EMS PLAN UPDATE FISCAL YEAR 2021 – 2022
SPECIALTY CARE SYSTEM PROGRAM

As required by the California Code of Regulations, Title 22, Division 9, Chapter 7.1, Article 2, §100270.122, Chapter 7.2, Article 2 §100270.221, and Chapter 14, Article 2, §1001450.217, the Los Angeles County Emergency Medical Services Agency is submitting the required Annual EMS System Plan Updates for the specialty care system programs for Los Angeles County for fiscal year 2021 – 2022:

- STEMI Critical Care System – Exhibit 1
- Stroke Critical Care System – Exhibit 2
- Emergency Medical Services for Children – Exhibit 3
- Trauma System Plan – Exhibit 4

For FY 21-22, one (1) facility was added to the STEMI Receiving Center Program. A map of our current STEMI Centers is included for reference (Attachment A)

Changes since the previous plan was submitted and approved include:

- List of Designated STEMI Centers and Agreement Expiration Dates (Attachment B)
- Reference No. 320, ST-Elevation Myocardial Infarction (STEMI) Receiving Center (SRC) Standards – Revised 07-01-2021 (Attachment C)
- Reference No. 320.1, Target Temperature Management (TTM) Guideline – Revised 01-01-2022 (Attachment D)
- Reference No. 620, EMS Quality Improvement Program – Revised 01-01-2022 (Attachment E)
- Reference No. 622.1, Data Requests and Levels of Support – Revised 04-15-2022 (Attachment F)

The STEMI Receiving Center Data Dictionary is updated annually. Due to its size, Reference No. 648, SRC Data Dictionary 2022 is not included but available upon request or can be accessed on our Los Angeles EMS Agency website. The SRC Data Dictionary Summary of Changes 2022 is attached and details all the changes made. (Attachment G)

EMS Update and EmergiPress Topics included:

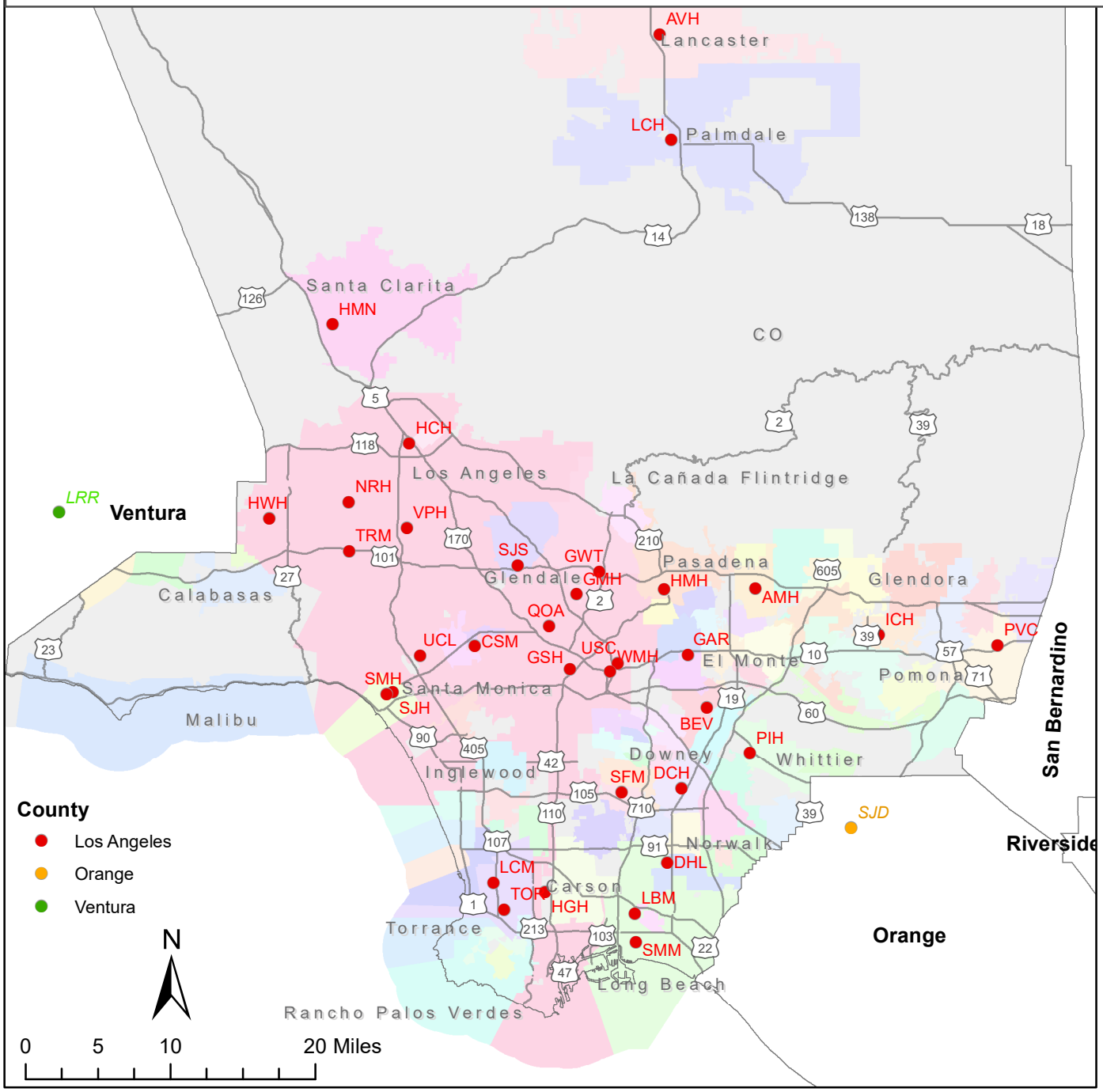
- Lateral STEMI on ECG
- Atypical signs and symptoms of STEMI in women
- Anatomy of the coronary arteries affected in lateral STEMI
- Field management and patient disposition for patients with STEMI
- ECMO Pilot for cardiac arrest
- Mechanical circulatory support devices
- Ventricular bigeminy on ECG
- Common causes of ventricular bigeminy

The STEMI Center Advisory/QI Committee met on October 19, 2021 and April 19, 2022. Topics included:

- STEMI/ROSC/ROSC System-Wide Data Reports
- COVID-19 update
- Cardiac Arrest Registry to Enhance Survival (CARES) data update
- EMCO Study Pilot Program update
- I-gel Pilot Study in respiratory or cardiac arrests
- Data Collaborative Projects – Prehospital predictors of atypical STEMI, Bystander CPR in the community
- SRC Agreements
- SRC Standards – Cardiovascular surgery requirements, Impella credentialing, SRC Program Manager qualifications, performance measures
- Targeted Temperature Management requirements

LOS ANGELES COUNTY

ST ELEVATION MYOCARDIAL INFARCTION APPROVED RECEIVING CENTERS



STEMI Centers As of Nov 1, 2021

Code	Hospital Name
AMH	Methodist Hospital of Southern California
AVH	Antelope Valley Hospital
BEV	Beverly Hospital
CSM	Cedars Sinai Medical Center
DCH	PIH Health Hospital - Downey
DHL	Lakewood Regional Medical Center
GAR	Garfield Medical Center
GMH	Dignity Health-Glendale Memorial Hospital and Health Center
GSH	Good Samaritan Hospital
GWT	Adventist Health - Glendale
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
HWH	West Hills Hospital and Medical Center
ICH	Emanate Health Inter-Community Hospital
LBM	MemorialCare Long Beach Medical Center
LCH	Palmdale Regional Medical Center
LCM	Providence Little Company of Mary Medical Center-Torrance
LRR	Los Robles Regional Medical Center
NRH	Dignity Health-Northridge Hospital Medical Center
PIH	PIH Health Hospital - Whittier
PVC	Pomona Valley Hospital Medical Center
QOA	Hollywood Presbyterian Medical Center
SFM	St. Francis Medical Center
SJD	St. Jude Medical Center
SJH	Providence Saint John's Health Center
SJS	Providence Saint Joseph Medical Center
SMH	Santa Monica-UCLA Medical Center
SMM	Dignity Health-St. Mary Medical Center
TOR	Torrance Memorial Medical Center
TRM	Providence Cedars-Sinai Tarzana Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center
VPH	Valley Presbyterian Hospital
WMH	Adventist Health - White Memorial

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List of Designated STEMI Centers and Agreement Expiration Dates as of June 30, 2022

STEMI Receiving Centers	Agreement Expiration Date
Adventist Health - Glendale	June 30, 2025
Adventist Health – White Memorial	August 30, 2023
Antelope Valley Hospital	February 28, 2024*
Beverly Hospital	September 30, 2022
Cedars Sinai Medical Center	September 30, 2024*
Dignity Health – Glendale Memorial Hospital and Health Center	August 31, 2023
Dignity Health – Northridge Hospital Medical Center	April 30, 2025
Dignity Health – Saint Mary Medical Center	August 31, 2024
Emanate Health Intercommunity Hospital	November 30, 2022
Garfield Medical Center	December 31, 2024
Henry Mayo Newhall Hospital	October 31, 2022
Hollywood Presbyterian Medical Center	April 30, 2023
Huntington Hospital	November 30, 2022
LAC Harbor UCLA Medical Center	January 31, 2025
LAC+USC Medical Center	February 29, 2024*
Lakewood Regional Medical Center	May 31, 2022^
Los Robles Medical Center (Ventura County)	March 31, 2025
MemorialCare Long Beach Medical Center	September 30, 2022
Palmdale Regional Medical Center	June 30, 2023
PIH Health – Downey	October 31, 2024
PIH Health – Good Samaritan	March 31, 2025
PIH Health – Whittier	May 31, 2024*
Pomona Valley Hospital Medical Center	March 31, 2025
Providence Cedars-Sinai Tarzana Medical Center	June 30, 2023
Providence Holy Cross Hospital Medical Center	April 30, 2022*
Providence Little Company Mary Medical Center Torrance	October 31, 2022
Providence Saint John's Health Center	January 31, 2023
Providence Saint Joseph Medical Center	May 30, 2025
Ronald Reagan UCLA Medical Center	March 31, 2025
Santa Monica UCLA Medical Center	January 31, 2023
St. Francis Medical Center	February 28, 2023
St. Jude Medical Center (Orange County)	March 31, 2025
Torrance Memorial Medical Center	April 30, 2025
USC Arcadia Hospital	December 31, 2022
Valley Presbyterian Hospital	March 31, 2023
West Hills Hospital & Medical Center	January 31, 2024

*Deferred for the following year

^Pending action items

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTER (SRC) STANDARDS** REFERENCE NO. 320

PURPOSE: To establish minimum standards for the designation of a ST-Elevation Myocardial Infarction Receiving Center (SRC) to ensure that patients transported by the 9-1-1 system in Los Angeles County who exhibit ST-elevation myocardial infarction (STEMI) and/or non-traumatic out-of-hospital cardiac arrest (OHCA), are transported to a hospital appropriate to their needs.

AUTHORITY: California Code of Regulations (CCR), Title 22, Division 9, Chapter 7.1

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialists (ABMS) or American Osteopathic Association (AOA) including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA for a specific specialty.

Interventional Cardiologist: Physician who has completed a residency in internal medicine, or fellowship in cardiology and/or interventional cardiology, and is BC or BE, and has privileges to perform percutaneous interventions.

Out-of-Hospital Non-traumatic Cardiac Arrest (OHCA): Sudden, sometimes temporary cessation of function of the heart not due to a traumatic cause.

Percutaneous Coronary Intervention (PCI): A procedure used to open or widen a narrowed or blocked coronary artery to restore blood flow supplying the heart.

Promptly Available: Able to be physically present in the emergency department (ED) within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should not have a measurable harmful effect on the course of the patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians, usually 30 minutes or less.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA).

Return of Spontaneous Circulation (ROSC): Following cardiopulmonary arrest, ROSC is the restoration of a spontaneous perfusing rhythm. Signs include: palpable pulse, breathing (more than an occasional gasp), a measurable blood pressure and/or a sudden rise in capnography to a normal/high reading.

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SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTER (SRC) STANDARDS** REFERENCE NO. 320

SRC Medical Director: A physician licensed in the State of California and Board Certified in Interventional Cardiology, privileged by the hospital and active in performing PCI.

SRC Program Manager: A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to monitor, coordinate and evaluate the SRC Program.

ST- Elevation Myocardial Infarction (STEMI): A myocardial infarction that generates ST-segment elevation on a 12-lead ECG.

STEMI Receiving Center (SRC): A licensed general acute care facility that meets the minimum hospital STEMI care requirements pursuant to CCR Section 100270.124 and is able to perform PCI, manage cardiac arrest and post-resuscitation care, and designated as a SRC by the Los Angeles County EMS Agency.

STEMI Referral Facility (SRF): A non-PCI capable hospitals that transfer a STEMI patient requiring emergency cardiac intervention to a designated SRC.

Targeted Temperature Management (TTM): Maintaining body temperature at a target between 32 and 36 degrees Celsius in a person for a specific duration of time for the purpose of preserving neurological function post cardiac arrest.

POLICY:

I. SRC Designation / Re-Designation

A. SRC initial designation and re-designation is granted for up to three years based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.

B. The EMS Agency reserves the right to perform a scheduled on-site survey or request additional data at any time.

C. The SRC shall immediately provide written notice to the Medical Director of the EMS Agency if unable to adhere to any of the provisions set forth in these SRC Standards.

D. The SRC shall provide a 90-day, written notice to the EMS Agency Medical Director of intent to withdraw from the SRC program.

E. The SRC shall notify the EMS Agency, in writing, of any change in status of the SRC Medical Director, SRC Program Manager, or data entry personnel by submitting Reference No. 621.2, Notification of Personnel Change Form.

F. Prior to designation, the SRC shall meet the performance measures, for a minimum of six months, listed in Ref. No. 320.3 and ensure quality improvement process of measures are in place. Performance measures shall be consistently achieved to maintain SRC designation.

II. General Hospital Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

1. Have a special permit for Basic or Comprehensive Emergency Medical Service; and

2. Accredited by a Centers for Medicare and Medicaid Services (CMS) recognized Hospital Accreditation Organization\; and

3. Have a special permit to provide cardiac catheterization laboratory (cath lab) and cardiovascular surgery services pursuant to the provisions of Title 22, Division 5, California Code of Regulations.

B. Appoint a SRC Medical Director and SRC Program Manager who shall be responsible for meeting the SRC Program requirements and allocate non-clinical time such that they can meet the requirements of the SRC standards.

C. Have a fully executed Specialty Care Center SRC Designation Agreement with the EMS Agency.

D. Have the capability to receive transmitted 12-Lead ECG from EMS providers through a process that is agnostic to monitor type and optimizes efficiency, and includes the following:

1. An alert when hospital receives ECG transmission; and

2. A process to ensure that firewalls do not block the transmission and distribution of the transmitted ECGs.

E. Establish a Memorandum of Understanding (Ref. No. 320.2 MOU IFT for Acute STEMI) for the timely transfer of STEMI patients for emergent PCI from the regional SRFs to the SRC.

III. SRC Leadership Requirements

A. SRC Medical Director

1. Responsibilities:

a. Medical oversight and ongoing performance of the STEMI and OHCA quality improvement (QI) programs

b. Participate in the hospital Cardiology Committee or equivalent and other committees associated with STEMI, cardiac arrest, and post-resuscitation care

c. Collaborate with the SRC Program Manager to ensure adherence to these Standards

d. Liaison with hospital administration, SRC Program Manager, medical and clinical staff across the STEMI and OHCA patient's continuums of care

e. Attend 100% of the EMS Agency's SRC QI Meetings onsite or via video conference. Fifty percent (50%) of meetings may be attended by an alternate interventional cardiologist from the same SRC.

B. SRC Program Manager

1. Qualifications:

a. Currently assigned in the cath lab (if duties are shared with another RN(s), one RN must be assigned to the cath lab)

b. Knowledgeable in critical care and interventional cardiac procedures

c. Able to facilitate internal hospital policy and procedure development and implementation

2. Responsibilities:

a. Collaborate with the ED Medical and Clinical Directors regarding STEMI, cardiac arrest, and post-resuscitation care

b. Collaborate with the SRC Medical Director to ensure adherence to these Standards

c. Maintain and monitor STEMI and OHCA QI programs

d. Participate in the hospital Cardiology Committee or equivalent and other committees associated with STEMI, cardiac arrest, and post-resuscitation care

e. Assure hospital policies are consistent with these Standards

f. Liaison with hospital administration, SRC Medical Director, medical and clinical staff across the STEMI and OHCA patient's continuums of care

g. Liaison with prehospital cardiac monitor vendors and EMS Provider Agencies to ensure successful ECG transmission

h. Attend 100% of the EMS Agency's SRC QI Meetings on site or via video conference. Fifty percent (50%) of meetings may be attended by an alternate cath lab RN from the same SRC.

i. Assure processes are in place to identify and track patients transported to the SRC by EMS providers, including patients transferred from other acute care hospitals

j. Provide oversight of accurate and timely data collection and submission

k. Develop relationships and collaborate with the surrounding SRFs to meet specified time metrics

l. Assures SRC diversion is consistent with EMS policies and processes are in place to minimize the need for diversion

IV. SRC Program Physician Participants

A. Hospital shall maintain a cardiac catheterization team and cardiothoracic surgery on-call panel 24 hours per day/7 days per week/365 days per year.

B. All physicians attending in the ED shall be BC or BE in Emergency Medicine.

C. Interventional Cardiologists performing emergent percutaneous interventions must:

1. Maintain current board certification or, board eligibility, in interventional cardiology with privileges in PCI procedures, and credentialed by the hospital;

OR

2. Maintain current board certification in internal medicine or cardiovascular disease with privileges in PCI procedures, and credentialed by the hospital.

D. On-call interventionalists may only be on-call for **one** facility at a time.

E. Surgeons performing coronary artery bypass grafting (CABG), must maintain current board certification, or is board eligible in Cardiovascular/Cardiothoracic surgery with specific privileges in CABG and credentialed by the hospital.

F. On-call physicians should be promptly available, not to exceed 30 minutes, for a cath lab activation.

V. SRC Program Plan

The hospital shall develop and maintain a SRC Program Plan pertaining to the care of patients with STEMI and/or those who had an OHCA. The plan shall be reviewed annually and approved by the appropriate committee(s) every three years. The SRC Program should include, at minimum, the following:

A. Job descriptions and organization structure clarifying the relationship between the SRC Medical Director, SRC Program Manager and the cardiac catheterization team

B. Cath lab activation guidelines with the ability to track the activation and/or cancelation

C. Procedures for triage, diagnosis and cardiac catheterization team activation following EMS notification of impending arrival of a STEMI/OHCA patient, which shall include, at minimum, the following:

1. A process for immediate notification of the emergency physician and/or interventional cardiologist upon EMS notification of a STEMI patient transport

2. A protocol for physician review of patient data, including ECG if available, to determine if activation from the field is appropriate

3. A single call activation system to directly activate the cardiac catheterization team

4. A process for the triage and treatment of simultaneously arriving STEMI/OHCA patients

5. Post resuscitation care, including initiation of TTM

6. A process for direct feedback to the transporting paramedics on the patient's presumed diagnosis and ED disposition

D. A process to administer fibrinolytics, move other cath lab patients, or transfer a STEMI patient to another SRC when there is a mechanical issue in the cath lab, or the hospital is on internal disaster

E. Mechanisms to assure SRC diversion is consistent with EMS policies and processes are in place to minimize the need for diversion

F. A process to collaborate with EMS providers and 12-Lead ECG vendors to integrate electronic prehospital patient care (ePCR) records into the hospital electronic medical record

G. SRC Program Manager shall ensure review and recommend revisions to the SRC Program Plan, policies and procedures to maintain compliance with SRC Standards.

VI. Data Collection and Submission Requirements

A. Ensure adequate data entry personnel, collaborate with ED personnel to assure capture and entry of patients meeting inclusion criteria into the Los Angeles County EMS Agency database on an ongoing basis. Back-up data entry personnel should be identified and trained in the event primary data personnel is unable to meet the data entry requirements.

B. Participate in the data collection process established by the EMS Agency.

C. Maintain an Emergency Department (ED) Log to capture patients who are transported to the ED due to SRC designation.

D. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include all patients who meet data inclusion criteria and all applicable data elements listed in Ref. No. 648, STEMI Receiving Center Data Dictionary.

E. Submit a monthly tally of patients who meet the inclusion criteria to the EMS Agency by the 15th of the month for the previous month (For example: January tally is due February 15th).

F. Submit SRC quarterly data within four weeks from the end of the quarter (For example: 1st quarter's data is due April 30th).

G. Maintain a minimum 90% compliance for:

1. Capture of patients meeting the data inclusion criteria
2. Data field completion
3. Data field accuracy
4. Timely data entry
5. Timely tally submission
6. Timely quarterly submission

VII. Quality Improvement

A. SRC Program must include a comprehensive-multidisciplinary SRC QI Meeting.

1. Meeting participation should include the SRC Medical Director, SRC Program Manager, EMS providers and educators, interventional cardiologists, ED physicians, ED and cath lab personnel, other associated healthcare providers, as well as other healthcare specialties including neurology, thoracic surgery or TTM specialists when applicable.
2. Meeting to be held quarterly, at a minimum.
3. Meeting minutes and roster must be maintained for each meeting and available for review.
4. SRCs that are also a Base Hospital are encouraged to provide periodic SRC Base Hospital education with the collaboration of the SRC Program Manager.

B. Pertinent aspects of care should be tracked and trended with the identification of areas requiring improvement and the action(s) necessary to improve care.

C. The SRC QI program shall:

1. Track and trend performance measures as per Ref. No. 320.3, SRC Performance Measures
2. Review the care and outcome on, but not limited to, the following patients:
   a. In-hospital STEMI deaths
   b. Coronary angiography complicated by intra-procedure or post-procedure bleeding requiring transfusion
   c. Coronary angiography complicated by intra-procedural or post-procedural stroke
   d. Any delays in care

e. All patients with OHCA with sustained ROSC – to include whether TTM and PCI were performed when indicated

3. Collaborate with SRF(s) to evaluate care of transfer patients, to include:

a. Door-in to door-out time (DIDO) at SRF (Goal <30 minutes)

b. Proportion of 9-1-1 IFTs for STEMI who went for emergency coronary angiogram (goal ≥90%)

c. Use of 9-1-1 for non-STEMI transfers

d. Quality of care issues and delays

4. Address other issues, processes or personnel trends identified from hospital specific data (i.e., less than 90% TIMI documentation, increase in fallouts over time and proportion of patients transported to the cath lab found not to have a STEMI).

5. SRC shall have a mechanism to provide feedback to EMS Providers and SRFs (i.e., encrypted/secure e-mail). The feedback shall be provided within one (1) week of patient arrival at the SRC. Feedback shall include, but be not limited to, the following:

a. Date of service, sequence number, provider unit, patient age and gender, whether the patient received coronary angiogram and/or PCI, and positive feedback when a job was well done.

b. Rationale for not performing angiogram, which may be in the following three categories:

i. Patient factor (e.g., patient refusal, contraindication to angiogram)

ii. ECG quality (e.g., poor quality field ECG which led to misinterpretation)

iii. Non-ischemic ST elevation (e.g., early repolarization, bundle branch blocks, hyperkalemia)

3. Any quality of care concerns

XI. Public Education

SRC shall participate in the annual Los Angeles County EMS Agency sponsored Side-Walk CPR public education programs or annually provide a minimum of one public education class on CPR. Sign-in rosters need to be maintained. Classes may be in collaboration with other health care providers/organizations.

CROSS REFERENCE

Prehospital Care Manual

Ref. No. 320.1, **Target Temperature Management Guidelines**

SUBJECT: **ST-ELEVATION MYOCARDIAL INFARCTION (STEMI) RECEIVING CENTER (SRC) STANDARDS** REFERENCE NO. 320

Ref. No. 320.2, **Interfacility Transfer Memorandum of Understanding for Acute STEMI**
Ref. No. 320,3, **SRC Performance Measures**
Ref. No. 321.2, **Notification of Personnel Change Form**
Ref. No. 502, **Patient Destination**
Ref. No. 503, **Guidelines for Hospitals Requesting Diversion of ALS Patients**
Ref. No. 513, **S-T Elevation Myocardial Infarction (STEMI) Patient Destination**
Ref. No. 513.1, **Interfacility Transfer of Patients with STEMI**
Ref. No. 516, **Cardiac Arrest Patient Destination**
Ref. No. 624, **STEMI Receiving Center QI Committee**
Ref. No. 1303, **Medical Control Guideline: Algorithm for Cath Lab Activation**
Ref. No. 1308, **Medical Control Guideline: Cardiac Monitoring / 12-Lead ECG**

2015 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

ACKNOWLEDGEMENTS:

The input of the Hospital Association of Southern California's (HASC) Emergency Health Services Committee and the Cardiac Technical Advisory Group (TAG) was essential in the initial development of these standards. The TAG was composed of a cardiologist from the American Heart Association; Emergency Department physicians from teaching and community hospitals; an EMS Commissioner; nurse managers from emergency departments and catheterization labs; members of the Association of Prehospital Care Coordinators; a Paramedic Nurse Educator; and the Emergency Medical Services (EMS) Agency. Additional contributions were made by the Medical Council of the EMS Agency, the Commission, the American Heart Association and the Los Angeles County Medical Association.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **TARGETED TEMPERATURE MANAGEMENT GUIDELINE**

REFERENCE NO. 320.1

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 7.1

PRINCIPLES:

1. Targeted temperature management (TTM) preserves cerebral function in patients resuscitated after cardiac arrest. This occurs through decreasing cellular metabolism and oxygen demand, reducing production of excitatory neurotransmitters, minimizing disruption of ion homeostasis, and reducing free radicals.

2. Previously referred to as “therapeutic hypothermia”, the term TTM has been adopted to refer to either induced hypothermia or strict temperature control at a target core temperature at or below normothermia (32-37.5ºC) for at least 24 hours.

3. Current guidelines recommend that all comatose adult patients with return of spontaneous circulation (ROSC) after cardiac arrest have TTM for both shockable and non-shockable rhythms.

4. While there are no data demonstrating a benefit of therapeutic hypothermia in children who remain comatose after out-of-hospital cardiac arrest, these children with ROSC may benefit from TTM with target temperatures between 36 and 37.5°C.

5. Initiating hypothermia in the prehospital setting has **not** improved survival or neurologic outcomes. Currently there is no role for prehospital cooling.

6. Fever in the post-cardiac arrest patient is associated with poor outcome.

7. TTM is the only intervention demonstrated to improve neurological recovery after cardiac arrest. TTM should not affect the decision to perform percutaneous coronary intervention (PCI). Concurrent PCI and hypothermia are reported to be feasibly safe.

GUIDELINES:

1. Fever should be avoided in all comatose post-cardiac arrest pediatric and adult patients.

2. Comatose adult (greater than 14 years of age) patients with ROSC after cardiac arrest should receive TTM.

3. There are no absolute contraindications for TTM; however, it is reasonable to withhold TMM in the following scenarios:

   a. Known wishes for limitations in resuscitation and/or a Do Not Resuscitate-order

   b. Known comorbid disease making 180 days survival unlikely

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c. Preceding poor neurologic function (Pre-arrest Cerebral Performance Category of 3 or 4)

d. Temperature on admission <30°C

4. A temperature between 32°C and 37.5°C should be selected and maintained for **at least 24 hours** once target temperature is achieved. Core temperature should be monitored. Axillary or oral temperatures are inadequate for measurement of core temperature.

5. Targets below 36°C should typically be avoided for the following conditions:

   a. Pregnancy

   b. Known intrinsic bleeding diathesis (e.g. hemophilia or Von Willebrand)

   c. Acute intracranial bleeding and/or major head trauma

   d. Active significant bleeding

   e. Suspected or confirmed acute stroke

   f. Systolic blood pressure <80 mm Hg despite fluid resuscitation, vasopressor(s) and possibly including inotropic medication and/or intra-aortic balloon pump

   g. Delays longer than 6 hours from ROSC to cooling

6. TTM may be achieved and maintained using:

   a. Intravenous Normal Saline 4°C

   b. Ice packs (axillae, groin, neck)

   c. Cooling blankets

   d. Cooling vests

   e. Intravascular devices (including extracorporeal membrane oxygenation)

CROSS REFERENCE

2020 American Heart Association Guidelines for Cardiopulmonary Resuscitation and Emergency Cardiovascular Care

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS QUALITY IMPROVEMENT PROGRAM** REFERENCE NO. 620

PURPOSE: To establish a process for the Los Angeles County Emergency Medical Services (EMS) Agency and system participants to evaluate the EMS system to ensure safety and continued improvement in prehospital patient care delivery.

AUTHORITY: California Code of Regulations, Title 22, Chapter 12
Health and Safety Code Division 2.5
California Evidence Code, Section 1157.7
California Civil Code Part 2.6, Section 56

DEFINITIONS:

Adverse Event: A preventable or non-preventable unintended event that results or has the potential to result in harm to the patient.

Indicator: A well-defined, objective, measurable, and important aspect of care. Other terms for indicators include: key performance indicator, metric and quality indicator or measure.

Important Aspects of Care: Patient care activities that are of greatest significance to the quality of patient care. These include activities that are high in volume, high risk, and/or problem prone for patients and/or healthcare providers.

Near Miss Event: An incident or unsafe condition with the potential for injury, damage or harm that is resolved before reaching the patient. Also referred to as a “close call” or “good catch”.

Periodic Review: A re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

Quality Improvement (QI): The continuous and systematic analysis of performance in an effort to improve it.

System Participant: For the purposes of this policy, a system participant is any prehospital care agency or entity required by law, regulation, agreement, or policy to develop and maintain a QI program consistent with state and local requirements.

Threshold: A pre-established level of performance related to a specific indicator.

PRINCIPLES:

1. An EMS QI program is an essential component of an effective EMS system capable of providing quality patient care and achieving system performance goals.

2. Key components of an EMS QI program include:
   a. Personnel
   b. Equipment and Supplies

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c. Documentation
d. Data Collection and Analysis
e. Clinical Care/Patient Outcome
f. Skills Maintenance/Competency
g. Transportation/Facilities
h. Risk Management
i. Public Education/Prevention

3. EMS organizations become valuable stakeholders in the State QI program by participating in the local EMS Agency QI program.

4. Data sampling may be utilized to measure an indicator or monitor performance. However, to obtain meaningful data that are representative of the study population, factors such as the population affected, the frequency of the activity, and the severity of consequence when thresholds are not met, must all be considered when determining the size and population of data samples.

POLICY:

I. EMS Agency Responsibilities:

A. Implement a state-approved EMS QI plan consistent with ~~all~~ regulatory requirements.

B. Review QI programs and approve QI plans of local EMS system participants.

C. Maintain a systemwide QI program.

II. System Participant Responsibilities:

A. Implement and maintain a QI program approved by the EMS Agency that reflects the organization's current QI process(es).

B. Demonstrate how EMS QI is integrated within the organization.

C. Designate a representative to attend the relevant EMS Agency QI Committee meeting(s).

D. Participate in systemwide QI studies, to include timely submission of requested data to the EMS Agency.

E. Provide education, training, or other methods utilized to disseminate information specific to findings identified in the QI process.

F. Establish and maintain relationships with stakeholders and, as needed, convene meetings to facilitate the QI process.

G. Review the QI plan annually and update as needed. If there are no revisions, a signed copy of the QI plan signature page (signed by the Medical Director) or written statement to that effect, along with a copy of the current QI indicators, may be submitted in lieu of the entire plan.

H. Describe method(s) utilized to ensure accurate and reliable documentation of patient care delivered.

III. Other Specified Specialty Care Center Responsibilities:

A. Participate in the EMS Systemwide QI Program

B. Collect and submit requested data to the EMS Agency.

IV. QI Plan Requirements:

Each QI plan shall include a description, at a minimum, of the following components:

A. Organizational Structure

1. Mission statement and/or philosophy of the organization.

2. Goals and objectives.

3. Organizational chart or narrative description of how the QI program is integrated within the organization's EMS Agency QI Program, and State EMS QI Program.

4. Organizational chart or narrative description of how the organization's QI program is integrated with local and State QI programs

B. Methodology, processes and tools used to facilitate the QI Process (i.e., FOCUS-PDSA)

F Find a process to improve
O Organize an effort to work on improvement
C Clarify current knowledge of the process
U Understand process variation and capability
S Select a strategy for further improvement

P Plan a change or test aimed at improvement
D Do – carry out the change or the test
S Study the results, what was learned, what went wrong
A Act – adopt the change, or abandon it, or run through the cycle again

C. Approach to identifying and evaluating QI indicators

D. Data Collection and Reporting

1. All reliable sources of information utilized in the QI plan; including EMS databases, patient care records, checklists, customer input, direct observations, and skills simulation.

2. Flow of information.

3. Methods used to document QI findings.

4. Process used to submit data to the EMS Agency.

E. Training or educational methods that will be used to communicate relevant information among stakeholders.

V. QI Program Requirements:

Each QI Program shall include, at minimum, the following:

A. An approved QI Plan

B. Develop QI indicators that relate to important aspects of care, to include the following:

1. Well-defined description of the important aspect of care being measured.

2. Threshold for compliance.

3. Timeline for tracking indicator once the threshold has been achieved.

4. Data source.

C. Methods for tracking compliance and identifying trends.

D. Written analysis that summarizes the QI findings.

E. Corrective actions utilized to improve processes.

F. Written trending report that includes effectiveness of performance improvement action plans.

G. Education and training specific to findings identified in the QI process.

H. Methods utilized for dissemination of the QI findings to stakeholders.

I. Recognition and acknowledgment of performance improvement.

J. Periodic review or a re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

K. Methods for identifying, tracking, documenting and addressing near miss events.

L. Record Keeping

1. All QI records shall be maintained in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

2. The following records shall be maintained and available for review until the EMS Agency Program Review is concluded:

a. QI meeting minutes and attendance rosters/sign-in sheets.

b. Attendance rosters/sign-in sheets for activities where QI findings and/or actions are discussed.

c. QI indicator(s) data collection tools.

d. Written summaries of the trending/analysis.

e. Documentation of dissemination of QI findings within the organization and to stakeholders.

f. Dates and times of continuing education and skill training based on QI findings.

g. Dates and times of remedial education or skills training, when provided.

h. A tracking tool for monitoring performance excellence, adverse events, near misses or issues regarding non-compliance with current policies and procedures outside of QI activities.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 618, **EMS Quality Improvement Program Committees**

California EMS Authority, Quality Improvement Program Model Guidelines, 2005
Los Angeles County EMS Agency Quality Improvement Plan

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DATA REQUEST AND LEVELS OF SUPPORT** REFERENCE NO. 622.1

Data Request Tracking Number: (To be completed by the EMS Agency) _____

Complete all requested information below and submit applicable documents. Review Ref. No. 622, Release of EMS Data, prior to completion.

1. Date:
2. Date by which data is requested:
3. Data Recipient (person submitting request)
    a. Name:
    b. Title/Position:
    c. Facility/Agency/Organization/Affiliation:
    d. Mailing Address:
    e. Telephone number:
    f. E-mail address:
4. Indicate preference on how the data should be provided:
    a. ☐ E-Mail
    b. ☐ U.S. Mail
    c. ☐ Phone
    d. ☐ Fax (____) _____-_____
    e. ☐ Other (specify) _____
5. Indicate documents submitted with this request
    a. ☐ Limited Data Set Information (Ref. No. 622.2)
    b. ☐ Intended Use of Limited Data Set Information (Ref. No. 622.3)
    c. ☐ Data Use Agreement (Ref. No. 622.4)
    d. ☐ Confidentiality Agreement (Ref. No. 622.5)

6. Indicate the level(s) of support requested from the EMS Agency (check all that apply):

   a. ☐ Support in concept – letter of support or verbal accord of project

   b. ☐ Guidance – provide feedback on methodology, analysis, manuscript, etc.

   c. ☐ Data Abstraction – provide raw data from EMS Agency data registries

   d. ☐ Data Analysis – provide summary data, statistical analysis, tables, figures, etc.

   e. ☐ Other (this may include manuscript revision, operations/system resources, grant support, etc.) – please describe other support requested

      _____

7. Submit completed data request and applicable documents to:

   Sara Rasnake, Data Systems/Research Programs Manager
   10100 Pioneer Boulevard, Suite 200
   Santa Fe Springs, CA 90670
   Phone: (562) 378-1658
   Fax: (562) 946-6701
   E-Mail: srasnake@dhs.lacounty.gov

Summary of SRC Data Dictionary/Database Changes - July 2021

Date	Change	Section	Reason For Change
7/2021	Revised Cardiac Arrest Inclusion Criteria language	Data Dictionary ─ Inclusion Criteria	Revised to clarify that out-of-hospital cardiac arrest includes patients where resuscitation is attempted by a 911 responder, an AED shock by a bystander prior to arrival of 911 responders, and STEMI patients transported by EMS that are complicated by cardiac arrest at any point in the acute phase.
7/2021	Added language to Cardiac Arrest Inclusion Criteria regarding patients in non-acute care facilities	Data Dictionary ─ Inclusion Criteria	Revised to clarify that the inclusion criteria for cardiac arrest includes patients from non-acute care facilities (SNF, LTC, etc.)
7/2021	Added language to Cardiac Arrest Inclusion Criteria regarding 'bystander' definition	Data Dictionary ─ Inclusion Criteria	Revised to clarify that 'bystander' is any person outside an acute healthcare setting, including personnel working at skilled nursing facilities and other healthcare professionals not in a hospital setting
7/2021	Added language to Cardiac Arrest Inclusion Criteria regarding what patients should not be entered into the database	Data Dictionary ─ Inclusion Criteria	Revised to clarify that if EMS does not document PI=CANT or there is no evidence of cardiac arrest (AED defibrillation) prior to EMS arrival, patient should not be entered into the database
7/2021	Revised EMS Report Form to EMS Record	Data Dictionary – Data Source Hierarchy - All Sections	Revised to reflect terminology that includes electronic and paper documentation
7/2021	Added language to Sequence Number regarding correct sequence number formats and responsibilities of SRC to locate the missing sequence numbers	Data Dictionary ─ Gen Info	Revised to improve documentation of the correct sequence number format and what actions should be taken to obtain missing or incorrect sequence numbers

Summary of SRC Data Dictionary/Database Changes - July 2021

Date	Change	Section	Reason For Change
7/2021	Removed CB LA County Beaches	Data Dictionary/Database – Gen Info/Provider	CB is considered part of CF so code is no longer needed
7/2021	Removed UF Upland Fire, VF Vernon Fire and RO Rescue Ambulance	Data Dictionary/Database – Gen Info/Provider	Revised to reflect providers no longer operating within LA County
7/2021	Added CO College Coastal Care, LLC, GG Go Green Ambulance, JA Journey Ambulance, VI Vital Care Ambulance	Data Dictionary/Database – Gen Info/Provider	Revised to reflect new providers approved to operate within LA County
7/2021	Changed SO Southern California Ambulance to Symbiosis (Di Biassi)	Data Dictionary/Database – Gen Info/Provider	Revised to reflect the provider name change
7/2021	Added language to 1st Dispatch Time, 1st Prehospital ECG Time, 1st Prehospital STEMI ECG Time, Init. Cardiac Arrest Time, and Init. ROSC Time fields to address mismatched times	Data Dictionary – Gen Info – SRC – Cardiac Arrest	Revised to clarify that the times documented by EMS should be entered, even if the time does not align with other times documented in the EMS record
7/2021	Removed ND from Patient Gender	Data Dictionary/Database – Gen Info	Revised to improve documentation and accuracy of data
7/2021	Changed ND Not Documented to U Unknown/ from Race/Ethnicity	Data Dictionary/Database – Gen Info	Revised to clarify that unknown occurs when Race/Ethnicity is either unknown or not documented
7/2021	Added ED Outcome field	Data Dictionary/Database – Gen Info	Added to align with data collection by the CARES database
7/2021	Added data entry rule that if ED Outcome=DE, ED Pronounced Time must have a value	Database – Gen Info/ED Outcome/ED Pronounced Time	Revised to ensure documentation of ED pronounced time when the patient dies in the ED
7/2021	Renamed Outcome to Hospital Outcome	Data Dictionary/Database – Gen Info	Clarification of field
7/2021	Removed ED Died in ED from Hospital Outcome	Data Dictionary/Database – Gen Info	Revised due to addition of a separate ED Outcome field
7/2021	Removed SP Sepsis from Comorbidities	Data Dictionary/Database – Gen Info	Revised to align with the current ACC list of comorbidities

Summary of SRC Data Dictionary/Database Changes - July 2021

Date	Change	Section	Reason For Change
7/2021	Added COVID-19 Diagnosis Prior to Hospitalization? field	Data Dictionary – Gen Info	Field added to database in July 2020 to capture if patient had a COVID-19 diagnosis prior to hospitalization
7/2021	Added Date Test Performed field	Data Dictionary – Gen Info	Field added to database in July 2020 to capture the date the COVID test was performed prior to hospitalization
7/2021	Added COVID-19 PCR Test During Hospitalization? field	Data Dictionary – Gen Info	Field added to database in July 2020 to capture if a COVID-19 PCR test was completed during hospitalization
7/2021	Added Hospital Test Results field	Data Dictionary – Gen Info	Field added to database in July 2020 to capture the test results of the COVID-19 PCR test completed during hospitalization
7/2021	Added Data Hospital Test Performed field	Data Dictionary – Gen Info	Field added to database in July 2020 to capture the date the hospital COVID-19 PCR test was performed
7/2021	Added Hospice to Hosp. Disposition	Data Dictionary/Database – Gen Info	Revised to allow for documentation of patients who are discharged to hospice
7/2021	Added language to Hosp. Disposition regarding patients discharged home with hospice	Data Dictionary/Database – Gen Info	Revised to clarify that if a patient is discharged home with hospice, value for this field should be “Home”
7/2021	Removed HEV Glendora Community Hospital, SVH St. Vincent Medical Center and MID Olympia Medical Center	Data Dictionary – SRC/Transferring Facility	Revised to reflect hospitals that are no longer 9-1-1 receiving facilities
7/2021	Added LBC Community Hospital Long Beach	Data Dictionary – SRC/Transferring Facility	Revised to reflect hospitals that are 9-1-1 receiving facilities
7/2021	Changed CPM Coast Plaza Doctors Hospital to Coast Plaza Hospital, DCH PIH Health Hospital – Downey to PIH Health Downey Hospital, DFM Marina Del Rey Hospital to Cedars-Sinai Marina Del Rey Hospital, FPH Foothill Presbyterian Hospital to Emanate Health Foothill Presbyterian Hospital, GSH Good Samaritan Hospital to PIH	Data Dictionary – SRC/Transferring Facility	Revised to reflect hospital name changes

Summary of SRC Data Dictionary/Database Changes - July 2021

Date	Change	Section	Reason For Change
	Health Good Samaritan Hospital, LBM Long Beach Memorial Medical Center to MemorialCare Long Beach Medical Center, PIH Health Hospital – Whittier to PIH Health Whittier Hospital, TRM Providence Tarzana Medical Center to Providence Cedars-Sinai Tarzana Medical Center		
7/2021	Revised Pre-hospital ECG=STEMI? definition	Data Dictionary – SRC	Revised definition to be consistent with definitions of other prehospital fields
7/2021	Added Was the Prehospital ECG Reviewed by the ED MD? field	Data Dictionary/Database – SRC	Revised to capture if the prehospital ECG was reviewed by the SRC ED MD
7/2021	Added ED MD Prehospital ECG Review Date field	Data Dictionary/Database – SRC	Revised to capture the date the prehospital ECG was reviewed by the SRC ED MD
7/2021	Added ED MD Prehospital EGG Review Time field	Data Dictionary/Database – SRC	Revised to capture the time the prehospital ECG was reviewed by the SRC ED MD
7/2021	Added language to SRC ED BP field	Data Dictionary – SRC	Revised to clarify that the initial CL SBP should be entered for patients that bypass the ED and go directly to the CL
7/2021	Added language to SRC ED HR field	Data Dictionary – SRC	Revised to clarify that the initial CL HR should be entered for patients that bypass the ED and go directly to the CL
7/2021	Add D Not Drawn to Elevated Troponin?	Data Dictionary/Database – SRC	Revised to allow for documentation when a troponin was not drawn
7/2021	Renamed CL Activated? to CL Activated from Pre-SRC or SRC ED?	Data Dictionary/Database – SRC	Clarification of the field
7/2021	Added language to CL Activated From Pre-SRC or SRC ED? field regarding inpatients	Data Dictionary/SRC	Revised to clarify that if patients are routed to the CL from an inpatient bed, value for this field should be “No”
7/2021	Removed Poor Quality Poor quality Pre-SRC ECG, Non-ischemic Non-ischemic cause of ST elevation, Dysrhythmia Dysrhythmia, Early Repol.	Data Dictionary/Database – SRC	Revised due to the addition of a new picklist option of MD Interpret. to collect this information

Summary of SRC Data Dictionary/Database Changes - July 2021

Date	Change	Section	Reason For Change
	Early Repolarization, MD Physician Judgment from Reason CL Not Activated		
7/2021	Added MD Interpret. Physician Interpretation is not a STEMI to Reason CL Not Activated	Data Dictionary/Database – SRC	User request: revised to allow documentation that the reason the CL was not activated was because the physician interpretation of the ECG was not a STEMI
7/2021	Added language to CL Activation Date and CL Activation Time fields regarding cancellations and reactivations	Data Dictionary – CL	Revised to clarify that if the CL activation was cancelled, then re-activated, the date and time it was re-activated should be entered
7/2021	Removed Poor Quality Poor quality Pre-SRC ECG, Non-ischemic Non-ischemic cause of ST elevation, Dysrhythmia Dysrhythmia, Early Repol. Early Repolarization from Reason Pt Did Not Go To CL	Data Dictionary/Database – CL	Revised due to the addition of a new picklist option of MD Interpret. to collect this information
7/2021	Added MD Interpret. Physician Interpretation is not a STEMI to Reason Pt Did Not Go To CL	Data Dictionary/Database – CL	User request: revised to allow documentation that the reason the patient did not go to the CL was because the physician interpretation of the ECG was not a STEMI
7/2021	Added language to Reason CL Not Activated and Reason Pt Did Not Go to CL fields regarding MD interpretation	Data Dictionary – SRC – CL	Revised to clarify that the MD interpretation includes a review of the ECG by the ED Physician or Cardiologist and it is determined that the ECG does not show ST elevation
7/2021	Added Was a Hemodynamic Support Device Used? field	Data Dictionary/Database – CL	Revised to allow documentation of whether a hemodynamic support device was used
7/2021	Added If Yes, What Type of Device? field	Data Dictionary/Database – CL	Revised to capture the type of hemodynamic device that was used

Summary of SRC Data Dictionary/Database Changes - July 2021

Date	Change	Section	Reason For Change
7/2021	Added Presumed Cardiac Arrest Etiology field	Data Dictionary/Database – Cardiac Arrest	Revised to allow documentation of the likely cause for the patient's cardiac arrest
7/2021	Added If Other, Please Explain field	Data Dictionary/Database – Cardiac Arrest	Revised to allow documentation of why "Other" was selected as the presumed cardiac arrest etiology
7/2021	Added CL Cath Lab to Init Cardiac Arrest Location	Data Dictionary/Database – Cardiac Arrest	Revised to allow documentation of when the patient's cardiac arrest occurred in the CL
7/2021	Added Was Patient in CA Upon Arrival to ED? field	Data Dictionary/Database – Cardiac Arrest	Revised to allow documentation of whether the patient was in cardiac arrest upon arrival to the ED
7/2021	Added CL Cath Lab to Init ROSC Location	Data Dictionary/Database – Cardiac Arrest	Revised to allow documentation of when ROSC occurred in the CL
7/2021	Added ECMO Performed? field	Data Dictionary/Database – Cardiac Arrest	Revised to allow documentation of whether ECMO was performed
7/2021	Added ECMO Date field	Data Dictionary/Database – Cardiac Arrest	Revised to capture the date ECMO was performed
7/2021	Added ECMO Time field	Data Dictionary/Database – Cardiac Arrest	Revised to capture the time ECMO was performed
7/2021	Changed 17 Age <18 yrs to 14 Age <15 yrs for Contraindications to TTM	Data Dictionary/Database – TTM	Revised to align with the contraindications to TTM in the current TTM policy
7/2021	Added BD Known Intrinsic Bleeding Diathesis and ST Suspected or Confirmed Acute Stroke to Contraindications to TTM	Data Dictionary/Database – TTM	Revised to align with the contraindications to TTM in the current TTM policy

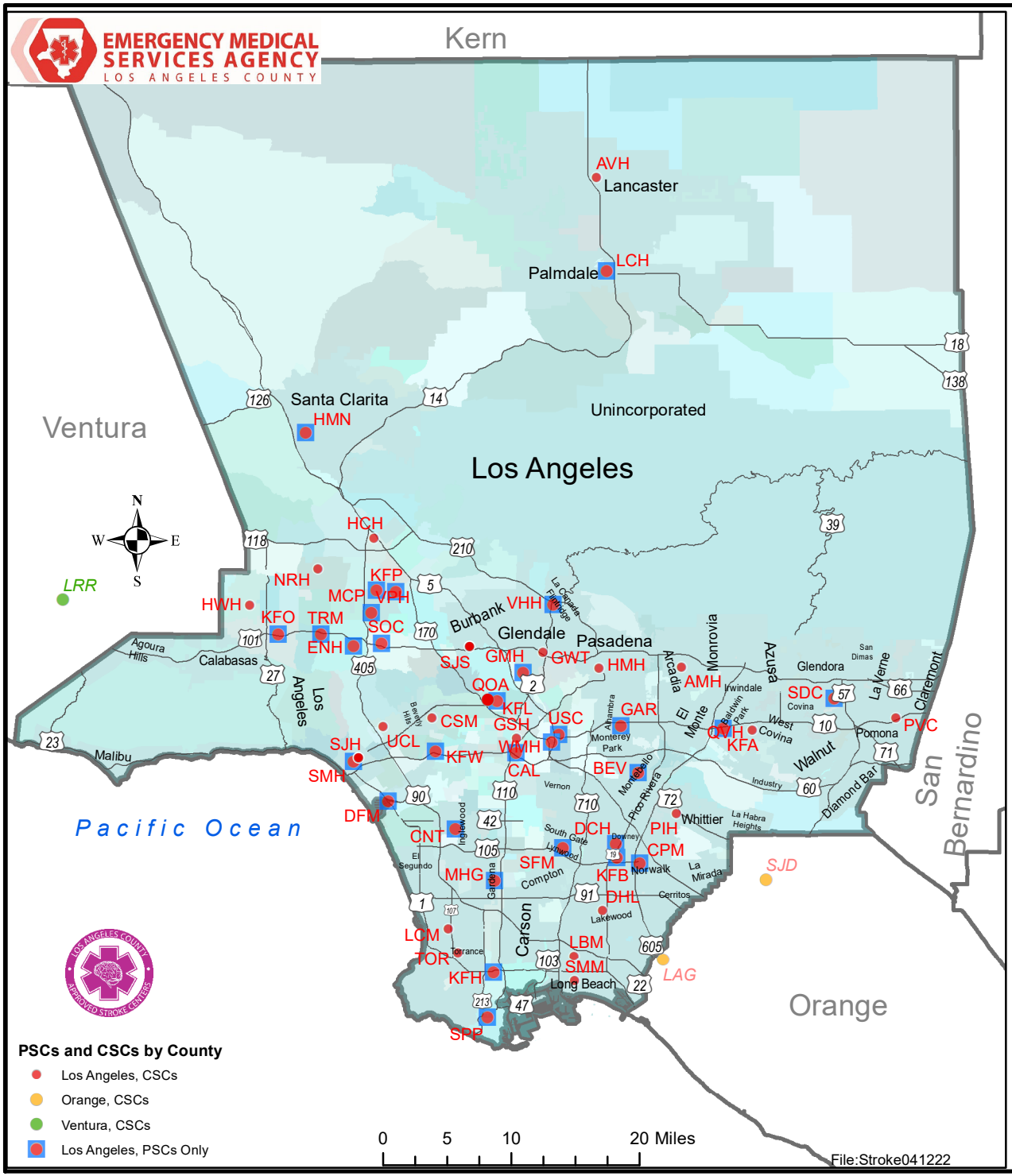
For FY 21-22, two facilities were added to the Stroke Center Program as Primary Stroke Centers and one facility upgraded from Primary Stroke Center designation to Comprehensive Stroke Center designation. A map of our Stroke Centers is included for reference (Attachment A).

Changes since the previous plan was submitted and approved include:

- List of Designated Stroke Centers and Agreement Expiration Dates (Attachment B)
- Reference No. 322, Stroke Receiving Center Standards – Revised 04-01-2022 (Attachment C)
- Reference No. 620, EMS Quality Improvement Program – Revised 01-01-2022 (Attachment D)
- Reference No. 622.1, Data Requests and Levels of Support – Revised 04-15-2022 (Attachment E)
- Reference No. 1232, Treatment Protocol: Stroke/CVA/TIA – Revised 01-01-2022 (Attachment F)

The Stroke Advisory/QI Committee met on February 14, 2022. Topics included:

- Review of system-wide stroke reports
- System-wide Stroke QI Projects
- Stroke Data Collaborative update
- Stroke Receiving Center Standards On-Call requirements
- Reddinet Diversion for PSC



Code	stroke Centers As Of 03/21/2022
AMH	Methodist Hospital of Southern California
AVH	Antelope Valley Hospital
BEV	Beverly Hospital
CAL	Dignity Health-California Hospital Medical Center
CNT	Centinela Hospital Medical Center
CPM	Coast Plaza Hospital
CSM	Cedars Sinai Medical Center
DCH	PIH Health Hospital - Downey
DFM	Cedars-Sinai Marina Del Rey Hospital
DHL	Lakewood Regional Medical Center
ENH	Encino Hospital Medical Center
GAR	Garfield Medical Center
GMH	Dignity Health-Glendale Memorial Hospital and Health Center
GSH	Good Samaritan Hospital
GWT	Adventist Health - Glendale
HCH	Providence Holy Cross Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
HWH	West Hills Hospital and Medical Center
KFA	Kaiser Foundation Hospital - Baldwin Park
KFB	Kaiser Foundation Hospital - Downey
KFH	Kaiser Foundation Hospital - South Bay
KFL	Kaiser Foundation Hospital - Sunset (Los Angeles)
KFO	Kaiser Foundation Hospital - Woodland Hills
KFP	Kaiser Foundation Hospital - Panorama City
KFW	Kaiser Foundation Hospital - West Los Angeles
LAG	Los Alamitos Medical Center
LBM	MemorialCare Long Beach Medical Center
LCH	Palmdale Regional Medical Center
LCM	Providence Little Company of Mary Medical Center-Torrance
LRR	Los Robles Regional Medical Center
MCP	Mission Community Hospital
MHG	Memorial Hospital of Gardena
NRH	Dignity Health-Northridge Hospital Medical Center
PIH	PIH Health Hospital - Whittier
PVC	Pomona Valley Hospital Medical Center
QOA	Hollywood Presbyterian Medical Center
QVH	Emanate Health Queen of the Valley Hospital
SDC	San Dimas Community Hospital
SFM	St. Francis Medical Center
SJD	St. Jude Medical Center
SJH	Providence Saint John's Health Center
SJS	Providence Saint Joseph Medical Center
SMH	Santa Monica-UCLA Medical Center
SMM	Dignity Health-St. Mary Medical Center
SOC	Sherman Oaks Hospital
SPP	Providence Little Company of Mary Medical Center-San Pedro
TOR	Torrance Memorial Medical Center
TRM	Providence Cedars-Sinai Tarzana Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center
VHH	USC Verdugo Hills Hospital
VPH	Valley Presbyterian Hospital
WMH	Adventist Health - White Memorial

List of Designated Stroke Centers and Agreement Expiration Dates as of June 30, 2022

Stroke Center	Designation Level	Agreement Expiration Date
Adventist Health - Glendale	Comprehensive	August 31, 2024
Adventist Health – White Memorial	Primary	March 31, 2024
Antelope Valley Hospital	Primary	December 31, 2024
Beverly Hospital	Primary	October 31, 2023
Cedars Sinai Medical Center	Comprehensive	December 31, 2023
Centinela Hospital Medical Center	Primary	November 30, 2023
Coast Plaza Doctors Hospital	Primary	September 30, 2023
Dignity Health – California Hospital Medical Center	Primary	February 28, 2023
Dignity Health – Glendale Memorial Hospital and Health Center	Primary	October 31, 2024
Dignity Health – Northridge Hospital Medical Center	Comprehensive	December 31, 2022
Dignity Health – Saint Mary Medical Center	Comprehensive	December 31, 2023
Emanate Health Queen of the Valley	Comprehensive	October 31, 2023
Encino Hospital Medical Center	Primary	July 31, 2023
Garfield Medical Center	Primary	October 31, 2023
Henry Mayo Newhall Hospital	Primary	December 31, 2022
Hollywood Presbyterian Medical Center	Primary	February 28, 2024
Huntington Hospital	Comprehensive	September 30, 2023
Kaiser Foundation Hospital – Baldwin Park Medical Center	Primary	December 31, 2022
Kaiser Foundation Hospital – Downey Medical Center	Primary	November 30, 2022
Kaiser Foundation Hospital – Los Angeles Medical Center	Comprehensive	February 28, 2024
Kaiser Foundation Hospital – Panorama City	Primary	December 14, 2022
Kaiser Foundation Hospital – South Bay	Primary	December 31, 2024
Kaiser Foundation Hospital – West Los Angeles	Primary	November 30, 2024
Kaiser Foundation Hospital – Woodland Hills	Primary	July 31, 2023
LAC+USC Medical Center	Primary	November 30, 2022
Lakewood Regional Medical Center	Comprehensive	October 31, 2022
Los Alamitos Medical Center (Orange County)	Comprehensive	November 30, 2023
Los Robles Medical Center (Ventura County)	Comprehensive	October 31, 2022
MemorialCare Long Beach Medical Center	Comprehensive	December 31, 2022
Memorial Hospital of Gardena	Primary	October 31, 2023
Mission Community Hospital	Primary	November 30, 2023
Palmdale Regional Medical Center	Primary	December 31, 2022
PIH Health – Downey	Primary	December 31, 2022

PIH Health – Good Samaritan	Comprehensive	December 31, 2025
PIH Health – Whittier	Comprehensive	October 31, 2023
Pomona Valley Hospital Medical Center	Comprehensive	August 31, 2023
Providence Cedars-Sinai Tarzana Medical Center	Primary	October 31, 2024
Providence Holy Cross Hospital Medical Center	Comprehensive	August 31, 2022
Providence Little Company Mary Medical Center San Pedro	Primary	December 31, 2023
Providence Little Company Mary Medical Center Torrance	Comprehensive	November 31, 2022
Providence Saint John's Health Center	Comprehensive	December 31, 2024
Providence Saint Joseph Medical Center	Comprehensive	January 31, 2024
Ronald Reagan UCLA Medical Center	Comprehensive	October 31, 2023
San Dimas Community Hospital	Primary	July 31, 2023
Santa Monica UCLA Medical Center	Primary	May 31, 2024
Sherman Oaks Hospital	Primary	July 31, 2023
St. Francis Medical Center	Primary	July 31, 2023
St. Jude Medical Center (Orange County)	Comprehensive	December 31, 2023
Torrance Memorial Medical Center	Comprehensive	December 31, 2022
USC Arcadia Hospital	Comprehensive	June 30, 2024
USC Verdugo Hills Hospital	Primary	March 31, 2024
Valley Presbyterian Hospital	Primary	March 31, 2024
West Hills Hospital & Medical Center	Comprehensive	October 31, 2022

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **STROKE RECEIVING CENTER STANDARDS** REFERENCE NO. 322

PURPOSE: To establish minimum standards for the designation of Primary Stroke Centers (PSC) and Comprehensive Stroke Centers (CSC) to ensure that patients transported by the 9-1-1 system in Los Angeles County who exhibit signs and symptoms of stroke are transported to a hospital appropriate for their needs.

AUTHORITY: California Health and Safety Code, Sections 1255, 1256, 1797.220, 1798, 1798.170, 1798.172;
California Code of Regulations, Title 22, Sections 100170 and Division 9, Chapter 7.2

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialists (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess knowledge, skills and experience necessary to provide quality patient care in a specific specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA for a specific specialty.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by ABMS or AOA. For endovascular neurointerventionalist, this is a physician who has obtained Committee on Advanced Subspecialty Training (CAST) certification in NeuroEndovascular Surgery (NES) **or** Accreditation Council of Graduate Medical Education specialty training for Endovascular Surgical Neuroradiology **or** experience in ischemic stroke treatments including thrombectomy and carotid stenting with on-going experience in neurovascular interventions including five (5) per year of any of the following:

- Aneurysm management, including those presenting with rupture
- Intracranial embolization
- Intracranial stent placements
- Intracranial infusions
- Extracranial embolization

Stroke Center: A licensed general acute care hospital that has met all the PSC or CSC requirements listed in this policy and has been designated by the LA County EMS Agency as a PSC or CSC.

Stroke Medical Director: A Qualified Specialist in Neurology, Neurosurgery, Neuroradiology, or Emergency Medicine, privileged by the hospital and active in performing stroke care.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

Stroke Program Manager: A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to monitor, coordinate and evaluate the Stroke Program.

Telemedicine: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. Stroke Center Designation/Re-Designation

A. Stroke Center designation and re-designation is granted for up to three years based on maintenance of these standards and after a satisfactory review and approval by the EMS Agency.

B. The EMS Agency reserves the right to perform a scheduled on-site survey or request additional data at any time.

C. The Stroke Center shall provide, within 72 hours, written notice to the Medical Director of the EMS Agency if unable to adhere to any of the provisions set forth in these Stroke Receiving Center Standards.

D. The Stroke Center shall provide a 90-day, written notice to the Medical Director of the EMS Agency if Stroke Center intends to withdraw from the Stroke Program.

E. The Stroke Center shall notify the EMS Agency, in writing, of any changes in status of the Stroke Medical Director or Stroke Program Manager by submitting Ref. No. 621.2, Notification of Personnel Change Form.

F. Prior to designation, the Stroke Center shall provide six months of performance and tracking measure data listed in Ref. No. 322.1 and ensure quality improvement process of measures are in place. Performance measures shall be consistently achieved to maintain PSC/CSC designation.

G. The Stroke Center shall have a fully executed Specialty Care Center PSC/CSC Designation Agreement with the EMS Agency.

H. The Stroke Center shall establish a fully executed written transfer agreement with a CSC that is certified by an EMS Agency approved accrediting body and designated by the EMS Agency as a Comprehensive Stroke Center.

II. General Hospital Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

1. Have a special permit for Basic or Comprehensive Emergency Medicine Service

2. Accredited by a Centers for Medicare and Medicaid Services (CMS) recognized Hospital Accreditation Organization

3. Certified as a Stroke Center (e.g., Primary Stroke, Primary Plus, Thrombectomy Capable, Comprehensive) by an EMS Agency approved certifying body – representatives from the EMS Agency may attend the certification site review. In the event of action items, deficiencies or similar findings are identified, the hospital shall submit a copy of the findings and any action plans for improvement to the EMS Agency

4. All physicians attending in the Emergency Department (ED) shall be qualified specialists in Emergency Medicine (EM) or Pediatric EM

B. Appoint a Stroke Medical Director and Stroke Program Manager who shall be responsible for meeting the Stroke Program requirements and allocate adequate time such that they can meet the requirements of the Stroke Receiving Center Standards.

C. Develop and maintain a Clinical Stroke Team that is immediately available to evaluate a potential stroke patient and provide appropriate care.

D. Have the ability to perform the following diagnostic studies when clinically necessary:

1. Transesophageal echocardiography (TEE) and transthoracic echocardiography (TTE)

2. Computed tomography angiography (CTA) and/or magnetic resonance angiography (MRA)

III. Stroke Leadership Requirements

A. Stroke Medical Director

1. Medical oversight and ongoing performance of the Stroke quality improvement (QI) programs

2. Participates in the hospital Stroke Committee or equivalent and other committees associated with stroke care

3. Collaborates with the Stroke Program Manager to ensure adherence to these Standards

4. Liaison with hospital administration, Stroke Program Manager, medical and clinical staff across the stroke patient's continuums of care

5. Attends 100% of the EMS Agency's Stroke QI Meetings. Fifty percent (50%) of meetings may be attended by one of the following:

a. Alternate neurologist, neuroradiologist or neurosurgeon from the same Stroke Center. For PSCs, may also be an alternate EM physician

b. Call-in option when available

B. Stroke Program Manager

1. Qualifications:

a. Knowledgeable in neurocritical care and interventional stroke procedures

b. Able to facilitate internal hospital policy and procedure development and implementation

2. Responsibilities:

a. Collaborates with the ED Medical and Clinical Directors regarding stroke care

b. Collaborates with the Stroke Medical Director to ensure adherence to these Standards

c. Maintain and monitor Stroke QI Program

d. Participates in the hospital Stroke Committee or equivalent and other committees associated with stroke care

e. Assure hospital policies are consistent with these Standards

f. Liaison with hospital administration, Stroke Medical Director, medical and clinical staff across the stroke patient's continuums of care

g. Attends 100% of the EMS Agency's Stroke QI Meetings. Fifty percent (50%) of meetings may be attended by one of the following:

a. Alternate stroke RN from the same Stroke Center

b. Call-in option when available

h. Assures processes are in place to capture data from patients transported to the Stroke Center by EMS providers, including patients transferred from other acute care hospitals

i. Provide oversight of accurate and timely data collection and submission

j. Assures stroke diversion is consistent with EMS policies and processes are in place to minimize the need for diversion

IV. Clinical Stroke Team

The Stroke Center shall have a clinical stroke team available to evaluate the potential acute stroke patient within 15 minutes following patient's arrival to the ED or following a suspected diagnosis of potential acute stroke. The clinical stroke team shall include, at a minimum:

A. A Qualified Specialist in EM and neurology, neurosurgery, or interventional neuro-radiology in person or via telemedicine.

B. A registered nurse (RN), physician assistant or nurse practitioner with education and training in the care of the acute stroke patient

V. Data Collection and Submission Requirements

A. Ensure adequate data entry personnel, who work collaboratively with ED personnel, to assure capture and entry of patients meeting inclusion criteria into the Stroke Database on an ongoing basis.

1. Back-up data entry personnel should be identified and trained in the event primary data personnel are unable to meet the data entry requirements.

2. Data Inclusion Criteria – all patients who are initially transported via the 9-1-1 system and meet **one or more** of the following:

a. EMS Provider Impression is Stroke/CVA/TIA

b. EMS Provider utilized Treatment Protocol 1232

c. Final hospital (if admitted) or ED (if not admitted) diagnosis is ischemic stroke, transient ischemia attack, intracerebral hemorrhage, intraventricular hemorrhage, or subarachnoid hemorrhage

d. Transfer from a non-stroke center to a PSC or CSC for stroke care and the initial transport to the non-stroke center was via the 9-1-1 system within 24 hours prior to transfer

e. Transfer from a PSC to the CSC for stroke care and the initial transport to the PSC was via the 9-1-1 system within 24 hours prior to transfer

B. Stroke data shall be entered within 45 days of patient's discharge into the Stroke Database and shall include all patients who meet data inclusion criteria and all applicable data elements listed in Ref. No. 650, Stroke Data Dictionary.

C. Submit a monthly tally of patients meeting inclusion criteria to the EMS Agency Stroke Program Coordinator by end of the month for the previous month (e.g., January tally is due February 28th).

D. The Stroke Center must maintain a minimum 90% compliance for:

1. Capture of patients meeting the data inclusion criteria

2. Data field completion

3. Data field accuracy

4. Timely data entry

5. Timely tally submission

VI. Quality Improvement

A. Stroke Program must include a comprehensive-multidisciplinary QI Meeting.

1. Meeting participation should include the Stroke Medical Director, Stroke Program Manager, EMS providers, stroke care coordinators, stroke/provider educators, neurologists, ED physicians and ED personnel, as well as other healthcare specialties including neurointerventionalists, or endovascular neurosurgery when applicable.

2. Meetings to be held quarterly, at a minimum.

3. Meeting minutes and roster must be maintained for each meeting and available for review.

4. Stroke Centers that are also a Base Hospital are encouraged to provide periodic Stroke Base Hospital education with the collaboration of the Stroke Clinical Director.

B. The stroke QI program shall:

1. Track and trend performance measures as per Ref. No. 322.1, Stroke Performance Measures

2. Collaborate with referral/receiving facilities in regard to inter-facility transfers to evaluate care of transfer patients to include:

a. Door-in to door-out time at sending facility (goal <120 minutes)

b. Quality of care issues and delays

C. Address other issues, processes or personal trends identified from hospital specific data.

VII. A Comprehensive Stroke Center (CSC) shall:

1. Meet all the requirements specified in Sections I through VI of this policy

2. Appoint a Stroke Medical Director who is BC/BE in Neurology, Neuroradiology or Neurosurgery by ABMS or AOA with extensive experience and expertise in one or more of the cerebrovascular disease subspecialties of:
   a. Stroke or vascular neurologist
   b. Neurocritical Care
   c. Endovascular Neurosurgery

3. Appoint a Stroke Program Manager who shall be dedicated solely to the CSC program.

4. Have the capacity to perform mechanical thrombectomy for the treatment of ischemic stroke 24 hours per day/7 days per week.

5. Have fully executed written transfer agreements with LA County surrounding stroke referral facilities, including PSCs.

6. Provide guidance and continuing stroke-specific medical education to hospitals designated as a PSC with which they have transfer agreements.

7. Have fully executed written transportation agreements with LA County licensed ambulance operators, written agreements shall include provisions to ensure transportation is available 24 hours a day/7 days a week and transport vehicle is available at the stroke referral facility within 60 minutes, including critical care transportation.

8. Provide neurosurgical services or have a written transfer agreement with another CSC that provides neurosurgical services 24 hours per day/7 days a week/365 days a year. For hospitals that provide neurosurgical services, a written plan for neurosurgical coverage and a neurosurgical call schedule is readily available to staff. The neurosurgeon must be BC or BE and dedicated to the CSC and cannot be concurrently on-call at any other hospital. If concurrently on-call for another specialty service within the same hospital (e.g., trauma) must have back-up identified on the on-call schedule.

9. Have dedicated on-call endovascular neurointerventionalist 24 hours per day/7 days a week/365 days a year
    a. May be primary on-call at only one hospital at any given time
    b. May be on primary and/or back up call for up to two (2) hospitals at any given time e.g., primary call at one facility and back-up at one (1) facility for a total of two facilities.

10. ,Have a BC/BE neurologist available 24 hours per day/7 days a week/365 days a year.

11. Have a written back-up plan in case of two simultaneous stroke patients or for situations when the on-call physician is unreachable/unresponsive for both neurosurgery and endovascular neurointervention.,

12. Have tele-medicine capabilities with surrounding PSCs that have an established transfer agreement with the CSC.

CROSS REFERENCE:

Prehospital Care Policy Manual:

Reference No. 322.1 Stroke Performance Measures
Reference No. 502, Patient Destination
Reference No. 503, Guidelines for Hospitals Requesting Diversion of ALS Patients
Reference No. 521, Stroke Patient Destination
Reference No. 620, EMS Quality Improvement Program
Reference No. 622.2 Notification of Personnel Change Form
Reference No. 650 Stroke Data Dictionary
Reference No. 1232, Treatment Protocol: Stroke/CVA/TIA

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS QUALITY IMPROVEMENT PROGRAM** REFERENCE NO. 620

PURPOSE: To establish a process for the Los Angeles County Emergency Medical Services (EMS) Agency and system participants to evaluate the EMS system to ensure safety and continued improvement in prehospital patient care delivery.

AUTHORITY: California Code of Regulations, Title 22, Chapter 12
Health and Safety Code Division 2.5
California Evidence Code, Section 1157.7
California Civil Code Part 2.6, Section 56

DEFINITIONS:

Adverse Event: A preventable or non-preventable unintended event that results or has the potential to result in harm to the patient.

Indicator: A well-defined, objective, measurable, and important aspect of care. Other terms for indicators include: key performance indicator, metric and quality indicator or measure.

Important Aspects of Care: Patient care activities that are of greatest significance to the quality of patient care. These include activities that are high in volume, high risk, and/or problem prone for patients and/or healthcare providers.

Near Miss Event: An incident or unsafe condition with the potential for injury, damage or harm that is resolved before reaching the patient. Also referred to as a “close call” or “good catch”.

Periodic Review: A re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

Quality Improvement (QI): The continuous and systematic analysis of performance in an effort to improve it.

System Participant: For the purposes of this policy, a system participant is any prehospital care agency or entity required by law, regulation, agreement, or policy to develop and maintain a QI program consistent with state and local requirements.

Threshold: A pre-established level of performance related to a specific indicator.

PRINCIPLES:

1. An EMS QI program is an essential component of an effective EMS system capable of providing quality patient care and achieving system performance goals.

2. Key components of an EMS QI program include:
   a. Personnel
   b. Equipment and Supplies

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

c. Documentation
d. Data Collection and Analysis
e. Clinical Care/Patient Outcome
f. Skills Maintenance/Competency
g. Transportation/Facilities
h. Risk Management
i. Public Education/Prevention

3. EMS organizations become valuable stakeholders in the State QI program by participating in the local EMS Agency QI program.

4. Data sampling may be utilized to measure an indicator or monitor performance. However, to obtain meaningful data that are representative of the study population, factors such as the population affected, the frequency of the activity, and the severity of consequence when thresholds are not met, must all be considered when determining the size and population of data samples.

POLICY:

I. EMS Agency Responsibilities:

A. Implement a state-approved EMS QI plan consistent with ~~all~~ regulatory requirements.

B. Review QI programs and approve QI plans of local EMS system participants.

C. Maintain a systemwide QI program.

II. System Participant Responsibilities:

A. Implement and maintain a QI program approved by the EMS Agency that reflects the organization's current QI process(es).

B. Demonstrate how EMS QI is integrated within the organization.

C. Designate a representative to attend the relevant EMS Agency QI Committee meeting(s).

D. Participate in systemwide QI studies, to include timely submission of requested data to the EMS Agency.

E. Provide education, training, or other methods utilized to disseminate information specific to findings identified in the QI process.

F. Establish and maintain relationships with stakeholders and, as needed, convene meetings to facilitate the QI process.

G. Review the QI plan annually and update as needed. If there are no revisions, a signed copy of the QI plan signature page (signed by the Medical Director) or written statement to that effect, along with a copy of the current QI indicators, may be submitted in lieu of the entire plan.

H. Describe method(s) utilized to ensure accurate and reliable documentation of patient care delivered.

III. Other Specified Specialty Care Center Responsibilities:

A. Participate in the EMS Systemwide QI Program

B. Collect and submit requested data to the EMS Agency.

IV. QI Plan Requirements:

Each QI plan shall include a description, at a minimum, of the following components:

A. Organizational Structure

1. Mission statement and/or philosophy of the organization.

2. Goals and objectives.

3. Organizational chart or narrative description of how the QI program is integrated within the organization's EMS Agency QI Program, and State EMS QI Program.

4. Organizational chart or narrative description of how the organization's QI program is integrated with local and State QI programs

B. Methodology, processes and tools used to facilitate the QI Process (i.e., FOCUS-PDSA)

F Find a process to improve
O Organize an effort to work on improvement
C Clarify current knowledge of the process
U Understand process variation and capability
S Select a strategy for further improvement

P Plan a change or test aimed at improvement
D Do – carry out the change or the test
S Study the results, what was learned, what went wrong
A Act – adopt the change, or abandon it, or run through the cycle again

C. Approach to identifying and evaluating QI indicators

D. Data Collection and Reporting

1. All reliable sources of information utilized in the QI plan; including EMS databases, patient care records, checklists, customer input, direct observations, and skills simulation.

2. Flow of information.

3. Methods used to document QI findings.

4. Process used to submit data to the EMS Agency.

E. Training or educational methods that will be used to communicate relevant information among stakeholders.

V. QI Program Requirements:

Each QI Program shall include, at minimum, the following:

A. An approved QI Plan

B. Develop QI indicators that relate to important aspects of care, to include the following:

1. Well-defined description of the important aspect of care being measured.

2. Threshold for compliance.

3. Timeline for tracking indicator once the threshold has been achieved.

4. Data source.

C. Methods for tracking compliance and identifying trends.

D. Written analysis that summarizes the QI findings.

E. Corrective actions utilized to improve processes.

F. Written trending report that includes effectiveness of performance improvement action plans.

G. Education and training specific to findings identified in the QI process.

H. Methods utilized for dissemination of the QI findings to stakeholders.

I. Recognition and acknowledgment of performance improvement.

J. Periodic review or a re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

K. Methods for identifying, tracking, documenting and addressing near miss events.

L. Record Keeping

1. All QI records shall be maintained in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

2. The following records shall be maintained and available for review until the EMS Agency Program Review is concluded:

a. QI meeting minutes and attendance rosters/sign-in sheets.

b. Attendance rosters/sign-in sheets for activities where QI findings and/or actions are discussed.

c. QI indicator(s) data collection tools.

d. Written summaries of the trending/analysis.

e. Documentation of dissemination of QI findings within the organization and to stakeholders.

f. Dates and times of continuing education and skill training based on QI findings.

g. Dates and times of remedial education or skills training, when provided.

h. A tracking tool for monitoring performance excellence, adverse events, near misses or issues regarding non-compliance with current policies and procedures outside of QI activities.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 618, **EMS Quality Improvement Program Committees**

California EMS Authority, Quality Improvement Program Model Guidelines, 2005
Los Angeles County EMS Agency Quality Improvement Plan

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DATA REQUEST AND LEVELS OF SUPPORT** REFERENCE NO. 622.1

Data Request Tracking Number: (To be completed by the EMS Agency) _____

Complete all requested information below and submit applicable documents. Review Ref. No. 622, Release of EMS Data, prior to completion.

1. Date:
2. Date by which data is requested:
3. Data Recipient (person submitting request)
    a. Name:
    b. Title/Position:
    c. Facility/Agency/Organization/Affiliation:
    d. Mailing Address:
    e. Telephone number:
    f. E-mail address:
4. Indicate preference on how the data should be provided:
    a. ☐ E-Mail
    b. ☐ U.S. Mail
    c. ☐ Phone
    d. ☐ Fax (____) _____-_____
    e. ☐ Other (specify) _____
5. Indicate documents submitted with this request
    a. ☐ Limited Data Set Information (Ref. No. 622.2)
    b. ☐ Intended Use of Limited Data Set Information (Ref. No. 622.3)
    c. ☐ Data Use Agreement (Ref. No. 622.4)
    d. ☐ Confidentiality Agreement (Ref. No. 622.5)

6. Indicate the level(s) of support requested from the EMS Agency (check all that apply):

   a. ☐ Support in concept – letter of support or verbal accord of project

   b. ☐ Guidance – provide feedback on methodology, analysis, manuscript, etc.

   c. ☐ Data Abstraction – provide raw data from EMS Agency data registries

   d. ☐ Data Analysis – provide summary data, statistical analysis, tables, figures, etc.

   e. ☐ Other (this may include manuscript revision, operations/system resources, grant support, etc.) – please describe other support requested

      _____

7. Submit completed data request and applicable documents to:

   Sara Rasnake, Data Systems/Research Programs Manager
   10100 Pioneer Boulevard, Suite 200
   Santa Fe Springs, CA 90670
   Phone: (562) 378-1658
   Fax: (562) 946-6701
   E-Mail: srasnake@dhs.lacounty.gov

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: STROKE / CVA / TIA **Ref. No. 1232**

Base Hospital Contact: Required prior to transport for all patients with suspected Stroke or TIA.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

2. Administer **Oxygen** prn *(MCG 1302)*

3. Initiate cardiac monitoring *(MCG 1308)*
   Perform 12-lead ECG if concern for cardiac ischemia or dysrhythmia

4. Establish vascular access prn *(MCG 1375)* ❶
   Establish IV in all patients with LAMS 4 or 5, large bore catheter (16g or 18g) preferred

5. Check blood glucose
   If < 60mg/dL or > 400mg/dL, treat in conjunction with *TP 1203, Diabetic Emergencies*

6. Assess for signs of trauma
   If traumatic injury suspected, treat in conjunction with *TP 1244, Traumatic Injury*

7. Perform Modified Los Angeles Prehospital Stroke Screen (mLAPSS) on all patients exhibiting local neurologic signs. ❷❸
   The mLAPSS is positive if **all** of the following criteria are met:
   i. No history of seizures or epilepsy
   ii. Age 40 years or older
   iii. At baseline, patient is not wheelchair bound or bedridden
   iv. Blood glucose between 60 and 400 mg/dL
   v. Obvious asymmetry-unilateral weakness with any of the following motor exams:
      a. Facial Smile/Grimace
      b. Arm Strength
      c. Grip Strength

8. If mLAPSS is positive, or your provider impression remains stroke despite negative mLAPSS ❷❸, calculate Los Angeles Motor Score (LAMS) from the mLAPSS motor items:
   i. Facial Droop
      a. Absent = 0
      b. Present = 1
   ii. Arm Drift
      a. Absent = 0
      b. Drifts down = 1
      c. Falls rapidly = 2
   iii. Grip Strength
      a. Normal = 0
      b. Weak grip = 1
      c. No grip = 2

9. Verify and document date and time of Last Known Well Time (LKWT) ❹

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: STROKE / CVA / TIA **Ref. No. 1232**

10. Determine patient destination based on mLAPSS, LAMS and LKWT: ❹
    mLAPSS positive, LAMS 4-5, LKWT < 24 hours → Transport to Comprehensive Stroke Center (CSC) if within 30 min
    mLAPSS positive, LAMS ≤ 3, LKWT < 24 hours → Transport to closest Stroke Center
    mLAPSS negative but acute stroke suspected → **CONTACT BASE** for destination

11. Transport with head of bed elevated 30-45 degrees ❺

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: STROKE / CVA / TIA **Ref. No. 1232**

SPECIAL CONSIDERATIONS

❶ If LAMS is 4 or greater, place 18 gauge IV if possible to facilitate advanced imaging studies at CSC.

❷ The Modified LAPSS (mLAPSS) is a validated tool that helps to identify stroke mimics and excludes patients that will not benefit from stroke care. Using a stroke scale, such as mLAPSS, increases the chances of diagnosing strokes. However, stroke scales do not catch all strokes, including presentations such as aphasia, ataxia and vertigo. For patients in whom you suspect stroke but are mLAPSS negative, calculate the LAMS and contact the Base to discuss the destination decision. History of prior stroke does not exclude the need to evaluate for possible new deficits. New findings in a patient with prior stroke should be managed similarly to first-time strokes and such patients should be routed to the closest appropriate approved stroke center per Ref. 521.

❸ In patients with suspected stroke, the LAMS is performed by verbally requesting movement of face, arm, and grip or, if the patient is aphasic, by non-verbally encouraging such movement via pantomime and/or by gentle placement of limbs (painful stimulation is avoided). In patients with suspected stroke with ALOC (e.g., GCS <9) attempt neurologic assessment as noted above; alternatively, for patients unable to perform movements, compare tone and strength through passive movement of the limbs.

❹ LKWT determines the patient's eligibility for TPA and/or interventional procedures for clot removal. Document the name and contact information of the family member, caregiver, or witness who can verify the patient's LKWT and report this information to ED providers. If possible, transport the witness with the patient.

❺ Whenever possible transport patients with suspected stroke with head of bed elevated 30-45 degrees. This reduces risk of aspiration and also reduces elevation in intracranial pressure.

For FY 21-22, there were no changes to the emergency medical system for pediatrics. A map of our hospitals with children's services is included for reference (Attachment A)

Changes since the previous plan was submitted and approved include:

- List of Designated EDAP and PMCs with Agreement Expiration Dates (Attachment B)
- Reference No. 216, Pediatric Advisory Committee – Revised 07-01-021 (Attachment C)
- Reference No. 318, Pediatric Medical Center (PMC) Standards – Revised 10-01-2021 (Attachment D)
- Reference No. 620, EMS Quality Improvement Program – Revised 01-01-2022 (Attachment E)
- Reference No. 622.1, Data Requests and Levels of Support – Revised 04-15-2022 (Attachment F)
- Reference No. 822, Suspected Child Abuse/Neglect Reporting Guidelines – Revised 04-04-2022 (Attachment G)
- Reference No. 822.1, Guide to Suspected Child Abuse Reporting – Revised 04-01-2022 (Attachment H)
- Reference No. 822.2, Suspected Child Abuse Report – Revised 04-01-2022 (Attachment I)
- Reference No. 822.2a, Suspected Child Abuse Report Definitions and General Instructions – Revised 04-01-2022 (Attachment J)
- Reference No. 1203-P, Treatment Protocol: Diabetic Emergencies – Revised 02-01-2022 (Attachment K)
- Reference No. 1219-P, Treatment Protocol: Allergy – Revised 02-01-2022 (Attachment L)
- Reference No. 1225-P, Treatment Protocol: Submersion – Revised 10-01-2021 Attachment M)

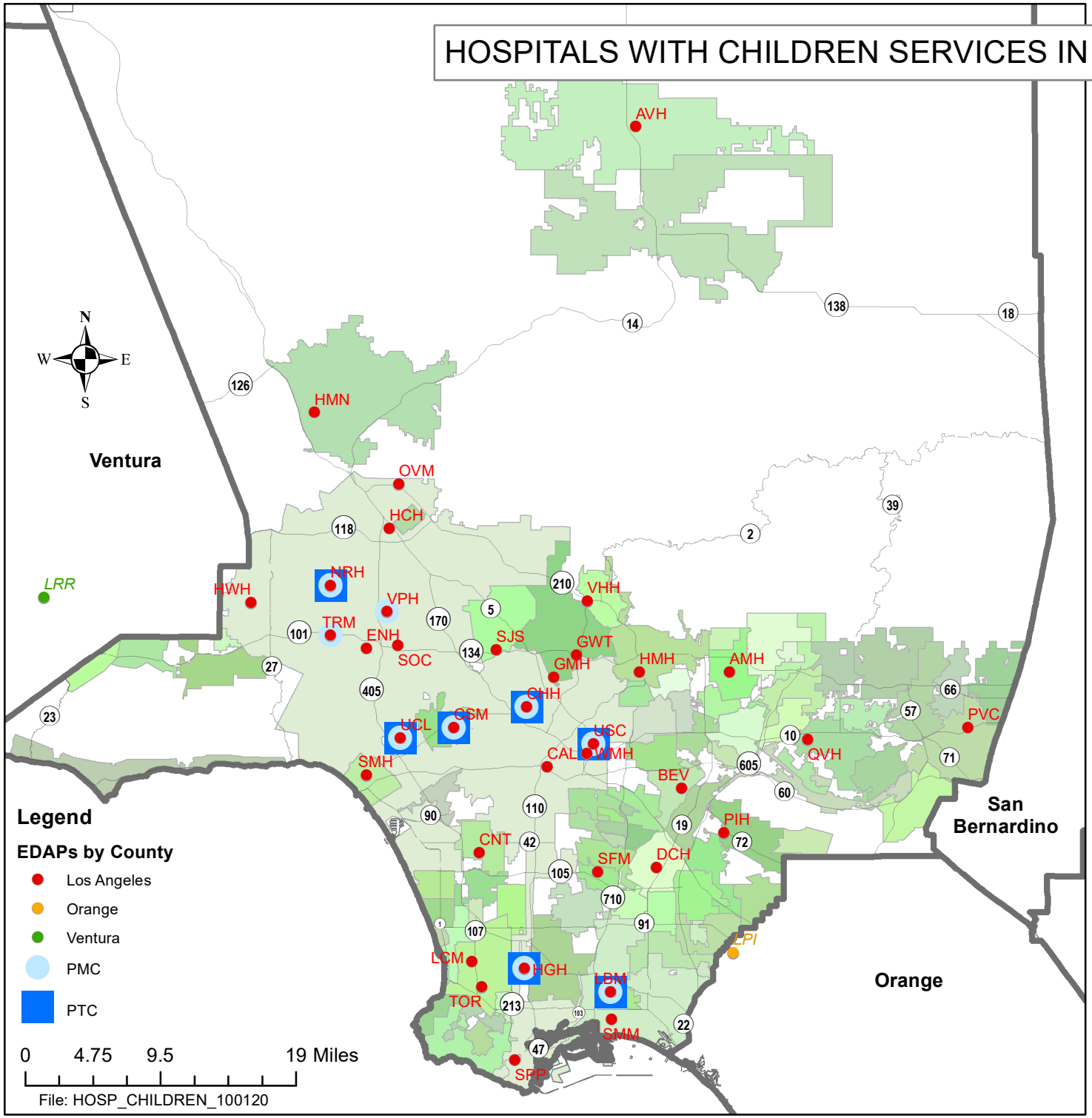
Pediatric EMS Update and EmergiPress Topics Included:

- Use if i-gel and pediatric airway management
- Precipitous Childbirth – Field Delivery
- Complicated Delivery
    - Breech delivery, shoulder dystocia, nuchal cord, prolapsed cord
- Newborn Resuscitation
    - Recognition of newborn in distress, resuscitation actions, positive pressure ventilation, indication of chest compression and use of epinephrine, cardiopulmonary resuscitation

The Pediatric Advisory/QI Committee met quarterly on September 7, 2021, November 30, 2021, March 1, 2022, and June 7, 2022. Topics included:

- Covid-19 Update
- Pediatric Out of Hospital Cardiac Arrest (OHCA) for Cardiac Arrest Registry for Enhanced Survival (CARES) database update Pediatric Medical Center (PMC) Standards QI
- National Pediatric Readiness Project (NPRP) Assessment Gap Analysis
- EDAP/PDLN System-Wide QI Indicators and Quarterly Reports
- Innovation, Technology, and Advancement Committee Updates
- Pediatric Data Collaboratives Update – BRUE, PECARN, & Pedi-Dose

HOSPITALS WITH CHILDREN SERVICES IN LOS ANGELES COUNTY



EDAPs As of 10/01/2020

Code	Name
AMH	Methodist Hospital of Southern California
AVH	Antelope Valley Hospital
BEV	Beverly Hospital
CAL	Dignity Health-California Hospital Medical Center
CHH	Children's Hospital Los Angeles
CNT	Centinela Hospital Medical Center
CSM	Cedars Sinai Medical Center
DCH	PIH Health Hospital - Downey
ENH	Encino Hospital Medical Center
GMH	Dignity Health-Glendale Memorial Hospital and Health Center
GWT	Adventist Health - Glendale
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
HWH	West Hills Hospital and Medical Center
LBM	MemorialCare Long Beach Medical Center
LCM	Providence Little Company of Mary Medical Center-Torrance
LPI	La Palma Intercommunity Hospital
LRR	Los Robles Regional Medical Center
NRH	Dignity Health-Northridge Hospital Medical Center
OVM	LAC Olive View-UCLA Medical Center
PIH	PIH Health Hospital - Whittier
PVC	Pomona Valley Hospital Medical Center
QVH	Emanate Health Queen of the Valley Hospital
SFM	St. Francis Medical Center
SJS	Providence Saint Joseph Medical Center
SMH	Santa Monica-UCLA Medical Center
SMM	Dignity Health-St. Mary Medical Center
SOC	Sherman Oaks Hospital
SPP	Providence Little Company of Mary Medical Center-San Pedro
TOR	Torrance Memorial Medical Center
TRM	Providence Cedars-Sinai Tarzana Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center
VHH	USC Verdugo Hills Hospital
VPH	Valley Presbyterian Hospital
WMH	Adventist Health - White Memorial

EMERGENCY MEDICAL SERVICES AGENCY
LOS ANGELES COUNTY

List of Pediatric Care Services with Agreement Expiration Dates as of June 30, 2022

Pediatric Hospitals	Designation Level	Agreement Expiration Date
Adventist Health - Glendale	EDAP	October 31, 2023
Adventist Health – White Memorial	EDAP	September 30, 2023
Antelope Valley Hospital	EDAP	October 31, 2025
Beverly Hospital	EDAP	September 30, 2023
Cedars Sinai Medical Center	PMC EDAP	July 31, 2023 September 30, 2024
Centinela Hospital Medical Center	EDAP	July 31, 2024
Children's Hospital Los Angeles	EDAP PMC	April 30, 2022* February 28, 2023
Dignity Health – California Hospital Medical Center	EDAP	July 31, 2023
Dignity Health – Glendale Memorial Hospital and Health Center	EDAP	September 30, 2023
Dignity Health – Northridge Hospital Medical Center	EDAP PMC	March 30, 2023 January 31, 2023
Dignity Health – Saint Mary Medical Center	EDAP	May 31, 2025
Emanate Health Queen of the Valley	EDAP	June 30, 2025
Encino Hospital Medical Center	EDAP	October 31, 2023
Henry Mayo Newhall Hospital	EDAP	June 30, 2023
Huntington Hospital	EDAP	February 28, 2024
LAC Harbor UCLA Medical Center	EDAP PMC	January 31, 2025 February 28, 2025
LAC+USC Medical Center	EDAP PMC	September 30, 2023 April 30, 2023
LAC Olive View-UCLA Medical Center	EDAP	August 31, 2023
La Palma Intercommunity Hospital	EDAP	May 31, 2023
Los Robles Medical Center (Ventura County)	EDAP	August 31, 2025
MemorialCare Long Beach Medical Center	EDAP PMC	August 31, 2023 August 31, 2023
PIH Health – Downey	EDAP	January 31, 2025
PIH Health – Whittier	EDAP	October 31, 2023
Pomona Valley Hospital Medical Center	EDAP	September 30, 2025
Providence Cedars-Sinai Tarzana Medical Center	EDAP PMC	July 31, 2025 December 31, 2023
Providence Holy Cross Hospital Medical Center	EDAP	June 31, 2023
Providence Little Company Mary Medical Center San Pedro	EDAP	June 30, 2025
Providence Little Company Mary Medical Center Torrance	EDAP	September 30, 2025

Providence Saint Joseph Medical Center	EDAP	September 30, 2024
Ronald Reagan UCLA Medical Center	EDAP PMC	October 31, 2025 March 31, 2023
Santa Monica UCLA Medical Center	EDAP	April 30, 2024
Sherman Oaks Hospital	EDAP	October 31, 2023
St. Francis Medical Center	EDAP	January 31, 2024
Torrance Memorial Medical Center	EDAP	September 30, 2022
USC Arcadia Hospital	EDAP	July 31, 2022
USC Verdugo Hills Hospital	EDAP	July 31, 2023
Valley Presbyterian Hospital	EDAP PMC	December 31, 2022 October 31, 2025
West Hills Hospital & Medical Center	EDAP	February 28, 2025

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PEDIATRIC ADVISORY COMMITTEE (PedAC)** REFERENCE NO. 216

PURPOSE: To describe the composition and function of the Pediatric Advisory Committee (PedAC).

POLICY:

I. General Committee Description

A. The PedAC acts in an advisory capacity to the Emergency Medical Services Agency. This committee is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation and administration of prehospital care, emergency departments (ED), and pediatric intensive care units (PICU).

B. The Chairperson shall have general supervision of all members pertaining to the PedAC.

C. A Committee member shall not take any action on behalf of, or in the name of PedAC unless specifically authorized to do so by the PedAC.

D. All Committee meetings shall be open to the public. This policy shall be stated in all agendas.

E. PedAC agendas shall be provided to members in advance of the meetings.

II. Officers

A. Chair and Vice Chair with pediatric expertise to be elected by the PedAC at its March meeting and shall serve a term of three years or until their successor is elected.

B. The Chair or Vice Chair shall be a physician.

III. Election and Replacement of Officers

A. Election of Officers:

1. At the December meeting, the Chair shall appoint three Committee members, subject to the approval of the PedAC to form a Nominating Committee.

2. At the March meeting, the Nominating Committee shall present a slate of candidates for the offices of the Chair and Vice Chair. Additional nominations of willing candidates may be made from the floor.

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill
Medical Director, EMS Agency

3. An election shall be conducted at the March meeting. If there is only one nominee for either office, the Chair can declare that the nominee is elected; otherwise, election shall be by majority vote (50% + 1) of the PedAC.

4. The newly elected Officers shall assume Duties at the next scheduled meeting.

B. Replacement of Officers

1. If, for any reason, the Chair is unable to complete a term of office, the Vice Chair will assume the Chair position for the remainder of the term and an election for the Vice Chair will be held at the next meeting.

2. If, for any reason, the Vice Chair is unable to complete a term of office, a new Vice Chair shall be choses as follows:

a. The Chair shall appoint three members to form a Nominating Committee, subject to the approval of the PedAC.

b. The Nominating Committee shall present a slate of candidates for the office of the Vice Chair at the first regular meeting following their nomination.

c. Additional nominations may be made and the elections shall be conducted in compliance with III.A., Items 3 and 4 of this policy.

d. If neither the Chair nor Vice Chair is able to preside at any PedAC meeting, the Committee shall elect a member to act as Chair Pro Tempore. Election shall be by majority vote of the PedAC.

IV. Duties of Officers

A. The Chair shall:

1. Preside over all meetings of the PedAC.

2. Rule on all points of order.

3. Represent PedAC at public functions or appoint a PedAC member to do so on their behalf.

4. Sign all official PedAC documents.

5. Ensure that minutes are maintained.

B. The Vice Chair shall:

1. Perform the duties of the Chair in their absence.

2. Perform other duties as assigned to them by the Chair or the PedAC.

V. Committee Membership Structure

A. Chair elected by PedAC.

B. Vice Chair elected by the PedAC.

C. Pediatric Physician Specialist appointed by the EMS Agency (Staff).

D. Pediatric Program Coordinator appointed by the EMS Agency (Staff).

E. One Pediatric Liaison Nurse (PdLN) from each Emergency Department Approved for Pediatric (EDAP) Regions, appointed by the Pediatric Liaison Nurses of Los Angeles County.

F. One EDAP Medical Director (or ED Physician designee) from each of the EDAP Regions.

G. One Pediatric Medical Center (PMC) Nurse Coordinator (PICU nurse) from each of the PMC Regions.

H. One PMC Medical Director (or PICU Physician designee) from each of the PMC Regions.

I. One Pediatric Trauma Center (PTC) Program Manager, appointed by the Trauma Hospital Advisory Committee.

J. One PTC Medical Director, appointed by the Trauma Hospital Advisory Committee.

K. One alternate for each member listed in V., Items E. through J of this policy.

L. Both the member and alternate members are encouraged to attend each meeting.

M. Each term is three years.

IV. EDAP Regions

A. Northern Valley Region

1. Antelope Valley Hospital

2. Dignity Health – Northridge Hospital Medical Center

3. Henry Mayo Newhall Hospital

4. Los Robles Regional Medical Center

5. Providence Holy Cross Medical Center

6. West Hills Hospital and Medical Center

7. LAC Olive View-UCLA Medical Center

B. Southern Valley Region

1. Adventist Health – Glendale

2. Dignity Health – Glendale Memorial Hospital and Health Clinic
3. Encino Hospital Medical Center
4. Providence Cedars-Sinai Tarzana Medical Center
5. Providence St. Joseph Medical Center
6. Sherman Oaks Hospital
7. Valley Presbyterian Hospital
8. USC Verdugo Hills Hospital

C. Eastern Region

1. Beverly Hospital
2. Emanate Health Queen of the Valley Hospital
3. Huntington Hospital
4. Methodist Hospital of Southern California
5. PIH Health Hospital – Whittier
6. Pomona Valley Hospital Medical Center

D. Metro/Western Region

1. Adventist Health White Memorial
2. Cedars Sinai Medical Center
3. Centinela Hospital Medical Center
4. Children's Hospital Los Angeles
5. Dignity Health – California Hospital Medical Center
6. LAC+USC Medical Center
7. Ronald Reagan UCLA Medical Center
8. Santa Monica-UCLA Medical Center

E. Southern Region

1. Dignity Health – St. Mary Medical Center
2. LAC Harbor-UCLA Medical Center
3. La Palma Intercommunity Hospital

4. MemorialCare Long Beach Medical Center
5. PIH Health Hospital – Downey
6. Providence Little Company of Mary Medical Center San Pedro
7. Providence Little Company of Mary Medical Center Torrance
8. St. Francis Medical Center
9. Torrance Memorial Medical Center

VII. PMC Regions

A. Northern Valley Region

1. Dignity Health – Northridge Hospital Medical Center
2. Providence Cedars-Sinai Tarzana Medical Center
3. Valley Presbyterian Hospital

B. Eastern Region

1. Children's Hospital Los Angeles
2. LAC+USC Medical Center

C. Metro/Western Region

1. Cedars-Sinai Medical Center
2. Ronald Reagan UCLA Medical Center

D. Southern Region

1. LAC Harbor-UCLA Medical Center
2. MemorialCare Long Beach Medical Center

VIII. Meeting and Activity Requirements

A. Regular meetings of the PedAC shall be held on a Tuesday, date to be determined, at 10:00 am in the third month of each quarter, March, June, September, and December. If any regular meeting falls on a holiday, the regular meeting shall be held one week later. Additional meetings may be held as determined by the Chair.

B. A quorum is required for any official business, including regular and special meetings. A quorum shall consist of a majority (50% + 1) of the committee members.

C. A minimum of 50% committee attendance is required for each voting members and alternate members. Member not meeting this requirement may be replaced.

D. Committee members are appointed, to ensure the five EDAP and four PMC regions are represented.

E. For non-committee members, a minimum of 50% attendance is highly encouraged for Pediatric Liaison Nurses and PMC Nurse Coordinators.

F. The Committee shall review, evaluate and make recommendations on issues related to emergency medical services which impact the pediatric population.

G. Minutes of Committee meetings shall be maintained by Staff, and distributed to all Committee members before the regular PedAC meeting.

IX. Policy Amendment

This policy maybe amended by a three-fourths (3/4) vote of the voting PedAC members if notice of intention to amend the policy, setting forth the proposed amendments, has been sent to each member of the PedAC no less than ten days before the date set for consideration of the amendments.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **PEDIATRIC MEDICAL CENTER (PMC) STANDARDS** REFERENCE NO. 318

PURPOSE: To establish minimum standards for the designation of Pediatric Medical Centers (PMC). The PMC will provide an emergency department capable of managing complex pediatric emergencies, a Pediatric Intensive Care Unit (PICU), physicians with pediatric sub-specialties and/or experience in pediatric care, pediatric critical care consultation for community hospitals, and outreach education programs for the Emergency Medical Services (EMS) community.

AUTHORITY: California Code of Regulations, Title 22, Division 9, Chapter 14

DEFINITIONS:

Board Certified (BC): Successful completion of the evaluation process through one of the Member Boards of the American Board of Medical Specialties (ABMS) or American Osteopathic Association (AOA), including an examination designed to assess the knowledge, skills, and experience necessary to provide quality patient care in a particular specialty.

Board Eligible (BE): Successful completion of a residency training program with progression to board certification based on the timeframe as specified by the ABMS or AOA.

Certified Registered Nurse Anesthetist (CRNA): An advanced practice registered nurse (APRN) who has acquired graduate-level education and board certification in anesthesia.

Children with Special Health Care Needs: Children who have or are at increased risk for a chronic physical, developmental, behavioral, or emotional condition and who also require health and related services of a type or amount beyond that is required by children generally.

Department of Children and Family Services (DCFS): A mandated component of Emergency Response Services, administered by the Los Angeles County Department of Children and Family Services. The Child Protection Hotline (CPH) intake evaluation staff is responsible for assessing any referral, whether verbal or written, which alleges child abuse, neglect, or exploitation to determine whether an in-person investigation and consultation is required.

The CPH operates 24 hours a day, seven days a week. The 24 hour number (1-800-540-4000), staffed by employees of the DCFS, is responsible for screening calls from the community related to issues of child abuse and neglect.

Emergency Department Approved for Pediatrics (EDAP): A licensed basic or comprehensive emergency department (ED) that is designated by the Emergency Medical Services (EMS) Agency to receive pediatric patients via the 9-1-1 system. These EDs provide care to pediatric patients by meeting specific requirements for professional staff,

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

quality improvement, education, support services, equipment, supplies, medications, and established policies and procedures, as per the guidelines outlined in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards.

Immediately Available: Unencumbered by conflicting duties or responsibilities, responding without delay when notified, and being physically available to the specified area of the PMC.

On call: Agreeing to be available, according to a predetermined schedule, to respond to the Pediatric Medical Center (PMC) in order to provide a defined service.

Pediatric Advisory Committee (PedAC): Acts in an advisory capacity to the EMS Agency and is responsible for all matters regarding pediatric care and policy development pertinent to the practice, operation, and administration of prehospital care, emergency departments, and pediatric intensive care units (PICU). Committee reviews, evaluates, and makes recommendations on EMS issues impacting the pediatric population.

Pediatric Critical Care Education: Topics in pediatric critical care that addresses fundamental principles for the management of the critically ill pediatric patient, and a minimum of 14 hours of continuing education every four years.

Pediatric Advanced Life Support (PALS): Pediatric resuscitation course that is recognized by the EMS Agency and valid for two years (e.g. American Heart Association, American Red Cross).

Pediatric Experience: A physician specialty approved by the appropriate hospital body and the PMC Medical Director, based on education, training, and experience to provide care to the pediatric patient.

Pediatric Intensivist: A Qualified Specialist in Pediatric Critical Care Medicine.

Pediatric Liaison Nurse (PdLN): A Registered Nurse currently licensed to practice in the State of California and appointed by the hospital to coordinate pediatric emergency care required by the EDAP Standards, also referred to as Nurse Pediatric Emergency Care Coordinator.

Pediatric Medical Center (PMC): A licensed acute care hospital that is designated by the EMS Agency to receive **critically ill** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 510, Pediatric Patient Destination.

PMC Medical Director: A Qualified Specialist in Pediatric Critical Care Medicine who oversees and directs implementation of these standards within the designated PMC.

PMC Nurse Coordinator: A Registered Nurse currently licensed to practice in the State of California and appointed by the Hospital to coordinate pediatric critical care.

Pediatric Trauma Center (**PTC):** A licensed acute care hospital that is designated by the EMS Agency to receive **injured** pediatric patients via the 9-1-1 system based on guidelines outlined in Ref. No. 506, Trauma Triage. These centers provide tertiary pediatric care and serve as referral centers for critically injured pediatric patients.

Promptly Available: Able to be physically present in the PMC within a period of time that is medically prudent and appropriate to the patient's clinical condition; and further, should

not have a measurable harmful effect on the course of patient management or outcome. Hospital guidelines shall be established that address response time for on-call physicians not to exceed thirty (30) minutes by telephone and in person within one hour.

Qualified Specialist: A physician licensed in the State of California who has become BC or BE in the corresponding specialty by the ABMS or the AOA.

Senior Resident: A physician licensed in the State of California who is in training as a member of the residency program at the designated hospital, has completed at least two years of the residency, and is in good standing.

Sexual Assault Response Team (SART) Centers: A center specializing in forensic examinations in the case of an acute sexual assault/abuse event (defined as occurring within 120 hours), which has the capabilities of providing comprehensive medical and psychological forensic examinations and consist of a knowledgeable staff whose training, expertise, and state-of-the-art equipment exceeds the community standards.

Suspected Child Abuse and Neglect (SCAN) Team: A team of healthcare professionals who are specialists in diagnosing and treating suspected child abuse, neglect, and sexual assault.

Telehealth: The remote delivery of health care services and clinical information using telecommunications technology. This includes a wide array of clinical services using internet, wireless, satellite, and telephone media.

POLICY:

I. PMC Designation / Re-Designation

A. PMC initial designation and re-designation is granted for a period of three years after a satisfactory review by the EMS Agency.

B. The EMS Agency reserves the right to perform scheduled site visits or request additional data of the PMC at any time.

C. The PMC shall immediately (within 72 hours) provide written notice to the Director of the EMS Agency if unable to adhere to any of the provisions set forth in the PMC Standards including structural changes or relocation of the PICU.

D. The PMC shall provide a 90-day, written notice to the EMS Agency Director of intent to withdraw from the PMC program.

E. The PMC shall notify the EMS Agency within 15 days, in writing of any change in status of the PMC Medical Director, PMC Nurse Coordinator, or PICU Nurse Manager/Director by submitting Ref. No. 621.2, Notification of Personnel Change Form.

F. Have a fully executed Specialty Care Center PMC Designation Agreement with the EMS Agency.

II. General Hospital Requirements

A. Licensed by the State of California Department of Public Health (CDPH) as a General Acute Care Hospital, and

1. Have a special permit for Basic or Comprehensive Emergency Medical Service; and

2. Accredited by a Centers for Medicare & Medicaid Services (CMS) recognized Hospital Accreditation Organization.

B. Designated by the EMS Agency as an Emergency Department Approved for Pediatrics (EDAP).

C. Have a Suspected Child Abuse and Neglect (SCAN) Team.

D. Have a licensed inpatient pediatric unit.

E. Have a Pediatric Intensive Care Unit (PICU).

F. Appoint a PMC Medical Director and a PMC Nurse Coordinator.

III. PMC Leadership Requirements

A. PMC Medical Director

1. Responsibilities:

a. Implement and ensure compliance with the PMC Standards.

b. Serve as chairperson of the PMC Committee or assign a designee.

c. Coordinate medical care across departmental and multidisciplinary committees.

d. Maintain direct involvement in the development, implementation, and maintenance of a comprehensive multidisciplinary QI program.

e. Identify, review, and correct deficiencies in the delivery of pediatric critical care.

f. Review, approve, and assist in the development of transfer guidelines and all PMC policies and procedures.

g. Collaborates with the PMC Nurse Coordinator, ED Medical Director, and ED Nursing Director to ensure appropriate pediatric critical care education programs are provided to the staff related to the quality improvement findings.

h. Coordinates with PMC Nurse Coordinator to liaison with other PMCs, pediatricians, ED Directors, PdLNs, and community hospitals.

i. Shall have direct involvement in defining the credentialing/privileging criteria/process utilized in determining pediatric experience for the non-boarded physicians.

B. PMC Nurse Coordinator

1. Qualifications:

a. Current PALS provider or instructor certification.

b. Shall have a minimum of three years' experience or specialty certification, in the care of critically ill children, and currently working in the PICU.

c. Shall have education, training, and demonstrated competency in pediatric critical care nursing and attend at least 14 hours of Board of Registered Nursing (BRN) approved pediatric critical care education every four years.

d. May hold other positions in the hospital organization (e.g., PICU staff nurse, PICU Charge Nurse, PICU Nurse Manager/Director).

2. Responsibilities:

a. Ensure the implementation and compliance of the PMC Standards in collaboration with the PMC Medical Director and PICU Nurse Manager/Director.

b. Serve as a member of the PMC Committee.

c. Direct involvement in the development, implementation, and maintenance of comprehensive multidisciplinary QI program.

d. Liaison with other hospital multidisciplinary committees.

e. Ensure appropriate pediatric critical care education programs are provided to the staff.

f. Liaison with other PMCs, hospitals, and PdLNs.

g. Serve as the contact person for the EMS Agency and be available upon request to respond to County business.

h. Participate in EMS Agency activities and meetings and attend a minimum of two (2) PedAC meetings per year.

i. Maintain joint responsibility with the PICU Medical Director and PICU Nurse Manager/Director for the development and review of policies, procedures, and QI activities in the PICU.

C. PICU Nurse Manager/Director – Shall serve as a member of the PMC committee.

IV. Personnel Requirements

A. Pediatric Intensivist

1. Responsibilities:

a. Shall be on-call and promptly available

b. Shall not be on-call for more than one facility at the same time

c. Participate in all major therapeutic decisions and interventions

B. Anesthesiologist with pediatric experience

1. Responsibilities:

a. Shall be on-call and promptly available

b. Provide oversight for all patients requiring interventions by the senior resident or Certified Registered Nurse Anesthetist (CRNA) and be present for all surgical procedures

C. Specialties who shall be on-call and promptly available:

1. Radiologist with pediatric experience (can be achieved by off-site capabilities)

2. Neonatologist

3. Pediatric Cardiologist

4. General Surgeon with pediatric experience

5. Otolaryngologist with pediatric experience

6. Obstetrics/Gynecologist with pediatric experience

7. Mental health professionals with pediatric experience

8. Orthopedist with pediatric experience

D. Qualified specialists who shall be available 24 hours per day, 7 days per week for consultation which may be met through a transfer and/or telehealth agreement:

1. Pediatric Gastroenterologist
2. Pediatric Hematologist/Oncologist
3. Pediatric Infectious Disease
4. Pediatric Nephrologist
5. Pediatric Neurologist
6. Pediatric Surgeon
7. Cardiac surgeon with pediatric experience
8. Neurosurgeon with pediatric experience

9. Pulmonologist with pediatric experience
10. Pediatric endocrinologist

E. Nursing Personnel on the Pediatric Unit

1. The Pediatric Unit shall be staffed with RNs and Licensed Vocational Nurses (LVNs) who are licensed to practice in the State of California.

2. RNs and LVNs shall have current PALS provider or instructor certification.

3. RNs and LVNs shall have attended at least 14 hours of BRN or Board of Vocational Nursing and Psychiatric Technicians approved pediatric education every four years.

4. Nursing staff shall have experience and demonstrated pediatric clinical competence. The hospital shall have methods for documenting clinical competency (i.e., course completion certificates, course attendance rosters, etc.).

V. Special Services and Resources

The following services may be met by contractual or written transfer agreements:

A. Acute burn care management

B. Urgent dialysis (i.e., hemodialysis)

C. Peritoneal dialysis

D. Pediatric rehabilitation

E. Organ transplantation

F. Home health

G. Reimplantation

H. Hospice

VI. Pediatric Intensive Care Unit

A. General Requirements for the PICU:

1. Shall be a distinct, separate unit within the hospital

2. Provide at minimum, eight licensed beds

3. Admit a minimum of 200 patients per year and a minimum or 40 ventilator day per year

B. PICU Medical Director

1. Serve as a member of the PMC Committee, and may hold PMC Medical Director position

2. Work with the PMC Medical Director to ensure PMC Standards are met

C. PICU Clinical Nurse Specialist (CNS) shall:

1. Be licensed to practice in the State of California as a CNS

2. Collaborate with the PMC Nurse Coordinator to ensure the PMC Standards are met

3. Develop and oversee pediatric critical care educational programs for the nursing staff in the PICU

D. PICU Staff Nurse shall:

1. Be licensed to practice in the State of California as RN or LVN

2. Have a current PALS provider or instructor certification

3. Have education, training, demonstrated competency in pediatric critical care nursing and have attended at least 14 hours of BRN or Board of Vocational Nursing and Psychiatric Technician approved pediatric education every four years

E. Social Worker shall:

1. Be licensed to practice in the State of California as a Medical Social Worker (MSW)

2. Have a Master's Degree in Social Work

3. Have pediatric experience in psychosocial issues affecting seriously ill children and their families, including management of child abuse and neglect cases

4. Have 4 hours of continuing education every two (2) years in topics related to health, housing and welfare of children (e.g., child abuse reporting)

F. Other professional services with minimum one year pediatric experience shall be available to the PICU:

1. Pharmacist shall be available 24 hours per day, 7 days a week

2. Clinical Registered Dietician

3. Occupational Therapist

4. Physical Therapist

5. Behavioral health specialist to include psychiatrists, psychologists, and nurses

VII. Policies and Procedures

The hospital shall develop and maintain policies and procedures required in Ref. No. 316, Emergency Department Approved for Pediatrics (EDAP) Standards, and those listed below. These policies and procedures, shall be reviewed periodically by the PICU Medical Director in collaboration with the PICU Nurse Manager/Director, and endorsed by hospital administration. All policies and procedures shall be easily accessible in the PICU.

Additional PMC policies and procedures shall address the following:

A. Policies

1. Age appropriate physical environment

2. Credentialing process for physicians who provide care for pediatric patients

3. Do-Not-Resuscitate Orders

4. Family centered care

a. Care of grieving family and caregivers

b. Contacting appropriate clergy per request of the parents or primary caregiver

c. Death of a child in the PICU

5. Infection surveillance and prevention

6. Mechanism and guidelines for bioethical review to include an Ethics Committee

7. Mental health and substance abuse

8. PICU admission, transfer, and discharge criteria and process

9. Referral for rehabilitation

B. Procedures

1. Appropriate use and monitoring of equipment

2. Pain management, includes utilization of developmentally appropriate pain tools

3. Patient care, which include nursing and respiratory management of infants, children, and adolescents

4. Procedural sedation

VIII. PICU Equipment, Supplies, and Medications

A. Pediatric equipment, supplies, and medications shall be easily accessible to PICU staff and may be physically housed in other locations besides the PICU. A mobile pediatric crash cart shall be utilized and available on all units where pediatric patients are treated to include but not limited to, ED, radiology, and in-patient services.

B. A locator chart or grid identifying the locations of all required equipment and supplies shall developed and be maintained in order for staff to easily identify location of all items.

C. Required equipment, supplies, and medications:

1. General Equipment

a. Weight scale measuring only in kilograms for both infants and children, including bed scales

b. Standardized length-base resuscitation tape, approved by the EMS Agency (e.g., Broselow 2011A or newer) to estimate pediatric weights in kilograms

c. Pediatric drug dosage reference material with dosages calculated in milligrams per kilogram (either posted or readily available)

d. Developmentally appropriate pain scale assessment tools for infants and children

e. Blood and IV fluid warmer (rapid infuser)

f. Warming and cooling system with appropriate disposable blankets

g. Restraints in various sizes

2. Monitoring Equipment

a. Blood pressure cuffs

1) Neonatal
2) Infant
3) Child
4) Adult arm
5) Adult thigh

b. Vascular Doppler device (handheld)

c. ECG monitor/Defibrillator/Pacing (Crash cart unit and Transport unit)

1) ECG electrodes in pediatric and adult sizes
2) Defibrillator paddles in pediatric and adult sized, and/or; hands-free defibrillation device
3) External pacing capability
4) Multifunction pads in pediatric and adult

d. Thermometer with hypothermic capabilities

e. Respiration and oxygen saturation monitoring

1) Pulse oximeter unit with sensors
   i. Infant
   ii. Pediatric
   iii. Adult

2) Continuous end-tidal CO_2 monitoring device for pediatric and adult

f. Arterial pressure

g. Central venous pressure

h. Intracranial pressure

i. Pulmonary arterial pressure

j. Automated/noninvasive blood pressure modules

3. Airway Management

a. Bag- Mask-Ventilation (BMV) device with self-inflating bag

1) Infant (minimum 450mL)
2) Child
3) Adult

b. BMV clear masks

1) Neonate
2) Infant
3) Child
4) Adult

c. Laryngoscope handle

1) Pediatric
2) Adult

d. Laryngoscope blades

1) Macintosh/curved: 2, 3
2) Miller/straight: 00, 0,1, 2, 3

e. Endotracheal tubes

1) Uncuffed: mm 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5
2) Cuffed: mm 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0

f. Stylets for endotracheal tubes

1) Pediatric
2) Adult

g. Magill Forceps

1) Pediatric
2) Adult

h. Nasopharyngeal Airways

1) Infant
2) Child
3) Adult

i. Oropharyngeal Airways

1) Infant
2) Child (size 0-2)
3) Adult (size 3-5)

j. Clear oxygen masks

1) Infant
2) Child
3) Adult

k. Non-rebreather masks

1) Infant
2) Child
3) Adult

l. Nasal cannula

1) Infant
2) Child
3) Adult

m. Oxygen capability

n. Suction capability

o. Suction catheters

6, 8, 10, 12 Fr

p. Yankauer suction tips

q. Feeding tubes

5, 8 Fr

r. Nasogastric tubes

5, 8, 10, 12, 14, 16, 18 Fr

s. Supraglottic Airways

1) Neonatal
2) Infant
3) Child
4) Adult

t. Cricothyrotomy Catheter set (pediatric)

u. Tracheostomy trays:

1) Pediatric
2) Adult

v. Tracheostomy Tubes

1) Neonatal: size mm 2.0, 2.5, 3.0, 3.5, 4.0, 4.5
2) Pediatric: size mm 3.0, 3.5, 4.0, 5.0, 5.5, 6.0

4. Vascular Access Equipment

a. Arm boards

1) Infant
2) Child
3) Adult

b. IV volume rate control administration sets with calibrated chambers

c. IV catheters

16, 18, 20, 22, 24 gauge

d. 3-way stopcocks

e. Device or needle to achieve intraosseous (IO) vascular access, to include needles in the appropriate sizes for pediatric and adult patients

f. IV solutions, in 250mL and/or 500mL bags

1) 0.9 NS
2) D5.45NS
3) D5NS
4) D10W
5) Lactated Ringers

g. Ultrasound for facilitating peripheral and central venous access

5. Fracture Management Devices

a. Splinting supplies for long bone fractures

b. Cervical spine motion restriction equipment (e.g. cervical collar)

c. Spinal board with the appropriate straps

6. Specialized Trays or Kits

a. Thoracostomy tray

b. Chest drainage system

c. Chest tubes, one in each size

8, 12, 16, 20, 24, 28, 36 Fr

d. Lumbar Puncture trays and spinal needles

1) 22 g, 3 inch
2) 22-25 g, 1½ inch

e. Urinary catheterization sets and indwelling urinary catheters

5, 8, 10, 12, 14, 16 Fr

f. Central line trays, with one of each catheter size

1) 4.0 Fr
2) 5.5 Fr
3) 7.0 Fr

g. Tray for insertion of ICP monitor

h. Arterial line trays with one of each catheter size

1) 2.5 Fr
2) 4.0 Fr

i. Paracentesis tray

7. Pediatric-Specific Resuscitation

a. Immediately available drug calculation resources

b. The following medications must be immediately available:

1) Adenosine
2) Albuterol
3) Amiodarone
4) Atropine
5) Atrovent
6) Calcium chloride
7) Dobutamine
8) Dopamine
9) Epinephrine 0.1mg/mL **(IV administration**)
10) Epinephrine 1mg/mL (**IM administration**)
11) Epinephrine for inhalation
12) Fentanyl
13) Ketamine
14) Lidocaine
15) Mannitol or hypertonic saline
16) Milrinone
17) Naloxone
18) Norepinephrine
19) Procainamide
20) Prostaglandin E1
21) Neuromuscular blocking agent
22) Sedative agent
23) Sodium Bicarbonate 4.2% (or a process to obtain the drug in an emergency situation)
24) Sodium Bicarbonate 8.4%
25) Vasopressin

8. Portable Equipment (promptly available)

a. Air-oxygen blenders (21-100%)

b. Air Compressor

c. Bilirubin lights

d. Cribs

e. Electrocardiogram (ECG 12 lead)

f. Electroencephalogram (EEG)

g. Echocardiogram (Echo)

h. Oxygen tank

i. Radiant warmer

j. Servo-controlled heating units (with or without open crib)

k. Suction unit

l. Transcutaneous pCO_2 monitor

m. Transcutaneous pO_2 monitor

n. ECG monitor/Defibrillator/Pacing transport unit

o. Ultrasound

p. Ventilator – pediatric capability

IX. Outreach and Education Program

A. Establish outreach with surrounding facilities to facilitate transfer of pediatric patients.

B. Inform and provide educational programs to EMS providers regarding pediatric patients discharged with special health care needs in their jurisdiction.

C. Provide outreach and pediatric education to EDAPs and EMS providers.

X. Ancillary Services

Ancillary services shall have the capabilities and technologist appropriately trained to manage a critically ill pediatric patient. These services shall be in-house and available 24 hours per day.

A. Respiratory Care Practitioners working in the PICU shall:

1. Be license as a Respiratory Car Practitioner (RCP) in the State of California

2. Have current PALS provider or instructor certification

3. Successfully complete additional training in pediatric critical care and attend a minimum of 4 hours of pediatric critical care education annually

B. Radiology

1. Shall have pediatric-specific policies and procedures pertaining to imaging studies of children

2. Radiology technicians must be in-house 24 hours per day, 7 days per week

3. Provide the following services 24 hours per day:

a. Nuclear medicine on-call and promptly available

b. Computerized Tomography (CT)

c. Ultrasound

d. Magnetic Resonance Imaging (MRI) on-call and promptly available

e. Angiography (may be provided through a transfer agreement)

C. Clinical laboratory shall have pediatric-specific policies and procedures pertaining to laboratory studies of children, including, but not limited to, obtaining samples by trained phlebotomists, micro technique for small or limited sample sizes, and ability to provide autologous and designated donor transfusions.

XI. PMC Committee

A. The purpose of the Committee is to establish a forum for exchange of ideas regarding the provision of emergency, inpatient, and critical care to the pediatric patient.

B. The membership shall include interdepartmental and multidisciplinary representatives from the emergency department, PICU, pediatric unit, nursing, social services, respiratory services, discharge planning, SCAN team, and other relevant services as applicable, such as: prehospital care, pediatric sub-specialties, and pediatric interfacility transport team.

C. The Committee is responsible for all matters regarding the medical care provided to the pediatric patient which include, but not limited to, the following:

1. Review and recommend revision to policies and procedures to verify compliance with the PMC Standards

2. Review the quality improvement process to identify system-related performance and operational issues, and recommend corrective action plans

D. Meeting Frequency: Quarterly, additional meetings may be held on an as needed basis.

E. Meeting minutes and attendance rosters shall be maintained and made available to the EMS Agency when requested.

XII. Suspected Child Abuse and Neglect

A. Suspected Child Abuse and Neglect (SCAN) Team shall:

1. Consist of a medical director, coordinator, social worker, physician, and/or nurse consultants as applicable.

2. Assist nursing and medical staff in the evaluation of pediatric patients who have alleged to have been abused or neglected.

3. Have a member on-call and available to all areas of the hospital 24 hours per day.

4. Review cases of suspected child abuse/neglect to verify adequacy of care, reporting, and follow-up.

B. SCAN Team Medical Director

Shall be board certified in Pediatrics and/or Child Abuse Pediatrics:

Responsibilities:

1. Collaborate with the SCAN Team Coordinator:

   a. To monitor the SCAN Team's activities

   b. Ensure the development of education for nursing and medical staff in the evaluation of children suspected of child abuse and neglect.

2. Serve as a member of the PMC Committee.

3. Oversee the review of suspected child abuse, neglect, and sexual assault cases for appropriateness of care, compliance with mandated reporting and appropriateness of follow-up.

C. SCAN Team Coordinator

Shall have experience and training in the management of a child abuse, neglect and sexual assault victim, and obtain 14 hours of pediatric education every four years.

Responsibilities:

1. Oversees scheduling to ensure a SCAN Team member is available 24 hours per day/seven day a week.

2. Serve as a member of the PMC Committee.

3. Review cases of suspected child abuse, neglect, and sexual assault in consultation with the SCAN Team Medical Director for appropriateness of care, compliance with mandated reporting, appropriateness of follow-up, and completeness of documentation.

4. Assist nursing and medical staff in the evaluation of children who have alleged to have been abused, neglected, or sexually assaulted.

5. Develop educational training for medical and nursing staff in the recognition and management of children with suspected child abuse, neglect, and sexual assault.

D. Social Worker

1. Qualifications:

   a. Licensed to practice as a Medical Social Worker (MSW) by the State of California.

   b. Must have experience and training in the management of child abuse, neglect, and sexual assault.

   c. Have 4 hours of continuing education every two (2) years in topics related to health, housing, and welfare of children (e.g., child abuse reporting).

2. Responsibilities:

   a. Assist nursing and medical staff in the evaluation of children alleged to have been abused, neglected, or sexually assaulted.

   b. Provide support and resources for the abused, neglected, or sexually assaulted children and their family.

E. SCAN Team Physician and/or Nurse Consultants

1. Qualifications:

   a. Physicians shall be board certified in Pediatrics, Child Abuse Pediatrics, or Emergency Medicine with medical experience in diagnosing and managing suspected child abuse, neglect, and sexual assault cases.

   b. Nurse consultant shall have training and experience in evaluating and managing suspected child abuse, neglect, and sexual assault cases.

2. Responsibilities:

   a. Provide guidance or consultation, as needed, in suspected child abuse, neglect, or sexual assault cases.

F. Pediatric Forensic Examination

1. The PMC shall ensure a forensic examination and an interview are completed for acute (defined as occurring within 120 hours) sexual assault/abuse event, or appropriate referral was made for such examination, if the event occurred over 120 hours.

2. If the PMC does not provide the necessary forensic examination, a written consultation and transfer agreement shall exist with an EMS Agency designated SART Center.

XIII. Pediatric Interfacility Transport (PIFT) Program

PMCs shall have a PIFT program or have written agreements to provide PIFT services for the timely transport of patients *in or out* of the PMC. The PIFT program shall have the capability to transport neonatal and pediatric patients. The PIFT program shall also include back-up processes or agreements for the timely transport of patients with time sensitive conditions when the estimated time of arrival of the primary transport team is greater than 1 hour.

A. PMCs with a PIFT program shall have program policies and procedures and composition of PIFT as determined by the level of care needed.

1. The hospital maintaining the PIFT program shall have written agreements with referring and receiving facilities that utilize the program.

2. Agreements should specify the role and responsibilities of the transport program and the hospitals to include the following:

a. Agreement to transfer and receive appropriate pediatric patients when indicated

b. Responsibilities for patient care before, during and after transport

c. Documentation and transferring appropriate information/records

B. If the PMC does not have a PIFT program, written agreements shall exist with agencies or other programs that will provide timely transportation of critically ill pediatric patients to and from the PMC. Written agreements shall be with a PIFT program that meets the specifications outlined in XIII.A.

XIV. Quality Improvement (QI) Program

A. The PMC shall develop a multidisciplinary QI program for the purpose of improving patient outcomes of critically ill children. The QI program shall interface with the emergency department, PICU, NICU, pediatric unit, SCAN Team, PIFT Program, and EMS providers. The QI program shall also interface with hospital wide and emergency department QI activities.

B. The PMC Medical Director and Nurse Coordinator shall be responsible for the development, implementation, and review of the QI program as it pertains to the care of the pediatric patients transported to the PMC.

C. The PMC's QI program shall meet the requirements stipulated in Ref. No. 620, Section V, QI Program Requirements, which includes, at minimum, the following:

1. QI Plan
2. Identification of indicators
3. Methods to collect data
4. Written results and conclusions
5. Recognition of improvement

6. Action(s) taken (e.g., education of staff or feedback to referring facilities and EMS providers)
7. Assessment of effectiveness of action(s) taken
8. Dissemination of QI information to stakeholders

D. The QI review process shall include, at a minimum, a detailed 100% physician review, tracking, and trending of the following cases:

1. Unexpected deaths in the PICU
2. Unexpected cardiac arrests in the PICU
3. Unexpected transfers for higher level of care
4. Sentinel events
5. Child maltreatment (suspected child abuse, neglect and sexual assault) to include the mandated reporting process
6. Readmissions to the PICU within 48 hours
7. Unexpected admissions from the operating room
8. Unplanned admissions to the PICU

DI. The QI process shall include providing feedback, via appropriate process or channels, to referral facilities and/or EMS providers on items that may require commendation, positive reinforcement, fact-finding, case/peer review, and education/competency verification or remediation.

XV. Data Requirement

A. Participate in the data collection process established by the EMS Agency.

B. Submit data to the EMS Agency, within 45 days of patient's discharge, which shall include data elements listed in Ref. No. 652, EDAP and PMC Data Dictionary.

CROSS REFERENCE:

Prehospital Care Policy Manual:

Ref. No. 216, **Pediatric Advisory Committee (PedAC)**
Ref. No. 316, **Emergency Department Approved for Pediatrics (EDAP) Standards**
Ref. No. 324, **SART Center Standards**
Ref. No. 506, **Trauma Triage**
Ref. No. 508, **Sexual Assault Patient Destination**
Ref. No. 508.1, **SART Center Roster**
Ref. No. 510, **Pediatric Patient Destination**
Ref. No. 620, **EMS Quality Improvement Program**
Ref. No. 621, **Notification of Personnel Change**
Ref. No. 621.2, **Notification of Personnel Change Form**
Ref. No. 652, **EDAP and PMC Data Dictionary**

California Clinical Forensic Medical Training Center, California Sexual Assault Response Team (SART) Manual

California Children's Services: Provider Standards, https://www.dhcs.ca.gov/services/ccs/Pages/ProviderStandards.aspx

ACEP: Emergency Information Form, https://www.acep.org/by-medical-focus/pediatrics/medical-forms/emergency-information-form-for-children-with-special-health-care-needs/
AAP: Emergency Information Form, https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-child-care/Documents/AR_EmergencyInfo.pdf

ACKNOWLEDGEMENTS

The EMS Agency Pediatric Medical Center Standards were first developed by the Committee on Pediatric Emergency Medicine (COPEM), Los Angeles County Pediatric Society, Pediatric Liaison Nurses of Los Angeles County, California Chapter of American College of Emergency Physicians (ACEP) National Emergency Medical Services for Children (EMSC) Resource Alliance, American Academy of Pediatrics California Chapter 2, Emergency Nurses Association, and the EMS Agency.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **EMS QUALITY IMPROVEMENT PROGRAM** REFERENCE NO. 620

PURPOSE: To establish a process for the Los Angeles County Emergency Medical Services (EMS) Agency and system participants to evaluate the EMS system to ensure safety and continued improvement in prehospital patient care delivery.

AUTHORITY: California Code of Regulations, Title 22, Chapter 12
Health and Safety Code Division 2.5
California Evidence Code, Section 1157.7
California Civil Code Part 2.6, Section 56

DEFINITIONS:

Adverse Event: A preventable or non-preventable unintended event that results or has the potential to result in harm to the patient.

Indicator: A well-defined, objective, measurable, and important aspect of care. Other terms for indicators include: key performance indicator, metric and quality indicator or measure.

Important Aspects of Care: Patient care activities that are of greatest significance to the quality of patient care. These include activities that are high in volume, high risk, and/or problem prone for patients and/or healthcare providers.

Near Miss Event: An incident or unsafe condition with the potential for injury, damage or harm that is resolved before reaching the patient. Also referred to as a “close call” or “good catch”.

Periodic Review: A re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

Quality Improvement (QI): The continuous and systematic analysis of performance in an effort to improve it.

System Participant: For the purposes of this policy, a system participant is any prehospital care agency or entity required by law, regulation, agreement, or policy to develop and maintain a QI program consistent with state and local requirements.

Threshold: A pre-established level of performance related to a specific indicator.

PRINCIPLES:

1. An EMS QI program is an essential component of an effective EMS system capable of providing quality patient care and achieving system performance goals.

2. Key components of an EMS QI program include:
   a. Personnel
   b. Equipment and Supplies

APPROVED: Cathy Chidester
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

c. Documentation
d. Data Collection and Analysis
e. Clinical Care/Patient Outcome
f. Skills Maintenance/Competency
g. Transportation/Facilities
h. Risk Management
i. Public Education/Prevention

3. EMS organizations become valuable stakeholders in the State QI program by participating in the local EMS Agency QI program.

4. Data sampling may be utilized to measure an indicator or monitor performance. However, to obtain meaningful data that are representative of the study population, factors such as the population affected, the frequency of the activity, and the severity of consequence when thresholds are not met, must all be considered when determining the size and population of data samples.

POLICY:

I. EMS Agency Responsibilities:

A. Implement a state-approved EMS QI plan consistent with ~~all~~ regulatory requirements.

B. Review QI programs and approve QI plans of local EMS system participants.

C. Maintain a systemwide QI program.

II. System Participant Responsibilities:

A. Implement and maintain a QI program approved by the EMS Agency that reflects the organization's current QI process(es).

B. Demonstrate how EMS QI is integrated within the organization.

C. Designate a representative to attend the relevant EMS Agency QI Committee meeting(s).

D. Participate in systemwide QI studies, to include timely submission of requested data to the EMS Agency.

E. Provide education, training, or other methods utilized to disseminate information specific to findings identified in the QI process.

F. Establish and maintain relationships with stakeholders and, as needed, convene meetings to facilitate the QI process.

G. Review the QI plan annually and update as needed. If there are no revisions, a signed copy of the QI plan signature page (signed by the Medical Director) or written statement to that effect, along with a copy of the current QI indicators, may be submitted in lieu of the entire plan.

H. Describe method(s) utilized to ensure accurate and reliable documentation of patient care delivered.

III. Other Specified Specialty Care Center Responsibilities:

A. Participate in the EMS Systemwide QI Program

B. Collect and submit requested data to the EMS Agency.

IV. QI Plan Requirements:

Each QI plan shall include a description, at a minimum, of the following components:

A. Organizational Structure

1. Mission statement and/or philosophy of the organization.

2. Goals and objectives.

3. Organizational chart or narrative description of how the QI program is integrated within the organization's EMS Agency QI Program, and State EMS QI Program.

4. Organizational chart or narrative description of how the organization's QI program is integrated with local and State QI programs

B. Methodology, processes and tools used to facilitate the QI Process (i.e., FOCUS-PDSA)

F Find a process to improve
O Organize an effort to work on improvement
C Clarify current knowledge of the process
U Understand process variation and capability
S Select a strategy for further improvement

P Plan a change or test aimed at improvement
D Do – carry out the change or the test
S Study the results, what was learned, what went wrong
A Act – adopt the change, or abandon it, or run through the cycle again

C. Approach to identifying and evaluating QI indicators

D. Data Collection and Reporting

1. All reliable sources of information utilized in the QI plan; including EMS databases, patient care records, checklists, customer input, direct observations, and skills simulation.

2. Flow of information.

3. Methods used to document QI findings.

4. Process used to submit data to the EMS Agency.

E. Training or educational methods that will be used to communicate relevant information among stakeholders.

V. QI Program Requirements:

Each QI Program shall include, at minimum, the following:

A. An approved QI Plan

B. Develop QI indicators that relate to important aspects of care, to include the following:

1. Well-defined description of the important aspect of care being measured.

2. Threshold for compliance.

3. Timeline for tracking indicator once the threshold has been achieved.

4. Data source.

C. Methods for tracking compliance and identifying trends.

D. Written analysis that summarizes the QI findings.

E. Corrective actions utilized to improve processes.

F. Written trending report that includes effectiveness of performance improvement action plans.

G. Education and training specific to findings identified in the QI process.

H. Methods utilized for dissemination of the QI findings to stakeholders.

I. Recognition and acknowledgment of performance improvement.

J. Periodic review or a re-evaluation of a discontinued indicator within a predetermined time frame after achievement of threshold to ensure ongoing compliance.

K. Methods for identifying, tracking, documenting and addressing near miss events.

L. Record Keeping

1. All QI records shall be maintained in accordance with Health Insurance Portability and Accountability Act (HIPAA) regulations.

2. The following records shall be maintained and available for review until the EMS Agency Program Review is concluded:

a. QI meeting minutes and attendance rosters/sign-in sheets.

b. Attendance rosters/sign-in sheets for activities where QI findings and/or actions are discussed.

c. QI indicator(s) data collection tools.

d. Written summaries of the trending/analysis.

e. Documentation of dissemination of QI findings within the organization and to stakeholders.

f. Dates and times of continuing education and skill training based on QI findings.

g. Dates and times of remedial education or skills training, when provided.

h. A tracking tool for monitoring performance excellence, adverse events, near misses or issues regarding non-compliance with current policies and procedures outside of QI activities.

CROSS REFERENCES:

Prehospital Care Manual:
Ref. No. 602, **Confidentiality of Patient Information**
Ref. No. 618, **EMS Quality Improvement Program Committees**

California EMS Authority, Quality Improvement Program Model Guidelines, 2005
Los Angeles County EMS Agency Quality Improvement Plan

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **DATA REQUEST AND LEVELS OF SUPPORT** REFERENCE NO. 622.1

Data Request Tracking Number: (To be completed by the EMS Agency) _____

Complete all requested information below and submit applicable documents. Review Ref. No. 622, Release of EMS Data, prior to completion.

1. Date:
2. Date by which data is requested:
3. Data Recipient (person submitting request)
    a. Name:
    b. Title/Position:
    c. Facility/Agency/Organization/Affiliation:
    d. Mailing Address:
    e. Telephone number:
    f. E-mail address:
4. Indicate preference on how the data should be provided:
    a. ☐ E-Mail
    b. ☐ U.S. Mail
    c. ☐ Phone
    d. ☐ Fax (____) _____-_____
    e. ☐ Other (specify) _____
5. Indicate documents submitted with this request
    a. ☐ Limited Data Set Information (Ref. No. 622.2)
    b. ☐ Intended Use of Limited Data Set Information (Ref. No. 622.3)
    c. ☐ Data Use Agreement (Ref. No. 622.4)
    d. ☐ Confidentiality Agreement (Ref. No. 622.5)

6. Indicate the level(s) of support requested from the EMS Agency (check all that apply):

   a. ☐ Support in concept – letter of support or verbal accord of project

   b. ☐ Guidance – provide feedback on methodology, analysis, manuscript, etc.

   c. ☐ Data Abstraction – provide raw data from EMS Agency data registries

   d. ☐ Data Analysis – provide summary data, statistical analysis, tables, figures, etc.

   e. ☐ Other (this may include manuscript revision, operations/system resources, grant support, etc.) – please describe other support requested

      _____

7. Submit completed data request and applicable documents to:

   Sara Rasnake, Data Systems/Research Programs Manager
   10100 Pioneer Boulevard, Suite 200
   Santa Fe Springs, CA 90670
   Phone: (562) 378-1658
   Fax: (562) 946-6701
   E-Mail: srasnake@dhs.lacounty.gov

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **SUSPECTED CHILD ABUSE/NEGLECT REPORTING GUIDELINES**

EMT-1, PARAMEDIC, MICN
REFERENCE NO. 822

PURPOSE: To provide guidelines and procedures for prehospital care personnel to report suspected child abuse.

AUTHORITY: California Penal Code, Chapter 916, Sections 11164-11174.3
County of Los Angeles Department of Children and Family Services

DEFINITIONS:

Agencies authorized to accept mandated reports: Any police department or sheriff's department, and the Department of Children and Family Services (DCFS) Child Protection Hotline (CPH). School district police and security departments are not authorized to accept reports.

Child: Any person less than eighteen years of age.

Mandated reporter: Any healthcare practitioner, child care custodian, or an employee of a child protective agency. This includes EMTs and paramedics.

Neglect: The negligent treatment or maltreatment of a child by a person responsible for the child's welfare under circumstances indicating harm or threatened harm to the child's health or welfare. The term includes both acts and omissions on the part of the responsible person.

Physical abuse: Physical injury or death inflicted by other than accidental means upon a child by another person.

Sexual abuse: Sexual assault or the exploitation of a minor. Sexual assault includes, but is not limited to, any intrusion by one person into the genitals; anal opening of a child; oral copulation intentional touching for the purposes of sexual arousal or gratification, or masturbation in the presence of a child. Sexual exploitation includes conduct involving matters depicting minors engaged in obscene acts; and/or prostitution.

PRINCIPLES:

1. The purpose of reporting suspected child abuse/neglect is to protect the child, prevent further abuse of the child and other children in the home, and to facilitate treatment for the entire family. The presence of abuse, rather than the degree of that abuse, is the determinant for intervention by DCFS and law enforcement.

2. California Penal Code, Sections 11166 and 11168, require mandated reporters to promptly report all suspected non-accidental injuries, sexual abuse, or neglect of children that they suspect, have knowledge of, or observe in their professional capacity. A verbal report shall be made to DCFS Child Protection Hotline

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Gausche-Hill, MD
Medical Director, EMS Agency

immediately, or as soon as practically possible, and the Suspected Child Abuse Report shall be completed within 36 hours.

In Los Angeles County, it is recommended that a report be made to local law enforcement as well.

3. It is not necessary for the mandated reporter to determine child abuse but only to suspect that it may have occurred. Law enforcement, DCFS and the courts determine whether child abuse/neglect has, in fact, occurred.

4. Current law mandates (CPC 11166) all healthcare professionals to report suspected child abuse/neglect that they know of or observe in their professional capacity. Mandated reporters are required to sign a statement acknowledging their understanding of the law (See Ref. No. 822.3, Sample Employee Acknowledgement as a Mandated Reporter). Any person who fails to report as required may be punished by a fine or imprisonment.

5. When a mandated reporter suspects or has observed child abuse/neglect, that individual is required to report by telephone to local law enforcement and/or to DCFS Child Protection Hotline.

6. When two or more mandated reporters are present at scene and jointly know or suspect an instance of child abuse/neglect, a member of the reporting team may be designated to report on behalf of the team. Any member who knows that the designated reporter failed to uphold their agreement shall thereafter make the report. If paramedics are not selected as the designated reporters, they shall document the name and agency of the designated reporting team member on the EMS Report Form.

7. Persons legally required to report suspected child abuse are immune from criminal or civil liability for reporting as required.

POLICY:

I. Reporting Procedure

A. Notify local law enforcement immediately if a child is suspected to be in imminent danger. Prehospital care providers should be aware of their local law enforcement reporting procedures and telephone numbers for notification.

B. Call the 24-hour Child Protection Hotline at **(800) 540-4000** as soon as possible to make the verbal report. (Refer to 822.1 for reporting options and instructions).

The telephone report shall include the following:

- Name of the person making the report
- Name of the child
- Present location of the child
- Nature and extent of the injury
- Information that led reporting party to suspect child abuse

The reporting party will be provided with a Referral Number (Case Number) that shall to be transcribed onto Form SS8572 in the upper right hand corner under "Case Number"

Within 36 hours:

1. Compete and submit the Suspected Child Abuse Report (SS8572), that is accessible on the DCFS web site at http://dcfs.lacounty.gov

OR

2. Complete a hard copy according to the instructions on the back of the form (Ref. No. 822.2 and 822.2a, SS8572). The completed form must be mailed to local law enforcement and either mailed to DCFS (1933 S. Broadway Avenue, 5th floor, Los Angeles, CA 90007) or faxed (213) 745-1728 or (213) 745-1730

C. Document the following on the EMS Report Form

1. The name of the DCFS social worker and/or name, department and badge number of the law enforcement officer contacted.

2. Time of notification

3. Disposition of the child

CROSS REFERENCES:

Prehospital Care Manual:
Reference No. 822.1, **Guide to Suspected Child Abuse Reporting**
Reference No. 822.2, **Suspected Child Abuse Report Form SS 8572**
Reference No. 822.2a, **Definitions and General Instructions for Completion of Form SS 8572**
Reference No. 822.3, **Sample Employee Acknowledgement as a Mandated Reporter**

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SUBJECT: **GUIDE TO SUSPECTED CHILD ABUSE REPORTING** REFERENCE NO. 822.1

GUIDE TO SUSPECTED CHILD ABUSE REPORTING

1. **NOTIFY** law enforcement **IMMEDIATELY** if the child is suspected to be in imminent danger.

2. **CALL** the 24-hour Child Protection Hotline at **1 (800) 540-4000** as soon as possible to make the verbal report to the **Department of Child and Family Services (DCFS)**.

   - You will be given a **REFERRAL NUMBER,** which is also the Case Number.

3. **COMPLETE** the **Suspected Child Abuse Report** (SCAR) form SS8572 **within 36 hours** and **submit to DCFS** via ONE of the following ways:

   - **Mail: Department of Child and Family Services (DCFS)**
     1933 S. Broadway Avenue, 5th Floor, Los Angeles, CA 90007

   - **Fax: (213) 745-1728 or (213) 745-1730**

   - **Online:**

     1. **dcfs.lacounty.gov**
     2. On the left-hand side, under RESOURCES, click on “For Mandated Reporters Only (Complete your Mandated Report Online)”
     3. Enter the REFERRAL NUMBER and proceed

   Keep a copy for yourself, and a copy to mail to local law enforcement.

4. **MAIL** (or FAX if available) a copy of the completed **Suspected Child Abuse Report** to the jurisdictional law enforcement agency.

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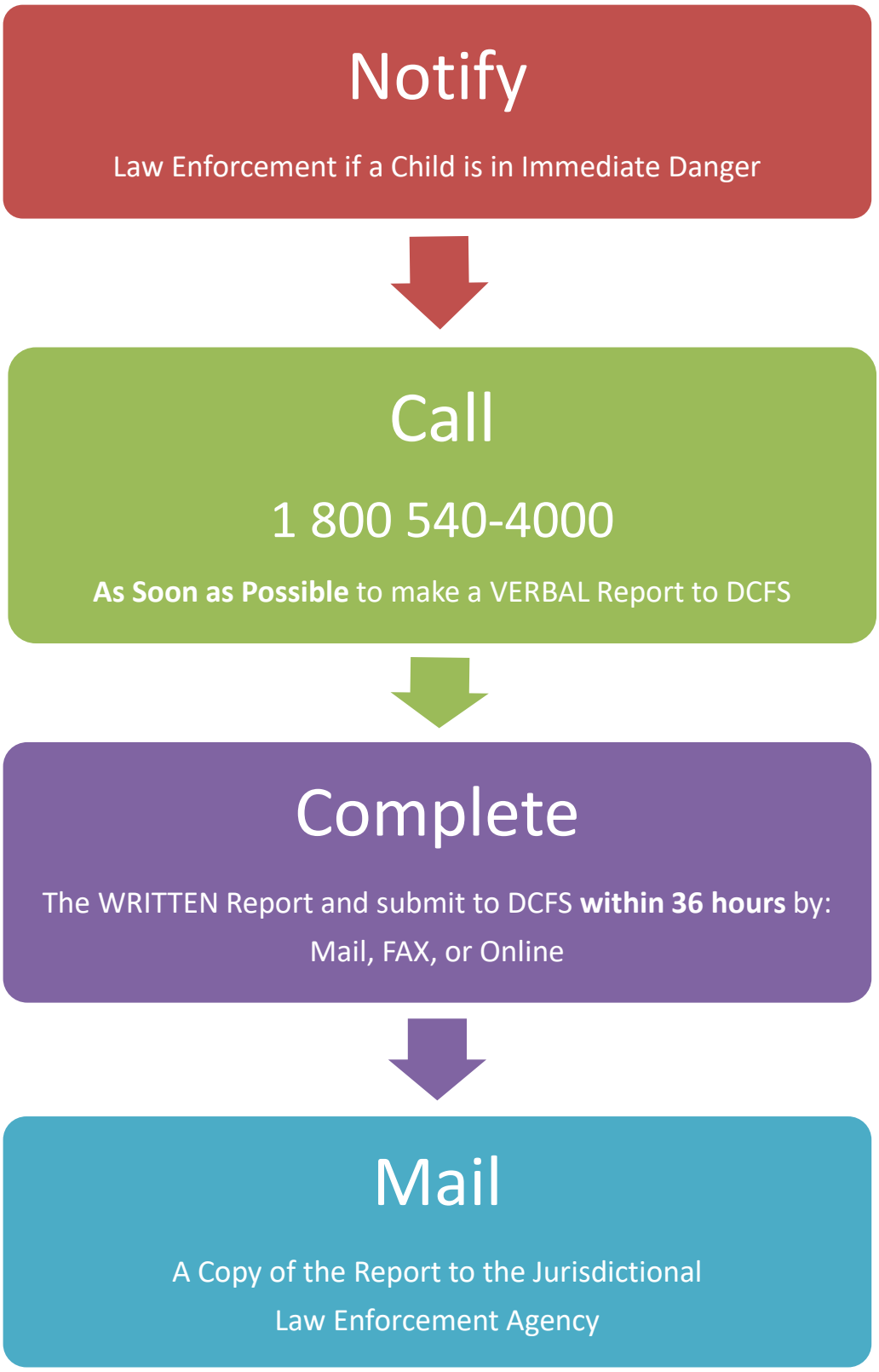
SUBJECT: **GUIDE TO SUSPECTED CHILD ABUSE REPORTING** REFERENCE NO. 822.1



STATE OF CALIFORNIA
BCIA 8572
(Rev. 04/2017)

REFERENCE NO. 822.2

SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

Print Form | Clear Form

To Be Completed by Mandated Child Abuse Reporters
PLEASE PRINT OR TYPE

CASE NAME: _____

CASE NUMBER: _____

A. REPORTING PARTY

NAME OF MANDATED REPORTER	TITLE	MANDATED REPORTER CATEGORY
REPORTER'S BUSINESS/AGENCY NAME AND ADDRESS Street City Zip		DID MANDATED REPORTER WITNESS THE INCIDENT? ☐ YES ☐ NO
REPORTER'S TELEPHONE (DAYTIME)	SIGNATURE	TODAY'S DATE

B. REPORT NOTIFICATION

☐ LAW ENFORCEMENT ☐ COUNTY PROBATION ☐ COUNTY WELFARE / CPS (Child Protective Services)

AGENCY

ADDRESS Street City Zip

DATE/TIME OF PHONE CALL

OFFICIAL CONTACTED - NAME AND TITLE

TELEPHONE

C. VICTIM — One report per victim

NAME (LAST, FIRST, MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE
PRESENT LOCATION OF VICTIM	SCHOOL	CLASS	GRADE
PHYSICALLY DISABLED? ☐ YES ☐ NO	DEVELOPMENTALLY DISABLED? ☐ YES ☐ NO	OTHER DISABILITY (SPECIFY)	PRIMARY LANGUAGE SPOKEN IN HOME

IN FOSTER CARE? ☐ YES ☐ NO

IF VICTIM WAS IN OUT-OF-HOME CARE AT TIME OF INCIDENT, CHECK TYPE OF CARE:
☐ DAY CARE ☐ CHILD CARE CENTER ☐ FOSTER FAMILY HOME
☐ FAMILY FRIEND ☐ GROUP HOME OR INSTITUTION ☐ RELATIVE'S HOME

TYPE OF ABUSE *(CHECK ONE OR MORE)*:
☐ PHYSICAL ☐ MENTAL
☐ SEXUAL ☐ NEGLECT
☐ OTHER (SPECIFY) _____

RELATIONSHIP TO SUSPECT

PHOTOS TAKEN? ☐ YES ☐ NO

DID THE INCIDENT RESULT IN THIS VICTIM'S DEATH? ☐ YES ☐ NO ☐ UNK

D. INVOLVED PARTIES

VICTIM'S SIBLINGS

NAME	BIRTHDATE	SEX	ETHNICITY	NAME	BIRTHDATE	SEX	ETHNICITY
1.				3.			
2.				4.			

VICTIM'S PARENTS/GUARDIANS

NAME (LAST, FIRST. MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE		BUSINESS PHONE
NAME (LAST, FIRST. MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip	HOME PHONE		BUSINESS PHONE

SUSPECT

SUSPECT'S NAME (LAST, FIRST. MIDDLE)	BIRTHDATE OR APPROX. AGE	SEX	ETHNICITY
ADDRESS Street City Zip			TELEPHONE

OTHER RELEVANT INFORMATION

E. INCIDENT INFORMAT

IF NECESSARY, ATTACH EXTRA SHEET(S) OR OTHER FORM(S) AND CHECK THIS BOX ☐ IF MULTIPLE VICTIMS, INDICATE NUMBER: _____

DATE/TIME OF INCIDENT	PLACE OF INCIDENT

NARRATIVE DESCRIPTION (What victim(s) said/what the mandated reporter observed/what person accompanying the victim(s) said/similar or past incident's involving the victim(s) or suspect)

DO NOT submit a copy of this form to the Department of Justice (DOJ). The investigating agency is required under Penal Code section 11169 to submit to DOJ a Child Abuse or Severe Neglect Indexing Form BCIA 8583 if (1) an active investigation was conducted and (2) the incident was determined to be substantiated.

STATE OF CALIFORNIA
BCIA 8572
(Rev. 04/2017)

SUSPECTED CHILD ABUSE REPORT
(Pursuant to Penal Code section 11166)

DEPARTMENT OF JUSTICE

REFERENCE NO. 822.2a

DEFINITIONS AND GENERAL INSTRUCTIONS FOR COMPLETION OF FORM BCIA 8572

All Penal Code (PC) references are located in Article 2.5 of the California PC. This article is known as the Child Abuse and Neglect Reporting Act (CANRA). The provisions of CANRA may be viewed at: http://leginfo.legislature.ca.gov/faces/codes.xhtml (specify "Penal Code" and search for sections 11164-11174.3). A mandated reporter must complete and submit form BCIA 8572 even if some of the requested information is not known. (PC section 11167(a).)

I. MANDATED CHILD ABUSE REPORTERS

Mandated child abuse reporters include all those individuals and entities listed in PC section 11165.7.

II. TO WHOM REPORTS ARE TO BE MADE ("DESIGNATED AGENCIES")

Reports of suspected child abuse or neglect shall be made by mandated reporters to any police department or sheriff's department (not including a school district police or security department), the county probation department (if designated by the county to receive mandated reports), or the county welfare department. (PC section 11165.9.)

III. REPORTING RESPONSIBILITIES

Any mandated reporter who has knowledge of or observes a child, in his or her professional capacity or within the scope of his or her employment, whom he or she knows or reasonably suspects has been the victim of child abuse or neglect shall report such suspected incident of abuse or neglect to a designated agency immediately or as soon as practically possible by telephone and shall prepare and send a written report thereof ***within 36 hours*** of receiving the information concerning the incident. (PC section 11166(a).)

No mandated reporter who reports a suspected incident of child abuse or neglect shall be held civilly or criminally liable for any report required or authorized by CANRA. Any other person reporting a known or suspected incident of child abuse or neglect shall not incur civil or criminal liability as a result of any report authorized by CANRA unless it can be proven the report was false and the person knew it was false or made the report with reckless disregard of its truth or falsity. (PC section 11172(a).)

IV. INSTRUCTIONS

SECTION A – REPORTING PARTY: Enter the mandated reporter's name, title, category (from PC section 11165.7), business/agency name and address, daytime telephone number, and today's date. Check yes/no whether the mandated reporter witnessed the incident. The signature area is for either the mandated reporter or, if the report is telephoned in by the mandated reporter, the person taking the telephoned report.

IV. INSTRUCTIONS (*continued*)

SECTION B – REPORT NOTIFICATION: Complete the name and address of the designated agency notified, the date/time of the phone call, and the name, title, and telephone number of the official contacted.

SECTION C – VICTIM (One Report per Victim): Enter the victim's name, birthdate or approximate age, sex, ethnicity, address, telephone number, present location, and, where applicable, enter the school, class (indicate the teacher's name or room number), and grade. List the primary language spoken in the victim's home. Check the appropriate yes/no box to indicate whether the victim may have a developmental disability or physical disability and specify any other apparent disability. Check the appropriate yes/no box to indicate whether the victim is in foster care, and check the appropriate box to indicate the type of care if the victim was in out-of-home care. Check the appropriate box to indicate the type of abuse. List the victim's relationship to the suspect. Check the appropriate yes/no box to indicate whether photos of the injuries were taken. Check the appropriate box to indicate whether the incident resulted in the victim's death.

SECTION D – INVOLVED PARTIES: Enter the requested information for Victim's Siblings, Victim's Parents/Guardians, and Suspect. Attach extra sheet(s) if needed (provide the requested information for each individual on the attached sheet(s)).

SECTION E – INCIDENT INFORMATION: If multiple victims, indicate the number and submit a form for each victim. Enter date/time and place of the incident. Provide a narrative of the incident. Attach extra sheet(s) if needed.

V. DISTRIBUTION

Reporting Party: After completing form BCIA 8572, retain a copy for your records and submit copies to the designated agency.

Designated Agency: ***Within 36 hours*** of receipt of form BCIA 8572, the initial designated agency will send a copy of the completed form to the district attorney and any additional designated agencies in compliance with PC sections 11166(j) and 11166(k).

ETHNICITY CODES

1 Alaskan Native	6 Caribbean	11 Guamanian	16 Korean	22 Polynesian	27 White-Armenian
2 American Indian	7 Central American	12 Hawaiian	17 Laotian	23 Samoan	28 White-Central American
3 Asian Indian	8 Chinese	13 Hispanic	18 Mexican	24 South American	29 White-European
4 Black	9 Ethiopian	14 Hmong	19 Other Asian	25 Vietnamese	30 White-Middle Eastern
5 Cambodian	10 Filipino	15 Japanese	21 Other Pacific Islander	26 White	31 White-Romanian

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: DIABETIC EMERGENCIES **Ref. No. 1203-P**

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*

2. Administer **Oxygen** prn *(MCG 1302)*

3. Initiate cardiac monitoring prn *(MCG 1308)*

4. Establish vascular access prn *(MCG 1375)*

5. Check blood glucose

6. For blood glucose < 60 mg/dL:
   Oral glucose preparation or **Glucopaste 15gm PO (4 years or older)** if patient awake and alert
   OR
   Dextrose 10% 5mL/kg IV/IO
   ≤24kg: **Dextrose 10% in water, 5mL/kg IV in 1mL/kg** increments dose per *MCG 1309*, reassess for clinical improvement after every 1mL/kg. Administer slow IVP. May repeat as needed, maximum total dose 5mL/kg. Recheck glucose prn after 3mL/kg infused
   >24 kg: **Dextrose 10% in water, administer 125mL IVPB** and reassess, continue infusion as needed with maximum dose of 5mL/kg

   CONTACT BASE for persistent hypoglycemia for repeat dose of Dextrose 10% 5mL/kg IV in 1mL/kg increments

   Document Provider Impression as *Hypoglycemia* ❶ ❷
   If unable to obtain venous access, **Glucagon (1mg/mL) IM** per *MCG 1309*
   <1 year of age: **Glucagon 0.5mL IM**, may repeat x1 in 20 min prn
   ≥1 year of age: **Glucagon 1.0mL IM**, may repeat x1 in 20 min prn

7. For blood glucose > 200 mg/dL:
   Document Provider Impression as *Hyperglycemia* ❸

   For blood glucose >250mg/dL
   Normal Saline 10mL/kg IV rapid infusion per *MCG 1309*

8. For poor perfusion:
   Normal Saline 20mL/kg IV/IO rapid infusion per *MCG 1309*
   For persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*

9. For nausea or vomiting in patients ≥ 4 years old:
   Ondansetron 4mg ODT

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

SPECIAL CONSIDERATIONS

❶ In pediatric patients with hypoglycemia consider causes such as medication error or medication given without appropriate oral intake, infection, or toxins. Survey scene and ask family for types of medications in the home including those in various forms (e.g., pill, patch, drops, salves, inhaled or herbal). Caretakers of pediatric patients should always be encouraged to have patient be transported to the hospital for evaluation as hypoglycemia in this population is rare as compared to adults and is often caused by serious disease or poisonings. Glucagon may not work well in young infants because in these patients there are few glycogen stores, therefore IV dextrose is preferred.

❷ Pediatric patients with hypoglycemia who are successfully treated with oral glucose or Dextrose 10% IV and then their parent wishes to decline transport to the hospital should be discouraged to do so, especially if they have abnormal vital signs, fever, are taking long acting hypoglycemic agents possible ingestion or poisoning, or if they DO NOT have a history of diabetes mellitus as these patients are at high risk for recurrent hypoglycemic episodes.

Long Acting hypoglycemic agents

- Sulfonylureas: gliclazide, glimepiride, glipizide, gliquidone, glyburide, glyclopyramide,
- Thiazolidinediones (TZDs): pioglitazone (Actos), rosiglitazone (Avandia), troglitazone (Rezulin)
- Alpha-glucosidase inhibitors: acarbose, miglitol, voglibose
- Meglitinides – nateglinide, repaglinide
- Combination drugs: glipizide and metformin (Metaglip), glyburide and metformin (Glucovance), pioglitazone and glimepiride (Duetact), pioglitazone and metformin (ACTOplus Met), rosiglitazone and metformin (Avandamet), rosiglitazone and glimepiride (Avandaryl)

❸ Patients with hyperglycemia are at risk for significant volume losses leading to dehydration and electrolyte abnormalities. Fluid resuscitation with **Normal Saline** is recommended until their glucose can be lowered with medications. Hyperglycemia can also be associated with trauma, infection, or other serious illness. For patients with elevated glucose requiring fluids IV Normal Saline should be given – only those patients who show signs of poor perfusion and an IV cannot be obtained would have an IO placed for fluid resuscitation.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: ALLERGY **Ref. No. 1219-P**

Base Hospital Contact: Required for anaphylaxis.

1. Assess airway and initiate basic airway maneuvers *(MCG 1302)*
   Continually assess patient's airway and ventilation status

2. Administer **Oxygen** prn *(MCG 1302)*
   High-flow Oxygen 15L/min for anaphylaxis with poor perfusion or airway compromise

3. Advanced airway prn *(MCG 1302)*

4. Initiate cardiac monitoring prn *(MCG 1308)*

5. For anaphylaxis:
   Epinephrine (1mg/mL) 0.01mg/kg IM, dose per *MCG 1309*, in the lateral thigh ❶
   CONTACT BASE: Repeat **Epinephrine (1mg/mL) 0.01mg/kg IM** every 10 min x2 prn persistent symptoms, maximum total 3 doses

6. Establish vascular access prn *(MCG 1375)*
   Vascular access for all patients with anaphylaxis

7. For poor perfusion:
   Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*

8. For persistent poor perfusion after initial 5mL/kg Normal Saline (anaphylactic shock):
   Continue **Normal Saline 20mL/kg IV rapid infusion**
   Push-dose Epinephrine – mix 9mL Normal Saline with 1mL Epinephrine (0.1mg/mL) IV formulation in a 10mL syringe; administer **Push-dose Epinephrine (0.01mg/mL)**, dose per *MCG 1309* every 1-5 minutes as needed to maintain SBP > 70mmHg until hospital arrival

   CONTACT BASE concurrent with initial dose of **Push-dose Epinephrine**

   Treat in conjunction with *TP 1207-P, Shock/Hypotension*

9. If wheezing: ❷
   < 4 year of age: **Albuterol 2.5mg (3mL) via neb or 2 puffs via MDI** per *MCG 1309* ❸
   ≥ 4 year of age: **Albuterol 5mg (6mL) via neb or 4 puffs via MDI** per *MCG 1309* ❸
   Repeat x2 prn, maximum 3 total doses prior to Base contact

10. For itching/hives:
    Diphenhydramine (50mg/mL) 1mg/kg slow IV push one time, dose per *MCG 1309* ❹
    If unable to obtain venous access, **Diphenhydramine (50mg/mL) 1mg/kg deep IM**, dose per *MCG 1309*

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: ALLERGY **Ref. No. 1219-P**

SPECIAL CONSIDERATIONS

1. Epinephrine is the drug of choice for allergic reactions with any angioedema, respiratory compromise or poor perfusion. It should be given IM into a large muscle group, lateral thigh preferred or alternatively the lateral gluteus. Vital signs vary by age and normal ranges can be found in *MCG 1309*. Any pediatric patient with vital signs outside the normal range for age should be considered potentially ill and transported to an EDAP or PMC if criteria are met.

2. Patients with wheezing due to allergic reaction should be treated with Epinephrine IM. Albuterol may be administered in addition to Epinephrine IM if wheezing persists.

3. Consider blow-by to avoid agitation in pediatric patients if a mask cannot be tolerated (e.g., infants and toddlers).

4. Diphenhydramine does not treat anaphylaxis. For patients in anaphylaxis, Epinephrine administration is the first priority. Diphenhydramine may be considered once other treatments are complete or in stable patients with discomfort for isolated hives.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: SUBMERSION **Ref. No. 1225-P**

Base Hospital Contact: Required for ALOC and decompression emergencies *(Ref. 518)*.

1. Assess airway and initiate basic and/or advanced airway maneuvers prn *(MCG 1302)*
2. For cardiac arrest, treat per *TP 1210-P, Cardiac Arrest* ❶
3. Administer **Oxygen** prn *(MCG 1302)*
   For suspected decompression illness ❷, provide **high-flow Oxygen 15L/min** and **CONTACT BASE**
4. Maintain supine if suspected decompression illness
5. Advanced airway prn *(MCG 1302)*
6. Initiate cardiac monitoring *(MCG 1308)*
7. Provide warming measures ❸ ❹
8. Establish vascular access prn *(MCG 1375)*
9. For altered level of consciousness, treat in conjunction with *TP 1229-P, Altered Level of Consciousness (ALOC)*
10. For respiratory distress, treat in conjunction with *TP 1237-P, Respiratory Distress* ❺
11. For poor perfusion or for suspected decompression illness:
    Normal Saline 20mL/kg IV rapid infusion per *MCG 1309*; use warm saline if available ❺
    For persistent poor perfusion, treat in conjunction with *TP 1207-P, Shock/Hypotension*
12. Contact **Public Health 213-989-7140** for all submersion incidents involving pools or spas after transfer of patient care in the emergency department or upon termination of resuscitation in the field. ❻

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

Treatment Protocol: SUBMERSION **Ref. No. 1225-P**

SPECIAL CONSIDERATIONS

❶ Cardiac arrest from drowning should be treated per *TP 1210-P, Cardiac Arrest*. Ventilation is particularly important as the cardiac arrest is almost always due to respiratory failure. In cases of cold water drowning follow usual protocols for resuscitation while simultaneously rewarming the patient. Patients with hypothermia due to cold water drowning, may have good neurologic outcome despite prolonged resuscitation; resuscitative efforts should continue until the patient is rewarmed. Consultation with the Base Physician is required before consideration of termination of resuscitation in patients with suspected hypothermia.

❷ Decompression illness includes arterial gas embolism from barotrauma and decompression sickness (aka “the bends”) due to dissolved nitrogen in the blood coming out of solution. Decompression illness most frequently occurs in scuba divers after breathing compressed air at depth. While arterial gas embolism presents almost immediately after ascent, decompression sickness is often delayed and should be considered in any patient with symptoms (e.g. respiratory distress, ALOC, chest or body pain) within 24 hours of completing a dive. All patients with possible decompression illness need immediate evaluation for possible hyperbaric treatment. Per *Ref. 518*, contact Base immediately to discuss.

❸ Warming measures should include moving the patient to a warm environment as quickly as possible, removing wet clothing/items, covering with an emergency/rescue blanket or other blankets/sheets, and using warm Normal Saline if available.

❹ Infants and small children are at high risk for hypothermia due to their large surface area to body mass ratio, reduced ability to shiver, and limited body fat.

❺ Rales may be present in patients after submersion/drowning due to direct lung injury and/or aspiration of water. This is not an indication of cardiogenic pulmonary edema (such as from congestive heart failure), which is extremely rare in children, and does not prohibit administration of IV fluids. IV fluids should be initiated and continued unless respiratory status worsens during administration.

❻ EMS is assisting the Department of Public Health (DPH) in promptly investigating fatal or nonfatal drownings at public pools or spas in order to ensure safety can be verified before reopening. Contacting the on-call DPH officer will allow timely investigation of these incidents and prevent future incidents.

A map of our current Trauma Centers is included for reference (Attachment A)

Changes since the previous plan was submitted and approved include:

- List of Designated Trauma Centers and Agreement Expiration Dates (Attachment B)
- Reference No. 814, Determination/Pronouncement of Death in the Field – Revised 04-01-2022 (Attachment C)

Trauma Center Data Dictionary – The Trauma Center Data Dictionary (TDD) is updated annually to ensure continued compliance with the minimum data set and definitions of NTDS™ and ACS TQIP®. Due to its size, Reference No. 646, Trauma Center Data Dictionary 2022, is not included but is available upon request or on our Los Angeles County EMS Agency website. The Trauma Center Data Dictionary Summary of Changes 2022 is attached detailing the changes made. (Attachment D)

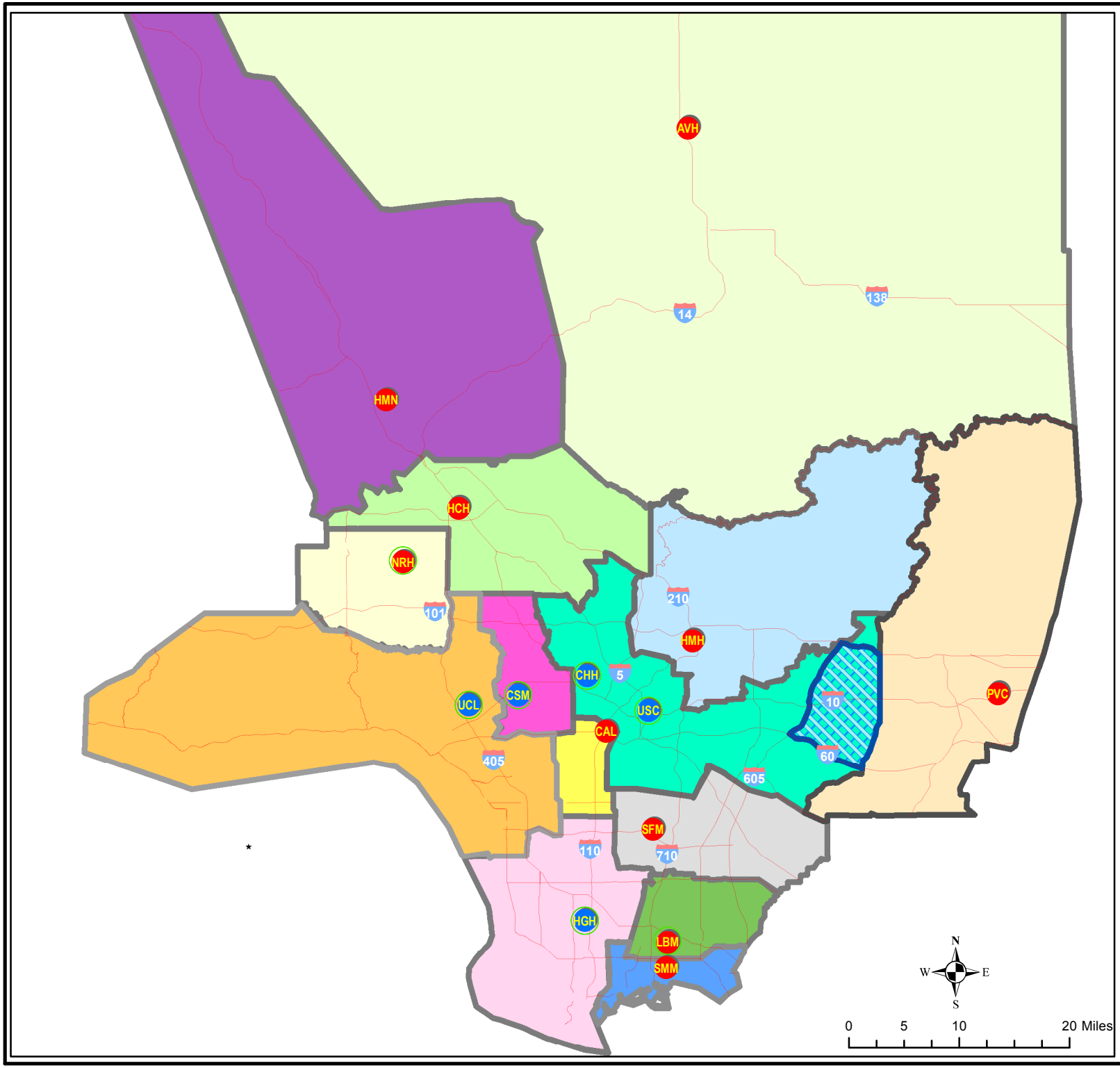
EMS Update and EmergiPress Topics included:

- Managing Epitaxis
- Diabetic Keto Acidosis
- Childbirth Emergency
- Managing a Mechanical Circulatory Support Devise Patient
- Traumatic Out of Hospital Cardiac Arrest
- Adult and Pediatric Out of Hospital Cardiac Arrest
- Neonatal Resuscitation
- Patient Refusal of Treatment and Transport, and Treat and Release at the Scence
- Needle thoracostomy update
    - Complications of needle thoracostomy
    - Locations approved for needle thoracostomy in Los Angeles County
    - Indications for needle thoracostomy
    - Needle thoracostomy placement considerations in children
- Mass casualty incidents
    - START and JumpSTART triage

Los Angeles County utilizes Trauma Quality Improvement Program (TQIP) and our collaborative reports as the basis for our QI program. The Trauma QI Subcommittee meets quarterly to review TQIP reports and evaluate the need for system-wide QI indicators. Additionally, there are quarterly regional QI meetings where case reviews are presented and discussed.

Attachment 4-A

Los Angeles County Trauma Centers



Trauma Centers As of 2017

Code	Name
AVH	Antelope Valley Hospital
CAL	California Hospital Medical Center
CHH	Children's Hospital Los Angeles
CSM	Cedars Sinai Medical Center
HCH	Providence Holy Cross Medical Center
HGH	LAC Harbor-UCLA Medical Center
HMH	Huntington Hospital
HMN	Henry Mayo Newhall Hospital
LBM	Long Beach Memorial Medical Center
NRH	Northridge Hospital Medical Center
PVC	Pomona Valley Hospital Medical Center
SFM	Saint Francis Medical Center
SMM	Saint Mary Medical Center
UCL	Ronald Reagan UCLA Medical Center
USC	LAC+USC Medical Center

TRAUMA012017

Trauma Centers

- LEVEL I/PTC
- LEVEL II
- LEVEL II/PTC
- PVC_USC_shared

TraumaAll_82417

List of Designated Trauma Centers as of June 30, 2021

TRAUMA CENTER	LEVEL	PTC	FISCAL YEAR FOR NEXT REVIEW
Antelope Valley Hospital	II		August 24, 2024
Cedars-Sinai Medical Center	I	X	July 2, 2022
Children's Hospital Los Angeles	I	X	June 11, 2023
Dignity Health – California Hospital Medical Center	II		May 16, 2024
Dignity Health – Northridge Hospital Medical Center	II	X	June 24, 2022
Dignity Health – Saint Mary Medical Center	II		November 9, 2023
LAC Harbor UCLA Medical Center	I	X	November 9, 2023
LAC+USC Medical Center	I	X	July 1, 2022
Henry Mayo Newhall Hospital	II		June 4, 2022
Huntington Hospital	II		November 9, 2021
MemorialCare Long Beach Medical Center	II	X	November 8, 2021
Pomona Valley Hospital	II		September 5, 2022
Providence Holy Cross Medical Center	II		May 15, 2024
Saint Francis Medical Center	II		November 20, 2022
Ronald Reagan UCLA Medical Center	I	X	June 12, 2023

In response to the COVID-19 pandemic, all ACS verified centers were granted an extension of one year for centers with an expiration date falling between January 2020 and December 2023. At the time the extension was granted all LA County Trauma Centers were verified except for SMM.

DEPARTMENT OF HEALTH SERVICES
COUNTY OF LOS ANGELES

(EMT/ PARAMEDIC/MICN)

SUBJECT: **DETERMINATION / PRONOUNCEMENT OF DEATH IN THE FIELD**

REFERENCE NO. 814

PURPOSE: This policy is intended to provide EMS personnel with parameters to determine whether or not to withhold resuscitative efforts in accordance with the patient's wishes, and to provide guidelines for base hospital physicians to discontinue resuscitative efforts and pronounce death.

AUTHORITY: California Health and Safety Code, Division 2.5
California Probate Code, Division 4.7
California Family Code, Section 297-297.5
California Health and Safety Code, Division 1, Part 1.8, Section 443 et seq.

DEFINITIONS:

Advance Health Care Directive (AHCD): A written document that allows patients who are unable to speak for themselves to provide health care instructions and/or appoint a Power-of-Attorney for Health Care. There is no one standard format for an AHCD. Examples of AHCDs include:

- Durable power of attorney for Healthcare (DPAHC)
- Healthcare proxies
- Living wills (valid in California if dated prior to 7-1-2000; advisory but not legally binding after that date)

Agent: An individual, eighteen years of age or older, designated in a durable power of attorney for health care to make health care decisions for the patient, also known as "attorney-in-fact".

Aid-in-Dying Drug: A drug determined and prescribed by a physician for a qualified individual, which the qualified individual may choose to self-administer to bring about his or her death due to terminal illness. The prescribed drug may take effect within minutes to several days after self-administration.

Conservator: Court-appointed authority to make health care decisions for a patient.

Determination of Death: To conclude that a patient has died by conducting an assessment to confirm the absence of respiratory, cardiac, and neurologic function.

End of Life Option Act: This California state law authorizes an adult, eighteen years or older, who meets certain qualifications, and who has been determined by his or her attending physician to be suffering from a terminal disease to make a request for an "aid-in-dying drug" prescribed for the purpose of ending his or her life in a humane and dignified manner.

Immediate Family: The spouse, domestic partner, parent, adult children, adult sibling(s), or family member intimately involved in the care of the patient.

APPROVED: Richard Tadeo
Director, EMS Agency

Marianne Pouchot Hillmon
Medical Director, EMS Agency

Organized ECG Activity: A sinus, atrial or junctional (supraventricular) rhythm.

Pronouncement of Death: A formal declaration by a base hospital physician that life has ceased.

Standardized Patient-Designated Directives: Forms or medallions that recognize and accommodate a patient's wish to limit prehospital treatment at home, in long term care facilities, or during transport between facilities. Examples include:

- Statewide Emergency Medical Services Authority (EMSA)/California Medical Association (CMA) Prehospital DNR Form (Ref. No. 815.1)
- Physician Orders for Life-Sustaining Treatment (POLST, Ref. No. 815.2)
- State EMS Authority-approved DNR Medallion

PRINCIPLES:

1. Resuscitative efforts are of no benefit to patients whose physical condition precludes any possibility of successful resuscitation.

2. EMTs and paramedics may **determine** death based on specific criteria set forth in this policy.

3. Base hospital physicians may **pronounce** death based on information provided by the paramedics in the field and guidelines set forth in this policy.

4. If there is any objection or disagreement by family members or EMS personnel regarding terminating or withholding resuscitation, basic life support (BLS) resuscitation, including defibrillation, may continue or begin immediately and paramedics should contact the base hospital for further directions.

5. Aggressive resuscitation in the field to obtain the return of spontaneous circulation (ROSC) is encouraged. Transporting patients without ROSC is discouraged.

6. EMS personnel should honor valid do-not-resuscitate (DNR) orders and other patient designated end-of-life directives in the field and act in accordance with the patient's wishes when death appears imminent.

POLICY:

I. EMS personnel may determine death in the following circumstances:

   A. In addition to the absence of respiration, cardiac activity, and neurologic reflexes, one or more of the following physical or circumstantial conditions exist:

      1. Decapitation

      2. Massive crush injury

      3. Penetrating or blunt injury with evisceration of the heart, lung or brain

4. Decomposition

5. Incineration

6. Pulseless, non-breathing victims with extrication time greater than fifteen minutes, where no resuscitative measures can be performed prior to extrication.

7. Penetrating trauma patients who, based on the paramedic's thorough assessment, are found apneic, pulseless, asystolic, and without pupillary reflexes upon the arrival of EMS personnel at the scene.

8. Blunt trauma patients who, based on a paramedic's thorough patient assessment, are found apneic, pulseless, and without organized ECG activity (sinus, atrial or junctional rhythm) due to traumatic mechanism upon the arrival of EMS personnel at the scene.

    a. For patients with shockable ventricular rhythm, defibrillate as per TP 1243/1243-P in attempt to restore organized ECG activity prior to determination of death.

9. Pulseless, non-breathing victims of a multiple victim incident where insufficient medical resources preclude initiating resuscitative measures.

10. Drowning victims, when it is reasonably determined that submersion has been greater than one hour.

11. Rigor mortis (requires assessment as described in Section I, B.)

12. Post-mortem lividity (requires assessment as described in Section I, B.)

B. If the initial assessment reveals rigor mortis and/or post-mortem lividity only, EMTs and/or paramedics shall perform the following assessments (may be performed concurrently) to confirm the absence of respiratory, cardiac, and neurologic function for determination of death in the field:

1. Assessment of respiratory status:

    a. Assure that the patient has an open airway.

    b. Look, listen and feel for respirations. Auscultate the lungs for a minimum of 30 seconds to confirm apnea.

2. Assessment of cardiac status:

    a. Auscultate the apical pulse for a minimum of 60 seconds to confirm the absence of heart sounds.

    b. Adults and children: Palpate the carotid pulse for a minimum of 60 seconds to confirm the absence of a pulse.

c. Infants: Palpate the brachial pulse for a minimum of 60 seconds to confirm the absence of a pulse.

3. Assessment of neurological reflexes:

a. Check for pupillary response with a penlight or flashlight to determine if pupils are fixed and dilated.

b. Check and confirm unresponsive to pain stimuli.

C. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I. A. require immediate BLS measures to be initiated. If one or more of the following conditions is met, resuscitation may be discontinued and the patient is determined to be dead:

1. A valid standardized patient-designated directive indicating DNR.

2. A valid AHCD with written DNR instructions or the agent identified in the AHCD requesting no resuscitation.

3. Immediate family member present at scene:

a. With a patient-designated directive on scene requesting no resuscitation

b. Without said documents at scene, with full agreement of immediate family requesting no resuscitation, and EMS providers concur

4. Parent or legal guardian is required and must be present at scene to withhold or terminate resuscitation for patients less than 18 years of age.

II. Patients in atraumatic cardiopulmonary arrest who do not meet the conditions described in Section I require immediate cardiopulmonary resuscitation in accordance with Ref. No. 1210, Treatment Protocol: Cardiac Arrest. Base contact for medical direction shall be established when indicated by Ref. No. 1210.

A. EMS Personnel may determine death if a patient is in **asystole** after 20 minutes of quality cardiopulmonary resuscitation on scene and meets ALL of the following criteria:

1. Patient 18 years or greater

2. Arrest not witnessed by EMS personnel

3. No shockable rhythm identified at any time during the resuscitation

4. No ROSC at any time during the resuscitation

5. No hypothermia

B. Base Physician consultation for pronouncement is not required if Section A is

met.

C. Base Physician contact shall be established to guide resuscitation and to make decisions regarding timing of transport, if transport is indicated, for all patients in cardiopulmonary arrest who do not meet the conditions described in Section I or IIA of this policy.

D. In the event that immediate family members on scene request termination of resuscitation after resuscitation is in progress, and the patient does not meet criteria in section IIA, base physician consultation shall be made for termination and pronouncement. This does not apply to brief initiation of CPR while establishing patient/family wishes as per I.C.3.

III. Physician guidelines for transport versus termination

A. Resuscitation should be continued on-scene until one of the following:

1. ROSC is confirmed with a palpable pulse and corresponding rise in $EtCO_2$ Paramedics should stabilize the patient on scene after ROSC (for approximately 5 minutes) per TP 1210 and initiate transport once ROSC is maintained.

2. Base physician determines further resuscitative efforts are futile

B. Patients who have NOT maintained ROSC after on-scene resuscitation and stabilization should NOT be transported unless the Base physician determines transport is indicated.

1. Early transport for patients with ongoing resuscitation is NOT advised.

2. The decision to transport a patient with refractory OHCA should be based on the availability of therapies at the receiving center that are not available on scene.

IV. Crime Scene Responsibility, Including Presumed Accidental Deaths and Suspected Suicides

A. Responsibility for medical management rests with the most medically qualified person on scene.

B. Authority for crime scene management shall be vested in law enforcement. To access the patient, it may be necessary to ask law enforcement officers for assistance to create a “safe path” that minimizes scene contamination.

C. If law enforcement is not on scene, EMS personnel should attempt to create a "safe path" and secure the scene until law enforcement arrives.

V. Procedures Following Pronouncement of Death

A. The deceased should not be moved without the coroner’s authorization. Any invasive equipment (i.e., intravenous line, endotracheal tube) used on the patient

should be left in place.

NOTE: If it is necessary to move the deceased because the scene is unsafe, the body is creating a hazard, or the body is at risk of loss through fire or flood, the EMS personnel may relocate the deceased to a safer location, or transport to the most accessible receiving facility.

B. If law enforcement or the coroner confirms that the deceased will not be a coroner's case and the personal physician is going to sign the death certificate, any invasive equipment used during the resuscitation may be removed.

C. EMS personnel should remain on scene until law enforcement arrives. During this time, when appropriate, the provider should provide grief support to family members.

VI. Required Documentation for Patients Determined Dead/Pronounced in the Field

A. The time and criteria utilized to determine death; the condition, location and position of the body, and any care provided.

B. The location and the rationale if the deceased was moved. If the coroner authorized movement of the deceased, document the coroner's case number (if available) and the coroner's representative who authorized the movement.

C. Time of pronouncement and name of the pronouncing physician if base hospital contact was initiated

D. The name of the agent identified in the AHCD or patient-designated directive or the name of the immediate family member who made the decision to withhold or withdraw resuscitative measures. Obtain their signature on the EMS Report Form.

E. If the deceased is **not** a coroner's case and their personal physician is going to sign the death certificate:

1. Document the name of the coroner's representative who authorized release of the patient, and

2. The name of the patient's personal physician signing the death certificate, and

3. Any invasive equipment removed

VII. End of Life Option Act

A. Resuscitation shall be withheld on patients in cardiopulmonary arrest who have self-administered an aid-in-dying drug (see Ref. No. 815.4, End of Life Option Field Quick Reference Guide).

B. Document the presence of a Final Attestation and attach a copy if available.

SUBJECT: **DETERMINATION / PRONOUNCEMENT OF DEATH IN THE FIELD**

REFERENCE NO. 814

CROSS REFERENCE:

Prehospital Care Manual:
Ref. No. 516, **Cardiac Arrest (Non-Traumatic) Patient Destination**
Ref. No. 518, **Decompression Emergencies/Patient Destination**
Ref. No. 519, **Management of Multiple Casualty Incidents**
Ref. No. 606, **Documentation of Prehospital Care**
Ref. No. 815, **Honoring Prehospital Do Not Resuscitate Orders**
Ref. No. 815.1, **EMSA/CMA Prehospital Do Not Resuscitate (DNR) Form**
Ref. No. 815.2, **Physician Orders for Life-Sustaining Treatment (POLST) Form**
Ref. No. 815.3, **Sample - Final Attestation For An Aid-In-Dying Drug to End My Life in a Humane and Dignified Manner**
Ref. No. 815.4, **End of Life Option Field Quick Reference Guide**
Ref. No. 819, **Organ Donor Identification**

County of Los Angeles • Department of Health Services
Emergency Medical Services Agency

Trauma Hospital Advisory Committee

TRAUMA DATA SUBCOMMITTEE

SUMMARY OF CHANGES 2022

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td colspan="2">GENERAL INFORMATION</td></tr>
<tr><td>TRANSFERRED FROM</td><td>Added the following FIELD VALUES in the DD and TO:
• LBC Community Hospital Long Beach

Deleted the following FIELD VALUE in the DD and TO for TRANSFERRED FROM:
• ~~MID- Olympia Medical Center~~</td></tr>
<tr><td colspan="2">PREHOSPITAL</td></tr>
<tr><td>PROVIDER</td><td>Revised the following FIELD VALUE in the DD and TO:
• FC ~~First Care~~ First Rescue Ambulance</td></tr>
<tr><td colspan="2">EMERGENCY DEPARTMENT</td></tr>
<tr><td>NEXT PHASE AFTER ED</td><td>Added the following FIELD VALUE in the DD:
<table>
<tr><td colspan="2">LA COUNTY</td><td colspan="2">NTDS</td></tr>
<tr><td colspan="2">Next Phase After ED</td><td colspan="2">ED Discharge Disposition</td></tr>
<tr><td>ORR</td><td>Operating Room Recovery</td><td>7</td><td>Operating Room</td></tr>
</table></td></tr>
<tr><td colspan="2">RADIOLOGY / LABORATORY</td></tr>
<tr><td>ORGANS INJURED</td><td>ADDED the following FIELD VALUE in the DD and TO:
PANCREAS</td></tr>
<tr><td>ORGAN GRADE – Liver</td><td>ADDED the following to Additional Information:
• ORGAN GRADE – Pancreas</td></tr>
<tr><td>ORGAN GRADE – Spleen</td><td>ADDED the following to Additional Information:
• ORGAN GRADE – Pancreas</td></tr>
<tr><td>ORGAN GRADE – Kidney</td><td>ADDED the following to Additional Information:
• ORGAN GRADE – Pancreas</td></tr>
</table>

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>ORGAN GRADE - Pancreas</td><td>
ADDED the following FIELD in the DD and TO:
Definition
Results of solid organ grading of the pancreas, if applicable.

Field Values

<table>
<tr><th colspan="3">LA COUNTY</th></tr>
<tr><td rowspan="2">Grade I</td><td>Hematoma</td><td>Minor contusion without ductal injury</td></tr>
<tr><td>Laceration</td><td>Superficial laceration without ductal injury</td></tr>
<tr><td rowspan="2">Grade II</td><td>Hematoma</td><td>Major contusion without ductal injury or tissue loss</td></tr>
<tr><td>Laceration</td><td>Major laceration without ductal injury or tissue loss</td></tr>
<tr><td>Grade III</td><td>Laceration</td><td>Distal transection or pancreatic parenchymal injury with ductal injury</td></tr>
<tr><td>Grade IV</td><td>Laceration</td><td>Proximal transection or pancreatic parenchymal injury involving the ampulla</td></tr>
<tr><td>Grade V</td><td>Laceration</td><td>Massive disruption of the pancreatic head</td></tr>
</table>
Uses
• Assists with determination of appropriate treatment.
• Provides documentation of assessment and/or care.
• System evaluation and monitoring.

Data Source Hierarchy
• Radiology Records
• ED Records

Other Associated Elements
• RADIOLOGY: Body Part/ICD-10
• RADIOLOGY: Study
• RADIOLOGY: Date
• RADIOLOGY: Time
• RADIOLOGY: Result
• RADIOLOGY: Description
• SOLID ORGAN INJURY?
• ORGANS INJURED
• ORGAN GRADE – Liver
• ORGAN GRADE - Spleen
• ORGAN GRADE – Kidney
</td></tr>
<tr><td>WHOLE BLOOD (4 HOURS)</td><td>
Added the following bullet to the Additional Information:
• EXCLUDE: Cell Saver Blood
</td></tr>
</table>

DATA ELEMENT	ISSUE / CONCERN / ACTION
PACKED CELLS (PRBC) (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE**: Cell Saver Blood
PLASMA (FFP) (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLATELETS (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
CRYOPRECIPITATE (4 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
WHOLE BLOOD (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PACKED CELLS (PRBC) (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLASMA (FFP) (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLATELETS (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
CRYOPRECIPITATE (24 HOURS)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
WHOLE BLOOD (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PACKED CELLS (PRBC) (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLASMA (FFP) (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PLATELETS (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
CRYOPRECIPITATE (TOTAL)	**Added** the following bullet to the Additional Information: • **EXCLUDE:** Cell Saver Blood
PROCEDURES / OPERATIONS	
ICU / ACUTE CARE	

<table>
<tr><th>DATA ELEMENT</th><th>ISSUE / CONCERN / ACTION</th></tr>
<tr><td>VTE PROPHLAXIS TYPE</td><td>Added the following bullet to the Additional Information in the DD:
If patient refuses prophylaxis utilize “None”</td></tr>
<tr><td colspan="2">POSTHOSPITAL</td></tr>
<tr><td>PHASE PRIOR TO DISCHARGE</td><td>Added the following FIELD VALUE in the DD:
ORR: Operating Room Recovery</td></tr>
<tr><td>FACILITY NAME</td><td>Added the following FIELD VALUES in the DD and TO:
LBC Community Hospital Long Beach
Deleted the following FIELD VALUE in the DD and TO:
~~MID- Olympia Medical Center~~</td></tr>
<tr><td colspan="2">UNPLANNED READMISSION</td></tr>
<tr><td>READMIT TRANSFER TO</td><td>Added the following FIELD VALUES in the DD and TO:
LBC Community Hospital Long Beach
Deleted the following FIELD VALUE in the DD and TO:
~~MID- Olympia Medical Center~~</td></tr>
<tr><td colspan="2">APPENDIX 1: REFERENCE DOCUMENTS</td></tr>
<tr><td>NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA</td><td>Replaced the NATIONAL TRAUMA DATA STANDARD INCLUSION CRITERIA in the DD with the version from the NTDS Data Dictionary for 2022.</td></tr>
<tr><td>TRANSPORTATION MECHANISMS FO INJURIES QUICK REFERENCE GUIDE</td><td>Revised the following:<table><tr><td>STRUCK BY
a moving transport, and
NOT in an enclosed vehicle</td><td>Force is equal to or less than 20mph</td></tr><tr><td>OPERATING
any transport</td><td>Transport is unenclosed, and force is EQUAL to or LESS than 20mph</td></tr></table></td></tr>
<tr><td colspan="2">APPENDIX 2: REFERENCE GUIDES</td></tr>
<tr><td colspan="2">Appendix will be deleted.</td></tr>
<tr><td colspan="2">APPENDIX 3: GLOSSARY OF TERMS</td></tr>
<tr><td colspan="2">CO-MORBID (PRE-EXISTING) CONDITIONS</td></tr>
<tr><td>Advanced Directive (limiting care)</td><td>Revised the definition:
The patient had a ~~Do-Not-Resuscitate (DNR) document or similar advance directive recorded~~ written request, signed/dated by the patient and/or his/her designee, to limit life-sustaining treatment that restricted the care for the patient during this patient care event prior to arrival at your center.</td></tr>
</table>

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	Life-sustaining treatments include but are not limited to intubation, ventilator support, CPR, transfusion of blood products, dialysis or other forms of renal support, institution of medications to support blood pressure or cardiac function, or a specific surgical, interventional or radiological procedure (e.g., decompressive craniectomy, operation for hemorrhage control, angiography).
Angina (Pectoris):	**Revised** the definition: Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of ~~Angina or Chest Pain~~ angina including microvascular angina, Prinzmetal's angina, stable angina, unstable angina, and variant angina, consistent with American Heart Association (AHA), May 2015, must be documented in the patient's medical record.
Congenital Anomalies	**Revised** the definition to include the following: Only report on patients ≤ 18 years-of -age.
Disseminated Cancer	**Revised** the definition: Patients who have cancer that: • Has spread to one site or more sites in addition to the primary site **AND** • In ~~whom~~ the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. ~~Other~~ Another term~~s~~ describing disseminated cancer is metastatic. ~~include "diffuse," "widely metastatic," "widespread," or "carcinomatosis." Common sites of metastases include major organs (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, or bone).~~
Hypertension	**Revised** the definition: History of persistent elevated blood pressure requiring antihypertensive medication.~~medical therapy,~~ present prior to injury, even if non-compliant with their prescribed antihypertensive medication. A diagnosis of Hypertension must be documented in the patient's medical record.
Prematurity	**Revised** the definition to include the following: Only report on patients ≤ 18 years-of -age.
Steroid Use	**Revised** the definition: ~~Patients that required the~~ Regular administration of oral or parenteral corticosteroid medications (e.g., Prednisone, Decadron) in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

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HOSPITAL *(EVENTS)* COMPLICATIONS	
Acute Kidney Injury (dialysis):	**Revised** the definition: A diagnosis of AKI must be documented in the patient's medical record, that is consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline and onset of symptoms began after arrival to your ED/hospital.
Acute Respiratory Distress Syndrome (ARDS)	**Revised** the definition: A diagnosis of ARDS must be documented in the patient's medical record, that is consistent with the 2012 New Berlin Definition and onset of symptoms began after arrival to your ED/hospital.
Alcohol Withdrawal (Syndrome)	**Revised** the definition: Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). ~~Must have occurred during the patient's initial stay at your hospital~~ Onset of symptoms began after arrival to your ED/hospital, and documentation of alcohol withdrawal must be in the patient's medical record, that is consistent with the 2019 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome.
Cardiac Arrest with CPR	**Revised** the definition: INCLUDE patients who, after arrival at your ED/hospital, have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.
Central Line-Associated Bloodstream Infection (CLABSI)	**Revised** the definition: A diagnosis of CLABSI must be documented in the patient's medical record, that is consistent with the January 2016 CDC defined CLABSI and onset of symptoms began after arrival to your ED/hospital. Criterion 1: Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST). **AND** Organism cultured from blood is not related to an infection at another site **OR** Criterion 2:
Cerebral Vascular Accident (CVA)/Stroke	**Revised** the definition: A focal or global neurological deficit of rapid onset and ~~NOT present on admission~~ onset of symptoms began after arrival to your ED/hospital.

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Decubitus (Pressure) Ulcer	**Revised** the definition: A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury. Documentation of Pressure Ulcer must be in the patient's medical record, consistent with the NPUAP 2014, and ~~must have occurred during the patient's initial stay at your~~ onset of symptoms began after arrival to your ED/hospital.
Deep Vein Thrombosis (DVT)/Thrombophlebitis	**Revised** the definition to include the following: Onset of symptoms began after arrival to your ED/hospital.
Delirium	**Revised** the definition: Acute onset of behaviors ~~occurring during the patient's initial hospital stay at your~~ with an onset after arrival to your ED/hospital characterized by restlessness, illusions, and incoherence of thought and speech. Delirium can often be traced to one or more contributing factors, such as a severe or chronic medical illness, changes in your metabolic balance (such as low sodium), medication, infection, surgery, or alcohol or drug withdrawal.
Myocardial Infarction (MI)	**Revised** the definition: An acute myocardial infarction must be noted with documentation of ECG changes indicative of acute MI with onset of symptoms beginning after arrival to your ED/hospital
Osteomyelitis	**Revised** the definition: • A diagnosis of osteomyelitis must be documented in the patient's medical record, that is consistent with the January 2020 ~~2016~~ CDC definition of Bone and Joint Infection and onset of symptoms began after arrival to your ED/hospital.
Pulmonary Embolism (PE)	**Revised** the definition to include the following: Onset of symptoms began after arrival to your ED/hospital.
Sepsis/Severe Sepsis	**Revised** the definition: Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs. Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation. A diagnosis of Sepsis must be documented in the patient's medical record, consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010, and ~~must have occurred during the patient's initial stay at your~~ onset of symptoms began after arrival to your ED/hospital.
Surgical Site Infection (SSI) (superficial)	**Revised** the definition: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, onset of symptoms began after arrival to your ED/hospital, and meet the following criteria:

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Surgical Site Infection (deep)	**Revised** the definition: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CSC defined SSI, and ~~must have occurred during the patient's initial stay at~~ onset of symptoms began after arrival to your ED/hospital.
Surgical Site Infection (organ/space)	**Revised** the definition: A diagnosis of SSI must be documented in the patient's medical record, consistent with the January 2019 CDC defined SSI, and ~~must have occurred during the patient's initial stay at~~ onset of symptoms began after arrival to your ED/hospital.
Unplanned Return (admission) to the ICU	**Revised** the definition: EXCLUDE patients ~~in which the ICU care is required postoperatively for a planned surgical procedure~~ with a planned ICU stay post-operative. INCLUDE patients who required ICU care due to an event that occurred during surgery or in the PACU.
Unplanned Visit to the OR	**Revised** the definition: EXCLUDE non-urgent tracheostomy and percutaneous endoscopic gastrostomy; pre-planned, staged and/or procedures for incidental findings; and operative management related to a procedure that was initially performed prior to arrival at your center.
Urinary Tract Infection Catheter-Associated (CAUTI)	**Revised** the definition: A diagnosis of UTI must be documented in the patient's medical record that is consistent with the January 2019 CDC defined CAUTI and onset of symptoms began after arrival to your ED/hospital.
Pneumonia Ventilator-Associated (VAP)	**Revised** the definition: A diagnosis of pneumonia must be documented in the patient's medical record that is consistent with the January 2019 CDC defined VAP and onset of symptoms began after arrival to your ED/hospital.