest

Medical:

- M2 Altered Level of Consciousness
- M4 Chest Pain
- M7 NonTraumatic Abdominal/Pelvic Pain
- M9 Overdose/Poisoning Suspected
- M13 Seizure (Adult)
- M14 Stroke/Acute Neuro Deficits
- M15 Syncope

BASE HOSPITAL FORM INSTRUCTION MANUAL

- M17 Respiratory Distress
- Pediatric/Childbirth:
 - P1 Active Labor/Emergency Childbirth(Mother)
 - P2 Emergency Childbirth (Newborn)
 - P5 Seizure (Pediatric)
- Trauma:
 - T1 Burns
 - T2 Minor Trauma
 - T3 Major Trauma
 - T4 Traumatic Arrest

3. TRAUMA:

T R A U M A	<input type="checkbox"/> No Apparent Injuries	<input type="checkbox"/> Burns/Shock	<input type="checkbox"/> Spinal Cord Inj.	M E C H O F I N J	<input type="checkbox"/> Enc. Veh. <input type="checkbox"/> S Belt <input type="checkbox"/> A Bag	<input type="checkbox"/> Assault	<input type="checkbox"/> Fall		
	<input type="checkbox"/> Inpatient Trauma				<input type="checkbox"/> Pass Space Intrusion	<input type="checkbox"/> With Blunt Instr	<input type="checkbox"/> > 15 ft		
	<input type="checkbox"/> Minor Lac/	<input type="checkbox"/> Head	<input type="checkbox"/> Abdomen		<input type="checkbox"/> Surv. of Fatal Acc.	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Electric Shock		
	<input type="checkbox"/> Flail Chest	<input type="checkbox"/> GCS ≤ 14	<input type="checkbox"/> Diffuse Tend		<input type="checkbox"/> Ejected from Vehicle	<input type="checkbox"/> GSW	<input type="checkbox"/> Hazmat Expos.		
	<input type="checkbox"/> T. Pneumo	<input type="checkbox"/> Facial/Dental	<input type="checkbox"/> Genital/Buttocks		<input type="checkbox"/> Extrication Required	<input type="checkbox"/> Trunk	<input type="checkbox"/> Thermal Burn		
	<input type="checkbox"/> Trauma	<input type="checkbox"/> Neck	<input type="checkbox"/> Extremities		<input type="checkbox"/> Ped/Bike vs Vehicle	<input type="checkbox"/> SI Accidental	<input type="checkbox"/> Sports		
	<input type="checkbox"/> Arrest	<input type="checkbox"/> Chest	<input type="checkbox"/> Fractures		<input type="checkbox"/> Motorcycle/Moped	<input type="checkbox"/> SI Intentional	<input type="checkbox"/> Wk Related		
	<input type="checkbox"/> Back	<input type="checkbox"/> Bot Mid Clav	<input type="checkbox"/> Amputations		<input type="checkbox"/> Vs Vehicle	<input type="checkbox"/> ANimal Bite	<input type="checkbox"/> UNknown		
			<input type="checkbox"/> Neuro/Vase Comp		<input type="checkbox"/> Helmet	<input type="checkbox"/> CRush	<input type="checkbox"/> OTHER		

The paramedic report for an SFTP run is generally limited to pertinent information. On trauma SFTPs the paramedics should give the major complaint(s) and mechanism of injury. Base Hospitals may request additional information as needed to activate the trauma team. Trauma information should be documented on the Base Hospital Form as specified in Section 6 – Trauma

4. TRANSPORT:

T R A N S P O R T	Indicate Codes & ETA's on all Transport Options		Rationale for Trans. to Other	<input type="checkbox"/> ALS	T R A U M A / P E D S	Complete on ALL injured patients and ALL pediatric patients	
	Transported to:	CODE	ETA	<input type="checkbox"/> BLS		<input type="checkbox"/> Does Not Meet Criteria/Guidelines	
	<input type="checkbox"/> MAR			<input type="checkbox"/> Hell ETA		Meets Rationale AND Transported to TC/PTC/PMC because:	
	<input type="checkbox"/> EDAP (Age < 15 years)			<input type="checkbox"/> Police		<input type="checkbox"/> Criteria	<input type="checkbox"/> Shared Ambulance
	<input type="checkbox"/> Other (specify req'd)			<input type="checkbox"/> Other		<input type="checkbox"/> Guidelines	<input type="checkbox"/> Requested By
	SP Center Type			<input type="checkbox"/> Not Transported		<input type="checkbox"/> B.H. Judgment	<input type="checkbox"/> Other
	<input type="checkbox"/> TC			<input type="checkbox"/> AMA		Meets Rationale and NOT trans. to TC/PTC/PMC because:	
	<input type="checkbox"/> PTC (Age < 15 years)			<input type="checkbox"/> DOA		<input type="checkbox"/> ETA > 20 min (PMC) or 30 min (TC/PTC)	<input type="checkbox"/> Hemorrhage (uncontrolled)
	<input type="checkbox"/> PMC (Age < 15 years)			<input type="checkbox"/> Unwarranted		<input type="checkbox"/> Cardiac Arrest	<input type="checkbox"/> Requested By
	<input type="checkbox"/> PERINATAL			<input type="checkbox"/> Pronounced		<input type="checkbox"/> Airway (unmanageable)	<input type="checkbox"/> Minimal Injuries
<input type="checkbox"/> SRC (STEMI)			By _____ MD	<input type="checkbox"/> Other	<input type="checkbox"/> Diversion		
<input type="checkbox"/> ASC (Stroke)			<input type="checkbox"/> Other				

This section identifies if and where a patient is transported and the mode of transportation, ETA's and the rationale for transporting to a facility.

See Section 7 for information regarding completion of this section.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Transported To
- Rationale for Transport to Other
- Method of Transport/Reason if Not Transported

5. DISPOSITION:

D O U	Time Clear _____	If Base is = Receiving hospital: <input type="checkbox"/> Cath Lab <input type="checkbox"/> Ward <input type="checkbox"/> OB <input type="checkbox"/> Expired <input type="checkbox"/> Discharged
	Time Receiving Hosp. Notified _____	Adm. to Rm # _____ <input type="checkbox"/> ICU/CCU <input type="checkbox"/> OR <input type="checkbox"/> Stepdown <input type="checkbox"/> Other _____
	Person Notified _____	Transferred from E.D. to _____ E.D. Diagnosis _____

This section identifies specific information regarding the disposition of the patient. See Section 8 for information regarding completion of this section.

Time Clear:

Time Rec. Hosp. Notified:

Person Notified _____:

If Base is also the Receiving Hospital:

This subsection deals with the disposition of a patient from the base hospital emergency department. This section is filled out when a patient is transferred out of the emergency department.

To complete this section, mark the appropriate disposition of the patient from the emergency department:

- Cath Lab Patient went to the cardiac catheterization lab.
- Ward Admitted to the ward.
- OB Admitted to the obstetrics ward.
- ICU/CCU Admitted to the Intensive Care Unit or the Cardiac Care Unit.
- OR Transferred directly from the emergency department to the operating room.
- Stepdown Transferred to the Direct Observation Unit (DOU) or Stepdown Unit. This includes the telemetry unit.

BASE HOSPITAL FORM INSTRUCTION MANUAL

- Expired Mark if the patient dies in the emergency department.
- Discharged Mark if the patient is discharged home from the emergency department.
- Other When marked, write a comment on the line provided.

Adm. to Rm.# _____:

Transferred from E.D. to:

E.D. Diagnosis:

On the line provided, enter the emergency department diagnosis documented on the emergency department chart by the physician. This section may be completed at a later time by personnel other than the MICN/MD who handled the run.

6. SIGNATURE:

MICN/Cert. #					Physician			Patient Name/Number
--------------	--	--	--	--	-----------	--	--	---------------------

This section identifies the nurse and base hospital physician responsible for the run, and the patient's medical record number, if known. See Section 10 for information regarding completion of this section.

BASE HOSPITAL FORM INSTRUCTION MANUAL

GLOSSARY

The following are the data elements and element definitions for the Los Angeles County Base Hospital Form. Definitions are explained as they apply to the Base Hospital Form.

Term	Section(s) of Form	Definition
Abdomen	Trauma/Complaints	Injury to abdomen including the flank and pelvis as well as the four quadrants of the abdomen.
Abd/Pelvic Pain (Abdominal/Pelvic Pain)	Medical Chief Complaint	Pain or discomfort in the abdomen or pelvic region.
Acc. Mus. Use (Accessory Muscle Use)	Physical/Breathing	The patient is using accessory muscles to breathe (sternal/intercostal indrawing, etc.)
Adm. To Rm# (Admitted to Room #)	Disposition	The specific room number within a hospital unit that the patient is admitted to. The hospital unit is specified in one of the adjacent boxes.
AED Defib. (Automated External Defibrillator)	Assessment/PTBC	The EMS personnel used the AED on a patient in cardiac arrest and a shock or shocks were delivered.
Age	General Information	Hours (up to 24 hours) Days (up to 1 month) Months (up to 2 years [24 months]) Years (over 2 years [24months])

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Agitated	Medical Chief Complaint	Behavioral emergency where patients exhibit an acute onset of extreme agitation, combative and bizarre behavior that may be accompanied by paranoid delusions, hallucinations, aggression with an unusual increase in human strength, and hyperthermia.
Air Bag	Trauma/Mechanism of Injury	An air bag inflated at the time of impact in an enclosed vehicle accident and directly protected the patient; i.e., a driver side air bag protecting a driver, or a passenger-side air bag protecting a front-seat passenger.
Alert	Physical/LOC	Patient is awake and responsive to the environment.
Allergic Reaction	Medical Chief Complaint	Hives, itching, redness of the skin, runny nose or shortness of breath that have occurred suddenly. The history may relate the signs and symptoms to a known allergen (e.g. animals, cologne, plants, milk products, medications, etc.) with which the patient has had contact.
Allergies	Assessment	The patient has an allergy to one or more medications. The medication(s) to which the patient is allergic must be identified on the adjacent line. List any allergies to food, dust, bee stings, hay fever, etc., only if they are relevant to the current problem. See also, NKA.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
ALTE (Apparent Life Threatening Event)	Medical Chief Complaint	An infant (12 months or younger) has an episode that is frightening to the observer and characterized by a combination of transient apnea, color change (usually cyanosis, but occasionally erythematic), marked change in muscle tone (usually limpness), and choking and/or gagging. The infant (12 months or younger) may appear normal by the time rescuers arrive.
ALS	Transport/VIA	Patient is transported accompanied by at least one paramedic.
Altered LOC (Altered Level of Consciousness)	Medical Chief Complaint	Characterized by an abnormal response to the environment, (e.g. disorientation, no spontaneous eye opening, etc.). Refer to Los Angeles County, <u>Prehospital Care Manual</u> , Reference No. 1243 Altered Level of Consciousness.
AMA (Against Medical Advice)	Transport/No Transport	Patient refuses medically recommended treatment and/or transportation by EMS personnel. Patient must be oriented and aware of the consequences of his/her actions. Patient (or parent/legal guardian, etc.) must sign a release. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 834, Patient Refusal of Treatment or Transport.
Amputations	Trauma/Complaints	A subcategory of Extremities that identifies amputation of any digit or extremity.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Animal Bite	Mechanism of Injury	The injury was inflicted by the teeth of a human, reptile, dog, cat, or other animal. This box can be marked whether the skin was punctured or not. Insect bites and bee stings are not considered animal bites.
Apnea	Physical/ Breathing	The patient is not breathing.
Apnea Episode	Medical Chief Complaint	The patient suffers one or more brief episodes during which respiration has ceased for a brief period of time.
Artifact	Physical/ECG 12-lead	Artifact is evident on the 12-Lead ECG (may be electronically read as positive for STEMI).
Approved Stroke Center (ASC)	Transport/Specialty Center	A facility designated as a 9-1-1 receiving hospital and approved as a stroke center by Los Angeles (LA) County Emergency Medical Services (EMS) Agency. Patients with signs of a stroke as exhibited by meeting the mLAPSS screening criteria and a transport time of 30 minutes or less should be taken to a designated open ASC.
Assault	Trauma/Mechanism of Injury	A violent physical attack by one or more persons upon another with a blunt instrument (fist, bat, etc.).
B/P (Blood Pressure)	Treatments	Blood pressure – systolic and diastolic.
Back	Trauma/Complaints	An injury occurring to the back from the shoulders down to, but not including the buttocks.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Behavioral	Medical Chief Complaint	Any abnormal behavior that seems to be of mental or emotional origin. Do not mark this box for psychiatric patients unless their bizarre behavior is the cause of, or related to, their current complaint.
Bet. Mid. Clav. (Between Mid-Clavicular Lines)	Trauma/Complaints	A subcategory of Chest. Penetrating injury between the mid-clavicular lines. Refers to anterior penetrating injuries that occur above the sixth rib between the mid-clavicular lines.
Bleeding Other Site	Medical Chief Complaint	Bleeding (not related to trauma) from a site other than GI, nasal, or vaginal, which are listed in the Medical Complaint Section.
Blood Pressure	Treatments	See "B/P".
Blow by O2 (Blow By Oxygen)	Treatments	Oxygen delivered by a device placed near but not connected to the patient's face. Utilized primarily for infants or small children.
BLS (Basic Life Support)	Transport/VIA	Patient is transported by EMT personnel only.
BS after ET/KING (Breath Sounds after Advanced Airway)	Physical/Breathing	Breath sounds are heard bilaterally after insertion of an endotracheal tube, or a King LTs-D.
Burns/Shock	Trauma/Complaints	Thermal/chemical burn or electric shock.
Blunt	Trauma/Complaints	An injury that was caused by a non-piercing or non knife-like object. A blunt object can cause laceration (e.g. a facial laceration from a boxing glove).

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
BVM (Bag-Valve-Mask)	Treatments	Patient is ventilated by way of a bag-valve-mask device.
Capillary Refill	Physical/Skin	Indicate whether the patient has normal (2 seconds or less) or delayed (more than 2 seconds) capillary refill.
Capno # (Capnometry measure)	Physical/Breathing	A device used to measure the amount of CO ₂ present in the exhaled air. Document the number that the device displays. Must also ensure that there an adequate "waveform" on the device.
Cardiac Arrest	Medical Chief Complaint	Cardiac arrest is defined as a sudden cessation of cardiac output and effective circulation. This code should not be used when the arrest was caused by a traumatic injury.
CAR(Cardioversion)	Prior To Base/PTBC treatments	The patient received synchronized cardioversion to convert an unstable cardiac rhythm (e.g.: Supraventricular Tachycardia) to a stable rhythm
CCU (Coronary Care Unit)	Disposition	See "ICU/CCU."
Chest	Trauma/Complaints	Injury occurring in the chest from below the clavicles to the lower costal margin, bordered on each side by the posterior axillary line.
Chest Pain	Medical Chief Complaint	Pain in the chest from the clavicles to the lower costal margin.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Chief Complaint Code	Assessment	Two letter codes to identify specific complaints of both medical and trauma patients. Medical Chief Complaint Codes are listed on the back of the form. Trauma Chief Complaint Codes are the two bolded letters of items in the Trauma portion of the "Trauma/ Mechanism of Injury" section. The primary reason(s) the patient or third party has called 9-1-1. May be medical, trauma, or both.
Chief M.O.I. 1/Chief M.O.I 2 (Chief Mechanism of Injury)	Trauma/Mechanism of Injury	M.O.I. 1 Two bold letters taken from the most general category of Mechanism of Injury. M.O.I. 2 Two bold letters taken from the subcategory of Mechanism of Injury (e.g. PS for passenger space intrusion, SB for seat belt, etc.)
Choking/Airway Obstruction	Medical Chief Complaint	Characterized by apnea, choking and/ or difficulty breathing of rapid onset, which appears to be due to an obstruction of the airway.
Clear	Physical/Breathing	The patient's lungs are clear bilaterally to auscultation.
Clear by Algorithm	Treatments	Spinal immobilization was not performed based on negative indications per the spinal immobilization algorithm. Refer to Los Angeles County <u>Medical Control Guidelines</u> , Spinal Immobilization.
CMS Intact - After	Treatments	Indicate that the patient's circulation, sensation, and motor function of the extremities are intact after applying spinal immobilization.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
CMS Intact - Before	Treatments	Indicate that the patient's circulation, sensation, and motor function of the extremities were intact prior to applying spinal immobilization.
CO2 Detected +/-	Physical/Breathing	Denoting the presence or absence of carbon dioxide when using an end tidal CO2 monitoring device.
Cough/Congestion	Medical Chief Complaint	Cough and/or congestion in the chest, nasal passages, or throat.
Combative	Physical/LOC	The patient is physically resisting medical aid.
Comments	Comments	Any additional information regarding the disposition of the patient at the base hospital can be added here. Comments regarding crucial run information or run information not noted elsewhere should be written on the available lines in the "Assessment" section.
Cool	Physical/Skin	The patient's skin feels cooler than normal.
Crush	Trauma/Mechanism of injury	The injuries sustained were a result of external pressure being placed on body parts between two opposing forces.
CPAP (Continuous Positive Airway Pressure)	Treatments	A non-invasive mechanically assisted oxygen delivery system designed to decrease the work of breathing. CPAP is approved for patients >14 years of age with moderate to severe respiratory distress.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
CPR	Physical/Arrest	Cardiopulmonary Resuscitation.
CPR by Citizen	Physical/Arrest	CPR performed by a layperson (law enforcement personnel are to be considered citizens).
CPR by EMS	Physical/Arrest	CPR performed by EMT's, paramedics, or firefighters.
CT (Cat Scan)	Transport/rationale	The patient is transported to a facility other than the Emergency Department of the most accessible receiving (MAR) hospital because the MAR is closed to patients whose treatment would depend on the CT Scanner. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Units.
Cyanotic	Physical/Skin	The patient's skin or lips appear blue.
Date	General Info	The date the Provider contacted the base hospital
Defibrillation(Defib)	Assessment/Prior to Base PTBC(treatments)	The patient received an unsynchronized counter shock in an effort to convert a ventricular fibrillation or pulseless ventricular tachycardia to a more stable rhythm.
Device (Medical) Complaint	Medical Chief Complaint	Any complaint with a medical device (e.g. G-tube dislodged or clogged, ventilator malfunction, etc.)
Diaphoretic	Physical/Skin	The patient's skin is sweaty or moist to the touch.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Diffuse Tenderness	Trauma/Complaints	A subcategory of Abdomen. The abdomen is tender in response to palpation in two or more of the four quadrants.
Discharged	Disposition	The patient is discharged from the emergency department.
Disoriented	Physical/LOC	The patient is not oriented to person, place or time.
Dizzy	Medical Chief Complaint	The patient is experiencing dizziness or lightheadedness.
DNR/AHCD/POLST (Do-Not-Resuscitate/Advance Health Care Directive/Physician Order for Life Sustaining Treatment)	Transport/No Transport	The patient has a valid DNR or Advance Healthcare Directive (AHCD) or Physician Order for Life Sustaining Treatment (POLST) form. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 815, Honoring Prehospital Do-Not-Resuscitate Orders and Physician Orders for Life Sustaining Treatment.
Dose	Treatments	Identifies the medication dosage or the joules used during defibrillation.
Drug	Treatments	Identifies the medication(s) given and/or ordered during the run.
Dysrhythmia	Medical Chief Complaint	The ECG indicates a cardiac rhythm that requires medical attention.
E.D. Diagnosis (Emergency Department Diagnosis)	Disposition	Physician's diagnosis of the patient made at the time of discharge from the emergency department. Enter into TEMIS as an ICD-9 code.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
ED Sat (Emergency Department Saturation)	Transport/Rationale	The patient is transported to a facility other than the Emergency Department of the Most Accessible Receiving (MAR) hospital because the most accessible receiving (MAR) hospital is closed due to emergency department saturation. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Units.
EDAP (Emergency Department Approved for Pediatrics)	Transport	A licensed basic emergency department (physician on duty 24 hours) that has been confirmed as meeting specific service criteria in order to provide optimal pediatric care. A code and ETA is entered when such a facility is a transport option for the patient.
Ejected From Vehicle	Trauma/Mechanism of Injury	A subcategory of Enclosed Vehicle resulting from a traffic accident in which the victim was thrown from the car, truck or other enclosed vehicle. Patients thrown from a motorcycle are not included.
ECG Codes (Initial Rhythm)	Physical/ECG	A code identifying the patient's initial ECG; found on the back of the form.
Electric Shock	Trauma/Mechanism of Injury	Passage of electrical current through body tissue.
Enc Veh. (Enclosed Vehicle)	Trauma/Mechanism of Injury	An accident in which the victim was riding in a car, truck or back of a pickup truck at the time of impact. Convertibles, buses, and large construction/farm vehicles are also considered enclosed vehicles.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
ET (Endotracheal Tube)	Treatments	An airway was established with an endotracheal tube.
ETA (Est. Time of Arrival)	Transport	The estimated time the patient will arrive at each transport option.
Estimated Age(Est)	General Info	The actual patient age is not available and the age recorded is an estimate.
Estimated Weight(Est)	General Info	The actual patient weight is not available and the weight recorded is an estimate.
Est. Down Time (Estimated Down Time)	Physical/Arrest	The estimated time in minutes from the time of witnessed cardiac arrest/collapse to the initiation of CPR. (If unwitnessed arrest this would be UNK [unknown]).
King (King LTs - D [Laryngeal Tube suction])	Treatments	An airway was established with a King LTs- D airway.
Exist. Trach (existing tracheostomy)	Treatments	The patient has an existing tracheotomy tube which can be used to deliver oxygen or ventilate the patient.
Expired	Disposition	The patient is pronounced dead in the emergency department.
Extremities	Trauma/Complaints	Any significant blunt injury, strain, sprain to shoulders, arms, hands, legs or feet; or any penetrating injury that extends beneath the skin and subcutaneous tissue of the shoulders, arms, hands, legs or feet.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Extrication Required	Trauma/Mechanism of Injury	A subcategory of Enclosed Vehicle. Use of special equipment is necessary to free the patient from the automobile.
Eye	Physical/GCS	A number indicating eye status according to Glasgow Coma Scale standards.
Facial/Dental	Trauma/Complaints	Blunt or penetrating injury (when penetration extends beyond the skin and subcutaneous tissue) to the face, jaw, or ears. When caused by excessive blunt force that might be associated with cranial injury, "head" should also be marked.
Fall > 15 Ft. (Greater than 15 Feet)	Trauma/Mechanism of Injury Trauma/Mechanism of Injury	The patient's injuries resulted from a fall. This category includes all injuries that result from any height (e.g., falls in a bathtub, from a bicycle, out of a window, from a horse, etc.). A subcategory of Fall. A vertical uninterrupted fall of greater than 15 feet . This type of fall meets criteria for transport to a trauma center.
FC (Fluid Challenge)	Treatments	One of the possible rates of infusion for an IV administered by paramedics in the field. A specific amount of IV fluid is given as fast as possible over a short period of time. The amount ordered (usually 200-500 cc's) is written on the adjacent line.
Fever	Medical Chief Complaint	The patient exhibits an elevated body temperature.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Fixed & Dilated	Physical/Pupils	The patient's pupils are dilated and unresponsive to light.
Flail Chest	Trauma/Complaints	Blunt injury to the chest resulting in an unstable chest wall identified by paradoxical chest wall movement.
Flushed	Physical/Skin	The patient's skin appears abnormally red.
Foreign Body	Medical Chief Complaint	A foreign object within any orifice of the body.
Fractures	Trauma/Complaints	A subcategory of Extremities. Identifies fractures to the extremities, clavicle or hip.
GCS (Glasgow Coma Scale)	Physical/GCS	A numerical system for describing a patient's level of consciousness.
GCS≤14	Trauma/Complaints	A subcategory of blunt head trauma to identify patients who have sustained blunt head trauma and have a GCS of 14 or less.
Genital/Buttocks	Trauma/Complaints	Injury to the buttocks or external reproductive structures.
GI Bleed (Gastrointestinal Bleeding)	Medical Chief Complaint	Bleeding from the upper or lower GI tract. Patient may have bloody or tarry stool or coffee ground emesis.
Glucometer	Treatments	Blood glucose result obtained using a metered device.
GSW (Gunshot Wound)	Trauma/Mechanism of Injury	The victim received a wound from a firearm.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Guidelines	Transport	Guidelines that have been established under trauma triage protocol. These guidelines assist the paramedics and the base hospitals in determining patient destination. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 506, Trauma Triage.
Hazmat Exposure (Hazardous Material Exposure)	Trauma/Mechanism in Injury	The patient was exposed to toxic or poisonous agent(s). Agents included are liquids, gases, powders, foams and radiation. This item includes chemical burns. NOTE: For pepper spray incidents or brief exposures to other minor irritants use the medical code "OT" unless another more appropriate major chief complaint exists.
Head	Trauma/Complaints	An injury to the head or skull, from above the eyebrows and behind the ears.
Head Pain	Medical Chief Complaint	"Headache" or any other type of head pain not associated with trauma.
HEAR Radio (Hospital Emergency Administrative Radio)	General Information	These calls are routed through the Centralized Medical Alert System. This radio system is typically used when the paramedic's radio is unable to make contact with the base hospital, or during large-scale emergencies.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Heli ETA (Helicopter Estimated Time of Arrival)	Transport/Via	Transportation is provided by a helicopter with paramedics on board. This is usually not the primary provider. ETA designates when the helicopter is expected to arrive on scene.
Helmet	Trauma/Mechanism of Injury	A patient is involved in motorcycle/moped accident and was wearing a helmet at the time of impact.
Hospital Code	General Information	A three-letter code used to identify the base hospital. Codes are listed on the back of the form.
Hot	Physical/Skin	The patient's skin feels much warmer than normal and the patient appears to have a fever.
Hypoglycemia	Medical Chief Complaint	The patient is experiencing signs/symptoms of hypoglycemia (altered, diaphoresis, seizures, combative, etc.) and the documented blood glucose is below normal limits.
ICU/CCU (Intensive Care/Cardiac Care Unit)	Disposition	Patient was admitted to an Intensive Care or Cardiac Care Unit.
Indicate rationale below:	Transport	The reason for the decision to transport a patient to the selected receiving hospital.
Info Only	General Information	The radio communication is for the purpose of documenting information only. No treatments or interventions are given. AMA's are not considered Information Only calls.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Initial ECG	ECG and Arrest	The first rhythm recorded by the electrocardiograph when it is placed on the patient.
Inpatient Medical	Medical Chief Complaint	Interfacility transport of a patient with a medical chief complaint from a hospital ward or unit (not the Emergency Department).
Int. Disaster (Internal Disaster)	Transport/Rationale	The patient is transported to other than the Emergency Department of the most accessible receiving facility (MAR) because the most accessible receiving facility (MAR) is closed due to an internal disaster. These disasters include fire, flood, bomb threat, etc. Refer to Los Angeles County Prehospital Care Manual, Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Units.
Inter. Rad (Interventional Radiology)	Dispo	The patient is dispositioned from the Emergency Department directly to Interventional Radiology (angio).
I.V. Unobtainable	Treatments	The paramedics are unable to start an IV on the patient. This typically occurs when a suitable vein cannot be found.
Jaundiced	Physical/Skin	A yellow appearance of the patient's skin or sclera.
Joint Run	General Information	A run that was initially called in to the base as a Standing Field Treatment Protocol (SFTP) but has evolved into a regular run due to the need for medical direction/consultation.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Judgment	Transport	The patient in the judgment of the base hospital has sustained injuries that warrant transport to a trauma center. Explains why a patient not meeting Criteria or Guidelines is transported to a trauma center.
Labor	Medical Chief Complaint	An obstetric patient late in her pregnancy experiences regular uterine contractions.
Labored	Physical - Breathing	The patient is exhibiting signs of labored respiration and increased effort of breathing (accessory muscle use, pursed lip breathing, etc.)
Last Known well: Date Time	Physical/mLAPSS	The date the patient was last seen at their baseline neurological status. The time the patient was last seen at their baseline neurological status.
Local Neuro Signs	Medical Chief Complaint	Weakness/numbness of a specific part of the body, or expressive aphasia.
Location	General Information	The environment of the incident, (e.g. street, house, canyon, etc.). Location codes are found on the back of the form.
Log #	Medical Record Information	A number specific to each patient found in the base hospital logbook.
MAR (Most Accessible Receiving)	Transport	The receiving hospital that can be accessed in the shortest possible time. Depending on traffic patterns, this facility is not necessarily the closest. The MAR is determined by the paramedic.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Mask	Treatments	High flow oxygen is delivered to the patient via a facemask.
Medical HX	Assessment	Any significant medical history pertinent to the situation. This includes past occurrences of the current ailment.
Medications	Assessment	Any medication currently taken by the patient. This includes non-prescription drugs.
Meds prior to BC (Medications prior to Base Contact)	Assessment	Medications given by paramedics prior to initial radio contact with the base hospital. These medications include a limited number of specially approved drugs. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 806, Procedures Prior to Base Contact.
MICN/Cert. #	Signature	The Los Angeles County Mobile Intensive Care Nurse Certification number. This number should be preceded by the letter "N."
Mild	Assessment	A subcategory of Severity of Distress. Exhibits a low level of distress. Shows few external cues indicating a low level of distress related to the chief complaint. The patient can easily divert attention from signs and symptoms related to the chief complaint.
mLAPSS(Modified Los Angeles Prehospital Stroke Screen)	Physical/mLaPSS	A screening tool used to determine patient destination to an ASC. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 521, Stroke Patient Destination.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Minor Lac (Minor Laceration /Contusion /Abrasion)	Trauma/Complaints	A minor surface injury not associated with excessive blunt force or penetration beyond the skin and subcutaneous tissue.
Mod. (Moderate)	Assessment	A subcategory of Severity of Distress. Exhibits an increasing level of distress. The patient is not easily distracted and remains more focused on chief complaint/ signs and symptoms.
Motor Response	Physical/GCS	A number indicating patient motor status according to the Glasgow Coma Scale.
Motorcycle/Moped	Trauma/Mechanism of injury	The victim was riding on an unenclosed motorized vehicle (motorcycle, moped, ATV, etc.) at the time of the accident.
Myocardial Infarction	Medical Chief Complaint	The patient has a myocardial infarction according to the 12-Lead ECG electronic interpretation.
Nausea/Vomiting	Medical Chief Complaint	The patient is experiencing nausea and/or vomiting.
N/C (Nasal Cannula)	Treatments	Low flow oxygen is delivered via nasal cannula.
Near Drowning	Medical Chief Complaint	History of submersion causing signs/symptoms (including difficulty breathing). This category includes patients who die from drowning.
Neck	Trauma/Complaints	Pain or injury occurring between the angle of the jaw and the clavicle, including probable cervical spine injures.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Neck/Back Pain	Medical Chief Complaint	Pain in the neck or the back from the shoulders to the buttocks not immediately resulting from trauma.
Needle Thoracostomy	Treatments	A needle thoracostomy was attempted or performed.
Neuro/Vasc. Comp. (Neurological and/or vascular Compromise)	Trauma/Complaints	The victim sustained a blunt or penetrating injury to an extremity that resulted in neurological and/or vascular compromise of that extremity.
Newborn	Medical Chief Complaint	The chief complaint for a baby who is born in the course of an EMS run. A separate report must be completed for both the mother and the newborn child.
NKA (No Known Allergies)	Assessment	The patient is not aware of any allergies to medicines. List allergies to food, dust, bee stings, hay fever, etc., only if they are relevant to the patient's current problem.
No Medical Complaint	Medical Chief Complaint	The patient has no medical complaint. Do not use this code for injured patients.
No Apparent Injuries	Trauma/Complaints	The patient has experienced a trauma mechanism of injury but does not have any complaints of, or visible signs of injury.
No Response	Physical/LOC	The patient is unconscious and does not respond to stimuli.
Non-purposeful	Physical/LOC	A subcategory of Response to Pain. The patient is unconscious and the response to painful stimulus is non-purposeful.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
None	Assessment	A subcategory of Severity of Illness. The patient appears well and has no acute signs or symptoms relative to the incident. Advanced life support and transportation are usually not necessary. Also used for DOA's (not Cardiac Arrests).
Normal	Physical/Breathing	Respirations appear normal with respect to rate and rhythm.
Normal	Physical/Skin	The skin is of normal color, temperature and moisture.
Normal for Pt.	Physical/LOC	The patient's behavior, although not typical, is the same as it was before the "incident". This should also be used for a child who is behaving appropriately for their age.
Nosebleed	Medical Chief Complaint	A type of external bleeding that refers to bleeding from the nose that occurs spontaneously and is not associated with trauma.
Not Alert	Physical/LOC	Patient is awake but is not as responsive to the environment as the alert person.
O2 (Oxygen)	Treatments	Patient received oxygen. The flow rate entered in liters per minute and the device used to deliver the oxygen is indicated by marking an adjacent box. Types of devices include nasal cannula, mask, etc.
O2Sat (Oxygen Saturation)	Treatments	Oxygen saturation obtained using pulse oximetry.
OB (Obstetrics)	Disposition	The patient is admitted to the obstetrics ward.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Obstetrics/GYN	Medical Chief Complaint	Any signs or symptoms, in a patient who is known to be pregnant, that are likely to be related to the pregnancy. These signs/symptoms may include: edema, severe headaches, vaginal bleeding, dizziness or any signs or symptoms of labor. If the patient exhibits signs or symptoms of labor, use the chief complain of "Labor".
OD (Overdose)	Medical Chief Complaint	Ingestion/injection of a poisonous substance.
O/P/Q/R/S/T	Assessment	An acronym to assist with documentation of pain. <ul style="list-style-type: none"> • Onset (sudden or gradual) • Provoking/Palliating factors • Quality of the pain (sharp, dull, colicky, etc). The 0-10 pain scale should be used to rate the pain. • Region/Radiation/Relief (location of the pain, relieving factors) • Severity • Time (Time of onset or how long the patient has been in pain.
OR (Operating Room)	Disposition	The patient is admitted directly from the emergency department to the operating room.
Oriented x3	Physical/LOC	Patient is oriented to person, place, and time.
Other	Disposition	Any disposition of the patient from the emergency department that is not listed.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Other	Medical Chief Complaint	Signs or symptoms that do not fit into any of the categories mentioned in this section.
Other	Trauma/Mechanism of Injury	Any mechanism of injury that is not listed.
Other	Transport/Rationale	Mark this option only when another more specific reason is not listed. Specify the reason on the line provided.
Other Pain	Medical Chief Complaint	Pain in a site other than the chest, head, neck, abdomen, pelvis, or back.
Paced Rhythm	Physical/ECG 12-Lead	The underlying rhythm is paced (may be electronically read as a positive STEMI).
Pain (0-10)	Treatments	A subjective pain score obtained by the EMS personnel asking the patient to rate their pain on a 1-10 scale with 10 being the most severe pain the patient can imagine.
P (Pulse)	Treatments	The patient's heart rate for one minute.
Page 2	Medical Record Information	A supplemental page to the Base Hospital form when extra space is needed for documentation.
Pale	Physical/Skin	The patient's skin is abnormally pale, ashen or gray.
Palpitations	Medical Chief Complaint	The patient feels an abnormal heartbeat, which may be described as a pounding sensation or racing.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Pass. Space Intrus. (Passenger Space Intrusion)	Trauma/Mechanism of Injury	A subcategory of Enclosed Vehicle. Following an accident the patient is unable to sit in the normal position in the space previously occupied due to encroachment of the dash, another auto, etc., into this patient's passenger space.
Patient Name/Number	Signature	The name and medical record number of the patient when transported to the Base hospital.
PMC (Pediatric Medical Care)	Transport	A designation for hospitals that are approved to receive critically ill pediatric patients. Guidelines for the mandatory transport of pediatric patients to a designated PMC are contained in Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 510, Pediatric Patient Destination.
PTC (Pediatric Trauma Center)	Transport	A designation for hospitals that are approved to receive critically injured pediatric patients. Criteria/Guidelines for the mandatory transport of pediatric patients to a designated PTC are contained in Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 510, Pediatric Patient Destination and Reference No. 506, Trauma Triage.
PEA (Pulseless Electrical Activity)	ECG Codes	A cardiac rhythm without pulses.
Ped/Bike vs. Vehicle (Pedestrian/Bicyclist versus Vehicle)	Mechanism of Injury	The victim is a pedestrian or bicyclist who hits or is hit by a motorized vehicle.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Peds Weight Color Code	General Information	The color that corresponds to the length of an infant or child to determine approximate weight and to provide guidance in pediatric drug dosages.
Penetrating	Trauma/Complaints	The injury is piercing or knife-like in nature and extends beyond the skin through the subcutaneous tissue. See also, Minor Lac/Cont/Abra.
Perinatal	Transport	A hospital with an obstetrical department. Refer to Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 511, Perinatal Patient Destination.
PERL (Pupils Equal and Reactive to Light)	Physical/Pupils	Patient's pupils are the same size and react equally to light.
Person Notified	Disposition	If the patient is transported to a facility other than the base hospital, this is the name of the person at the receiving hospital who was notified of the impending transport.
Phone	General Information	Paramedics contact the base hospital by telephone.
Physician	Signature	The name and number of the physician who is responsible for handling the call or who was consulted during the call.
Pinpoint	Physical/Pupils	The patient's pupils are extremely constricted.
Poisoning	Medical Chief Complaint	Accidental ingestion of medication or chemical substance.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Preexist	Physical/IV	A patient already who upon arrival of EMS personnel already had IV access established. Usually by a clinic, urgent care, doctor's office, etc.
PRN	Treatments	A medication that has been ordered to be given only if needed during transport based on certain parameters specified by the base hospital (e.g. glucose for glucometer reading of <60, Morphine for pain unrelieved by NTG, etc.).
Pronounced	Transport/No Transport	A patient who has had field resuscitation initiated and is subsequently declared dead in the field by a physician.
Pronounced Rhythm	Transport/No Transport	The ECG rhythm that exists on the cardiac monitor at the time of pronouncement.
Protocol	Assessment	Standing Field Treatment Protocol used by approved EMS Provider Agencies.
Prov. Code (Provider Code)	General Information	A two-letter code used to identify the provider agency making base hospital contact.
Pt. # ___ of ___	General Information	Identifies a particular patient among the total number of patients involved in an incident.
Pulse	Treatments	See "P."
Pulses with CPR	Physical/Arrest	The patient has pulses with CPR. Validates the effectiveness of CPR.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Purposeful	Physical/LOC	A subcategory of Response to Pain. The patient is unconscious and responds to painful stimuli by avoiding or removing the source of pain.
R (Respiration)	Treatment	The patient's respiratory rate for one minute.
Radio	General Information	The base station radio console transmits and records the run.
Rales	Physical/Breathing	An abnormal crackling sound heard upon auscultation of the chest.
Refused	Physical/IV	Patient refused to allow paramedics to attempt to insert IV access.
Request	Transport/Rationale	At the request of the patient, patient's family, patient's physician, or other authorized party, the patient is transported to a hospital other than the one to which the paramedic would ordinarily transport the patient.
Respiratory Arrest	Medical Chief Complaint	The patient has stopped breathing.
Responds to Pain	Physical/LOC	The patient is unconscious and responds to pain either purposefully or non-purposefully. Check the appropriate box.
Responds to Verbal	Physical/LOC	The patient is unconscious but does respond to verbal stimuli.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Restoration of Pulse (ROSC)	Physical/Arrest	A patient who was in full arrest has pulses restored at any time during the prehospital phase, even if the pulses are lost prior to arrival at the receiving facility. Not the time (use military time) that pulses were restored. All patients who have ROSC and are transported must go to a STEMI Receiving Center (SRC).
Results	Treatments	Identifies the effect of administration of a drug or therapy. The effect is either: <ul style="list-style-type: none"> • improvement (up arrow ↑) • deterioration (down arrow ↓) • no change (N)
Resus DC @ (resuscitation Discontinued at)	Transport/No Transport	The time that CPR and other life saving therapies are terminated by decision of the base hospital physician. The time should be documented using military time.
Rhonchi	Physical/Breathing	An abnormal coarse rattling sound heard on auscultation of the chest.
Seat Belt	Trauma/Mechanism of Injury	A subcategory of Enclosed Vehicle. At the time of the accident, the patient was wearing a seat belt.
Seizure	Medical Chief Complaint	Active convulsions or current incident history that suggests the patient was seizing.

EXHIBIT S
BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Seq. # (Sequence Number)	Medical Record Information	The EMS Report form number that the paramedics give to the base hospital. This number is printed in the "Patient Information" section of the EMS Report Form that the paramedics complete in the field or prepopulated for providers using electronic patient care records (ePCR's).
Severe	Assessment	A subcategory of Severity of Distress. Exhibits a great level of distress. The patient is completely focused on the chief complaint/signs and symptoms. Nothing can distract the patient from the serious signs and symptoms that he/she is experiencing.
Severity of Distress	Assessment	The objective assessment by EMS personnel of the patient's presentation of signs and symptoms related to the chief complaint.
Sex	General Information	The gender of the patient, indicated by "M" for male and "F" for female.
SFT Protocol (Standing Field Treatment Protocol - SFTP).	General Information	Designation to be used when paramedic treats the patient according to standing field treatment protocols and contacts the base for destination information ONLY (no medical direction is given).
Short of Breath	Medical Chief Complaint	The patient states he/she is short of breath and/or breathing is characterized by gasping, rapid respirations, cyanosis, use of accessory muscles, retractions, etc.
S.I. Accidental (Self Inflicted)	Trauma/Mechanism of Injury	The injury was caused accidentally by the patient.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
S.I. Intentional (Self Inflicted)	Trauma/Mechanism of Injury	The injury was caused intentionally by the patient.
SL (Saline Lock)	Treatments	An IV access is established using a catheter and a flush of Normal Saline to keep the vein open.
Sluggish	Physical/Pupils	One or both pupils react more slowly to light than normal.
Snoring	Physical/Breathing	A rough, hoarse breathing caused by relaxation of the soft palate.
Spinal Cord Injury	Trauma/Complaints	Spinal cord injury is suspected. Patient may have weakness, paralysis, paresthesia, etc. after a traumatic injury.
Spinal Immob. (Spinal Immobilization)	Treatments	The spine is stabilized using one or more immobilizing techniques. Mark if CMS is intact before and after immobilization.
Sports	Trauma/Mechanism of Injury	The injury occurred while the patient engaged in a sporting or recreational athletic activity.
SRC (STEMI Receiving Center)	Transport/Specialty Center	ST Elevation Myocardial Infarction approved receiving facility.
Stabbing	Trauma/Mechanism of Injury	A subcategory of Assault. Penetration beyond the skin and subcutaneous tissue using a sharp piercing instrument, such as a knife or ice pick.
Stepdown	Disposition	The patient was admitted to the DOU or Step-down Unit.
Stridor	Breathing	A harsh, high-pitched, crowing sound heard during respiration.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Surv. Of Fatal Acc. (Survivor of Fatal Accident)	Trauma/Mechanism of Injury	A subcategory of Enclosed Vehicle. The patient's injuries resulted from a motor vehicle accident in which one or more fatalities occurred in the patient's vehicle.
Suspected Drugs/ETOH	Assessment	The situation, statements by the patient, family or bystanders and/or the patient's behavior cause the paramedics to suspect that the patient has been drinking or is under the influence of alcohol or an illicit drug.
Syncope	Medical Chief Complaint	The patient exhibits or exhibited a transient loss of consciousness.
T. Pneumo (Tension Pneumothorax)	Trauma/Complaints	A life-threatening collection of air under increased pressure in the pleural cavity. Signs and symptoms include those of a pneumothorax plus, shock, neck vein distension and tracheal deviation.
Total min EMS CPR	Transport/No Transport	The time in minutes from the beginning of EMS CPR to the time of pronouncement.
TC (Trauma Center)	Transport/Transport To	A designation for hospitals that are approved to receive critically injured patients. Criteria/Guidelines for the mandatory transport of trauma patients to a designated TC are contained in Los Angeles County <u>Prehospital Care Manual</u> , Reference No. 506, Trauma Triage.
T.C.P (Transcutaneous Pacing)	Treatments	Document the MA (milliamps), rate and indicate (Y or N) if capture is obtained.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Thermal Burn	Trauma/Mechanism of Injury	A burn resulting from heat.
Tidal Vol. (Tidal Volume)	Physical/Breathing	The depth of respiration identified as increased, decreased or normal.
Time	General Information	The time of the incident. Use military time.
Time	Treatments	The time the vital signs are reported or the times drugs or treatments are ordered. Use military time.
Time Clear	Disposition	The time the run is finished. Use military time.
Time Rec. Hosp. Notified (Time the Receiving Hospital Notified)	Disposition	Time the receiving hospital was notified that a patient is being transported to their facility. Use military time.
TKO (To Keep Open)	Treatments	The slowest possible rate of infusion for an IV administered by paramedics in the field.
Too Tall	General Information/Peds weight color code	A pediatric patient is taller than the measuring tape.
Transferred from E.D. to	Disposition	The patient is transferred from the emergency department to another facility.
Trauma Arrest	Trauma/Complaints	An absence of heart beat as a result of either blunt or penetrating injury.
Trauma Center	Transport/Rationale for Transport to Other	The patient is transported to an "Other" facility because the designated Trauma Center is closed to trauma patients.
Treatments	Treatments	Identifies the treatment(s) ordered during the run.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Trunk	Trauma/Mechanism of Injury	A subcategory of Gunshot Wound. A gunshot wound occurring to the chest, abdomen, back or buttocks.
Unequal	Physical/Breathing	Upon auscultation, breath sounds are absent or considerably decreased on one side of the chest.
Unequal	Physical/Pupils	A difference is observed between the right and left.
Unit	General Information	A numerical code to identify the specific squad or rescue ambulance of a given provider agency making base hospital contact.
Unknown	Trauma/Mechanism of Injury	The cause or the mechanism of injury is not known.
Unwarranted	Transport/No Transport	The patient's condition does not warrant transport.
Vaginal Bleed	Medical Chief Complaint	A type of external bleeding indicating abnormal vaginal bleeding.
Verbal Response	Physical/GCS	A number indicating the patient's verbal status according to Glasgow Coma Scale.
VF (Ventricular Fibrillation)	ECG Codes	The patient's initial ECG shows ventricular fibrillation (i.e., an erratic heartbeat pattern).
Vs Veh. (Verses Vehicle)	Trauma/Mechanism of Injury	A subcategory of Motorcycle/ Moped. The patient on the motorcycle or moped struck, or was struck by, an automobile.
Ward	Disposition	The patient is admitted to a general ward of the hospital.
Warm	Physical/Skin	Skin feels warm to touch.

EXHIBIT S

BASE HOSPITAL FORM INSTRUCTION MANUAL

Term	Section(s) of Form	Definition
Wavy Baseline	Physical/ECG 12-Lead	The baseline on the 12-Lead ECG is wavy (may be electronically read as a positive STEMI).
Weak	Medical Chief Complaint	The patient is experiencing weakness.
Weight	General Information	The weight of the patient in pounds or in kilograms.
Wheezes	Physical/Breathing	A high-pitched sound heard audibly or upon auscultation of the chest.
With Blunt Instr. (With Blunt Instrument)	Trauma/Mechanism of Injury	A subcategory of Assault. An assault using a non-penetrating instrument (i.e., club, tire iron, etc.).
Witnessed by Citizen	Physical/Arrest	A medical cardiac arrest or the collapse of a patient was witnessed by a citizen. Law enforcement personnel are considered citizens.
Witnessed by EMS	Physical/Arrest	A medical cardiac arrest witnessed by a paramedic, EMT, or firefighter.
Wk. Related (Work Related)	Trauma/Mechanism of Injury	Any injury that occurs while the patient is working, and would likely be covered by worker's compensation.
WO (Wide Open)	Treatments	The fastest possible rate of infusion for an IV administered by paramedics in the field.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **BASE HOSPITAL AND PROVIDER AGENCY** EMT, PARAMEDIC, MICN
REPORTING RESPONSIBILITIES REFERENCE NO. 214

PURPOSE: To provide guidelines for reporting possible violations of the California Health and Safety Code Section 1798.200, Sub-sections (a) through (c) and comply with relevant employer reporting responsibilities.

AUTHORITY: California Health and Safety Code, Division 2.5, Sections 1797.200, 1798.200. California Code of Regulations, Title 22, Chapter 4, Sections 100168, 100172 100173; Chapter 6, Section 100208.1; Base Hospital Agreement.

PRINCIPLE: Prior to initiating disciplinary proceedings, all information available to the EMS Agency or received from a credible source shall be evaluated for evidence of a threat to public health and safety pursuant to Section 1798.200 of the Health and Safety Code.

DEFINITIONS:

Certifying Entity: A public safety agency, if the agency has a training program for EMT personnel, that is approved pursuant to the standards developed pursuant to Section 1797.109 of the Health and Safety Code or the medical director of the local EMS Agency (LEMSA).

Disciplinary Cause: An act that is substantially related to the qualification, functions, and duties of prehospital personnel and is evidence of a threat to public health and safety, per Health and Safety Code Section 1798.200.

Discipline: A disciplinary action taken by a relevant employer pursuant to California Code of Regulations, Title 22, Division 9, Chapter 6, Section 100206.2 or certification action taken by a medical director, or both a disciplinary plan and certification action.

Disciplinary Plan: A written plan of action that can be taken by a relevant employer as a consequence of any action listed in the California Health and Safety Code Section 1798.200. The disciplinary plan may include recommendation for certification actions pursuant to the Model Disciplinary Orders

LEMSA: Local emergency medical services agency

Medical Director: The medical director of the local emergency medical services agency.

Model Disciplinary Orders: The Recommended Guidelines for Disciplinary Orders and Conditions of Probation for EMT's. and Paramedics developed by the State EMS Authority to provide consistent and equitable discipline in cases dealing with disciplinary cause.

EFFECTIVE DATE: 3-5-87
REVISED DATE: 8-1-11
SUPERSEDES: 10-3-05

APPROVED: _____
Director Medical Director

SUBJECT: BASE HOSPITAL AND PROVIDER AGENCY
REPORTING RESPONSIBILITIES

REFERENCE NO. 214

Relevant Employer: Ambulance providers permitted by the Department of the California Highway Patrol or a public safety agency, that the certificate holder works for or was working for at the time of the incident under review, as a paid employee or a volunteer.

Valid, Validate or Validation: Verification, within reasonable certainty, that a violation of Health and Safety Code Section 1798.200 may have occurred and that said violation may be reason for disciplinary cause.

POLICY:

- I. Base hospitals and provider agencies shall prepare and forward a written report within three working days to the local EMS Agency regarding any action of certificated or licensed EMS personnel which may potentially constitute a violation under Section 1798.200 (c) of the Health and Safety Code as listed in Section II. Any other items of concern resulting from an apparent deficiency of patient care should also be reported.
 - A. The report shall be signed by an authorized representative of the provider agency or base hospital and must contain, at a minimum, the following:
 1. Names and certification/license numbers of all EMS personnel involved in the incident.
 2. Date, time, and location of the incident.
 3. A written summary of the allegations related to the incident.
 4. The Health and Safety Code violation listed under 1798.200.
 5. A copy of the EMS Report Form, if applicable.
 6. A copy of the Base Hospital Report Form and audio recording, if applicable.
 - B. Any report made to the local EMS Agency shall be copied to the employer of the affected individual as approved by or per policies of the hospital or provider agency's Risk Management Department.
- II. Any of the following actions by EMS personnel shall be considered evidence of a threat to the public health and safety and, if found to be true, **may** result in probation, denial, suspension, or revocation of a certificate or license issued by the EMS Agency and or under the Health and Safety Code, Division 2.5, Section 1798.200 (c).
 - A. Fraud in the procurement of a certificate or license
 - B. Gross negligence
 - C. Repeated negligent acts
 - D. Incompetence
 - E. The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, and duties of prehospital personnel.
 - F. Conviction of any crime which is substantially related to the qualifications, functions, and duties of prehospital personnel. The record of conviction or certified copy of the record shall be conclusive evidence of the conviction.

SUBJECT: BASE HOSPITAL AND PROVIDER AGENCY
REPORTING RESPONSIBILITIES

REFERENCE NO. 214

- G. Violating or attempting to violate directly or indirectly, or assisting in or abetting the violation of, or conspiring to violate, any provision of this division or the regulations adopted by the authority pertaining to prehospital personnel.
- H. Violating or attempting to violate any federal or state statute or regulation which regulates narcotics, dangerous drugs, or controlled substances.
- I. Addiction to, the excessive use of, or the misuse of, alcoholic beverages, narcotics, dangerous drugs, or controlled substances.
- J. Functioning outside the supervision of medical control in the field care system operating at the local level, except as authorized by any other license or certification.
- K. Demonstration of irrational behavior or occurrence of a physical disability to the extent that a reasonable and prudent person would have reasonable cause to believe that the ability to perform the duties normally expected may be impaired.
- L. Unprofessional conduct exhibited by any of the following:
 - 1. The mistreatment or physical abuse of any patient resulting from force in excess of what a reasonable and prudent person trained and acting in a similar capacity while engaged in the performance of his or her duties would use if confronted with a similar circumstance. Nothing in this section shall be deemed to prohibit an EMT, Advanced EMT or paramedic from assisting a peace officer, or a peace officer who is acting in the dual capacity of peace officer and EMT, Advanced EMT or paramedic, from using force that is reasonably necessary to effect a lawful arrest or detention.
 - 2. The failure to maintain confidentiality of patient medical information, except as disclosure is otherwise permitted or required by law in Sections 56 to 56.6, inclusive, of the Civil Code.
 - 3. The commission of any sexually related offense specified under Section 290 of the Penal Code.

PROCEDURE:

I. BASE HOSPITAL RESPONSIBILITIES

A. MICN Personnel

- 1. May conduct investigations to determine disciplinary cause.
- 2. May request that the Agency conduct the investigation to determine disciplinary cause.
- 3. Shall notify the EMS Agency Medical Director that the alleged action occurred **within three (3) working days after an allegation has been**

validated as potential for disciplinary cause.

4. Upon determination of disciplinary cause, the Prehospital Care Coordinator may develop and implement a disciplinary plan.
 - a. The disciplinary plan, along with the relevant findings of the investigation related to disciplinary cause, shall be submitted to the EMS Agency Medical Director **within three (3) working days** of adoption of the disciplinary plan.
 - b. The disciplinary plan may include a recommendation that the EMS Agency Medical Director consider taking action against the holder's MICN certificate to include denial, suspension, revocation, or placement of a MICN certificate on probation.
5. Shall notify the EMS Agency Medical Director of the alleged action within three (3) working days or the occurrence of any of the following:
 - a. The MICN is terminated or suspended for a disciplinary cause.
 - b. The MICN resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or
 - c. The MICN is removed from their related duties for a disciplinary cause after the completion of the employer's investigation.

II. PROVIDER AGENCY RESPONSIBILITIES

A. EMT Personnel

1. May conduct investigations, to determine disciplinary cause.
2. May request that the local EMS agency (LEMSA) conduct the investigation to determine disciplinary cause.
3. Upon determination of disciplinary cause, the relevant employer may develop and implement a disciplinary plan in accordance with the Model Disciplinary Orders (MDOs).
 - a. The relevant employer shall submit that disciplinary plan along with the relevant findings of the investigation related to disciplinary cause to the LEMSAs that issued the certificate, **within three (3) working days** of adoption of the disciplinary plan. In the case where the certificate was issued by a non-LEMSA certifying entity, the disciplinary plan shall be submitted to the LEMSAs that has jurisdiction in the county in which the headquarters of the certifying entity is located.
 - b. The employer's disciplinary plan may include a recommendation that the LEMSAs medical director consider taking action against the holder's certificate to include denial, suspension, revocation,

SUBJECT: **BASE HOSPITAL AND PROVIDER AGENCY
REPORTING RESPONSIBILITIES**

REFERENCE NO. 214

or placement of a certificate on probation.

4. Shall notify the LEMSA medical director that has jurisdiction in the county in which the alleged action occurred **within three (3) working days after an allegation has been validated as potential for disciplinary cause.**
5. Shall notify the LEMSA medical director that has jurisdiction in the county in which the alleged action occurred within three (3) working days or the occurrence of any of the following:
 - a. The EMT is terminated or suspended for a disciplinary cause
 - b. The EMT resigns or retires following notification of an impending investigation based upon evidence that would indicate the existence of a disciplinary cause, or
 - c. The EMT is removed from their related duties for a disciplinary cause after the completion of the employer's investigation.
6. Disciplinary plans shall be signed and dated by an authorized representative of the prehospital provider agency or base hospital.

B. Paramedic Personnel

1. Paramedic employers shall report in writing to the LEMSA medical director and the EMS Authority and provide all supporting documentation within 30 days of whenever the following actions are taken:
 - a. A paramedic is terminated or suspended for disciplinary cause or reason.
 - b. A paramedic resigns following notice of an impending investigation based upon evidence indicating disciplinary cause or reason.
 - c. A paramedic is removed from paramedic duties for disciplinary cause or reason.

CROSS REFERENCES:

Prehospital Care Policy Manual:

Reference No. 201, **Medical Management of Prehospital Care**

Reference No. 216, **EMT Certification Review Process**

Reference No. 304, **Role of the Base Hospital**

Reference No. 308, **Base Hospital Medical Director**

Reference No. 310, **Prehospital Care Coordinator**

Los Angeles County EMS Agency Situation Report

**LOS ANGELES COUNTY
DEPARTMENT OF HEALTH SERVICES
EMERGENCY MEDICAL SERVICES AGENCY
EDAP STANDARDS
TABLE OF CONTENTS**

INTRODUCTION:	Page 2
DEFINITIONS	Page 2
Board certified	Page 2
Board prepared.....	Page 2
Emergency Department Approved for Pediatrics.....	Page 2
ENPC.....	Page 2
Medical Pediatric Critical Care Center.....	Page 2
PALS.....	Page 2
Pediatric Critical Care Center.....	Page 2
Promptly available.....	Page 2
Qualified specialist.....	Page 3
Senior resident	Page 3
ADMINISTRATION/COORDINATION	Page 3
EDAP Medical Director.....	Page 3
Responsibilities.....	Page 3
Designated Pediatric Consultant	Page 4
Responsibilities.....	Page 4
Pediatric Liaison Nurse (PdLN)	Page 4
Qualifications	Page 4
Responsibilities.....	Page 4
PERSONNEL	Page 5
Physicians-Qualifications/Education	Page 5
Nurses-Qualifications/Education.....	Page 5
Pediatric physicians/Specialty services.....	Page 5
Physician Assistant.....	Page 6
POLICIES, PROCEDURES, AND PROTOCOLS	Page 6
QUALITY IMPROVEMENT (QI)	Page 7
SUPPORT SERVICES	Page 7
Respiratory Therapy	Page 7
Radiology.....	Page 8
Laboratory	Page 8
EQUIPMENT, SUPPLIES, AND MEDICATIONS	Page 8
General Equipment.....	Page 8
Monitoring Equipment.....	Page 9
Respiratory Equipment.....	Page 9
Vascular Access Equipment.....	Page 10
Fracture Management Devices.....	Page 10
Specialized Trays	Page 10
Pediatric Specific Resuscitation Medications.....	Page 11

EDAP STANDARDS

INTRODUCTION:

The Emergency Department Approved for Pediatrics (EDAP) Standards were developed as a concerted effort by the Committee on Pediatric Emergency Medicine, which is made up of representatives from the following organizations: Los Angeles Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of the American College of Emergency Physicians, National EMSC Resource Alliance, California Chapter 2 of the American Academy of Pediatrics, Emergency Nurses Association, American College of Surgeons, and Los Angeles County Department of Health Services Emergency Medical Services Agency.

The Standards have been approved by The Hospital Association of Southern California and meet or exceed the standards established by the Emergency Medical Services for Children (EMSC) administration, personnel, and policy guidelines for the care of pediatric patients in the emergency department set forth by the California Emergency Medical Services Authority in 1995.

DEFINITIONS:

Board certified: Completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty.

Board prepared: Successful completion of a Board approved emergency medicine or pediatric residency training program and demonstrate active progression in the certifying process.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic emergency department that is approved by the County of Los Angeles to receive pediatric patients from the 9-1-1 system. These emergency departments provide care to pediatric patients by meeting specific requirements for professional staff, quality improvement, education, support services, equipment, supplies, medications, and established policies, procedures, and protocols.

ENPC: Emergency Nurses Association-Emergency Nursing Pediatric Course

Medical Pediatric Critical Care Center (MPCCC): A licensed acute care hospital that is approved by the County of Los Angeles to receive critically ill non-trauma pediatric patients from the 9-1-1 system.

PALS: American Heart Association Pediatric Advanced Life Support Course

Pediatric Critical Care Center (PCCC): A licensed acute care hospital that is approved by the County of Los Angeles to receive patients from the 9-1-1 system. In addition, this center provides tertiary-level pediatric care services and serves as a referral center for critically ill and injured pediatric patients.

Promptly available: Being in the emergency department within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, that the

EDAP STANDARDS

interval between the arrival of the patient to the emergency department and the arrival of the respondent should not have a measurably harmful effect on the course of patient management or outcome.

PTC: Pediatric Trauma Center

Qualified specialist: A physician licensed in the State of California who has: 1) taken special postgraduate medical training, or has met other specified requirements; and 2) active progression towards board certification in the corresponding specialty for those specialties that have board certification and are recognized by the American Board of Medical Specialties.

Senior resident: A physician licensed in the State of California who has completed at least two years of the residency under consideration and has the capability of initiating treatment when the clinical situation demands, and who is in training as a member of the residency program at the designated hospital.

APLS: American Academy of Pediatrics-American College of Emergency Physicians Advanced Pediatric Life Support Course

I. ADMINISTRATION/COORDINATION

A. EDAP Medical Director

1. Qualifications:

- a. Qualified specialist in Emergency Medicine or Pediatrics
- b. Completion of eight hours of CME in topics related to pediatrics every two years
- c. Current PALS or APLS provider or instructor

2. Responsibilities:

- a. Oversight of EDAP quality improvement (QI) program
- b. Member of hospital emergency department committee and pediatric committee
- c. Liaison with pediatric critical care centers (PCCC), trauma centers, base hospitals, community hospitals, prehospital care providers, and the EMS Agency
- d. Identify needs and facilitate pediatric education for emergency department physicians
- e. Review, approve, and assist in the development of all pediatric policies and procedures

B. Designated Pediatric Consultant *

1. Qualifications:

- a. Qualified specialist in pediatrics or subspecialty in pediatric

EDAP STANDARDS

emergency medicine

2. Responsibilities:

- a. Member of hospital emergency department committee and pediatric committee
- b. Participation with EDAP staff in developing and monitoring pediatric QI program, protocols, policies and procedures
- c. Consult with EDAP Medical Director and Pediatric Liaison Nurse as needed

* Pediatric Consultant may also be the EDAP Medical Director

C. Pediatric Liaison Nurse (PdLN)

1. Qualifications:

- a. At least two years experience in pediatrics or in an emergency department that sees pediatric patients, within the previous five years
- b. Experience with QI programs is recommended
- c. Current PALS or APLS provider /instructor
- d. Completion of a two day pediatric emergency nursing course or ENPC course *
- e. Completion of eight hours of Board of Registered Nursing (BRN) approved continuing education units (CEU) in pediatric topics every two years

2. Responsibilities:

- a. Attend monthly meetings of the Pediatric Liaison Nurses of Los Angeles County
- b. Participate in the development and maintenance of a pediatric QI program
- c. Liaison with PCCC's, trauma centers, base hospitals, community hospitals, prehospital care providers, and the EMS Agency
- d. Member of selected hospital based emergency department and/or pediatric committees
- e. Notify the EMS Agency in writing of any change in status of the EDAP Medical Director, Pediatric Consultant, and Pediatric Liaison Nurse

* A two day pediatric emergency nursing course should include but not limited to a broad spectrum of topics including: injury prevention, resuscitation, surgical emergencies, apparent life threatening event (ALTE), death

EDAP STANDARDS

of a child to include SIDS, trauma, medical conditions, submersions, respiratory emergencies, airway management, ingestion, child abuse and neglect, fever to include bacterial and viral infections, seizures, and neonatal emergencies.

II. PERSONNEL

A. Physicians-Qualifications/Education

1. Twenty four hour emergency department coverage shall be provided or directly supervised by physicians functioning as emergency physicians or pediatricians experienced in emergency care. This includes senior residents practicing at their respective hospitals only.
2. At least 75% of the emergency department coverage shall be provided by physicians who are Board certified or demonstrate active progression in the certifying process towards emergency medicine or pediatrics.
3. Those emergency department physicians who are not board certified or board prepared shall be a current PALS or APLS provider or instructor.

B. Nurses-Qualifications/Education

1. At least 75% of the total RN staff and at least one RN per shift in the emergency department shall be a current PALS or APLS provider or instructor.
2. At least one RN per shift shall have completed a two day pediatric emergency nursing course (within the last 4 years).

NOTE: It is highly recommended that all nurses regularly assigned to the emergency department meet the above requirements.

3. All nurses assigned to the emergency department shall attend at a minimum; eight hours of pediatric BRN approved education every two years, which may include the two day pediatric emergency nursing course.

C. Pediatric physicians/Specialty services

1. There shall be a pediatric on call panel that allows for telephone consultation and a promptly available pediatrician to the emergency department twenty four hours per day. This pediatrician shall be

EDAP STANDARDS

board certified or board prepared.

2. A plan shall exist whereby other pediatric specialists may be consulted and available in at least the following specialties: surgery, orthopedics, anesthesia and neurosurgery. This requirement may be met by a written agreement with a PCCC.
3. A plan shall exist whereby a second emergency physician or pediatrician will be available within thirty minutes to serve as back-up for the emergency department in critical situations.

D. Physician Assistant-Qualifications/Education

1. Physician Assistant licensed by the State of California
2. PA working in the emergency department shall be a current PALS or APLS provider or instructor.

III. POLICIES, PROCEDURES, AND PROTOCOLS

- A. Establish procedures and protocols for pediatric emergency patients to include but not limited to:
 1. Triage and initial evaluation
 2. Patient safety
 3. Suspected child abuse and neglect
 4. Transfers
 5. Consents
 6. Sedation/analgesia
 7. Do-not-resuscitate (DNR)/Advanced Health Care Directives
 8. Death to include SIDS and the care of the grieving family
 9. Aeromedical transport to include landing procedure
 10. Daily verification of proper location and functioning of equipment and supplies of the pediatric code cart.
 11. Immunizations
 12. Child abandonment to include a recent (within 72 hours) postpartum woman without evidence of a newborn
 13. Family presence
- B. Establish a written interfacility consult and transfer agreement with a PCCC to facilitate transfers of critically ill (PTC or MPCCC) and injured pediatric patients (PTC). The consult shall be available twenty four hour a day for telephone consultation.
- C. Establish a written interfacility consult and transfer agreement with a California Children Services (CCS) approved Level II or Level III Neonatal Intensive Care Unit (NICU).

EDAP STANDARDS

IV. QUALITY IMPROVEMENT (QI)

- A. A pediatric QI program shall be developed and monitored by the EDAP Medical Director and Pediatric Liaison Nurse with input from the Designated Pediatric Consultant as needed.
- B. The program should include an interface with prehospital care, emergency department, trauma, pediatric critical care, pediatric in-patient, and hospital wide QI activities.
- C. A mechanism shall be established to easily identify pediatric (14 years & under) visits to the emergency department.
- D. The pediatric QI program should include identification of the indicators, methods to collect data, results and conclusions, recognition of improvement, action(s) taken, assessment of effectiveness of actions and communication process for participants.
- E. The pediatric QI program should include review of the following pediatric patients seen in the emergency department:
 - 1. Deaths
 - 2. Cardiopulmonary and/or respiratory arrests, including all pediatric intubations
 - 3. Suspected child abuse or neglect
 - 4. Transfers to and/or from another facility
 - 5. Admissions from the ED to an adult ward or ICU
 - 6. Selected return visits to the ED
 - 7. Pediatric transports within the 9-1-1 system
- F. A mechanism to document and monitor pediatric education of EDAP staff shall be established.

V. SUPPORT SERVICES

- A. Respiratory Therapy
 - 1. At least one respiratory therapist shall be in house twenty four hours per day.
 - 2. Current PALS provider or instructor
- B. Radiology

EDAP STANDARDS

1. Radiologist on call and promptly available twenty four hours per day
 2. Radiology technician in house twenty four hours per day with a back up technician on call and promptly available
 3. CT scan technician on call and promptly available
- C. Laboratory
1. Technician in house twenty four hours per day and a back up technician on call and promptly available
 2. Clinical Laboratory capabilities in house:
 - a. Chemistry
 - b. Hematology
 - c. Blood bank
 - d. Arterial blood gas
 - e. Microbiology
 - f. Toxicology
 - g. Drug levels

NOTE: Toxicology and drug levels may be done offsite if routine tests are available within two hours.

VI. EQUIPMENT, SUPPLIES, AND MEDICATIONS

Pediatric equipment, supplies, and medications shall be easily accessible, labeled, and logically organized. EDAP staff shall be appropriately educated as to the locations of all items. Each EDAP shall have a method of daily verification of proper location and function of equipment and supplies. It is highly recommended that each EDAP have a mobile pediatric crash cart.

The following are requirements for equipment, supplies, and medications for an EDAP:

GENERAL EQUIPMENT

Foley catheters (8-22fr)

IV blood/fluid warmer

Length and weight tape for determining pediatric resuscitation drug dosages

Meconium Aspirator

OB Kit

EDAP STANDARDS

Posted or readily available pediatric drug dosage reference material calculated on a dose per kilogram basis.

Restraint device

Weight scale in kilograms

Warming device

MONITORING EQUIPMENT

Blood pressure cuffs (infant, child, adult, and thigh)

Doppler

ECG monitor/defibrillator (0-400 Joules) with pediatric and adult paddles

End tidal CO₂ monitor or detector, (adult and pediatric sizes)

Hypothermia thermometer

Pulse oximeter

RESPIRATORY EQUIPMENT

Bag-valve-mask device, self inflating (pediatric size: 450-900ml and adult size: 1000-2000ml)

Bag-valve, with clear masks (neonate, infant, child, and adult sizes)

Endotracheal tubes (uncuffed: 2.5-5.5 and cuffed: 6.0-9.0)

Laryngoscope (curved and straight: 0-3)

Magill forceps (pediatric and adult)

Nasal cannulae (infant, child, and adult)

Nasopharyngeal airways (infant, child, adult)

Nasogastric tubes (including 5 and 8fr feeding tubes)

Oral airways (sizes 0-5)

EDAP STANDARDS

Clear oxygen masks (standard and non-rebreathing) for infant, child, and adult

Stylets for endotracheal tubes

Suction catheters (sizes 6-12fr)

Tracheostomy tubes (sizes 0-6)

Yankauer suction tips

VASCULAR ACCESS EQUIPMENT

Arm boards (infant, child, and adult)

Infusion devices to regulate rate and volume

Intraosseous needles

IV administration sets with calibrated chambers

IV catheters (14-26ga)

IV solutions (D5.2NS, D5.45NS, D5NS, D10W, and NS)

Stopcocks (3 way)

Umbilical vein catheters

FRACTURE MANAGEMENT DEVICES

Pediatric cervical spine immobilization devices

Pediatric femur splint

Spine board (long and short)

SPECIALIZED TRAYS OR KITS

Cricothyrotomy tray

Pediatric lumbar puncture tray

Pediatric tracheostomy tray

Thoracostomy tray

EDAP STANDARDS

Chest tube (sizes 10-28fr)

Venous cutdown tray

PEDIATRIC SPECIFIC RESUSCITATION MEDICATIONS

Albuterol	Dobutamine
Amiodarone	Epinephrine (1:1000 and 1:10,000)
Atropine	Lidocaine
Adenosine	Naloxone
Calcium chloride	Procainamide
Dextrose (25% & 50%)	Racemic epinephrine for inhalation
Dopamine	Sodium Bicarbonate

Note: It is suggested that these drugs be immediately available in the resuscitation room and not locked in a computerized system.

VII. TERMINATION OF THE HOSPITAL'S EDAP PROGRAM

The request for termination of EDAP status shall be submitted in writing to the EMS Agency 90 days prior to termination of services. The request shall be addressed to the EMS Director from the requesting hospital's CEO.