DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Emergency Medical Services and Trauma Center Code

2) Code Citation: 77 Ill. Adm. Code 515

3)

Section Numbers:	Adopted Action:
515.330	Amended
515.455	New
515.850	New
515.APPENDIX D	Amended

4) Statutory Authority: Emergency Medical Services (EMS) Systems Act [210 ILCS 50]

5) Effective Date of Rulemaking: September 29, 2011

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) A copy of the adopted amendments, including any material incorporated by reference, is on file in the agency's principal office and is available for public inspection.

9) Notice of Proposed Amendments Published in Illinois Register: May 6, 2011; 35 Ill. Reg. 7271

10) Has JCAR issued a Statement of Objection to this rulemaking? No

11) Differences between proposal and final version:

The following changes were made in response to comments received during the first notice or public comment period:

In Section 515.455(a), after " Committee," add " hospital".

In Section 515.455(a), add "and approves" after "receives" and change "party to the dispute" to "entity's duly authorized representative".

In the last line of Section 515.455(a), add "The Director or designee will endeavor to issue a written decision within 30 days after receipt of all written submissions and verbal testimony, if verbal testimony is permitted." after "dispute."

In Section 515.455(b), add "," after "Emergency Medical Dispatcher" and delete "or" after "Emergency Medical Dispatcher".

In Section 515.455(b), add "or a member of the public" after "Trauma Nurse Specialist".

After Section 515.455(b), insert a new subsection (c) as follows:

> c) The Department's Practice and Procedure in Administrative Hearings shall govern all proceedings.

A further change was made in response to JCAR (see below)

In existing Section 515.455(c), change "c)" to "d)".

In Section 515.APPENDIX D, PEDIATRIC RESPIRATORY ARREST, change "in accordance" to "consistent".

The following change was made in response to comments and suggestions of JCAR:

In Section 515.455 (c), "(77 Ill. Adm. Code 100)" was added before "shall".

In addition, various typographical, grammatical, and form changes were made in response to the comments from JCAR.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreements issued by JCAR? Yes

13) Will this rulemaking replace any emergency rulemaking currently in effect? No

14) Are there any amendments pending on this Part? Yes

Section Numbers:	Proposed Action:	Reg. Ill. Citation:
515.100	Amend	35 Ill. Reg. 7926; May 20, 2011
515.470	New	35 Ill. Reg. 7926; May 20, 2011
515.630	New	35 Ill. Reg. 7926; May 20, 2011
515.835	New	35 Ill. Reg. 7926; May 20, 2011
515.845	New	35 Ill. Reg. 7926; May 20, 2011
515.100	Amend	35 Ill. Reg. 10520; July 8, 2011

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515.125	Amend	35 Ill. Reg. 10520; July 8, 2011
515.445	Amend	35 Ill. Reg. 10520; July 8, 2011
515.825	Amend	35 Ill. Reg. 10520; July 8, 2011
515.830	Amend	35 Ill. Reg. 10520; July 8, 2011
515.3090	New	35 Ill. Reg. 10520; July 8, 2011
515.4000	Amend	35 Ill. Reg. 10520; July 8, 2011
515.4010	Amend	35 Ill. Reg. 10520; July 8, 2011
515.4020	New	35 Ill. Reg. 10520; July 8, 2011
515.Appendix D	Amend	35 Ill. Reg. 10520; July 8, 2011
515.Appendix K	Amend	35 Ill. Reg. 10520; July 8, 2011
515.Appendix L	Amend	35 Ill. Reg. 10520; July 8, 2011
515.Appendix M	Amend	35 Ill. Reg. 10520; July 8, 2011
515.Appendix N	New	35 Ill. Reg. 10520; July 8, 2011
515.Appendix O	New	35 Ill. Reg. 10520; July 8, 2011
515.Appendix P	New	35 Ill. Reg. 10520; July 8, 2011
515.860	New	35 Ill. Reg. 12645; July 29, 2011

15) Summary and Purpose of Rulemaking: This rulemakings in Part 515 set forth requirements for Emergency Medical Services Systems, including emergency medical treatment, System requirements, and vehicle service providers. The proposed amendments to Section 515.330 and Section 515.Appendix D will reference Department-approved protocols for medical treatment, such as Basic Life Support (BLS), Emergency Medical Services for Children (EMSC) and other Emergency Medical Services (EMS) protocols, as part of the EMS System Plan.

A new Section is being added to set forth a process to end disputes between an EMS System, Vehicle Service Provider, Advisory Committee, EMS Medical Director or between any combination of any elements thereof if the dispute causes an imminent threat to the availability or quality of emergency pre-hospital care within the State of Illinois.

Public Act 96-1469 amended the Emergency Medical Services (EMS) Systems Act to authorize the Department to establish standards for the use of reserve ambulances. Section 515.850 is being added to implement this statutory change.

16) Information and questions regarding these adopted amendments shall be directed to:

Susan Meister

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

Division of Legal Services

Department of Public Health
535 West Jefferson, 5th Floor
Springfield, Illinois 62761
e-mail: dph.rules@illinois.gov

217/782-2043

The full text of the Adopted Amendments begins on the next page:

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF ADOPTED AMENDMENTS

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

PART 515
EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE

SUBPART A: GENERAL

Section
515.100 Definitions
515.125 Incorporated and Referenced Materials
515.150 Waiver Provisions
515.160 Violations, Hearings and Fines
515.170 Employer Responsibility

SUBPART B: EMS REGIONS

Section
515.200 Emergency Medical Services Regions
515.210 EMS Regional Plan Development
515.220 EMS Regional Plan Content
515.230 Resolution of Disputes Concerning the EMS Regional Plan
515.240 Bioterrorism Grants

SUBPART C: EMS SYSTEMS

Section
515.300 Approval of New EMS Systems
515.310 Approval and Renewal of EMS Systems
515.315 Bypass Status Review
515.320 Scope of EMS Service
515.330 EMS System Program Plan
515.340 EMS Medical Director's Course
515.350 Data Collection and Submission
515.360 Approval of Additional Drugs and Equipment
515.370 Automated Defibrillation (Repealed)
515.380 Do Not Resuscitate (DNR) Policy
515.390 Minimum Standards for Continuing Operation
515.400 General Communications

515.410 EMS System Communications
515.420 System Participation Suspensions
515.430 Suspension, Revocation and Denial of Licensure of EMTs
515.440 State Emergency Medical Services Disciplinary Review Board
515.445 Pediatric Care
515.450 Complaints
515.455 Intra- and Inter-system Dispute Resolution

SUBPART D: EMERGENCY MEDICAL TECHNICIANS

Section

515.500 Emergency Medical Technician-Basic Training
515.510 Emergency Medical Technician-Intermediate Training
515.520 Emergency Medical Technician-Paramedic Training
515.530 EMT Testing and Fees
515.540 EMT Licensure
515.550 Scope of Practice – Licensed EMT
515.560 EMT-B Continuing Education
515.570 EMT-I Continuing Education
515.580 EMT-P Continuing Education
515.590 EMT License Renewals
515.600 EMT Inactive Status
515.610 EMT Reciprocity
515.620 Felony Convictions

SUBPART E: EMS LEAD INSTRUCTOR, EMERGENCY MEDICAL DISPATCHER, FIRST RESPONDER, PRE-HOSPITAL REGISTERED NURSE, EMERGENCY COMMUNICATIONS REGISTERED NURSE, AND TRAUMA NURSE SPECIALIST

Section

515.700 EMS Lead Instructor
515.710 Emergency Medical Dispatcher
515.720 First Responder
515.725 First Responder – AED
515.730 Pre-Hospital Registered Nurse
515.740 Emergency Communications Registered Nurse
515.750 Trauma Nurse Specialist
515.760 Trauma Nurse Specialist Program Plan

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SUBPART F: VEHICLE SERVICE PROVIDERS

Section
515.800 Vehicle Service Provider Licensure
515.810 EMS Vehicle System Participation
515.820 Denial, Nonrenewal, Suspension and Revocation of a Vehicle Service Provider License
515.825 Alternate Response Vehicle
515.830 Ambulance Licensing Requirements
515.850 Reserve Ambulances

SUBPART G: LICENSURE OF SPECIALIZED EMERGENCY MEDICAL SERVICES VEHICLE (SEMSV) PROGRAMS

Section
515.900 Licensure of SEMSV Programs – General
515.910 Denial, Nonrenewal, Suspension or Revocation of SEMSV Licensure
515.920 SEMSV Program Licensure Requirements for All Vehicles
515.930 Helicopter and Fixed-Wing Aircraft Requirements
515.935 EMS Pilot Specifications
515.940 Aeromedical Crew Member Training Requirements
515.945 Aircraft Vehicle Specifications and Operation
515.950 Aircraft Medical Equipment and Drugs
515.955 Vehicle Maintenance for Helicopter and Fixed-wing Aircraft Programs
515.960 Aircraft Communications and Dispatch Center
515.965 Watercraft Requirements
515.970 Watercraft Vehicle Specifications and Operation
515.975 Watercraft Medical Equipment and Drugs
515.980 Watercraft Communications and Dispatch Center
515.985 Off-Road SEMSV Requirements
515.990 Off-Road Vehicle Specifications and Operation
515.995 Off-Road Medical Equipment and Drugs
515.1000 Off-Road Communications and Dispatch Center

SUBPART H: TRAUMA CENTERS

Section
515.2000 Trauma Center Designation
515.2010 Denial of Application for Designation or Request for Renewal

515.2020 Inspection and Revocation of Designation
515.2030 Level I Trauma Center Designation Criteria
515.2035 Level I Pediatric Trauma Center
515.2040 Level II Trauma Center Designation Criteria
515.2045 Level II Pediatric Trauma Center
515.2050 Trauma Center Uniform Reporting Requirements
515.2060 Trauma Patient Evaluation and Transfer
515.2070 Trauma Center Designation Delegation to Local Health Departments
515.2080 Trauma Center Confidentiality and Immunity
515.2090 Trauma Center Fund
515.2100 Pediatric Care (Renumbered)
515.2200 Suspension Policy for Trauma Nurse Specialist Certification

SUBPART I: EMS ASSISTANCE FUND

Section

515.3000 EMS Assistance Fund Administration

SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

Section

515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)
515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)

515.APPENDIX A A Request for Designation (RFD) Trauma Center
515.APPENDIX B A Request for Renewal of Trauma Center Designation
515.APPENDIX C Minimum Trauma Field Triage Criteria
515.APPENDIX D Standing Medical Orders
515.APPENDIX E Minimum Prescribed Data Elements
515.APPENDIX F Template for In-House Triage for Trauma Centers
515.APPENDIX G Credentials of General/Trauma Surgeons Level I and Level II
515.APPENDIX H Credentials of Emergency Department Physicians Level I and Level II
515.APPENDIX I Credentials of General/Trauma Surgeons Level I and Level II Pediatric Trauma Centers
515.APPENDIX J Credentials of Emergency Department Physicians Level I and Level II Pediatric Trauma Centers

DEPARTMENT OF PUBLIC HEALTH

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515.APPENDIX K	Application for Facility Recognition for Emergency Department with Pediatrics Capabilities
515.APPENDIX L	Pediatric Equipment Recommendations for Emergency Departments
515.APPENDIX M	Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline

AUTHORITY: Implementing and authorized by the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997; amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill. Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000; amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367, effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25, 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill. Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255, effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended at 35 Ill. Reg. 16697, effective September 29, 2011.

SUBPART C: EMS SYSTEMS

Section 515.330 EMS System Program Plan

An Emergency Medical Services (EMS) System Program Plan shall contain the following information:

a) The name, address and fax number of the Resource Hospital;

b) The names and resumes of the following persons:

1) The EMS MD~~Medical Director~~,

2) The Alternate EMS MDMedical Director,

3) The EMS Administrative Director,

4) The EMS System Coordinator;

c) The name, address and fax number of each Associate or Participating Hospital (see subsection (i) of this Section);

d) The name and address of each ambulance provider participating within the EMS System;

e) A map of the EMS System's service area indicating the location of all hospitals and ambulance providers participating in the System;

f) Current lettersletter(s) of commitment from the following persons at the Resource Hospital, which describe the commitment of the writer and his or her office to the development and ongoing operation of the EMS System, and which state the writer's understanding of and commitment to any necessary changes such as emergency department staffing and educational requirements:

1) The Chief Executive Officer of the hospital,

2) The Chief of the Medical Staff, and

3) The Director of the Nursing Services;

g) A letter of commitment from the EMS MDMedical Director that describes the EMS MD'sEMSMD's agreement to:

1) Be responsible for the ongoing education of all System personnel, including coordinating didactic and clinical experience;

2) Develop written standing orders (treatment protocols, standard operating procedures) to be used in the EMS MD'sEMSMD's absence and certify that all involved personnel will be knowledgeable in emergency care and capable of providing treatment and using communications equipment once the program is operational;

3) Be responsible for supervising all personnel participating within the System, as described in the System Program Plan;

4) Develop or approve one or more ambulance emergency run reports (run sheets) covering all types of ambulance runs performed by System ambulance providers;

5) Ensure that the Department has access to all records, equipment and vehicles under the authority of the EMS MDEMSMD during any Department inspection, investigation or site survey;

6) Notify the Department of any changes in personnel providing pre-hospital care in accordance with the EMS System Program Plan approved by the Department;

7) Be responsible for the total management of the System, including the enforcement of compliance with the System Program Plan by all participants within the System;

8) Ensure that a copy of the application for renewal (a form supplied by the Department) is provided to every EMT-B, EMT-I or EMT-P within the System who has not been recommended for re-licensurerelicensure by the EMS MDMedical Director; and

9) Be responsible for compliance with the provisions of Sections 515.400 and 515.410 of this Part;

h) A description of the methodmethod(s) of providing EMS services, which includes:

1) Singlesingle vehicle response and transport;

2) Dualdual vehicle response;

3) Levellevel of first response vehicle;

4) Levellevel of transport vehicle;

5) Useuse of mutual aid agreements; and

6) Informing~~informing~~ the caller requesting an emergency vehicle of the estimated time of arrival when this information is requested by the caller;

i) A letter of commitment from each Associate or Participating Hospital within the System, which ~~that~~ includes the following:

1) Signed statements by the hospital's Chief Executive Officer, Chief of the Medical Staff and Director of the Nursing Service describing their commitments to the standards and procedures of the System;

2) A description of how the hospital will relate to the EMS System Resource Hospital, its involvement in the ongoing planning and development of the program, and its use of the education and continuing education aspects of the program;

3) Only at an Associate Hospital, a commitment to meet the System's educational standards for ECRNs;

4) An agreement to provide exchange of all drugs and equipment with all pre-hospital providers participating in the System or other EMS system whose ambulances transport to them;

5) An agreement to use the standard treatment orders as established by the Resource Hospital;

6) An agreement to follow the operational policies and protocols of the System;

7) A description of the level of participation in the training and continuing education of pre-hospital personnel;

8) An agreement to collect and provide relevant data as determined by the Resource Hospital;

9) A description of the hospital's data collection and reporting methods and the personnel responsible for maintaining all data;

10) An agreement to allow the Department access to all records, equipment

and vehicles relating to the System during any Department inspection, investigation or site survey;

11) If the hospital is a participant in another System, a description of how it will interact within both Systems and how it will ensure that communications interference as a result of this dual participation will be minimized; and

12) The names and resumes of the Associate Hospital EMS MDMedical Director and Associate Hospital EMS Coordinator;

j) A letter of commitment from each ambulance provider participating within the System, which indicates compliance with Section 515.810 of this Part;

k) Descriptions and documentation of each communications requirement provided in Section 515.400 of this Part;

l) The Program Plan shall consist of the EMS System Manual, which shall be provided to all System participants and shall include the following Sections:

1) Education and Training

A) Content and curricula of training programs for EMT, Emergency Medical Dispatcher, First Responder, Pre-Hospital RN, ECRN and Lead Instructor candidates, including:

i) Entrance and completion requirements;

ii) Program schedules;

iii) Goals and objectives;

iv) Subject areas;

v) Didactic requirements, including skills laboratories;

vi) Clinical requirements; and

vii) Testing formats.;

B) Training program for Pre-arrivalPrearrival Medical Instructions, if applicable, including:

i) Entrance and completion requirements;

ii) Description of course materials; and

iii) Testing formats.;

C) Continuing education for EMTs, Pre-Hospital RNs, and ECRNs, including:

i) System requirements (hours, types of programs, etc.);

ii) System program for System participants: types of activities covered (e.g., telemetry review, and morbidity and mortality conferences) and protocols for enrollment and completion;

iii) Requirements for approval of academic course work;

iv) Didactic programs offered by the System;

v) Clinical opportunities available within the System; and

vi) Record-keeping requirements for participants, which must be maintained at the Resource Hospital.;

D) Renewal Protocols

i) System examination requirements for EMTs, Pre-Hospital RNs, ECRNs;

ii) Procedures for renewal of Pre-Hospital RN and ECRN approvals;

iii) Requirements for submissionSubmission of transaction cards for EMTs meeting renewal requirements; and

iv) ~~Providing~~ Department renewal application forms for~~to~~ EMTs who have not met renewal requirements according to System records.~~;~~

E) System participant education and information, including:

i) Distribution of System Manual amendments;

ii) In-services for policy and protocol changes;

iii) Methods for communicating updates on System and Regional activities, and other matters of medical, legal and/or professional interest; and

iv) Locations of library/resource materials, forms, schedules, etc.~~;~~

F) A plan that describes how Emergency Medical dispatch agencies and First Responders participate within the EMS System Program Plan~~A plan for phasing in Emergency Medical Dispatcher and First Responder registration requirements over a five-year period for Emergency Medical Dispatchers and First Responders who choose to be included in the Program Plan~~ (see Sections 515.710 and 515.720 of this Part).~~;~~

G) A System may require that up to one-half of the continuing education hours that are required toward re-licensure~~relicensure~~, as determined by the Department, be earned through attendance at system-taught courses.~~;~~

H) A didactic continuing education course that has received a State site code shall be accepted by the System, subject only to the requirements of subsection (l)(1)(C) of this Section.~~;~~

2) Drugs and Equipment

A) A list of all drugs and equipment required for each type of System vehicle; and

B) Procedures for obtaining replacements at System hospitals.;

3) Personnel Requirements for EMTs

A) Minimum staffing for each type and level of vehicle; and

B) Guidelines for EMT patient interaction.;

4) In-Field Protocols, including medical-legal policies, but not limited to:

A) The Regional Standing Medical Orders;

B) System Standing Medical Orders as listed in Section 515.Appendix D, to include Department-approved protocols for medical treatment, including, but not limited to, burns, hypothermia, respiratory distress, shock, trauma, cardiac arrest and toxic exposure (e.g., Department-approved BLS medical treatment protocol, EMSC medical treatment protocol) at a minimum;

C) Appropriate interaction with law enforcement on the scene;

D) When and how to notify a coroner or medical examiner;

E) Appropriate interaction with an independent physician/nurse on the scene;

F) The use of restraints;

G) Consent for treatment of minors;

H) Patient choice and refusal regarding treatment, transport, and/or destination;

I) The duty to perform all services without unlawful discrimination;

J) Offering immediate and adequate information regarding services available to victims of abuse, for any person suspected to be a victim of domestic abuse;

K) Patient abandonment;

L) Emotionally disturbed patients;

M) Patient confidentiality and release of information;

N) Durable power of attorney for health care;

O) Do Not Resuscitate (DNR) orders (see Section 515.380 of this Part); and

P) A policy concerning the use of latex-free supplies.~~;~~

5) Communications standards and protocols, including:

A) The information contained in the System Program Plan relating to the requirements of Sections 515.410(a)(1), (2), (3) and (4) and 515.390(b) and (g) of this Part;

B) Protocols ensuring that physician direction and voice orders to EMS vehicle personnel and other hospitals participating in the System are provided from the operational control point of the Resource or Associate Hospital;

C) Protocols ensuring that the voice orders via radio and using telemetry shall be given by or under the direction of the EMS MD~~Medical Director~~ or the EMS MD's designee, who shall be either an ECRN, or physician; and

D) Protocols defining when an ECRN should contact a physician.~~;~~

6) Quality improvement measures for both adult and pediatric patient care shall~~should~~ be performed on a quarterly basis and be available upon Department request; ambulance operation and System training activities, including, but not limited to, monitoring training activities to ensure that the instructions and materials are consistent with United States Department of Transportation training standards for EMTs and Section 3.50 of the Act; unannounced inspections of pre-hospital services; and

peer review.~~;~~

7) Data collection and evaluation methods that include:

A) The process that will facilitate problem identification, evaluation and monitoring in reference to patient care and/or reporting discrepancies from hospital and pre-hospital providers;

B) A copy of the pre-hospital reporting form; and

C) A sample of the information and data to be reported to the Department summarizing System activity (see Section 515.350 of this Part).~~;~~

8) Operational policies that delineate the respective roles and responsibilities of all providers in the System regarding the provision of emergency service, including:

A) Resource Hospital overrides (situations in which Associate Hospital orders are overruled by the Resource Hospital);

B) Infectious disease and disinfection procedures, including the policy on significant exposure;

C) Reporting and documentation of problems; and

D) Protocols for ILS/ALS System personnel to assess the condition of a patient being initially treated in the field by BLS personnel, for the purpose of determining whether a higher level of care is warranted and transfer of care of the patient to the ILS or ALS personnel is therefore appropriate. The~~Such~~ protocols shall include a requirement that neither the assessment nor the transfer of care can be initiated if it would appear to jeopardize the patient's condition, and shall require that the~~such~~ activities of the System personnel be ~~done~~ under the immediate direction of the EMS MD~~Medical Director~~ or designee.~~;~~

9) Any procedures regarding disciplinary ~~and/~~or suspension decisions and the review of those decisions that the System has elected to follow in addition

to those required by the Act.~~;~~

10) Any System policies regarding abuse of controlled substances or conviction of a felony crime by System personnel whether on or off duty.~~;~~

11) The responsibilities of the EMS Coordinator~~Coordinator(s)~~, as designated by the EMS MD~~Medical Director~~, including data evaluation, supervision of clinical, didactic and field experience training, and physician and nurse education as required.~~; and~~

12) The responsibilities of the EMS MD~~Medical Director~~;

m) *Written protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center, which provide that a person shall not be transported to a facility other than the nearest hospital, regional trauma center or trauma center unless 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, or the transport is in accordance with the System's protocols for patient choice or refusal.*~~A F4written protocol for the bypassing of or diversion toF2 a F4hospital, trauma center or Regional trauma center other than the nearest hospital, Regional trauma center or trauma center unless 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, or the transport is in accordance with the System's protocols for patient choice or refusal.~~ (Section 3.20(c)(5) of the Act) The bypass status policy should include a statement that for any life-threatening condition a patient may be transported to the closest facility, whether or not that facility is on bypass status. In addition, a hospital can declare a resource limitation, which is further outlined in the System Plan, for the following conditions:

1) There are no critical or monitored beds available in the hospital; or

2) An internal disaster occurs in the hospital;

n) Bypass status may not be honored if three or more hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility exceeds 15 minutes;

o) Each hospital shall have a policy addressing peak census procedures, such as the model policy developed by the Department.

(Source: Amended at 35 Ill. Reg. 16697, effective September 29, 2011)

Section 515.455 Intra- and Inter-system Dispute Resolution

a) If the Director determines that a dispute exists between an EMS System, Vehicle Service Provider, Advisory Committee, hospital, or EMS MD or between any combination of any elements of these entities and the dispute causes an imminent threat to the availability or quality of emergency pre-hospital care within the State, then the Director or designee shall have the authority to resolve those disputes, if one party to the dispute requests the Director's intervention in writing. If the Director receives and approves such a request, then each entity's duly authorized representative shall be given the opportunity to submit written arguments and evidence in support of any potential resolution. The Director or designee shall have the authority to hear oral arguments and testimony based upon the written submissions. Any decision by the Director or designee shall be issued in writing and state the basis for the decision, which shall be final and binding upon all parties to the dispute. The Director or designee will endeavor to issue a written decision within 30 days after receipt of all written submissions and verbal testimony, if verbal testimony is permitted.

b) This dispute resolution procedure shall not be available to any EMT, ECRN, Pre-Hospital RN, Lead Instructor, First Responder, Emergency Medical Dispatcher, Trauma Nurse Specialist or a member of the public. This procedure shall not be applicable to any EMS System Suspension, Local Board of Review, action by the State EMS Disciplinary Review Board or the Department.

c) The Department's Rules of Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100) shall govern all proceedings.

d) *All final administrative decisions of the Department hereunder shall be subject to judicial review pursuant to the provisions of the Administrative Review Law* [35 ILCS 5/Art. III] . (Section 3.145 of the Act) A decision by the Director in accordance with this Section shall be considered an administrative review decision under Section 3.145 of the Act and shall be subject to judicial review.

(Source: Added at 35 Ill. Reg. 16697, effective September 29, 2011)

SUBPART F: VEHICLE SERVICE PROVIDERS

Section 515.850 Reserve Ambulances

a) For the purposes of this Section, *"reserve ambulance" means a vehicle that meets all criteria set forth in* Section 515.830 of this Part, *except for the required inventory of medical supplies and durable medical equipment, which may be rapidly transferred from a fully functional ambulance to a reserve ambulance without the use of tools or special mechanical expertise.* (Section 3.85(a)(3)(C) of the Act)

b) No changes to the vehicular operating systems, such as the electrical, plumbing, lighting, emergency warning or dispatch and hospital communication systems, shall be permitted.

c) The vehicle service provider shall complete a vehicle inventory of equipment and supplies as required by Section 515.830 of this Part and any system specific requirements each time a reserve vehicle is placed into service.

d) The vehicle provider shall notify the EMS System within 48 hours after a reserve ambulance is placed into service. A copy of the vehicle inventory form shall be provided to the EMS System.

e) Any reserve ambulance placed into service for 10 days or more shall be inspected by the EMS System, and the System shall provide notification to the Department on a Department prescribed form.

f) Reserve ambulances shall be identified on the vehicle provider license in accordance with Section 515.800 of this Part.

(Source: Added at 35 Ill. Reg. 16697, effective September 29, 2011)

Section 515.APPENDIX D Standing Medical Orders

Department-approved medical treatment protocols (e.g., Department-approved BLS medical treatment protocol, EMSC medical treatment protocol) shall be included in all System protocols at a minimum.

1. STANDING MEDICAL ORDERS/CARDIAC PROTOCOLS shall include, at a minimum:

   Routine Cardiac Care
   Cardiac Arrest
   Cardiogenic Shock
   Ventricular Fibrillation
   Ventricular Tachycardia
   Ventricular Ectopy
   EMD (Electro-Mechanical Dissociation)/PEA (Pulseless Electrical Activity)
   PSVT (Paroxysmal Supraventricular Tachycardia)~~PVST~~
   Bradycardia
   Asystole

2. STANDING MEDICAL ORDERS/TRAUMA PROTOCOLS shall include, at a minimum:

   Field Triage Protocols
   Shock (Hypovolemia)
   Spinal Cord
   Head Trauma
   Load and Go Situations
   Traumatic Arrest
   Amputated Parts
   Burns

3. STANDING MEDICAL ORDERS/PROTOCOLS FOR MEDICAL EMERGENCIES shall include, at a minimum:

   Asthma
   Anaphylactic Shock
   Diabetic Emergencies

Drug Overdose
Coma, Origin Unknown
Status Epilepticus
Seizures
Heat Emergencies
Cold Emergencies
Poisoning
Radiation Injuries
Renal Protocols (care of patients with shunts and fistulas)
Near Drowning

4. STANDARD MEDICAL ORDERS/OBSTETRIC/GYNECOLOGICAL PROTOCOLS shall include, at a minimum:

Normal Deliveries
Hemorrhage, including third trimester bleeding
Abnormal Deliveries (i.e., cord or breech presentation)
Resuscitation of the Newborn
Rape/Sexual Assault

5. STANDING MEDICAL ORDERS/PEDIATRIC PROTOCOLS shall include, at a minimum:

PEDIATRIC PRIMARY ASSESSMENT − A foundation for all pediatric patient interactions, this protocol shall~~should~~ reinforce the need for consistent, methodical patient assessment. Commonly referred to as "routine medical care" in adult protocols, the protocol shall~~should~~ reinforce the following:

- Importance of rapid BLS interventions (i.e., CPR) specifically airway support
- Age-appropriate signs and symptoms of pediatric respiratory distress
- Age-appropriate airway interventions including the use of "blow-by" oxygen administration
- Indicators of adequate ventilation and perfusion
- Age-appropriate immobilization of the pediatric trauma patient
- Recognition of and monitoring for imminent life threats
- Unique assessment considerations and emergent care requirements of children with special health care needs (CSHN), including those who are technologically dependent. The~~Emphasize the~~ appropriate inclusion of

parents/primary caregivers shall be emphasized.

TREATMENT AND RECOGNITION OF THE FOLLOWING DYSRHYTHMIA:

- Asystole
- Pulseless Electrical Activity
- Ventricular Fibrillation or Pulseless Ventricular Tachycardia
- Ventricular Tachycardia

Treatment modalities/algorithms shall~~should~~ be consistent with the guidelines set forth by the American Heart Association's "Pediatric Advanced Life Support" algorithms. The use of intraosseous access shall~~should~~ be taught to all ALS providers.

NEONATAL RESUSCITATION − Shall~~Must~~ incorporate the specific heart rate parameters and requisite interventions according to the American Heart Association recommendations.

PEDIATRIC RESPIRATORY ARREST − Treatment shall~~must~~ be consistent ~~be in accordance~~ with the American Heart Association "Pediatric Advanced Life Support" guidelines.

PEDIATRIC RESPIRATORY DISTRESS − Differentiation shall~~should~~ be made between "upper airway obstruction" (i.e., croup, epiglottitis and foreign body) and other "non-obstructive" causes of respiratory insufficiency (i.e., asthma, bronthiolitis, pneumonia). The potential for invasive airway interventions shall~~must~~ also be identified.

PEDIATRIC BRADYCARDIA − Treatment in accordance with the American Heart Association recommendations.

PEDIATRIC TACHYCARDIA − Interventions for both wide and narrow complex tachycardias in accordance with the American Heart Association recommendations.

PEDIATRIC SHOCK − Differentiation shall~~should~~ be made between "hypovolemic" (dehydration, hemorrhagic) and "distributive" (sepsis).

PEDIATRIC ALLERGIC REACTION/ANAPHYLAXIS − Special attention shall be given to the differentiation between symptomatic (hives), mild respiratory distress and severe respiratory distress.

PEDIATRIC SEIZURE − Shall~~Must~~ include the identification of rapid blood glucose monitoring in the field, considerations for febrile seizures and administration of rectal benzodiazepines (specifically in children less than three~~3~~ years old).

PEDIATRIC ALTERED LEVEL OF CONSCIOUSNESS − The~~Emphasize the~~ importance of recognizing etiology, aggressive airway maintenance, glucose monitoring and naloxone administration shall be emphasized.

PEDIATRIC TOXIC EXPOSURES/INGESTIONS − Accidental~~Incorporate accidental/~~environmental events commonly encountered in the pediatric population shall be incorporated. Special consideration shall~~should~~ be made to the susceptibility of children to environmental events such as hyperthermia.

PEDIATRIC HYPOTHERMIA − The~~Emphasize the~~ pediatric population at high risk for hypothermia~~:~~ (neonates and infants) shall be emphasized. Aggressive~~Address aggressive~~ airway management, warming techniques and recognition of frostbite injury shall be addressed. Interventions for arrhythmias shall be in accordance with the American Heart Association recommendations.

PEDIATRIC NEAR DROWNING − Aggressive~~Emphasize aggressive~~ airway management and the potential for associated cervical spine injury and hypothermia shall be emphasized.

PEDIATRIC BURNS − Special emphasis shall be placed on the pediatric "rule of nines" for burn size estimation, aggressive airway management and triage to the appropriate facility. Differentiation shall~~should~~ be made between thermal injuries, chemical injuries and electrical injuries.

PEDIATRIC TRAUMA − Emphasis shall~~should~~ be made on mechanism of injury, limited on-scene time, aggressive airway maintenance and field triage to the appropriate facility and addressing the unique needs of the head-injured child.

SUSPECTED CHILD ABUSE/NEGLECT − Special emphasis shall~~should~~ be made on careful documentation of physical findings, discrepancy between history

of injury and physical findings, interaction between child and parent/caregiver, and characteristics of the environment. TheDiscuss the pre-hospital provider's responsibility as a mandated reporter, and responsibility to report suspicions to the emergency room staff shall be discussed. DirectionsInclude directions for responding to parent/caregiver refusal to allow transport shall be included.

6. STANDING MEDICAL ORDERS/PROTOCOLS FOR SPECIAL SITUATIONS shall include, at a minimum:

   Psychological Emergencies
   Spousal Abuse
   Geriatric Abuse
   Child Abuse

7. STANDING MEDICAL ORDERS/PROTOCOLS FOR THE PROCEDURES LISTED as well as any others thatwhich may be System specific:

   Adult Intubation Procedure
   Pediatric Intubation Procedure
   Defibrillation
   Transtracheal Ventilation-Cricothyrotomy
   Chest Decompression
   Cardioversion
   Medication Administration-IV/ett

8. Standing medical orders may be organized as assessment based versus diagnostic, such as, altered mental status, abnormal vital signs, dysrhythmias and/or blocks, respiratory distress, and chest pain.

(Source: Amended at 35 Ill. Reg. 16697, effective September 29, 2011)