FORM APPROVED COUNTY COUNSEL
BY: NEAL R. KIPNIS DATE 6/27/12
Departmental Concurrence

Purchasing: Mark Seiler, Assistant Director

☐ Consent ☒ Policy

☐ Consent ☒ Policy

Dep't Recomm.:

Per Exec. Ofc.:

SUBMITTAL TO THE BOARD OF SUPERVISORS
COUNTY OF RIVERSIDE, STATE OF CALIFORNIA

523

FROM: Department of Public Health

SUBMITTAL DATE:
June 20, 2012

SUBJECT: Approve the Multi-Year Agreements for Trauma Center Services from Trauma Center Hospitals in Riverside County.

RECOMMENDED MOTION: That the Board of Supervisors:

1) Approve Trauma Center Agreements with Tenet Health Systems, Inc. dba Desert Regional Medical Center (Level II), Riverside Community Hospital (Level II), and Universal Health Care, Inc. dba Inland Valley Medical Center (Level III) for the provisions and support for trauma center services for the period of July 1, 2012 through March 31, 2017; and

2) Authorize the Purchasing Agent to sign ministerial subsequent amendments not to exceed the period of performance of July 1, 2012 through March 31, 2017; and

3) Authorize the Chairman to sign four (4) copies of each said Agreements on behalf of the County.

BACKGROUND: (on Page 2)

BM/ys

Susan D. Harrington

Susan Harrington, Director
Department of Public Health

FINANCIAL DATA				
	Current F.Y. Total Cost:	$ 0	In Current Year Budget:	N/A
	Current F.Y. Net County Cost:	$ 0	Budget Adjustment:	N/A
	Annual Net County Cost:	$ 0	For Fiscal Year:	12/13

SOURCE OF FUNDS: N/A

Positions To Be Deleted Per A-30	☐
Requires 4/5 Vote	☐

C.E.O. RECOMMENDATION: APPROVE

County Executive Office Signature BY: Debra Cournoyer

MINUTES OF THE BOARD OF SUPERVISORS

On motion of Supervisor Ashley, seconded by Supervisor Buster and duly carried, IT WAS ORDERED that the above matter is approved as recommended.

Ayes:	Buster, Tavaglione, Benoit and Ashley
Nays:	None
Absent:	Stone
Date:	July 17, 2012
xc:	Public Health, Purchasing

Kecia Harper-Ihem
Clerk of the Board
By: Deputy

Prev. Agn. Ref.: 01/11/07 3.17, 3.11 | **District:** ALL | **Agenda Number:** 3.29

ATTACHMENTS FILED

SUBJECT: Approve the Multi-Year Agreements for Trauma Center Services from Trauma Center Hospitals in Riverside County.

BACKGROUND:

The revised Riverside County EMS Agency Trauma Plan was approved by the County Board of Supervisors on August 28, 2001 and by the State EMS Authority on October 25, 2002. Title 22 of the California Code of Regulations, Division 9, Section 100255(g) required that there be written agreements between the local EMS Agency and the individual trauma centers.

Riverside County EMS Agency, Riverside Emergency Medical Services Agency (REMSA) has refined the Trauma Center Standards of the Agreements with the cooperation and collaboration from the Trauma Center Managers from each of the aforementioned trauma centers. The following enhancements in the Agreement and Trauma Center Standards are expected to be completed by the March 31, 2017 expiration date for each Agreement:

1. Additional educational requirements for the Emergency Department and Intensive Care Unit trauma nurses.
2. Further defines trauma activations and responses.
3. Further defines levels of staff responses for activations.
4. Adds Level I and Level IV trauma center requirements.
5. Provisions for the Trauma Program Manager to become a dedicated Full Time Equivalent position.
6. Trauma Registrar requirements will have to meet the American College of Surgeons' (ACS) recommendations.
7. Provisions for trauma surgeons and trauma team members to meet ACS recommended educational requirements.
8. ACS Site Consultation or an agreed upon substitution.
9. A prevision for REMSA to implement a fee schedule to recover County costs for trauma center oversight.

These modifications will help make our trauma system even better by requiring higher standards from trauma centers in Riverside County. These agreements present no additional Net County Cost (NCC).

WHEN DOCUMENT IS FULLY EXECUTED RETURN
CLERK'S COPY
to Riverside County Clerk of the Board, Stop 1010
Post Office Box 1147, Riverside, Ca 92502-1147
Thank you.

COUNTY OF RIVERSIDE
DEPARTMENT OF PUBLIC HEALTH

FOR COUNTY USE ONLY

COUNTY DEPT/DIVISION		CONTRACT NO.	RFP NO.
DPH/EMS		12-139	----
FUND	DEPARTMENT ID	PROGRAM:	CLASS/LOCATION
10000	4200101700	93300	6572-33222
CONTRACT AMOUNT		PERIOD OF PERFORMANCE	
$-0-		July 1, 2012 thru March 31, 2017	
COUNTY CONTACT: Brian MacGavin (951) 358-5029			
CONTRACTOR REPRESENTATIVE: Teri Waites Ph: (951) 677-9710 x6025 Fax: (951) 698-7721 teriwaites@uhsinc.com			
PROGRAM NAME: Trauma Level II Center			

This Agreement is made and entered into by and between the County of Riverside, Department of Public Health a political subdivision of the State of California, hereinafter referred to as COUNTY, and Universal Health Services Inc. dba Southwest Healthcare System – Inland Valley Medical Center, hereinafter referred to as HOSPITAL.

WITNESSETH:

WHEREAS, Health and Safety Code Section 1798.100 authorizes the local Emergency Medical Services (EMS) Agency, with the approval of its medical director, to designate and contract with hospitals or other entities approved by the medical director of the Agency to provide medical direction for the provisions and support for trauma center services, within its areas of jurisdiction; and

WHEREAS, the State of California Code of Regulations, Title 22, Section 100168 of Division 9, requires local EMS agencies to have written agreements with a base hospital indicating requirements for program participation a specified by law and by the agency's policies and procedures; and

WHEREAS, the Emergency Medical Services Plan, has been approved by the County of Riverside, Board of Supervisors on October 4, 1994.

NOW THEREFORE in consideration of the mutual promises, covenants and conditions hereinafter contained, the Parties hereto mutually agree as provided on pages 1 thru 15, Exhibit A, consisting of thirteen (13) pages, Exhibit B, consisting of three (3) pages and Exhibit C, consisting of six (6) pages.

HOSPITAL

By_____

Teri Waites

Date_____

COUNTY

By_____

John F. Tavaglione,
Chairman, Board of Supervisors

Date JUL 17 2012

ATTEST: Kecia Harper-Ihem, Clerk of the Board

By_____, Deputy

Date JUL 17 2012

FORM APPROVED COUNTY COUNSEL

BY: NEAL R. KIPNIS DATE 6/28/12

JUL 17 2012 3.29

A. TERM OF AGREEMENT:

The term of this Agreement shall commence on July 1, 2012 and continue through and include March 31, 2017 unless earlier terminated or otherwise extended pursuant to this Agreement. Either party may terminate this Agreement upon (90) days written notice to the other party at any time during the term of this agreement.

B. DEFINITIONS:

As used within this Agreement:

1. "ACS" means American College of Surgeons
2. "COUNTY" means the County of Riverside.
3. "Contract Administrator" – The Contract Administrator shall be the Director of the Riverside County EMS Agency (REMSA) or his / her designee.
4. "Critical Trauma Patient" or "CTP" means an injured person as defined by triage criteria, which has been approved by the COUNTY.
5. REMSA shall mean the County's designated "local EMS Agency" established pursuant to Health and Safety Code Section 1797.200.
6. "EMS Policy and Procedure Manual" – The collection of policies and procedures approved by REMSA for the provision of pre-hospital care within Riverside County.
7. "Trauma Center" means a licensed general acute hospital designated by the Board of Supervisors and contracted with the COUNTY as a Trauma Center in accordance with State laws and regulations.
8. "Triage Criteria" means a measure or method approved by REMSA of assessing the severity of a person's injuries. Triage criteria are used for patient evaluation, especially in the pre-hospital setting, and utilize mechanism of injury, physiologic and/or anatomic considerations.
9. "Trauma Audit Committee" performs periodic trauma audit and performance review of each trauma center and the trauma care system as required assuring optimal trauma care delivery in the designated Trauma Centers.
10. "Trauma Registry" is the county-wide trauma system database. Trauma Center data is transferred to COUNTY in a prescribed manner.
11. "Trauma Center Medical and Physician Services" are those medical and physician services, which are customary, appropriate and necessary during the full period of acute in-hospital, care. These services include medical diagnosis, treatment and care to be provided to "Critical Trauma Patients" and include, but are not limited to, the personnel, services, equipment, and facilities described in the "Trauma Center Minimum Requirements" section of the Riverside County Trauma Care System Plan.

C. STANDARD CONDITIONS:

1. CONTRACT ADMINISTRATION:

The CONTRACT Administrator shall represent the COUNTY in all matters pertaining to this Agreement and shall administer this Agreement on behalf of COUNTY. The CONTRACT Administrator or his or her designee(s) shall audit and inspect records, monitor HOSPITAL'S services and provide other technical guidance as required. HOSPITAL Chief Executive Officer or his/ her designee shall administer this Agreement on behalf of HOSPITAL.

2. RESPONSIBILITIES OF THE PARTIES:

A. **Responsibilities of the COUNTY:**

(1) To define HOSPITAL catchments area;

(2) To develop, implement and monitor trauma care system policies and guidelines;

(3) To develop and implement triage procedures which include injury severity assessment and the determination of patient destination and to monitor compliance therewith;

(4) To develop, with input from HOSPITAL, a process and appoint committee(s) to monitor, evaluate and report on the necessity, quality and level of trauma care services;

(5) To perform periodic announced or unannounced site visits to HOSPITAL for the purpose of monitoring contract performance and compliance. Site visits shall be conducted in accordance with guidelines defined in Exhibit A and/or other specific requirements as mutually agreed upon by HOSPITAL and COUNTY;

(6) To develop, with input from HOSPITAL, and implement a Trauma Registry and a Trauma Information System for the purpose of data collection, compliance monitoring of Trauma Centers and the evaluation of the Trauma Care System;

(7) To provide for independent audit and evaluation of for total hospital charges (aggregate dollars only) that impact the fiscal status of the system. (Title 22: Division 9, Chapter 7, Section 100256 (8) and 100257 (3) (A).)

(8) COUNTY makes no guarantees and cannot assure that any minimum number of Clinical Trauma Patients will be delivered to HOSPITAL during the term of this Agreement.

(9) To evaluate the ongoing cost and available funding to support the efficient function of the County-wide trauma program. County reserves the right to implement a fee schedule to be paid by HOSPITAL based upon actual costs incurred by COUNTY in meeting its statutory responsibilities for the oversight of designated Trauma Centers within its jurisdiction.

B. Responsibility of HOSPITAL:

(1) To provide physicians, surgeons, and other medical staff including nursing staff who possess that degree of learning and skill ordinarily possessed by reputable medical personnel practicing in the same or similar circumstances for the provision of Trauma Center medical services. HOSPITAL will continuously monitor, maintain and upgrade where necessary the care, skill and diligence provided Critical Trauma Patients, so that each Critical Trauma Patient receives that kind of care, skill and diligence which meets or exceeds the County of Riverside Trauma Center Standards. Documentation of the process for monitoring and up-grading practitioner skills will be maintained by HOSPITAL;

(2) To assure that where specific individuals have been identified to assume responsibility for a component of the HOSPITAL'S operation, said individuals have been assigned and formally appointed;

(3) To address the reception, treatment and care of any trauma patient when the Trauma Center does not have the physical and/or human resources available for that trauma patient. The diversion and/or transfer of patients by the Trauma Center shall be reported to REMSA on a regular basis;

(4) To arrange services for patients requiring a licensed rehabilitation center;

(5) To divert ambulances transporting Critical Trauma Patients intended for HOSPITAL only in accordance with protocols and procedures adopted by the COUNTY;

(6) To ensure that the transfer of a trauma patient will comply with State/County/Federal Regulations/Policies;

(7) To develop and maintain telephone or on-site consultations for the community physicians and other providers regarding the immediate management of the care of Critical Trauma Patients;

(8) To adhere to HOSPITAL'S own standards, if greater than those of the County, for the purpose of complying with Exhibit A, and to monitor the compliance of the Trauma Center with said standards. HOSPITAL'S standards shall reflect expectations of timely performance from all ancillary and surgical units of the Trauma Center;

(9) To submit to the COUNTY a Plan of Performance Improvement. The documentation of the monitoring identified in this plan shall be available to the COUNTY upon request. This documentation must reflect the on-going monitoring of the structure, process and outcome standards outlined in Exhibit A;

(10) To take corrective action where there is a failure to meet either the Trauma Center's own standards or the Trauma Center Standards established by STATE/COUNTY'S Regulations (Exhibit A) whichever are more stringent. HOSPITAL shall be notified by COUNTY and given thirty (30) days to correct the deviation. Failure to take timely action may result in a breach of this Agreement;

(11) To assure the Trauma Director, Trauma Nurse Coordinator, and other specified individuals as identified, participate as a member of COUNTY'S Trauma Audit Committee and other related committees as may be named and organized by COUNTY and/or other Hospitals;

(12) To permit announced and unannounced site surveys of its facilities at any time (weekend/night included) by REMSA or its designated representatives and have reasonable access to any and all documentation on any trauma patient or on the trauma system as a whole for the purposes of monitoring contract compliance, quality of care and adherence to performance standards during the designation period;

(13) To submit to COUNTY data on trauma patients seen and/or discharged for a period of time identified by COUNTY and agreed upon by HOSPITAL for focus studies;

(14) To submit **a** plan for the public education/injury prevention activities such as: formal presentations to civic, school community and business organizations; preparation and distribution of written materials describing the Trauma Care System including its use and purpose; explanation including the location and purpose of Trauma Centers; how to access the County EMS System for emergency

medical services; safety promotion and injury prevention. A yearly overview of completed activities to be submitted for review by COUNTY for consistency with trauma system goals;

(15) To develop and/or conduct periodic instructional and educational programs for the benefit of hospital and pre-hospital care personnel which are related to pre-hospital and in-hospital trauma care;

(16) To work mutually with COUNTY to develop a work plan and time line to meet the provisions of Exhibit A;

(17) To document and provide, trauma patient aggregate hospital charges, sources of payment and aggregate totals, to REMSA on request;

(18) To document and provide trauma patient information as required to, meet Trauma and MADDY Funding regulations as identified in Exhibits B and C.

(19) HOSPITAL agrees to cooperate with REMSA in investigating complaints and concerns regarding patient care issues.

(20) HOSPITAL agrees to achieve ACS Trauma Center Site Consultation or an agreed upon substitution before the end of the tern of this agreement.

(21) If HOSPITAL decides to have an, ACS Site Verification, it will be coordinated with REMSA.

(22) Pay fees if required by COUNTY based upon actual costs incurred by COUNTY in meeting its statutory responsibilities for the oversight of designated Trauma Centers within its jurisdiction. Methodology for the development of a fee schedule based upon COUNTY's costs shall be shared with HOSPITAL and shall include, but no be limited to; ACS site visits, trauma registry, continuous quality improvement activities, regulatory compliance activities and commensurate required personnel. Fee schedule methodology shall include equal division of cost between approved Trauma Centers. Any requirement for HOSPITAL to pay fees based upon their share of the COUNTY's costs of oversight shall be preceded by one (1) year advanced notice.

3. **NOTICE:**

Any notice or notices required or permitted to be given pursuant to this Agreement may be personally served on the other party by the party giving such notice, or may be served by certified mail, postage prepaid, return receipt requested, to the following representatives at the addresses cited below:

HOSPITAL:
Universal Health Services Inc., dba
Southwest Healthcare System
Inland Valley Medical Center
Trauma Level III Center
36485 Inland Valley Drive
Wildomar, CA 92595

COUNTY: County of Riverside, Department of Public Health
Procurement and Contracts Division
4065 County Circle Drive
Suite #305
Riverside, CA 92503

CC:
REMSA: Riverside County EMS Agency
4065 County Circle Drive
Suite 102
Riverside, CA 92503

4. **INDEPENDENT HOSPITAL:**
Direct operation of the facility or facilities utilized in the provision of the services described herein shall be the responsibility of HOSPITAL. HOSPITAL'S status, as well as the status of its officers, agents, employees, and sub-hospitals, including its professional and non-professional staff personnel in the performance of services under this Agreement, shall be in an independent capacity and not as officers, employees, or agents of COUNTY. This is an agreement by and between two independent contractors; therefore, no relationship of agent, servant, employee, partnership, joint venture, or association is created or intended to be created hereby.

5. **HOLD HARMLESS:**
A. The HOSPITAL shall defend, save harmless and indemnify COUNTY and its officers, agents, employees, and independent contractors from all liabilities and claims for damages for death, sickness or injury to persons or property, including without limitation, all consequential damages, from any cause whatsoever arising from or connected with the operations or the services of HOSPITAL hereunder, resulting from the conduct, negligent or otherwise, of HOSPITAL, its agents or employees.

B. The COUNTY shall defend, save harmless and indemnify the HOSPITAL and its officers, agents, employees, and independent contractors from all liabilities and claims for damages for death, sickness or injury to persons or property, including without limitations, all consequential damages, from any cause whatsoever arising from or connected with the operations of the services of the COUNTY hereunder, resulting from the conduct, negligent or otherwise, of the COUNTY, its agents or employees.

6. **INSURANCE:**

Without limiting or diminishing the HOSPITAL'S obligation to indemnify or hold the COUNTY harmless, Hospital shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this agreement.

A. **Workers' Compensation:**

If the HOSP1TAL has employees as defined by the State of California, the HOSPITAL shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than S 1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside, and, if applicable, to provide a Borrowed Servant/Alternate Employer Endorsement.

B. **Commercial General Liability:**

Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury covering claims which may arise from or out of HOSPITAL'S performance of its obligations hereunder. Policy shall name all Agencies, Districts, Special Districts, and Departments of the County of Riverside, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured's. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

Exhibit A
Riverside County EMS Agency Trauma Center Standards

The following standards have been adopted from the American College of Surgeons Committee on Trauma and Title 22.

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means a physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.

A non-board certified physician may be recognized as a "qualified specialist" by the local EMS Agency upon substantiation of need by a trauma center if:

- The physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Examination (ACGME) or the Royal College of Physicians and Surgeons of Canada; and
- The physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
- The physician has successfully completed a residency program.

Trauma Activations and Tiered Responses

Various other states and organizations have differing interpretations of trauma activation, immediately available, tiered activations, delayed response, role of the trauma center ED physician, trauma consultation, promptly available, and medically prudent which may create some confusion. The State of California has addressed most of these topics through regulation; however, the key regulation is:

Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 7. Trauma Care Systems
Article 3. Trauma Center Requirements
§100259 Level I and Level II Trauma Centers
(a) (8) Qualified surgical specialist(s) or specific availability, which shall be available as follows:

(A): general surgeon capability of evaluating and treating adult and pediatric trauma patients shall be immediately available for trauma team activation and promptly available for consultation;

Further explanation of the following terms will further clarify trauma activations and tiered responses:

Trauma activation:
California regulations specify that if a level I or II trauma center initiates a trauma activation all participants of the team are expected to meet the patient in the trauma resuscitation area [§100249] upon arrival. The trauma activation includes the immediate availability [§100237] of a trauma or general surgeon capable of evaluating and treating adult and pediatric trauma patients [§100259 (a) (8) (A)]. Typically, the presence of the trauma surgeon is required for insurance reimbursement of the activation fee.

Immediately available:
Immediately available signifies that the trauma or general surgeon shall be present in the trauma resuscitation upon arrival of the patient [§100237.] The American College of Surgeons specifies that the surgeon should be present in the trauma resuscitation area with 15 minutes of notification, and for PI purposes 80% of the time. Additionally, immediate means:

- Unencumbered by conflicting duties or responsibilities; and
- Responding without delay when notified; and
- Being physically available to the specified area of the trauma center when the patient is delivered.

Promptly available:
Promptly available specifies that the surgeon will respond without delay when notified and be physically available in a period of time that is medically prudent [§100241]. Many local EMS agencies and the American College of Surgeons recognize promptly available as accessible within 30 minutes.

Tiered activation:
The word "tiered" is silent in the regulations; however, the spirit of "tiered" within the California trauma system refers to resources marshaled by a trauma center for trauma team activations. A hospital may create policies to determine what level of peripheral assistance may be necessary once trauma activation occurs. Examples of peripheral assistance may include (but not limited to) duplicate personnel, blood bank, or social workers. California Regulations require that trauma activations include a surgeon that is immediately available [§100259 (a) (8) (A)].

Delayed response:
A delayed response occurs when a patient has injuries indicating a trauma activation yet the activation occurs after the patient arrived at the trauma center. A delayed response should be avoided. If the delayed response does occur the event should be vetted through the quality assurance/performance improvement process [§100265].

Role of the trauma center ED physician:
When field EMS personnel initiate a trauma activation the trauma center ED physician receives the information and determines if the situation requires trauma activation. If a

trauma activation is needed, all participants of the team are expected to meet the patient in the trauma resuscitation area [§100249] upon arrival which includes the immediate availability [§100237] of a trauma or general surgeon capable of evaluating and treating adult and pediatric trauma patients [§100259 (a) (8) (A)]. If the trauma center ED physician determines that a trauma activation is not necessary then that physician determines what team will be needed to receive the patient. The physician may choose to have a trauma surgeon consultation.

Trauma surgeon consultation:
When a trauma center ED physician needs a trauma consultation then a trauma surgeon will be promptly available [§100259 (a) (8) (A)]. Many local EMS agencies and the American College of Surgeons recognize promptly available as accessible within 30 minutes. Once a trauma center initiates a trauma activation a trauma consultation does not apply.

Medically prudent:
Medically prudent represents the combined decision of the trauma center ED physician, trauma center surgeon, and standard of care as to when the surgeon should be present in the trauma resuscitation area [§100241]. The decision must also comply with local EMS agency policies and procedures [§100241].

Summary:
When a trauma center activation is initiated a trauma or general surgeon shall be immediately available. Hospitals may choose to triage resources with an internal tiered response; however, the tiered response shall not compromise the initial membership of the trauma team which includes the leader (trauma or general surgeon). If a trauma center chooses not to initiate a trauma activation, the trauma center ED physician may utilize a trauma consultation. The following chart provides a summary of required trauma center services by the level held by a trauma center.

For a complete copy of trauma regulations go to:
http://www.emsa.ca.gov/laws/files/regs7.pdf

Exhibit A
Riverside County EMS Agency Trauma Center Standards

California Trauma Center Criteria: California Code of Regulations, Title 22, Chapter 7-Trauma Care System					
1	**TRAUMA CENTER CRITERIA**	**Level**	**Level**	**Level**	**Level**
2	**E = Essential (Title 22), D = Desired (Title 22), R=REMSA required**	**I**	**II**	**III**	**IV**
3	**INSTITUTIONS/ORGANIZATION:**				
4	TJC Accreditation (Joint Commission on Accreditation of Healthcare Organizations)	E	E	E	E
5	Licensed hospital in the State of California	E	E	E	E
6	Basic or comprehensive emergency services with special permits	E	E	E	E
7	A minimum of 1200 trauma program hospital admissions, OR	E			
8	A minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is >15, OR	E			
9	An average of of 35 trauma patients (with an ISS of >15) per trauma program surgeon per year	E			
10	A trauma research program	E			
11	An ACGME approved surgical residency program	E			
12	**TRAUMA PROGRAM MEDICAL DIRECTOR:**	E	E	E	E
13	Board Certified Surgeon	E	E	E	
14	Qualified Surgical Specialist (*Level IV may be a non-surgical qualified specialist.)			E	* E
15	Responsibilities include but not limited to:				
16	Recommending trauma team physician privileges	E	E	E	E
17	Working with nursing & administration to support needs of trauma patients	E	E	E	E
18	Developing trauma treatment protocols	E	E	E	E
19	Determining appropriate equipment and supplies	E	E	D	D
20	Ensuring development of policies/procedures for domestic violence, elder/child abuse/neglect	E	E	D	D
21	Having authority and accountability for QI peer review process,	E	E	E	E
22	Correcting deficiencies in trauma care/excluding from trauma call those team members who no longer meet standards,	E	E	E	E
23	Coordinating with local and State EMS agencies,	E	E	R	R
24	Coordinating pediatric trauma care with other hospitals/professional services,	E	E	R	R

25	Assisting with the coordination of budgetary processes for trauma program,	E	E	E	E
26	Identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program,	E	E	E	R
27	Using the expertise of representatives from neurosurgery, orthopaedics, emergency medicine, pediatrics and other appropriate disciplines,	E	E	R	R
28	Will recruit physicians to be members of the trauma ,	E	E	R	R
29	Coordinating with local and State EMS agencies, (Level IV with local EMS only.)	E	E	R	R
30	**TRAUMA PROGRAM MANAGER**	E	E	E	E
31	Qualifications are:				
32	Registered Nurse	E	E	E	E
33	Dedicated FTE. Current in TNCC or ATCN. Completes 16 hr of trauma education/yr	R	R	R	R
34	Provide evidence of educational preparation, clinical expertise in care of adult & pediatric trauma patient, & administrative responsibilities	E	E	E	E
35	Responsibilities include but not limited to:				
36	Organizing services and systems necessary for multidisciplinary care,	E	E	E	E
37	Coordinating day-to-day clinical process & performance improvement of nursing and ancillary personnel,	E	E	E	E
38	Collaborating with trauma program medical director to carry out educational, clinical, research, administrative and outreach activities of the trauma program.	E	E	E	E
39	**TRAUMA SERVICE**	E	E	E	E
40	Implementation of requirements as specified & provide for coordination with the local EMS agency	E	E	E	E
41	**TRAUMA TEAM**				
42	A multidisciplinary team responsible for the initial resuscitation and management of the trauma patient	E	E	E	E
43	**Trauma Nursing ED**				
44	Registered Nurse	R	R	R	R
45	Expertise in adult and pediatric trauma care	E	E	E	R

46	Maintains TNCC or ATCN	R	R	R	R
47	6 hr/yr of trauma nursing education	R	R	R	R
48	ENPC	R	R	R	R
49	Responsibilities include but not limited to:				
50	Capability of providing *immediate* initial resuscitation/management of the trauma patient	E	E	E	E
51	Ability to provide treatment or arrange for transportation to higher level trauma center.		E	E	E
52	Trauma Data/Registry				
53	Trauma registrar FTE requirements as per the most current ACS recommendations.	R	R	R	R
54	Registrar shall be trauma certified/ credentialed and have 4 hr CE/yr	R	R	R	R
55	**SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTIONS(S):**				
56	Which includes at least the following surgical specialties and staffed by qualified specialists:				
57	General	E	E	E	
58	Orthopedic	E	E	E	
59	Neurologic (*May be provided through transfer agreement)	E	E	E*	
60	Obstetric/Gynecologic	E	E		
61	Ophthalmologic	E	E		
62	Oral/maxillofacial or head and neck	E	E		
63	Plastic	E	E		
64	Urologic	E	E		
65	**NON-SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTIONS(S):**				
66	Which includes at least the following non-surgical specialties and staffed by qualified specialists:				
67	Anesthesiology	E	E	E	
68	Internal Medicine	E	E		
69	Pathology	E	E		
70	Psychiatry	E	E		
71	Radiology	E	E		
72	Emergency Medicine, immediately available	E	E	E	E
73	**QUALIFIED SURGICAL SPECIALIST(S):**available as				

	follows:				
74	Is a Qualified Surgical Specialist (Applies to all specialties)	E	E	E	
75	Residency Coverage:				
76	Surgical Specialists' requirements may be fulfilled by supervised senior residents.	E	E		
77	Senior Resident				
78	Senior Resident must be capable of assessing emergent situations in their respective specialty, and	E	E		
79	Shall be able to provide overall control and surgical leadership including surgical care if needed, and	E	E		
80	Supervising, staff trauma surgeon/surgeon with experience in trauma care shall be on-call & promptly available	E	E		
81	Supervising, staff trauma surgeon shall be advised of all trauma patient admissions, participate in major therapeutic decisions, & be present in the ED for major resuscitations & in the OR for all trauma operative procedures	E	E		
82	General Surgeon:	E	E	E	
83	Capable of evaluating & treating adult and pediatric trauma patients	E	E		
84	Trauma Team Activation: Tiered activations are monitored and reviewed through the PI process for accuracy of under/over triage. Immediate response is defined as 15" 80% of the time, Promptly is defined as 30" 80% of the time.	R	R	R	R
85	Other Qualified Surgical Specialists on-call and *promptly* available:				
86	Neurologic (*Level III - May be provided through written transfer agreement)	E	E	*E	
87	Obstetric/Gynecologic	E	E		
88	Ophthalmologic	E	E		
89	Oral/maxillofacial or head and neck	E	E		
90	Orthopedic	E	E	E	
91	Plastic	E	E		
92	Urologic	E	E		
93	Surgical Consultations:				

94	Available for consultation and transfer agreements for adult and pediatric trauma patients **(in-house or through written agreements)***REMSA note: EMTALA supersedes "written agreements" for higher level of care from the ED.*				
95	Burn Care	E	E	E	E
96	Cardiothoracic - On-Call and *Promptly available*	E			
97	Cardiothoracic		E	E	E
98	Pediatric - On-Call and *Promptly Available*	E			
99	Pediatrics		E	E	E
100	Reimplantation / microsurgery	E	E	E	E
101	Spinal cord injury	E	E	E	E
102	Qualified Non-Surgical Specialist (Applies to all specialties)	E	E	E	
103	*Residency Coverage*				
104	Emergency Medicine and Anesthesiology Specialists' requirements may be fulfilled by supervised senior residents.	E	E		
105	Senior Resident must be capable of assessing emergent situations in their respective specialty and initiating treatment	E	E		
106	*Supervising physician* with experience in trauma care shall be on-call & promptly available	E	E		
107	Supervising qualified specialists shall be advised of all trauma patient admissions, participate in major therapeutic decisions, & be present in the ED for major resuscitations (Anesthesiologists will be in the OR for all trauma operative procedure)	E	E		
108	Emergency Medicine: In-house and *Immediately Available*	E	E	E	E
109	Board certified or recognized qualified specialists in emergency medicine	E	E		
110	ATLS Certification: Required for emergency medicine physicians boarded in other specialties	E	E	E	E
111	Anesthesiology	E	E	E	
112	In-house 24hrs/day and *Immediately Available*	E			
113	On-call and *promptly available* with a mechanism to ensure presence when patient arrives.		E	E	
114	Senior Resident/CRNA in-house with Staff Anesthesiologist *promptly* available and present for surgery	E	E	E	

115	Radiology				
116	On Call and *Promptly Available*	E	E		
117	Other Non-Surgical Specialists Available for consultation:				
118	Cardiology	E	E		
119	Gastroenterology	E	E		
120	Hematology	E	E		
121	Infectious Diseases	E	E		
122	Internal Medicine	E	E		
123	Nephrology	E	E		
124	Neurology	E	E		
125	Pathology	E	E		
126	Pulmonary Medicine	E	E		
127	**SERVICE CAPABILITIES:**				
128	Radiological Service	E	E	E	E
129	Radiological technician *immediately available* for general radiological procedures & computer tomography	E	E		
130	Shall have a radiological technician *promptly available*			E	E
131	Angiography & ultrasound services shall be *promptly available*	E	E		
132	Clinical Laboratory Service				
133	Comprehensive blood bank or access to community central blood bank	E	E	E	E
134	Clinical laboratory services *immediately* available	E	E		
135	Clinical laboratory services *promptly* available			E	E
136	Surgical Services				
137	Shall have an operating suite available or being utilized for trauma patients and has:	E	E	E	
138	A surgical service that has at least the following: (1) operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available.	E			
139	Operating staff, *promptly* available, and back-up staff who are promptly available unless operating on trauma patients. *Back up staff not required		E	*E	
140	Appropriate surgical equipment and supplies as determined by the trauma program Medical Director	E	E		
141	Appropriate surgical equipment and supplies requirements which have been approved by the local			E	

	EMS agency				
142	Cardiopulmonary bypass equipment	E			
143	Operating microscope	E			
144	Basic or comprehensive emergency services with special permits	E	E	E	E
145	Designate emergency physician to be member of trauma team	E	E	E	E
146	Provide emergency services to adult and pediatric patients	E	E	E	E
147	Personnel knowledgeable in the treatment of adult and pediatric trauma	E	E	E	E
148	Designated trauma resuscitation area physically separated from other patient care areas. Of adequate size to accommodate multi-system injured patient and equipment	E	E	E	D
149	Appropriate equipment and supplies for adult and pediatric patients as approved by the director of emergency medicine an in collaboration with the trauma program medical director	E	E	E	E
150	Key controlled elevator, where necessary for immediate access between trauma resuscitation area and helipad, or radiology.	R	R	R	R
151	Intensive Care Service				
152	Special permit licensing ICU service	E	E		
153	Qualified specialist in-house 24 hours/day *and immediately* available to care for the trauma ICU patient	E			
154	Qualified specialist *promptly* available to care for trauma patients in the ICU		E	E	
155	RN's caring for trauma patients are TNCC, ATCN or TCAR and have 6 hrs/2yr of trauma nursing education	R	R	R	R
156	Qualified specialist may be a resident with 2 years of training who is supervised by staff intensivist or attending surgeon who participates in all critical decision making	E	E	E	
157	Qualified specialist shall be a member of the trauma team	E	E	E	
158	Appropriate equipment and supplies determined by physician responsible for intensive care service and the trauma program medical director.	E	E	E	
159	Burn Center - In House or Transfer Agreement	E	E	E	E

160	Physical Therapy Service:				
161	Personnel trained in physical therapy	E	E		
162	Equipped for acute care of critically injured patient	E	E		
163	Rehabilitation Center - May be provided by written transfer agreement to a rehabilitation center	E	E	E	
164	Personnel trained in rehabilitation care	E	E		
165	Equipped for acute care of critically injured patient	E	E		
166	Respiratory Care Service:	E	E		
167	Personnel trained in respiratory therapy	E	E		
168	Equipped for acute care of critically injured patient	E	E		
169	Acute Hemodialysis Capability	E	E		
170	Occupational Therapy Service:	E	E		
171	Personnel trained in Occupational therapy	E	E		
172	Equipped for acute care of critically injured patient	E	E		
173	Speech Therapy Service	E	E		
174	Personnel trained in speech therapy	E	E		
175	Equipped for acute care of critically injured patient	E	E		
176	Social Service	E	E		
177	Trauma Centers shall have the following services and programs (special license or permit not required)				
178	Pediatric Service:				
179	In-house pediatric service shall have:				
180	PICU approved by CCS or a written transfer agreement with an approved PICU	E	E		
181	Hospitals without a PICU shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care	E	E	E	E
182	A multidisciplinary team to manage child abuse and neglect	E	E		
183	Acute spinal cord injury - In-House or Transfer Agreement	E	E	E	E
184	**ORGAN DONOR PROTOCOL**	E	E		
185	**OUTREACH PROGRAM to include:**				
186	Telephone and on-site physician consultations with physicians in the community and outlying areas	E	E	E	E
187	Trauma prevention for general public	E	E	E	E
188	**CONTINUING EDUCATION** in Trauma Care for:				
189	Trauma Medical Director: Current in ATLS and 16 CME per year in trauma care	E	E	E	E

190	Ongoing education requirements as per the most current ACS recommendations. ATLS as per the most current ACS recommendations.	E	E	E	E
191	Staff nurses	E	E	E	E
192	Staff allied health personnel	E	E	E	E
193	EMS personnel	E	E	E	E
194	Other community physicians and health care personnel	E	E	E	E
195	**PERFORMANCE IMPROVEMENT:**				
196	Must have a quality improvement process in place which includes structure, process and outcome evaluations	E	E	E	E
197	Must have improvement process in place to identify root causes of problems	E	E	E	E
198	Must have interventions to reduce or eliminate the causes	E	E	E	E
199	Must take steps/actions to correct the problems identified	E	E	E	E
200	*In addition the process shall include:*				
201	A detailed audit of all trauma -related deaths, major complications and transfers	E	E	E	E
202	A multidisciplinary trauma peer review committee that includes all members of the trauma team	E	E	E	E
203	Participation in the trauma date management system	E	E	E	E
204	Participation in the local EMS agency trauma evaluation committee	E	E	E	E
205	Have a written system in place for patients, parents of minor children who are patients, legal guardians of children who are patients, and or primary care givers of children who are patients to provide input and feedback to hospital staff regarding the care provided to the children	E	E	E	E
206	Interfacility transfer of Trauma Patients				
207	Patients may be transferred between and from trauma centers providing that: (REMSA note :EMTALA supersedes Title 22 for higher level of care and the need for written transfer agreements, however, repatriation agreements should be in writing.)				
208	Transfers shall be medically prudent as determined by the trauma physician of record	E	E	E	E

209	Shall be in accordance with the local EMS Agency interfacility transfer policies	E	E	E	E
210	Written transfer agreements exists with receiving trauma centers.	E	E	E	E
211	Shall have written criteria for consultation and transfer of patients needing a higher level of care	E	E	E	E
212	Hospitals which have repatriated trauma patients from a designated trauma center will provide the trauma center with all required information for the trauma registry, as specified by local EMS policy.	E	E	E	E
213	Hospitals receiving trauma patients shall participate in system and trauma center quality improvement activities for those trauma patients they have transferred.	E	E	E	E

Exhibit B

CHAPTER 3.75 TRAUMA CARE FUND

1797.198. The Legislature finds and declares all of the following:

(a) Trauma care is an essential public service. It is as vital to the safety of the public as the services provided by law enforcement and fire departments. In communities with access to trauma centers, mortality and morbidity rates from traumatic injuries are significantly reduced. For the same reasons that each community in California needs timely access to the services of skilled police, paramedics, and fire personnel, each community needs access to the services provided by certified trauma centers.

(b) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(c) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury, and serious disability necessitating expensive long-term care.

(d) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(e) It is essential for persons in need of trauma care to receive that care within the 60-minute period immediately following injury. It is during this period, referred to as the "golden hour," when the potential for survival is greatest, and the need for treatment for shock or injury is most critical.

(f) It is the intent of the Legislature in enacting this act to promote access to trauma care by ensuring the availability of services through EMS agency-designated trauma centers.

[Added by AB 430 (CH 171) 2001. Amended by AB 131 (CH 80) 2005.

1797.199. (a) There is hereby created in the State Treasury, the Trauma Care Fund, which, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated without regard to fiscal years to the authority for the purposes specified in subdivision (c).

(b) The fund shall contain any moneys deposited in the fund pursuant to appropriation by the Legislature or from any other source, as well as, notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund.

(c) Moneys in the fund shall be expended by the authority to provide for allocations to local EMS agencies, for distribution to local EMS agency-designated trauma centers provided for by this chapter.

(d) Within 30 days of the effective date of the enactment of an appropriation for purposes of implementing this chapter, the authority shall request all local EMS agencies with an approved trauma plan, that includes at least one designated trauma center, to submit within 45 days of the request the total number of trauma patients and the number of trauma patients at each facility that were reported to the local trauma registry for the most recent fiscal year for which data are available, pursuant to Section
100257 of Title 22 of the California Code of Regulations. However, the local EMS agency's report shall not include any registry entry that is in reference to a patient who is discharged from the trauma center's
emergency department without being admitted to the hospital unless the nonadmission is due to the patient's death or transfer to another facility. Any local EMS agency that fails to provide these data shall not receive funding pursuant to this section.

(e) Except as provided in subdivision (m), the authority shall distribute all funds to local EMS agencies with an approved trauma plan that includes at least one designated trauma center in the local EMS agency's jurisdiction as of July 1 of the fiscal year in which funds are to be distributed.

(1) The amount provided to each local EMS agency shall be in the same proportion as the total number of trauma patients reported to the local trauma registry for each local EMS agency's area of jurisdiction compared to the total number of all trauma patients statewide as reported under subdivision (d).

(2) The authority shall send a contract to each local EMS agency that is to receive funds within 30 days of receiving the required data and shall distribute the funds to a local EMS agency within 30 days of receiving a signed contract and invoice from the agency.

(f) Local EMS agencies that receive funding under this chapter shall distribute all those funds to eligible trauma centers, except that an agency may expend 1 percent for administration. It is the intent of the Legislature that the funds distributed to eligible trauma centers be spent on trauma services. The funds shall not be used to supplant existing funds designated for trauma services or for training ordinarily provided by the trauma hospital. The local EMS agency shall utilize a competitive grant-based system. All grant proposals shall demonstrate that funding is needed because the trauma center cares for a high percentage of uninsured patients. Local EMS agencies shall determine distribution of funds based on whether the grant proposal satisfies one or more of the following
criteria:

(1) The preservation or restoration of specialty physician and surgeon oncall coverage that is demonstrated to be essential for trauma services within a specified hospital.

(2) The acquisition of equipment that is demonstrated to be essential for trauma services within a specified hospital.

(3) The creation of overflow or surge capacity to allow a trauma hospital to respond to mass casualties resulting from an act of terrorism or natural disaster.

(4) The coordination or payment of emergency, nonemergency, and critical care ambulance transportation that would allow for the time-urgent movement or transfer of critically injured patients to trauma centers outside of the originating region so that specialty services or a higher level of care may be provided as necessary without undue delay.

(g) A trauma center shall be eligible for funding under this section if it is designated as a trauma center by a local EMS agency pursuant to Section 1798.165 and complies with the requirements of this section. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(h) A trauma center that receives funding under this section shall agree to remain a trauma center through June 30 of the fiscal year in which it receives funding. If the trauma center ceases functioning as a trauma center, it shall pay back to the local EMS agency a pro rata portion of the funding that has been received. If there are one or more trauma centers remaining in the local EMS agency's service area, the local EMS agency shall distribute the funds among the other trauma centers. If there is no other trauma center within the local EMS agency's service area, the local EMS agency shall return the moneys to the authority.

(i) In order to receive funds pursuant to this section, an eligible trauma center shall submit, pursuant to a contract between the trauma center and the local EMS agency, relevant and pertinent data requested by the local EMS agency. A trauma center shall demonstrate that it is appropriately submitting data to the local EMS agency's trauma registry and a local EMS agency shall audit the data annually within two years of a distribution from the local EMS agency to a

trauma center. Any trauma center receiving funding pursuant to this section shall report to the local EMS agency how the funds were used to support trauma services.

(j) It is the intent of the Legislature that all moneys appropriated to the fund be distributed to local EMS agencies during the same year the moneys are appropriated. To the extent that any moneys are not distributed by the authority during the fiscal year in which the moneys are appropriated, the moneys shall remain in the fund and be eligible for distribution pursuant to this section during subsequent fiscal years.

(k) By October 31, 2002, the authority shall develop criteria for the standardized reporting of trauma patients to local trauma registries. The authority shall seek input from local EMS agencies to develop the criteria. All local EMS agencies shall utilize the trauma patient criteria for reporting trauma patients to local trauma registries by July 1, 2003.

(*l*) By December 31 of the fiscal year following any fiscal year in which funds are distributed pursuant to this section, a local EMS agency that has received funds from the authority pursuant to this chapter shall provide a report to the authority that details the amount of funds distributed to each trauma center, the amount of any balance remaining, and the amount of any claims pending, if any, and describes how the respective centers used the funds to support trauma services. The report shall also describe the local EMS agency's mechanism for distributing the funds to trauma centers, a description of their audit process and criteria, and a summary of the most recent audit results.

(m) The authority may retain from any appropriation to the fund an amount sufficient to implement this section, up to two hundred eighty thousand dollars ($280,000). This amount may be adjusted to reflect any increases provided for wages or operating expenses as part of the authority's budget process. [Added by AB 430 (CH 171) 2001. Amended by AB 131 (CH 80) 2005]

Exhibit C

Statutes in Effect as of
January 1, 2006

CHAPTER 2.5 THE MADDY EMERGENCY MEDICAL SERVICES FUND

[Added by SB 12 (CH 1240) 1987.]

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund, based on the actual administrative costs, not to exceed 10 percent of the amount of the fund.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year. The administering agency shall not disburse funds in excess of the total amount of a qualified claim.

[Amended by SB 612 (CH 945) 1988; SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; SB 1683 (CH 1143) 1994; AB 2021 (CH 58) 1998; SB 476 (CH 707) 2003; and SB 941 (CH 671) 2005.]

1797.98b. (a) Each county establishing a fund, on January 1,1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes.

(3) The pattern and distribution of claims and the percentage of claims paid to those submitted.

(4) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon and hospital claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(6) A name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contracted to review claims payment methodologies.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

[Amended by SB 623 (CH 679) 1999; and SB 476 (CH 707) 2003.]

1797.98c. (a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom

payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.

[Amended by SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; AB 1833 (CH 430) 2002; SB 476 (CH 707) 2003; and SB 941 (CH 671) 2005.]

1797.98d. [Repealed by AB 1257 (CH 237) 1989.]

1797.98e. (a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each

claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential
treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the emergency medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

(4) For the 1991-92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

(g) Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical
emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

(*l*) Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California. [Amended by SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; SB 1497 (CH 1023) 1996; AB 1833 (CH 430) 2002; SB 476 (CH 707) 2003; SB 635 (CH 524) 2004; and SB 941 (CH 671) 2005.]

[Section 1797.98e of the Health and Safety Code, as added by Section 3 of Chapter 524 of the Statutes of 2004, was repealed by SB 941 (CH 671) of 2005.]

1797.98f. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients.

[Added by SB 2098 (CH 1171) 1990. Amended by SB 277 (CH 1016) 1998.]

1797.98g. The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code.

[Added by SB 946 (CH 1169) 1991.]

1797.98h. [Automatically repealed on January 1, 2000 as stated in SB 1683 (CH 1143) 1994]

WHEN DOCUMENT IS FULLY EXECUTED RETURN
CLERK'S COPY
to Riverside County Clerk of the Board, Stop 1010
Post Office Box 1147, Riverside, Ca 92502-1147
Thank you.

COUNTY OF RIVERSIDE
DEPARTMENT OF PUBLIC HEALTH

FOR COUNTY USE ONLY

COUNTY DEPT/DIVISION DPH/EMS		CONTRACT NO. 12-138	RFP NO. ----
FUND 10000	DEPARTMENT ID 4200101700	PROGRAM: 93300	CLASS/LOCATION 6572-33222
CONTRACT AMOUNT $-0-		PERIOD OF PERFORMANCE July 1, 2012 thru March 31, 2017	
COUNTY CONTACT: Brian MacGavin (951) 358-5029			
CONTRACTOR REPRESENTATIVE: Lori Coronado Ph: (951) 788-3545 Fax: (951) 788-3518 Loretta.coronado@hcahealthcare.com			
PROGRAM NAME: Trauma Level II Center			

This Agreement is made and entered into by and between the County of Riverside, Department of Public Health a political subdivision of the State of California, hereinafter referred to as COUNTY, and Riverside Community Hospital, hereinafter referred to as HOSPITAL.

WITNESSETH:

WHEREAS, Health and Safety Code Section 1798.100 authorizes the local Emergency Medical Services (EMS) Agency, with the approval of its medical director, to designate and contract with hospitals or other entities approved by the medical director of the Agency to provide medical direction for the provisions and support for trauma center services, within its areas of jurisdiction; and

WHEREAS, the State of California Code of Regulations, Title 22, Section 100168 of Division 9, requires local EMS agencies to have written agreements with a base hospital indicating requirements for program participation a specified by law and by the agency's policies and procedures; and

WHEREAS, the Emergency Medical Services Plan, has been approved by the County of Riverside, Board of Supervisors on October 4, 1994.

NOW THEREFORE in consideration of the mutual promises, covenants and conditions hereinafter contained, the Parties hereto mutually agree as provided on pages 1 thru 15, Exhibit A, consisting of thirteen (13) pages, Exhibit B, consisting of three (3) pages and Exhibit C, consisting of six (6) pages, Attachment 1, consisting of one (1) page.

HOSPITAL

By _____

Lori Coronado

Date _____

COUNTY

By _____

John F. Tavaglione,
Chairman, Board of Supervisors

Date JUL 17 2012

ATTEST: Kecia Harper-Ihem, Clerk of the Board

By _____, Deputy

Date JUL 17 2012

FORM APPROVED COUNTY COUNSEL

BY: _____ 6/26/12
NEAL R. KIPNIS DATE

JUL 17 2012 3.29

A. TERM OF AGREEMENT:

The term of this Agreement shall commence on July 1, 2012 and continue through and include March 31, 2017 unless earlier terminated or otherwise extended pursuant to this Agreement. Either party may terminate this Agreement upon (90) days written notice to the other party at any time during the term of this agreement.

B. DEFINITIONS:

As used within this Agreement:

1. "ACS" means American College of Surgeons
2. "COUNTY" means the County of Riverside.
3. "Contract Administrator" – The Contract Administrator shall be the Director of the Riverside County EMS Agency (REMSA) or his / her designee.
4. "Critical Trauma Patient" or "CTP" means an injured person as defined by triage criteria, which has been approved by the COUNTY.
5. REMSA shall mean the County's designated "local EMS Agency" established pursuant to Health and Safety Code Section 1797.200.
6. "EMS Policy and Procedure Manual" – The collection of policies and procedures approved by REMSA for the provision of pre-hospital care within Riverside County.
7. "Trauma Center" means a licensed general acute hospital designated by the Board of Supervisors and contracted with the COUNTY as a Trauma Center in accordance with State laws and regulations.
8. "Triage Criteria" means a measure or method approved by REMSA of assessing the severity of a person's injuries. Triage criteria are used for patient evaluation, especially in the pre-hospital setting, and utilize mechanism of injury, physiologic and/or anatomic considerations.
9. "Trauma Audit Committee" performs periodic trauma audit and performance review of each trauma center and the trauma care system as required assuring optimal trauma care delivery in the designated Trauma Centers.
10. "Trauma Registry" is the county-wide trauma system database. Trauma Center data is transferred to COUNTY in a prescribed manner.
11. "Trauma Center Medical and Physician Services" are those medical and physician services, which are customary, appropriate and necessary during the full period of acute in-hospital, care. These services include medical diagnosis, treatment and care to be provided to "Critical Trauma Patients" and include, but are not limited to, the personnel, services, equipment, and facilities described in the "Trauma Center Minimum Requirements" section of the Riverside County Trauma Care System Plan.

C. STANDARD CONDITIONS:

1. CONTRACT ADMINISTRATION:

The CONTRACT Administrator shall represent the COUNTY in all matters pertaining to this Agreement and shall administer this Agreement on behalf of COUNTY. The CONTRACT Administrator or his or her designee(s) shall audit and inspect records, monitor HOSPITAL'S services and provide other technical guidance as required. HOSPITAL Chief Executive Officer or his/ her designee shall administer this Agreement on behalf of HOSPITAL.

2. RESPONSIBILITIES OF THE PARTIES:

A. **Responsibilities of the COUNTY:**

(1) To define HOSPITAL catchments area;

(2) To develop, implement and monitor trauma care system policies and guidelines;

(3) To develop and implement triage procedures which include injury severity assessment and the determination of patient destination and to monitor compliance therewith;

(4) To develop, with input from HOSPITAL, a process and appoint committee(s) to monitor, evaluate and report on the necessity, quality and level of trauma care services;

(5) To perform periodic announced or unannounced site visits to HOSPITAL for the purpose of monitoring contract performance and compliance. Site visits shall be conducted in accordance with guidelines defined in Exhibit A and/or other specific requirements as mutually agreed upon by HOSPITAL and COUNTY;

(6) To develop, with input from HOSPITAL, and implement a Trauma Registry and a Trauma Information System for the purpose of data collection, compliance monitoring of Trauma Centers and the evaluation of the Trauma Care System;

(7) To provide for independent audit and evaluation of for total hospital charges (aggregate dollars only) that impact the fiscal status of the system. (Title 22: Division 9, Chapter 7, Section 100256 (8) and 100257 (3) (A).)

(8) COUNTY makes no guarantees and cannot assure that any minimum number of Clinical Trauma Patients will be delivered to HOSPITAL during the term of this Agreement.

(9) To evaluate the ongoing cost and available funding to support the efficient function of the County-wide trauma program. County reserves the right to implement a fee schedule to be paid by HOSPITAL based upon actual costs incurred by COUNTY in meeting its statutory responsibilities for the oversight of designated Trauma Centers within its jurisdiction.

B. **Responsibility of HOSPITAL:**

(1) To provide physicians, surgeons, and other medical staff including nursing staff who possess that degree of learning and skill ordinarily possessed by reputable medical personnel practicing in the same or similar circumstances for the provision of Trauma Center medical services. HOSPITAL will continuously monitor, maintain and upgrade where necessary the care, skill and diligence provided Critical Trauma Patients, so that each Critical Trauma Patient receives that kind of care, skill and diligence which meets or exceeds the County of Riverside Trauma Center Standards. Documentation of the process for monitoring and up-grading practitioner skills will be maintained by HOSPITAL;

(2) To assure that where specific individuals have been identified to assume responsibility for a component of the HOSPITAL'S operation, said individuals have been assigned and formally appointed;

(3) To address the reception, treatment and care of any trauma patient when the Trauma Center does not have the physical and/or human resources available for that trauma patient. The diversion and/or transfer of patients by the Trauma Center shall be reported to REMSA on a regular basis;

(4) To arrange services for patients requiring a licensed rehabilitation center;

(5) To divert ambulances transporting Critical Trauma Patients intended for HOSPITAL only in accordance with protocols and procedures adopted by the COUNTY;

(6) To ensure that the transfer of a trauma patient will comply with State/County/Federal Regulations/Policies;

(7) To develop and maintain telephone or on-site consultations for the community physicians and other providers regarding the immediate management of the care of Critical Trauma Patients;

(8) To adhere to HOSPITAL'S own standards, if greater than those of the County, for the purpose of complying with Exhibit A, and to monitor the compliance of the Trauma Center with said standards. HOSPITAL'S standards shall reflect expectations of timely performance from all ancillary and surgical units of the Trauma Center;

(9) To submit to the COUNTY a Plan of Performance Improvement. The documentation of the monitoring identified in this plan shall be available to the COUNTY upon request. This documentation must reflect the on-going monitoring of the structure, process and outcome standards outlined in Exhibit A;

(10) To take corrective action where there is a failure to meet either the Trauma Center's own standards or the Trauma Center Standards established by STATE/COUNTY'S Regulations (Exhibit A) whichever are more stringent. HOSPITAL shall be notified by COUNTY and given thirty (30) days to correct the deviation. Failure to take timely action may result in a breach of this Agreement;

(11) To assure the Trauma Director, Trauma Nurse Coordinator, and other specified individuals as identified, participate as a member of COUNTY'S Trauma Audit Committee and other related committees as may be named and organized by COUNTY and/or other Hospitals;

(12) To permit announced and unannounced site surveys of its facilities at any time (weekend/night included) by REMSA or its designated representatives and have reasonable access to any and all documentation on any trauma patient or on the trauma system as a whole for the purposes of monitoring contract compliance, quality of care and adherence to performance standards during the designation period;

(13) To submit to COUNTY data on trauma patients seen and/or discharged for a period of time identified by COUNTY and agreed upon by HOSPITAL for focus studies;

(14) To submit **a** plan for the public education/injury prevention activities such as: formal presentations to civic, school community and business organizations; preparation and distribution of written materials describing the Trauma Care System including its use and purpose; explanation including the location and purpose of Trauma Centers; how to access the County EMS System for emergency

medical services; safety promotion and injury prevention. A yearly overview of completed activities to be submitted for review by COUNTY for consistency with trauma system goals;

(15) To develop and/or conduct periodic instructional and educational programs for the benefit of hospital and pre-hospital care personnel which are related to pre-hospital and in-hospital trauma care;

(16) To work mutually with COUNTY to develop a work plan and time line to meet the provisions of Exhibit A;

(17) To document and provide, trauma patient aggregate hospital charges, sources of payment and aggregate totals, to REMSA on request;

(18) To document and provide trauma patient information as required to, meet Trauma and MADDY Funding regulations as identified in Exhibits B and C.

(19) HOSPITAL agrees to cooperate with REMSA in investigating complaints and concerns regarding patient care issues.

(20) HOSPITAL agrees to achieve ACS Trauma Center Site Consultation or an agreed upon substitution before the end of the tern of this agreement.

(21) If HOSPITAL decides to have an, ACS Site Verification, it will be coordinated with REMSA.

(22) Pay fees if required by COUNTY based upon actual costs incurred by COUNTY in meeting its statutory responsibilities for the oversight of designated Trauma Centers within its jurisdiction. Methodology for the development of a fee schedule based upon COUNTY's costs shall be shared with HOSPITAL and shall include, but no be limited to; ACS site visits, trauma registry, continuous quality improvement activities, regulatory compliance activities and commensurate required personnel. Fee schedule methodology shall include equal division of cost between approved Trauma Centers. Any requirement for HOSPITAL to pay fees based upon their share of the COUNTY's costs of oversight shall be preceded by one (1) year advanced notice.

3. **NOTICE:**

Any notice or notices required or permitted to be given pursuant to this Agreement may be personally served on the other party by the party giving such notice, or may be served by certified mail, postage prepaid, return receipt requested, to the following representatives at the addresses cited below:

HOSPITAL:

Riverside Community Hospital
Trauma Level II Center
4445 Magnolia Avenue
Riverside, CA 92501

COUNTY: County of Riverside, Department of Public Health
Procurement and Contracts Division
4065 County Circle Drive
Suite #305
Riverside, CA 92503

CC:
REMSA: Riverside County EMS Agency
4065 County Circle Drive
Suite 102
Riverside, CA 92503

4. **INDEPENDENT HOSPITAL:**

Direct operation of the facility or facilities utilized in the provision of the services described herein shall be the responsibility of HOSPITAL. HOSPITAL'S status, as well as the status of its officers, agents, employees, and sub-hospitals, including its professional and non-professional staff personnel in the performance of services under this Agreement, shall be in an independent capacity and not as officers, employees, or agents of COUNTY. This is an agreement by and between two independent contractors; therefore, no relationship of agent, servant, employee, partnership, joint venture, or association is created or intended to be created hereby.

5. **HOLD HARMLESS:**

A. The HOSPITAL shall defend, save harmless and indemnify COUNTY and its officers, agents, employees, and independent contractors from all liabilities and claims for damages for death, sickness or injury to persons or property, including without limitation, all consequential damages, from any cause whatsoever arising from or connected with the operations or the services of HOSPITAL hereunder, resulting from the conduct, negligent or otherwise, of HOSPITAL, its agents or employees.

B. The COUNTY shall defend, save harmless and indemnify the HOSPITAL and its officers, agents, employees, and independent contractors from all liabilities and claims for damages for death, sickness or injury to persons or property, including without limitations, all consequential damages, from any cause whatsoever arising from or connected with the operations of the services of the COUNTY hereunder, resulting from the conduct, negligent or otherwise, of the COUNTY, its agents or employees.

6. **INSURANCE:**

Without limiting or diminishing the HOSPITAL'S obligation to indemnify or hold the COUNTY harmless, Hospital shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this agreement.

A. **Workers' Compensation:**

If the HOSP1TAL has employees as defined by the State of California, the HOSPITAL shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than S 1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside, and, if applicable, to provide a Borrowed Servant/Alternate Employer Endorsement.

B. **Commercial General Liability:**

Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury covering claims which may arise from or out of HOSPITAL'S performance of its obligations hereunder. Policy shall name all Agencies, Districts, Special Districts, and Departments of the County of Riverside, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured's. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

C. **Vehicle Liability:**

If HOSPITAL'S vehicles or mobile equipment are used in the performance of the obligations under this Agreement, then HOSPITAL shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit. Policy shall name all Agencies, Districts, Special Districts, and Departments of the County of Riverside, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured's.

D. **Professional Liability Insurance:**

Contractor shall maintain Professional Liability Insurance providing coverage for the Contractor's performance of work included within this Agreement, with a limit of liability of not less than $2,000,000 per occurrence and $4,000,000 annual aggregate. If Contractor's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this agreement and HOSPITAL shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Agreement; or 3) demonstrate through Certificates of Insurance that HOSPITAL has Maintained continuous coverage with the same or original insurer. Coverage provided under items; 1), 2) or 3) will continue for a period of five *(5)* years beyond the termination of this Agreement.

E. **General Insurance Provisions – All lines:**

1) Any insurance earner providing insurance coverage hereunder shall be admitted to the State of California and have an A M BEST rating of not less than A: VIII (A:8) unless such requirements are waived, in writing, by the County Risk Manager. If the County's Risk Manager waives a requirement for a particular insurer such waiver is only valid for that specific insurer and only for one policy term.
2) The HOSPITAL'S insurance carrier(s) must declare its insurance deductibles or self-insured retentions. If such deductibles or self-insured retentions exceed $500,000 per occurrence such deductibles and/or retentions shall have the prior written consent of the County Risk Manager before the commencement of operations under this

agreement. Upon notification of deductibles or self insured retention's unacceptable to the COUNTY, and at the election of the Country's Risk Manager, HOSPITAL'S carriers shall either; 1) reduce or eliminate such deductibles or self-insured retention's as respects this Agreement with the COUNTY, or 2) procure a bond which guarantees payment of losses and related investigations, claims administration, and defense costs and expenses.

3) HOSPITAL shall cause HOSPITAL'S insurance carrier(s) to furnish the County of Riverside with either; 1) a properly executed original Certificate(s) of Insurance and certified original copies of Endorsements effecting coverage as required herein and 2) if requested to do so orally or in writing by the County Risk Manager, provide original certified copies of policies including all Endorsements and all attachments thereto, showing such insurance is full force and effect. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. In the event of a material modification, cancellation, expiration, or reduction in coverage, this Agreement shall terminate forthwith, unless the County of Riverside receives, prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements or certified original policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. HOSPITAL shall not commence operations until the COUNTY has been furnished original Certificate (s) of Insurance and certified original copies of endorsements and if requested, certified original policies of insurance including all endorsements and any and all other attachments as required in this Section. An individual authorized by the insurance carrier to do so, on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.

4) It is understood and agreed to by the parties hereto and the insurance company(s), that the Certificate(s) of Insurance and policies shall so covenant and shall be construed as primary insurance, and the COUNTY'S insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

5) HOSPITAL shall pass down the insurance obligations contained herein to all tiers of subcontractors working tinder this Agreement.
6) The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the COUNTY.

7. **HOSPITAL EMPLOYEES AND EQUIPMENT:**
HOSPITAL agrees that HOSPITAL has secured or will secure at HOSPITAL'S sole expense all persons, employees, supplies, equipment and facilities needed to perform the services required under this Agreement and that all such services will be performed by HOSPITAL, or under HOSPITAL'S supervision, by persons authorized by HOSPITAL to perform such services.

8. **ASSIGNABILITY:**
HOSPITAL shall not delegate its duties and responsibilities or assign its rights hereunder, or both either in whole or in part, without the prior written consent of COUNTY.

9. **CONFLICT OF INTEREST:**
HOSPITAL covenants that HOSPITAL presently has no interest in other projects or contracts, and shall not acquire any such interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this Agreement. HOSPITAL further covenants that in the performance of this Agreement no person having such interest shall be employed or retained by HOSPITAL under this Agreement. HOSPITAL shall comply with all applicable federal, state, and local conflict of interest laws and regulations.

10. **RESPONSIBILITY FOR COSTS:**
COUNTY shall not be liable for any costs or expenses incurred by HOSPITAL to satisfy its responsibilities under this Agreement.

11. **NONDISCRIMINATION IN SERVICES AND BENEFITS:**
The HOSPITAL shall not discriminate in the provision of services, allocation of benefits, accommodation in facilities, or employment of personnel, on the basis of ethnic group identification, race, color, creed, ancestry, religion, national origin, sexual preference, sex, age (over 40), marital status, medical condition, or physical or mental handicap, and shall comply with all other requirements of law regarding nondiscrimination and affirmative action including those laws pertaining to the prohibition of discrimination against qualified handicapped persons in all programs or activities. For the purpose of this Agreement, distinctions on the grounds of

race, religion, color, sex, national origin, age, or physical or mental handicap include, but are not limited to, the following:

a. Denying an eligible person or providing to an eligible person any services or benefit which is different, or is provided in a different manner or at a different time from that provided to other eligible persons under this Agreement.

b. Subjecting an eligible person to segregation or separate treatment in any matter related to his receipt of any service, except when necessary for infection control.

c. Restricting an eligible person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving a similar service or benefit.

d. Treating an eligible person differently from others in determining whether he/she satisfied any eligibility, membership, or other requirement or condition which individuals must meet in order to be provided a similar service or benefit.

e. The assignment of times or places for the provision of services on the basis of race, religion, color, sex, national origin, age, or physical or mental handicap of the eligible person to be served.

HOSPITAL assures that it will comply with the Americans with Disabilities Act and Title VII of the Civil Rights Act of 1964 and that no person shall, on the grounds of race, creed, color, disability, sex, sexual orientation or national origin, age, religion, Vietnam Era Veteran's status, political affiliation, or any other non-merit factors be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement thereafter be amended or added.

12. <u>CONFORMANCE WITH RULES AND REGULATIONS:</u>

HOSPITAL shall comply with applicable Federal, State, County and local rules and regulations, ordinances, policies and procedures current and hereinafter enacted, including facility and professional licensing and/or certification laws and regulations, policies and procedures, and maintain in effect any and all licenses, permits, notices and certificates as are required. This shall include but not be limited to Chapter 6, Article 2.5 of the California Health and Safety Code (commencing with Section 1798.160 et esq.) and the regulations promulgated as Title 22, CCR, Division 9, Chapter 7 and California Evidence Code, Section 1157.7.

13. **ADVERTISING:**
HOSPITAL may advertise itself as a trauma center.

14. **CONFIDENTIALITY:**
COUNTY and HOSPITAL agree to maintain the confidentiality of all information and records obtained in the course of providing services to patients under this Agreement in accordance with all-applicable Federal and State statutes and regulations and local Ordinances relating to confidentiality. Such information shall be divulged only as provided by law or as necessarily relating to the audit and evaluation of HOSPITAL'S performance as a Trauma Center. COUNTY agrees to consult with HOSPITAL prior to the establishment of standards and practices to ensure the confidentiality of patient care information.

15. **HIPAA COMPLIANCE:**
a. The Parties agree to take reasonable steps to maintain the confidentiality of all healthcare files and client data, and shall use appropriate safeguards to prevent inappropriate use of disclosure of individually identifiable patient's information except as permitted by this contract or as required by law. Each Party shall immediately report to the other any impermissible use of disclosure that occurs as to such files and data. Party agrees to destroy in a secure manner, or return to the other, all patient health information shared upon termination of this Agreement as determined by the other. Breach of this provision may serve as grounds for termination of the Agreement.
b. The Parties agree that in the event that either subcontracts their duties and/or obligations created by this Agreement, said subcontractors shall be required to comply with Section a. above.
c. The Parties agree that the Agreement may be amended as necessary to comply with any federal regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) of 1996b or other law or regulation promulgated for HIPAA's purpose.

16. **MAINTENANCE OF RECORDS:**
HOSPITAL shall maintain or cause to be maintained patient care, total hospital and physician charge and cost data for each Critical Trauma Patient, in such a fashion as to be able to separately identify Critical Trauma Patients from all other patients. All administrative records under this Agreement shall be maintained by; HOSPITAL for a minimum of five (5) years after the termination date of the Agreement for COUNTY inspection.

17. **FISCAL AND PERFORMANCE AUDITS AND INSPECTION OF RECORDS:**
Federal and State representatives as required by law or COUNTY representatives shall have the right to monitor, assess, and evaluate HOSPITAL'S performance pursuant to this Agreement.

18. **REPORTS:**
HOSPITAL agrees it shall not unreasonably hold its consent to submit reports and materials on its services according to this Agreement as requested by the Contract Administrator, as necessary to comply with applicable Federal, State and local laws and regulations, and COUNTY policies. Format for the content of such reports will be developed by the COUNTY. Due dates for submission of various reports and other materials will be set by the COUNTY with concurrence of HOSPITAL. The timely submission of reports and materials is a necessary and material term and condition of this Agreement and HOSPITAL agrees that failure to meet a specified deadline for submission of reports or materials will be sufficient cause for termination of this Agreement. COUNTY agrees not to release any data that may identify the HOSPITAL as the trauma care provider without the consent of the HOSPITAL, unless required by laws, regulations, or ordinance.

19. **EVALUATION STUDIES:**
HOSPITAL will participate as requested by the COUNTY in reasonable research and/or evaluation studies designed to show the effectiveness of Pre-hospital/HOSPITAL services or to provide information about Pre-hospital/HOSPITAL'S services to Critical Trauma Patients as necessary to comply with Federal, State, and local laws and regulations, and COUNTY policies.

20. **TERMINATION FOR CAUSE:**
Prior to the exercise of any termination right under this paragraph by COUNTY, COUNTY shall give HOSPITAL a thirty day written notice specifying all deficiencies, requiring correction of all deficiencies, the grounds for termination, and its intent to terminate in respect thereof. The thirty-day period shall commence upon receipt of notice by HOSPITAL. COUNTY may shorten the period of correction to whatever it deems appropriate under the circumstances, if it determines that HOSPITAL'S actions or inaction has seriously threatened or will threaten public health and safety. If an acceptable plan or correction has not been approved by COUNTY within the given correction period, or all significant deficiencies have not been corrected, COUNTY shall have the right to terminate this Agreement immediately for cause by giving not less than seven days written notice specifying the effective date thereof. Cause for termination shall include but not be limited to:

a. A material failure of HOSPITAL to comply with the terms of this Agreement which affects HOSPITAL'S ability to provide care to trauma victims or which affects COUNTY'S ability to administer the Trauma Care System in the County of Riverside.

b. Failure to provide timely surgical and non-surgical physician coverage for trauma patients, causing unnecessary risk of mortality and morbidity for the trauma patient;

c. Submission by HOSPITAL to the COUNTY or appropriate departments of the County or State of reports or information that are incorrect or incomplete in any material respect;

d. Failure to comply with Federal, State, or County statutes, regulations, and ordinances or failure to comply with COUNTY EMS policies as provided to the HOSPITAL by COUNTY and which are related to the obligations of the HOSPITAL by this Agreement;

e. Loss or suspension of licensure as an acute care hospital, loss of suspension of any existing or future special permits issued by state or federal agencies related to the services provided by the hospital, or loss or suspension of accreditation by the Joint Commission (TJC) ;

f. Failure to comply with established provisions in regard to COUNTY'S monitoring of HOSPITAL'S trauma care services;

g. Failure to cooperate with quality assessment and improvement and audit findings and resulting recommendations of the COUNTY;

h. Gross misrepresentation or fraud by HOSPITAL, its employees, officers, agents, or sub hospitals with respect to this Agreement;

i. Failure to remedy recurring equipment malfunction, physician, nursing and other staff shortage, staff response delays or facility problems which may be or are cause for HOSPITAL to divert ambulances transporting Critical Trauma Patients intended for HOSPITAL.

21. <u>JURISDICTION, VENUE, ATTORNEY FEES:</u>

Should any dispute arise out of the performance of this Agreement, or to establish the right or remedy of either Party under this Agreement, IT IS HEREBY PROVIDED AND AGREED that such dispute shall be submitted to the jurisdiction of the, State of California. This Agreement shall be construed and enforced in accordance with the laws of the State of California. Any action filed arising out of or under this Agreement shall be instituted in Riverside County, California. In the event that costs or attorney's fees arise out of such dispute, the prevailing Party shall be entitled to recover reasonable attorney's fees and costs as part of such action or proceeding, including non-reimbursable litigation expense such as expert witness fees and investigation expenses.

22. **IDENTIFICATION OF MINORITY, WOMEN, DISABLED VETERAN BUSINESS ENTERPRISES:**
In compliance with Federal and State requirements and COUNTY policy to promote the active participation of Minority, Women and Disabled Veteran Business Enterprises (M/W/DVBE's) in the COUNTY'S contracting activities, the COUNTY of Riverside Board of Supervisors has implemented a data collection mandate.

23. **CAPTIONS AND PARAGRAPH HEADING:**
Captions and paragraph headings used in this Agreement are for convenience only and are not a part of this Agreement and shall not be used in construing this Agreement.

24. **WAIVERS, AMENDMENTS, AND AGREEMENTS OUTSIDE OF CONTRACT:**
This document and its exhibits and references incorporated herein fully express all understandings of the parties concerning the matters covered herein and supersede any other agreements between the parties for the services described herein. However, this Agreement does not affect any existing Base Hospital Agreement between the COUNTY and HOSPITAL. No waiver, addition to or alteration of the terms of this Agreement and no verbal understanding of the parties, or their officers, agents or employees, shall be valid unless made in the form of a written amendment.

25. **OWNERSHIP, PUBLICATION, REPRODUCTION AND USE OF MATERIALS:**
HOSPITAL agrees to meet with all other designated Trauma Centers to establish guidelines concerning the publication and use of data relating to the Trauma Care System and any other designated Trauma Center. COUNTY shall acknowledge HOSPITAL'S contribution, and HOSPITAL shall acknowledge COUNTY'S contribution in any materials published or issued as a result of this Agreement. COUNTY agrees not to publish information that would be identifiable to a specific trauma center, without the consent of the HOSPITAL.

26. **MUTUAL COOPERATION:**
Care of the injured patient requires a system approach to ensure optimal care. A systematic approach involves not only one facility, but also an entire community. It is agreed that mutual cooperation and not competition between each of the designated trauma centers and the COUNTY is vital to provide optimal medical care; and that a system approach be used for the care of the trauma patient.

Exhibit A
Riverside County EMS Agency Trauma Center Standards

The following standards have been adopted from the American College of Surgeons Committee on Trauma and Title 22.

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means a physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.

A non-board certified physician may be recognized as a "qualified specialist" by the local EMS Agency upon substantiation of need by a trauma center if:

- The physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Examination (ACGME) or the Royal College of Physicians and Surgeons of Canada; and
- The physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
- The physician has successfully completed a residency program.

Trauma Activations and Tiered Responses

Various other states and organizations have differing interpretations of trauma activation, immediately available, tiered activations, delayed response, role of the trauma center ED physician, trauma consultation, promptly available, and medically prudent which may create some confusion. The State of California has addressed most of these topics through regulation; however, the key regulation is:

Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 7. Trauma Care Systems
Article 3. Trauma Center Requirements
§100259 Level I and Level II Trauma Centers
(a) (8) Qualified surgical specialist(s) or specific availability, which shall be available as follows:

(A): general surgeon capability of evaluating and treating adult and pediatric trauma patients shall be immediately available for trauma team activation and promptly available for consultation;

Further explanation of the following terms will further clarify trauma activations and tiered responses:

Trauma activation:
California regulations specify that if a level I or II trauma center initiates a trauma activation all participants of the team are expected to meet the patient in the trauma resuscitation area [§100249] upon arrival. The trauma activation includes the immediate availability [§100237] of a trauma or general surgeon capable of evaluating and treating adult and pediatric trauma patients [§100259 (a) (8) (A)]. Typically, the presence of the trauma surgeon is required for insurance reimbursement of the activation fee.

Immediately available:
Immediately available signifies that the trauma or general surgeon shall be present in the trauma resuscitation upon arrival of the patient [§100237.] The American College of Surgeons specifies that the surgeon should be present in the trauma resuscitation area with 15 minutes of notification, and for PI purposes 80% of the time. Additionally, immediate means:

- Unencumbered by conflicting duties or responsibilities; and
- Responding without delay when notified; and
- Being physically available to the specified area of the trauma center when the patient is delivered.

Promptly available:
Promptly available specifies that the surgeon will respond without delay when notified and be physically available in a period of time that is medically prudent [§100241]. Many local EMS agencies and the American College of Surgeons recognize promptly available as accessible within 30 minutes.

Tiered activation:
The word "tiered" is silent in the regulations; however, the spirit of "tiered" within the California trauma system refers to resources marshaled by a trauma center for trauma team activations. A hospital may create policies to determine what level of peripheral assistance may be necessary once trauma activation occurs. Examples of peripheral assistance may include (but not limited to) duplicate personnel, blood bank, or social workers. California Regulations require that trauma activations include a surgeon that is immediately available [§100259 (a) (8) (A)].

Delayed response:
A delayed response occurs when a patient has injuries indicating a trauma activation yet the activation occurs after the patient arrived at the trauma center. A delayed response should be avoided. If the delayed response does occur the event should be vetted through the quality assurance/performance improvement process [§100265].

Role of the trauma center ED physician:
When field EMS personnel initiate a trauma activation the trauma center ED physician receives the information and determines if the situation requires trauma activation. If a

trauma activation is needed, all participants of the team are expected to meet the patient in the trauma resuscitation area [§100249] upon arrival which includes the immediate availability [§100237] of a trauma or general surgeon capable of evaluating and treating adult and pediatric trauma patients [§100259 (a) (8) (A)]. If the trauma center ED physician determines that a trauma activation is not necessary then that physician determines what team will be needed to receive the patient. The physician may choose to have a trauma surgeon consultation.

Trauma surgeon consultation:
When a trauma center ED physician needs a trauma consultation then a trauma surgeon will be promptly available [§100259 (a) (8) (A)]. Many local EMS agencies and the American College of Surgeons recognize promptly available as accessible within 30 minutes. Once a trauma center initiates a trauma activation a trauma consultation does not apply.

Medically prudent:
Medically prudent represents the combined decision of the trauma center ED physician, trauma center surgeon, and standard of care as to when the surgeon should be present in the trauma resuscitation area [§100241]. The decision must also comply with local EMS agency policies and procedures [§100241].

Summary:
When a trauma center activation is initiated a trauma or general surgeon shall be immediately available. Hospitals may choose to triage resources with an internal tiered response; however, the tiered response shall not compromise the initial membership of the trauma team which includes the leader (trauma or general surgeon). If a trauma center chooses not to initiate a trauma activation, the trauma center ED physician may utilize a trauma consultation. The following chart provides a summary of required trauma center services by the level held by a trauma center.

For a complete copy of trauma regulations go to:
http://www.emsa.ca.gov/laws/files/regs7.pdf

Exhibit A
Riverside County EMS Agency Trauma Center Standards

California Trauma Center Criteria: California Code of Regulations, Title 22, Chapter 7-Trauma Care System					
1	**TRAUMA CENTER CRITERIA**	**Level**	**Level**	**Level**	**Level**
2	**E = Essential (Title 22), D = Desired (Title 22), R=REMSA required**	**I**	**II**	**III**	**IV**
3	**INSTITUTIONS/ORGANIZATION:**				
4	TJC Accreditation (Joint Commission on Accreditation of Healthcare Organizations)	E	E	E	E
5	Licensed hospital in the State of California	E	E	E	E
6	Basic or comprehensive emergency services with special permits	E	E	E	E
7	A minimum of 1200 trauma program hospital admissions, OR	E			
8	A minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is >15, OR	E			
9	An average of of 35 trauma patients (with an ISS of >15) per trauma program surgeon per year	E			
10	A trauma research program	E			
11	An ACGME approved surgical residency program	E			
12	**TRAUMA PROGRAM MEDICAL DIRECTOR:**	E	E	E	E
13	Board Certified Surgeon	E	E	E	
14	Qualified Surgical Specialist (*Level IV may be a non-surgical qualified specialist.)			E	* E
15	Responsibilities include but not limited to:				
16	Recommending trauma team physician privileges	E	E	E	E
17	Working with nursing & administration to support needs of trauma patients	E	E	E	E
18	Developing trauma treatment protocols	E	E	E	E
19	Determining appropriate equipment and supplies	E	E	D	D
20	Ensuring development of policies/procedures for domestic violence, elder/child abuse/neglect	E	E	D	D
21	Having authority and accountability for QI peer review process,	E	E	E	E
22	Correcting deficiencies in trauma care/excluding from trauma call those team members who no longer meet standards,	E	E	E	E
23	Coordinating with local and State EMS agencies,	E	E	R	R
24	Coordinating pediatric trauma care with other hospitals/professional services,	E	E	R	R

25	Assisting with the coordination of budgetary processes for trauma program,	E	E	E	E
26	Identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program,	E	E	E	R
27	Using the expertise of representatives from neurosurgery, orthopaedics, emergency medicine, pediatrics and other appropriate disciplines,	E	E	R	R
28	Will recruit physicians to be members of the trauma ,	E	E	R	R
29	Coordinating with local and State EMS agencies, (Level IV with local EMS only.)	E	E	R	R
30	**TRAUMA PROGRAM MANAGER**	E	E	E	E
31	Qualifications are:				
32	Registered Nurse	E	E	E	E
33	Dedicated FTE. Current in TNCC or ATCN. Completes 16 hr of trauma education/yr	R	R	R	R
34	Provide evidence of educational preparation, clinical expertise in care of adult & pediatric trauma patient, & administrative responsibilities	E	E	E	E
35	Responsibilities include but not limited to:				
36	Organizing services and systems necessary for multidisciplinary care,	E	E	E	E
37	Coordinating day-to-day clinical process & performance improvement of nursing and ancillary personnel,	E	E	E	E
38	Collaborating with trauma program medical director to carry out educational, clinical, research, administrative and outreach activities of the trauma program.	E	E	E	E
39	**TRAUMA SERVICE**	E	E	E	E
40	Implementation of requirements as specified & provide for coordination with the local EMS agency	E	E	E	E
41	**TRAUMA TEAM**				
42	A multidisciplinary team responsible for the initial resuscitation and management of the trauma patient	E	E	E	E
43	**Trauma Nursing ED**				
44	Registered Nurse	R	R	R	R
45	Expertise in adult and pediatric trauma care	E	E	E	R

46	Maintains TNCC or ATCN	R	R	R	R
47	6 hr/yr of trauma nursing education	R	R	R	R
48	ENPC	R	R	R	R
49	Responsibilities include but not limited to:				
50	Capability of providing *immediate* initial resuscitation/management of the trauma patient	E	E	E	E
51	Ability to provide treatment or arrange for transportation to higher level trauma center.		E	E	E
52	Trauma Data/Registry				
53	Trauma registrar FTE requirements as per the most current ACS recommendations.	R	R	R	R
54	Registrar shall be trauma certified/ credentialed and have 4 hr CE/yr	R	R	R	R
55	**SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTIONS(S):**				
56	Which includes at least the following surgical specialties and staffed by qualified specialists:				
57	General	E	E	E	
58	Orthopedic	E	E	E	
59	Neurologic (*May be provided through transfer agreement)	E	E	E*	
60	Obstetric/Gynecologic	E	E		
61	Ophthalmologic	E	E		
62	Oral/maxillofacial or head and neck	E	E		
63	Plastic	E	E		
64	Urologic	E	E		
65	**NON-SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTIONS(S):**				
66	Which includes at least the following non-surgical specialties and staffed by qualified specialists:				
67	Anesthesiology	E	E	E	
68	Internal Medicine	E	E		
69	Pathology	E	E		
70	Psychiatry	E	E		
71	Radiology	E	E		
72	Emergency Medicine, immediately available	E	E	E	E
73	**QUALIFIED SURGICAL SPECIALIST(S):**available as				

	follows:				
74	Is a Qualified Surgical Specialist (Applies to all specialties)	E	E	E	
75	Residency Coverage:				
76	Surgical Specialists' requirements may be fulfilled by supervised senior residents.	E	E		
77	Senior Resident				
78	Senior Resident must be capable of assessing emergent situations in their respective specialty, and	E	E		
79	Shall be able to provide overall control and surgical leadership including surgical care if needed, and	E	E		
80	Supervising, staff trauma surgeon/surgeon with experience in trauma care shall be on-call & promptly available	E	E		
81	Supervising, staff trauma surgeon shall be advised of all trauma patient admissions, participate in major therapeutic decisions, & be present in the ED for major resuscitations & in the OR for all trauma operative procedures	E	E		
82	General Surgeon:	E	E	E	
83	Capable of evaluating & treating adult and pediatric trauma patients	E	E		
84	Trauma Team Activation: Tiered activations are monitored and reviewed through the PI process for accuracy of under/over triage. Immediate response is defined as 15" 80% of the time, Promptly is defined as 30" 80% of the time.	R	R	R	R
85	Other Qualified Surgical Specialists on-call and *promptly* available:				
86	Neurologic (*Level III - May be provided through written transfer agreement)	E	E	*E	
87	Obstetric/Gynecologic	E	E		
88	Ophthalmologic	E	E		
89	Oral/maxillofacial or head and neck	E	E		
90	Orthopedic	E	E	E	
91	Plastic	E	E		
92	Urologic	E	E		
93	Surgical Consultations:				

94	Available for consultation and transfer agreements for adult and pediatric trauma patients **(in-house or through written agreements)***REMSA note: EMTALA supersedes "written agreements" for higher level of care from the ED.*				
95	Burn Care	E	E	E	E
96	Cardiothoracic - On-Call and *Promptly available*	E			
97	Cardiothoracic		E	E	E
98	Pediatric - On-Call and *Promptly Available*	E			
99	Pediatrics		E	E	E
100	Reimplantation / microsurgery	E	E	E	E
101	Spinal cord injury	E	E	E	E
102	Qualified Non-Surgical Specialist (Applies to all specialties)	E	E	E	
103	*Residency Coverage*				
104	Emergency Medicine and Anesthesiology Specialists' requirements may be fulfilled by supervised senior residents.	E	E		
105	Senior Resident must be capable of assessing emergent situations in their respective specialty and initiating treatment	E	E		
106	*Supervising physician* with experience in trauma care shall be on-call & promptly available	E	E		
107	Supervising qualified specialists shall be advised of all trauma patient admissions, participate in major therapeutic decisions, & be present in the ED for major resuscitations (Anesthesiologists will be in the OR for all trauma operative procedure)	E	E		
108	Emergency Medicine: In-house and *Immediately Available*	E	E	E	E
109	Board certified or recognized qualified specialists in emergency medicine	E	E		
110	ATLS Certification: Required for emergency medicine physicians boarded in other specialties	E	E	E	E
111	Anesthesiology	E	E	E	
112	In-house 24hrs/day and *Immediately Available*	E			
113	On-call and *promptly available* with a mechanism to ensure presence when patient arrives.		E	E	
114	Senior Resident/CRNA in-house with Staff Anesthesiologist *promptly* available and present for surgery	E	E	E	

115	Radiology				
116	On Call and *Promptly Available*	E	E		
117	Other Non-Surgical Specialists Available for consultation:				
118	Cardiology	E	E		
119	Gastroenterology	E	E		
120	Hematology	E	E		
121	Infectious Diseases	E	E		
122	Internal Medicine	E	E		
123	Nephrology	E	E		
124	Neurology	E	E		
125	Pathology	E	E		
126	Pulmonary Medicine	E	E		
127	**SERVICE CAPABILITIES:**				
128	Radiological Service	E	E	E	E
129	Radiological technician *immediately available* for general radiological procedures & computer tomography	E	E		
130	Shall have a radiological technician *promptly available*			E	E
131	Angiography & ultrasound services shall be *promptly available*	E	E		
132	Clinical Laboratory Service				
133	Comprehensive blood bank or access to community central blood bank	E	E	E	E
134	Clinical laboratory services *immediately* available	E	E		
135	Clinical laboratory services *promptly* available			E	E
136	Surgical Services				
137	Shall have an operating suite available or being utilized for trauma patients and has:	E	E	E	
138	A surgical service that has at least the following: (1) operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available.	E			
139	Operating staff, *promptly* available, and back-up staff who are promptly available unless operating on trauma patients. *Back up staff not required		E	*E	
140	Appropriate surgical equipment and supplies as determined by the trauma program Medical Director	E	E		
141	Appropriate surgical equipment and supplies requirements which have been approved by the local			E	

	EMS agency				
142	Cardiopulmonary bypass equipment	E			
143	Operating microscope	E			
144	Basic or comprehensive emergency services with special permits	E	E	E	E
145	Designate emergency physician to be member of trauma team	E	E	E	E
146	Provide emergency services to adult and pediatric patients	E	E	E	E
147	Personnel knowledgeable in the treatment of adult and pediatric trauma	E	E	E	E
148	Designated trauma resuscitation area physically separated from other patient care areas. Of adequate size to accommodate multi-system injured patient and equipment	E	E	E	D
149	Appropriate equipment and supplies for adult and pediatric patients as approved by the director of emergency medicine an in collaboration with the trauma program medical director	E	E	E	E
150	Key controlled elevator, where necessary for immediate access between trauma resuscitation area and helipad, or radiology.	R	R	R	R
151	Intensive Care Service				
152	Special permit licensing ICU service	E	E		
153	Qualified specialist in-house 24 hours/day *and immediately* available to care for the trauma ICU patient	E			
154	Qualified specialist *promptly* available to care for trauma patients in the ICU		E	E	
155	RN's caring for trauma patients are TNCC, ATCN or TCAR and have 6 hrs/2yr of trauma nursing education	R	R	R	R
156	Qualified specialist may be a resident with 2 years of training who is supervised by staff intensivist or attending surgeon who participates in all critical decision making	E	E	E	
157	Qualified specialist shall be a member of the trauma team	E	E	E	
158	Appropriate equipment and supplies determined by physician responsible for intensive care service and the trauma program medical director.	E	E	E	
159	Burn Center - In House or Transfer Agreement	E	E	E	E

160	Physical Therapy Service:				
161	Personnel trained in physical therapy	E	E		
162	Equipped for acute care of critically injured patient	E	E		
163	Rehabilitation Center - May be provided by written transfer agreement to a rehabilitation center	E	E	E	
164	Personnel trained in rehabilitation care	E	E		
165	Equipped for acute care of critically injured patient	E	E		
166	Respiratory Care Service:	E	E		
167	Personnel trained in respiratory therapy	E	E		
168	Equipped for acute care of critically injured patient	E	E		
169	Acute Hemodialysis Capability	E	E		
170	Occupational Therapy Service:	E	E		
171	Personnel trained in Occupational therapy	E	E		
172	Equipped for acute care of critically injured patient	E	E		
173	Speech Therapy Service	E	E		
174	Personnel trained in speech therapy	E	E		
175	Equipped for acute care of critically injured patient	E	E		
176	Social Service	E	E		
177	Trauma Centers shall have the following services and programs (special license or permit not required)				
178	Pediatric Service:				
179	In-house pediatric service shall have:				
180	PICU approved by CCS or a written transfer agreement with an approved PICU	E	E		
181	Hospitals without a PICU shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care	E	E	E	E
182	A multidisciplinary team to manage child abuse and neglect	E	E		
183	Acute spinal cord injury - In-House or Transfer Agreement	E	E	E	E
184	**ORGAN DONOR PROTOCOL**	E	E		
185	**OUTREACH PROGRAM to include:**				
186	Telephone and on-site physician consultations with physicians in the community and outlying areas	E	E	E	E
187	Trauma prevention for general public	E	E	E	E
188	**CONTINUING EDUCATION** in Trauma Care for:				
189	Trauma Medical Director: Current in ATLS and 16 CME per year in trauma care	E	E	E	E

190	Ongoing education requirements as per the most current ACS recommendations. ATLS as per the most current ACS recommendations.	E	E	E	E
191	Staff nurses	E	E	E	E
192	Staff allied health personnel	E	E	E	E
193	EMS personnel	E	E	E	E
194	Other community physicians and health care personnel	E	E	E	E
195	**PERFORMANCE IMPROVEMENT:**				
196	Must have a quality improvement process in place which includes structure, process and outcome evaluations	E	E	E	E
197	Must have improvement process in place to identify root causes of problems	E	E	E	E
198	Must have interventions to reduce or eliminate the causes	E	E	E	E
199	Must take steps/actions to correct the problems identified	E	E	E	E
200	*In addition the process shall include:*				
201	A detailed audit of all trauma -related deaths, major complications and transfers	E	E	E	E
202	A multidisciplinary trauma peer review committee that includes all members of the trauma team	E	E	E	E
203	Participation in the trauma date management system	E	E	E	E
204	Participation in the local EMS agency trauma evaluation committee	E	E	E	E
205	Have a written system in place for patients, parents of minor children who are patients, legal guardians of children who are patients, and or primary care givers of children who are patients to provide input and feedback to hospital staff regarding the care provided to the children	E	E	E	E
206	Interfacility transfer of Trauma Patients				
207	Patients may be transferred between and from trauma centers providing that: (REMSA note :EMTALA supersedes Title 22 for higher level of care and the need for written transfer agreements, however, repatriation agreements should be in writing.)				
208	Transfers shall be medically prudent as determined by the trauma physician of record	E	E	E	E

209	Shall be in accordance with the local EMS Agency interfacility transfer policies	E	E	E	E
210	Written transfer agreements exists with receiving trauma centers.	E	E	E	E
211	Shall have written criteria for consultation and transfer of patients needing a higher level of care	E	E	E	E
212	Hospitals which have repatriated trauma patients from a designated trauma center will provide the trauma center with all required information for the trauma registry, as specified by local EMS policy.	E	E	E	E
213	Hospitals receiving trauma patients shall participate in system and trauma center quality improvement activities for those trauma patients they have transferred.	E	E	E	E

Exhibit B

CHAPTER 3.75 TRAUMA CARE FUND

1797.198. The Legislature finds and declares all of the following:

(a) Trauma care is an essential public service. It is as vital to the safety of the public as the services provided by law enforcement and fire departments. In communities with access to trauma centers, mortality and morbidity rates from traumatic injuries are significantly reduced. For the same reasons that each community in California needs timely access to the services of skilled police, paramedics, and fire personnel, each community needs access to the services provided by certified trauma centers.

(b) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(c) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury, and serious disability necessitating expensive long-term care.

(d) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(e) It is essential for persons in need of trauma care to receive that care within the 60-minute period immediately following injury. It is during this period, referred to as the "golden hour," when the potential for survival is greatest, and the need for treatment for shock or injury is most critical.

(f) It is the intent of the Legislature in enacting this act to promote access to trauma care by ensuring the availability of services through EMS agency-designated trauma centers.
[Added by AB 430 (CH 171) 2001. Amended by AB 131 (CH 80) 2005.

1797.199. (a) There is hereby created in the State Treasury, the Trauma Care Fund, which, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated without regard to fiscal years to the authority for the purposes specified in subdivision (c).

(b) The fund shall contain any moneys deposited in the fund pursuant to appropriation by the Legislature or from any other source, as well as, notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund.

(c) Moneys in the fund shall be expended by the authority to provide for allocations to local EMS agencies, for distribution to local EMS agency-designated trauma centers provided for by this chapter.

(d) Within 30 days of the effective date of the enactment of an appropriation for purposes of implementing this chapter, the authority shall request all local EMS agencies with an approved trauma plan, that includes at least one designated trauma center, to submit within 45 days of the request the total number of trauma patients and the number of trauma patients at each facility that were reported to the local trauma registry for the most recent fiscal year for which data are available, pursuant to Section
100257 of Title 22 of the California Code of Regulations. However, the local EMS agency's report shall not include any registry entry that is in reference to a patient who is discharged from the trauma center's
emergency department without being admitted to the hospital unless the nonadmission is due to the patient's death or transfer to another facility. Any local EMS agency that fails to provide these data shall not receive funding pursuant to this section.

(e) Except as provided in subdivision (m), the authority shall distribute all funds to local EMS agencies with an approved trauma plan that includes at least one designated trauma center in the local EMS agency's jurisdiction as of July 1 of the fiscal year in which funds are to be distributed.

(1) The amount provided to each local EMS agency shall be in the same proportion as the total number of trauma patients reported to the local trauma registry for each local EMS agency's area of jurisdiction compared to the total number of all trauma patients statewide as reported under subdivision (d).

(2) The authority shall send a contract to each local EMS agency that is to receive funds within 30 days of receiving the required data and shall distribute the funds to a local EMS agency within 30 days of receiving a signed contract and invoice from the agency.

(f) Local EMS agencies that receive funding under this chapter shall distribute all those funds to eligible trauma centers, except that an agency may expend 1 percent for administration. It is the intent of the Legislature that the funds distributed to eligible trauma centers be spent on trauma services. The funds shall not be used to supplant existing funds designated for trauma services or for training ordinarily provided by the trauma hospital. The local EMS agency shall utilize a competitive grant-based system. All grant proposals shall demonstrate that funding is needed because the trauma center cares for a high percentage of uninsured patients. Local EMS agencies shall determine distribution of funds based on whether the grant proposal satisfies one or more of the following
criteria:

(1) The preservation or restoration of specialty physician and surgeon oncall coverage that is demonstrated to be essential for trauma services within a specified hospital.

(2) The acquisition of equipment that is demonstrated to be essential for trauma services within a specified hospital.

(3) The creation of overflow or surge capacity to allow a trauma hospital to respond to mass casualties resulting from an act of terrorism or natural disaster.

(4) The coordination or payment of emergency, nonemergency, and critical care ambulance transportation that would allow for the time-urgent movement or transfer of critically injured patients to trauma centers outside of the originating region so that specialty services or a higher level of care may be provided as necessary without undue delay.

(g) A trauma center shall be eligible for funding under this section if it is designated as a trauma center by a local EMS agency pursuant to Section 1798.165 and complies with the requirements of this section. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(h) A trauma center that receives funding under this section shall agree to remain a trauma center through June 30 of the fiscal year in which it receives funding. If the trauma center ceases functioning as a trauma center, it shall pay back to the local EMS agency a pro rata portion of the funding that has been received. If there are one or more trauma centers remaining in the local EMS agency's service area, the local EMS agency shall distribute the funds among the other trauma centers. If there is no other trauma center within the local EMS agency's service area, the local EMS agency shall return the moneys to the authority.

(i) In order to receive funds pursuant to this section, an eligible trauma center shall submit, pursuant to a contract between the trauma center and the local EMS agency, relevant and pertinent data requested by the local EMS agency. A trauma center shall demonstrate that it is appropriately submitting data to the local EMS agency's trauma registry and a local EMS agency shall audit the data annually within two years of a distribution from the local EMS agency to a

trauma center. Any trauma center receiving funding pursuant to this section shall report to the local EMS agency how the funds were used to support trauma services.

(j) It is the intent of the Legislature that all moneys appropriated to the fund be distributed to local EMS agencies during the same year the moneys are appropriated. To the extent that any moneys are not distributed by the authority during the fiscal year in which the moneys are appropriated, the moneys shall remain in the fund and be eligible for distribution pursuant to this section during subsequent fiscal years.

(k) By October 31, 2002, the authority shall develop criteria for the standardized reporting of trauma patients to local trauma registries. The authority shall seek input from local EMS agencies to develop the criteria. All local EMS agencies shall utilize the trauma patient criteria for reporting trauma patients to local trauma registries by July 1, 2003.

(*l*) By December 31 of the fiscal year following any fiscal year in which funds are distributed pursuant to this section, a local EMS agency that has received funds from the authority pursuant to this chapter shall provide a report to the authority that details the amount of funds distributed to each trauma center, the amount of any balance remaining, and the amount of any claims pending, if any, and describes how the respective centers used the funds to support trauma services. The report shall also describe the local EMS agency's mechanism for distributing the funds to trauma centers, a description of their audit process and criteria, and a summary of the most recent audit results.

(m) The authority may retain from any appropriation to the fund an amount sufficient to implement this section, up to two hundred eighty thousand dollars ($280,000). This amount may be adjusted to reflect any increases provided for wages or operating expenses as part of the authority's budget process. [Added by AB 430 (CH 171) 2001. Amended by AB 131 (CH 80) 2005]

CHAPTER 2.5 THE MADDY EMERGENCY MEDICAL SERVICES FUND

[Added by SB 12 (CH 1240) 1987.]

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund, based on the actual administrative costs, not to exceed 10 percent of the amount of the fund.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year. The administering agency shall not disburse funds in excess of the total amount of a qualified claim.

[Amended by SB 612 (CH 945) 1988; SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; SB 1683 (CH 1143) 1994; AB 2021 (CH 58) 1998; SB 476 (CH 707) 2003; and SB 941 (CH 671) 2005.]

1797.98b. (a) Each county establishing a fund, on January 1,1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes.

(3) The pattern and distribution of claims and the percentage of claims paid to those submitted.

(4) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon and hospital claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(6) A name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contracted to review claims payment methodologies.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

[Amended by SB 623 (CH 679) 1999; and SB 476 (CH 707) 2003.]

1797.98c. (a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom

payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.

[Amended by SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; AB 1833 (CH 430) 2002; SB 476 (CH 707) 2003; and SB 941 (CH 671) 2005.]

1797.98d. [Repealed by AB 1257 (CH 237) 1989.]

1797.98e. (a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each

claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential
treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the emergency medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

(4) For the 1991-92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

(g) Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical
emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

(*l*) Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California. [Amended by SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; SB 1497 (CH 1023) 1996; AB 1833 (CH 430) 2002; SB 476 (CH 707) 2003; SB 635 (CH 524) 2004; and SB 941 (CH 671) 2005.]

[Section 1797.98e of the Health and Safety Code, as added by Section 3 of Chapter 524 of the Statutes of 2004, was repealed by SB 941 (CH 671) of 2005.]

1797.98f. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients.

[Added by SB 2098 (CH 1171) 1990. Amended by SB 277 (CH 1016) 1998.]

1797.98g. The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code.
[Added by SB 946 (CH 1169) 1991.]

1797.98h. [Automatically repealed on January 1, 2000 as stated in SB 1683 (CH 1143) 1994]

WHEN DOCUMENT IS FULLY EXECUTED RETURN

CLERK'S COPY

COUNTY OF RIVERSIDE to Riverside County Clerk of the Board, Stop 1010
Post Office Box 1147, Riverside, Ca 92502-1147

DEPARTMENT OF PUBLIC HEALTH Thank you.

FOR COUNTY USE ONLY

COUNTY DEPT/DIVISION		CONTRACT NO.	RFP NO.
DPH/EMS		12-137	----
FUND	DEPARTMENT ID	PROGRAM:	CLASS/LOCATION
10000	4200101700	93300	6572-33222
CONTRACT AMOUNT		PERIOD OF PERFORMANCE	
$-0-		July 1, 2012 thru March 31, 2017	
COUNTY CONTACT: Brian MacGavin (951) 358-5029			
CONTRACTOR REPRESENTATIVE: Karolee M. Sowle, C.O.O. Ph: (760) 323-6370 Fax: (760) 864-9577 karolee.sowle@tenethealth.com			
PROGRAM NAME: Trauma Level II Center			

This Agreement is made and entered into by and between the County of Riverside, Department of Public Health a political subdivision of the State of California, hereinafter referred to as COUNTY, and Tenet Health System, Inc. dba Desert Regional Medical Center, hereinafter referred to as HOSPITAL.

WITNESSETH:

WHEREAS, Health and Safety Code Section 1798.100 authorizes the local Emergency Medical Services (EMS) Agency, with the approval of its medical director, to designate and contract with hospitals or other entities approved by the medical director of the Agency to provide medical direction for the provisions and support for trauma center services, within its areas of jurisdiction; and

WHEREAS, the State of California Code of Regulations, Title 22, Section 100168 of Division 9, requires local EMS agencies to have written agreements with a base hospital indicating requirements for program participation a specified by law and by the agency's policies and procedures; and

WHEREAS, the Emergency Medical Services Plan, has been approved by the County of Riverside, Board of Supervisors on October 4, 1994.

NOW THEREFORE in consideration of the mutual promises, covenants and conditions hereinafter contained, the Parties hereto mutually agree as provided on pages 1 thru 15, Exhibit A, consisting of thirteen (13) pages, Exhibit B, consisting of three (3) pages and Exhibit C, consisting of six (6) pages.

HOSPITAL

By_____

Karolee M. Sowle, C.O.O.

Date_____

COUNTY

By_____

John F. Tavaglione,
Chairman, Board of Supervisors

Date JUL 17 2012

ATTEST: Kecia Harper-Ihem, Clerk of the Board

By_____, Deputy

FORM APPROVED COUNTY COUNSEL

BY: NEAL R. KIRNIS DATE JUL 17 2012

JUL 17 2012 3.29

A. TERM OF AGREEMENT:

The term of this Agreement shall commence on July 1, 2012 and continue through and include March 31, 2017 unless earlier terminated or otherwise extended pursuant to this Agreement. Either party may terminate this Agreement upon (90) days written notice to the other party at any time during the term of this agreement.

B. DEFINITIONS:

As used within this Agreement:

1. "ACS" means American College of Surgeons
2. "COUNTY" means the County of Riverside.
3. "Contract Administrator" – The Contract Administrator shall be the Director of the Riverside County EMS Agency (REMSA) or his / her designee.
4. "Critical Trauma Patient" or "CTP" means an injured person as defined by triage criteria, which has been approved by the COUNTY.
5. REMSA shall mean the County's designated "local EMS Agency" established pursuant to Health and Safety Code Section 1797.200.
6. "EMS Policy and Procedure Manual" – The collection of policies and procedures approved by REMSA for the provision of pre-hospital care within Riverside County.
7. "Trauma Center" means a licensed general acute hospital designated by the Board of Supervisors and contracted with the COUNTY as a Trauma Center in accordance with State laws and regulations.
8. "Triage Criteria" means a measure or method approved by REMSA of assessing the severity of a person's injuries. Triage criteria are used for patient evaluation, especially in the pre-hospital setting, and utilize mechanism of injury, physiologic and/or anatomic considerations.
9. "Trauma Audit Committee" performs periodic trauma audit and performance review of each trauma center and the trauma care system as required assuring optimal trauma care delivery in the designated Trauma Centers.
10. "Trauma Registry" is the county-wide trauma system database. Trauma Center data is transferred to COUNTY in a prescribed manner.
11. "Trauma Center Medical and Physician Services" are those medical and physician services, which are customary, appropriate and necessary during the full period of acute in-hospital, care. These services include medical diagnosis, treatment and care to be provided to "Critical Trauma Patients" and include, but are not limited to, the personnel, services, equipment, and facilities described in the "Trauma Center Minimum Requirements" section of the Riverside County Trauma Care System Plan.

C. STANDARD CONDITIONS:

1. CONTRACT ADMINISTRATION:

The CONTRACT Administrator shall represent the COUNTY in all matters pertaining to this Agreement and shall administer this Agreement on behalf of COUNTY. The CONTRACT Administrator or his or her designee(s) shall audit and inspect records, monitor HOSPITAL'S services and provide other technical guidance as required. HOSPITAL Chief Executive Officer or his/ her designee shall administer this Agreement on behalf of HOSPITAL.

2. RESPONSIBILITIES OF THE PARTIES:

A. **Responsibilities of the COUNTY:**

(1) To define HOSPITAL catchments area;

(2) To develop, implement and monitor trauma care system policies and guidelines;

(3) To develop and implement triage procedures which include injury severity assessment and the determination of patient destination and to monitor compliance therewith;

(4) To develop, with input from HOSPITAL, a process and appoint committee(s) to monitor, evaluate and report on the necessity, quality and level of trauma care services;

(5) To perform periodic announced or unannounced site visits to HOSPITAL for the purpose of monitoring contract performance and compliance. Site visits shall be conducted in accordance with guidelines defined in Exhibit A and/or other specific requirements as mutually agreed upon by HOSPITAL and COUNTY;

(6) To develop, with input from HOSPITAL, and implement a Trauma Registry and a Trauma Information System for the purpose of data collection, compliance monitoring of Trauma Centers and the evaluation of the Trauma Care System;

(7) To provide for independent audit and evaluation of for total hospital charges (aggregate dollars only) that impact the fiscal status of the system. (Title 22: Division 9, Chapter 7, Section 100256 (8) and 100257 (3) (A).)

(8) COUNTY makes no guarantees and cannot assure that any minimum number of Clinical Trauma Patients will be delivered to HOSPITAL during the term of this Agreement.

(9) To evaluate the ongoing cost and available funding to support the efficient function of the County-wide trauma program. County reserves the right to implement a fee schedule to be paid by HOSPITAL based upon actual costs incurred by COUNTY in meeting its statutory responsibilities for the oversight of designated Trauma Centers within its jurisdiction.

B. <u>Responsibility of HOSPITAL:</u>

(1) To provide physicians, surgeons, and other medical staff including nursing staff who possess that degree of learning and skill ordinarily possessed by reputable medical personnel practicing in the same or similar circumstances for the provision of Trauma Center medical services. HOSPITAL will continuously monitor, maintain and upgrade where necessary the care, skill and diligence provided Critical Trauma Patients, so that each Critical Trauma Patient receives that kind of care, skill and diligence which meets or exceeds the County of Riverside Trauma Center Standards. Documentation of the process for monitoring and up-grading practitioner skills will be maintained by HOSPITAL;

(2) To assure that where specific individuals have been identified to assume responsibility for a component of the HOSPITAL'S operation, said individuals have been assigned and formally appointed;

(3) To address the reception, treatment and care of any trauma patient when the Trauma Center does not have the physical and/or human resources available for that trauma patient. The diversion and/or transfer of patients by the Trauma Center shall be reported to REMSA on a regular basis;

(4) To arrange services for patients requiring a licensed rehabilitation center;

(5) To divert ambulances transporting Critical Trauma Patients intended for HOSPITAL only in accordance with protocols and procedures adopted by the COUNTY;

(6) To ensure that the transfer of a trauma patient will comply with State/County/Federal Regulations/Policies;

(7) To develop and maintain telephone or on-site consultations for the community physicians and other providers regarding the immediate management of the care of Critical Trauma Patients;

(8) To adhere to HOSPITAL'S own standards, if greater than those of the County, for the purpose of complying with Exhibit A, and to monitor the compliance of the Trauma Center with said standards. HOSPITAL'S standards shall reflect expectations of timely performance from all ancillary and surgical units of the Trauma Center;

(9) To submit to the COUNTY a Plan of Performance Improvement. The documentation of the monitoring identified in this plan shall be available to the COUNTY upon request. This documentation must reflect the on-going monitoring of the structure, process and outcome standards outlined in Exhibit A;

(10) To take corrective action where there is a failure to meet either the Trauma Center's own standards or the Trauma Center Standards established by STATE/COUNTY'S Regulations (Exhibit A) whichever are more stringent. HOSPITAL shall be notified by COUNTY and given thirty (30) days to correct the deviation. Failure to take timely action may result in a breach of this Agreement;

(11) To assure the Trauma Director, Trauma Nurse Coordinator, and other specified individuals as identified, participate as a member of COUNTY'S Trauma Audit Committee and other related committees as may be named and organized by COUNTY and/or other Hospitals;

(12) To permit announced and unannounced site surveys of its facilities at any time (weekend/night included) by REMSA or its designated representatives and have reasonable access to any and all documentation on any trauma patient or on the trauma system as a whole for the purposes of monitoring contract compliance, quality of care and adherence to performance standards during the designation period;

(13) To submit to COUNTY data on trauma patients seen and/or discharged for a period of time identified by COUNTY and agreed upon by HOSPITAL for focus studies;

(14) To submit **a** plan for the public education/injury prevention activities such as: formal presentations to civic, school community and business organizations; preparation and distribution of written materials describing the Trauma Care System including its use and purpose; explanation including the location and purpose of Trauma Centers; how to access the County EMS System for emergency

medical services; safety promotion and injury prevention. A yearly overview of completed activities to be submitted for review by COUNTY for consistency with trauma system goals;

(15) To develop and/or conduct periodic instructional and educational programs for the benefit of hospital and pre-hospital care personnel which are related to pre-hospital and in-hospital trauma care;

(16) To work mutually with COUNTY to develop a work plan and time line to meet the provisions of Exhibit A;

(17) To document and provide, trauma patient aggregate hospital charges, sources of payment and aggregate totals, to REMSA on request;

(18) To document and provide trauma patient information as required to, meet Trauma and MADDY Funding regulations as identified in Exhibits B and C.

(19) HOSPITAL agrees to cooperate with REMSA in investigating complaints and concerns regarding patient care issues.

(20) HOSPITAL agrees to achieve ACS Trauma Center Site Consultation or an agreed upon substitution before the end of the tern of this agreement.

(21) If HOSPITAL decides to have an, ACS Site Verification, it will be coordinated with REMSA.

(22) Pay fees if required by COUNTY based upon actual costs incurred by COUNTY in meeting its statutory responsibilities for the oversight of designated Trauma Centers within its jurisdiction. Methodology for the development of a fee schedule based upon COUNTY's costs shall be shared with HOSPITAL and shall include, but no be limited to; ACS site visits, trauma registry, continuous quality improvement activities, regulatory compliance activities and commensurate required personnel. Fee schedule methodology shall include equal division of cost between approved Trauma Centers. Any requirement for HOSPITAL to pay fees based upon their share of the COUNTY's costs of oversight shall be preceded by one (1) year advanced notice.

3. **NOTICE:**

Any notice or notices required or permitted to be given pursuant to this Agreement may be personally served on the other party by the party giving such notice, or may be served by certified mail, postage prepaid, return receipt requested, to the following representatives at the addresses cited below:

HOSPITAL:

Tenet Health System dba Desert Regional Medical Center
Trauma Level II Center
1150 North Indian Canyon Blvd.
Palm Springs, CA 92543
Attn: Karolee M. Sowle, C.O.O.

COUNTY: County of Riverside, Department of Public Health
Procurement and Contracts Division
4065 County Circle Drive
Suite #305
Riverside, CA 92503

CC:
REMSA: Riverside County EMS Agency
4065 County Circle Drive
Suite 102
Riverside, CA 92503

4. **INDEPENDENT HOSPITAL:**

Direct operation of the facility or facilities utilized in the provision of the services described herein shall be the responsibility of HOSPITAL. HOSPITAL'S status, as well as the status of its officers, agents, employees, and sub-hospitals, including its professional and non-professional staff personnel in the performance of services under this Agreement, shall be in an independent capacity and not as officers, employees, or agents of COUNTY. This is an agreement by and between two independent contractors; therefore, no relationship of agent, servant, employee, partnership, joint venture, or association is created or intended to be created hereby.

5. **HOLD HARMLESS:**

A. The HOSPITAL shall defend, save harmless and indemnify COUNTY and its officers, agents, employees, and independent contractors from all liabilities and claims for damages for death, sickness or injury to persons or property, including without limitation, all consequential damages, from any cause whatsoever arising from or connected with the operations or the services of HOSPITAL hereunder, resulting from the conduct, negligent or otherwise, of HOSPITAL, its agents or employees.

B. The COUNTY shall defend, save harmless and indemnify the HOSPITAL and its officers, agents, employees, and independent contractors from all liabilities and claims for damages for death, sickness or injury to persons or property, including without limitations, all consequential damages, from any cause whatsoever arising from or connected with the operations of the services of the COUNTY hereunder, resulting from the conduct, negligent or otherwise, of the COUNTY, its agents or employees.

6. **INSURANCE:**

Without limiting or diminishing the HOSPITAL'S obligation to indemnify or hold the COUNTY harmless, Hospital shall procure and maintain or cause to be maintained, at its sole cost and expense, the following insurance coverage's during the term of this agreement.

A. **Workers' Compensation:**

If the HOSP1TAL has employees as defined by the State of California, the HOSPITAL shall maintain statutory Workers' Compensation Insurance (Coverage A) as prescribed by the laws of the State of California. Policy shall include Employers' Liability (Coverage B) including Occupational Disease with limits not less than S 1,000,000 per person per accident. The policy shall be endorsed to waive subrogation in favor of The County of Riverside, and, if applicable, to provide a Borrowed Servant/Alternate Employer Endorsement.

B. **Commercial General Liability:**

Commercial General Liability insurance coverage, including but not limited to, premises liability, contractual liability, products and completed operations liability, personal and advertising injury covering claims which may arise from or out of HOSPITAL'S performance of its obligations hereunder. Policy shall name all Agencies, Districts, Special Districts, and Departments of the County of Riverside, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured's. Policy's limit of liability shall not be less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit.

C. **Vehicle Liability:**

If HOSPITAL'S vehicles or mobile equipment are used in the performance of the obligations under this Agreement, then HOSPITAL shall maintain liability insurance for all owned, non-owned or hired vehicles so used in an amount not less than $1,000,000 per occurrence combined single limit. If such insurance contains a general aggregate limit, it shall apply separately to this agreement or be no less than two (2) times the occurrence limit. Policy shall name all Agencies, Districts, Special Districts, and Departments of the County of Riverside, their respective directors, officers, Board of Supervisors, employees, elected or appointed officials, agents or representatives as Additional Insured's.

D. **Professional Liability Insurance:**

Contractor shall maintain Professional Liability Insurance providing coverage for the Contractor's performance of work included within this Agreement, with a limit of liability of not less than $2,000,000 per occurrence and $4,000,000 annual aggregate. If Contractor's Professional Liability Insurance is written on a claims made basis rather than an occurrence basis, such insurance shall continue through the term of this agreement and HOSPITAL shall purchase at his sole expense either 1) an Extended Reporting Endorsement (also known as Tail Coverage); or 2) Prior Dates Coverage from new insurer with a retroactive date back to the date of, or prior to, the inception of this Agreement; or 3) demonstrate through Certificates of Insurance that HOSPITAL has Maintained continuous coverage with the same or original insurer. Coverage provided under items; 1), 2) or 3) will continue for a period of five *(5)* years beyond the termination of this Agreement.

E. **General Insurance Provisions – All lines:**

1) Any insurance earner providing insurance coverage hereunder shall be admitted to the State of California and have an A M BEST rating of not less than A: VIII (A:8) unless such requirements are waived, in writing, by the County Risk Manager. If the County's Risk Manager waives a requirement for a particular insurer such waiver is only valid for that specific insurer and only for one policy term.
2) The HOSPITAL'S insurance carrier(s) must declare its insurance deductibles or self-insured retentions. If such deductibles or self-insured retentions exceed $500,000 per occurrence such deductibles and/or retentions shall have the prior written consent of the County Risk Manager before the commencement of operations under this

agreement. Upon notification of deductibles or self insured retention's unacceptable to the COUNTY, and at the election of the Country's Risk Manager, HOSPITAL'S carriers shall either; 1) reduce or eliminate such deductibles or self-insured retention's as respects this Agreement with the COUNTY, or 2) procure a bond which guarantees payment of losses and related investigations, claims administration, and defense costs and expenses.

3) HOSPITAL shall cause HOSPITAL'S insurance carrier(s) to furnish the County of Riverside with either; 1) a properly executed original Certificate(s) of Insurance and certified original copies of Endorsements effecting coverage as required herein and 2) if requested to do so orally or in writing by the County Risk Manager, provide original certified copies of policies including all Endorsements and all attachments thereto, showing such insurance is full force and effect. Further, said Certificate(s) and policies of insurance shall contain the covenant of the insurance carrier(s) that thirty (30) days written notice shall be given to the County of Riverside prior to any material modification, cancellation, expiration or reduction in coverage of such insurance. In the event of a material modification, cancellation, expiration, or reduction in coverage, this Agreement shall terminate forthwith, unless the County of Riverside receives, prior to such effective date, another properly executed original Certificate of Insurance and original copies of endorsements or certified original policies, including all endorsements and attachments thereto evidencing coverage's set forth herein and the insurance required herein is in full force and effect. HOSPITAL shall not commence operations until the COUNTY has been furnished original Certificate (s) of Insurance and certified original copies of endorsements and if requested, certified original policies of insurance including all endorsements and any and all other attachments as required in this Section. An individual authorized by the insurance carrier to do so, on its behalf shall sign the original endorsements for each policy and the Certificate of Insurance.

4) It is understood and agreed to by the parties hereto and the insurance company(s), that the Certificate(s) of Insurance and policies shall so covenant and shall be construed as primary insurance, and the COUNTY'S insurance and/or deductibles and/or self-insured retention's or self-insured programs shall not be construed as contributory.

5) HOSPITAL shall pass down the insurance obligations contained herein to all tiers of subcontractors working tinder this Agreement.
6) The insurance requirements contained in this Agreement may be met with a program(s) of self-insurance acceptable to the COUNTY.

7. HOSPITAL EMPLOYEES AND EQUIPMENT:

HOSPITAL agrees that HOSPITAL has secured or will secure at HOSPITAL'S sole expense all persons, employees, supplies, equipment and facilities needed to perform the services required under this Agreement and that all such services will be performed by HOSPITAL, or under HOSPITAL'S supervision, by persons authorized by HOSPITAL to perform such services.

8. ASSIGNABILITY:

HOSPITAL shall not delegate its duties and responsibilities or assign its rights hereunder, or both either in whole or in part, without the prior written consent of COUNTY.

9. CONFLICT OF INTEREST:

HOSPITAL covenants that HOSPITAL presently has no interest in other projects or contracts, and shall not acquire any such interest, direct or indirect, which would conflict in any manner or degree with the performance of services required to be performed under this Agreement. HOSPITAL further covenants that in the performance of this Agreement no person having such interest shall be employed or retained by HOSPITAL under this Agreement. HOSPITAL shall comply with all applicable federal, state, and local conflict of interest laws and regulations.

10. RESPONSIBILITY FOR COSTS:

COUNTY shall not be liable for any costs or expenses incurred by HOSPITAL to satisfy its responsibilities under this Agreement.

11. NONDISCRIMINATION IN SERVICES AND BENEFITS:

The HOSPITAL shall not discriminate in the provision of services, allocation of benefits, accommodation in facilities, or employment of personnel, on the basis of ethnic group identification, race, color, creed, ancestry, religion, national origin, sexual preference, sex, age (over 40), marital status, medical condition, or physical or mental handicap, and shall comply with all other requirements of law regarding nondiscrimination and affirmative action including those laws pertaining to the prohibition of discrimination against qualified handicapped persons in all programs or activities. For the purpose of this Agreement, distinctions on the grounds of

race, religion, color, sex, national origin, age, or physical or mental handicap include, but are not limited to, the following:

a. Denying an eligible person or providing to an eligible person any services or benefit which is different, or is provided in a different manner or at a different time from that provided to other eligible persons under this Agreement.

b. Subjecting an eligible person to segregation or separate treatment in any matter related to his receipt of any service, except when necessary for infection control.

c. Restricting an eligible person in any way in the enjoyment of any advantage or privilege enjoyed by others receiving a similar service or benefit.

d. Treating an eligible person differently from others in determining whether he/she satisfied any eligibility, membership, or other requirement or condition which individuals must meet in order to be provided a similar service or benefit.

e. The assignment of times or places for the provision of services on the basis of race, religion, color, sex, national origin, age, or physical or mental handicap of the eligible person to be served.

HOSPITAL assures that it will comply with the Americans with Disabilities Act and Title VII of the Civil Rights Act of 1964 and that no person shall, on the grounds of race, creed, color, disability, sex, sexual orientation or national origin, age, religion, Vietnam Era Veteran's status, political affiliation, or any other non-merit factors be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under this Agreement thereafter be amended or added.

12. <u>CONFORMANCE WITH RULES AND REGULATIONS:</u>

HOSPITAL shall comply with applicable Federal, State, County and local rules and regulations, ordinances, policies and procedures current and hereinafter enacted, including facility and professional licensing and/or certification laws and regulations, policies and procedures, and maintain in effect any and all licenses, permits, notices and certificates as are required. This shall include but not be limited to Chapter 6, Article 2.5 of the California Health and Safety Code (commencing with Section 1798.160 et esq.) and the regulations promulgated as Title 22, CCR, Division 9, Chapter 7 and California Evidence Code, Section 1157.7.

13. ADVERTISING:

HOSPITAL may advertise itself as a trauma center.

14. CONFIDENTIALITY:

COUNTY and HOSPITAL agree to maintain the confidentiality of all information and records obtained in the course of providing services to patients under this Agreement in accordance with all-applicable Federal and State statutes and regulations and local Ordinances relating to confidentiality. Such information shall be divulged only as provided by law or as necessarily relating to the audit and evaluation of HOSPITAL'S performance as a Trauma Center. COUNTY agrees to consult with HOSPITAL prior to the establishment of standards and practices to ensure the confidentiality of patient care information.

15. HIPAA COMPLIANCE:

a. The Parties agree to take reasonable steps to maintain the confidentiality of all healthcare files and client data, and shall use appropriate safeguards to prevent inappropriate use of disclosure of individually identifiable patient's information except as permitted by this contract or as required by law. Each Party shall immediately report to the other any impermissible use of disclosure that occurs as to such files and data. Party agrees to destroy in a secure manner, or return to the other, all patient health information shared upon termination of this Agreement as determined by the other. Breach of this provision may serve as grounds for termination of the Agreement.

b. The Parties agree that in the event that either subcontracts their duties and/or obligations created by this Agreement, said subcontractors shall be required to comply with Section a. above.

c. The Parties agree that the Agreement may be amended as necessary to comply with any federal regulations issued under the Health Insurance Portability and Accountability Act (HIPAA) of 1996b or other law or regulation promulgated for HIPAA's purpose.

16. MAINTENANCE OF RECORDS:

HOSPITAL shall maintain or cause to be maintained patient care, total hospital and physician charge and cost data for each Critical Trauma Patient, in such a fashion as to be able to separately identify Critical Trauma Patients from all other patients. All administrative records under this Agreement shall be maintained by; HOSPITAL for a minimum of five (5) years after the termination date of the Agreement for COUNTY inspection.

17. **FISCAL AND PERFORMANCE AUDITS AND INSPECTION OF RECORDS:**

Federal and State representatives as required by law or COUNTY representatives shall have the right to monitor, assess, and evaluate HOSPITAL'S performance pursuant to this Agreement.

18. **REPORTS:**

HOSPITAL agrees it shall not unreasonably hold its consent to submit reports and materials on its services according to this Agreement as requested by the Contract Administrator, as necessary to comply with applicable Federal, State and local laws and regulations, and COUNTY policies. Format for the content of such reports will be developed by the COUNTY. Due dates for submission of various reports and other materials will be set by the COUNTY with concurrence of HOSPITAL. The timely submission of reports and materials is a necessary and material term and condition of this Agreement and HOSPITAL agrees that failure to meet a specified deadline for submission of reports or materials will be sufficient cause for termination of this Agreement. COUNTY agrees not to release any data that may identify the HOSPITAL as the trauma care provider without the consent of the HOSPITAL, unless required by laws, regulations, or ordinance.

19. **EVALUATION STUDIES:**

HOSPITAL will participate as requested by the COUNTY in reasonable research and/or evaluation studies designed to show the effectiveness of Pre-hospital/HOSPITAL services or to provide information about Pre-hospital/HOSPITAL'S services to Critical Trauma Patients as necessary to comply with Federal, State, and local laws and regulations, and COUNTY policies.

20. **TERMINATION FOR CAUSE:**

Prior to the exercise of any termination right under this paragraph by COUNTY, COUNTY shall give HOSPITAL a thirty day written notice specifying all deficiencies, requiring correction of all deficiencies, the grounds for termination, and its intent to terminate in respect thereof. The thirty-day period shall commence upon receipt of notice by HOSPITAL. COUNTY may shorten the period of correction to whatever it deems appropriate under the circumstances, if it determines that HOSPITAL'S actions or inaction has seriously threatened or will threaten public health and safety. If an acceptable plan or correction has not been approved by COUNTY within the given correction period, or all significant deficiencies have not been corrected, COUNTY shall have the right to terminate this Agreement immediately for cause by giving not less than seven days written notice specifying the effective date thereof. Cause for termination shall include but not be limited to:

a. A material failure of HOSPITAL to comply with the terms of this Agreement which affects HOSPITAL'S ability to provide care to trauma victims or which affects COUNTY'S ability to administer the Trauma Care System in the County of Riverside.

b. Failure to provide timely surgical and non-surgical physician coverage for trauma patients, causing unnecessary risk of mortality and morbidity for the trauma patient;

c. Submission by HOSPITAL to the COUNTY or appropriate departments of the County or State of reports or information that are incorrect or incomplete in any material respect;

d. Failure to comply with Federal, State, or County statutes, regulations, and ordinances or failure to comply with COUNTY EMS policies as provided to the HOSPITAL by COUNTY and which are related to the obligations of the HOSPITAL by this Agreement;

e. Loss or suspension of licensure as an acute care hospital, loss of suspension of any existing or future special permits issued by state or federal agencies related to the services provided by the hospital, or loss or suspension of accreditation by the Joint Commission (TJC) ;

f. Failure to comply with established provisions in regard to COUNTY'S monitoring of HOSPITAL'S trauma care services;

g. Failure to cooperate with quality assessment and improvement and audit findings and resulting recommendations of the COUNTY;

h. Gross misrepresentation or fraud by HOSPITAL, its employees, officers, agents, or sub hospitals with respect to this Agreement;

i. Failure to remedy recurring equipment malfunction, physician, nursing and other staff shortage, staff response delays or facility problems which may be or are cause for HOSPITAL to divert ambulances transporting Critical Trauma Patients intended for HOSPITAL.

21. JURISDICTION, VENUE, ATTORNEY FEES:

Should any dispute arise out of the performance of this Agreement, or to establish the right or remedy of either Party under this Agreement, IT IS HEREBY PROVIDED AND AGREED that such dispute shall be submitted to the jurisdiction of the, State of California. This Agreement shall be construed and enforced in accordance with the laws of the State of California. Any action filed arising out of or under this Agreement shall be instituted in Riverside County, California. In the event that costs or attorney's fees arise out of such dispute, the prevailing Party shall be entitled to recover reasonable attorney's fees and costs as part of such action or proceeding, including non-reimbursable litigation expense such as expert witness fees and investigation expenses.

22. **IDENTIFICATION OF MINORITY, WOMEN, DISABLED VETERAN BUSINESS ENTERPRISES:**

In compliance with Federal and State requirements and COUNTY policy to promote the active participation of Minority, Women and Disabled Veteran Business Enterprises (M/W/DVBE's) in the COUNTY'S contracting activities, the COUNTY of Riverside Board of Supervisors has implemented a data collection mandate.

23. **CAPTIONS AND PARAGRAPH HEADING:**

Captions and paragraph headings used in this Agreement are for convenience only and are not a part of this Agreement and shall not be used in construing this Agreement.

24. **WAIVERS, AMENDMENTS, AND AGREEMENTS OUTSIDE OF CONTRACT:**

This document and its exhibits and references incorporated herein fully express all understandings of the parties concerning the matters covered herein and supersede any other agreements between the parties for the services described herein. However, this Agreement does not affect any existing Base Hospital Agreement between the COUNTY and HOSPITAL. No waiver, addition to or alteration of the terms of this Agreement and no verbal understanding of the parties, or their officers, agents or employees, shall be valid unless made in the form of a written amendment.

25. **OWNERSHIP, PUBLICATION, REPRODUCTION AND USE OF MATERIALS:**

HOSPITAL agrees to meet with all other designated Trauma Centers to establish guidelines concerning the publication and use of data relating to the Trauma Care System and any other designated Trauma Center. COUNTY shall acknowledge HOSPITAL'S contribution, and HOSPITAL shall acknowledge COUNTY'S contribution in any materials published or issued as a result of this Agreement. COUNTY agrees not to publish information that would be identifiable to a specific trauma center, without the consent of the HOSPITAL.

26. **MUTUAL COOPERATION:**

Care of the injured patient requires a system approach to ensure optimal care. A systematic approach involves not only one facility, but also an entire community. It is agreed that mutual cooperation and not competition between each of the designated trauma centers and the COUNTY is vital to provide optimal medical care; and that a system approach be used for the care of the trauma patient.

Exhibit A
Riverside County EMS Agency Trauma Center Standards

The following standards have been adopted from the American College of Surgeons Committee on Trauma and Title 22.

"Qualified specialist" or "qualified surgical specialist" or "qualified non-surgical specialist" means a physician licensed in California who is board certified in a specialty by the American Board of Medical Specialties, the Advisory Board for Osteopathic Specialties, a Canadian board or other appropriate foreign specialty board as determined by the American Board of Medical Specialties for that specialty.

A non-board certified physician may be recognized as a "qualified specialist" by the local EMS Agency upon substantiation of need by a trauma center if:

- The physician can demonstrate to the appropriate hospital body and the hospital is able to document that he/she has met requirements which are equivalent to those of the Accreditation Council for Graduate Medical Examination (ACGME) or the Royal College of Physicians and Surgeons of Canada; and
- The physician can clearly demonstrate to the appropriate hospital body that he/she has substantial education, training, and experience in treating and managing trauma patients which shall be tracked by the trauma quality improvement program; and
- The physician has successfully completed a residency program.

Trauma Activations and Tiered Responses

Various other states and organizations have differing interpretations of trauma activation, immediately available, tiered activations, delayed response, role of the trauma center ED physician, trauma consultation, promptly available, and medically prudent which may create some confusion. The State of California has addressed most of these topics through regulation; however, the key regulation is:

Title 22. Social Security
Division 9. Prehospital Emergency Medical Services
Chapter 7. Trauma Care Systems
Article 3. Trauma Center Requirements
§100259 Level I and Level II Trauma Centers
(a) (8) Qualified surgical specialist(s) or specific availability, which shall be available as follows:

(A): general surgeon capability of evaluating and treating adult and pediatric trauma patients shall be immediately available for trauma team activation and promptly available for consultation;

Further explanation of the following terms will further clarify trauma activations and tiered responses:

Trauma activation:
California regulations specify that if a level I or II trauma center initiates a trauma activation all participants of the team are expected to meet the patient in the trauma resuscitation area [§100249] upon arrival. The trauma activation includes the immediate availability [§100237] of a trauma or general surgeon capable of evaluating and treating adult and pediatric trauma patients [§100259 (a) (8) (A)]. Typically, the presence of the trauma surgeon is required for insurance reimbursement of the activation fee.

Immediately available:
Immediately available signifies that the trauma or general surgeon shall be present in the trauma resuscitation upon arrival of the patient [§100237.] The American College of Surgeons specifies that the surgeon should be present in the trauma resuscitation area with 15 minutes of notification, and for PI purposes 80% of the time. Additionally, immediate means:

- Unencumbered by conflicting duties or responsibilities; and
- Responding without delay when notified; and
- Being physically available to the specified area of the trauma center when the patient is delivered.

Promptly available:
Promptly available specifies that the surgeon will respond without delay when notified and be physically available in a period of time that is medically prudent [§100241]. Many local EMS agencies and the American College of Surgeons recognize promptly available as accessible within 30 minutes.

Tiered activation:
The word "tiered" is silent in the regulations; however, the spirit of "tiered" within the California trauma system refers to resources marshaled by a trauma center for trauma team activations. A hospital may create policies to determine what level of peripheral assistance may be necessary once trauma activation occurs. Examples of peripheral assistance may include (but not limited to) duplicate personnel, blood bank, or social workers. California Regulations require that trauma activations include a surgeon that is immediately available [§100259 (a) (8) (A)].

Delayed response:
A delayed response occurs when a patient has injuries indicating a trauma activation yet the activation occurs after the patient arrived at the trauma center. A delayed response should be avoided. If the delayed response does occur the event should be vetted through the quality assurance/performance improvement process [§100265].

Role of the trauma center ED physician:
When field EMS personnel initiate a trauma activation the trauma center ED physician receives the information and determines if the situation requires trauma activation. If a

trauma activation is needed, all participants of the team are expected to meet the patient in the trauma resuscitation area [§100249] upon arrival which includes the immediate availability [§100237] of a trauma or general surgeon capable of evaluating and treating adult and pediatric trauma patients [§100259 (a) (8) (A)]. If the trauma center ED physician determines that a trauma activation is not necessary then that physician determines what team will be needed to receive the patient. The physician may choose to have a trauma surgeon consultation.

Trauma surgeon consultation:
When a trauma center ED physician needs a trauma consultation then a trauma surgeon will be promptly available [§100259 (a) (8) (A)]. Many local EMS agencies and the American College of Surgeons recognize promptly available as accessible within 30 minutes. Once a trauma center initiates a trauma activation a trauma consultation does not apply.

Medically prudent:
Medically prudent represents the combined decision of the trauma center ED physician, trauma center surgeon, and standard of care as to when the surgeon should be present in the trauma resuscitation area [§100241]. The decision must also comply with local EMS agency policies and procedures [§100241].

Summary:
When a trauma center activation is initiated a trauma or general surgeon shall be immediately available. Hospitals may choose to triage resources with an internal tiered response; however, the tiered response shall not compromise the initial membership of the trauma team which includes the leader (trauma or general surgeon). If a trauma center chooses not to initiate a trauma activation, the trauma center ED physician may utilize a trauma consultation. The following chart provides a summary of required trauma center services by the level held by a trauma center.

For a complete copy of trauma regulations go to:
http://www.emsa.ca.gov/laws/files/regs7.pdf

Exhibit A
Riverside County EMS Agency Trauma Center Standards

California Trauma Center Criteria: California Code of Regulations, Title 22, Chapter 7-Trauma Care System					
1	**TRAUMA CENTER CRITERIA**	**Level**	**Level**	**Level**	**Level**
2	**E = Essential (Title 22), D = Desired (Title 22), R=REMSA required**	**I**	**II**	**III**	**IV**
3	**INSTITUTIONS/ORGANIZATION:**				
4	TJC Accreditation (Joint Commission on Accreditation of Healthcare Organizations)	E	E	E	E
5	Licensed hospital in the State of California	E	E	E	E
6	Basic or comprehensive emergency services with special permits	E	E	E	E
7	A minimum of 1200 trauma program hospital admissions, OR	E			
8	A minimum of 240 trauma patients per year whose Injury Severity Score (ISS) is >15, OR	E			
9	An average of of 35 trauma patients (with an ISS of >15) per trauma program surgeon per year	E			
10	A trauma research program	E			
11	An ACGME approved surgical residency program	E			
12	**TRAUMA PROGRAM MEDICAL DIRECTOR:**	E	E	E	E
13	Board Certified Surgeon	E	E	E	
14	Qualified Surgical Specialist (*Level IV may be a non-surgical qualified specialist.)			E	* E
15	Responsibilities include but not limited to:				
16	Recommending trauma team physician privileges	E	E	E	E
17	Working with nursing & administration to support needs of trauma patients	E	E	E	E
18	Developing trauma treatment protocols	E	E	E	E
19	Determining appropriate equipment and supplies	E	E	D	D
20	Ensuring development of policies/procedures for domestic violence, elder/child abuse/neglect	E	E	D	D
21	Having authority and accountability for QI peer review process,	E	E	E	E
22	Correcting deficiencies in trauma care/excluding from trauma call those team members who no longer meet standards,	E	E	E	E
23	Coordinating with local and State EMS agencies,	E	E	R	R
24	Coordinating pediatric trauma care with other hospitals/professional services,	E	E	R	R

25	Assisting with the coordination of budgetary processes for trauma program,	E	E	E	E
26	Identifying representatives from neurosurgery, orthopaedic surgery, emergency medicine, pediatrics and other appropriate disciplines to assist in identifying physicians from their disciplines who are qualified to be members of the trauma program,	E	E	E	R
27	Using the expertise of representatives from neurosurgery, orthopaedics, emergency medicine, pediatrics and other appropriate disciplines,	E	E	R	R
28	Will recruit physicians to be members of the trauma ,	E	E	R	R
29	Coordinating with local and State EMS agencies, (Level IV with local EMS only.)	E	E	R	R
30	**TRAUMA PROGRAM MANAGER**	E	E	E	E
31	Qualifications are:				
32	Registered Nurse	E	E	E	E
33	Dedicated FTE. Current in TNCC or ATCN. Completes 16 hr of trauma education/yr	R	R	R	R
34	Provide evidence of educational preparation, clinical expertise in care of adult & pediatric trauma patient, & administrative responsibilities	E	E	E	E
35	Responsibilities include but not limited to:				
36	Organizing services and systems necessary for multidisciplinary care,	E	E	E	E
37	Coordinating day-to-day clinical process & performance improvement of nursing and ancillary personnel,	E	E	E	E
38	Collaborating with trauma program medical director to carry out educational, clinical, research, administrative and outreach activities of the trauma program.	E	E	E	E
39	**TRAUMA SERVICE**	E	E	E	E
40	Implementation of requirements as specified & provide for coordination with the local EMS agency	E	E	E	E
41	**TRAUMA TEAM**				
42	A multidisciplinary team responsible for the initial resuscitation and management of the trauma patient	E	E	E	E
43	**Trauma Nursing ED**				
44	Registered Nurse	R	R	R	R
45	Expertise in adult and pediatric trauma care	E	E	E	R

46	Maintains TNCC or ATCN	R	R	R	R
47	6 hr/yr of trauma nursing education	R	R	R	R
48	ENPC	R	R	R	R
49	Responsibilities include but not limited to:				
50	Capability of providing *immediate* initial resuscitation/management of the trauma patient	E	E	E	E
51	Ability to provide treatment or arrange for transportation to higher level trauma center.		E	E	E
52	Trauma Data/Registry				
53	Trauma registrar FTE requirements as per the most current ACS recommendations.	R	R	R	R
54	Registrar shall be trauma certified/ credentialed and have 4 hr CE/yr	R	R	R	R
55	**SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTIONS(S):**				
56	Which includes at least the following surgical specialties and staffed by qualified specialists:				
57	General	E	E	E	
58	Orthopedic	E	E	E	
59	Neurologic (*May be provided through transfer agreement)	E	E	E*	
60	Obstetric/Gynecologic	E	E		
61	Ophthalmologic	E	E		
62	Oral/maxillofacial or head and neck	E	E		
63	Plastic	E	E		
64	Urologic	E	E		
65	**NON-SURGICAL DEPARTMENT (S), DIVISION(S), SERVICE(S), SECTIONS(S):**				
66	Which includes at least the following non-surgical specialties and staffed by qualified specialists:				
67	Anesthesiology	E	E	E	
68	Internal Medicine	E	E		
69	Pathology	E	E		
70	Psychiatry	E	E		
71	Radiology	E	E		
72	Emergency Medicine, immediately available	E	E	E	E
73	**QUALIFIED SURGICAL SPECIALIST(S):**available as				

	follows:				
74	Is a Qualified Surgical Specialist (Applies to all specialties)	E	E	E	
75	Residency Coverage:				
76	Surgical Specialists' requirements may be fulfilled by supervised senior residents.	E	E		
77	Senior Resident				
78	Senior Resident must be capable of assessing emergent situations in their respective specialty, and	E	E		
79	Shall be able to provide overall control and surgical leadership including surgical care if needed, and	E	E		
80	Supervising, staff trauma surgeon/surgeon with experience in trauma care shall be on-call & promptly available	E	E		
81	Supervising, staff trauma surgeon shall be advised of all trauma patient admissions, participate in major therapeutic decisions, & be present in the ED for major resuscitations & in the OR for all trauma operative procedures	E	E		
82	General Surgeon:	E	E	E	
83	Capable of evaluating & treating adult and pediatric trauma patients	E	E		
84	Trauma Team Activation: Tiered activations are monitored and reviewed through the PI process for accuracy of under/over triage. Immediate response is defined as 15" 80% of the time, Promptly is defined as 30" 80% of the time.	R	R	R	R
85	Other Qualified Surgical Specialists on-call and *promptly* available:				
86	Neurologic (*Level III - May be provided through written transfer agreement)	E	E	*E	
87	Obstetric/Gynecologic	E	E		
88	Ophthalmologic	E	E		
89	Oral/maxillofacial or head and neck	E	E		
90	Orthopedic	E	E	E	
91	Plastic	E	E		
92	Urologic	E	E		
93	Surgical Consultations:				

94	Available for consultation and transfer agreements for adult and pediatric trauma patients **(in-house or through written agreements)***REMSA note: EMTALA supersedes "written agreements" for higher level of care from the ED.*				
95	Burn Care	E	E	E	E
96	Cardiothoracic - On-Call and *Promptly available*	E			
97	Cardiothoracic		E	E	E
98	Pediatric - On-Call and *Promptly Available*	E			
99	Pediatrics		E	E	E
100	Reimplantation / microsurgery	E	E	E	E
101	Spinal cord injury	E	E	E	E
102	Qualified Non-Surgical Specialist (Applies to all specialties)	E	E	E	
103	*Residency Coverage*				
104	Emergency Medicine and Anesthesiology Specialists' requirements may be fulfilled by supervised senior residents.	E	E		
105	Senior Resident must be capable of assessing emergent situations in their respective specialty and initiating treatment	E	E		
106	*Supervising physician* with experience in trauma care shall be on-call & promptly available	E	E		
107	Supervising qualified specialists shall be advised of all trauma patient admissions, participate in major therapeutic decisions, & be present in the ED for major resuscitations (Anesthesiologists will be in the OR for all trauma operative procedure)	E	E		
108	Emergency Medicine: In-house and *Immediately Available*	E	E	E	E
109	Board certified or recognized qualified specialists in emergency medicine	E	E		
110	ATLS Certification: Required for emergency medicine physicians boarded in other specialties	E	E	E	E
111	Anesthesiology	E	E	E	
112	In-house 24hrs/day and *Immediately Available*	E			
113	On-call and *promptly available* with a mechanism to ensure presence when patient arrives.		E	E	
114	Senior Resident/CRNA in-house with Staff Anesthesiologist *promptly* available and present for surgery	E	E	E	

115	Radiology				
116	On Call and *Promptly Available*	E	E		
117	Other Non-Surgical Specialists Available for consultation:				
118	Cardiology	E	E		
119	Gastroenterology	E	E		
120	Hematology	E	E		
121	Infectious Diseases	E	E		
122	Internal Medicine	E	E		
123	Nephrology	E	E		
124	Neurology	E	E		
125	Pathology	E	E		
126	Pulmonary Medicine	E	E		
127	**SERVICE CAPABILITIES:**				
128	Radiological Service	E	E	E	E
129	Radiological technician *immediately available* for general radiological procedures & computer tomography	E	E		
130	Shall have a radiological technician *promptly available*			E	E
131	Angiography & ultrasound services shall be *promptly available*	E	E		
132	Clinical Laboratory Service				
133	Comprehensive blood bank or access to community central blood bank	E	E	E	E
134	Clinical laboratory services *immediately* available	E	E		
135	Clinical laboratory services *promptly* available			E	E
136	Surgical Services				
137	Shall have an operating suite available or being utilized for trauma patients and has:	E	E	E	
138	A surgical service that has at least the following: (1) operating staff who are immediately available unless operating on trauma patients and back-up personnel who are promptly available.	E			
139	Operating staff, *promptly* available, and back-up staff who are promptly available unless operating on trauma patients. *Back up staff not required		E	*E	
140	Appropriate surgical equipment and supplies as determined by the trauma program Medical Director	E	E		
141	Appropriate surgical equipment and supplies requirements which have been approved by the local			E	

	EMS agency				
142	Cardiopulmonary bypass equipment	E			
143	Operating microscope	E			
144	Basic or comprehensive emergency services with special permits	E	E	E	E
145	Designate emergency physician to be member of trauma team	E	E	E	E
146	Provide emergency services to adult and pediatric patients	E	E	E	E
147	Personnel knowledgeable in the treatment of adult and pediatric trauma	E	E	E	E
148	Designated trauma resuscitation area physically separated from other patient care areas. Of adequate size to accommodate multi-system injured patient and equipment	E	E	E	D
149	Appropriate equipment and supplies for adult and pediatric patients as approved by the director of emergency medicine an in collaboration with the trauma program medical director	E	E	E	E
150	Key controlled elevator, where necessary for immediate access between trauma resuscitation area and helipad, or radiology.	R	R	R	R
151	Intensive Care Service				
~~152~~	~~Special permit licensing ICU service~~	~~E~~	~~E~~		
153	Qualified specialist in-house 24 hours/day *and immediately* available to care for the trauma ICU patient	E			
154	Qualified specialist *promptly* available to care for trauma patients in the ICU		E	E	
155	RN's caring for trauma patients are TNCC, ATCN or TCAR and have 6 hrs/2yr of trauma nursing education	R	R	R	R
156	Qualified specialist may be a resident with 2 years of training who is supervised by staff intensivist or attending surgeon who participates in all critical decision making	E	E	E	
157	Qualified specialist shall be a member of the trauma team	E	E	E	
158	Appropriate equipment and supplies determined by physician responsible for intensive care service and the trauma program medical director.	E	E	E	
159	Burn Center - In House or Transfer Agreement	E	E	E	E

160	Physical Therapy Service:				
161	Personnel trained in physical therapy	E	E		
162	Equipped for acute care of critically injured patient	E	E		
163	Rehabilitation Center - May be provided by written transfer agreement to a rehabilitation center	E	E	E	
164	Personnel trained in rehabilitation care	E	E		
165	Equipped for acute care of critically injured patient	E	E		
166	Respiratory Care Service:	E	E		
167	Personnel trained in respiratory therapy	E	E		
168	Equipped for acute care of critically injured patient	E	E		
169	Acute Hemodialysis Capability	E	E		
170	Occupational Therapy Service:	E	E		
171	Personnel trained in Occupational therapy	E	E		
172	Equipped for acute care of critically injured patient	E	E		
173	Speech Therapy Service	E	E		
174	Personnel trained in speech therapy	E	E		
175	Equipped for acute care of critically injured patient	E	E		
176	Social Service	E	E		
177	Trauma Centers shall have the following services and programs (special license or permit not required)				
178	Pediatric Service:				
179	In-house pediatric service shall have:				
180	PICU approved by CCS or a written transfer agreement with an approved PICU	E	E		
181	Hospitals without a PICU shall establish and utilize written criteria for consultation and transfer of pediatric patients needing intensive care	E	E	E	E
182	A multidisciplinary team to manage child abuse and neglect	E	E		
183	Acute spinal cord injury - In-House or Transfer Agreement	E	E	E	E
184	**ORGAN DONOR PROTOCOL**	E	E		
185	**OUTREACH PROGRAM to include:**				
186	Telephone and on-site physician consultations with physicians in the community and outlying areas	E	E	E	E
187	Trauma prevention for general public	E	E	E	E
188	**CONTINUING EDUCATION** in Trauma Care for:				
189	Trauma Medical Director: Current in ATLS and 16 CME per year in trauma care	E	E	E	E

190	Ongoing education requirements as per the most current ACS recommendations. ATLS as per the most current ACS recommendations.	E	E	E	E
191	Staff nurses	E	E	E	E
192	Staff allied health personnel	E	E	E	E
193	EMS personnel	E	E	E	E
194	Other community physicians and health care personnel	E	E	E	E
195	**PERFORMANCE IMPROVEMENT:**				
196	Must have a quality improvement process in place which includes structure, process and outcome evaluations	E	E	E	E
197	Must have improvement process in place to identify root causes of problems	E	E	E	E
198	Must have interventions to reduce or eliminate the causes	E	E	E	E
199	Must take steps/actions to correct the problems identified	E	E	E	E
200	*In addition the process shall include:*				
201	A detailed audit of all trauma -related deaths, major complications and transfers	E	E	E	E
202	A multidisciplinary trauma peer review committee that includes all members of the trauma team	E	E	E	E
203	Participation in the trauma date management system	E	E	E	E
204	Participation in the local EMS agency trauma evaluation committee	E	E	E	E
205	Have a written system in place for patients, parents of minor children who are patients, legal guardians of children who are patients, and or primary care givers of children who are patients to provide input and feedback to hospital staff regarding the care provided to the children	E	E	E	E
206	Interfacility transfer of Trauma Patients				
207	Patients may be transferred between and from trauma centers providing that: (REMSA note :EMTALA supersedes Title 22 for higher level of care and the need for written transfer agreements, however, repatriation agreements should be in writing.)				
208	Transfers shall be medically prudent as determined by the trauma physician of record	E	E	E	E

209	Shall be in accordance with the local EMS Agency interfacility transfer policies	E	E	E	E
210	Written transfer agreements exists with receiving trauma centers.	E	E	E	E
211	Shall have written criteria for consultation and transfer of patients needing a higher level of care	E	E	E	E
212	Hospitals which have repatriated trauma patients from a designated trauma center will provide the trauma center with all required information for the trauma registry, as specified by local EMS policy.	E	E	E	E
213	Hospitals receiving trauma patients shall participate in system and trauma center quality improvement activities for those trauma patients they have transferred.	E	E	E	E

Exhibit B

CHAPTER 3.75 TRAUMA CARE FUND

1797.198. The Legislature finds and declares all of the following:

(a) Trauma care is an essential public service. It is as vital to the safety of the public as the services provided by law enforcement and fire departments. In communities with access to trauma centers, mortality and morbidity rates from traumatic injuries are significantly reduced. For the same reasons that each community in California needs timely access to the services of skilled police, paramedics, and fire personnel, each community needs access to the services provided by certified trauma centers.

(b) Trauma centers save lives by providing immediate coordination of highly specialized care for the most life-threatening injuries.

(c) Trauma centers save lives, and also save money, because access to trauma care can mean the difference between full recovery from a traumatic injury, and serious disability necessitating expensive long-term care.

(d) Trauma centers do their job most effectively as part of a system that includes a local plan with a means of immediately identifying trauma cases and transporting those patients to the nearest trauma center.

(e) It is essential for persons in need of trauma care to receive that care within the 60-minute period immediately following injury. It is during this period, referred to as the "golden hour," when the potential for survival is greatest, and the need for treatment for shock or injury is most critical.

(f) It is the intent of the Legislature in enacting this act to promote access to trauma care by ensuring the availability of services through EMS agency-designated trauma centers.

[Added by AB 430 (CH 171) 2001. Amended by AB 131 (CH 80) 2005.

1797.199. (a) There is hereby created in the State Treasury, the Trauma Care Fund, which, notwithstanding Section 13340 of the Government Code, is hereby continuously appropriated without regard to fiscal years to the authority for the purposes specified in subdivision (c).

(b) The fund shall contain any moneys deposited in the fund pursuant to appropriation by the Legislature or from any other source, as well as, notwithstanding Section 16305.7 of the Government Code, any interest and dividends earned on moneys in the fund.

(c) Moneys in the fund shall be expended by the authority to provide for allocations to local EMS agencies, for distribution to local EMS agency-designated trauma centers provided for by this chapter.

(d) Within 30 days of the effective date of the enactment of an appropriation for purposes of implementing this chapter, the authority shall request all local EMS agencies with an approved trauma plan, that includes at least one designated trauma center, to submit within 45 days of the request the total number of trauma patients and the number of trauma patients at each facility that were reported to the local trauma registry for the most recent fiscal year for which data are available, pursuant to Section
100257 of Title 22 of the California Code of Regulations. However, the local EMS agency's report shall not include any registry entry that is in reference to a patient who is discharged from the trauma center's
emergency department without being admitted to the hospital unless the nonadmission is due to the patient's death or transfer to another facility. Any local EMS agency that fails to provide these data shall not receive funding pursuant to this section.

(e) Except as provided in subdivision (m), the authority shall distribute all funds to local EMS agencies with an approved trauma plan that includes at least one designated trauma center in the local EMS agency's jurisdiction as of July 1 of the fiscal year in which funds are to be distributed.

(1) The amount provided to each local EMS agency shall be in the same proportion as the total number of trauma patients reported to the local trauma registry for each local EMS agency's area of jurisdiction compared to the total number of all trauma patients statewide as reported under subdivision (d).

(2) The authority shall send a contract to each local EMS agency that is to receive funds within 30 days of receiving the required data and shall distribute the funds to a local EMS agency within 30 days of receiving a signed contract and invoice from the agency.

(f) Local EMS agencies that receive funding under this chapter shall distribute all those funds to eligible trauma centers, except that an agency may expend 1 percent for administration. It is the intent of the Legislature that the funds distributed to eligible trauma centers be spent on trauma services. The funds shall not be used to supplant existing funds designated for trauma services or for training ordinarily provided by the trauma hospital. The local EMS agency shall utilize a competitive grant-based system. All grant proposals shall demonstrate that funding is needed because the trauma center cares for a high percentage of uninsured patients. Local EMS agencies shall determine distribution of funds based on whether the grant proposal satisfies one or more of the following
criteria:

(1) The preservation or restoration of specialty physician and surgeon oncall coverage that is demonstrated to be essential for trauma services within a specified hospital.

(2) The acquisition of equipment that is demonstrated to be essential for trauma services within a specified hospital.

(3) The creation of overflow or surge capacity to allow a trauma hospital to respond to mass casualties resulting from an act of terrorism or natural disaster.

(4) The coordination or payment of emergency, nonemergency, and critical care ambulance transportation that would allow for the time-urgent movement or transfer of critically injured patients to trauma centers outside of the originating region so that specialty services or a higher level of care may be provided as necessary without undue delay.

(g) A trauma center shall be eligible for funding under this section if it is designated as a trauma center by a local EMS agency pursuant to Section 1798.165 and complies with the requirements of this section. Both public and private hospitals designated as trauma centers shall be eligible for funding.

(h) A trauma center that receives funding under this section shall agree to remain a trauma center through June 30 of the fiscal year in which it receives funding. If the trauma center ceases functioning as a trauma center, it shall pay back to the local EMS agency a pro rata portion of the funding that has been received. If there are one or more trauma centers remaining in the local EMS agency's service area, the local EMS agency shall distribute the funds among the other trauma centers. If there is no other trauma center within the local EMS agency's service area, the local EMS agency shall return the moneys to the authority.

(i) In order to receive funds pursuant to this section, an eligible trauma center shall submit, pursuant to a contract between the trauma center and the local EMS agency, relevant and pertinent data requested by the local EMS agency. A trauma center shall demonstrate that it is appropriately submitting data to the local EMS agency's trauma registry and a local EMS agency shall audit the data annually within two years of a distribution from the local EMS agency to a

trauma center. Any trauma center receiving funding pursuant to this section shall report to the local EMS agency how the funds were used to support trauma services.

(j) It is the intent of the Legislature that all moneys appropriated to the fund be distributed to local EMS agencies during the same year the moneys are appropriated. To the extent that any moneys are not distributed by the authority during the fiscal year in which the moneys are appropriated, the moneys shall remain in the fund and be eligible for distribution pursuant to this section during subsequent fiscal years.

(k) By October 31, 2002, the authority shall develop criteria for the standardized reporting of trauma patients to local trauma registries. The authority shall seek input from local EMS agencies to develop the criteria. All local EMS agencies shall utilize the trauma patient criteria for reporting trauma patients to local trauma registries by July 1, 2003.

(*l*) By December 31 of the fiscal year following any fiscal year in which funds are distributed pursuant to this section, a local EMS agency that has received funds from the authority pursuant to this chapter shall provide a report to the authority that details the amount of funds distributed to each trauma center, the amount of any balance remaining, and the amount of any claims pending, if any, and describes how the respective centers used the funds to support trauma services. The report shall also describe the local EMS agency's mechanism for distributing the funds to trauma centers, a description of their audit process and criteria, and a summary of the most recent audit results.

(m) The authority may retain from any appropriation to the fund an amount sufficient to implement this section, up to two hundred eighty thousand dollars ($280,000). This amount may be adjusted to reflect any increases provided for wages or operating expenses as part of the authority's budget process. [Added by AB 430 (CH 171) 2001. Amended by AB 131 (CH 80) 2005]

CHAPTER 2.5 THE MADDY EMERGENCY MEDICAL SERVICES FUND

[Added by SB 12 (CH 1240) 1987.]

1797.98a. (a) The fund provided for in this chapter shall be known as the Maddy Emergency Medical Services (EMS) Fund.

(b) (1) Each county may establish an emergency medical services fund, upon adoption of a resolution by the board of supervisors. The moneys in the fund shall be available for the reimbursements required by this chapter. The fund shall be administered by each county, except that a county electing to have the state administer its medically indigent services program may also elect to have its emergency medical services fund administered by the state.

(2) Costs of administering the fund shall be reimbursed by the fund, based on the actual administrative costs, not to exceed 10 percent of the amount of the fund.

(3) All interest earned on moneys in the fund shall be deposited in the fund for disbursement as specified in this section.

(4) Each administering agency may maintain a reserve of up to 15 percent of the amount in the portions of the fund reimbursable to physicians and surgeons, pursuant to subparagraph (A) of, and to hospitals, pursuant to subparagraph (B) of, paragraph (5). Each administering agency may maintain a reserve of any amount in the portion of the fund that is distributed for other emergency medical services purposes as determined by each county, pursuant to subparagraph (C) of paragraph (5).

(5) The amount in the fund, reduced by the amount for administration and the reserve, shall be utilized to reimburse physicians and surgeons and hospitals for patients who do not make payment for emergency medical services and for other emergency medical services purposes as determined by each county according to the following schedule:

(A) Fifty-eight percent of the balance of the fund shall be distributed to physicians and surgeons for emergency services provided by all physicians and surgeons, except those physicians and surgeons employed by county hospitals, in general acute care hospitals that provide basic or comprehensive emergency services up to the time the patient is stabilized.

(B) Twenty-five percent of the fund shall be distributed only to hospitals providing disproportionate trauma and emergency medical care services.

(C) Seventeen percent of the fund shall be distributed for other emergency medical services purposes as determined by each county, including, but not limited to, the funding of regional poison control centers. Funding may be used for purchasing equipment and for capital projects only to the extent that these expenditures support the provision of emergency services and are consistent with the intent of this chapter.

(c) The source of the moneys in the fund shall be the penalty assessment made for this purpose, as provided in Section 76000 of the Government Code.

(d) Any physician and surgeon may be reimbursed for up to 50 percent of the amount claimed pursuant to subdivision (a) of Section 1797.98c for the initial cycle of reimbursements made by the administering agency in a given year, pursuant to Section 1797.98e. All funds remaining at the end of the fiscal year in excess of any reserve held and rolled over to the next year pursuant to paragraph (4) of subdivision (b) shall be distributed proportionally, based on the dollar amount of claims submitted and paid to all physicians and surgeons who submitted qualifying claims during that year. The administering agency shall not disburse funds in excess of the total amount of a qualified claim.

[Amended by SB 612 (CH 945) 1988; SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; SB 1683 (CH 1143) 1994; AB 2021 (CH 58) 1998; SB 476 (CH 707) 2003; and SB 941 (CH 671) 2005.]

1797.98b. (a) Each county establishing a fund, on January 1,1989, and on each April 15 thereafter, shall report to the Legislature on the implementation and status of the Emergency Medical Services Fund. The report shall cover the preceding fiscal year, and shall include, but not be limited to, all of the following:

(1) The total amount of fines and forfeitures collected, the total amount of penalty assessments collected, and the total amount of penalty assessments deposited into the Emergency Medical Services Fund.

(2) The fund balance and the amount of moneys disbursed under the program to physicians and surgeons, for hospitals, and for other emergency medical services purposes.

(3) The pattern and distribution of claims and the percentage of claims paid to those submitted.

(4) The amount of moneys available to be disbursed to physicians and surgeons, descriptions of the physician and surgeon and hospital claims payment methodologies, the dollar amount of the total allowable claims submitted, and the percentage at which those claims were reimbursed.

(5) A statement of the policies, procedures, and regulatory action taken to implement and run the program under this chapter.

(6) A name of the physician and surgeon and hospital administrator organization, or names of specific physicians and surgeons and hospital administrators, contracted to review claims payment methodologies.

(b) (1) Each county, upon request, shall make available to any member of the public the report required under subdivision (a).

(2) Each county, upon request, shall make available to any member of the public a listing of physicians and surgeons and hospitals that have received reimbursement from the Emergency Medical Services Fund and the amount of the reimbursement they have received. This listing shall be compiled on a semiannual basis.

[Amended by SB 623 (CH 679) 1999; and SB 476 (CH 707) 2003.]

1797.98c. (a) Physicians and surgeons wishing to be reimbursed shall submit their claims for emergency services provided to patients who do not make any payment for services and for whom no responsible third party makes any payment.

(b) If, after receiving payment from the fund, a physician and surgeon is reimbursed by a patient or a responsible third party, the physician and surgeon shall do one of the following:

(1) Notify the administering agency, and, after notification, the administering agency shall reduce the physician and surgeon's future payment of claims from the fund. In the event there is not a subsequent submission of a claim for reimbursement within one year, the physician and surgeon shall reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of reimbursement received from the fund.

(2) Notify the administering agency of the payment and reimburse the fund in an amount equal to the amount collected from the patient or third-party payer, but not more than the amount of the reimbursement received from the fund for that patient's care.

(c) Reimbursement of claims for emergency services provided to patients by any physician and surgeon shall be limited to services provided to a patient who does not have health insurance coverage for emergency services and care, cannot afford to pay for those services, and for whom

payment will not be made through any private coverage or by any program funded in whole or in part by the federal government, with the exception of claims submitted for reimbursement through Section 1011 of the federal Medicare Prescription Drug, Improvement and Modernization Act of 2003, and where all of the following conditions have been met:

(1) The physician and surgeon has inquired if there is a responsible third-party source of payment.

(2) The physician and surgeon has billed for payment of services.

(3) Either of the following:

(A) At least three months have passed from the date the physician and surgeon billed the patient or responsible third party, during which time the physician and surgeon has made two attempts to obtain reimbursement and has not received reimbursement for any portion of the amount billed.

(B) The physician and surgeon has received actual notification from the patient or responsible third party that no payment will be made for the services rendered by the physician and surgeon.

(4) The physician and surgeon has stopped any current, and waives any future, collection efforts to obtain reimbursement from the patient, upon receipt of moneys from the fund.

(d) A listing of patient names shall accompany a physician and surgeon's submission, and those names shall be given full confidentiality protections by the administering agency.

(e) Notwithstanding any other restriction on reimbursement, a county shall adopt a fee schedule and reimbursement methodology to establish a uniform reasonable level of reimbursement from the county's emergency medical services fund for reimbursable services.

(f) For the purposes of submission and reimbursement of physician and surgeon claims, the administering agency shall adopt and use the current version of the Physicians' Current Procedural Terminology, published by the American Medical Association, or a similar procedural terminology reference.

(g) Each administering agency of a fund under this chapter shall make all reasonable efforts to notify physicians and surgeons who provide, or are likely to provide, emergency services in the county as to the availability of the fund and the process by which to submit a claim against the fund. The administering agency may satisfy this requirement by sending materials that provide information about the fund and the process to submit a claim against the fund to local medical societies, hospitals, emergency rooms, or other organizations, including materials that are prepared to be posted in visible locations.

[Amended by SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; AB 1833 (CH 430) 2002; SB 476 (CH 707) 2003; and SB 941 (CH 671) 2005.]

1797.98d. [Repealed by AB 1257 (CH 237) 1989.]

1797.98e. (a) It is the intent of the Legislature that a simplified, cost-efficient system of administration of this chapter be developed so that the maximum amount of funds may be utilized to reimburse physicians and surgeons and for other emergency medical services purposes. The administering agency shall select an administering officer and shall establish procedures and time schedules for the submission and processing of proposed reimbursement requests submitted by physicians and surgeons. The schedule shall provide for disbursements of moneys in the Emergency Medical Services Fund on at least a quarterly basis to applicants who have submitted accurate and complete data for payment. When the administering agency determines that claims for payment for physician and surgeon services are of sufficient numbers and amounts that, if paid, the claims would exceed the total amount of funds available for payment, the administering agency shall fairly prorate, without preference, payments to each

claimant at a level less than the maximum payment level. Each administering agency may encumber sufficient funds during one fiscal year to reimburse claimants for losses incurred during that fiscal year for which claims will not be received until after the fiscal year. The administering agency may, as necessary, request records and documentation to support the amounts of reimbursement requested by physicians and surgeons and the administering agency may review and audit the records for accuracy. Reimbursements requested and reimbursements made that are not supported by records may be denied to, and recouped from, physicians and surgeons. Physicians and surgeons found to submit requests for reimbursement that are inaccurate or unsupported by records may be excluded from submitting future requests for reimbursement. The administering officer shall not give preferential treatment to any facility, physician and surgeon, or category of physician and surgeon and shall not engage in practices that constitute a conflict of interest by favoring a facility or physician and surgeon with which the administering officer has an operational or financial relationship. A hospital administrator of a hospital owned or operated by a county of a population of 250,000 or more as of January 1, 1991, or a person under the direct supervision of that person, shall not be the administering officer. The board of supervisors of a county or any other county agency may serve as the administering officer. The administering officer shall solicit input from physicians and surgeons and hospitals to review payment distribution methodologies to ensure fair and timely payments. This requirement may be fulfilled through the establishment of an advisory committee with representatives comprised of local physicians and surgeons and hospital administrators. In order to reduce the county's administrative burden, the administering officer may instead request an existing board, commission, or local medical society, or physicians and surgeons and hospital administrators, representative of the local community, to provide input and make recommendations on payment distribution methodologies.

(b) Each provider of health services that receives payment under this chapter shall keep and maintain records of the services rendered, the person to whom rendered, the date, and any additional information the administering agency may, by regulation, require, for a period of three years from the date the service was provided. The administering agency shall not require any additional information from a physician and surgeon providing emergency medical services that is not available in the patient record maintained by the entity listed in subdivision (f) where the emergency medical services are provided, nor shall the administering agency require a physician and surgeon to make eligibility determinations.

(c) During normal working hours, the administering agency may make any inspection and examination of a hospital's or physician and surgeon's books and records needed to carry out this chapter. A provider who has knowingly submitted a false request for reimbursement shall be guilty of civil fraud.

(d) Nothing in this chapter shall prevent a physician and surgeon from utilizing an agent who furnishes billing and collection services to the physician and surgeon to submit claims or receive payment for claims.

(e) All payments from the fund pursuant to Section 1797.98c to physicians and surgeons shall be limited to physicians and surgeons who, in person, provide onsite services in a clinical setting, including, but not limited to, radiology and pathology settings.

(f) All payments from the fund shall be limited to claims for care rendered by physicians and surgeons to patients who are initially medically screened, evaluated, treated, or stabilized in any of the following:

(1) A basic or comprehensive emergency department of a licensed general acute care hospital.

(2) A site that was approved by a county prior to January 1, 1990, as a paramedic receiving station for the treatment of emergency patients.

(3) A standby emergency department that was in existence on January 1, 1989, in a hospital specified in Section 124840.

(4) For the 1991-92 fiscal year and each fiscal year thereafter, a facility which contracted prior to January 1, 1990, with the National Park Service to provide emergency medical services.

(g) Payments shall be made only for emergency medical services provided on the calendar day on which emergency medical services are first provided and on the immediately following two calendar days.

(h) Notwithstanding subdivision (g), if it is necessary to transfer the patient to a second facility providing a higher level of care for the treatment of the emergency condition, reimbursement shall be available for services provided at the facility to which the patient was transferred on the calendar day of transfer and on the immediately following two calendar days.

(i) Payment shall be made for medical screening examinations required by law to determine whether an emergency condition exists, notwithstanding the determination after the examination that a medical
emergency does not exist. Payment shall not be denied solely because a patient was not admitted to an acute care facility. Payment shall be made for services to an inpatient only when the inpatient has been admitted to a hospital from an entity specified in subdivision (f).

(j) The administering agency shall compile a quarterly and yearend summary of reimbursements paid to facilities and physicians and surgeons. The summary shall include, but shall not be limited to, the total number of claims submitted by physicians and surgeons in aggregate from each facility and the amount paid to each physician and surgeon. The administering agency shall provide copies of the summary and forms and instructions relating to making claims for reimbursement to the public, and may charge a fee not to exceed the reasonable costs of duplication.

(k) Each county shall establish an equitable and efficient mechanism for resolving disputes relating to claims for reimbursements from the fund. The mechanism shall include a requirement that disputes be submitted either to binding arbitration conducted pursuant to arbitration procedures set forth in Chapter 3 (commencing with Section 1282) and Chapter 4 (commencing with Section 1285) of Part 3 of Title 9 of the Code of Civil Procedure, or to a local medical society for resolution by neutral parties.

(*l*) Physicians and surgeons shall be eligible to receive payment for patient care services provided by, or in conjunction with, a properly credentialed nurse practitioner or physician's assistant for care rendered under the direct supervision of a physician and surgeon who is present in the facility where the patient is being treated and who is available for immediate consultation. Payment shall be limited to those claims that are substantiated by a medical record and that have been reviewed and countersigned by the supervising physician and surgeon in accordance with regulations established for the supervision of nurse practitioners and physician assistants in California. [Amended by SB 2098 (CH 1171) 1990; SB 946 (CH 1169) 1991; SB 1497 (CH 1023) 1996; AB 1833 (CH 430) 2002; SB 476 (CH 707) 2003; SB 635 (CH 524) 2004; and SB 941 (CH 671) 2005.]

[Section 1797.98e of the Health and Safety Code, as added by Section 3 of Chapter 524 of the Statutes of 2004, was repealed by SB 941 (CH 671) of 2005.]

1797.98f. Notwithstanding any other provision of this chapter, an emergency physician and surgeon, or an emergency physician group, with a gross billings arrangement with a hospital shall be entitled to receive reimbursement from the Emergency Medical Services Fund for services provided in that hospital, if all of the following conditions are met:

(a) The services are provided in a basic or comprehensive general acute care hospital emergency department or in a standby emergency department in a small and rural hospital as defined in Section 124840.

(b) The physician and surgeon is not an employee of the hospital.

(c) All provisions of Section 1797.98c are satisfied, except that payment to the emergency physician and surgeon, or an emergency physician group, by a hospital pursuant to a gross billings arrangement shall not be interpreted to mean that payment for a patient is made by a responsible third party.

(d) Reimbursement from the Emergency Medical Services Fund is sought by the hospital or the hospital's designee, as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group.

For purposes of this section, a "gross billings arrangement" is an arrangement whereby a hospital serves as the billing and collection agent for the emergency physician and surgeon, or an emergency physician group, and pays the emergency physician and surgeon, or emergency physician group, a percentage of the emergency physician and surgeon's or group's gross billings for all patients.

[Added by SB 2098 (CH 1171) 1990. Amended by SB 277 (CH 1016) 1998.]

1797.98g. The moneys contained in an Emergency Medical Services Fund, other than moneys contained in a Physician Services Account within the fund pursuant to Section 16952 of the Welfare and Institutions Code, shall not be subject to Article 3.5 (commencing with Section 16951) of Chapter 5 of Part 4.7 of Division 9 of the Welfare and Institutions Code.

[Added by SB 946 (CH 1169) 1991.]

1797.98h. [Automatically repealed on January 1, 2000 as stated in SB 1683 (CH 1143) 1994]