EMS TRAUMA REGION X

POLICY AND PROCEDURE MANUAL

SEPTEMBER 1998
REVISION JANUARY 2024

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EMS TRAUMA REGION X

POLICY STATEMENT AND PROCEDURE
EFFECTIVE: April 1998
REVISED: January 2024

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: January 2024

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	60/100 Hours/4 years
HIGHLAND PARK EMS SYSTEM:	60/100 Hours/4 years
LAKE FOREST EMS SYSTEM:	25 Hours/Year
NORTH LAKE COUNTY EMS SYSTEM:	60/100 Hours/4 years
SAINT FRANCIS EMS SYSTEM:	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. 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

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1, 1998
REVISED: January 2024

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. 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. In Region X there are no EMS System approved Mental Health Facility that an EMS provider can transport to.

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.

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: March 2001
REVISED: January 2024

POLICY TITLE: DIVERSION PROCEDURE FOR TRAUMA HOSPITALS EXPERIENCING TRANSIENT RESOURCE LIMITATIONS - CASE BY CASE EVENTS

POLICY: 0004
Guidelines have been established by Illinois Department of Public Health regarding circumstances in which a hospital may go on bypass. 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 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) on EmResource, including the reason for the bypass 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.

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: January 2024

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
* profound 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 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:
    a. non-traumatic arrest.
    b. patient is at least 18 years of age
    c. patient experienced an unwitnessed arrest by an EMS provider

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: January 2024

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: January 2024

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(ies).

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		
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	847-316-2369
		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
Vista Lindenhurst Freestanding ED	NLC	847-356-4782	847-356-4705	
North Chicago VA Hospital	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
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
Lake Bluff Fire Department	LFH	ALS - NT
Lake Forest Fire Department	LFH	ALS
Lake Villa Fire Department	LFH	ALS
Lifeline Ambulance	SFH	BLS/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: January 2024

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

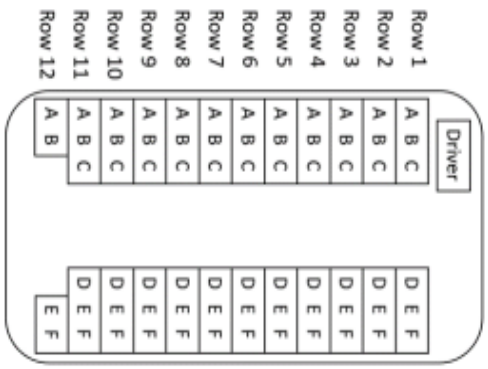
Date of Incident: _____ Incident Number: _____ Page: _____ of _____

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: January 2024

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 IUDPH 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: June 2023

POLICY TITLE: TRAUMA CENTER DESIGNATION

POLICY: 0009

Region X Hospitals	Location	EMS Designation	STEMI Center	Trauma Center Level	Stroke Center	EDAP
Advocate Aurora Condell Medical Center	801 S Milwaukee Ave Libertyville	Resource	Yes	Level 1	Primary	Yes
Ascension Saint Francis Hospital	355 Ridge Ave, Evanston	Resource	Yes	Level 1	Primary	Yes
NorthShore Evanston Hospital	2650 Ridge Ave Evanston	Associate	Yes	Level 1	Comprehensive	Yes
NorthShore Glenbrook Hospital	2100 Pfingsten Glenview	Associate	Yes	Level 2	Primary	Yes
NorthShore Highland Park Hospital	777 Park Ave West Highland Park	Resource	Yes	Level 2	Primary	Yes
North Shore 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		Level 2	Primary	
Advocate Aurora Medical Center Kenosha	10400 75th St Kenosha WI	Associate	No	Level 2	Primary	Yes

Vista Lindenhurst Freestanding Emergency Department	1050 Red Oak Lane Lindenhurst	Associate	No	No	No	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: January 2024

POLICY TITLE: TRAUMA PATIENT TRIAGE CRITERIA

POLICY: 10
Pre-hospital providers and participating Level I and Level II Trauma Centers will categorize trauma patients based on the same criteria according to ACS "Resource".

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.

   B. Category I Criteria
      i. Unstable Vital Signs
         1. Glasgow Coma Scale ≤ 13 with associated head trauma
         2. Respiratory Rate < 10 OR > 29 (<20in infant < 1 yr.) or need for ventilatory support
         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

   C. 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. Falls ≥ 20 feet (Peds falls ≥ 2 X body length)

6. Pedestrian thrown or run over
7. Auto vs. Pedestrian/bicyclist with > 20 mph impact
8. Intrusion, including roof; > 12 inches on th 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

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

EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1, 1998
REVISED: January 2024

POLICY TITLE: TRANSPORTATION OF TRAUMA PATIENTS

POLICY: 11

Within Region X there are three Level I and five Level II Trauma Centers, all of which are prepared to accept both adult and pediatric trauma patients. EMS Providers transport these patients to the appropriate level facility based on patient criteria, transport time and distance.

It is the responsibility of each EMS System to educate their providers as to the level status and location of all trauma centers within the Provider's transport jurisdiction.

PROCEDURE:

See Region X Field Trauma Triage and Transport Criteria on the next page.

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

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EMS TRAUMA REGION X
POLICY STATEMENT AND PROCEDURE
EFFECTIVE: June 1, 1998
REVISED: January 2024

POLICY TITLE: REGION X TRAUMA PI PROTOCOLS

POLICY:
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: January 2024

POLICY TITLE: Provider Information Sharing

POLICY:
All systems within Region X agree to share information about an EMS provider. Shared information will be transmitted between EMS System Coordinators. Information shared will be with the written approval of the EMS Provider(s) and may include Multiple Patient Management Quiz score, Continuing Education Records, SOP Test Score and if the EMS Provider is in good standing within their current primary System.

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