EMS TRAUMA REGION X

POLICY AND PROCEDURE MANUAL

SEPTEMBER 1998
REVISION OCTOBER 2025

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EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: April 1998
REVISED: April 2025

POLICY TITLE: RESOLVING REGIONAL OR INTER-SYSTEM CONFLICTS
POLICY: 0001

Disputes relating to patient care issues, expected standards of professionalism, or any other EMS/Trauma related issues, between Systems or Regions, are to be resolved emphasizing communication, chain of authority, and confidentiality as described in the procedure below. All paperwork shall be confidential for peer review only.

PROCEDURE:

1. In the event a Regional or Inter-System conflict arises, the concerned party shall provide written documentation of all identified issues to the EMS System Coordinator(s) of the involved EMS System(s) within 5 business days of the said conflict. A copy shall also be sent to the Region X EMS Trauma Region Committee and Illinois Department of Public Health.

2. Upon receiving the written documentation, the EMS System Coordinator shall immediately notify the EMS Medical Director. The complaint shall be investigated, and resolution determined acceptable to all involved parties.

3. A written response shall be provided to the individual(s) who initiated the conflict documentation. This is to occur within 30 days of receiving the complaint.

4. At the next quarterly Region X Meeting a report of the conflict and its resolution may be presented by the chair or designee, in an effort to provide education to all members.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: March 1, 1998
REVISED: April 2025

POLICY TITLE: REGIONAL STANDARDIZATION OF CONTINUING EDUCATION REQUIREMENTS

POLICY: 0002

Continuing education hours for Paramedics, EMTs, EMDs and ECRNs are mandated by the Illinois Department of Public Health. Region X EMS System participants have widely different needs based on the geographics, demographics and types of EMS Providers. Therefore, continuing education topics should follow the IDPH recommended topics and total number of hours.

PROCEDURE:

1. Provider participants must follow the Continuing Education Policies set forth within their Primary EMS System. If a participant also functions within another Region X EMS System, only mandatory continuing education requirements of a non-primary System must be attended.

2. EMT/Paramedic Participants shall meet the continuing education requirements as set forth by the EMS system within Region X. EMT/Paramedic Participants shall meet their System standard as follows:

CONDELL MEDICAL CENTER EMS SYSTEM	24/60/100 Hours/4 years
HIGHLAND PARK EMS SYSTEM:	24/60/100 Hours/4 years
LAKE FOREST EMS SYSTEM:	24/60/100 Hours/4 years
NORTH LAKE COUNTY EMS SYSTEM:	24/60/100 Hours/4 years
SAINT FRANCIS EMS SYSTEM:	24/60/100 Hours/4 years

4. ECRNs shall have 8 hours of continuing education per year (32 hours total in the 4-year licensing period).

5. EMDs shall have 12 hours of continuing education per year (48 hours total in the 4-year licensing period).

6. EMR/EMT/Paramedic will follow the suggested IDPH licensure guidelines.

6. Content for Paramedic, EMT, EMD and ECRN participants shall be consistent with IDPH-EMS Rules and Regulations, as decided by individual EMS System needs as determined by QI and System activity.

7. Teaching methods shall include, but not limited to lecture and skill labs.

8. Testing requirements are to be determined by each EMS System

Illinois Department of Public Health

Division of EMS & Highway Safety

www.dph.illinois.gov/topics-services/emergency-preparedness-response/ems

Emergency Medical Systems

Continuing Education / Relicensure Recommendations APPROVED by EMS Education Committee 1-22-24

Continuing education for all EMS clinicians must meet or exceed the criteria listed in the IDPH EMS Rules Sections 515.560 EMT Continuing Education; 515.570 A-EMT and EMT-I Continuing Education; 515.580 Paramedic Continuing Education; and 515.590 EMS Personnel License Renewals as well as CE that may be mandated by law, rule, or guideline for EMS clinicians (Example: Alzheimer education).

Illinois Minimum CE hours required in 4 years: Paramedics/PHRNs: 100 | A-EMTs/EMT-Is: 80 | EMTs: 60 | ECRNs: 32

CE Approval: System and agency-sponsored continuing education classes, seminars or other programs shall be approved by the Department (IDPH) before being offered to EMS personnel. See EMS rules for application procedure (site code request process). Content must be consistent with the EMS education standards for the appropriate license level. Commercial CE, webinars, or seminars/conferences sponsored by other agencies and entities shall be approved by the EMS MD and should have CE hours awarded by the Commission on Accreditation for Prehospital Continuing Education (CAPCE- See https://www.capce.org/) or by another official education credentialing center/organization.

The Continuing Education (CE) options below are NOT intended to be all-inclusive. A wide variety of educational offerings that are not listed may also meet the intent of national, state, and local standards for EMS continuing education and **must be considered and approved by the local EMS MD and IDPH**

Max hours per subject area: May not exceed 20% of total hours for one general subject area. Educators may not get credit for presenting the same topic/lecture multiple times.

Standard Documentation required to validate completion: CE certificate, course card, or paper or electronic roster verified by instructor or authorizing person to include: name of participant; date; times; topic(s); number of CE hours awarded; Illinois site code, CAPCE and/or medical or nursing accrediting body number. All CE hours awarded must be approved by the EMS Medical Director or designee.

Local verification: EMS personal must verify the CE requirements within their EMS System(s) of affiliation. EMS System MDs may require their EMS personnel to obtain EMS CE above the minimum requirements outlined in Illinois EMS Administrative Code, Section 515.590.

Optional/voluntary consideration:

National Continued Competency Program (NCCP) (Required for NREMT recertification): The NCCP has three continuing education (CEU) requirement areas: National, State/Local, and Individual. The NREMT sets the requirements for the National portion. State/Local and individual credits must related to EMS Services or EMS patient care. The national component of the NCCP constitutes 50% of the total recertification requirements. Topics included in the national content reflect current trends in evidence-based medicine, scope of practice changes and position papers from numerous associations involved with EMS research. There is an additional focus on those patient presentations that have a low frequency but high criticality acuity. At least 10% of the National Component must be pediatric-focused content.

National Component Requirements

Expiration dates through Sept. 30, 2025: Download the 2016 NCCP Model (PDF)

Expiration dates after March 31, 2026: Download the 2025 NCCP Model (PDF)

(National Continued Competency Program | National Registry of Emergency Medical Technicians (nremt.org)

Courses that cannot be applied towards NREMT recertification requirements include duplicate courses, clinical rotations, EMS instructor courses, management/ leadership courses, performance of duty, preceptor hours, serving as a skill examiner, and volunteer time with agencies. If you have questions on accepted education, please review the NREMT Recertification Guide (link above).

Activity		Documentation	Max Hours Recommended	Comments
Initial standardized "Life Support" courses (Provider level) (Traditional or adaptive learning approaches)			Hr/Hr to max recommended by sponsoring entity for each course	
Cardiology				
CPR-HCP	CPR for Healthcare Professional	Standard	4 hr	
ACLS	Advanced Cardiac Life Support	Standard	10 hr / course	
ALS	**Advanced life support content**	Standard	5 hr / yr | 20 hrs in 4 yrs	PM, PHRN, PHAPRN, PHPA
Medical				
AMLS	Advanced Medical Life Support	Standard	16	
EMPACT	Emergency Medical Patients: Assessment, Care and Transport	Standard	16	
ASLS	Advanced Stroke Life Support	Standard	8	
ENLS	Emergency Neurological Life Support	Standard	15	
Special Populations				
PALS	Pediatric Advanced Life Support		12	
APLS	Advanced Pediatric Life Support		14	
PEARS	Pediatric Emergency, Recognition and Stabilization		8	
NRP	Neonatal Resuscitation Program		8	
PEPP	Pediatric Education for Prehospital Professionals (ALS)		12	
EPC	Emergency Pediatric Course		16	
GEMS	Geriatric Education for EMS		8	
Trauma				
ABLS	Advanced Burn Life Support			
ATLS	Advanced Trauma Life Support (ALS)			PM, PHRN, PHAPRN, PHPA
ITLS	International Trauma Life Support		16	
PHTLS	Prehospital Trauma Life Support		16	
	Stop the Bleed course			
	Tactical Casualty Combat Care – Military Personnel			
	Will specify individual classes			
	Wilderness EMS Training, TEMS			Hr/Hr for EMS content of course
Initial standardized "Life Support" (Instructor course)		Standard	Hr/Hr to max recommended by sponsoring entity	
Standardized "Life Support" courses renewal		Standard	Hr/Hr to max recommended by sponsoring entity	
CPR/ACLS/PALS/NRP frequent ongoing competency with rolling renewal if using RQI		Standard	Hr/Hr to max recommended by AHA	
ADDITIONAL Sources OF CE				
Attending/Teaching , MIH Community PM, Critical Care PM		Standard	Hr/Hr to max recommended by sponsoring entity	
Pediatric related CE		Standard	At least 10% of total CE hours required	Illinois recommends at least 10% of total required hours in 4 yrs are related to pediatric patients. Topics include: Pediatrics, Neonatology, Gynecology and Obstetrics.
Initial courses: Emergency Vehicle Operators course,		Standard	Hr/Hr up to	

Activity	Documentation	Max Hours Recommended	Comments
		12 hrs max	
Locally offered CE Examples of approved offerings:	Standard	Hr/Hr to max subject hours	May not exceed 20% of total minimum required hours in one general subject area, e.g., cardiac, trauma, medical, rescue, etc.
Local credentialing (System entry) activities	Standard	"	
Local orientation/onboarding; equipment competency education/labs	Standard	"	
After action reports, debriefs	Standard	"	
Quality improvement case reviews	Standard	"	
Agency-sponsored CE w/ site codes	Standard	"	
High fidelity simulations/scenarios	Standard	"	
Virtual task trainers and virtual simulations	Standard	"	
Microlearning modules of EBGs w/ posttest/assessment	Standard	"	
Bloodborne Pathogens course in compliance with the 2023 Occupational Safety and Health Administration (OSHA) regulation 29 CFR 1910.1030. Online Training acceptable See https://www.nationaloshafoundation.com/	Standard	1 hour/year	
Mandated reporter status: Free online education available from DCSF: See https://mr.dcfstraining.org/UserAuth/Login!loginPage.action	Standard	2 hrs/year	
CHEMPACK Program & the State of Illinois CHEMPACK Plan/EMS Stockpile: Instructional materials available on the IDPH website. See: https://dph.illinois.gov/topics-services/emergency-preparedness-response/public-health-care-system-preparedness.html	Standard	1 hour/year	
For license renewals occurring on or after January 1, 2023, EMS personnel must complete at least a one one-hour course on the diagnosis, treatment, and care of individuals with **Alzheimer's disease or other dementias** per license renewal period.	Standard	1 hr in 4 years	This training shall include, but not be limited to, assessment and diagnosis, effective communication strategies, and management and care planning. Public Act 102-0772 https://www.ilga.gov/legislation/publicacts/102/PDF/102-0772.pdf
Audit of entry level EMT, AEMT, Paramedic courses	Standard	Hr/Hr to max content hours	Unlimited hours if subject matter is at the appropriate level for the participant's license. May not exceed 20% of total required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Author/editor/instructor of educational offerings related to EMS care • Author of modules/ presentations/ other media • Author of journal article/ book chapter(s) • Journal/book reviewer | Textbook editor • Creator of poster presentation | Author of an unpublished thesis • Instructor for EMS-related subject at your license level • Preceptor to EMS students/personnel	Signed letter from EMSC or lead instructor; see right.	Hr/Hr to max hrs locally allowable	Submit a copy of the article, chapter, or presentation for credit consideration | Submit summary and photo of poster project Submit evidence of participation as an instructor in the form of student handouts prepared and a brochure or written statement from the course coordinator verifying the topics and hours of participation.
Emergency Preparedness activities include completing FEMA National Incident Management System (NIMS) Training, participating in emergency preparedness planning activities, and/or a System-recognized exercise and/or after action critique.	Written statement of participation from EMSC/EMS MD or exercise director.	Hr/Hr up to 12 hrs (ALS clinician 10 hrs (A-EMT/EMT-I) 8 hrs (EMT)	EMS personnel must be able to demonstrate an active participating role during the preparedness event, exercise or training.

Activity	Documentation	Max Hours Recommended	Comments
College courses: Courses that relate to the role of an EMS professional (A&P, assessment, physiology, biology, chemistry, microbiology, pharmacology, psychology, sociology, nursing/PA courses, Communication/Speech, etc.)	Syllabus or catalogue description of course and evidence of successful completion (minimum grade of C on official transcripts or evidence from school)	*Hr/Hr 1 college credit = 8 CEU*	May not exceed 20% of total hours for one subject area. Should be considered on a case by case basis for any topics in EMS education standards.
Participation/observation in surgery, physical therapy, childbirth, autopsy, etc.	Written statement of participation from: preceptor or physician validating attendance	Hr/Hr up to max of 5 hrs/licensure period	Max 5 hours; must be part of an approved educational experience or include defined educational objectives.
Seminars/Conferences: EMS related education approved by CAPCE or medical or nursing accrediting body	Copy of agenda/program plus certificate of attendance	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Commercial CE: Electronic digital media, journal articles with publication dates of 5 years or less prior to the date of CE completion. Approved by CAPCE or medical or nursing accrediting body	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area, e.g., cardiac, trauma, rescue, etc.
Trauma Nurse Specialist or TNS Review Courses: May audit for CE with prior approval of TNS Course Coordinator to ensure space availability	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area. Course covers multiple areas of A&P, fluid & electrolytes, acid base balance, shock pathophysiology and systems trauma appropriate for PMs and PHRNs for full credit.
ECRN *Course (apart from Life Support courses)*: May audit for CE with prior approval of Course Lead Instructor to ensure space availability	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area. Course may cover multiple across the spectrum of EMS appropriate for PMs and PHRNS for full credit
On-line options: Webinars and on-line offerings with subject matter found in the EMS Education Standards [e.g. sponsored by a governmental agency (infectious diseases, emergency preparedness); legal experts (documentation; HIPAA); organizations or commercial offerings].	Standard	Hr/Hr to max content hrs	May not exceed 20% of total minimum required hours in one subject area,

Illinois recommended Core Content CE hour distribution during each relicensure period. EMS System MDs may require alternate EMS CE based on local QAPI data and additional hours above the minimum requirements as outlined in the Illinois EMS Administrative Code, Section 515.590 (EMT Licensure Renewal).

Suggested IL CE Hr distribution (optional – subject to local EMS MD approval)						
Topic area	**PM**	**AEMT**	**EMT**	**ECRN**	**PM NR**	**PM NR %**
Airway, Respiratory	20	16	12	6	**6/30**	0.2
Cardiology	23	19	14	8	**7/30**	0.233
Medical	27	21	16	8	**8/30**	0.267
Trauma	17	13	10	6	**5/30**	0.167
Operations	13	11	8	4	**4/30**	0.133
Total Hrs IL	100/4 yrs	80 / 4y	60 / 4y	32 / 4y	NREMT 30/ **2** yrs	

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1, 1998
REVISED: April 2025

POLICY TITLE: SPECIALIZED CARE TRANSFERS / DIVERSIONS
POLICY: 0003

Trauma

1. Category I trauma patients
    a. Transport to the closest Level I Trauma Center unless transport times from the scene exceed 25 minutes.
    b. If transport times to the closest Level I Trauma Center exceed 25 minutes, the patient should be transported to the nearest Level II Trauma Center for initial resuscitation and stabilization.
    c. Once stabilization is accomplished within the capability of the Level II Trauma Center, consider transfer to a Level I Trauma Center for further specialized care.

2. Medical Control may divert to a Level I Trauma Center at their discretion.

3. Transport to closest Trauma Center
    a. Traumatic arrest
4. Transport to **closest** Comprehensive Emergency Department
    a. No airway

STEMI

1. Transport to the closest Chest Pain Center.
    a. Condell Hospital
    b. Evanston Hospital
    c. Glenbrook Hospital
    d. Highland Park Hospital
    e. Lake Forest Hospital
    f. Saint Francis Hospital
    g. Vista Hospital
2. Skokie Hospital is not a Chest Pain Center

Stroke

1. Comprehensive Stroke Center
    a. Evanston Hospital
2. Primary Stroke Center
    a. Condell Hospital
    b. Glenbrook Hospital
    c. Highland Park Hospital
    d. Lake Forest Hospital
    e. Saint Francis Hospital
    f. Vista Hospital
3. Skokie Hospital is not a primary stroke center.

4. If an LVO is suspected, transport to Comprehensive Stroke Center if within 30 minutes and within the agency's typical transport destination.

Mental Health Facility

1. Follow the Region X guidelines regarding transporting behavioral patients to approved Mental Health Facilities.

Urgent Care/Immediate Care

1. In Region X there are no EMS System approved Urgent Care or Immediate Care Facility that an EMS provider can transport to.

Pediatric Patients

All pediatric patients should be transported to an approved pediatric emergency department. EDAP Capable.

Freestanding Emergency Departments

Ambulances should only transport BLS patients to a Freestanding ED.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: March 2001
REVISED: April 2025

POLICY TITLE: BYPASS / RESOURCE LIMITATIONS
POLICY: 0004

Definitions:

Bypass: Bypassing of or diversion by an ambulance to a hospital other than the nearest hospital when the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from transport to the more distant facility.
Diversion: Open-Resource Limitations: This status indicates that the hospital ED is open; however, there is an equipment-related resource limitation (i.e. CT scanner down), which currently limits the hospital's ability to treat specific patient types as a result. When selecting this status type, the hospital is required to indicate the specific resource limitation in the comments section. For example, "CT scanner is down until further notice."

Guidelines have been established by Illinois Department of Public Health regarding circumstances in which a hospital may go on bypass/Resource limitation. Once a peak census or surge capacity is reached, the hospital must have utilized its' surge plan to prevent avoidable diversion status addressing ED, inpatient and observation/outpatient procedure/surge beds. All reasonable efforts must be made to resolve the essential resource limitation(s).

NOTE: Bypass status may not be honored if three or more hospitals in a geographic area are on bypass status and transport time by ambulance to the nearest hospital exceeds 15 minutes. It is understood a geographic area may cross regional boundaries.

NOTE: This policy follows the IDPH EMS Rules and Regulations. Region X EMS and Trauma Advisory Council continues to vote in favor of no bypass unless of an internal disaster. Region X will continue with the No Bypass until the day the vote is changed and then we will default to the IDPH EMS Rules and Regulations.

During the period of diversion, resource limitation, a hospital can respond on a case-by-case basis and thereby divert a provider, through direct communication, only when necessary.

1. Types of resource limitations include but are not limited to:
    a. CT scanner out of service
    b. All staffed OR suites are in use.
    c. No critical care or monitored beds available in the hospital.

d. Number of staff (after attempts have been made to call in additional staff in accordance with facility policy)
e. Internal disaster

PROCEDURE:

1. Upon determining a resource limitation exists, a hospital designee shall contact the next closest acceptable facilities and alert the Emergency Department(s) of the limitation. In addition, the hospital shall notify the affected fire departments, private ambulance agencies and surrounding hospitals.

2. The hospital designee shall post the ED status (Bypass/Open-Resource Limitations) on Em Resource, including the reason for the bypass/Open-Resource Limitations) and provide updates at least every 4 hours.

3. In the event a patient has an unstable/time sensitive (for example: STEMI, stroke-like symptoms, categorized trauma) condition which would be detrimental to transport further, then the hospital on bypass is to accept that patient, stabilize and transfer out when acceptable and if necessary.

NOTE: Regarding unstable/time-sensitive patients, the attending ED physician must be involved in the decision to accept or divert a patient while on bypass/Open-Resource Limitations).

4. In the event a prehospital provider contacts the hospital on bypass, a full report shall be received from the provider unit, medical orders given, and transport time to the next closest facility determined. The attending Emergency Department Physician or designee shall immediately notify the receiving facility and provide a full EMS report and transport time.

5. When resource limitation(s) is/are corrected, the facility and agencies originally notified, shall be contacted and updated.

6. EmResource shall be updated with the corrected status (Open).

7. Any complication(s) arising from this policy shall be addressed utilizing Policy 001 Resolving Regional or Inter-System Conflicts.

BYPASS / Diversion Procedure for Hospitals
Case By Case Events
Checklist

Name of person completing form: _____

Date of form completion: _____ **Time:** _____: _____ AM / PM

Resource Limitation
(check all that apply)

☐ CT scanner status out of service

☐ Operating suites at capacity

☐ All critical care beds unavailable

☐ All monitored beds unavailable

☐ Active internal disaster

Type: _____

Date and time of resource limitation:

_____

_____: _____ AM / PM

☐ Inadequate number of available staff despite attempts, per protocol, to call in additional staff
(be prepared to provide call logs)

Determination Checklist

At time of bypass determination:

_____ Number of critical care beds

_____ Number of monitored beds

_____ Number of staff

_____ Number of critical care beds unstaffed

_____ Number of monitored beds unstaffed

☐ EmResource reflects current status

Hospitals in the area on bypass:

_____

_____

_____

Date of "Peak Census" policy activation: _____

Time of "Peak Census" policy activation: _____: _____ AM / PM
(must be 3 hours prior to request of bypass)

_____ Number of hours for in-patient holds waiting for bed assignments

_____ Number of patients in the Emergency Department waiting room

_____ Longest number hour hours wait time in the Emergency Department

_____ In-house open beds that are not able to be staffed

_____ Number of beds ED beds occupied by in-patient holds

_____ Number of potential in-patient discharges

_____ Number of open ICU beds

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1998
REVISED: April 2025

POLICY TITLE: WITHHOLDING OR WITHDRAWING RESUSCITATIVE EFFORTS AND ADVANCED DIRECTIVES

POLICY: 0005

All EMS Personnel covered by this Standard Operating Procedure must initiate resuscitative efforts on all pulseless and apneic patients except those patients who present with one or more of the following indications that an irreversible death process has occurred.

* decapitation
* rigor mortis without profound hypothermia
* dependent lividity
* obvious body decomposition
* incineration
* transection
* obvious mortal trauma

Note: If there is any uncertainty regarding any aspects of this policy, institute care and contact Medical Control for direction.

Specific Circumstances Regarding Resuscitative Efforts Include:
POLST (Practitioner's Orders of Life-Sustaining Treatment) / DNR (Do Not Resuscitate) Orders

1. Attempt to confirm that the POLST/DNR Order is valid.
   COMPONENTS OF A VALID DNR ORDER:
   * Must be a document that has not been revoked, and contains the following information:
   * Name of patient
   * Name and signature of the Health Care Practitioner
   * Effective date
   * The Words "DO NOT ATTEMPT RESUSCITATION"
   * **Evidence of consent – either/or:**
     A. Signature of the patient, or the patient's legal guardian; or
     B. Signature of durable power of attorney for Health Care agent; or
     C. Signature of surrogate decision maker.

Medical Interventions

1. Refer to the IDPH POLST form for further information.

2. If resuscitative efforts were established prior to the POLST/DNR document being presented, efforts may be withdrawn once the validity of the POLST/DNR order is confirmed, and Medical Control is contacted for confirmation of cessation of resuscitative efforts.

Advanced Directive

If an individual presents themselves as the "agent" having Durable Power of Attorney for Healthcare to direct medical care of a patient and/or a document referred to as a Living Will is presented, follow these guidelines:

1. When EMS Personnel are presented with Durable Power of Attorney for Healthcare, EMS Personnel are to contact Medical Control for guidance since no form can address all the medical treatment decisions that may need to be made.
2. Living Wills, cannot be recognized by prehospital care providers.
3. Bring all documentation to the receiving hospital or in the case of no transport, have the documentation available for medical examiner/coroner.

Hospice Patients

Terminally ill patients participating in a hospice program often have written treatment orders and may possess a valid DNR/POLST document. Medical Control is to be contacted regarding supportive treatment measures.

Sustained Cardiac Arrest Not Responding to Treatment

Note: Only a Physician may decide to withdraw resuscitative efforts and pronounce the patient dead at the scene.

In the event of communication failure, this policy should <u>not</u> be considered a standing order.

1. While continuing patient care, contact Medical Control and report the events of the call including estimated duration of cardiopulmonary arrest and treatment rendered.

2. Reaffirm all of the following: add from SOP
    a. non-traumatic arrest.
    b. Normothermic
    c. patient is at least 18 years of age
    d. patient experienced an unwitnessed arrest by an EMS provider
    e. No respirations, pulse, heart sounds
    f. in asystole or wide complex PEA < 60 bpm

3. If the Physician orders the termination of resuscitative efforts, note the time of withdrawal of efforts, and the Physician's name who terminated the effort.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: March 1998
REVISED: April 2025

POLICY TITLE: DISBURSEMENT OF EMS ASSISTANCE FUNDS
POLICY: 0006

The Region X EMS Systems will provide a systematic process for the disbursement of money received from the EMS Assistance Fund. These funds shall be used for organizational, development and improvement of Region X Emergency Medical Services Systems, including, but not limited to training of personnel and acquisition, modification and maintenance of necessary supplies, equipment and vehicles.

PROCEDURE:

1. Any Region X EMS participant may apply for funds through IDPH EGrams.

2. All Region X EMS participants will be notified by Illinois Department of Public Health. The application shall be made through the Illinois Department of Public Health Egrams software program.

3. The awarding of funds shall be based on demonstrated need and one or more of the following:

    A. Establishment of a new EMS agency, program or service where needed to improve emergency medical services available in an area
    B. Expansion or improvement of an existing EMS agency, program or service
    C. Replacement of equipment that is unserviceable or procurement of new equipment
    D. Establishment, expansion or improvement of EMS education and training programs including the adult and pediatric population.

4. Applications for regional requests will be forwarded by IDPH to the Chair of the Region X EMS Advisory Committee.

5. The Region X EMS Advisory Executive Group shall review all applications received before the deadline established by IDPH.

6. The award amount will be based upon the amount requested within the application, the recommendation of the Region X EMS Advisory Committee and the amount available in the Fund for distribution. The final decision rests with IDPH.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: December 1999
REVISED: April 2025

POLICY TITLE: INTER-SYSTEM GUIDELINES FOR MEDICAL CONTROL
POLICY: 0007

Within Region X there are five EMS Systems coordinating and providing Medical Control for prehospital care providers. One Standard Operating Procedure document exists for all five EMS Systems. It is in the patient's best interest to allow any Region X Resource or Associate Hospital to direct Medical Control. NOTE: Associate Hospitals may be located outside of the Region X boundaries.

PROCEDURE:

1. Prehospital Provider Agency **MUST** be approved to function in Region X.

2. Medical Control **MUST** be obtained from a Region X Resource or Associate Hospital.

3. Providers are encouraged to contact Medical Control at the receiving hospital.

4. In the event any Region X approved Provider cannot communicate with the intended receiving facility, the Provider shall contact their Resource Hospital for Medical Control.

5. Individual EMS System's Override Policies will prevail in the event of a Medical Control conflict.

6. Conflicts regarding patient care or any other difficulties shall be addressed by using the Region X Inter-System Conflict Resolution Policy.

7. In the event of an Inter-System conflict, all written and or recorded documentation will be shared between the involved Systems and provider agency(is).

8. Authority for this policy has been delegated by each System EMS Medical Director.

REGION X
INTER-SYSTEM MEDICAL CONTROL
COMMUNICATION POINTS

HOSPITAL CONTACTS

NLC - NORTH LAKE COUNTY HPH – HIGHLAND PARK CMC – CONDELL MEDICAL CENTER SFH - ST. FRANCIS

HOSPITAL	SYSTEM	CELLULAR TELEMETRY	ER PHONE NUMBER	Care Point Fax/Email
Condell Medical Center	CMC	847-362-2963	847-990-5300	847-990-2992
		847-573-4258		Cond-emscarepointradio@aah.org
Evanston Hospital	HPH/SFH	847-492-9453	847-570-2111	847-570-2932
		847-492-1457		847-733-5838
Glenbrook Hospital	HPH/SFH	847-729-9260	847-657-5632	847-657-5960
		847-657-6010		847-503-6186
Highland Park Hospital	HPH	847-432-2294	847-480-3751	847-926-55325
		847-432-2295		847-926-5325
Lake Forest Hospital	LFH	847-535-7375	847-535-6150	nlfhcarepoint1@nm.org
LF Grayslake Freestanding ED	LFH	847-535-8736	847-535-8950	
St. Francis Hospital	SFH	847-864-6564	847-316-2440	847-316-2615
		847-864-8550		
Skokie Medical Center	HPH/SFH	847-674-2665	847-933-6950	847-674-2647
		847-674-2694		
Vista East Medical Center	NLC	847-360-4234		847-360-4181 carepoint-east@amhealthsystems.gdcarepoint.com
James Lovell	NLC	224-610-1442	224-610-5505	224-610-5306
		224-610-1076		
Froedtert South	NLC	262-697-5563		262-577-8202
Aurora Medical Center	NLC	262-694-1968	262-948-5640	
		262-694-1973		

REGION X
INTER-SYSTEM PROVIDER LISTING

NLC – North Lake County HPH – Highland Park SFH – Saint Francis
CMC – Condell Medical Center LFH – Lake Forest

Provider	EMS System	Level of Service
Abbott	CMC	BLS
Alpha Medical Transport	CMC	BLS
Ambulnz	NLC	BLS/ALS
A-TEC	NLC	BLS / ALS
Antioch Fire Department	CMC	ALS
Beach Park Fire Department	NLC	ALS
Countryside Fire Department	LFH	ALS
Deerfield Fire Department	HPH	ALS
Elite Ambulance	SFH/NLC	BLS/ALS
Evanston Fire Department	SFH	ALS
Glencoe Public Safety	HPH	ALS
Grayslake Fire Department	LFH	ALS
Great Lakes Fire Department	LFH	ALS
Gurnee Fire Department	HPH	ALS
Highland Park Fire Department	HPH	ALS
Houston PI	HPH	BLS
IMG	NCL	BLS/ALS/CCT
Lake Bluff Fire Department	LFH	ALS - NT
Lake Forest Fire Department	LFH	ALS
Lake Villa Fire Department	LFH	ALS
Libertyville Fire Department	LFH	ALS
Lincolnwood Fire Department	SFH	ALS
MedEx Ambulance	SFH	BLS/ALS/CCT
Mundelein Fire Department	LFH	ALS
Murphy Ambulance	CMC/NLC	BLS/ALS/CCT
Newport Fire Department	LFH	ALS
North Chicago Fire Department	LFH	ALS
Northbrook Fire Department	HPH	ALS
Northfield Fire Department	SFH	ALS
Round Lake Fire Department	CMC	ALS
Sedgebrook	CMC	BLS
Six Flags / Great America	HPH	BLS/ALS
Skokie Fire Department	SFH	ALS
Superior Ambulance	HPH/NLC/SFH	BLS/ALS/CCT
Waukegan Fire Department	LFH	ALS
Wheeling Fire Department	SFH	ALS
Wilmette Fire Department	SFH	ALS
Winnetka Fire Department	SFH	ALS
Winthrop Harbor Fire Department	NLC	ALS
Zion Fire Department	NLC	ALS

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: February 2000
REVIEWED: April 2025

POLICY TITLE: SCHOOL BUS ACCIDENTS

POLICY: 0007
The purpose of this policy is to provide guidance for the management of school bus accidents involving minors. It is to be implemented by EMS personnel in conjunction with the Region X and EMS System's policies governing mass casualties. The goal of this policy is to reduce the number of uninjured children transported to hospitals, to reduce the EMS scene time and utilization of resources.

Each EMS provider within the System is required to design and implement a procedure for discharging uninjured children to their parents/legal guardians or to local school officials who are ***willing*** to take custody of the children. The Provider may adopt whatever policy it chooses to best accomplish the goal of transferring custody of uninjured children to the parents/legal guardians or school officials. It is recommended these policies be developed with the collaboration of local school officials and provider legal counsel.

Once it is determined minor children are not injured, the custody and responsibility for these children will remain with the EMS provider agency until the children are transferred to parents or school officials.

PROCEDURE:
1. Upon arrival at the scene
   A. Determine the category of the accident:

      CATEGORY A BUS ACCIDENT - significant injuries present in one or more children or there is documented mechanism of injury that can reasonably be expected to cause significant injuries.

      CATEGORY B BUS ACCIDENT - minor injuries present in one or more children and no documented mechanism of injury that could reasonably be expected to cause significant injuries. Uninjured children may also be present.

      CATEGORY C BUS ACCIDENT - no injuries present in any children and no obvious mechanism of injury present.

B. Determine if implementation of this policy is appropriate. Implement this policy only if the accident is a Category B or C bus accident.

All children involved in a Category A accident will be transported to the hospital(s). Do not implement this policy if the accident/incident is a Category A bus accident/incident - follow multiple victim and disaster preparedness policies for all Category A bus accidents/incidents and transport all children/students to the hospital(s).

C. Other injured patients are treated and transported as required. For adults, follow your EMS System's policy.

D. Contact medical control, advise of a Category B or C bus accident, and determine if a scene discharge of uninjured children by the emergency department physician in charge of the call is appropriate.

E. Implement provider procedures for contacting parents/legal guardians or school officials to receive custody of the uninjured children.

F. The provider agency then transfers the custody of the minor children, consistent with its own policies and procedures, to parents/legal guardians or school officials.

G. The school representative will then follow their own policies to include informing the parent(s)/legal guardians as regards the accident/incident.

2. **DISPOSITION OF UNINJURED CHILDREN**: This policy only governs the disposition of uninjured children. A list of children who have been determined to be uninjured by medical personnel will be completed at the scene of the accident. All uninjured students will be discharged to the custody of school officials upon approval of medical control as per procedure in 1) F. Use your EMS System's approved form for such documentation.

3. **PROVIDER RESPONSIBILITY**: Once the decision is made by the emergency department physician to discharge the children at the scene, it is the responsibility of the local responding EMS agency in charge of the scene to make certain that these children are returned to their parents/legal guardians or appropriate school officials.

Region X Emergency Medical Service System
Bus Accident Student Log

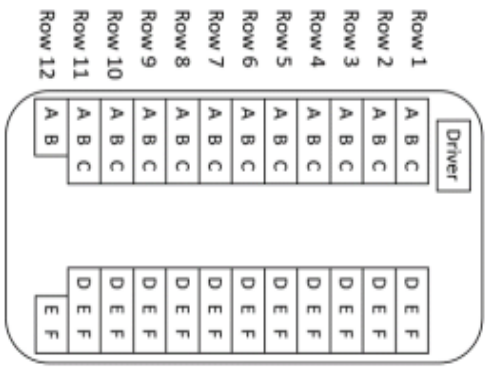
Date of Incident: _____ Incident Number: _____ Page: _____ of _____

Host Department: _____ Location: _____

School Name/District: _____ Bus Number: _____

Per the Region X EMS Policy, the children listed below have been determined to be in a Category B or C accident. These children have been determined to be uninjured and therefore Medical Control has approved discharge to the custody of school officials:

Name	Seat Location (Optional)	Address	Telephone



Signature/Title of School Authorized Representative

Signature/Title of Fire Department Officer

Hospital Contacted and RN/MD Name

White Copy to EMS Agency; Yellow Copy to EMS System; Pink Copy to School Representative; Goldenrod Copy to Local Police

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: March 2001
REVISED: April 2025

POLICY TITLE: EMS SYSTEM-WIDE CRISIS PREPAREDNESS POLICY

POLICY: 0008
The purpose of this policy is to **enhance communication** between the EMS System Resource Hospital(s), Associate Hospital(s), EMS provider(s) and community agencies regarding a potential or actual area-wide crisis, including but not limited to such events as overcrowding events due to same like symptoms, weather, special events, or other potential or real crisis situations.

PROCEDURE:

1. Any individual in the above-named organizations may identify a potential or actual crisis and initiate this policy.

2. That individual should contact their supervisor (i.e., Charge Nurse, Medical Officer, etc.).

3. The supervisor shall contact the Resource Hospital EMS System Coordinator, or their designee and identify their concerns.

4. The EMS System Coordinator/Designee shall determine the need to activate this policy and notify the RHCC hospital.

5. If deemed appropriate, the EMS System Coordinator/Designee at the RHCC hospital will notify IDPH Division of EMS.

6. Communications shall continue between applicable agencies per the specifics of the situation.

7. Once the crisis is determined to be over, the EMS System Coordinator / Designee will reconnect with all impacted agencies to validate the cessation of crisis operations..

8. Appropriate documentation shall be maintained.

9. Discussion, critique, and Performance Improvement measures regarding this policy and its activation will be conducted quarterly at the Region X Trauma Meeting.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1, 1998
REVISED: April 2025

POLICY TITLE: TRAUMA CENTER DESIGNATION
POLICY: 0009

Region X Hospitals	Location	EMS Designation	STEMI Center	Trauma Center Level	Stroke Center	EDAP
Advocate Condell Medical Center	801 S Milwaukee Ave Libertyville	Resource	Yes	Level 1	Primary	Yes
Saint Francis Hospital	355 Ridge Ave, Evanston	Resource	Yes	Level 1	Primary	Yes
Endeavor Evanston Hospital	2650 Ridge Ave Evanston	Associate	Yes	Level 1	Comprehensive	Yes
Endeavor Glenbrook Hospital	2100 Pfingsten Glenview	Associate	Yes	Level 2	Primary	Yes
Endeavor Highland Park Hospital	777 Park Ave West Highland Park	Resource	Yes	Level 2	Primary	Yes
Endeavor Skokie Hospital	9600 Gross Point Rd Skokie	Associate	No	No	No	Yes
NWM Grayslake Freestanding Emergency	1475 E Belvidere Rd Grayslake	Associate	No	No	No	Yes
NWM Lake Forest Hospital	660 N Westmoreland Lake Forest	Resource	Yes	Level 2	Primary	Yes
Froedtert South Hospital	9555 76th St Pleasant Prairie WI	Associate	NO	Level 2	Primary	No
Aurora Medical Center Kenosha	10400 75th St Kenosha WI	Associate	No	Level 2	Primary	Yes
Vista East Medical Center	1324 N Sheridan Rd. Waukegan IL	Resource	Yes	Level 2	Primary	Yes

*Emergency Department Approved for Pediatrics, (EDAP) certified facility

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1998
REVISED: April 2025

POLICY TITLE: TRAUMA PATIENT TRIAGE & TRANSPORT CRITERIA
POLICY: 0010

1. Mandatory Categorization
   A. Minimum Field Triage Criteria: Patients determined in the pre-hospital setting to have sustained hypotension, and/or are the victim of cavity penetration of the neck or torso, shall be classified as Category I patients in the field. Any EMS System transporting patients classified as a Category I requires rapid transport to the highest-level trauma center within 25 minutes.
2. Transport criteria:
   A. Category I: Transport to the highest-level Trauma Center within 25 minutes transport time
   B. Category II: Transport to the closest Trauma Center
   C. Traumatic Arrest – rapid transport to closest Trauma Center
   D. No Airway – rapid transport to closest Comprehensive Emergency Center
   E. Category I Criteria
      i. Unstable Vital Signs
      . SBP Adult $\leq$ 90 (2 consecutive readings)
      Peds $\leq$ 80 (2 consecutive readings)
      1. Glasgow Coma Scale $\leq$14 with associated head trauma
      2. Respiratory Rate 0-12mo: , 20/min
      >> 1 yr: <10 or > 29/ min
      3. ADULT Shock Index (HR>SBP)

      ii. Anatomy of Injury
      1. Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
      2. Two or more proximal long bone fractures
      3. Unstable pelvis
      4. Chest Wall instability or deformity
      5. Crush, degloved, mangle or pulseless extremity
      6. Open or depressed skull fracture
      7. Paralysis
      8. Amputation proximal to wrist or ankle

   F. Category II Criteria:
      i. Mechanism of Injury
      1. Ejection from automobile

2. Death in the same passenger compartment
3. Motorcycle crash > 20 mph
4. Rollover (Unrestrained)
5. Pedestrian thrown or run over
6. Auto vs. Pedestrian/bicyclist with > 20 mph impact
8. Intrusion, including roof; > 12 inches on the occupant site or >
   18 inches any site
9. Vehicle telemetry data consistent with a high risk for injury.
10. Adult Falls> 20 feet, Peds Falls > 10 feet or 2X height of the Child.
11. Auto vs. Bicyclist thrown, run over or with > 20 mph impact

3. Transport Criteria

A. Multiple Victims:

i. The first victim(s) should be transported to the nearest Trauma Center, while communicating the disposition of the remaining victims with Medical Control.
ii. Medical Control will direct the remaining victims as indicated.
iii. When the number and severity of injured patients dictates implementation of the area-wide mass casualty plan, the management of the field situation and transportation of victims will follow the Multiple Patient Management Plan.

B. Contact Medical Control if considering air transport.

C. In the rare instance when geographic considerations and/or home rule dictate against the principles identified by the Region, the exception would be documented by the paramedics and reported to the Trauma Nurse Coordinator at the responsible Level I Trauma Center.

4. Inter-Region Transports

A. In some Region X areas, the closest Level I Trauma Center is in another Region. Transporting to the closest Level I Trauma Center is advisable and sanctioned by all involved parties to provide optimal patient care.
B. Inter-Region transfers from facility to facility are determined by need for specialty care in the original receiving facility. Each trauma center should secure agreements with the intended receiving facility.

REGION X FIELD TRAUMA TRIAGE AND TRANSPORT CRITERIA

NOTE: Traumatic Arrest – Transport to closest Trauma Center
No Airway – Transport to closest Comprehensive Emergency Department

Systolic Blood Pressure Adult ≤ 90 (2 consecutive measurements) Peds ≤ 80 (2 consecutive measurements)	⇒ Yes	Transport to **highest level** Trauma Center within 25 minutes transport time

No⇓

Category I Unstable Vital Signs •Glasgow Coma Scale ≤ 13 with associated head trauma •Respiratory Rate <10 or > 29 (<20 infant<1 year) or need for ventilatory support •ADULT Shock Index (HR>SBP) Anatomic Criteria •Penetrating injuries to head, neck, torso and extremities proximal to elbow or knee •Two or more proximal long bone fractures •Unstable pelvis •Chest wall instability or deformity (e.g. flail chest) •Crushed, degloved, mangled or pulseless extremity •Open or depressed skull fractures •Amputation proximal to wrist or ankle •Paralysis	⇒ Yes	Transport to **highest level** Trauma Center within 25 minutes transport time

No⇓

Category II Mechanism of Injury High Risk Auto Crash •Ejection from Automobile (partial or complete) •Death in same passenger compartment •Intrusion, including roof; >12 inches occupant site or >18 inches any site •Vehicle telemetry data consistent with a high risk for injury •Motorcycle crash > 20 mph •Rollover (Unrestrained) Falls •Adult Falls ≥ 20 feet (1 story = 10 feet) •Peds falls ≥ 10 feet or 2X height of the child Other •Auto vs. Pedestrian thrown or run over or with > 20 mph impact •Auto vs. Bicyclist thrown, run over or with > 20 mph impact	⇒ Yes	Transport to **closest** Trauma Center

No⇓

Special Considerations Age: Adults >55 years; risk of injury and death increases SBP <110; might be shock if age >65 years Low impact mechanisms/standing falls may lead to severe injury Children should be preferentially transported to a pediatric-capable trauma center Anticoagulation and bleeding disorders: Patient with head injury is at high risk for rapid deterioration Burns: MOI with or without trauma: transfer to the closest trauma center Pregnancy >20 weeks should be preferentially transported to a facility with emergency obstetrics capabilities EMS Provider judgment	⇒ Yes	Transport to **closest** most appropriate facility. If non-trauma center contact **MEDICAL CONTROL**

No⇓

Transport to closest appropriate comprehensive emergency department

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1, 1998
REVISED: April 2025

POLICY TITLE: REGION X TRAUMA PI PROTOCOLS
POLICY: 0011

All Trauma Centers within the region will perform quarterly PI reviews, which shall include the following criteria:

1. All trauma related deaths. This review should exclude trauma patients who were dead on arrival.

2. ISS review
   a. Level I trauma center patients with an ISS $\geq$ 25
   b. Level II trauma center patients with an ISS $\geq$ 20

3. All trauma patients that were transferred for specialized care.

4. Any QI indicators/audit filters determined by the Region.

5. Cumulative data reports will be made available to IDPH.

Procedure:

1. Data collected will be reviewed and discussed at the quarterly Region X Trauma Coordinator PI committee meeting.

2. If further action is required it will be addressed by the Region X Executive committee, which includes a Region X designated Trauma Surgeon.

3. All trauma centers will maintain records of their PI reports/statistics discussed at the quarterly Region X Trauma Coordinator meetings.

4. The Level I Trauma Center will maintain a copy of each hospital's report.

5. All data collected will be maintained and available to IDPH upon request by the Level I Trauma Coordinator.

6. If there is more than one Level I Trauma Center, this role will work on a rotating basis.

7. All minutes will be confidential and protected by peer review.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1, 1998
REVISED: April 2025

POLICY TITLE: Provider Information Sharing
POLICY: 0012

1. All systems within Region X agree to share information about an EMS provider through the impacted EMS System Coordinators.
2. Information shared may include:
    a. Multiple Patient Management Quiz score
    b. Continuing Education Records if available
    c. SOP Test Score
    d. EMS Providers standing within any System.

3. EMS System Coordinators may share information with the EMS Providers' primary System or another System that the provider belongs to.
    a. The information to be shared would include any suspension where IDPH has been notified.
    b. It is at the discretion of the EMS System Coordinator and/or EMS Medical Director to make any changes to their system affiliation based on the information provided.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
SUPERSEDES: NEW
EFFECTIVE: 4/30/2025
REVISED: _____

POLICY TITLE: REGIONAL PEDIATRIC QUALITY IMPROVEMENT SUBCOMMITTEE

POLICY: 0013

Each region shall have a regional pediatric quality improvement subcommittee. Hospitals within each region that are designated as an SEDP, EDAP or PCCC shall have their Pediatric Quality Coordinator (PQC) participate in their respective regional pediatric quality improvement subcommittee, which shall minimally meet on a quarterly basis and conduct regional pediatric quality improvement projects. The chair of each regional subcommittee (or designee) shall report their quality improvement activities to their Regional EMS Advisory Committee
Regional EMS Advisory Committee

PROCEDURE:

1. The Pediatric Quality Coordinator shall attend the Regional Trauma/EMS quarterly meeting and report on QA/QI projects within the Region