# REGION 11
# CHICAGO EMS SYSTEM

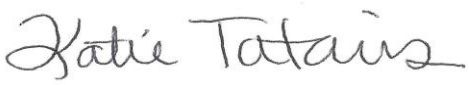
# POLICIES

# REGION 11
# CHICAGO EMS SYSTEM
# EMS POLICIES

These Region 11 Chicago EMS System Protocols, Policies, and Procedures for EMTs and Paramedics are prehospital medical guidelines for patient assessment, treatment, and transportation within the system. They provide a framework for all patient encounters and Online Medical Control should be consulted in situations where there is not clear direction from the written documents.

Eddie Markul, M.D.
EMS Medical Director
Advocate Illinois Masonic Medical Center
Chicago, IL

Kenneth Pearlman, M.D.
EMS Medical Director
Northwestern Memorial Hospital
Chicago, IL



Katie Tataris, M.D., MPH
EMS Medical Director
University of Chicago Medical Center
Chicago, IL

Joseph Weber, M.D.
EMS Medical Director
John H. Stroger, Jr. Hospital of Cook County
Chicago, IL

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# POLICIES
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# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## GENERAL

Professional Ethical Standards and Behavioral Expectations
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Region 11 (Chicago) EMS Organizational Structure
Resource and Associate Hospitals

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Professional Ethical Standards and Behavioral Expectations |
|---|---|
| | Section: General |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PROFESSIONAL ETHICAL STANDARDS AND BEHAVIORAL EXPECTATIONS

I. Professional status as an Emergency Medical Services (EMS) Practitioner is maintained and enriched by the willingness of the individual practitioner to accept and fulfill obligations to society, other medical professionals, and the EMS profession. EMS Practitioners in Region 11 have a duty to the following code of professional ethics:

A. To conserve life, alleviate suffering, promote health, do no harm, and encourage the quality and equal availability of emergency medical care.

B. To provide services based on human need, with compassion and respect for human dignity, unrestricted by consideration of nationality, race, creed, color, or status; to not judge the merits of the patient's request for service, nor allow the patient's socioeconomic status to influence demeanor or the care provided.

C. To not use professional knowledge and skills in any enterprise detrimental to the public well-being.

D. To respect and hold in confidence all information of a confidential nature obtained in the course of professional service unless required by law to divulge such information.

E. To use social media in a responsible and professional manner that does not discredit, dishonor, or embarrass an EMS organization, co-workers, other health care practitioners, patients, individuals or the community at large.

F. To maintain professional competence, striving always for clinical excellence in the delivery of patient care.

G. To assume responsibility in upholding standards of professional practice and education.

H. To assume responsibility for individual professional actions and judgment, both in dependent and independent emergency functions, and to know and uphold the laws which affect the practice of EMS.

I. To be aware of and participate in matters of legislation and regulation affecting EMS.

J. To work cooperatively with EMS associates and other allied healthcare professionals in the best interest of our patients.

K. To refuse participation in unethical procedures and assume the responsibility to expose incompetence or unethical conduct of others to the appropriate authority in a proper and professional manner.

Reference: National Association of Emergency Medical Technicians (NAEMT), Code of Ethics for EMS Practitioners, https://www.naemt.org/about-ems/code-of-ethics

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Participating Hospital Responsibilities |
|---|---|
| | Section: General |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PARTICIPATING HOSPITAL RESPONSIBILITIES

## I. PURPOSE

To define a participating hospital and responsibilities under an EMS System.

## II. DEFINITION

Participating Hospital: A licensed hospital that has signed a letter of agreement to participate in an EMS System and follow the EMS System Plan as defined below.

## III. POLICY

### A. Drug, Equipment and Supply (DES) Item Replacement

1. Each participating hospital is required to replace all drugs, supplies and exchange equipment as defined by the Region 11 EMS System Drug, Equipment and Supply List (DES).

2. Replacement of drugs and supplies to Region 11 EMS personnel should be facilitated by the receiving hospital and includes the following patient categories:

    a. Transported by EMS to an Emergency Department
    b. Transported by EMS to an inpatient bed
    c. Non-transports of termination of resuscitation patients that would have otherwise been transported to the hospital.

3. All replacement items should be immediately available to the EMT or paramedic as documented in the patient care report so as not to delay their return to service.

4. Failure to replace an item should be documented on a standardized form as provided by the employer agency.

5. EMS should retain this form and restock at their Resource Hospital and/or internally with their EMS agency.

6. In the event of transport of a patient with a suspected communicable disease, the following items must be made available to the EMT or paramedic for use:

    a. An EPA-registered disinfectant or surface disinfectant wipes
    b. Additional ambulance cleaning supplies as needed.

7. Controlled Substances

    a. Use of any controlled substance should be documented on a controlled substance accountability form and signed by the paramedic and a representative from the

receiving participating hospital. The hospital and EMS agency are responsible for maintenance of these forms as per internal policy and DEA requirements.

b. Each participating hospital must accept any waste or residual controlled substances from EMS personnel and dispose of it according to existing hospital and Drug Enforcement Agency (DEA) policy.
c. Upon documentation of use, each participating hospital will then replace only the controlled substance from the EMS unit as listed according to the Region 11 EMS System Drug, Equipment and Supply List.
d. Resource and Associate Hospitals in Region 11 have the additional responsibility to replace "soon to expire" controlled substances according to the Controlled Substance Requirements Policy.

**B. Communication With EMS**

1. Each participating hospital should have a dedicated phone line for EMS pre-notification calls.

2. Every participating hospital must have a functioning MERCI radio.

3. A dedicated fax number or direct platform is required to receive EMS patient care reports.

4. A dedicated computer terminal is required to receive 12 lead ECG transmissions.

5. A dedicated computer terminal is required to access EMResource.

C. **Emergency Department Status and Hospital Capacity**

1. Each hospital should maintain adequate staff and capacity to allow for EMS patient transports to the Emergency Department or implement surge protocols when resources are limited.

2. Each hospital should have a protocol that addresses peak census, surge, and hospital diversion/ambulance bypass; current status should be updated in EMResource as detailed in the Hospital Diversion/Ambulance Bypass or Resource Limitation Policy.

3. According to federal EMTALA regulations, once a patient arrives at a hospital Emergency Department they become the responsibility of the hospital and its staff, and a transfer of patient care is considered to have occurred, regardless of whether or not a gurney or wheelchair is immediately available for the physical transfer.

4. Ambulances on hospital property cannot and will not be rerouted to another hospital for initial patient evaluation.

5. For patients arriving with cardiac rhythm monitoring by EMS, the hospital staff's triage assessment and internal protocols should dictate if continued rhythm monitoring is

necessary. Region 11 EMS Protocols require cardiac monitoring for a wide variety of conditions that may not be the same for 'in hospital' care (i.e. a 'monitored bed' might not be necessary in the Emergency Department).

6. It is mandatory for EMS crews to transfer care to hospital staff, generate a patient care report (PCR), clean their equipment, and restock their supplies in a MAXIMUM of 60 minutes so that they can return to service. Extended "wall times" or "ambulance offload delays" are not acceptable and create a potentially dangerous delay in responding to the next emergency.

7. Each participating hospital must have access to EMResource and report their bed availability according to the Illinois Department of Public Health (IDPH) requirements.

D. **Notification of a Significant Exposure to a Communicable Disease**

1. All hospitals are required to be compliant with the requirements outlined in the Illinois Hospital Licensing Act (210 ILCS 85/6.08).

2. Each participating hospital must have an internal policy addressing notification of communicable diseases to an EMS agency's Designated Infection Control Officer (DICO).

3. The guidelines for the notification for Emergency Response Employees (ERE) and *List of Potentially Life-Threatening Infectious Diseases to Which Emergency Response Employees May Be Exposed* can be found on the CDC webpage: https://www.cdc.gov/niosh/topics/ryanwhite/background.html

E. **EMS Case Review and Continuous Quality Improvement (CQI)**

1. Participating hospitals have the responsibility to notify the Resource Hospital EMS Coordinator of any concerns involving prehospital patient care, the Request for Clarification Form may be used for this purpose.

2. Participating hospitals must share patient medical information with the Resource Hospital for case review and/or quality improvement purposes.

**Attachment I: List of Region 11 EMS System Participating Hospitals**

Attachment 1

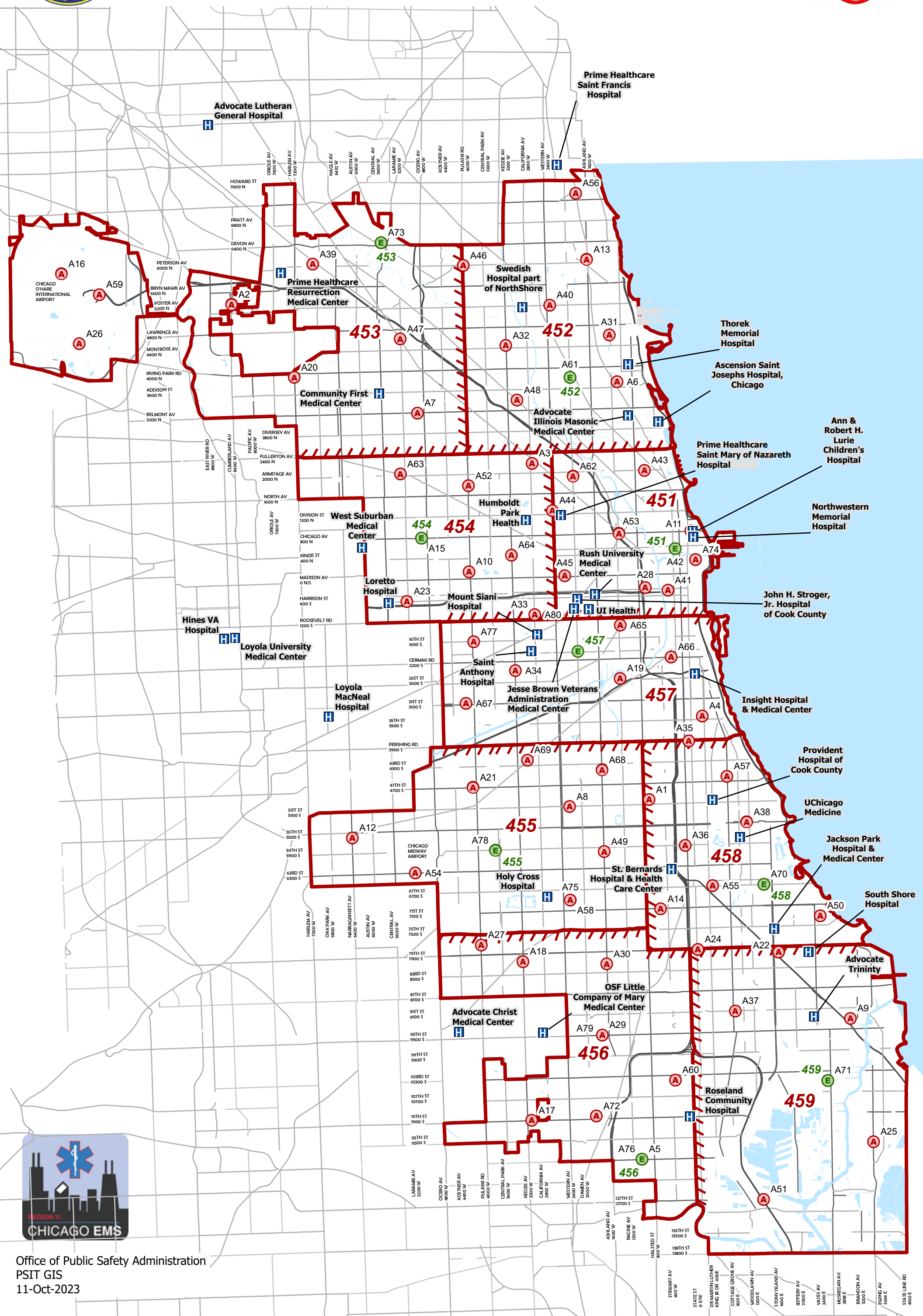
# PARTICIPATING HOSPITALS

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Advocate Trinity Hospital
Ann & Robert H. Lurie Children's Hospital of Chicago (Pediatrics ONLY)
Ascension Saint Joseph Hospital - Chicago
Community First Medical Center
Edward Hines, Jr. Veterans Affairs Hospital
Endeavor Health Swedish Hospital
Holy Cross Hospital
Humboldt Park Health
Insight Hospital & Medical Center
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Affairs Medical Center
John H. Stroger, Jr. Hospital of Cook County
Loretto Hospital
Loyola MacNeal Hospital
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
OSF Little Company of Mary Medical Center
Prime Healthcare Resurrection Medical Center
Prime Healthcare Saint Francis Hospital
Prime Healthcare Saint Mary of Nazareth Hospital
Provident Hospital of Cook County
Roseland Community Hospital
Rush University Medical Center
Saint Anthony Hospital
South Shore Hospital
St. Bernard Hospital & Health Care Center
Thorek Memorial Hospital
UChicago Medicine
UI Health
West Suburban Medical Center

Each hospital listed participates in the Chicago EMS System (Region 11) and is licensed by IDPH as providing Comprehensive Emergency Services.

Updated 8/8/25

# Region 11 Participating Hospitals




Office of Public Safety Administration
PSIT GIS
11-Oct-2023

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Region 11 (Chicago) EMS Organizational Structure |
|---|---|
| | Section: General |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# REGION 11 (CHICAGO) EMS ORGANIZATIONAL STRUCTURE

## I. PURPOSE

To define the organizational structure of the Region 11 (Chicago) EMS Systems.

## II. DEFINITIONS

A. EMS System: An organization of hospitals, EMS agencies and licensed EMS personnel in a specific geographic area, which coordinates and provides prehospital and interhospital emergency care and non-emergency medical transports at a BLS and/or ALS level pursuant to an EMS System Plan.

B. Resource Hospital: The hospital with the authority and responsibility for an EMS System as outlined in the EMS System Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire EMS System, including clinical aspects, operations, and education. This hospital agrees to replace medical supplies and provide for equipment exchange for EMS agencies participating in the EMS System, in addition to the roles and responsibilities outlined in the Region 11 EMS Resource and Associate Hospital Policy and Participating Hospital Policy.

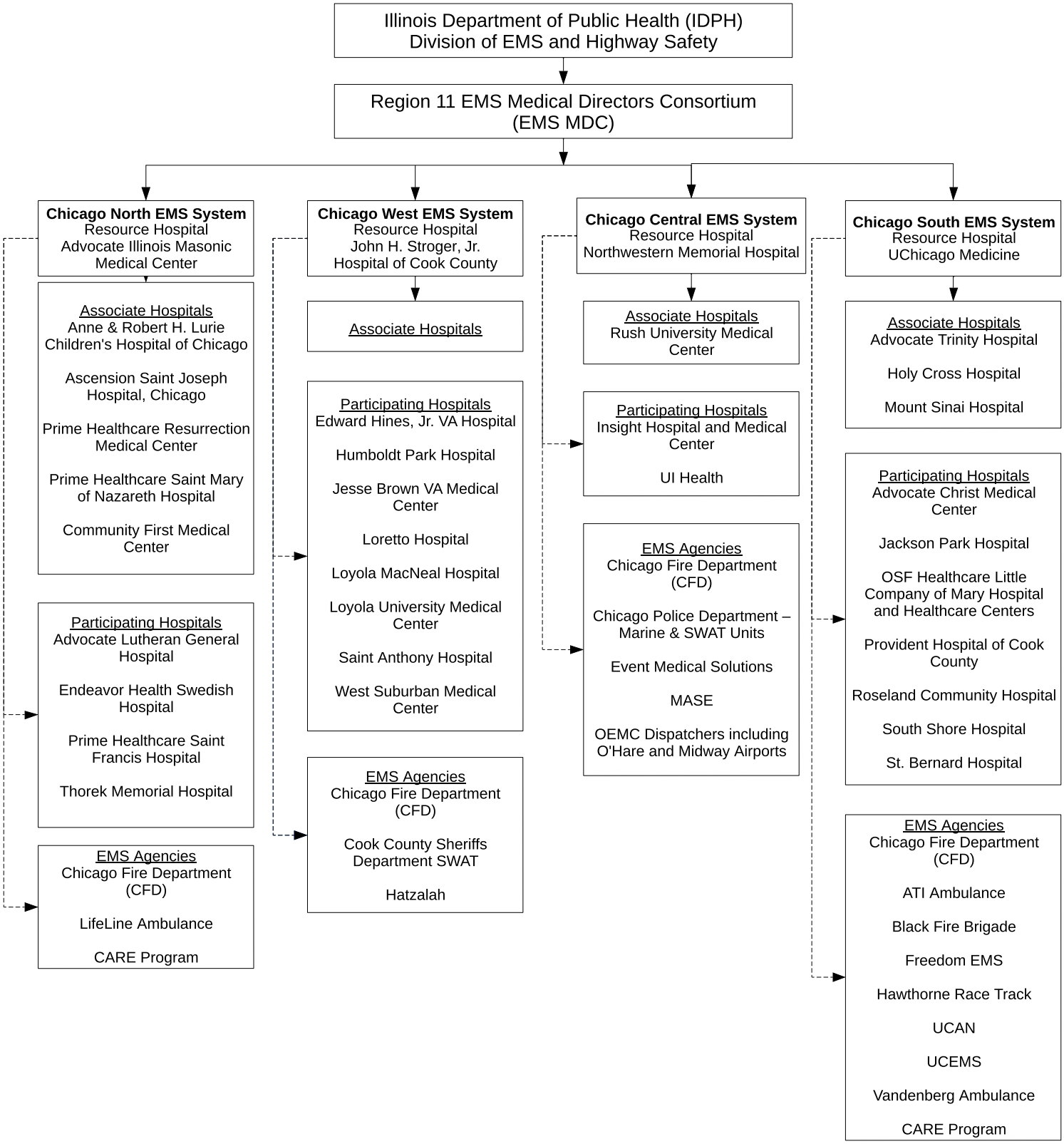
C. Associate Hospital: A hospital participating in an approved EMS System in accordance with the EMS System Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs, nor the responsibility for the overall operation of the EMS System program. This hospital agrees to replace medical supplies and provide for equipment exchange for EMS agencies participating in the EMS System, in addition to the roles and responsibilities outlined in the Region 11 EMS Resource and Associate Hospital Policy and Participating Hospital Policy.

D. Participating Hospital: A hospital participating in an approved EMS System in accordance with the EMS System Program Plan, which is not a Resource Hospital or an Associate Hospital. This hospital agrees to replace medical supplies and provide for equipment exchange for EMS agencies participating in the EMS System, in addition to the roles and responsibilities outlined in the Region 11 EMS Participating Hospital Policy.

E. EMS Agency: An entity licensed by IDPH to provide emergency or non-emergency medical services in compliance with the State of Illinois EMS Act and an operational plan approved by its EMS System(s).

See next page for an outline of the Region 11 (Chicago) EMS Organizational Structure.

# Region 11 (Chicago) EMS Organizational Structure



| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Resource and Associate Hospitals |
|---|---|
| | Section: General |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# RESOURCE AND ASSOCIATE HOSPITALS

## I. PURPOSE

To define the responsibilities of the Resource and Associate Hospitals as part of an EMS System Plan under IDPH.

## II. POLICY

A. Resource Hospital: The hospital with the authority and responsibility for an EMS System as outlined in the EMS System Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire EMS System, including clinical aspects, operations, and education.

1. EMS System Program Plan Defined Roles and Responsibilities:

   a. EMS System Medical Director: Physician appointed by the Resource Hospital who has the authority and responsibility for overseeing EMS continuing education, developing and authorizing EMS Protocols, Policies and Procedures and supervising all EMS personnel as described in the EMS System Program Plan.
   b. Alternate EMS System Medical Director: Responsible for the management of the EMS System Program Plan under the EMS System Medical Director.
   c. EMS System Coordinator: Responsible for data evaluation, quality management, complaint investigation, supervision of all didactic education, clinical and field experiences, and physician and nurse education as required under the EMS System Program Plan and under the authority of the EMS System Medical Director.

2. Region 11 Resource Hospitals and EMS Systems:

   a. Advocate Illinois Masonic Medical Center = Chicago North EMS System
   b. Northwestern Memorial Hospital = Chicago Central EMS System
   c. Stroger Hospital of Cook County = Chicago West EMS System
   d. University of Chicago Medicine = Chicago South EMS System

3. Region 11 EMS is defined as the City of Chicago city limits and is geographically comprised of four EMS Systems (Chicago EMS Systems). See attached Region 11 EMS System Geographical Boundaries Map.

B. Associate Hospital: A hospital participating in an approved EMS System in accordance with the EMS System Plan, fulfilling the same clinical and communications requirements as the Resource Hospital. This hospital has neither the primary responsibility for conducting training programs, nor the responsibility for the overall operation of the EMS System program.

1. EMS System Program Plan Defined Roles and Responsibilities:

    a. Associate Hospital EMS Medical Director: Physician appointed by the Associate Hospital who is responsible for day-to-day operations of the Associate Hospital and supervision of ECPs, as it relates to the EMS System Program Plan and under the authority of the Resource Hospital.
    b. Associate Hospital EMS Coordinator: Responsible for following the EMS System Program Plan and supervision of ECRNs under the authority of the Resource Hospital.

2. Region 11 Associate Hospitals

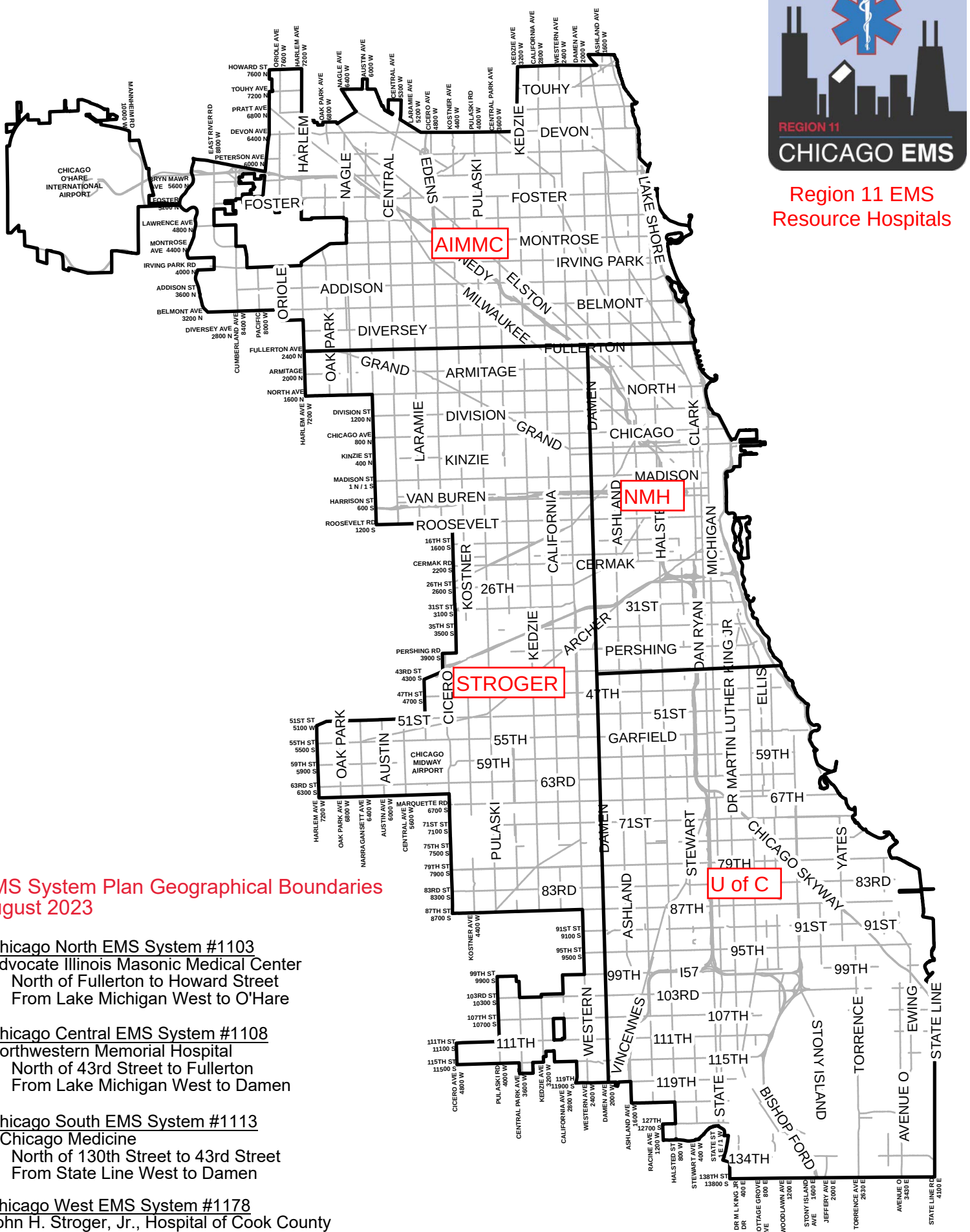
    a. Chicago North EMS System - Advocate Illinois Masonic Medical Center
    Ann & Robert H. Lurie Children's Hospital of Chicago
    Ascension St. Joseph Hospital - Chicago
    Prime Healthcare Resurrection Medical Center
    Prime Healthcare Saint Mary of Nazareth Hospital
    Community First Medical Center

    b. Chicago Central EMS System - Northwestern Memorial Hospital
    Rush University Medical Center

    c. Chicago West EMS System - Stroger Hospital of Cook County

    d. Chicago South EMS System - University of Chicago Medicine
    Advocate Trinity Hospital
    Holy Cross Hospital
    Mount Sinai Hospital

C. In addition to the roles and responsibilities outlined above, Resource and Associate Hospitals must also follow the Participating Hospital Responsibilities Policy.


REGION 11
CHICAGO EMS
Region 11 EMS
Resource Hospitals
AIMMC
NMH
STROGER
U of C
CHICAGO O'HARE INTERNATIONAL AIRPORT
CHICAGO MIDWAY AIRPORT
HOWARD ST 7600 N
TOUHY AVE 7200 N
PRATT AVE 6800 N
DEVON AVE 6400 N
PETERSON AVE 6000 N
BRYN MAWR AVE 5600 N
FOSTER 5200 N
LAWRENCE AVE 4800 N
MONTROSE AVE 4400 N
IRVING PARK RD 4000 N
ADDISON ST 3600 N
BELMONT AVE 3200 N
DIVERSEY AVE 2800 N
FULLERTON AVE 2400 N
ARMITAGE 2000 N
NORTH AVE 1600 N
DIVISION ST 1200 N
CHICAGO AVE 800 N
KINZIE ST 400 N
MADISON ST 1 N / 1 S
HARRISON ST 600 S
ROOSEVELT RD 1200 S
16TH ST 1600 S
CERMAK RD 2200 S
26TH ST 2600 S
31ST ST 3100 S
35TH ST 3500 S
PERSHING RD 3900 S
43RD ST 4300 S
47TH ST 4700 S
51ST ST 5100 S
55TH ST 5500 S
59TH ST 5900 S
63RD ST 6300 S
MARQUETTE RD 6700 S
71ST ST 7100 S
75TH ST 7500 S
79TH ST 7900 S
83RD ST 8300 S
87TH ST 8700 S
91ST ST 9100 S
95TH ST 9500 S
99TH ST 9900 S
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111TH ST 11100 S
115TH ST 11500 S
119TH ST 11900 S
127TH ST 12700 S
134TH ST 13400 S
138TH ST 13800 S
HARLEM AVE 7200 W
OAK PARK AVE 6800 W
NARRAGANSETT AVE 6400 W
AUSTIN AVE 6000 W
CENTRAL AVE 5600 W
CICERO AVE 4800 W
PULASKI RD 4000 W
CENTRAL PARK AVE 3600 W
KEDZIE AVE 3200 W
CALIFORNIA AVE 2800 W
WESTERN AVE 2400 W
DAMEN AVE 2000 W
ASHLAND AVE 1600 W
HALSTED ST 800 W
STEWART AVE 400 W
STATE ST E / 1 W
RACINE AVE 1200 W
KOSTNER AVE 4400 W
DR M L KING JR DR 400 E
COTTAGE GROVE AVE 800 E
WOODLAWN AVE 1200 E
STONY ISLAND AVE 1600 E
JEFFERY AVE 2000 E
TORRENCE AVE 2530 E
AVENUE O 3430 E
STATE LINE RD 4100 E
HOWARD
TOUHY
DEVON
FOSTER
MONTROSE
IRVING PARK
ADDISON
BELMONT
DIVERSEY
FULLERTON
GRAND
ARMITAGE
NORTH
DIVISION
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MADISON
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PULASKI
KEDZIE
LAKE SHORE
ORIOLE
OAK PARK
LARAMIE
KOSTNER
CALIFORNIA
DAMEN
CLARK
HALSTED
MICHIGAN
CICERO
ARCHER
DAN RYAN
DR MARTIN LUTHER KING JR
ELLIS
AUSTIN
STEWART
CHICAGO SKYWAY
YATES
ASHLAND
WESTERN
VINCENNES
I57
STATE
BISHOP FORD
STONY ISLAND
TORRENCE
EWING
AVENUE O
STATE LINE
EMS System Plan Geographical Boundaries
August 2023
Chicago North EMS System #1103
Advocate Illinois Masonic Medical Center
North of Fullerton to Howard Street
From Lake Michigan West to O'Hare
Chicago Central EMS System #1108
Northwestern Memorial Hospital
North of 43rd Street to Fullerton
From Lake Michigan West to Damen
Chicago South EMS System #1113
UChicago Medicine
North of 130th Street to 43rd Street
From State Line West to Damen
Chicago West EMS System #1178
John H. Stroger, Jr., Hospital of Cook County
North of 119th Street to Fullerton
From Damen West to Harlem Avenue

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## COMMUNICATION

Field to Hospital Communication
EMS Report Format
EMS System Communications
Notification to the Resource Hospital
Resource and Associate Hospital EMS Communications Standards

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Field To Hospital Communication |
|---|---|
| | Section: Communication |
| | Approved: EMS Medical Directors Consortium |
| | Effective: September 3, 2020 |

# FIELD TO HOSPITAL COMMUNICATION

I. **Offline Medical Control:** These are the written Region 11 EMS Protocols and Policies that establish guidelines for prehospital patient care.

A. EMS providers will initiate care in accordance with these guidelines;

B. EMS providers should determine the appropriate hospital to contact for each patient encounter as defined below.

II. **Field to Hospital Communication:** For every patient encounter, EMS providers should provide a field to hospital communication report. Reports shall be categorized as:

A. "**Online Medical Control**" for medical, trauma, or refusal calls requiring Base Station contact and/or medical direction; or

B. "**Pre-notification**" for calls that do not require Base Station contact.

III. **Online Medical Control (OLMC)**: Base Station contact is required for: 1) Medical direction in Regionalized Systems of Care patients or complex patient care situations or 2) Situations not clearly defined by the Region 11 EMS Protocols and Policies as needed by the EMS provider.

A. Goal: To provide immediate medical direction to the EMS provider for situations where patient care or destination may be impacted.

B. Hospital staffing requirements: OLMC calls will only be answered by trained ECRNs or ECPs at Region 11 EMS Resource or Associate Hospitals.

C. Communication method: OLMC calls will be made through the MED Channels or cellular lines and all contact will be recorded.

D. Report format: The radio report should follow the Online Medical Control Report (OLMC) format (See EMS Report Format) and be presented in a clear and concise manner.

E. OLMC Assignments: Providers should directly contact the receiving hospital if it is a Region 11 EMS Base Station or contact their assigned Resource or Associate Hospital. If the contact is unsuccessful:

1. Attempt to contact the next closest Resource/Associate Hospital.

2. All attempts at contact must be documented in the patient care report.

3. Notification of a communication problem must be made to the Resource/Associate Hospital and the ambulance service provider's supervisor on duty after arriving at the receiving hospital.

F. **Situations requiring OLMC contact include, but are not limited to:**

1. Regionalized Systems of Care transports including patients with:
   a. Acute coronary syndrome and STEMI criteria
   b. Suspected acute stroke
   c. Trauma Field Triage Criteria (Steps 1-4)
   d. Ventricular Assist Device (VAD)
   e. Obstetric related complaint

2. Cardiac Arrest
   a. For patients in whom resuscitation is initiated, OLMC should be consulted before moving the patient. OLMC is required in making the decision to continue on-scene resuscitation, transport, or terminate resuscitation.
   b. Patients that meet criteria for withholding resuscitation (see Determination of Death / Withholding of Resuscitative Measures policy) do not require OLMC consultation (i.e. DOA).

3. Complex patient care situations and/or questions regarding the appropriate destination. For example:
   a. Any patient potentially requiring a Level 1 Trauma Center, but not clearly meeting Trauma Field Triage Criteria
   b. Patients with possible acute coronary syndrome or stroke symptoms that may not meet defined criteria for specialty center transport
   c. Patients potentially requiring diversion for critical airway stabilization

4. Refusals of care (as defined in the Consent/Refusal of Service policy)

5. Bypass: Transportation to a hospital on bypass

6. Multiple Patient Incidents: As per the Multiple Patient Incident (MPI) policy, in an EMS Plan Response the initial communication should be with the Resource Hospital and each transporting ambulance shall contact the appropriate hospital for a brief OLMC or pre-notification report.

7. Pediatric patients: Pediatric ALS transports should be called in to OLMC, all other pediatric transports require pre-notification.

8. Patient care situations not defined by protocols: Advanced life support (ALS) patients where EMS providers encounter a situation not clearly defined by the Region 11 EMS Protocols and Policies.

***The base station is an available resource for any situation as requested by the EMS provider***

IV. **Pre-Notification**: EMS should contact the receiving hospital directly for **ALL** transports not meeting criteria for Online Medical Control (OLMC).

A. Goal: To provide direct communication between EMS providers and the receiving hospital for straightforward BLS or ALS patient transports.

B. Hospital staffing requirements: All pre-notification calls shall be answered by receiving hospital personnel trained at minimum of Registered Nurse (RN).

C. Communication method: Pre-notification reports should be given through a hospital's dedicated telemetry line if the hospital is a Resource/Associate Hospital within Region 11 (or another Region). Contact may also be through a dedicated EMS telephone line if the participating hospital does not have a telemetry line.

D. Report format: The radio report should follow the 'Pre-Notification Report' format (see EMS Report Format) and be presented as a brief, clear report that provides pertinent information to the receiving hospital staff.

E. If there is a concern about patient treatment and/or transport, a non-Region 11 EMS Base Station receiving hospital may ask the EMS provider to call their assigned base station for online medical control direction.

F. No medical direction will be given by non-Region 11 EMS Base Station hospitals receiving pre-notification reports.

G. Any concern about patient care or transport destination should be reported to the Resource Hospital through a Request for Clarification (RFC) form.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Report Format |
|---|---|
| | Section: Communication |
| | Approved: EMS Medical Directors Consortium |
| | Effective: September 3, 2020 |

# EMS REPORT FORMAT

## I. Field to Hospital Communication

### A. Online Medical Control (OLMC) Report - Use the I-SBAR mnemonic

1. **Identify**
   a. Agency
   b. Number
   c. Level of care (BLS, ALS, Critical Care)

2. **Situation**
   a. State primary reason for call (For example: "*We have a STEMI, Stroke, Trauma, Cardiac Arrest, or Refusal call for Online Medical Control*")

3. **Background**
   a. Age and sex
   b. History including:
      (1) Medical: brief history of present illness, including time of onset of symptoms for patients with suspected acute stroke
      (2) Trauma: description of the mechanism of injury
      (3) Pertinent past medical history
      (4) Medications applicable to circumstance
   c. Allergies, if applicable to circumstance

4. **Assessment**
   a. Vital signs including:
      (1) Level of consciousness and orientation
      (2) Blood pressure
      (3) Pulse and rhythm
      (4) Respiratory rate and degree of distress
      (5) Pulse oximeter
   b. Pertinent physical findings
      (1) Medical assessment including Cincinnati Stroke Scale (CSS) for patients with suspected acute stroke
      (2) Trauma assessment findings

5. **Rx(Treatment)/Response/Request**
   a. Treatment initiated
      (1) Procedures performed
      (2) Medications given
      (3) ETCO2 if advanced airway/cardiac arrest
      (4) Computer interpretation of 12-lead ECG
   b. Patient response to treatment and reassessment
   c. Request medical direction from ECRN/ECP as needed
   d. Destination and ETA

**B. Pre-Notification Report**

1. Identify agency and number
2. State “This is a pre-notification report.”
3. Age and sex
4. Chief complaint
5. Vital signs
6. “Routine protocols followed”
7. Additional details that may be needed for the receiving hospital to prepare for the patient
8. Destination and ETA

## II. EMS Patient Handoff Report

A. On arrival to the Emergency Department, EMS should provide the receiving hospital nursing and physician staff a handoff report with pertinent prehospital information and then transition patient care.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS System Communications |
|---|---|
| | Section: Communications |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMS SYSTEM COMMUNICATIONS

## I. PURPOSE

To define EMS System Communications for which the Region 11 Chicago EMS Systems, EMS Agencies and Base Station Hospitals will utilize.

## II. DEFINITIONS

A. Cellular Line: Communication method which utilizes a cellular phone and cellular towers for data transmission between prehospital providers and the hospital base station.

B. MED Channels: Communication method which utilizes push to talk radios and radio towers, with or without circuit lines, for data transmission between prehospital providers and the hospital base station.

C. MERCI: Communication method which utilizes push to talk radios and VHF/UHF radio frequencies for data transmission between ambulance to hospital, hospital to hospital, and statewide communications.

1. MERCI 340 (155.340 MHz) is Region 11 ambulance to hospital communication line

2. MERCI 280 (155.280 MHz) is Region 11 hospital to hospital communication line

3. MERCI 340 SW (155.340 MHz tone 201.7) is statewide disaster communication line

*For MERCI 340 and 280, tone will vary for each agency and institution*

D. STARCOM21: State Radio (Voice) Communications is a 700/800 MHz digital trunked statewide voice radio communications network.

## III. REGIONAL COMMUNICATION SYSTEM PLAN

A. Regional Plan is approved to IDPH and includes the following items:

1. A listing of access numbers of Emergency Medical Services, including a description of plans to use or to implement a "911" Public Safety Answering Point (PSAP).

2. A description of plans to handle hospital-to-hospital communications, including redundancies.

3. A description of communication methods for EMS personnel to communicate with Resource and Associate Hospitals including communication redundancy.

4. Copies of Federal Communications Commission (FCC) licenses or applications.

B. EMS telecommunications equipment shall be configured to allow the EMS Medical Director, or designee, to monitor all vehicle to hospital transmissions and hospital-to-vehicle transmissions within the EMS System.

C. Resource and Associate Hospitals shall have an operational control point for a Medical Emergency Communications of Illinois (MERCI) VHF/UHF base station, EMS telecommunication receiving and monitoring, and any Associate to Resource Hospital communications.

D. Physician direction shall be provided from the operational control point of an approved Resource or Associate Hospital. All medical direction given shall be recorded.

E. All on-line medical direction calls are to be recorded for retrospective review for a minimum of 365 days. Recording retention shall comply with the Resource and Associate Hospital's corporate record retention policy if it exceeds IDPH's minimum requirements.

F. Telecommunications equipment necessary to fulfill the requirements of this policy shall be staffed and maintained 24 hours every day, including radio base stations, telephone and computer, and their required equipment.

G. EMS System personnel shall be capable of properly operating their respective communications equipment.

H. All telecommunications equipment shall be maintained to minimize service interruptions. Procedures shall be established to provide immediate action to be taken by operating personnel to utilize secondary forms of communication and ensure rapid restoration in case breakdowns do occur.

I. Written protocols shall describe communications procedures for operation of the EMS System, all base station control points, and field units. Mobile base control points (e.g., mobile CAREpoint) and EMS units (e.g., ambulances, non-transport vehicles, SEMSVs) shall have an easily accessible copy of the protocols pertaining to their stations.

J. Written protocols shall include a requirement that before terminating communications with medical direction, pre-hospital personnel must notify medical direction of a method by which the ambulance can be re-contacted, and must set its communications equipment so as to be able to receive a call from medical direction.

## IV. PRIMARY, ALTERNATE, CONTINGENCY, EMERGENCY (PACE) PLAN

A. The chart below identifies preferred routes of communication from EMS personnel to hospital base stations during field to hospital communications (see Region 11 Field to Hospital Communication Policy).

| EMS PERSONNEL TO HOSPITAL BASE STATION COMMUNICATION PREFERENCES | |
|---|---|
| **PRIMARY** | Cellular Phone Line |
| **ALTERNATE** | MED Channel |
| **CONTINGENCY** | MERCI 340 |
| **EMERGENCY** | MERCI 340SW or STARCOM |

B. Region 11 EMS Communication Standards

1. Refer to Field to Hospital Communication Policy

2. Refer Resource and Associate Hospital Communication Standards Policy

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Notification to the Resource Hospitals |
|---|---|
| | Section: Communications |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# NOTIFICATION TO THE RESOURCE HOSPITAL

## I. DEFINITIONS

A. Emergency Management Assistance Compact (EMAC): A national interstate mutual aid agreement that enables states to share resources during times of disaster.

B. National Ambulance Contract (NAC): To provide licensed ambulance services and para-transit services in response to a disaster, an act of terrorism, or another public health emergency.

## II. EMS RESPONSIBILITIES

A. There are special circumstances which require licensed EMS personnel and/or the EMS provider agency to provide notification to their respective Resource Hospital.

B. The following circumstances require written and verbal notification to the assigned Resource Hospital within the specified time frames:

1. Felony Conviction

    a. Under the EMS Act, all applicants for any license shall fully disclose any and all felony convictions in writing at the time of initial application or renewal.
    b. Under the EMS Act, all license holders shall report all new felony convictions to the Resource Hospital who will then notify IDPH within seven days after conviction.

2. Disaster Deployment

    a. The EMS provider agency must notify, and receive approval from, the EMS Medical Director and IDPH prior to any EMAC or NAC deployments.
    b. An EMS system modification form must be completed at the time of deployment and when returning from deployment.
    c. This form must be signed and approved by the Resource Hospital and IDPH.

3. Line of Duty Death

    a. The EMS provider agency must notify the Resource Hospital in the event of a line of duty death within 24 hours following the incident.
    b. The Resource Hospital will notify IDPH.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Resource and Associate Hospital EMS Communications Standards |
|---|---|
| | Section: Communications |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# RESOURCE AND ASSOCIATE HOSPITAL EMS COMMUNICATIONS STANDARDS

I. Physician direction and voice orders to EMS personnel and other hospitals participating in the EMS System are provided from the operational control point of a Region 11 Resource or Associate Hospital, which are also known as "EMS Base Stations" and provide Online Medical Control (OLMC) through radio or phone communication.

II. All telecommunications equipment shall be maintained to minimize service interruptions. Procedures shall be established by the EMS Base Station hospital for immediate action to be taken to restore service. Operating personnel should utilize secondary forms of communication through either the MED Channels, cellular line, or MERCI VHF/UHF frequencies until service is restored to primary route of notification.

III. An Emergency Communications RN (ECRN) will request the EMS Medical Director (EMSMD) or designated physician (ECP) consultation in:

   A. Patient clinical care situations; and/or

   B. Complex medical or legal issues and interpretation of the EMS System policies.

IV. It is the responsibility of the attending ECP in the emergency department to assure that there is immediate ECP response whenever medical consultation and assistance is requested by EMS.

V. The EMT/Paramedic may request to speak with the ECP if there are concerns relative to orders received from the ECRN or unique circumstances that require ECP decision-making.

VI. All online medical direction calls are recorded for retrospective review for a minimum of 365 days, or consistent with the hospital's record retention policy, whichever is longer.

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## PATIENT CARE

Abandoned Newborn Infant Protection
Advanced Directives and POLST
ALS Expanded Scope and Critical Care Transport
ALS Upgrade of EMS Service
Approval of Additional Pilot Programs, Medications, and Equipment
Call Disposition
CARE EMS Program
Consent and Refusal of EMS Service
Controlled Substance Requirements
Conveyance of Patients
Determination of Death / Withholding of Resuscitative Measures
EMS Guidelines for Infection Control
EMS Staffing
Epinephrine Dilution for Shortage
Initiation of Patient Care
Interaction with an Independent Nurse/Physician on Scene
Interaction with Law Enforcement at a Crime Scene
Large Gathering/Special Events
Management of Multiple Patient Incidents
Medication Administration Cross Check (MACC)
Mobile Integrated Health Program
Notification of the Coroner/Medical Examiner
Region 11 Medication, Equipment, and Supply (MES) List
Reporting Abused and/or Neglected Patients
Restraints
Safe Transport of Children by EMS
SEMSV (Specialized EMS Vehicle) EMS Bus Program
School Incidents
Termination of Resuscitation
Use of Latex Free Supplies
Watercraft SEMSV Program

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Abandoned Newborn Infant Protection |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# ABANDONED NEWBORN INFANT PROTECTION

## I. PURPOSE

A. To define EMS responsibilities under the *Abandoned Newborn Infant Protection Act*.

B. Abandoned Newborn Infant Protection Act: Illinois legislation that allows a parent to relinquish a newborn infant, whom a physician reasonably believes is 30 days old or less, to personnel of a hospital, police station (including campus police), fire station, or emergency medical facility which are considered "Safe Havens". The parent may remain anonymous and is immune from liability, as long as the infant is unharmed. It is recognized that establishing an adoption plan is preferable, to relinquishing a child using the procedures outlined in this Act, but to reduce the chance of injury to a newborn infant, this Act provides a safer alternative.

## II. DEFINITIONS

A. Newborn Infant: A child who a licensed physician reasonably believes is 30 days old or less at the time the child is initially relinquished and who is not an abused or neglected child.

B. Relinquish: To bring a newborn infant, who a licensed physician reasonably believes is 30 days old or less to a hospital, police station, fire station, emergency medical facility, and to leave the infant with personnel of the facility, if the person leaving the infant does not express an intent to return for the infant or states that he or she will not return for the infant.

C. Emergency Medical Professional: Includes licensed physicians and any EMS personnel as defined in the EMS Systems Act.

D. Fire Station: A fire station within the State that is staffed with at least one full-time person.

E. Safe Haven: a hospital, police station (including campus police), fire station, or emergency medical facility with signage to visually help identify their location.

## III. POLICY

A. EMS personnel in the Chicago EMS System will provide assessment, treatment, and transportation to the closest EDAP hospital for relinquished infants.

B. EMS personnel are required to provide the necessary information to the relinquishing parent as specified in this Act.

## IV. INFANT CARE AND HOSPITAL CONTACT

A. The relinquishing person is presumed to be the infant's biological parent.

B. Assess the infant. Look particularly for any signs of abuse or neglect.

C. Ask the relinquishing parent for the infant's name and date of birth.

D. Ask the relinquishing parent if they have any medical issues that need to be addressed.

E. If the child is presumed to be more than 30 days old, or has been abused or neglected, EMS personnel should proceed as if the child is abused or neglected. Follow the Reporting Abused and/or Neglected Patients Policy and file a report with DCFS. While this is all that is required under the Act, refusing to take an infant presumed to be older than 30 days or one who is abused or neglected from a parent who wishes to relinquish him or her could possibly result in harm to the infant. It is in the best interest of the child to accept them and proceed as below.

F. Initiate emergency treatment that is necessary per Region 11 EMS Protocols under implied consent and keep the infant warm.

G. Transport to the closest, most appropriate Region 11 EDAP hospital with pre-notification.

H. Complete a patient care report on the infant. List the infant's name as "Baby Doe" if it is unknown.

## V. COMMUNICATION WITH THE RELINQUISHING PARENT

A. EMS personnel must offer the relinquishing parent the information specified in the Act (see below), and if possible, **verbally inform the parent that**:

1. **His or her acceptance of the information is completely voluntary;**

2. Completion of the *Illinois Adoption Registration* form and *Medical Information Exchange* form is voluntary;

3. By relinquishing the infant anonymously, he or she will have to petition the court to prevent the termination of parental rights and regain custody of the child.

4. If the parent returns within 30 days to reclaim the infant, they should be told the name and location of the hospital to which the infant was transported.

B. **Information to give to relinquishing parent** - Hospitals, fire stations, police stations, and emergency medical facilities must offer a "Safe Haven Information Packet" or refer the parent to a website or another electronic resource that contains the following:

1. Safe Haven law information and optional self-mailer registration form.

2. Illinois Adoption Registry and Medical Information Exchange (IARMIE) form.

3. Post-partum health information for the mother.

4. Save Abandoned Babies Foundation which includes resources on counseling and adoption services.

C. Document on the infant's patient care report that the “Safe Haven Information Packet” or referral to a website or electronic resource was offered to the parent and whether it was received.

## VI. **RESOURCES**

A. The forms required above are located at the Illinois Department of Children and Family Services (DCFS) website: https://www2.illinois.gov/dcfs

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Advanced Directives and POLST |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# ADVANCED DIRECTIVES AND POLST

## I. HEALTH CARE AGENT/POWER OF ATTORNEY FOR HEALTH CARE (POAHC)

A. Illinois law allows people to appoint an agent to make health care decisions for the patient in the event that the patient is unable to make his or her own medical decisions. The person chosen by the patient to make these decisions is called the "agent." An agent is appointed by the patient via a document called “power of attorney for health care." The agent can ask you to withdraw or withhold medical care of the patient.

B. A health care agent has no authority if the patient himself or herself is alert and able to articulate consent to treatment or transport. If the patient is alert and consents to treatment, continue to treat the patient, even if thereafter the patient is unable to communicate with you. In such situations, the health care agent has no authority over the treatment of the patient.

C. In a situation where someone represents to you that they have power of attorney to make medical decisions for the patient, EMS personnel should do the following:

1. Begin treatment of the patient.

2. As soon as it is practical, ask the agent for the power of attorney form and examine the form to determine if the agent's name appears on the form as agent and ask the agent to verify that his/her signature appears on the form. Review the form to see what decision-making authority has been given to the agent.

3. Notify medical control as indicated of the confirmed presence of a health care agent and follow the instructions of the agent by the authority granted in the power of attorney form unless instructed otherwise by medical control.

4. If you have doubt as to the identity of the agent, the extent of the authority of the agent, or if communications with medical control cannot be established, continue treatment of the patient and document the situation.

## II. LIVING WILLS AND PATIENT SURROGATES

Illinois law allows terminally ill patients to instruct their health care providers, either directly with a living will or indirectly through a patient surrogate, on their treatment in near death situations. However, the technical requirements of these laws make them difficult for field use. Therefore, Region 11 EMS personnel shall not follow the instructions contained in a living will or given by any person representing to be a surrogate for the patient unless instructed otherwise by medical control.

## III. IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Advanced Directives and POLST |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

For the purpose of this policy, the POLST decision making process and form are defined as medical orders by a physician or practitioner for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. These orders provide guidance during life threatening emergencies and must be followed by all healthcare providers.

A. The IDPH Uniform POLST Form was revised in September 2022 and is detailed below. Prior versions of the DNR/POLST Form are still valid.

B. The sections of the POLST Form are defined as follows:

1. Section A of the POLST Form references "Orders for Patient in Cardiac Arrest." This section notes if the patient wishes to have resuscitation/CPR attempted or if they prefer medical providers "Do Not Attempt Resuscitation (DNAR)."

2. Section B of the POLST Form references "Orders for Patient Not in Cardiac Arrest." This section has three treatment options with the goal of maximizing comfort regardless of which treatment option is selected.

    a. **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments**. Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
    b. **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
    c. **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptoms management. Allow natural death. Use medication by any route as needed. Use oxygen, suctioning, and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.**

3. Section C of the POLST Form references "Additional Orders or Instructions." These orders are in addition to those in the above sections and include language that EMS protocols may limit emergency responder ability to act on orders in this section.

4. Section D of the POLST Form references "Orders for Medically Administered Nutrition".

5. Section E of the POLST Form references documentation of the discussion of the form and signatures of the patient or legal representative.

6. Section F of the POLST Form references the printed name, signature, and date of the patient's Qualified Health Care Practitioner.

C. Region 11 EMS personnel are permitted to follow a valid POLST Form regarding medical care in a life-threatening clinical event. This includes situations for patients in long-term care facilities, with hospice and home-care patients, and with patients who arrest during interhospital transfers or transportation to or from home.

D. A valid POLST Form will contain at least the following information:

1. Name of the patient.
2. "Orders for Patient in Cardiac Arrest" - Section A option selected.
3. Signature of patient or legal representative as defined on the form:
    a. Parent of minor
    b. Agent under Power of Attorney for Health Care (POAHC)
    c. Heath care surrogate decision maker
4. Name and signature of the patient's Qualified Health Care Practitioner.
5. Date.

E. If the POLST Form does not have the required items completed on the form, the form is not valid for prehospital use.

F. In situations with a POLST Form, EMS providers should do the following:

1. Verify the form contains the criteria for a valid POLST Form as listed above.
2. Make a reasonable attempt to verify the identity of the patient (for example, identification by another person or an identifying bracelet) named in a valid POLST Form.
3. Contact medical control as needed to discuss the situation and advise them of the presence of a POLST Form, along with the description of any specific treatments as defined in the POLST Form.
4. If the order is valid, follow the terms of the POLST Form. Document all information from the POLST Form on the patient care report.
5. If there is any doubt as to the validity of the POLST Form, treat the patient and contact medical control. Document the situation in the patient care report.

G. Voiding or revoking a POLST Form:

1. A patient with decision making capacity can void or revoke the POLST Form and/or request alternative treatment.

2. Changing, modifying, or revising a POLST Form requires completion of a new POLST form.

H. Digital copies (including on a cell phone or tablet) and photocopies, including faxes, on any color paper are legal and valid. POLST Forms with e-signature are legal and valid.

I. EMS and healthcare providers should honor any completed POLST Form that is formally authorized by a state or territory within the United States, as well as the National POLST Form (http://polst.org/national-form/).

J. Reference “Notification of the Coroner / Medical Examiner” policy when there has been a death recorded by EMS to provide proper notification.

K. This policy is subject to EMS System Quality Improvement / Quality Assurance (QI/QA) Plan.

State of Illinois
Department of Public Health

# IDPH UNIFORM PRACTITIONER ORDER FOR LIFE-SUSTAINING TREATMENT (POLST) FORM

***For patients:*** *Use of this form is completely voluntary. If desired, have someone you trust with you when discussing a POLST form with a health care professional.* ***For health care providers:*** *Complete this form only after a conversation with the patient or the patient's representative. The POLST decision-making process is for patients who are at risk for a life-threatening clinical event because they have a serious life-limiting medical condition, which may include advanced frailty. With significant change in condition, new orders may need to be written.*

| ***PATIENT INFORMATION.*** *For patients: Use of this form is completely voluntary.* | | |
|---|---|---|
| Patient Last Name | Patient First Name | MI |
| Date of Birth (mm/dd/yyyy) | Address (street/city/state/ZIP code) | |

**A** *Required to Select One*

**ORDERS FOR PATIENT IN CARDIAC ARREST.** Follow if patient has NO pulse.

- ☐ **YES CPR**: **Attempt cardiopulmonary resuscitation (CPR).** Utilize all indicated modalities per standard medical protocol. (Requires choosing **Full Treatment** in Section B.)
- ☐ **NO CPR: Do Not Attempt Resuscitation (DNAR).**

**B** *Section may be Left Blank*

**ORDERS FOR PATIENT NOT IN CARDIAC ARREST.** Follow if patient has a pulse. Maximizing comfort is a goal regardless of which treatment option is selected. (When no option selected, follow Full Treatment.)

- ☐ **Full Treatment: Primary goal is attempting to prevent cardiac arrest by using all indicated treatments.** Utilize intubation, mechanical ventilation, cardioversion, and all other treatments as indicated.
- ☐ **Selective Treatment: Primary goal is treating medical conditions with limited medical measures.** Do not intubate or use invasive mechanical ventilation. May use non-invasive forms of positive airway pressure, including CPAP and BiPAP. May use IV fluids, antibiotics, vasopressors, and antiarrhythmics as indicated. Transfer to the hospital if indicated.
- ☐ **Comfort-Focused Treatment: Primary goal is maximizing comfort through symptom management. Allow natural death.** Use medication by any route as needed. Use oxygen, suctioning and manual treatment of airway obstruction. Do not use treatments listed in Full and Selective Treatment unless consistent with comfort goal. Transfer to hospital only if comfort cannot be achieved in current setting.

**C** *Section may be Left Blank*

**Additional Orders or Instructions.** These orders are in addition to those above (e.g., withhold blood products; no dialysis). [EMS protocols may limit emergency responder ability to act on orders in this section.]

**D** *Section may be Left Blank*

**ORDERS FOR MEDICALLY ADMINISTERED NUTRITION.** Offer food by mouth if tolerated. (When no selection made, provide standard of care.)

- ☐ Provide artificial nutrition and hydration by any means, including new or existing surgically-placed tubes.
- ☐ Trial period for artificial nutrition and hydration but NO surgically-placed tubes.
- ☐ No artificial nutrition or hydration desired.

**E** *Required*

***Signature of Patient or Legal Representative.*** *(eSigned documents are valid.)*

**X** Printed Name ***(required)*** | Date _____

Signature ***(required)*** *I have discussed treatment options and goals for care with a health care professional. If signing as legal representative, to the best of my knowledge and belief, the treatments selected are consistent with the patient's preferences.*

**X**

| *Relationship of Signee to Patient:* | | |
|---|---|---|
| ☐ Patient<br>☐ Parent of minor | ☐ Agent under Power of Attorney for Health Care | ☐ Health care surrogate decision maker (See Page 2 for priority list) |

**F** *Required*

***Qualified Health Care Practitioner.*** Physician, licensed resident (second year or higher), advanced practice nurse, or physician assistant. (eSigned documents are valid.)

| **X** Printed Authorized Practitioner Name ***(required)*** | Phone _____ |
|---|---|
| Signature of Authorized Practitioner ***(required)*** *To the best of my knowledge and belief, these orders are consistent with the patient's medical condition and preferences.*<br>**X** | Date ***(required)*** _____ |

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: ALS Expanded Scope and Critical Care Transport |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# ALS EXPANDED SCOPE AND CRITICAL CARE TRANSPORT

## I. PURPOSE

To define the requirements and responsibilities of an ALS expanded scope and critical care transport program.

## II. DEFINITIONS

A. **ALS Expanded Scope and Critical Care Transport**: Prehospital or inter-hospital transportation of a critically injured or ill patient by a vehicle service provider, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the Paramedic when medically indicated by a physician. For the purposes of this policy, critical care transport plans are defined in three tiers of care.

B. **Tier I Transports**: Tier I transports provide a level of care for patients who require care beyond the IDPH-approved Paramedic scope of practice, up to but not including the requirements of Tiers II and III. Tier I transport may include the use of a ventilator, the use of infusion pumps with administration of medication drips, and maintenance of chest tubes. Tier I transports are considered "expanded scope of practice".

C. **Expanded Scope of Practice**: Includes the accepted national curriculum plus additional education, experience and equipment as approved by the EMS Medical Director and IDPH.

D. **Tier II Transports**: Tier II transports provide an expanded scope of practice more comprehensive than Tier I and are approved by the EMS Medical Director and IDPH in accordance with the EMS System Plan. Tier II transports are considered critical care transports.

E. **Tier III Transports**: Tier III transports provide the highest level of transport care for patients who require advanced level treatment modalities and interventions as approved by the EMS Medical Director and IDPH and identified in the EMS System Plan. Tier III transports are considered critical care transports.

## III. POLICY

A. Critical care transport may be provided by:

1. IDPH-approved critical care transport agencies, not owned or operated by a hospital, utilizing Paramedics with additional training, nurses, or other qualified health professionals; or

2. Hospitals, when utilizing any licensed vehicle service provider or any hospital-owned or operated licensed vehicle service provider. Nothing in the Act requires a hospital to use, or to be, an IDPH-approved critical care transport provider when transporting patients, including those critically injured or ill. Nothing in the Act shall restrict or prohibit a hospital from providing, or arranging for, the medically appropriate transport of any patient, as determined by a physician.

3. Physician medical direction for critical care, as approved by the EMS Medical Director or delegate, shall have the qualifications consistent with the acuity and conditions of the critical care patients transported. Such medical direction includes an Illinois licensed practicing physician with competency in critical care transport medicine and board certification in a specialty relevant to the provider agency mission or experience in critical care transport medicine consistent with the types, acuity and severity of patients transported.

B. All critical care transport providers must be approved by the EMS Medical Director. Nothing in this policy shall restrict a hospital's ability to furnish personnel, equipment, and medical supplies to any vehicle service provider, including a critical care transport provider.

## IV. TIER I TRANSPORTS – ALS EXPANDED SCOPE

A. Licensure and Personnel Staffing

1. Licensed Illinois Paramedic, PHRN, PHPA or PHAPRN;

2. Scope of practice more comprehensive than the national EMS scope of practice model approved by IDPH; and

3. Approved to practice by IDPH in accordance with the EMS System plan.

B. Minimum Staffing

1. System authorized EMT, Paramedic, PHRN, PHPA or PHAPRN as driver; and

2. System authorized expanded scope of practice Paramedic, PHRN, PHPA, PHAPRN or physician who shall remain with the patient at all times.

C. Education, Certification and Experience

1. Initial Education

a. Documentation of initial education and demonstrated competencies of expanded scope of practice knowledge and skills as required by Tier I Level of Care and approved by IDPH in accordance with the EMS System plan.

2. Continuing Education Requirements

a. Annual competencies of expanded scope of practice knowledge, equipment and procedures shall be completed; and
b. The EMS vehicle service provider shall maintain documentation of competencies and provide documentation to the EMS System upon request.

3. Certifications

    a. Tier I personnel shall maintain the following renewable certifications and credentials in active status:
        - Advanced Cardiac Life Support (ACLS);
        - Pediatric Education for Pre-Hospital Professionals (PEPP) or Pediatric Advance Life Support (PALS);
        - International Trauma Life Support (ITLS) or Pre-Hospital Trauma Life Support (PHTLS); and
        - Any additional educational course work or certifications required by the EMS MD.

4. Experience

    a. Minimum of 6 months of experience functioning in the field at an ALS level or as a physician in an Emergency Department; and
    b. Documentation of education and demonstrated competencies of expanded scope of practice knowledge and skills required for Tier I Level of Care, approved by IDPH, and included in the EMS System Plan.

D. Medical Equipment and Supplies

1. Authorized equipment as approved by the EMS MD and IDPH and included in the EMS System Plan.

E. Vehicle Standards

1. Any vehicle used for providing expanded scope of practice care shall comply, at a minimum, with the Region 11 Ambulance Licensing Requirements Policy or the State of Illinois Administrative Code in regards to the Licensure of SEMSV (Specialized EMS Vehicle) Programs (Section 515.900) and SEMSV Program Licensure Requirements for Air Medical Transport Programs (Section 515.920) vehicle requirements, including additional medical equipment and ambulance equipment as defined in the EMS System Plan.

2. Any vehicle used for expanded scope of practice transport shall be equipped with an onboard alternating current (AC) supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

F. Treatment and Transport Protocols

1. Shall address written operating procedures and protocols signed by the EMS MD and approved for use by IDPH in accordance with the EMS System Plan; and

2. Use of authorized equipment as approved by the EMS MD.

G. Quality Assurance Program

1. The Tier I transport provider shall develop a written Quality Assurance (QA) plan approved by the EMS System and IDPH. The provider shall provide quarterly QA reports to the EMS System and to IDPH upon request for the first 12 months of operation.

2. If the EMS System has not identified any deficiencies or adverse outcomes after the first year, the EMS System shall establish the frequency of quality reports.

3. An EMS MD shall oversee the QA program.

4. The QA plan shall evaluate all expanded scope of practice activity. The review shall include at a minimum:

   a. Review of transferring physician orders and evidence of compliance with those orders;
   b. Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;
   c. Documentation of any side effects/complications, including hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;
   d. Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;
   e. Documentation that any unusual occurrences were promptly communicated to the EMS System; and
   f. A root cause analysis of any event or care inconsistent with standards.
   g. The QA plan shall be subject to review as part of an EMS System site survey and as deemed necessary by IDPH.

## V. TIER II TRANSPORTS – CRITICAL CARE

A. Licensure and Personnel Staffing

1. Licensed Illinois Paramedic, PHRN, PHPA or PHAPRN.

B. Minimum Staffing

1. System authorized Paramedic, PHRN, PHPA or PHAPRN; and

2. System authorized Paramedic, PHRN, PHPA, PHAPRN or physician who is critical care prepared and who shall remain with the patient at all times.

C. Education, Certification and Experience

1. Initial Advanced Education

a. At a minimum, 80 didactic hours of established higher collegiate critical care education nationally recognized; or two years of experience in critical care or emergency care with completion of an EMS MD approved critical care training program (consisting of, at minimum, 80 didactic hours) and obtaining a nationally recognized advanced certification within two years; and
b. Demonstrated competencies, as documented by the EMS MD or SEMSV MD and approved by IDPH.

2. Continuing Education Requirements

a. The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment, and procedures;
b. A minimum of 40 hours of critical care level education shall be completed every four years;
c. The EMS provider shall maintain documentation of compliance with continuing education requirements and shall provide documentation to the EMS System upon request; and
d. Nationally recognized critical care certifications shall be maintained and renewed based on national recertification criteria.

3. Certifications

a. Tier II personnel shall maintain, at a minimum, the following renewable certifications, and credentials in active status:
   - ACLS;
   - PEPP or PALS;
   - ITLS or PHTLS

4. Experience

a. Minimum of one year experience functioning in the field at an ALS level for Paramedics, PHRNs, PHPAs, and PHAPRNs and one year experience in an Emergency Department for physicians.

D. Medical Equipment and Supplies

1. Infusion pumps; and

2. Other authorized equipment as approved by the EMS MD or SEMSV MD and IDPH and included in the EMS System Plan.

E. Vehicle Standards

1. Any vehicle used for providing critical care transports shall comply, at a minimum, with the Region 11 Ambulance Licensing Requirements Policy or the State of Illinois Administrative Code in regards to the Licensure of SEMSV (Specialized EMS Vehicle) Programs (Section 515.900) and SEMSV Program Licensure Requirements for Air Medical Transport Programs (Section 515.920) vehicle

requirements, including additional medical equipment and ambulance equipment as defined in the EMS System Plan.

2. Any vehicle used for critical care transport shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

F. Treatment and Transport Protocols

1. Shall address equipment and medications used on Tier II transports.

G. Quality Assurance Program

1. The EMS System and Tier II transport providers shall have an IDPH-approved QA program in place that uses national standards performance indicators to evaluate the appropriateness and quality of patient care. The method and results of the quality improvement projects shall be available to IDPH upon request.

2. An EMS MD shall oversee the QA program.

## VI. TIER III TRANSPORTS – CRITICAL CARE

A. Minimum Personnel Staffing and Licensure

1. One driver holding a current Illinois EMS license; and

2. Two critical care prepared clinicians, who shall remain with the patient at all times:

a. Paramedic, PHRN, PHPA or PHAPRN; and
b. RN, PHRN, PHPA or PHAPRN.

B. Education, Certification and Experience

1. Paramedic, PHRN, PHPA or PHAPRN

a. Initial Advanced Education
- At a minimum, 80 didactic hours of established higher collegiate critical care education nationally recognized, or two years of experience in critical care or emergency care with completion of an EMS MD or SEMSV MD approved critical care training program (consisting of, at minimum, 80 didactic hours) and obtaining a nationally recognized advanced certification within two years; and; and
- Demonstrated competencies, as documented by the EMS MD and SEMSV MD and approved by IDPH.

b. Continuing Education Requirements
- The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment, and procedures;
- A minimum of 40 hours of critical care level continuing education shall be completed every four years;
- The EMS provider shall maintain documentation of compliance with continuing education requirements and shall provide documentation to the EMS System upon request; and
- Nationally recognized critical certifications shall be maintained and renewed based on national recertification criteria.

c. Certifications
Tier III Paramedic, PHRN, PHPA or PHAPRN personnel shall maintain, at a minimum, the following renewable certifications, and credentials in active status:
- ACLS;
- PEPP or PALS and Neonatal Resuscitation Program (NRP) or EMS System approved equivalent; and
- ITLS or PHTLS.

d. Experience
- Minimum of two years experience functioning in the field at an ALS Level;
- Documented demonstrated competencies; and
- Completion of annual competencies of expanded scope knowledge, equipment, and procedures.

2. Registered Nurses

a. Continuing Education Requirements
- A minimum of 48 hours of critical care level education shall be completed every four years; and
- The EMS provider shall maintain documentation of compliance with continuing education requirement and shall provide documentation to the EMS System upon request.

b. Certifications
Tier III RN personnel shall maintain, at a minimum, the following renewable certifications, and credentials in active status:
- ACLS;
- PEPP, PALS, or Emergency Nursing Pediatric Course (ENPC);
- NRP or EMS System approved equivalent; and
- ITLS, PHTLS, and Trauma Nursing Core Course (TNCC) or Trauma Nurse Specialist (TNC), TPATC or ATLS.

c. Experience
- Minimum of two years full-time critical care experience.

D. Medical Equipment and Supplies

1. As approved by the EMS MD or SEMSV MD and IDPH and included in the EMS System Plan.

E. Vehicle Standards

1. Any vehicle used for providing critical care transports shall comply, at a minimum, with the Region 11 Ambulance Licensing Requirements Policy or the State of Illinois Administrative Code in regards to the Licensure of SEMSV (Specialized EMS Vehicle) Programs (Section 515.900) and SEMSV Program Licensure Requirements for Air Medical Transport Programs (Section 515.920) vehicle requirements, including additional medical equipment and ambulance equipment as defined in the EMS System Plan.

2. Any vehicle used for critical care transport shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

F. Treatment and Transport Protocols

1. Shall address equipment and medications used on Tier III transports.

G. Quality Assurance Program

1. The EMS Systems and Tier III transport providers shall have an IDPH-approved QA program in place that uses national standards performance indicators to evaluate the appropriateness and quality of patient care. The method and results of the quality improvement projects will be available to IDPH upon request.

2. An EMS MD or SEMSV MD shall oversee the QA program.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: ALS Upgrade of EMS Service |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# ALS UPGRADE OF EMS SERVICE

## I. PURPOSE

To describe an in-field service level upgrade, using advanced level EMS vehicle service providers.

## II. POLICY

### BLS Vehicle Responding to a Patient Requiring ALS Care

A. If a BLS vehicle responds to a patient that meets criteria for ALS care as per the Initiation of Patient Care Policy, BLS personnel should contact Online Medical Control.

B. BLS personnel should estimate the patient transport time to the closest appropriate facility.

1. If the established patient transport time to the closest appropriate facility is within five minutes:

   a. The BLS vehicle shall transport the patient to the closest appropriate facility.
   b. The receiving facility shall be alerted to the unusual transport circumstances through the designated pre-notification phone line. If the receiving facility does not answer the phone call, the BLS vehicle should contact its dispatch.

2. If the estimated patient transport time to the closest appropriate facility is greater than five minutes:

   a. Consult with OLMC. OLMC will contact the private provider associated with the BLS vehicle and request availability of an ALS backup.
   b. If ALS response is not available in a timely manner by the provider of the BLS vehicle, OLMC will directly contact the Office of Emergency Management and Communications (OEMC) and request a CFD ambulance response.
   c. If the anticipated delay for ALS response is deemed detrimental to patient care, OLMC should recommend rapid transport by the BLS vehicle to the closest appropriate facility.

3. When a BLS ambulance transfers care to an ALS ambulance, the ALS ambulance will transport the patient.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Approval of Additional Pilot Programs, Medications, and Equipment |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# APPROVAL OF ADDITIONAL PILOT PROGRAMS, MEDICATIONS, AND EQUIPMENT

## I. PURPOSE

To review and approve all pilot programs, medications, and equipment, other than those covered by national EMS education standards, for use in the EMS System.

## II. POLICY

A. To apply for approval of a pilot program, or to add medications and/or equipment, the EMS Medical Director (EMS MD) shall submit documentation covering the following to the Illinois Department of Public Health (IDPH):

1. The education program for all additional psychomotor skills and the number of continuing education hours.

2. A curriculum for the pilot program or each additional medication, psychomotor skill, equipment, or device, which includes at least the following (as applicable):

   a. Objectives;
   b. Methods and materials;
   c. Content, which shall include, but not be limited to, usage, complications, adverse reactions, and equipment maintenance and use;
   d. Evidence-based standards and guidelines relevant to the proposal; and
   e. Evaluation of learning.

3. New written protocols or procedures.

B. Upon receipt of the application from the EMS System, the Office of Preparedness and Response (OPR) Medical Director or Division Chief, or his or her designee, shall either approve the program, medication, or equipment, approve the program, medication or equipment on a conditional basis, or disapprove the program, medication or equipment.

1. The OPR Medical Director or Division Chief, or their designee's, decision shall be based on a review and evaluation of the documentation submitted as above; the application of technical and medical knowledge and expertise; consideration of relevant literature and published studies on the subject; and whether the program, medication or equipment has been reviewed or tested in the field.

2. The OPR Medical Director or Division Chief may seek the recommendations of medical specialists or other professional consultants to determine whether to approve or disapprove the specific program, medication, or equipment.

C. The OPR Medical Director or Division Chief, or their designee, shall consider whether the medication or equipment may be used safely and with proper education by the pre-hospital care provider and shall

disapprove any program, medications or equipment that he or she finds are generally unsafe or dangerous in the pre-hospital care setting.

D. When a program, medication or equipment is approved on a conditional basis, the EMS System shall submit to IDPH, on a quarterly basis (January 1, April 1, July 1, and October 1) the following information:

1. Indications for use;
2. Number of times used;
3. Number and types of complications that occurred; and
4. Outcome of patient after use of medication or equipment; and
5. Description of follow-up actions taken by the EMS System on each case in which complications occurred.

E. When a death or complication that results in a deterioration of a patient's condition occurs, involving a program, medication or equipment approved on a conditional basis, the EMS System shall notify IDPH within three business days, followed by a written report of the situation submitted to IDPH within 10 business days.

F. Failure of the EMS System to submit the information as required above shall be considered as a basis for withdrawal of approval of the program, medication, or equipment on a conditional basis. Failure of the EMS System to notify IDPH as required above shall be considered as a basis for withdrawal of approval of the program, medication, or equipment on a conditional basis.

G. The OPR Medical Director, or their designee, shall evaluate the information submitted and any required notification as outlined above. IDPH will notify the EMS System that a program, medication or equipment is disapproved and may no longer be performed on a conditional basis when the evaluation of the information submitted indicates that the safety of the medication or equipment has not been established for use in the pre-hospital setting.

H. An EMS MD shall not approve EMS Personnel to implement a program or use new medications or equipment unless that individual has completed the EMS System-approved education program and examination and has demonstrated the required knowledge and skill to use that intervention safely and effectively.

I. An EMS MD shall not be required to provide education on new interventions to EMS Personnel who will not be using the new interventions.

J. IDPH may share best practice models with proven efficacy with the EMS System MDs.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Call Disposition |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: September 15, 2020 |

# CALL DISPOSITION

I. In accordance with NEMSIS, each EMS dispatch for service should be categorized with the following call dispositions.

II. A **patient** is an individual requesting or potentially needing medical evaluation or treatment. The patient-provider relationship is established by phone, radio, or personal contact.

A. **Assist:**

1. **Assist, Agency:** This EMS unit only provided assistance (e.g. manpower, equipment) to another agency and did not provide treatment or primary patient contact at any time during the incident.

2. **Assist, Public:** This EMS unit only provided assistance (e.g. manpower, equipment) to a member of the public where no patient (as locally defined) was present (e.g. welfare check, home medical equipment assistance).

3. **Assist, Unit:** This EMS unit only provided additional assistance (e.g. manpower, equipment) to another EMS unit from the same agency and was not responsible for primary patient care at any time during the incident.

B. **Canceled:**

1. **Canceled (Prior to Arrival at Scene):** This EMS unit's response is terminated prior to this unit's arrival on scene by the communications center or other on-scene units.

2. **Canceled on Scene (No Patient Contact):** This unit arrived on scene but was canceled by other on-scene units prior to initiating any patient contact or rendering any other assistance.

3. **Canceled on Scene (No Patient Found):** This unit arrived on scene, but no patient existed on scene (e.g. patient left the scene prior to arrival, result of a good intent call and no patient existed). EMS providers should make every attempt to identify the person for whom dispatch initiated the EMS response. All circumstances surrounding the event and a description of efforts to locate the patient must be documented in the patient care report.

C. **Patient Dead at Scene (see Determination of Death/Withholding of Resuscitative Measures policy):**

1. **Patient Dead at Scene – No Resuscitation Attempted (With Transport):** Patient shows obvious signs of death or Do Not Resuscitate (DNR) order was presented, and no attempt was made to resuscitate the patient. However, the

body was transported off scene by the EMS unit with primary transport responsibilities due to scene issues as defined in the above local policy

2. **Patient Dead at Scene – No Resuscitation Attempted (Without Transport):** Patient shows obvious signs of death or Do Not Resuscitate (DNR) order was presented, no attempts were made to resuscitate the patient, and the body remains on scene in custody of law enforcement.

3. **Patient Dead at Scene – Resuscitation Attempted (With Transport):** Resuscitation efforts were attempted on the patient and terminated on scene either due to Do Not Resuscitate (DNR) order or further attempts were deemed futile after discussion with Online Medical Control. However, the body was transported off the scene by the EMS unit with primary transport responsibilities due to scene issues as defined in the above local policy.

4. **Patient Dead at Scene – Resuscitation Attempted (Without Transport):** Resuscitation efforts were attempted on the patient and terminated on scene either due to Do Not Resuscitate (DNR) order or further attempts were deemed futile after discussion with Online Medical Control, and the body remains on scene in custody of law enforcement.

D. **Patient Transport:**

1. **Patient Refused Evaluation/Care (With Transport):** Patient refused to give consent or withdrew consent for evaluation and/or treatment, but consented to transport to an appropriate definitive care facility.

2. **Patient Treated, Transported by this EMS Unit**: Patient was evaluated and/or treatment was provided by this EMS Unit, and this EMS unit initiated transport or transported to a definitive care facility.

E. **Patient Refusal (see Consent & Refusal of Service) policy:**

1. **Patient Refused Evaluation/Care (Without Transport):** Patient refused to give consent or withdrew consent for evaluation and/or treatment and refused to be transported to a definitive care facility by EMS personnel. Each patient should be assessed for mental status, decision-making capacity, drug or alcohol intoxication, and medical or traumatic complaint. This refusal requires consultation with Online Medical Control while still on scene with the patient.

2. **Patient Evaluated and Refused Transport:** Patient was evaluated and treatment provided; however, the patient refused further treatment and/or transportation to a definitive care facility by EMS personnel. Each patient should be assessed for mental status, decision-making capacity, drug or alcohol intoxication, and medical or traumatic complaint. This refusal requires consultation with Online Medical Control while still on scene with the patient.

F. **Patient Treated, Transported by Law Enforcement (Handled by Police):** Patient was evaluated and/or treatment was provided by this EMS unit; however, the police assumed custody for transport to either a definitive care facility or to a police/jail disposition. This situation may include behavioral emergencies, Driving Under the Influence (DUI), or criminal investigations. In these situations, it is expected that EMS perform a full patient assessment unless law enforcement (CPD) refuses access to the patient due to scene safety. EMS should advise CPD of any potential risks associated with the patient not receiving EMS care and/or transport. Online Medical Control is required for these situations.

G. **Patient Treated, Transferred Care to Another EMS Unit:** Patient was evaluated and/or treatment was provided by this EMS unit; however patient care was transferred to another EMS air or ground unit for final disposition while still on scene (e.g. special events or large incidents).

H. **Standby**

1. **Standby – No Services or Support Provided**: Response was for purposes of being available in case of a medical/traumatic emergency (e.g. sporting event, fire, police action) and there was no patient contact or support provided.

2. **Standby – Public Safety, Fire, or EMS Operational Support Provided**: Response was for purposes of being available in case of a medical/traumatic emergency (e.g. sporting event, fire, police action) and operational support was provided, but no patient existed (e.g. operating fire rehab sector, SWAT standby).

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: CARE Team EMS Program |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: February 10, 2025 |

# CARE TEAM EMS PROGRAM

## I. PURPOSE

A. To describe the Crisis Assistance Response and Engagement (CARE) Team EMS Program which is a non-emergent mental health crisis response team operated by the Chicago Department of Public Health (CDPH) in the City of Chicago under Region 11 (Chicago North and Chicago South EMS Systems) and the Illinois Department of Public Health (IDPH).

B. To describe the CARE Team as a transport provider with a CARE Team EMS Van as a licensed SEMSV (Specialized EMS Vehicle).

C. To ensure proper medical oversight of patient care and transportation for a SEMSV (Specialized EMS Vehicle) Program.

## II. DEFINITIONS

A. SEMSV**:** A "Specialized Emergency Medical Services Vehicle" (SEMSV) is a vehicle or conveyance that is not an ambulance as defined in the EMS Act but is primarily intended to provide emergency care and transportation to ill or injured patients by means of air, water, or ground transportation.

B. CARE Team SEMSV Program: A program operating within an EMS System, pursuant to a program plan, submitted to and certified by IDPH, using specialized emergency medical services vehicles to provide non-emergent behavioral health care.

C. CARE Team EMS Medical Director/SEMSV Medical Director: The physician who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part of.

D. CARE Team EMS Van: A vehicle with capacity to transport one client secured on a seat and one seat for a CARE Team Mental Health Crisis Clinician, with a CARE EMT as the vehicle driver.

## III. POLICY

A. The CARE Team operates as an SEMSV program under the IDPH Administrative Code Section 515.900, *Licensure of SEMSV Programs – General*.

B. **CARE Team EMS Van (SEMSV) Resource Description**

1. The CARE Team EMS Van is licensed by IDPH as an SEMSV.

2. The CARE Team EMS Van is a Chicago Department of Public Health resource operating in approved Chicago Police Department districts.

3. The CARE Team EMS Van is maintained and operated by the Chicago Department of Public Health, who is responsible for daily inventory and restocking of the medication, equipment, and supplies.

4. The CARE Team EMS Van will be dispatched by radio through the Office of Emergency Management and Communication (OEMC) for any 9-1-1 call received with an appropriate mental health complaint within the CARE Program geographical districts during program hours. The CARE Team EMS Van may also self-dispatch for appropriate calls

5. The CARE Team is a non-emergent response with a goal response time of 15 minutes.

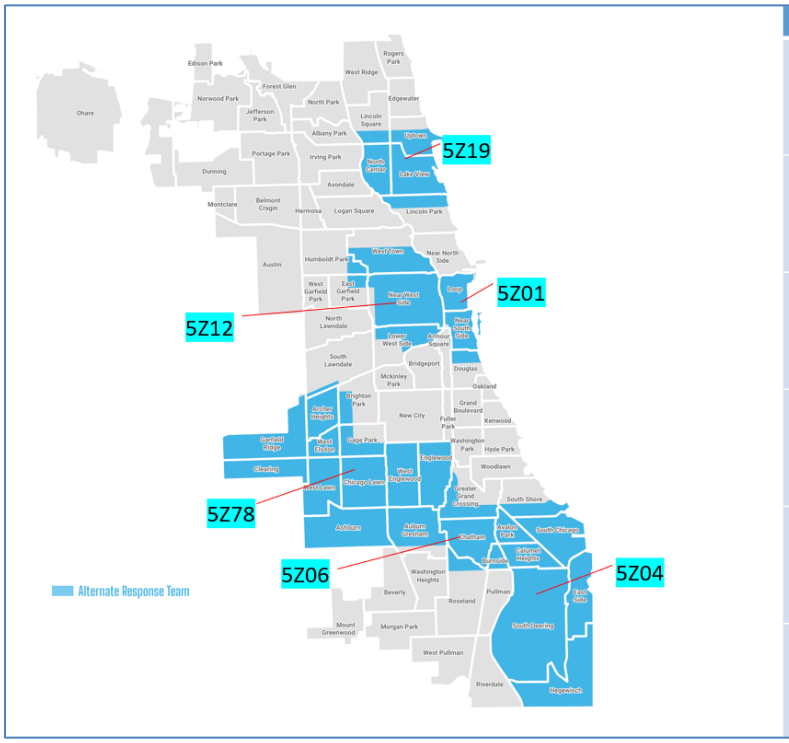
6. The CARE Team EMS Van will be driven by the CARE Team EMT.

7. The CARE Team EMT will have a valid Illinois Driver's License.

C. **CARE Team EMS Van Utilization**

1. <u>Program Districts</u>

   a. The CARE Team will operate in approved districts.
   b. CARE districts share geographical boundaries with Chicago Police Department districts as defined on the map below.




| Van | District | Street Boundaries |
|---|---|---|
| 5Z06 | 6 | Western Ave and Dan Ryan to the west |
| | | 75th St to the north |
| | | Metra Electric rails to the east |
| | | 87th St and 95th St to the south |
| 5Z01 | 1 | Highway 90 to the west |
| | | River and Lake St to the north |
| | | 16th St and 31st St to the south |
| | | Lake Michigan to the east |
| 5Z78 | 7 & 8 | Harlem Ave and Cicero Ave to the west |
| | | River and Garfield Blvd to the north |
| | | Kedzie Ave and Dan Ryan to the east |
| | | 75th St, 87th St, and 65th St to the south |
| 5Z19 | 19 | Lawrence Ave to the north |
| | | Fullerton Ave to the south |
| | | River to the west |
| | | Lake Michigan to the east |
| 5Z04 | 4 | 76th St to the north |
| | | Metra Electric rails & Bishop Ford Expy to the west |
| | | 138th St to the south |
| | | Lake Michigan and Indiana to the east |
| 5Z12 | 12 | Western Ave and Kedzie Ave to the west |
| | | Division St to the north |
| | | River, Kennedy & Dan Ryan Expy to the east |
| | | Madison, Cermak Rd, and river to the south |

2. Program Hours

   a. The CARE Team operates within the CARE districts from 1030-1600 on Monday through Friday except for city holidays.
   b. The CARE Team availability is communicated with OEMC.

## IV. CARE TEAM EMS PROGRAM

### A. Staffing

1. CARE EMT: licensed EMT (minimum requirement) or paramedic under Illinois Department of Public Health (IDPH).

2. CARE Crisis Clinician: licensed Master of Social Work (MSW) or Licensed Clinical Professional Counselor (LCPC) under Illinois Department of Financial and Professional Regulation (IDFPR).

### B. CARE Team Activation

1. OEMC primary dispatch: Calls will be screened by approved CARE dispatch protocols. Appropriate calls will be dispatched by a CFD dispatcher.

2. CPD Assist: The CARE Team can be requested by on scene CPD units as an assist company for appropriate calls determined to be primarily related to a behavioral health issue. Additionally, the CARE team can self-dispatch as assist unit for CPD calls.

3. OEMC Assist: OEMC can dispatch the CARE team as an assist unit for appropriate CPD calls using approved CARE dispatch protocols.

4. Non-emergent Follow Up: Each individual will receive a follow-up contact attempt at minimum at 1, 7, and 30 calendar day intervals after the initial contact with the CARE team. A CARE team member will conduct the follow-up phone call to the individual, and at least one of the scheduled follow-up engagements will be conducted in-person, as able.

5. Proactive Outreach: When not responding to calls for service, the CARE team may conduct proactive outreach to individuals, high utilizers of emergency services, and organizations or settings in each district that offer social services, mental health and/or substance use disorder treatment, housing supports, and other community services.

### C. Transport Considerations

1. Individuals without an active medical condition and without acute safety concern by the CARE team may be transported via the CARE Team EMS van to an Emergency Department or an alternate destination (including a mental health facility, shelter, community-based organization).

2. The CARE Crisis Clinician may call the mental health facility, shelter, or community-based organization as needed prior to transport.

3. The CARE EMT should provide a pre-notification to the mental health facility or Emergency Department stating that this is the “CARE Team with a client”.

4. For any patient with an active medical condition, a Chicago Fire Department (CFD) ambulance should be requested for transport.

5. For any patient with an acute safety concern, a Chicago Police Department (CPD) Crisis Intervention Team (CIT) Trained officer or other CPD officer should be requested.

### D. Medical Direction

1. The CARE EMT will contact the CARE Team EMS Medical Director On Call through a dedicated cell phone with a recorded line for any patient care issue or question.

2. Contact with the CARE Team EMS Medical Director will be documented in the patient care report.

3. In situations where there is a disagreement on scene regarding management of a patient, the CARE EMT should escalate to the CARE Team EMS Medical Director On Call by phone and the CARE Clinician should escalate to the CARE Team Director of Crisis Services for a collaborative resolution.

## V. EQUIPMENT AND MEDICATIONS

### A. Medications

1. Naloxone with mucosal atomization device (MAD)

2. Epinephrine intramuscular kit

3. Oral glucose

### B. Patient Assessment:

1. Blood pressure cuff

2. Stethoscope

3. Pulse oximeter

4. Glucometer

C. **Additional Equipment/Supplies**

1. Cardiac

   a. Automated External Defibrillator (AED)
   b. Adult and pediatric AED pads

2. Bleeding control

   a. Tourniquets
   b. Pressure dressings

3. Wound care

   a. Gauze
   b. Saline

4. Personal Protective Equipment (PPE)

   a. Gloves
   b. N-95 mask
   c. Face mask
   d. Gown
   e. Safety glasses

5. Communication

   a. Cellular phone
   b. Tablet
   c. Radio

## VI. PATIENT TREATMENT PROTOCOLS AND POLICIES

A. Patient care on the CARE Team EMS Van shall follow all Region 11 EMS Protocols, Policies, and Procedures as defined in this section.

B. The CARE Team EMS Van engages patients 12-65 years in age.

C. Reporting Abused or Neglected Patients Policy

1. All CARE Team members are mandated reporters and have received training on detecting and reporting suspected child abuse. If the CARE Team encounters an instance of suspected child abuse, the team will evaluate for medical emergency, notify DCFS to report the event, and CPD if there is concern for criminal matters.

2. If there are no immediate medical concerns, the CARE Team will transport the child and any family members to the closest pediatric emergency department.

## VII. CONSENT AND REFUSAL OF EMS SERVICE POLICY

A. Patients should be assessed for decision making capacity.

B. Patients with an active medical issue and refusing transport to an Emergency Department should be called into a CARE Team EMS Medical Director.

## VIII. MEDICAL RECORDS DOCUMENTATION AND REPORTING POLICY

A. An individual patient care report shall be completed for CARE Team response from CARE EMT using Image Trend.

B. The CARE Clinician will document on a separate report.

## IX. EMS SYSTEM INVENTORY REQUIREMENTS POLICY

A. A daily inventory must be completed by the CARE EMT on each day that the program is active for all operational CARE vehicles.

B. CARE Clinician is responsible for additional items that are non-medical.

## X. TRAINING

A. CARE EMT will receive initial training on the CARE program through Chicago Department of Public Health and a CARE Team EMS Medical Director.

B. Additional education and training will be planned as needed based on case review.

## XI. QUALITY ASSURANCE

A. The CARE Team EMS Program will be reviewed by the CARE Team Director, CARE Team EMS Supervisor, and the CARE Team EMS Medical Directors.

B. The CARE Team EMS Medical Director will hold monthly case review sessions to discuss patient care and identify opportunities for improvement.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Consent and Refusal of EMS Service |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# CONSENT AND REFUSAL OF EMS SERVICE

## I. APPROACH TO CONSENT/REFUSAL OF SERVICE

A. In the event that EMS is activated and the patient refuses some or all of the recommended treatment or transport, the following procedure should be followed:

1. Identify yourself and attempt to gain the patient's confidence and initiate care in a non-threatening manner.

2. Determine the specific treatment or transport that the patient is refusing and reasons for this decision.

B. Perform an assessment of the patient:

1. Assess mental status of the patient.

2. Conduct, if possible, a complete history and physical including a full set of vital signs.

3. Advise the patient of his/her medical condition and explain why the care and/or transport are necessary.

4. Advise the patient of the possible consequences of delaying or refusing the proposed care.

C. Evaluate the patient for **decision-making capacity**. A patient with decision-making capacity has the legal right to consent to or refuse some or all of the recommended treatment and to consent to or refuse transport.

D. **Decision-Making Capacity**: The patient's ability to understand the nature and consequences of proposed health care. This includes understanding the nature of their injury or illness and/or risk of illness, the possible consequences of delaying or refusing care, and the ability to clearly communicate a decision regarding the proposed care.

1. Evaluation of decision-making capacity involves assessing for conditions that may influence the ability to make sound choices and is a status beyond being alert and oriented.

2. Assess for the following conditions that may influence decision-making capability:

a. Hypoxia
b. Hypotension
c. Hypoglycemia
d. Trauma (e.g. Head Injury)
e. Alcohol/Drug/Chemical Intoxication or Reaction
f. Stroke/CVA

g. Postictal States/Seizures
h. Electrolyte Abnormality
i. Infection
j. Dementia
k. Psychiatric/behavioral emergencies (e.g., suicidal, inability to care for self, homicidal)

## II. **PATIENTS WITH DECISION-MAKING CAPACITY**

A. For situations in which a Paramedic/EMT assesses the patient and determines that they have decision-making capacity and are refusing medical assistance or transportation, they should next:

1. Follow below procedure for refusals.

2. Inform the patient of the risks of refusal and document your attempts to convey the importance of transport/treatment along with the patient's ability to comprehend.

3. Have the patient sign the written refusal of transport.

   a. There should be two witnesses to the refusal if possible. One witness should be the EMT/Paramedic assigned to the ambulance/ALS/BLS company and the other should be a family member or bystander (e.g., police officer, etc.).
   b. If a patient refuses to sign the refusal, the refusal to sign should be witnessed and signed by a family member or bystander if possible.

4. In the interest of assuring that the patient is transported to an appropriate medical facility rather than receive no care at all, deviations from the policies and procedures and standing medical orders may be necessary; consult with Online Medical Control while on the scene.

5. For refusal of treatment or any component of treatment, the refusal MUST BE thoroughly documented in the comments section.

B. Contact with Online Medical Control (OLMC)

1. <u>EMS providers should contact Online Medical Control prior to completing the refusal and departing the scene.</u> OLMC should be able to speak with the patient directly if requested.

2. In the event that EMS providers request OLMC consultation to determine decision-making capacity for a patient or, after consultation with OLMC, it is determined that the patient lacks decision-making capacity, EMS providers should follow the below guidelines (Section III. Patient Without Decision-Making Capacity).

## III. PATIENT WITHOUT DECISION-MAKING CAPACITY

A. A patient whose behavior and/or medical condition suggests lack of decision-making capacity has the right to neither consent to nor refuse care and/or transport. Patients without decision-making capacity will not be allowed to make health care decisions.

B. Procedure:

1. Once a patient is judged to lack decision-making capacity, EMS personnel should attempt to carry out treatment and transport in the interest of the patient's welfare.

   a. At all times EMS personnel should avoid placing themselves in danger; this may mean a delay in the initiation of treatment until the safety of the EMS personnel is assured.
   b. Try to obtain cooperation through conventional means.

2. If the patient resists care and/or transport:

   a. Request police and/or fire department backup as needed.
   b. Contact OLMC as needed.
   c. Reasonable force may be used to restrain the patient if the patient is a risk to self or others (see Restraints Policy).
   d. The requirement to initiate assessment and patient care may be waived in favor of assuring that the patient is transported to the closest appropriate emergency department. Document clearly and thoroughly the reasons for deviation in care.

## IV. MINOR PATIENT

A. In Illinois, any person under the age of 18 is a minor, but is legally recognized as an adult and may refuse care and/or transport if the person:

1. Has obtained a court order of emancipation

2. Is married

3. Is a parent

4. Is pregnant

5. Is a sworn member of the U.S. armed services

B. Parental or guardian consent is not required for patients over the age of 12 seeking treatment for mental health, sexually transmitted diseases, sexual abuse/assault, alcohol or drug abuse.

C. Parental or guardian consent is required for refusal of service for minors. If a parent or

guardian is not available to consent or refuse service, the following must be completed and documented:

1. Advise patient of his/her illness or injury and explain the need for further evaluation of the condition by a physician.

2. Contact OLMC and inform them of the situation while on the scene.

3. Administer appropriate care and if necessary request police assistance.

D. If a parent or guardian grants consent, but the minor refuses care:

1. Advise patient of his/her illness or injury and explain the need for further evaluation of the condition by a physician.

2. Contact OLMC and inform them of the situation while on the scene.

E. If a parent or guardian refuses to consent when medical care is indicated:

1. See Reporting Abused and/or Neglected Patients Policy.

2. Advise OLMC of the situation while on scene.

F. In any situation involving a minor patient, EMS personnel should attempt to solicit a responsible adult to accompany the minor from the scene.

## V. MULTIPLE PATIENT REFUSALS

A. To ensure the efficient use of resources, a provider agency may utilize a Multiple Patient Release form that has been approved by the Region for incidents where there are three or more patients refusing services.

B. Each patient should be assessed for mental status, decision-making capacity, drug or alcohol intoxication, and medical or traumatic complaint. Any abnormal vitals, evidence of intoxication, concern about decision making-capacity or any complaint should be called into Online Medical Control and an individual PCR must be completed for that patient.

C. If no complaints or injuries exist and there is no significant mechanism of injury, they may sign a multiple patient release form and a PCR must be generated summarizing the event.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Controlled Substance Requirements |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# CONTROLLED SUBSTANCE REQUIREMENTS

## I. DEFINITIONS

A. Controlled Substance: A drug whose manufacture, possession, or use is regulated by the government. Controlled substances for use by EMS in Region 11 include the following drugs:

1. Fentanyl
2. Midazolam

B. Drug Enforcement Agency (DEA): Federal organization in charge of enforcing the controlled substance laws in the United States.

## II. REGULATIONS

A. Controlled Substance Act (CSA): Federal law that regulates substances with the potential for abuse or dependence.

B. Protecting Patient Access to Emergency Medications Act (PPAEMA): Amends the federal Controlled Substance Act to provide guidance around the administration of controlled substances by EMS agencies and EMS personnel.

## III. RESPONSIBILITIES OF EMS AGENCIES

A. Drug Enforcement Administration (DEA) Registration

1. Each EMS agency and licensed EMS vehicle functions administratively under a Resource Hospital in an EMS System as defined in the system plan.
2. These EMS agencies are registered under the Resource Hospital and are supplied controlled substances under the hospital pharmacy.

B. Use of Standing Orders or Protocols

1. EMS personnel can administer a controlled substance as defined by EMS Protocols.
2. EMS personnel can also administer a controlled substance after a verbal order by the EMS Medical Director or after consultation with Online Medical Control.

C. Storage of Controlled Substances

1. Only controlled substances on the Region 11 Drug, Equipment, and Supply (DES) List shall be carried by EMS vehicles.

2. Controlled substances should be stored in a securely locked, substantially constructed cabinet or safe that cannot be readily removed.

3. Controlled substances shall be stored with the ability to examine for tampering, expiration dates, and counts.

4. EMS agencies may store controlled substances in EMS vehicles used by the agency.

5. EMS vehicles that are out of service should have their controlled substances secured and accounted for per agency policy.

6. If controlled substances are removed from the cabinet or safe, they should remain under the paramedic's direct supervision at all times.

D. Access to Controlled Substances

1. Access to controlled substances should be limited to crew members authorized to utilize the medication during the course of patient care and those responsible for inventory.

2. All access to controlled substances should occur in the presence of two personnel.

E. Documentation

1. Every use of controlled substance shall be documented in the patient care record as well as on a Region 11 controlled substance accountability form.

2. Every access to controlled substances, whether for shift change count and examination or restocking, shall be documented with a beginning and ending count on an inventory form.

3. All documentation shall have two signatures.

4. All documents shall be securely stored for a period of two years.

F. Use of Controlled Substances

1. After each use of a controlled substance, the following should be documented on the patient care report:

   a. Medication used
   b. Amount used
   c. Amount wasted
   d. Patient name
   e. Patient address
   f. Date given

g. Time given
h. Initials of Paramedic administering the controlled substance

2. Any amount of a controlled substance that is not administered to the patient and that is remaining in the vial should be brought to the hospital to be wasted. This process needs to be witnessed by at least two people (one paramedic and one hospital personnel) and recorded on the controlled substance accountability form.

3. After use, the entire stock of the controlled substance that was accessed should be counted by two personnel and the counts documented on the inventory form.

4. In the event that a controlled substance is administered by a non-transport EMS vehicle, the transporting EMS vehicle may exchange their stock of the same controlled substance vial with the non-transport EMS vehicle. The non-transport EMS vehicle should document the medication administration on the patient care report and both EMS vehicles should update their inventory records with the new lot number and expiration date.

G. Restocking EMS Vehicles at Hospitals

1. Following an emergency response, EMS agencies may restock their EMS vehicles with the controlled substance used from the receiving hospital.

2. For each use, a controlled substance accountability form should be completed by the paramedic and a hospital representative.

H. Accountability

1. At the start of every shift, all controlled substances must be examined for evidence of tampering, expiration dates, and counts.

a. Counts shall be verified against the last count.
b. Amount, concentration, and expiration date should be verified.
c. Medication vials should be visually inspected for evidence of tampering.

2. Documentation of the daily inventory of controlled substances must have two signatures for accountability.

3. Any damage, loss, or expired medication should be reported immediately to the EMS vehicle's supervisor and assigned Resource Hospital EMS Coordinator in verbal and written format.

I. Maintenance of Controlled Substance Records

1. EMS agencies must maintain records for each controlled substance administered or disposed of in the course of providing emergency medical services.

2. This includes the medication name, concentration, amount administered, patient name and incident number.

3. Records are required to be maintained for at least two years.

J. Expiring Controlled Substances

1. Each EMS vehicle is assigned to a Resource or Associate Hospital for exchange of soon to expire controlled substances.

2. Within seven calendar days of expiration, the EMS vehicle should report to their assigned hospital with the controlled substance and request an exchange.

3. Exchange will only occur at assigned hospitals and within the defined dates and hours on the Region 11 Expiring Controlled Substances Exchange Assignments list– see Appendix

K. EMS Agency Liability

1. EMS agencies are liable for ensuring the proper use, maintenance, reporting, and security of controlled substances used by the agency.

2. Each EMS agency should have an internal policy that defines and verifies controlled substance accountability.

3. EMS personnel should be trained in controlled substance accountability standards and policies.

## IV. RESPONSIBILITIES OF ALL HOSPITALS

A. Each hospital will maintain an internal policy regarding replacement of controlled substances for EMS.

B. Each hospital will maintain a record of each controlled substance restocked for EMS after field administration as documented in the patient care report.

C. Each hospital will accept any residual controlled substances or waste from EMS personnel after patient care and dispose of it according to existing hospital and Drug Enforcement Agency (DEA) policy.

D. After EMS submits the controlled substance accountability form, which documents the medication dose and concentration administered, the hospital will then replace the controlled substance according to the Region 11 Drug, Equipment and Supply (DES) List.

E. If the hospital does not have the exact amount and concentration as listed on the Region 11 DES list, the hospital should NOT restock the EMS vehicle and refer them to their

Resource Hospital.

F. Any damage, loss, or expired doses requires immediate verbal and written notification of the Resource Hospital EMS Coordinator.

## V. ADDITIONAL RESPONSIBILITIES OF RESOURCE HOSPITALS

A. If the receiving hospital is unable to restock an EMS vehicle, the Resource Hospital will be responsible for restocking the medication.

B. Cases of damage, loss, tampering, or expired medication shall be handled at the Resource Hospital.

1. The incident will be investigated per internal hospital policy by the Resource Hospital EMS Coordinator and the EMS Medical Director. Findings will be forwarded to IDPH.

2. A replacement will be issued to that vehicle by the Resource Hospital.

3. An investigation and report must be completed by the ambulance service provider with conclusions or outcomes forwarded to the Resource Hospital and IDPH.

# Region 11 Expiring Controlled Substance Exchange Assignments

EMS vehicles may only exchange controlled substances within 7 calendar days of expiration date as assigned and detailed below.

*Any missing doses, expired doses, or suspected tampering will be handled at the Resource Hospital per the Region 11 Controlled Substance Requirements Policy.*

## Chicago South EMS System #1113

**University of Chicago Medicine**
- CFD Ambulances: 1, 14, 24, 30, 35, 36, 38, 55, 57, 72, 78
- CFD Engines: 47, 50, 54, 60, 73, 84, 120, 122, 129
- CFD Mass Casualty Bus 8812
- Lifeline Ambulance
- Hawthorne Racetrack Ambulance

**Process for Exchange**
CCD Building (main hospital) Pharmacy 2nd floor
Monday-Friday 10am-2pm

**Advocate Trinity Hospital**
- CFD Ambulances: 5, 9, 22, 25, 29, 37, 50, 51, 60, 70, 71, 76, 79
- CFD Engines: 46, 62, 72, 74, 82, 93, 97, 126
- CFD Truck: 40

**Process for Exchange**
See Pharmacy for exchange
Monday-Friday 6:00am – 9:00pm

**Holy Cross Hospital**
- CFD Ambulances: 8, 12, 17, 18, 21, 27, 49, 54, 58, 75
- CFD Engines: 64, 88, 115, 116, 123, 127
- CFD Trucks: 41, 45, 60,

**Process for Exchange**
Emergency Department
Monday-Friday 9:00am – 3:00pm

**Mount Sinai Hospital**
- CFD Ambulances: 23, 33, 34, 69, 77, 80
- CFD Engines: 38, 113
- CFD Truck: 32

**Process for Exchange**
Emergency Department
Monday-Friday 10:00am – 6:00pm

## Chicago Central EMS System #1108

**Northwestern Memorial Hospital**
- CFD Ambulances: 11, 41, 42, 74
- CFD Engines: 1, 2 (Boat), 4, 13, 39, 98
- CFD FAS Boat 688, 689
- Event Medical Solutions
- MASE

**Process for Exchange**
9th floor Pharmacy Feinberg Building
Monday-Friday 8:00am – 4:30pm

**Rush University Medical Center**
- CFD Ambulances: 19, 45, 68
- CFD Engines: 23, 26, 49
- CFD Truck: 2

**Process for Exchange**
Emergency Department
Monday-Friday 9:00am – 3:00pm

# Region 11 Expiring Controlled Substance Exchange Assignments

EMS vehicles may only exchange controlled substances within 7 calendar days of expiration date as assigned and detailed below.

*Any missing doses, expired doses, or suspected tampering will be handled at the Resource Hospital per the Region 11 Controlled Substance Requirements Policy.*

## Chicago North EMS System #1103

**Advocate Illinois Masonic Medical Center**
- CFD Ambulances: 6, 32, 40, 61,
- CFD Engines: 71, 78, 124
- CFD Truck: 12
- Lifeline Ambulance

**Process for Exchange**
See Pharmacy for exchange
Monday-Friday 9am-5pm

**St. Joseph Hospital**
- CFD Ambulances: 13, 31, 56
- CFD Engines: 55, 59, 83, 102

**Process for Exchange**
Emergency Department
Monday-Friday 9:00am – 3:00pm

**St. Mary & Elizabeth Medical Center**
- CFD Ambulances: 3, 44, 52, 64
- CFD Engines: 30, 43, 57, 76
- CFD Truck: 36

**Process for Exchange**
Emergency Department
Monday-Friday 9:00am – 3:00pm

**Community First Medical Center**
- CFD Ambulances: 7, 20, 46, 47, 48, 63
- CFD Engines: 68, 91, 108, 125
- CFD Truck: 58

**Process for Exchange**
No Restrictions - 24/7 Emergency Department

**Resurrection Medical Center**
- CFD Ambulances: 2, 16, 26, 39, 59, 73
- CFD Engines: 9, 10, 11, 12, 79
- CFD Truck: 55
- CFD Tower Ladder: 63

**Process for Exchange**
No Restrictions - 24/7 Emergency Department
See ED Nurse/EMS Coordinator for exchange

**Lurie Children's Hospital**
- CFD Ambulances: 4,28, 43, 53, 62, 66
- CFD Engines: 8, 19, 29

**Process for Exchange**
Emergency Department
Monday-Friday 9:00am – 3:00pm

## Chicago West EMS System #1178

**Stroger Hospital of Cook County**
- CFD Ambulances: 10, 15, 65, 67
- CFD Engines: 18, 34, 95, 99, 117
- CFD Truck: 29
- CFD SLD: Special Ops, Surge Ambulances 150-151-152-153-154-155-156-157-158-159
- Hatzalah

**Process for Exchange**
By Appointment Only, Call 312-864-1291
Monday-Friday, No Holidays

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Conveyance of Patients |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# CONVEYANCE OF PATIENTS

## I. PURPOSE

To define safe conveyance of patients by licensed EMS personnel.

## II. DEFINITIONS

A. Conveyance: Movement of a patient from the response location to the ambulance and from the ambulance into the hospital Emergency Department.

B. Transport: Movement of a patient in an ambulance with appropriate safety restraint based on the age or size of the patient and clinical condition.

## III. CONVEYANCE

A. Methods

1. Stair chair
2. Stretcher
3. Backboard
4. Scoop stretcher
5. Basket stretcher
6. Patient tarp or OPCD (Oversized Patient Carrying Device)

B. Appropriate safety straps per manufacturer design should be used for all conveyance methods.

## IV. AMBULANCE TRANSPORTATION

A. All patients transported by ambulance will be secured to the stretcher for safe conveyance during patient transport.

B. For multiple patient incidents or as needed with additional passengers, proper restraint is required including the bench seat with restraints as recommended by the manufacturer.

C. For patients in a stretcher, all safety harness belts (as below) should be secured on the patient prior to transport.

1. Chest, hip, and knee straps

2. Shoulder straps

D. Pediatric patients should be transported with size appropriate child restraint system as per the Safe Transport of Children by EMS Policy.

E. Patients should never be transported in a stair chair.

## V. PATIENT CRITERIA THAT REQUIRE CONVEYANCE (NOT ABLE TO AMBULATE)

A. Require ALS (advanced life support) care per Initiation of Patient Care Policy.

B. Have a confirmed or potential significant acute condition.

C. Have any minor condition in which ambulation might result in clinical deterioration or further injury.

D. Have any of the following conditions, including (but not limited to):

1. Intoxication
2. Severe abdominal pain
3. Uncontrolled or controlled serious bleeding
4. Pregnancy related complaint
5. Extremely high or low body temperatures (hypothermia or high fever)

E. Are injured AND:

1. Require spinal motion restriction (SMR)
2. For whom ambulation will aggravate existing injury or risk new injury

F. Have unique circumstances that require conveyance

**NOTE: These above patients shall not be allowed to walk to the ambulance, or at the hospital, even if found to be ambulatory at the scene.**

## IV. PROCEDURE

A. Approach the patient with the quick response bag, oxygen bag, AED or cardiac monitor/defibrillator and conveyance device per Initiation of Patient Care Policy.

B. Perform an initial assessment and necessary on scene treatment. Evaluate the patient for any of the conditions requiring conveyance as above and prepare for appropriate

conveyance of the patient to the ambulance.

C. If it becomes apparent enroute to, or upon arrival at the scene, that EMS personnel will need additional assistance to appropriately and safely convey the patient to the ambulance, the responding crew should immediately request additional assistance.

D. Convey patient by appropriate means to the ambulance assuring the patient is appropriately covered to respect dignity and personal privacy.

E. At the hospital, the patient should be conveyed by appropriate means into the Emergency Department. EMS personnel shall request assistance of hospital personnel if additional lifting and moving help is necessary.

F. Document any problems obtaining requested additional assistance in a timely manner or any other circumstances that prevent appropriate conveyance of patient.

G. If the patient refuses to accept appropriate means of conveyance at any point from the scene to hospital hand-off, after explaining the risks, document this on the patient care report.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Determination of Death / Withholding of Resuscitative Measures |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: April 1, 2020 |

# DETERMINATION OF DEATH / WITHHOLDING OF RESUSCITATIVE MEASURES

## I. INITIATION OF RESUSCITATION

All EMS personnel practicing within the Region 11 EMS System are required to immediately initiate cardiopulmonary resuscitation (CPR) on any patient who is apneic and pulseless, unless the patient meets criteria for withholding resuscitation (see below).

## II. WITHHOLDING RESUSCITATION

A. Prior to withholding resuscitation, a thorough patient assessment must be performed to verify that the patient is:

1. Unresponsive
2. Apneic
3. Pulseless

B. Resuscitation should be withheld in the following circumstances:

**1. Medical signs of long term death including:**

a. Rigor Mortis: Stiffening of the body muscles due to chemical changes in muscle fibers, plus asystole on cardiac monitor in multiple leads.
b. Widespread Lividity: Skin discoloration in dependent body parts, plus asystole on cardiac monitor in multiple leads.
c. Decomposition or Putrefaction: The skin is bloated or ruptured, with or without soft tissue sloughed off, plus asystole on cardiac monitor in multiple leads.

2. **Traumatic injuries obviously incompatible with life including:**

a. Decapitation: The complete severing of the head from the patient's body.
b. Transection of the Torso: The body is completely cut across below the shoulders and above the hips through all major organs and vessels. The spinal column may or may not be severed.
c. Incineration: 90% of the body surface area with full thickness burns as exhibited by ash rather than clothing and complete absence of body hair with charred skin.

3. **Traumatic arrest plus asystole:** Blunt and penetrating trauma in an adult (age 16 years or greater) with a lethal mechanism of injury and asystole on cardiac monitor in multiple leads. The following conditions are excluded and should be resuscitated:

a. Drowning or strangulation
b. Lightning strike or electrocution
c. Situations involving hypothermia
d. Patients with visible pregnancy
e. The mechanism of injury does not correlate with the clinical condition suggesting a non-traumatic cardiac arrest.

4. If the patient has a valid DNR/POLST (see Advanced Directives policy).

C. IN CASES WHERE THE PATIENT'S STATUS IS UNCLEAR AND THE APPROPRIATENESS OF WITHHOLDING RESUSCITATION EFFORTS IS QUESTIONED, EMS PROVIDERS SHOULD INITIATE CPR IMMEDIATELY AND THEN CONTACT ONLINE MEDICAL CONTROL FOR FURTHER DIRECTION.

D. When resuscitation is withheld:

1. Notify Chicago Police Department (CPD) -- All notification of the Medical Examiner is done by the Chicago Police Department in accordance with Police General Order -- Processing Deceased Persons.

2. Preservation of crime scene elements may be appropriate (refer to Crime Scene Response policy).

3. EMS providers using the above criteria to determine death in the field should use the time when the assessment is complete or the cardiac monitor application as the time of death determination.

4. Online Medical Control is not required if the patient meets the above criteria to withhold resuscitation, but is a resource available as needed for clarification or direction.

5. In situations where determination of death is done by EMS providers in accordance with this policy, the name of the EMS Medical Director may be used for Medical Examiner documentation.

E. Documentation:

1. Scene environment

2. History from any family, bystanders, or other first responders on scene

3. Patient position and any movement of body

4. Patient assessment findings

5. Reasons for withholding resuscitation

6. Cardiac monitor verification with rhythm strip uploaded to the patient care report

F. Disposition of the patient when resuscitation is withheld:

1. Transfer custody of the body to CPD on scene.

2. In circumstances such as traumatic arrest with an unsafe scene, it may be necessary to remove the body from the scene. This may be appropriate or necessary given the nature of the scene. If so, transport the patient to the closest Emergency Department. The base station should notify the ED of the patient's arrival.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Guidelines for Infection Control |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | December 6, 2023 |

# EMS GUIDELINES FOR INFECTION CONTROL

## I. PURPOSE

To prevent or stop the spread of infection in the prehospital setting by using two levels of precautions: Standard Precautions and Transmission-Based Precautions.

## II. DEFINITIONS

A. Standard Precautions: Basic level of infection control for all patient care that includes both safe practices and use of Personal Protective Equipment (PPE) to protect EMS personnel from infection and prevent the spread of infection from patient to patient.

B. Transmission-Based Precautions: A second tier level of basic infection control that are used in addition to Standard Precautions for patients with known or suspected infections.

## III. POLICY:

### A. EMS PERSONNEL GUIDELINES

1. EMS personnel should be vigilant for travel history and signs and symptoms of communicable disease (e.g., fever, cough, gastrointestinal [GI] symptoms, unusual rash). Standard precautions should always be used with the addition of appropriate transmission-based precautions whenever history or exam findings warrant.

2. **EMS personnel should implement strict standard and transmission-based precautions based on the patient's clinical information to avoid exposure to potentially infectious bodily fluids, droplets, and airborne particles (Table 1).**

3. EMS personnel should avoid direct contact with a patient who may have a communicable disease until they are wearing appropriate PPE.

4. Maintaining distance from the patient and increasing fresh air circulation can reduce respiratory transmission. Maintaining a distance of at least six feet is generally recommended unless specific PPE is worn.

5. Limit the number of EMS personnel in direct contact with a potentially infectious patient to the minimum required to perform tasks safely.

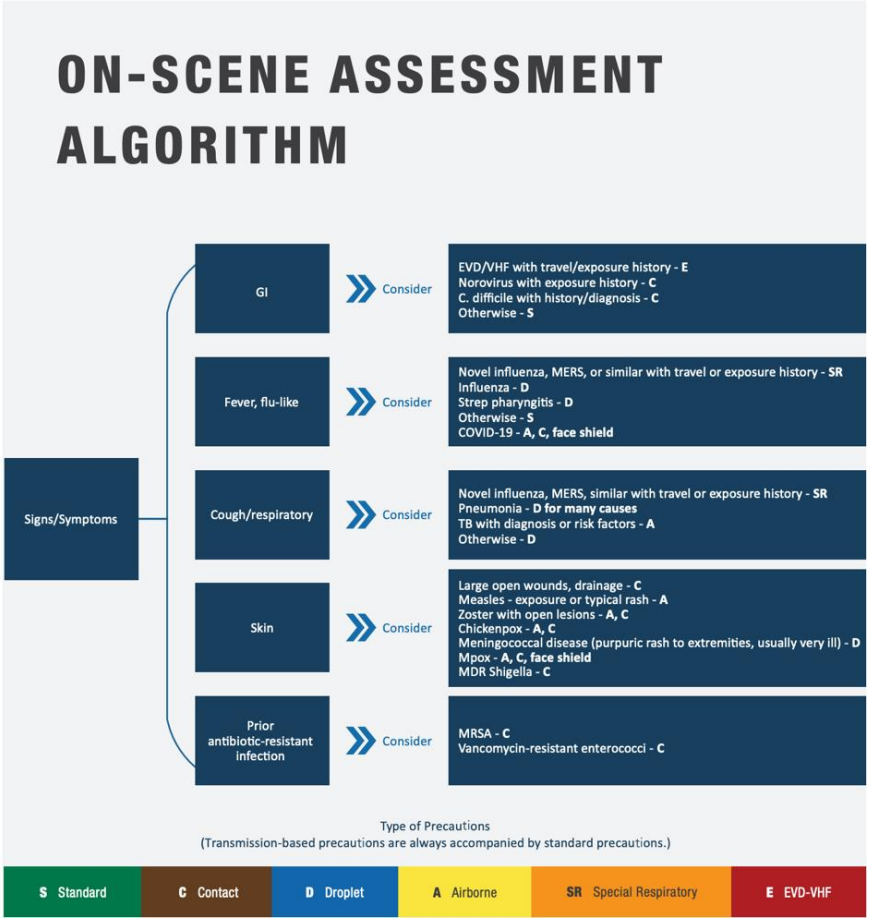
6. **Hand hygiene (e.g., handwashing with non-antimicrobial soap and water, alcohol-based hand rub [ABHR], or antiseptic handwash) is one of the best ways to remove pathogens, avoid getting sick, and prevent the spread of pathogens to others. Perform hand hygiene before and after all patient care activities.**

7. **Place a surgical mask on the patient (for source control) to contain infectious**

**respiratory droplets if tolerated.** Patients unable to tolerate a mask should cover their nose and mouth when coughing or sneezing, use tissues to contain respiratory secretions and properly dispose of them in the nearest waste receptacle after use, and perform hand hygiene after having contact with respiratory secretions and contaminated objects or materials.

8. Influenza and other diseases can transmit via the ocular surfaces as well as other mucous membranes. EMS personnel should use PPE to protect the mucous membranes of the eyes, nose, and mouth during procedures and patient care activities that are likely to generate splashes or sprays of blood, body fluids, secretions, and excretions. Select masks, goggles, face shields, and combinations of each according to the need anticipated by the task performed.

Table 1: On-Scene Assessment Algorithm (EMS Infectious Disease Playbook 2023)




## B. STANDARD PRECAUTIONS

1. <u>Goal of Precautions</u>: Apply standard practice to protect against contact with blood,

body fluids, non-intact skin (including rashes), and mucous membranes for all patient encounters. Examples include routine use of hand hygiene and gloves and adding eye protection and a mask when caring for patients with respiratory symptoms and during airway interventions, or gown for potential splash exposures.

2. Example Diseases: Acquired immune deficiency syndrome (AIDS)/human immunodeficiency virus (HIV), anthrax (cutaneous or pulmonary), botulism, cellulitis, dengue, minor wound infections including abscess, nonspecific upper respiratory infections.

3. Recommended Personal Protective Equipment (PPE)

    a. Gloves during patient contact for any potential exposure to infectious agents or bodily fluids.
    b. Goggles/face shield and surgical mask for any airway procedures (advanced airway insertion, suctioning) or patient with active cough from apparent infectious source and to protect mucous membranes from splash/ liquid exposure.
    c. Impermeable gown for any situation likely to generate splash/ liquid exposures.

4. Patient Care Considerations

    a. Provide a surgical mask for all patients with acute infectious respiratory symptoms who can tolerate it.
    b. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.

5. Transport Considerations

    a. Standard transportation to appropriate health care facility.
    b. If the patient compartment is equipped with an exhaust fan, ensure that it is turned on.

6. Ambulance Decontamination

    a. Any visibly soiled surface must first be cleaned and decontaminated using an Environmental Protection Agency (EPA)-registered disinfectant according to directions on the label.
    b. Disinfect all potentially contaminated/high touch surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
    c. Medical equipment (e.g., stethoscope, blood pressure cuff) making patient contact should be disposable or cleaned and disinfected before use on another patient.

## C. CONTACT PRECAUTIONS

1. Goal of Precautions: Provide impermeable barriers to infectious agents that are either highly pathogenic, drug resistant, contagious, or persistent and that can easily be contracted or spread to other environments via fomites and surface contact.

2. Example Diseases: Excessive wound drainage, MRSA, Vancomycin-resistant enterococci (VRE), C. difficile, norovirus, other suspected infectious diarrhea, head lice/body lice/scabies, respiratory syncytial virus (RSV).

3. Recommended PPE

   a. Disposable fluid-resistant gown.
   b. Disposable gloves.
   c. Ensure strict adherence to standard precautions based on situation (e.g., mask, goggles/face shield for splatter risk or airway interventions).

4. Patient Care Considerations

   a. Cover draining wounds with adequately absorbent dressings.
   b. Anticipate additional stool/vomitus to reduce contamination of EMS personnel and the ambulance (emesis bags, towels available, and/ or impermeable sheet placed on stretcher).

5. Transport Considerations

   a. Consider applying an impermeable barrier sheet to the patient to protect EMS personnel and environmental surfaces in the presence of excessive wound drainage, fecal incontinence, or other discharges.
   b. Advise receiving hospital of a patient on contact precautions who should preferably be transported to a private room.

6. Ambulance Decontamination

   a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
   b. Medical equipment (e.g., stethoscope, BP cuff) making patient contact should be disposable or cleaned and disinfected before use on another patient. Other visibly contaminated equipment should similarly be cleaned and disinfected.
   c. Confirmed or suspected C. difficile infection decontamination should utilize hypochlorite solutions. EPA-registered disinfectants with sporicidal activity may be sufficient but limited data is available.

**D. DROPLET PRECAUTIONS**

1. Goal of Precautions: Protection of EMS personnel mucous membranes and respiratory system from exposure to potentially infectious droplets during direct patient care activities.

2. Example Diseases: Neisseria meningitidis, mumps, mycoplasma, streptococcal and many other causes of pneumonia, parvovirus, pertussis, pneumonic plague, rhinovirus, rubella, seasonal influenza, streptococcal pharyngitis.

3. Recommended PPE

    a. Disposable surgical mask (N95 respirator not required but optional).
    b. Disposable gloves.
    c. Eye protection – goggles or face shield.

4. Patient Care Considerations

    a. Provide a surgical mask for all patients with acute infectious respiratory symptoms who can tolerate it.
    b. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.
    c. EMS personnel not in appropriate PPE should maintain a distance of at least 6 feet from the patient and should wear gloves to guard against infectious agents on the surfaces of objects close to the patient.
    d. Minimize use of nebulizers to avoid aerosolization of respiratory droplets; consider metered dose inhalers instead.
    e. Minimize airway interventions that may cause coughing (e.g., suctioning) to degree possible.

5. Transport Considerations

    a. Consider having the patient compartment exhaust vent on high and isolating the driver compartment if performing aerosol generating procedures (airway suctioning, advanced airway insertion, aerosolized medication administration, non-invasive positive pressure ventilation). Increase ventilation by having air or heat on non-recirculating cycle and/or opening windows.
    b. Advise receiving hospital of respiratory symptoms and that a private (but not negative pressure) room is preferred.

6. Ambulance Decontamination

    a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
    b. Disinfect all potentially contaminated/high touch surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
    c. Medical equipment (e.g., stethoscope, BP cuff) making patient contact should be disposable or cleaned and disinfected before use on another patient.

## E. AIRBORNE PRECAUTIONS

1. Goal of Precautions: Provide respiratory protection against inhalation of potentially infectious suspended droplet nuclei/aerosols (agents suspended in the air that are respirable and remain infectious over long distances).

2. Example Diseases: Measles, tuberculosis (suspected or confirmed pulmonary or laryngeal), varicella (chickenpox).

3. Recommended PPE:

   a. Disposable NIOSH-approved, fit-tested N95 respirator or PAPRs with full hood and HEPA filter for airborne precautions for employees who cannot safely fit test on N95 respirators due to facial hair, facial structure, and other factors.
   b. Disposable exam gloves.

4. Patient Care Considerations

   a. Ensure strict adherence with standard precautions.
   b. Ask the patient to wear a surgical mask (N95 respirator not required) if they are able to tolerate it.
   c. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.
   d. The performance of procedures that can generate suspended droplet nuclei/aerosols (i.e., aerosol-generating procedures), such as advanced airway insertion, non-invasive ventilation, and open suctioning of the respiratory tract have been associated with higher risk of transmission of infectious agents to health care personnel, including tuberculosis. Protection of the eyes, in addition to respirator and gloves, is recommended while performing these procedures in accordance with standard precautions.

5. Transport Considerations

   a. Notify the receiving hospital of the need for an airborne infection isolation room (AIIR) for patient placement.
   b. Consider having the patient compartment exhaust vent on high and isolating the driver compartment from the patient compartment. Consider having the driver compartment ventilation fan set to high without recirculation.
   c. If driver compartment is not isolated from the patient compartment, vehicle operator should wear N95 respirator.
   d. Patients who have an advanced airway in place should be ventilated with a bag-valve device or ventilator equipped with a viral or HEPA filter in-line or on the exhalation port.

6. Ambulance Decontamination

a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
b. Disinfect all potentially contaminated/high touch surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
c. Medical equipment (stethoscope, BP cuff, etc.) making patient contact should be disposable or cleaned and disinfected before use on another patient.

## F. SPECIAL RESPIRATORY PRECAUTIONS

1. Goal of Precautions:

   a. Provide protection of mucous membranes and respiratory protection against inhalation of potentially infectious suspended droplet nuclei/ aerosols (agents suspended in the air that are respirable and remain infectious over long distances).
   b. Create an impermeable barrier to reduce spread of highly pathogenic viruses on surfaces and via fomites during direct patient care activities (standard + contact + airborne + eye protection).

2. Example Diseases: MERS, novel influenza strains (e.g., H5N1), smallpox, Monkeypox, COVID-19.

3. Recommended PPE

   a. Disposable N95 or equivalent/higher level respirator (e.g., re-usable half face elastomeric respirator N95 or higher rating mask or PAPR with full hood and HEPA filter).
   b. Disposable face shield or disposable or cleanable goggles (if not using hooded PAPR).
   c. Disposable fluid-resistant gown that extends to at least mid-calf or disposable fluid-resistant coveralls.
   d. Disposable gloves with extended cuffs.
   e. Consider disposable boot/shoe covers.

4. Patient Care Considerations

   a. Ask the patient to wear a surgical mask (N95 respirator not required) if they are able to tolerate it.
   b. Provide tissues to patients for secretion control and encourage patient hand hygiene and cough etiquette practices.
   c. Exercise caution when performing aerosol-generating procedures (advanced airway insertion, airway suctioning, administration of nebulized medication, non-invasive ventilation [continuous positive airway pressure (CPAP)], and/or cardiopulmonary resuscitation [CPR]). Only perform these procedures if medically necessary and cannot be postponed.

d. Ventilate patients who have an advanced airway in place with a bag-valve device or ventilator with a viral or HEPA filter in-line or on the exhalation port.

5. Transport Considerations

   a. Notify the receiving hospital of the need for an airborne infection isolation room (AIIR) for patient placement.
   b. The patient compartment exhaust vent should be on high and the driver compartment should be isolated from the patient compartment if possible. The driver compartment ventilation fan should be set to high without recirculation.
   c. The vehicle operator should wear an N95 respirator if the patient compartment and cab cannot be isolated.
   d. EMS agencies should have a plan for family members wishing to accompany the patient that minimizes additional crew exposures.

6. Ambulance Decontamination

   a. Any visibly soiled surface should be cleaned using an EPA-registered disinfectant according to directions on the label.
   b. Disinfect all potentially contaminated surfaces including the stretcher with an EPA-registered disinfectant according to directions on the label.
   c. Medical equipment (e.g., stethoscope, BP cuff) making patient contact should be disposable or cleaned and disinfected using appropriate disinfectants before use on another patient.

## G. EVD-VHF (EBOLA VIRUS DISEASE-VIRAL HEMORRHAGIC FEVER) PRECAUTIONS

1. Goal of Precautions: Provide maximal impermeable barrier and respiratory protection against highly pathogenic VHF viruses.

2. Example Diseases: EVD, MVD (Marburg Virus Disease), Lassa fever, Crimean-Congo fever.

3. Arriving EMS Actions and Considerations

   a. Inquire about travel and direct exposure history within the previous 21 days. *Has the patient had direct contact with a person who is confirmed or suspected to have EVD/VHF (including local cases, if applicable)?*
      i. If yes, does the patient have any fever, severe headache, muscle pain, weakness, fatigue, diarrhea, vomiting, abdominal (stomach) pain, or unexplained hemorrhage (bleeding or bruising)?
   b. Positive EVD/VHF screen is travel or contact risk with symptoms of disease.

4. Guidance to Patients and EMS Personnel for EVD/VHF Positive Screen

a. EMS personnel should don appropriate PPE before direct contact with the patient.
b. If responding to an airport or other port of entry to the United States, notify the CDC Quarantine Station for the port of entry.
c. Notify EMS supervisor and Resource Hospital EMS Coordinator and Medical Director.
d. Consider alerting EVD/VHF specialized personnel and equipment/ ambulance if available as secondary EMS personnel and the patient is stable enough to await this resource.
e. If patient is transported, ensure follow-up with hospital regarding final diagnosis and report any exposures or issues to Chicago Department of Public Health.
f. Ensure that appropriate ALS/BLS care is provided. Most suspected cases will not have EVD/VHF.

5. PPE: Should be carefully donned and doffed with a checklist and trained observer.

a. Initial EMS personnel to suspect case WITHOUT active bleeding, vomiting, or diarrhea:
    i. Single-use (disposable) fluid-resistant gown that extends to at least mid-calf or single-use (disposable) fluid-resistant coveralls without integrated hood.
    ii. Single-use (disposable) full face shield.
    iii. Single-use (disposable) facemask
    iv. Single-use (disposable) gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs.

b. Initial EMS personnel to suspect case WITH active bleeding, vomiting, or diarrhea:
    i. **Impermeable Garment**: Single-use (disposable) impermeable gown that extends to at least mid-calf or single-use (disposable) impermeable coveralls without integrated hood.
    ii. **Respiratory, Head, and Face Protection**:
        - **PAPR**: A hooded respirator with a full face shield, helmet, or headpiece OR
        - Single-use (disposable) N95 respirator or higher in combination with single-use (disposable) surgical hood extending to shoulders and single-use (disposable) full face shield.
    iii. Single-use (disposable) gloves with extended cuffs. Two pairs of gloves should be worn. At a minimum, outer gloves should have extended cuffs.
    iv. Single-use (disposable) boot covers that extend to at least mid-calf.
    v. Single-use (disposable) apron that covers the torso to the level of the mid-calf should be used over the gown or coveralls

c. Doffing is a high-risk step in VHF patient care. PPE should be doffed in a

designated PPE removal area. Meticulous care should be taken during this process to avoid self-contamination as this is a major contributor to EMS personnel disease. Place all PPE waste in a labeled leak-proof biohazard bag.

d. EMS and hospital personnel caring for patients with VHF must have received comprehensive training and demonstrated competency in performing VHF-related infection control practices and procedures.

6. Patient Care Considerations

   a. Ask the patient to wear a surgical mask (N95 respirator not required) if they are able to tolerate it.
   b. Be aware that the biggest risk to suspect EVD/VHF patients is withholding appropriate treatment as few will actually have the disease.
   c. Recognize that the more body fluids, the higher the transmission risk.
   d. Anticipate potential stool/vomitus and control contamination of EMS personnel and the ambulance (use emesis bags, towels, and/ or place impermeable sheet on stretcher).
   e. Minimize the number of EMS personnel who make patient contact.
   f. Use dedicated medical equipment (ideally disposable) for the provision of patient care whenever possible.
   g. Strongly consider having the patient wear a barrier garment, surgical mask, and gloves if tolerated.
   h. Exercise caution when performing aerosol-generating procedures (advanced airway insertion, airway suctioning, administration of nebulized medication, CPAP, CPR). Only perform these procedures if medically necessary and cannot be postponed. (Note that cardiac arrest early in the illness may be due to electrolyte imbalance and may be survivable. Late cardiac arrest from multi-organ failure likely carries a dismal prognosis.)
   i. Do not perform IV insertion or any other invasive procedures unless urgently required for patient care or stabilization. Handle any needles and sharps with extreme care and dispose in puncture-proof, sealed containers that are specific to the single patient. Do not dispose of used needles and sharps in containers that have sharps from other patients in them.
   j. Consider giving oral or nasal medicine to reduce nausea and/or pain per Region 11 Protocols rather than injectable.
   k. Use hands-free communications devices (e.g., tactical headsets) inside the PPE ensemble to facilitate communication and avoid contamination of radios.
   l. Complete documentation in a clean area or after transport.

7. Transport Considerations

   a. Advise the designated “Specialized Pathogen Treatment Center” as early as possible about a suspect case to allow them preparation time.
   b. If the patient is a highly suspect case and stable, consider specialized ambulance preparation and transport (as approved by Region 11 and IDPH) if time and acuity allow.

c. Interfacility transport of confirmed case should be performed by EMS personnel with properly prepared ambulances or patient containment devices.
d. For emergency transport, consider applying an impermeable barrier sheet or containment system to the patient to protect EMS personnel and environmental surfaces in the presence of incontinence, draining wounds, or other discharges.
e. The driver's compartment should remain clean. No family members or patient belongings are permitted in the driver's compartment.
f. Suspect EVD/VHF cases should be transported to a hospital capable of evaluation and initial management and placed into a dedicated isolation room. Placement should be coordinated in consultation with local/state public health authorities and the receiving facility.
g. Consider deferring ambulance decontamination for a brief period to determine if EVD/VHF can be quickly ruled out during initial hospital assessment.
h. Formal decontamination after transport of a suspect/confirmed case should occur in a designated area by trained personnel as described in the next section.

8. Ambulance Decontamination

a. Select an appropriate site for ambulance decontamination that protects the vehicle and the team from the weather, preferably a well-ventilated, climate controlled, large, enclosed garage/structure.
b. All waste, including PPE, drapes, and wipes, should be considered Category A infectious substances, and should be packaged appropriately for disposal.
c. Personnel must be in appropriate PPE during decontamination and disinfection. A third person should also be available as a trained observer and to assist as needed.
d. Grossly contaminated and visibly soiled surfaces must be decontaminated prior to disinfection.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Staffing |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS STAFFING

## I. PURPOSE

To define Region 11 EMS staffing requirements in accordance with IDPH.

## II. POLICY

### A. Personnel Requirements

1. Each Basic Life Support (BLS) ambulance shall be staffed by a minimum of one system authorized EMT and one other system authorized EMT on all responses.

2. Each Advanced Life Support (ALS) ambulance shall be staffed by a minimum of one system authorized Paramedic and one other System authorized Paramedic on all responses.

### B. Alternative Staffing for Private Ambulance Providers

1. Private, nonpublic, ambulance providers may request approval from IDPH to use an alternative staffing model that includes an EMR with a licensed EMT or Paramedic, as appropriate. The use of alternative staffing models are pursuant to the approval of the EMS System Program Plan developed and approved by the EMS Medical Director. Basic requirements for the use of alternative staffing models include:

    a. Alternative staffing models for a BLS transport using an EMR shall only be utilized for interfacility BLS transports, as specified by the EMS System Program Plan, as determined by the EMS Medical Director.
    b. The licensed EMR must complete a defensive driving course prior to participation in the alternative staffing model.
    c. Dispatch protocols for properly screening and assessing patients appropriate for EMR-staffed transports.
    d. Implementation of a quality assurance plan that shall include the monthly review of at least 5% of total interfacility transports utilizing an EMR.
    e. This quality assurance plan must include mechanisms to audit dispatch screening, reason for transport, patient diagnosis, level of care, and the outcomes of transports performed.
    f. Quality assurance reports must be submitted and reviewed by the EMS System monthly and made available to IDPH upon request.

2. The EMS System Medical Director shall develop a minimum set of requirements for individuals based on level of licensure that includes education, training, and credentialing for all team members identified to participate in an alternative staffing plan.

    a. The EMT, Paramedic, and Critical Care transport staff shall have the minimum experience in pre-hospital and inter-hospital emergency care, as determined by the

EMS Medical Director in accordance with the EMS System Program Plan, but at a minimum of 6 months of prehospital experience or at least 50 documented patient care interventions during transport as the primary care provider and approved by the Department.

b. The EMS personnel licensed at the highest level shall provide the initial assessment of the patient to determine the level of care required for transport to the receiving health care facility. This assessment shall be documented in the patient care report and with online medical control. The EMS personnel licensed at or above the level of care required by the specific patient as directed by the EMS Medical Director shall be the primary care provider en-route to the destination facility or patient's residence.

3. The system plan modification form and alternative staffing model program plan shall be submitted to the EMS Medical Director for approval and forwarded to IDPH for review and approval. The provider shall not implement the alternative staffing plan until approval by the EMS Medical Director and IDPH.

   a. Alternative staffing models may include expanded scopes of practice as determined by the EMS Medical Director and approved by IDPH. This may include the use of an EMR at the BLS or ALS level of care.
   b. If the EMS Medical Director proposes an expansion of the scope of practice for EMRs, such expansion shall not exceed the education standards prescribed by IDPH.

4. Alternative staffing plans are approved for a maximum of year and may be renewed annually if the following criteria are met:

   a. All system modification forms and supportive planning documentation are submitted, validated, and approved by the EMS Medical Director who shall submit to IDPH for final approval.
   b. All plans must demonstrate that EMS personnel will meet the training and education requirements as determined by IDPH for expanding the scope of practice for EMRs, testing to assure knowledge and skill validation, and a quality assurance plan for monitoring transports utilizing alternative staffing models that include EMRs.

5. Any other alternate response staffing requires approval by the EMS Medical Director under the EMS System Plan.

6. Region 11 Chicago EMS does not serve a rural population or utilize volunteer EMS agencies, therefore the region does not utilize the rural population staffing credentialing exemption intended for populations of 5,000 or fewer.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Epinephrine Dilution for Shortage |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: March 6, 2025 |

# EPINEPHRINE DILUTION FOR SHORTAGE

## I. PURPOSE:

To define the proper dilution and administration of Epinephrine during times of drug shortage.

## II. DEFINITION:

Epinephrine may be carried in two forms for EMS use:

A. Epinephrine 1 mg/10 ml prefilled syringe

B. Epinephrine 1 mg/ml vial

Glass ampules should not be used for medication administration by EMS.

## III. USE:

A. Epinephrine 1 mg/10 ml prefilled syringe is the preferred formulation to administer IV epinephrine when indicated by EMS protocols.

B. For shortages of the Epinephrine prefilled syringe, Epinephrine from the 1 mg/ml vial may be used after one of the below Epinephrine Dilution Procedure methods.

## IV. EPINEPHRINE DILUTION PROCEDURE:

There are two methods that can be used to dilute the epinephrine:

A. Method 1: Place a 23-gauge needle on the end of a saline flush - 0.9% Sodium Chloride Injection (10 ml prefilled syringe) and discard 1 mL from the syringe. Remove the plastic top of the vial and clean with an alcohol wipe. Draw up 1 ml of 1 mg/ml epinephrine from the vial into the syringe. Gently swirl the medication. The syringe now contains 1 mg/10 ml of Epinephrine.

B. Method 2: Remove the plastic top of the epinephrine vial and clean with an alcohol wipe. Draw up 1 ml of 1 mg/ml Epinephrine from the vial into a 10 ml syringe using a 23-gauge needle. Draw up 9 mL from a bag of 0.9% Sodium Chloride IV Solution. Gently swirl the medication. The syringe now contains 1 mg/10 ml of Epinephrine.

## V. HOSPITAL REPLACEMENT:

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Epinephrine Dilution for Shortage |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: March 6, 2025 |

A. Hospitals should prioritize Epinephrine prefilled syringes for EMS replacement.

B. Hospitals that are unable to replace Epinephrine prefilled syringes may replace EMS providers with an "Epinephrine Dilution Kit" containing the following:

1. Epinephrine 1 mg/mL vial
2. 23-gauge needle
3. Alcohol wipe
4. Saline flush – 0.9% Sodium Chloride Injection (10 mL prefilled syringe) OR Syringe (10 mL)

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Initiation of Patient Care |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: March 6, 2025 |

# INITIATION OF PATIENT CARE

## I. PURPOSE

To define the initiation and transition of patient care by EMS clinicians.

## II. DEFINITIONS

A. Medical Negligence: Occurs when a healthcare provider's actions or inactions are below the level of care that a similarly trained professional would have provided under the same circumstances or when the provider fails to fulfill their professional obligations.

B. Patient Abandonment: A form of medical negligence that involves the termination of a patient/provider relationship without the patient's consent and at a time when continuing care is still needed.

## III. RESPONSE

A. When responding to all requests for out-of-hospital care, EMS clinicians must take all of the following equipment to the initial contact with the patient:

1. EMR/EMT

    a. AED
    b. Oxygen bag
    c. Quick response bag
    d. Conveyance device

2. Paramedic

    a. Cardiac monitor
    b. Oxygen bag
    c. Quick response bag
    d. Conveyance device

B. It is the expectation that crews dispatched to an emergency call for service should respond to the scene and assist with patient care until a patient assessment is complete. The lead paramedic may release the other EMS clinicians from the scene once patient care tasks are complete.

## IV. POLICY

A. Appropriate care, as directed by the Region 11 EMS System Protocols and Policies, should be initiated at the point of patient contact unless the patient refuses or scene safety cannot be secured. This includes care given by ALS or BLS Fire Suppression Companies before the arrival of an ALS ambulance.

B. Additional resources should be requested as needed for patient care and conveyance.

C. Advanced Life Support (ALS) level of care includes application of the cardiac monitor. Obtain IV access and administer oxygen as indicated. **The cardiac monitor must remain attached to the patient during transportation into the hospital and care endorsed to the emergency department staff.**

D. ALS care should be initiated according to the following guidelines:

1. Adult patients with abnormal vital signs, regardless of complaints.

   a. Pulse <60 or >110; or irregularity
   b. Respirations <10 or >24
   c. Systolic Blood Pressure >180 or <100
   d. Diastolic Blood Pressure >110
   e. Pulse oximeter < 94%

2. Pediatric patients with abnormal vital signs per Pediatric Initial Assessment Protocol.

3. Any patient (adult or pediatric) with a potentially life-threatening condition which exists or might develop during transport. Examples of situations in which ALS care is indicated include, but are not limited to:

   a. Altered mental status
   b. Suspected acute coronary syndrome or chest pain, including palpitations
   c. Seizure or postictal state
   d. Suspected stroke
   e. Syncope or near syncope
   f. Shortness of breath or difficulty breathing
   g. Complications of pregnancy or childbirth
   h. Gastrointestinal (GI) bleeding
   i. Traumatic injury in the Trauma Field Triage Criteria
   j. Overdose or poisoning
   k. Burns in the Burn Patient Destination criteria
   l. Moderate to severe allergic reaction/anaphylaxis

E. Scene safety: If scene safety is a concern, or if managing an uncooperative patient, the requirements to initiate assessment and full ALS care may be waived in favor of assuring that the patient is transported to an appropriate medical facility. The reasons for deviations in care should be clearly documented.

F. Once patient care is initiated, it should be continued unless:

   a. The patient meets criteria for refusal under the Consent/Refusal of Service Policy.
   b. Approval is granted by Online Medical Control; or
   c. Care has been transferred to higher level personnel at the receiving hospital.

G. Abandonment or neglect of a patient that requires emergency care is criteria for suspension as per the EMS System Participation Suspension Policy.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Interaction with an Independent Physician / Nurse on Scene |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# INTERACTION WITH AN INDEPENDENT PHYSICIAN / NURSE ON SCENE

## I. PURPOSE

To clearly delineate the roles of all personnel at a scene to provide the highest quality of patient care.

## II. POLICY

A. Only personnel licensed to perform in the prehospital setting, and who are members of Region 11 Chicago EMS, are allowed to perform patient care unless approved by Online Medical Control.

B. EMS personnel who are confronted by individuals wanting to render assistance at the scene of the emergency should follow these guidelines:

1. If assistance is needed, the senior EMS officer should contact Online Medical Control and advise that there are on scene healthcare providers (physician or nurse) from outside of Region 11 Chicago EMS.

2. Non-system personnel will function under the senior EMS personnel at their level of licensure.

3. When EMS personnel establish patient contact, they also establish a "healthcare provider/patient relationship" between the patient and the EMS Medical Director or Base Station ECP as a designee.

   In cases where the patient's personal physician is physically present, EMS personnel should respect the previously established healthcare provider/patient relationship.

4. If there is a disagreement between the EMS personnel and the physician on the scene regarding the care to be given to the patient, Online Medical Control should be consulted.

5. EMS personnel shall follow the direction of the Base Station ECP.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Interaction with Law Enforcement at a Crime Scene |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# INTERACTION WITH LAW ENFORCEMENT AT A CRIME SCENE

## I. PURPOSE

To define responsibilities of EMS personnel with patient assessment at a crime scene and interactions with law enforcement.

## II. POLICY

A. EMS and law enforcement are often dispatched together for incidents involving patients and criminal situations including suicide, accidental death or suspicious circumstances of a death.

B. The role of law enforcement is to investigate the crime and preserve evidence.

C. The role of EMS is to assess and treat the patient.

In circumstances where there is an active investigation, EMS should work with law enforcement to facilitate performing a patient assessment and any treatment indicated while maintaining the evidence at the scene.

D. If law enforcement is not on the scene and safety of the EMS personnel is a concern, patient care and transport may be delayed until law enforcement can secure the scene. Initiate patient assessment and treatment per Region 11 EMS Protocols.

E. Assess patients for traumatic injuries incompatible with life or traumatic arrest plus asystole per the Determination of Death/ Withholding of Resuscitative Measures Policy.

F. Maintain evidence at the crime scene

1. If circumstances require the alteration of the scene for patient assessment, inform law enforcement.

2. Avoid unnecessary contact with physical objects at the scene.

3. Anything carried onto the scene including bandages or packaging should be removed by EMS when leaving the scene. Do not remove anything else from the scene.

4. If it is necessary to cut through the clothing of the patient, avoid cutting through tears, bullet holes, or other damaged or stained areas of clothing.

5. Do not wash or clean the patient's hands or areas with bullet wounds.

6. During exposure of the patient during assessment, expended bullets can be found in the clothing of the patient (especially when heavy winter clothing is worn). These items of evidence may be lost during evaluation or transportation. Any evidence should be turned over to law enforcement and documented on the patient care report.

7. In hanging or asphyxiation cases, avoid cutting through or untying knots in the hanging device or other materials unless necessary to free the patient.

8. In stabbing cases, leave any impaled object in place for both medical reasons and evidence collection.

G. Document observations at the crime scene on the patient care report. Include name and star number or badge number of law enforcement personnel on scene.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Large Gathering / Special Events |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: August 1, 2018 |

# LARGE GATHERING/SPECIAL EVENTS

I. A minimum of 60 days prior to any large gathering/special event, each Provider Agency shall submit a completed IDPH Special Event Request Application to their respective Resource Hospital, which will include the following:

A. Ambulance license number, VIN, and level of care

B. Names and license numbers for EMS staff

C. Event name, date, hours, location, and expected attendance

D. Outline of the medical plan for the event

E. Map of the receiving hospitals

F. EMS system communication plan

II. **At large scale/special events, only those patients who are in need of further medical attention, but still refuse transport will be called into Online Medical Control. All other refusals will be documented on a run report.**

III. **Within 10 days following the large scale/special event, the Provider Agency shall submit a report to their respective Resource Hospital outlining those refusals not called in, as well as the number of the number and categories of patient encounters and transports. (Specified by EMS System Quality Improvement/Assurance Program policy).**

IV. EMS agencies providing staffing within Region 11 that are from an outside system should:

A. Have understanding of the specialty receiving centers.

B. Provide medical staffing plans to the regional EMS Medical Directors Consortium (MDC) for coordination and planning prior to the event.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Management of Multiple Patient Incidents |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: July 10, 2024 |

# MANAGEMENT OF MULTIPLE PATIENT INCIDENTS

## I. MULTIPLE PATIENT INCIDENT (MPI)

A. Definition: An incident where multiple patients (3 or more) exist and the EMS response is able to provide the adequate numbers of responders, EMS shall provide standard levels of care and transportation. This shall be used to prioritize the on-scene evaluation and treatment of multiple patients based on a primary triage category with the expectation that there is a complete assessment, hospital contact, and transport decision as per Region 11 Protocols and Policies for each individual patient.

B. MPI General Concepts

1. Scene safety is a universal consideration.

2. Field to hospital communication for each individual patient shall be either Online Medical Control to a Region 11 EMS Base Station or Pre-notification to the receiving hospital (per Field to Hospital Communication Policy).

3. Patient care reports to be completed as per policy.

C. Incident Priorities

1. First arriving unit on scene

   a. Scene size-up and activation of additional resources. The first arriving officer (EMS or Fire) may initiate an MPI response.
   b. Primary triage as per Attachment 1 “Region 11 Modified START/JumpSTART Triage Algorithm”:
      i. “Red” (Immediate)
      ii. “Yellow” (Delayed)
      iii. “Green” (Minimal)
      iv. “Black” (Deceased)

2. Life saving (focused) interventions that may be performed during the triage process include: control of major hemorrhage, basic airway opening maneuvers, and chest (pleural) decompression if within the responder’s scope of practice and only if the necessary equipment is immediately available.

D. Scene Management

1. Goal of Scene Management: Primary triage of patients with focused interventions with further treatment and transport prioritizing the most critical patients first.

2. Triage is a dynamic process and the initially assigned triage category may change subsequent to additional patient assessment.

3. Treatment: Each patient should receive a primary and secondary survey and treatment per Region 11 EMS Protocols.

   a. Trauma Patients should have the Trauma Field Triage Criteria applied (per policy) to identify critical patients requiring transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.
      i. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged "Red" and be transported to the appropriate Level 1 Trauma Center.
      ii. Patients that meet **Mechanism of Injury** or **High Risk Populations** criteria should be triaged "Yellow" and be transported to the appropriate Level 1 Trauma Center.
   b. Medical patients should be reassessed and triage level adjusted as indicated.
   c. First responders (EMS, Fire, Law Enforcement, etc.) that become ill or injured during the incident should be triaged and treated as above and will be given priority transport.

4. Transport: Begin transport of the most critical ("Red") patients to the closest, most appropriate hospital.

   a. After the most immediate priority ("Red") patients have been transported, the delayed prioity ("Yellow") patients should be transported next, and then minimal priority ("Green") patients.
   b. Ambulances may transport multiple "Green" or "Yellow" patients in the same vehicle for resource utilization subject to the availability of proper patient safety restraints. This may be done only after primary and secondary survey with medical stabilization. The maximum number of patients transported per ambulance should be one "Red", two "Yellow", or four "Green".
   c. After complete assessment, patients that meet criteria for withholding resuscitation (per Determination of Death/Withholding of Resuscitative Measures Policy) may be categorized as deceased ("Black") and left on scene, unless the situation warrants removal.

5. Communication: Each transporting ambulance shall contact the appropriate hospital for Online Medical Control or pre-notification (per Field to Hospital Communication Policy).

## II. EMS PLAN RESPONSE

A. Definition: The number of patients exceeds routine operational capacity of a Multiple Patient Incident (per Section I) wherein additional dispatch of EMS resources is required to provide normal levels of care and transportation. This shall be used to prioritize the on-scene evaluation and treatment of multiple patients based on a primary triage category with the expectation that there is a subsequent complete assessment and patient care per Region 11 Protocols and Policies. Specific hospital contact and transport decisions will be followed as defined in this section.

B. The EMS response is based on the scale of the incident and may include several levels, each corresponding to a specific number of ambulances and support personnel assigned. In Region 11 – Chicago EMS Systems, this is defined as an "EMS Plan 1, 2, or 3".

1. EMS Plan 1 = 5 ambulances

2. EMS Plan 2 = 10 ambulances

3. EMS Plan 3 = 15 ambulances

C. EMS Plan Response General Concepts:

1. Scene safety is a universal consideration.

2. For larger events such as an EMS Plan 2 or 3, triage tags (or other patient acuity identifier) should be used and patient tracking should be implemented.

3. An EMS Communications Officer will conduct initial field to hospital communication. Additional communication as detailed below (*see Communication section*).

4. The Resource Hospital (RH) with geographical jurisdiction over the incident (as per the Resource and Associate Hospital Policy Map) will be the Command Hospital for the EMS Plan response unless an alternate RH is designated based on operational needs.

5. Patient care reports to be completed as per policy.

D. Incident Priorities

1. First arriving unit on scene

   a. Scene size-up, activation of additional resources, and communication of need for EMS Plan activation. The first arriving officer (EMS or Fire) or OEMC may initiate an EMS Plan response.
   b. Primary triage as per Attachment 1 "Region 11 Modified START/JumpSTART Triage Algorithm":
      i. "Red" (Immediate)
      ii. "Yellow" (Delayed)
      iii. "Green" (Minimal)
      iv. "Black" (Deceased)

2. Life saving (focused) interventions that may be performed during the triage process include: control of major hemorrhage, basic airway opening maneuvers, and chest (pleural) decompression if within the responder's scope of practice and only if the necessary equipment is immediately available.

3. Establish a Casualty Collection Point (CCP) or treatment area if the situation warrants.

E. Scene Management

1. Goal of Scene Management: To maintain a consistent response structure that can be scaled or adapted for any type and size of incident.

2. Triage: All patients should receive a primary triage based on the Region 11 Modified START/JumpSTART Triage Algorithm. Triage is a dynamic process and the initially assigned triage category may change subsequent to additional patient assessment.

3. Treatment Area: A Treatment Area should be set up when the number and type of patients exceeds the number of ambulances available for immediate transport. A Treatment Officer at the level of paramedic, should be identified to manage this area and provide repetitive secondary triage and treatment as appropriate. Each patient should receive a primary and secondary survey and treatment per Region 11 EMS Protocols.

   a. Trauma patients should have the Trauma Field Triage Criteria applied (as per policy) to identify critical patients requiring transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.
      i. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged "Red" and be transported to the appropriate Level 1 Trauma Center.
      ii. Patients that meet **Mechanism of Injury** or **High Risk Populations criteria** should be triaged "Yellow" and be transported to the appropriate Level 1 Trauma Center.
   b. Medical patients should be reassessed and triage level adjusted as indicated.
   c. First responders (EMS, Fire, Law Enforcement, etc.) that become ill or injured during the incident should be triaged and treated as above and will be given priority transport.

4. Transport Area: Begin transport of the most critical or immediate priority ("Red") patients to the closest, most appropriate hospital. This is managed by the Transport Officer.

   a. After the immediate priority ("Red") patients have been transported, the immediate priority ("Yellow") patients should be transported next, and then minimal priority ("Green") patients.
   b. Ambulances may transport multiple "Green" or "Yellow" patients in the same vehicle for resource utilization subject to the availability of proper patient safety restraints. This may be done only after completing the primary and secondary survey with medical stabilization. The maximum number of patients transported per ambulance should be one "Red", two "Yellow", or four "Green".
   c. After complete assessment, patients that meet criteria for withholding resuscitation (as per Determination of Death/Withholding of Resuscitative Measures Policy) may be categorized as deceased ("Black") and left on scene unless the situation warrants removal.

5. Communication

a. There should be an initial communication with the Resource (Command) Hospital for Online Medical Control of the incident. There should be secondary individual ambulance communication as a pre-notification report to the receiving hospital. This may be limited in a large incident such as an EMS Plan 3 and above.
b. An EMS Communications Officer at the level of a paramedic should be identified to contact the Command Hospital. For large, complex, evolving incidents, there should be early notification to the Command Hospital.

c. After triage is complete, or in the case of a large scale event where triage may continue, the EMS Communications Officer will contact the Command Hospital to notify the ECRN/ECP of the EMS Plan Response and convey the following information:
    i. Location of the incident
    ii. Nature of the incident
    iii. Number of patients
    iv. Adult or pediatric
    v. Patient triage category
    vi. Ambulance transporting each patient

d. The EMS Communications Officer, in consultation with the Command Hospital, will discuss a transport plan based on triage category and nature and complexity of the incident.
e. The ECRN/ECP will assist with coordinating destination of special situations including transportation of family groups, unaccompanied minors, to a hospital on diversion, or any complex situation as requested by the EMS Communications Officer.
f. The ECRN/ECP will provide the receiving hospital an initial notification of the incoming patients.
g. The transporting ambulance should provide the receiving hospital a brief, updated pre-notification report while enroute, stating that the patient is from an EMS Plan response.
h. The EMS Communications Officer should notify the Command Hospital when the EMS Plan is secured or completed.

6. Receiving Hospitals

a. Distribution of patients will be based on the scale of the incident, patient triage category, and hospital capability.
b. Hospitals may receive a combination of patients in multiple triage categories.
c. Hospital Distribution for a Plan Response:
    i. Each hospital should be prepared to receive a potential **initial** distribution of 2 “Red” patients, 2 “Yellow” Patients, and 4 “Green” Patients.
    ii. This initial distribution may be higher to maintain family unification or based on the capacity of a receiving hospital.
    iii. In the event of an incident with a high number of “Green” patients (low speed bus collision or gas inhalation) a hospital may receive multiple “Green” patients.
    iv. Additional transport needs beyond this will be assessed with the individual hospital based on the incident. The EMS Communications Officer will contact the

Command Hospital with additional patient updates and the Command Hospital should contact the receiving hospitals as needed to assess capacity.

d. Hospitals will continue to receive transports from other simultaneous EMS incidents.
e. Hospitals on ALS bypass may receive patients transported from an EMS Plan Response. Hospitals on trauma bypass shall have capabilities assessed by the Command Hospital. Hospitals on Internal Disaster bypass should not receive patients from an EMS Plan Response (per policy).

f. Trauma patients meeting Trauma Field Triage Criteria (per Trauma Patient Destination Policy) should be transported to the appropriate Level 1 Trauma Center.

7. Quality Improvement - All EMS Plans will be reviewed by the responding agency and the Resource (Command) Hospital with feedback given to involved personnel.

## III. MASS CASUALTY INCIDENT (MCI)

A. Definition: The number of patients or type of situation has overwhelmed the operational ability of the provider wherein the number of patients and nature of their injuries make the normal prehospital level of stabilization and care unachievable, and/or available resources are insufficient to manage the scene under normal operating procedures.

B. MCI General Concepts

1. Triage tags (or other patient acuity identifier) and electronic tracking are to be used on all patients.

2. Communication will be handled by the EMS Communications Officer and the Command Hospital as defined in the previous section for EMS Plan Response.

C. Incident Priorities: Initial incident operations should be per EMS Plan response activation.

1. Primary triage as per Attachment 1 “Region 11 Modified START/JumpSTART Triage Algorithm”:

a. “Red” (Immediate)
b. “Yellow” (Delayed)
c. “Green” (Minimal)
d. “Black” (Deceased)

D. Scene Management

1. Additional resources may be requested by the Incident Commander to assist with the incident.

2. The Chicago Fire Commissioner or designee may request:

a. Mutual Aid Box Alarm System (MABAS)

b. Private Provider Emergency Response System (PPERS)

3. Communication

a. The Command Hospital will manage patient distribution.

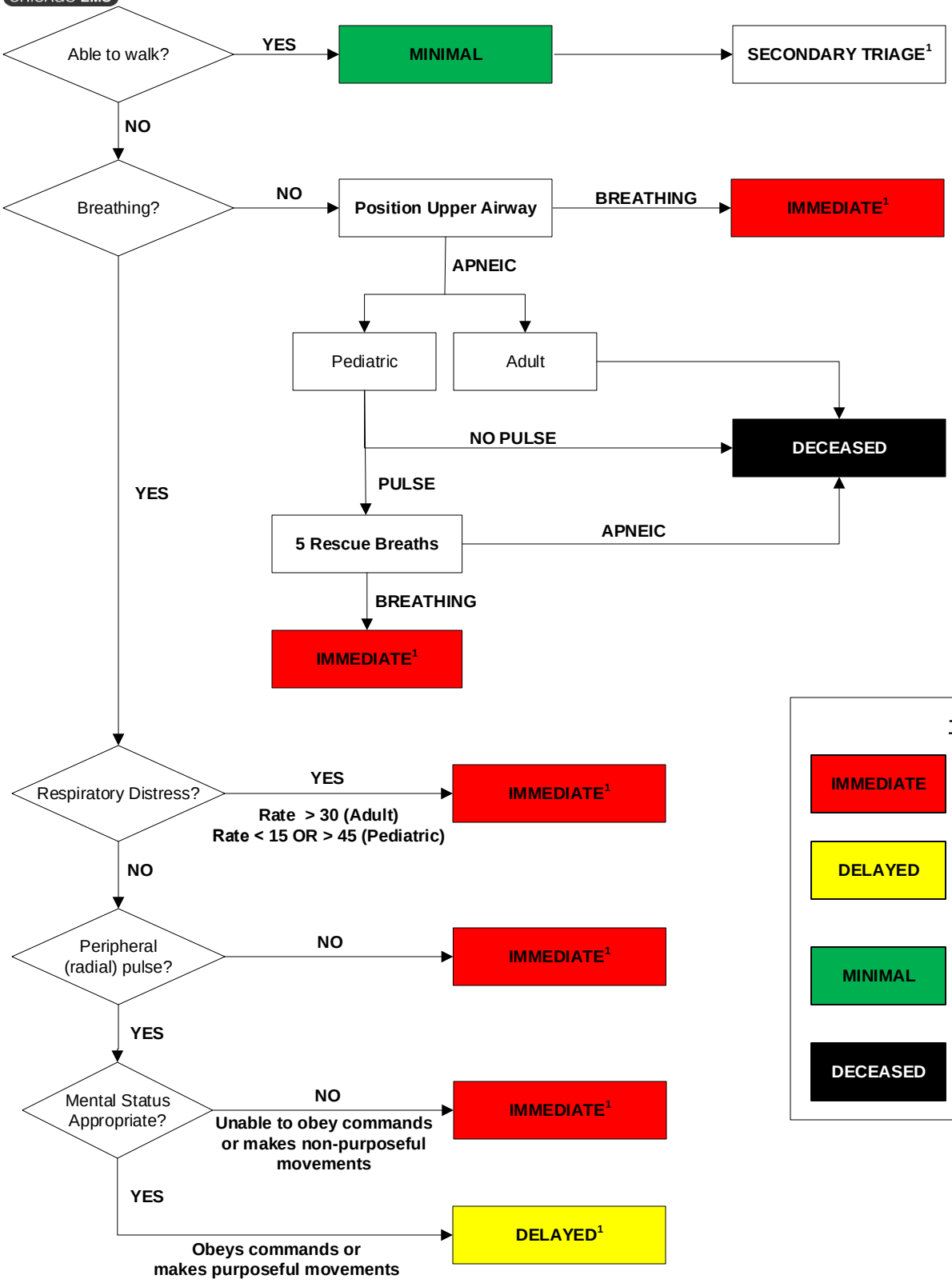
b. The Resource Hospital Coordinating Center (RHCC) hospital will be notified by the Command Hospital.
c. The RHCC will assist with incident communications and assessing hospital capacity as the situation warrants.

4. Transportation of the most critically injured trauma patients should be prioritized to Level 1 Trauma Centers unless these hospitals have provided notification they are overwhelmed. Activation of Helicopter EMS (per the Helicopter EMS Utilization Policy) may assist with distribution.

a. Ambulances may transport multiple patients in the same vehicle for resource utilization.
b. Transportation decisions should attempt to evenly distribute patients to area hospitals and not overburden one facility.
c. PPERS may also be activated for hospital decompression.
d. Alternate transport vehicles and destinations may be utilized and will be coordinated by the EMS Medical Director.

5. Quality Improvement: MCI events will be reviewed by the responding agencies and the Region 11 EMS Medical Directors.

# REGION 11 MODIFIED START/JumpSTART TRIAGE ALGORITHM




**Triage Categories**

| | |
|---|---|
| IMMEDIATE | Obvious threat to life or limb and requires immediate medical attention |
| DELAYED | Condition in need of definitive medical care, but is not likely to decompensate rapidly if care is delayed |
| MINIMAL | Minor injuries and can tolerate extended delays in treatment without increasing the risk of mortality |
| DECEASED | No respirations following basic airway maneuvers |

1- **Life-Saving (Focused) Interventions** that may be performed during the triage process include: control of major hemorrhage, basic airway opening maneuvers, and chest decompression if within the responder's scope of practice and only if the necessary equipment is immediately available.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Medication Administration Cross Check (MACC) |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: August 1, 2022 |

# MEDICATION ADMINISTRATION CROSS CHECK (MACC)

## I. PURPOSE

To define the proper use of Medication Administration Cross Check (MACC) in the Chicago EMS System.

## II. DEFINITION

The Medication Administration Cross Check (MACC) is a team-based communication method to standardize the medication verification process and reduce medication errors.

## III. USE

A. Safe medication administration is a process that optimally involves two EMS providers to collaboratively cross check the administration of medication.

B. When two EMS providers are available, MACC should be used by both EMTs and Paramedics prior to medication administration on all events.

C. When only one EMS Provider is available, the MACC cannot be applied.

D. If Provider 1 is a Paramedic and Provider 2 is an EMT, the MACC procedure should still be used with a slight alteration to the role of Provider 2. Provider 2 should visually verify the drug name, concentration, and expiration date.

## IV. PROCEDURE

A. Provider 1 initiates the procedure by stating “Medication Cross Check”.

B. Provider 2 responds that he or she is “Ready”. It is important to avoid using ambiguous responses such as “okay” and to participate in an engaged manner.

C. Provider 1 states the phrase “I am going to give . . .” and provides the following information: the dose, drug name, route, reason/indication. If there is concurrence from Provider 2, continue the cross check procedure. If there is not concurrence, stop and resolve any disagreement at this point.

D. If Provider 2 agrees, he or she responds with the question “Are there contraindications?”

E. Provider 1 must check the expiration date if he or she has not done so already, verify that the patient's vital signs are appropriate, and any drug allergies. Provider 1 should either respond by saying "No contraindications" or by stating and discussing the presence of any contraindications.

F. If Provider 2 concurs, he or she responds with the question "What is your volume?" or "Quantity?" for pills/tablets.

G. Provider 1 should state the drug concentration, the volume he or she intends to deliver, and should show the container to Provider 2.

H. If Provider 2 agrees and makes a positive visual verification, he or she should respond with the phrase "I agree; give it".

## V. CONSIDERATIONS

A. Contraindications include:

1. Verification of appropriate vital signs;

2. Known patient allergies; and

3. Expiration date.

B. If a discrepancy, disagreement, or need for clarification is encountered at any step in the process, it must be resolved prior to continuing the cross check.

C. Provider 2 can authorize the administration of the medication.

D. The Medication Administration Cross Check must be completed prior to the administration of any medication when two EMS providers are available.

E. If there is an interruption or change in patient condition of any kind, the process must be re-initiated by Provider 1.

F. Avoid ambiguous statements or confirmations like "okay".

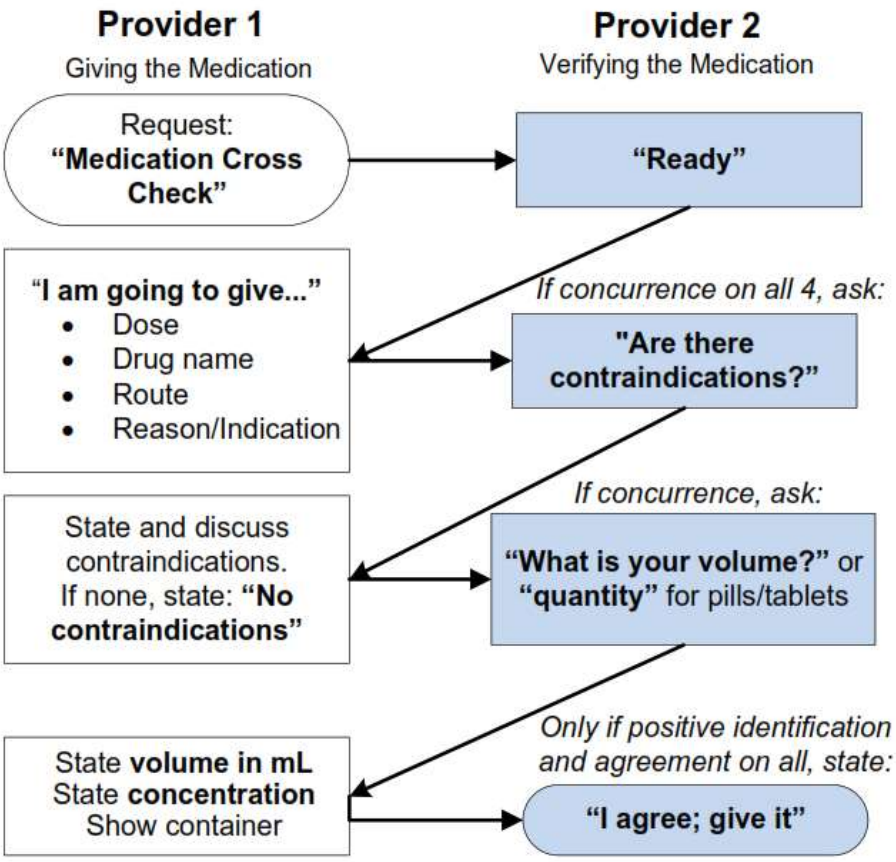
## VI. DOCUMENTATION

Use of the Medication Administration Cross Check (MACC) should be documented in the patient care report.

## VII. REPORTING

Medication administration errors should be reported to the receiving hospital.

# Medication Administration Cross Check

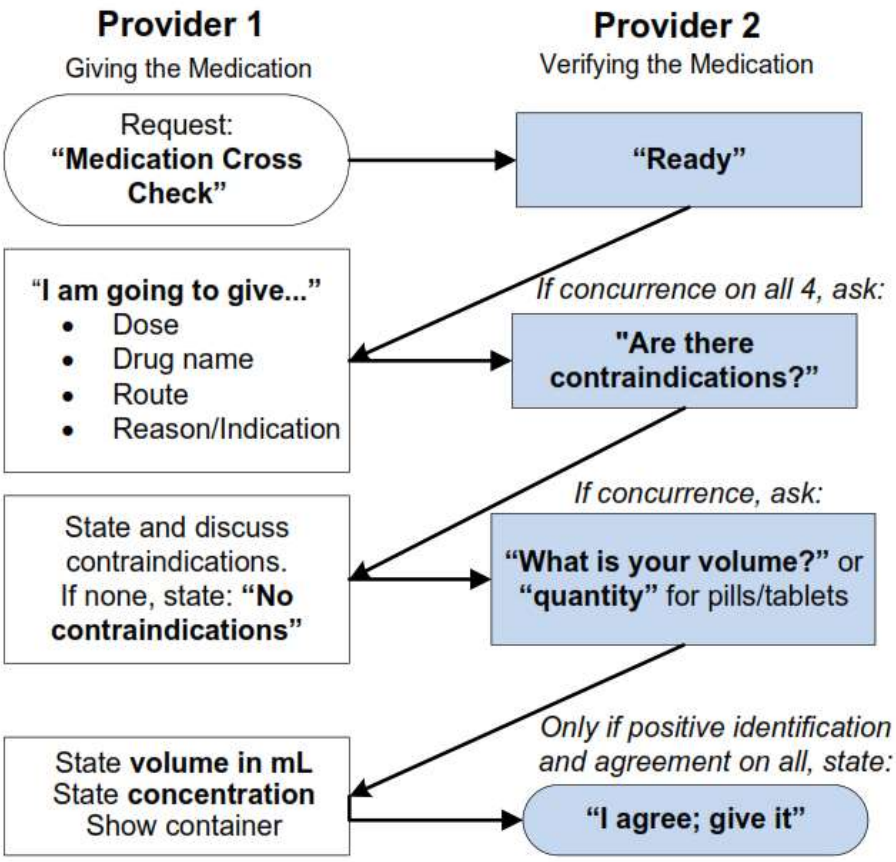



- "**Contraindications**" include: 1) verification of appropriate vital signs, 2) known patient allergies, and 3) expiration date.
- If a discrepancy, disagreement, or need for clarification is encountered at any step in the process, it must be resolved prior to continuing the cross check.
- Provider 2 can authorize the administration of the medication.
- The Medication Administration Cross Check must be completed prior to the administration of any medication when two EMS providers are available.
- If there is an interruption or change in patient condition of any kind, the process must be re-initiated by Provider 1.
- Avoid ambiguous statements or confirmations like "okay."

**RED RULE of Medication Administration**
**(A Duty to Avoid Causing UNJUSTIFIABLE Harm)**
**NEVER give the contents of a syringe that is not labeled or without visualizing the vial from which it was immediately drawn.**

Adapted with permission from Wichita-Sedgwick County EMS System
Approved: Region 11 EMS Medical Directors Consortium
Effective: August 1, 2022

# Medication Administration Cross Check




- "**Contraindications**" include: 1) verification of appropriate vital signs, 2) known patient allergies, and 3) expiration date.
- If a discrepancy, disagreement, or need for clarification is encountered at any step in the process, it must be resolved prior to continuing the cross check.
- Provider 2 can authorize the administration of the medication.
- The Medication Administration Cross Check must be completed prior to the administration of any medication when two EMS providers are available.
- If there is an interruption or change in patient condition of any kind, the process must be re-initiated by Provider 1.
- Avoid ambiguous statements or confirmations like "okay."

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Adapted with permission from Wichita-Sedgwick County EMS System
Approved: Region 11 EMS Medical Directors Consortium
Effective: August 1, 2022

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Mobile Integrated Healthcare Program (MIH) |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# MOBILE INTEGRATED HEALTHCARE (MIH) PROGRAM

## I. PURPOSE

A. To describe the Mobile Integrated Healthcare (MIH) Program which centers on the provision of healthcare using patient-centered, non-emergency mobile resources in the out-of-hospital environment. It may include, but is not limited to, providing community paramedicine care, chronic condition management, preventive care, or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care, not limited to hospital emergency departments.

## II. POLICY

A. An EMS Medical Director shall submit to IDPH a program plan covering the following for the EMS System's MIH Program:

1. IDPH's Mobile Integrated Healthcare application form provided by the Regional EMS Coordinator.

2. Statement from the Illinois licensed service provider that the EMS agency has the resources and personnel to meet both their response area and to support the MIH Program.

3. MIH EMS System Policy.

4. MIH Quality Improvement Plan to be submitted to IDPH on a quarterly basis.

5. MIH Orientation and training plan.

6. MIH Medication and Equipment list.

7. List of EMS Personnel that participate in the program.

B. MIH Paramedics are further defined in the Community Paramedic Policy.

C. Mobile Integrated Healthcare (MIH) Program oversight is by the EMS Medical Director and the EMS System.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Notification of the Coroner / Medical Examiner |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# NOTIFICATION OF THE CORONER / MEDICAL EXAMINER

## I. PURPOSE:

To establish a procedure for how and when to call the Coroner or Medical Examiner in Region 11 Chicago EMS.

## II. COOK COUNTY MEDICAL EXAMINER ORDIANCE

A. Under the Cook County Medical Examiner's Ordinance Number 15-5145, any EMS provider, who becomes aware of a death that a reasonable person would conclude may have occurred under any of the circumstances listed below shall immediately report such death to the Office of the Medical Examiner **or any law enforcement officer** within one hour of their becoming aware of the death.

1. Criminal violence;
2. Suicide;
3. Accident;
4. Suddenly, when in apparent good health;
5. Unattended by a practicing, licensed physician, other than apparent natural deaths;
6. Suspicious or unusual circumstances;
7. Unlawful fetal death under Public Act 101-0013;
8. Poisoning or attributable to an adverse reaction to drugs and/or alcohol;
9. Diseases constituting a threat to public health;
10. Disease, injury or toxic agent resulting from employment;
11. During medical diagnostic or therapeutic procedures that do not include death as a reasonable possible outcome;
12. In any prison or penal institution;
13. When involuntarily confined in jail, prison, hospitals or other institutions or in Police custody;
14. When any human body is to be cremated, dissected or buried at sea;

15. Unidentified human remains;

16. When a dead body is brought into a new medico-legal jurisdiction without proper medical certification.

B. No person who becomes aware of a death of the type described above, shall remove, cause to be removed, or release for removal, the deceased person from the place of their death without first reporting the death. The deceased person shall not be removed from the place of their death until the Medical Examiner gives approval for that removal.

C. EMS providers are excused from the duty to report a death only if they reasonably believe, based upon information presented to them, that the death has already been reported to the Medical Examiner.

D. No dead human body whose death may be subject to investigation, or the personal property of such a deceased person, shall be handled, disturbed, embalmed or removed from the place of death by any person except with the permission of the Medical Examiner, unless the same shall be necessary to preserve such body from damage or destruction, or to protect life, safety, or health.

E. Any person who knowingly violates any provision of this ordinance is subject to fines and legal charges.

## III. NOTIFICATION AND SCENE MANAGEMENT

A. In the case of a prehospital death, EMS Providers shall notify the Chicago Police Department (CPD). CPD will notify the Office of the Medical Examiner in accordance with Police General Order – Processing Deceased Persons.

B. Preservation of crime scene elements may be appropriate (see Interaction with Law Enforcement at a Crime Scene Policy).

C. In situations where determination of death is done by EMS providers in accordance with the Region 11 Determination of Death / Withholding of Resuscitative Measures Policy, the name of the EMS Medical Director may be used for Medical Examiner documentation.

## IV. SPECIAL CIRCUMSTACES

A. The body shall not be moved and the scene shall not be disturbed or altered in any way. The body may, however, be moved to verify the absence of vital signs, to perform an adequate assessment, or to gain access to a viable patient involved in the same incident.

B. EMS providers should not remove lines or tubes from unsuccessful cardiac arrest resuscitation attempts.

C. If there is a delay in the arrival of law enforcement the appropriate supervisor should be notified for escalation.

D. In situations where there is an order for the termination of resuscitation (see Termination of Resuscitation Policy) and the deceased is in a public place or unsafe scene, CPD should be called to take custody of the body. In the rare circumstance where transport is needed, EMS may transport the patient to the closest comprehensive emergency department. The base station should notify the receiving hospital that they are receiving a patient whose resuscitation was terminated in the field.

# REGION 11 CHICAGO EMS SYSTEM
# REQUIRED MEDICATION, EQUIPMENT, AND SUPPLY (MES) INVENTORY LIST

# REGION 11 CHICAGO EMS SYSTEM
# REQUIRED MEDICATION, EQUIPMENT, AND SUPPLY (MES) INVENTORY LIST

**ALL EXCHANGE ITEMS MUST BE IMMEDIATELY AVAILABLE TO THE EMERGENCY CARE PERSONNEL SO AS NOT TO DELAY THEIR RETURN TO SERVICE.**

**APPROVAL OF SIMILAR TYPE EQUIPMENT MUST BE MADE BY THE EMS MEDICAL DIRECTORS CONSORTIUM**

**In the event of transport of a patient with a suspected communicable disease, the following items must be made available to the EMT or paramedic for use:**

- **An EPA-registered disinfectant or surface disinfectant wipes**
- **Additional ambulance cleaning supplies as needed**

**The number in the "No. of items" column indicates the minimum quantity of the medication, supply or exchange equipment that must be carried on each EMS vehicle in Region 11.**

**"X"s in the indicated columns convey the following meanings:**

**HOSPITAL: It is the responsibility of the Participating Hospital to replace the medication, supply or exchange the equipment item as indicated.**

**PROVIDER - Private: It is the responsibility of the Provider to replace the medication, supply or exchange the equipment item indicated.**

**PROVIDER - CFD: This piece of equipment is unique to the Chicago Fire Department. The CFD is the only provider in the system required to have this medication, supply or piece of equipment in their inventory. The CFD is responsible for the replacement of this item.**

**CONTROLLED SUBSTANCE: These medications are controlled substances.**

## MEDICATIONS

| No. of Items | Hospital Replacement | Provider - Private Replacement | Provider - CFD Replacement | BLS | ALS | Controlled Substance | |
|---|---|---|---|---|---|---|---|
| 3 | X | | | | X | | Adenosine, 6 mg / 2 ml, injection, prefilled syringe or vial |
| 3 | X | | | X | X | | Albuterol, 0.083%, 2.5 mg / 3 ml, inhalation, vial |
| 3 | X | | | | X | | Amiodarone, 150 mg / 3 ml, injection, vial |
| 1 | X | | | X | X | | Aspirin, 81 mg, chewable, bottle |
| 3 | X | | | | X | | Atropine Sulfate, 1 mg / 10 ml, injection, prefilled syringe |
| 1 | X | | | | X | | Calcium Chloride, 10%, 1 gram / 10 ml, injection, prefilled syringe |
| 1 | X | | | | X | | Dextrose, 10%, 25 grams / 250 ml water OR 50 grams / 500 ml water, injection |
| 1 | X | | | | X | | Diphenhydramine HCl (Benadryl), 50 mg / 1 ml, injection, vial |
| 3 | X | | | | X | | Epinephrine (Adrenalin) 1 mg / 1 ml, injection, vial |
| 6 | X | | | | X | | Epinephrine 1 mg / 10 ml prefilled syringe (0.1 mg / ml), injection |
| 1 | X | | | | X | X | Fentanyl citrate (Sublimaze), 100 mcg / 2 ml, injection, vial |
| 1 | X | | | | X | | Glucagon (GlucaGen), 1 mg solvent with 1 ml solute (kit only), injection |
| 1 | X | | | X | X | | Glucose Gel (Glutose 15), Net weight of gel 37.5 grams, oral, tube |
| 2 | X | | | X | X | | Ipratropium bromide (Atrovent), 0.5 mg / 3 ml, inhalation, vial |
| 2 | X | | | | X | | Magnesium Sulfate, 2 grams / 50 ml water, injection, bag |
| 2* | X | | | | X | X | Midazolam (Versed), 10 mg / 2 ml, injection, vial |
| 1 | X | | | | X | | Ondansetron (Zofran), 4 mg / 2 ml, injection, vial |
| 1 | X | | | | X | | Ondansetron (Zofran), 4 mg, oral disintegrating tablet (ODT) |
| 2 | X | | | X | X | | Naloxone (Narcan), 2 mg / 2 ml, injection, prefilled syringe |
| 1 | X | | | | X | | Nitroglycerin (Nitrostat), 0.4 mg, sublingual tablets, bottle |
| 2 | X | | | | X | | Sodium Bicarbonate, 8.4%, 50 mEq / 50 ml, injection, prefilled syringe |
| 2 | X | | | | X | | Tranexamic Acid (TXA), 1000 mg / 10 ml (1 gram), injection, vial |
| 1 | | | X | | X ** | | Hydroxocobalamin (Cyanokit), 5 gram vial reconstituted with 200 ml of 0.9% Sodium Chloride, infusion |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1 | | | | | | | **Region 11 Approved Intramuscular (IM) Epinephrine Kit (containing at minimum):** |
| | X | | | X | | | *2 - Epinephrine (Adrenalin) 1 mg / 1 ml, vial* |
| | X | | | X | | | *2 - 23 gauge needle (1 inch)* |
| | X | | | X | | | *2 - Syringes, 1 ml* |
| | X | | | X | | | *2 - Alcohol wipes* |
| | X | | | X | | | *2 - Packages of 2X2 gauze bandages* |
| | X | | | X | | | *2 - Band-Aids* |
| | | X | X | X | | | *1 - Measuring tape device* |
| | | X | X | X | | | *1 - Pouch or small bag/container to hold kit contents* |

*** ALS Non-Transport = 1**
****Ambulance Only**

# AIRWAY & VENTILATION EQUIPMENT

| No. of Items | Hospital Replacement | Provider - Private Replacement | Provider - CFD Replacement | BLS | ALS | |
|---|---|---|---|---|---|---|
| | | | | | | **AIRWAY MANAGEMENT** |
| 2 ea. | X | | | X | X | Airway, Oropharyngeal (Sizes: 0/50mm, 1/60mm, 2/70mm, 3/80mm, 4/90mm, 5/100mm) |
| 1 ea. | X | | | X | X | Airway, Nasopharyngeal (Sizes: 14, 16, 18, 20, 22, 24, 26, 28, 30, 32, 34 French) |
| 1 | X | | | X | X | i-gel Supraglottic Airway, Size 1 (Neonate) |
| 1 | X | | | X | X | i-gel Supraglottic Airway, Size 1.5 (Infant) |
| 1 | X | | | X | X | i-gel Supraglottic Airway, Size 2 (Pediatric - Small) |
| 1 | X | | | X | X | i-gel Supraglottic Airway, Size 2.5 (Pediatric - Large) |
| 1 | X | | | X | X | i-gel Supraglottic Airway O2 Resus Pack, Size 3 (Adult - Small) |
| 1 | X | | | X | X | i-gel Supraglottic Airway O2 Resus Pack, Size 4 (Adult - Medium) |
| 1 | X | | | X | X | i-gel Supraglottic Airway O2 Resus Pack, Size 5 (Adult - Large) |
| 1 | | X | X | | X | Magill Forceps, Adult |
| 1 | | X | X | | X | Magill Forceps, Pediatric |
| 4 | X | | | X | X | Water based lubricant (single packet) |
| | | | | | | **INTUBATION** |
| 2 | X | | | | X | Airway Tube Holder |
| 1 ea. | X | | | | X | Endotracheal Tube, sterile, cuffed (Sizes: 3.0 mm, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5, 8.0) |
| 1 | X | | | | X | Stylet, Adult |
| 1 | X | | | | X | Stylet, Pediatric |
| 2 | | X | X | | X | Laryngoscope Handle, with fiber optic and/or LED light source (disposable) |
| 1 | | X | X | | X | # 1 Miller Straight Laryngoscope Metal Blade (disposable) |
| 1 | | X | X | | X | # 2 Miller Straight Laryngoscope Metal Blade (disposable) |
| 1 | | X | X | | X | # 3 Miller Straight Laryngoscope Metal Blade (disposable) |
| 1 | | X | X | | X | # 2 Macintosh Curved Laryngoscope Metal Blade (disposable) |
| 1 | | X | X | | X | # 3 Macintosh Curved Laryngoscope Metal Blade (disposable) |
| 1 | | X | X | | X | # 4 Macintosh Curved Laryngoscope Metal Blade (disposable) |
| | | | | | | **OXYGEN ADMINISTRATION** |
| 3 | X | | | X | X | Nasal Cannula, Adult |
| 3 | X | | | X | X | Nasal Cannula, Pediatric |
| 2 | X | | | X | X | Non-Rebreather Mask, Adult |
| 2 | X | | | X | X | Non-Rebreather Mask, Pediatric |
| 2 | X | | | X | X | Simple Face Mask, Infant |
| | | | | | | **OXYGEN EQUIPMENT** |
| 2 | | X | X | X | X | Adaptor for Oxygen Tubing (on-board and portable) |
| 1 | | X | X | X | X | Dial Flow Meter / Regulator for 25 LPM |
| 1 | | X | X | X | X | Main (On-Board) Oxygen Cylinder (Size H, K or M) |
| 1 | | X | X | X | X | Oxygen Regulator Seal (O-Ring) |
| 1 | | X | X | X | X | Oxygen Tank Key |
| 4 | | X | X | X | X | Portable Oxygen Cylinder (Size D or E) |
| | | | | | | **VENTILATION** |
| 1 | X | | | X | X | Adult Size Bag-Valve-Mask Ventilation Unit, with transparent adult mask |
| 1 | X | | | X | X | Child Size Bag-Valve-Mask Ventilation Unit, with transparent child mask |
| 1 | X | | | X | X | Infant Size Bag-Valve-Mask Ventilation Unit, with transparent infant mask |
| 1 | X | | | X | X | Transparent Neonatal Mask |

## AIRWAY & VENTILATION EQUIPMENT (CONTINUED)

**SUCTION**

| No. of Items | Hospital Replacement | Provider - Private Replacement | Provider - CFD Replacement | BLS | ALS | |
|---|---|---|---|---|---|---|
| 1 | X | | | X | X | Bulb Syringe Suction (separate from the OB Kit) |
| 1 | | X | X | X | X | Onboard Suction Device |
| 1 | | X | X | X | X | Portable Suction Unit |
| 3 | X | | | X | X | Semi-rigid Pharyngeal Suction Tips (Yankauer) |
| 2 | | X | X | X | X | Suction Cannisters, 1000 ml (or larger) |
| 2 each | X | | | X | X | Suction Catheters, sterile, single use with thumb suction control port (Sizes 6, 8, 10, 12, 14, 16, 18 French) |
| 2 | X | | | X | X | Suction Connecting Tubing |

**OTHER**

| | | | | | | |
|---|---|---|---|---|---|---|
| 2 | X | | | | X | Adapter for In-Line Nebulization, 22 mm to 14 mm I.D. |
| 2 | X | | | | X | Adapter for In-Line Nebulization, 22 mm to 22 mm I.D. |
| 1 | X | | | X | X | Aerosol Mask, Adult (for nebulization) |
| 1 | X | | | X | X | Aerosol Mask, Pediatric (for nebulization) |
| 1 | X | | | | X | CPAP Mask - Flow Safe II EZ Deluxe (adult) |
| 2 | X | | | X | X | Nebulizer (Acorn Type) with T-Piece Adapter, Oxygen Tubing, Mouthpiece and Flextube |
| 2 | | X | X | X | X | Viral/Bacterial Filter (22 mm X 15mm / 22 mm OD) |

## ASSESSMENT EQUIPMENT

**BLOOD PRESSURE**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | | X | X | X | X | Blood Pressure Cuff, Large Adult |
| 1 | | X | X | X | X | Blood Pressure Cuff, Adult |
| 1 | | X | X | X | X | Blood Pressure Cuff, Child |
| 1 | | X | X | X | X | Blood Pressure Cuff, Infant |
| 2 | | X | X | X | X | Stethoscope |
| 1 | | X | X | X | X | Pediatric Stethoscope |
| 1 | | X | X | X | X | Gauge(s) for Blood Pressure Cuffs, appropriately calibrated |

**CARDIAC**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | | X | X | X | | AED with Adult and Pediatric Pads |
| 1 | | X | X | | X | Cardiac Monitor / Defibrillator with Spare Battery |
| 2 | X | | | X | X | Disposable Razor |
| 4 | X | | | | X | Electrodes, Monitoring, Adult, Set of 3 |
| 4 | X | | | | X | Electrodes, Monitoring, Pediatric, Set of 3 |
| 1 | | X | X | | X | Patient Cables: 4 lead and 12 lead |
| 2 | | X | | | X | Rolls of ECG Paper |
| 2 | X | | | X | X | Zoll Adult CPR Stat Padz |
| 2 | X | | | | X | Zoll One Step Pediatric CPR Padz |
| 2 | | X | X | X | | Zoll Pedi-padz II (Pediatric AED) |

**OTHER**

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | | X | X | | X | CO Reusable Sensor |
| 1 | | X | X | X | X | Glucometer with lancets, alcohol swabs, test strips, band-aids |
| 6 | | X | X | | X | Masimo SET M-LNCS NeoPt-3 Neonatal Pulse Oximeter Adhesive Sensor |
| 2 | X | | | | X | Microstream Advance Adult-Pediatric Intubated CO2 Filter Line |
| 1 | | X | X | X | X | Penlight |
| 1 | | X | X | X | X | Pulse Oximetry with Adult and Pediatric Sensors |

# TRAUMA EQUIPMENT

| No. of Items | Hospital Replacement | Provider - Private Replacement | Provider - CFD Replacement | BLS | ALS | |
|---|---|---|---|---|---|---|
| | | | | | | **DRESSINGS** |
| 6 | X | | | X | X | ABD Dressings, 5" x 9" |
| 2 | X | | | X | X | Adhesive Tape Roll, 1" |
| 2 | X | | | X | X | Adhesive Tape Roll, 2" |
| 2 | | X | X | X | X | Burn Sheets, individually wrapped |
| 2 | X | | | X | X | Elastic Bandages, 4" (ACE Wrap) |
| 2 | X | | | X | X | Elastic Bandages, 6" (ACE Wrap) |
| 20 | X | | | X | X | Gauze Pads, 4" x 4", sterile |
| 10 | X | | | X | X | Gauze, soft, self-adhering (4" x 5 yards) - Kerlix |
| 1 | | X | X | X | X | Hyfin Vented Chest Seal - twin pack |
| 6 | X | | | X | X | Trauma Dressing (12" x 30") |
| | | | | | | **HEMORRHAGE CONTROL** |
| 2 | | | X | X | X | Pressure Dressing 6" (Emergency Trauma Dressing or Israeli Bandage) |
| 2 | | | X | X | X | Pressure Dressing 4" (Emergency Trauma Dressing or Israeli Bandage) |
| 2 | X | | | X | X | Tourniquet - CAT |
| 2 | | | X | X | X | Quickclot EMS Rolled Gauze Hemostatic Dressing or Combat Gauze |
| | | | | | | **SPLINTING** |
| 1 | X | | | X | X | Leg Traction Device, Adult Size, (Hare or approved similar device) |
| 1 | X | | | X | X | Leg Traction Device, Pediatric Size, (Hare or approved similar device) |
| 2 | | X | X | X | X | Extremity Splints, Adult, Long (moldable - SAM or equivalent) |
| 2 | | X | X | X | X | Extremity Splints, Adult, Short (moldable - SAM or equivalent) |
| 2 | | X | X | X | X | Extremity Splints, Pediatric, Long (moldable - SAM or equivalent) |
| 2 | | X | X | X | X | Extremity Splints, Pediatric, Short (moldable - SAM or equivalent) |
| 1 | X | | | X | X | Sheet to Stabilize Pelvis |
| 5 | X | | | X | X | Triangle Bandage or Arm Slings |
| | | | | | | **EXTRICATION** |
| 2 | X | | | X | X | Blanket Rolls or Disposable Head Immobilization Device |
| 2 | X | | | X | X | Cervical Collar, Adult, Adjustable (either StifNeck Select by Laerdal or Ambu) |
| 1 | X | | | X | X | Cervical Collar, Infant (if pediatric collars are non-adjustable) |
| 2 | X | | | X | X | Cervical Collar, Pediatric, (either StifNeck Select by Laerdal or Ambu) |
| 2 | X | | | X | X | Long Spine Board, with 3 sets of torso straps |
| 2 | | | | X | X | Spider Straps (or similar device) |
| 1 | X | | | X | X | Vest Type Wrap Around Extrication Device (KED) (including straps and case) |
| | | | | | | **OTHER** |
| 2 | X | | | | X | 16 - 18 gauge X 1.5 - 2 inch, catheter-over-needle device (for pediatric pleural decompression) |
| 2 | X | | | | X | ARS (Air Release System) Kit or 14 gauge X 3.25" angiocatheter |
| 1 | | X | X | X | X | Region 11 Modified START/JumpSTART Triage Algorithm Card State Approved (current version: 2020) |
| 2000ml | X | | | X | X | Sterile Solution (Normal Saline) for Irrigation, plastic bottles for a total of 2,000 ml |
| 1 | X | | | X | X | Sterile water (for drinking), plastic bottle, 1000 ml |
| 1 | | X | X | X | X | 10 Disaster Triage Tags **(**SMART), 1 package |
| 1 | | X | X | X | X | Trauma Shears |

## MEDICATION ADMINISTRATION

| No. of Items | Hospital Replacement | Provider - Private Replacement | Provider - CFD Replacement | BLS | ALS | |
|---|---|---|---|---|---|---|
| | | | | | | **INTRAVENEOUS** |
| 4 | X | | | | X | 0.9% Sodium Chloride IV Solution, plastic bag, 1000 ml |
| 2 | X | | | | X | 3-Way Stopcock |
| 1 | X | | | X | X | Box of Alcohol Prep Pads, disposable |
| 1 | X | | | X | X | Box of Band-Aids, 1" width |
| 4 ea. | X | | | | X | IV Catheter (14, 16, 18, 20, 22, 24 gauge), catheter-over-needle device, 1 - 2 inches |
| 5 | X | | | | X | IV Dressing (Tegaderm or similar type) |
| 2 | | X | X | X | X | IV Holders or Hooks, such as: ceiling mounted or perko clips |
| 4 | X | | | | X | IV Tubing, Macrodrip, 10 drops/mL, needleless connector and split septum port |
| 5 | X | | | | X | Needles, 18 Gauge x 1.5 inch |
| 5 | X | | | | X | Needles, 23 Gauge x 1 inch |
| 5 | X | | | | X | Needles, 23 Gauge x 1.5 inch |
| 5 | X | | | | X | Needles, 25 Gauge x ⅝ inch |
| 2 | X | | | | X | Padded Armboards |
| 3 | X | | | | X | Saline Flush - 0.9% Sodium Chloride Injection, 10 mL, pre-filled syringe |
| 5 | X | | | | X | Saline Locks |
| 2 | X | | | | X | Syringes, 1 ml |
| 2 | X | | | | X | Syringes, 3 ml |
| 2 | X | | | | X | Syringes, 10 ml |
| 2 | X | | | | X | Tourniquets |
| | | | | | | **INTRAOSSEOUS** |
| 1 | | X | X | | X | EZ-IO Driver |
| 1 | X | | | | X | EZ-IO Needle, Pink (15mm) + Stabilizer Kit |
| 2 | X | | | | X | EZ-IO Needle, Blue (25 mm) + Stabilizer Kit |
| 1 | X | | | | X | EZ-IO Needle, Yellow (45mm) + Stabilizer Kit |
| | | | | | | **OTHER** |
| 1 | X | | | | X | Buretrol Infusion Set |
| 2 | X | | | X | X | Mucosal Atomization Device (MAD) |

## OBSTETRIC / PEDIATRIC EQUIPMENT

| | | | | | | |
|---|---|---|---|---|---|---|
| 2 | X | | | X | X | **Obstetrical Kit (sterile), Pre-packaged with the following:**<br>*1 - Sterile towel*<br>*1 - Scissors or retractable blade/scalpel*<br>*2 - Umbilical cord clamps*<br>*1 - Maternal pad*<br>*1 - Placenta bag*<br>*1 - Pair of gloves*<br>*1 - Mask with eye protection*<br>*1 - Drape sheet*<br>*1 - Gauze sponge*<br>*1 - Underpad*<br>*1 - Disposable gown/apron*<br>*1 - Bulb syringe*<br>*1 - Clear plastic wrap or plastic bag*<br>*1 - Newborn cap* |
| 1 | X | | | X | X | Gloves, Sterile, Pair, Size 7 or 7.5 |
| 1 | X | | | X | X | Gloves, Sterile, Pair, Size 8 or 8.5 |
| 1 | X | | | X | X | Silver Swaddler or baby bunting mylar blanket |
| 1 | | X | X | | X | Region 11 EMS Pediatric Resuscitation Chart (current version: 2023) |
| 1 | | X | X | | X | Broselow Tape (current version: 2019) OR Dose by Growth Tape (current version: 2020) |

## PERSONAL PROTECTIVE EQUIPMENT (PPE)

| No. of Items | Hospital Replacement | Provider - Private Replacement | Provider - CFD Replacement | BLS | ALS | |
|---|---|---|---|---|---|---|
| 10 | X | | X | X | X | Face Mask (Surgical), disposable |
| 2 | X | | | X | X | Face Shields |
| 1 | X | | X | X | X | Gloves, Non-Sterile, Non-Porous, Disposable, Box |
| 2 | X | | X | X | X | Isolation Gowns, Long Sleeve |
| 2 | X | | X | X | X | N-95 Masks, NIOSH Approved |
| 2 | | X | X | X | X | Safety Glasses, Splash Protective (or) Goggles |

## INFECTION CONTROL EQUIPMENT

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | X | | | X | X | Impermeable Red Biohazard-Labeled Isolation Bag |
| 1 | | X | X | X | X | Sharps Container, puncture resistant |
| 1 | X | | | X | X | Topical Germicide Wipes, Container |
| 1 | | X | X | X | X | Waterless Hand Sanitizer |

## PATIENT TRANSPORT EQUIPMENT

| | | | | | | |
|---|---|---|---|---|---|---|
| 2 | X | | | X | X | Blankets |
| 1 | | X | X | X | X | Stair Chair or Collapsible Evacuation Chair (including 3 straps) |
| 2 | X | | | X | X | Cot Sheets |
| 1 | | X | X | X | X | Patient Stretcher, with 3 sets of straps and over-shoulder straps |
| 1 | | X | X | X | X | Pediatric Specific Restraint System or Age/Size Appropriate Car Safety Seat |
| 4 | | X | X | X | X | Restraints (two pair, arm and leg, for four-point restraint) |
| 1 | | X | X | X | X | Scoop Stretcher, including manufacture required safety restraints |
| 2 | X | | | X | X | Towels |

## COMMUNICATION EQUIPMENT

| | | | | | | |
|---|---|---|---|---|---|---|
| 1 | | X | X | X | X | Ambulance to Hospital Radio Communication Capability |
| 1 | | X | X | X | X | Cellular Telephone |
| 10 | | X | X | X | X | Electronic Documentation With Paper Back-Up (Region 11 EMS approved form) |
| 1 | | X | X | X | X | Electronic Patient Care Report Documentation Device |
| 1 | | X | X | X | X | UHF Portable Radio with Carrying Case and Remote Speaker / Microphone |

## OTHER EQUIPMENT

| | | | | | | |
|---|---|---|---|---|---|---|
| 2 | | X | X | X | X | ABC Dry Chemical Fire Extinguisher, Min. 5 lb with Quick Release Bracket |
| 2 | | X | X | X | X | ANSI Class 2 or 3 Reflective Vests or Outerwear |
| 1 | X | | | X | X | Bedpan |
| 1 | | X | X | X | X | Body Bag, disposable |
| 6 | X | | | X | X | Cold Packs |
| 1 | X | | | X | X | Emesis Collection Container |
| 1 | | X | X | X | X | Flashlight w/Batteries |
| 2 | X | | | X | X | Hot Packs |
| 1 | | X | X | X | X | Medication Administration Cross Check (MACC) Card (current version: 2022) |
| 1 | | X | X | X | X | Nonflammable Reflective and/or Illuminated Roadside Warning Devices |
| 1 | | X | X | X | X | Region 11 EMS Protocols, Policies and Procedures - Electronic Access |
| 1 | | X | X | X | X | Sign / Sticker: "No Smoking" |
| 1 | | X | X | X | X | Sign / Sticker: "Seat Belt Required" |
| 1 | | X | X | X | X | Sign / Sticker: Current Illinois Department of Transportation Safety Inspection Sticker |
| 1 | | X | X | X | X | Sign / Sticker: IDPH Central Complaint Registry Telephone Number Posted Where Visible to the Patient |
| 1 | | X | X | X | X | Sign / Sticker: Illinois Poison Center Telephone Number |
| 1 | X | | | X | X | Urinal |
| 1 | | X | X | X | X | Wrecking bar, 24" |

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Reporting Abused and Neglected Patients |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# REPORTING ABUSED AND NEGLECTED PATIENTS

## I. PURPOSE

To identify patients who are victims of abuse and neglect (including children, adults, adults age 60 and over, and those with disabilities) and to provide guidelines for prompt treatment and appropriate referral to support services.

## II. DEFINITIONS

A. Physical Abuse: Intentional bodily harm or injury.

B. Sexual Abuse: Any act of sexual contact that a person suffers from, submits to, participates in, or performs as a result of force, violence, threats, fear, deception or without having legally consented to the act.

C. Psychological Abuse: Provoking a fear of violence. This includes name calling, verbal assaults, or violent behaviors such as hitting inanimate objects.

D. Neglect: Failure of a parent or caretaker to meet "minimal standards" for providing adequate supervision, food, clothing, medical care, shelter or other basic needs.

E. Domestic Violence**:** A pattern of behaviors used by one partner to maintain power and control over another partner in an intimate relationship. Can also be referred to as intimate partner violence (IPV), dating abuse, or relationship abuse.

F. Child Abuse or Neglect**:** Mistreatment of a child under 18 years old by a parent, caregiver, relative or any person responsible for the child's welfare.

G. Mandated Reporter: An individual required by law to report cases of abuse or neglect when they have reasonable cause to believe that a child, an adult age 60 or over, or someone with a disability who otherwise is not capable of reporting the abuse or neglect themselves, know to them in their professional capacity may be abused or neglected. EMS personnel are considered mandated reporters under Illinois law.

H. Human Trafficking: Involves the use of force, fraud, or coercion to obtain some type of labor or commercial sex act, or in which the person performing the commercial sex act is under 18 years of age.

## III. POLICY

A. Suspected Child Abuse or Neglect

1. Under the Illinois Abused and Neglected Child Reporting Act, all EMS personnel are considered "mandated reporters" and are therefore ***required*** to report cases of

suspected child abuse or neglect to the Illinois Department of Children and Family Services (DCFS). State law protects the confidentiality of reporters and any mandated reporter acting in good faith shall be granted immunity from civil liability. However, any mandated reporter who fails to report suspected child abuse or neglect may be subject to legal penalties.

2. Reporting of cases of suspected child abuse or neglect should be done as soon as possible through the **DCFS Child Abuse and Neglect Hotline at 1-800-25-ABUSE**.

3. Guidelines for identifying suspected child abuse and neglect:

    a. Discrepancy between history of injury and physical exam.
    b. Prolonged interval between injury and the seeking of medical help.
    c. History/suspicion of repeated trauma.
    d. Parents or guardians respond inappropriately or do not comply with or refuse evaluation, treatment or transport of child.
    e. A child who does not seek comfort from parents or guardians.
    f. Poor nutritional status.
    g. Environment that puts the child in potential risk.

4. The following injuries are physical signs that should raise the suspicion of child abuse and indicate the need for more investigation:

    a. Perioral and perinasal injuries
    b. Fractures of long bones in children under three years of age
    c. Multiple soft tissue injuries
    d. Frequent injuries such as old scars, multiple bruises and abrasions in varying stages of healing
    e. Injuries such as bites, cigarette burns, rope marks
    f. Trauma to genital or perianal areas
    g. Sharply demarcated burns in unusual areas

5. Treatment of Suspected Child Abuse/Neglect

    a. Treat obvious injuries.
    b. If the parent or guardian refuses to let you treat and/or transport the child, remain at the scene. Contact OLMC and request police assistance. Request that the officer place the child in protective custody and assist with transport.
    c. A law enforcement officer, physician or a designated Department of Children and Family Services (DCFS) employee may take or retain temporary protective custody of the child.

B. Suspected Abuse or Neglect of Adults Age 60 Older and People With Disabilities

1. Under the Illinois Adult Protective Services Act, all EMS personnel are considered "mandated reporters" and are therefore ***required*** to report cases of suspected abuse or neglect of adults age 60 or older or people with disabilities age 18-59, if they believe that the adult is not capable of reporting the abuse or neglect themselves. State law protects the confidentiality of reporters and any mandated reporter acting in good faith shall be granted immunity from civil liability. However, any mandated reporter who fails to report the suspected abuse or neglect may be subject to legal penalties.

2. Reporting of suspected abuse or neglect:

    a. To report suspected abuse, neglect, or financial exploitation of an adult age 60 or older or a person with disabilities age 18-59 **call the statewide, 24-hour Adult Protective Services Hotline: 1-866-800-1409.**
    b. For residents who live in nursing facilities, **call the Illinois Department of Public Health's Nursing Home Complaint Hotline: 1-800-252-4343.**
    c. For residents who live in Supportive Living Facilities (SLFs), **call the Illinois Department of Healthcare and Family Services' SLF Complaint Hotline: 1-800-226-0768.**

3. If there is reason to believe that an adult patient has been abused or neglected, EMS personnel shall make every reasonable effort to transport the patient. If transport is refused, request police assistance if indicated.

C. Suspected Domestic Violence or Abuse

1. EMS personnel and other mandated reporters are **not** required by law to report suspected cases of domestic violence or abuse to adult patients. However, under the Illinois Domestic Violence Act all EMS personnel are required by law to provide immediate and adequate information regarding services available to victims of suspected domestic violence or abuse.

    a. National Domestic Violence Hotline: 1-800-799-SAFE (https://www.thehotline.org/)
    b. Illinois Domestic Violence Hotline: 1-877-863-6338 (https://the-network.org/knowledge-center/#availableResources)
    c. Chicagoland Domestic Violence Hotline: 1-877-863-6338 (https://www.chicago.gov/city/en/depts/fss/provdrs/dom_violence/svcs/domestic_violencehelpline.html)

2. If there is a reason to believe a patient is a victim of domestic violence and/or abuse, the Paramedic/EMT shall make every reasonable effort to transport the patient. If transport is refused, request police assistance if indicated.

D. Human Trafficking

1. Recognize the key indicators of human trafficking which include:

    a. Does the person appear disconnected from family, friends, community organizations, or houses of worship?Has a child stopped attending school?
    b. Has the person had a sudden or dramatic change in behavior?
    c. Is a juvenile engaged in commercial sex acts?
    d. Is the person disoriented or confused, or showing signs of mental or physical abuse?
    e. Does the person have bruises in various stages of healing?
    f. Is the person fearful, timid, or submissive?
    g. Does the person show signs of having been denied food, water, sleep, or medical care?
    h. Is the person often in the company of someone to whom he or she defers? Or someone who seems to be in control of the situation, e.g., where they go or who they talk to?
    i. Does the person appear to be coached on what to say?
    j. Is the person living in unsuitable conditions?
    k. Does the person lack personal possessions and appear not to have a stable living situation?
    l. Does the person have freedom of movement? Can the person freely leave where they live? Are there unreasonable security measures?
2. Not all indicators listed above are present in every human trafficking situation, and the presence or absence of any of the indicators is not necessarily proof of human trafficking.

3. Reporting suspected human trafficking

    a. **Do not attempt to confront a suspected trafficker directly or alert a victim to your suspicions.** Your safety, as well as the victim's safety, is paramount.
    b. Contact local law enforcement directly or call the confidential tip line at:**1-866-DHS-2-ICE (1-866-347-2423)** to report suspicious criminal activity to the U.S. Immigration and Customs Enforcement (ICE) Homeland Security Investigations (HSI) Tip Line 24 hours a day, 7 days a week, every day of the year.
    c. **The National Human Trafficking Hotline (NHTH) number is 1-888-373-7888 or can be accessed by texting HELP or INFO to BeFree (233733).** The NHTH can help connect victims with service providers in the area and provides training, technical assistance, and other resources. The NHTH is a national, toll-free hotline available to answer calls from anywhere in the country, 24 hours a day, 7 days a week, every day of the year. The NHTH is not a law enforcement or immigration authority and is operated by a nongovernmental organization funded by the Federal government.

E. Documentation

1. EMS personnel shall report suspicions of abuse or neglect to the Emergency Department physician and/or charge nurse and/or police and document on the patient care report.

2. Clearly document history and physical findings, environmental surroundings, patient interaction with others on scene, and discrepancies in the history.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Restraints |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: August 1, 2018 |

# RESTRAINTS

I. Hard or soft restraints may be used only as a therapeutic measure to prevent a patient from causing physical harm to self or others. In no event shall restraints be utilized to punish or discipline a patient.

II. Procedure

A. At no point, should the EMS personnel place themselves in danger. Additional manpower or police backup should be requested as needed.

B. EMS personnel may initiate application of restraints when appropriate.

C. Document the reason for the initiation of restraints on the patient care report.

D. Apply restraints:

1. Necessary force (minimum required) can be applied to neutralize the amount of force exerted by the patient. All attempts should be made to avoid injury to the patient and EMS personnel.

2. The patient must never be restrained in prone position.

3. Full restraint requires the application of a restraint to each limb.

E. The patient must be observed constantly by a paramedic or EMT-B while restrained.

F. Document neurovascular status to all extremities after application and every 15 minutes thereafter.

G. Handcuffs are to be applied by police officers **ONLY**. When the transportation of a patient who is hand cuffed is required, the police officer who has the key to the handcuffs must remain with the patient at all times.

*Reference:*

*"Mental Health and Development Code", Illinois Revised Statue 1983, Chapter 91 1/2. Section 2-108; 2-109; and 2-201 (and its amendments).*

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Safe Transport of Children by EMS |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# SAFE TRANSPORT OF CHILDREN BY EMS

## I. PURPOSE

A. To define the safe transport of children by EMS personnel in a ground ambulance.

B. To prevent forward motion and possible ejection with a primary focus to secure the torso; and provide support for the head, neck, and spine of all children transported by ambulance.

## II. DEFINITIONS

A. Child Restraint System (CRS): Any device (including child safety seat, booster seat, or harness) that is designed for use in a motor vehicle to restrain, seat, or position children who weigh 65 pounds (30 kilograms) or less and are certified to the federal motor vehicle safety standard prescribed by the National Highway Traffic Safety Administration for child restraints.

B. Spinal Motion Restriction (SMR): Attempting to maintain the head, neck, and torso in anatomic alignment and independent from device use.

## III. POLICY

A. EMS provider agencies in the Region 11 Chicago EMS System that transport children should develop specific policies and procedures to address the methods, training (initial and continuing), and equipment to safely transport children.

B. There are specific considerations for varied situations when a child needs transport to a hospital including:

1. Uninjured and not ill
2. Ill or injured, but requiring no intensive interventions or monitoring
3. Requiring intensive interventions or monitoring
4. Requiring spinal motion restriction and/or lying flat
5. Multiple patients

C. No children should be transported unrestrained (such as held in arms or lap).

D. No children should be transported on the bench seat.

E. When the number of patients exceeds the ability to provide adequate care with existing EMS providers and ambulances, or to secure child patients as described in the following recommendations, EMS providers should request additional transportation resources that can respond in a timely manner.

## IV. **TRANSPORT SITUATIONS**

A. Uninjured and Not Ill

1. When EMS has an injured or ill parent, guardian, or caregiver who needs transportation to the hospital with uninjured and not ill children on scene – it is best to leave the child in the care of a responsible adult.

2. If the child needs to accompany the patient to the hospital, transport the child with appropriate child restraint system depending on the age and size of the child.

B. Injured or Ill

1. Requiring No Intensive Interventions or Monitoring

   a. Transport the child in a size-appropriate child restraint system secured appropriately on cot.

2. Requiring Intensive Interventions or Monitoring

   a. Transport the child in a size-appropriate child restraint system secured appropriately on cot.
   b. If the child's condition requires medical interventions, which requires the removal of some restraints, the restraints should be re-secured as quickly as possible as soon as the interventions are completed and it is medically feasible to do so.

3. Requiring Spinal Motion Restriction and/or Lying Flat

   a. Transport the child in a size-appropriate child restraint system secured appropriately on cot.
   b. Apply a pediatric cervical collar or use towel rolls to stabilize neck and torso movement.

C. Multiple Patients

1. If possible, for multiple patients, transport each as a single patient according to the guidance shown for the above transport situations.

2. For mother and newborn, transport the newborn in an approved size-appropriate child restraint system. The mother should be properly secured to the cot.

3. A child passenger, especially a newborn, must never be transported on an adult's lap. Newborns must always be transported in an appropriate child restraint system. Never allow anyone to hold a newborn during transport.

## V. CHILD RESTRAINT SYSTEMS

A. The device(s) should cover, at minimum, a weight range of between five (5) and 99 pounds (2.3 - 45 kg), ideally supporting the safest transport possible for all persons of any age or size.

B. Only the manufacturer's recommendations for the weight/size of the patient should be considered when selecting the appropriate device for the specific child being transported.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: SEMSV EMS Bus Program |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: August 15, 2024 |

# SEMSV (SPECIALIZED EMS VEHICLE) EMS BUS PROGRAM

## I. PURPOSE

A. To describe a SEMSV (Specialized EMS Vehicle) Program for an EMS Bus serving the City of Chicago and Region 11, as licensed under the University of Chicago - Chicago South EMS System, per IDPH regulations.

B. To ensure proper medical oversight of patient care and transportation for a SEMSV (Specialized EMS Vehicle) Program.

## II. DEFINITIONS

A. SEMSV**:** A "Specialized Emergency Medical Services Vehicle" (SEMSV) is a vehicle or conveyance that is not an ambulance as defined in the EMS Act, but is primarily intended to provide emergency care and transportation to ill or injured patients by means of air, water, or ground transportation.

B. SEMSV Program: A program operating within an EMS System, pursuant to a program plan, submitted to and certified by IDPH, using specialized emergency medical services vehicles to provide emergency care and transportation to ill or injured persons.

C. SEMSV/EMS System Medical Director: The physician who has the responsibility and authority for total management of the SEMSV Program, subject to the requirements of the EMS System of which the SEMSV Program is a part of.

D. EMS Bus: A vehicle with capacity to transport up to eleven patients secured supine on a litter or stretcher and six seats for accompanying EMS personnel, equipped with medication and supplies for patient care.

## III. POLICY

A. Per IDPH Administrative Code Section 515.920, *SEMSV Program Licensure Requirements for all Vehicles:*

1. The SEMSV should be available 24 hours per day, every day of the year except when service is committed to another medical response or unavailable due to maintenance requirements.

2. The SEMSV Program shall provide prehospital emergency services within its service area on a per-need basis without regard to the patient's ability to pay for the service.

3. The SEMSV Program shall be supervised and managed by a Medical Director, who shall be a physician with appropriate experience in EMS.

B. SEMSV Resource Description

1. The SEMSV EMS Bus is a Chicago Fire Department resource named “8-8-12”.

2. The SEMSV EMS Bus is maintained and operated by the Division of EMS Logistics, who is responsible for daily inventory and restocking of the medication, equipment, and supplies.

3. The SEMSV EMS Bus will be dispatched through the Office of Emergency Management and Communication (OEMC) for any large incident at the level of an EMS Plan 2 or above, or as requested by the Chicago Fire Department Incident Commander.

4. The SEMSV EMS Bus will be driven to the incident or planned event by personnel from the Division of EMS Logistics and remain with the bus while deployed.

5. The EMS Bus shall be operated by personnel with a valid Illinois Class B non-CDL (Commercial Driving License).

6. The SEMSV EMS Bus is a resource under the Mutual Aid Box Alarm System (MABAS) agreement.

C. SEMSV Utilization

1. Primary Utilization

   a. The SEMSV EMS Bus will primarily be utilized as a staged resource for planned special events.
   b. The SEMSV EMS Bus may be used for patient care or warming and cooling of individuals.

2. Secondary Utilization

   a. The SEMSV EMS Bus will secondarily be utilized as an additional resource for large incidents.
   b. The SEMSV EMS Bus should be utilized as a stationary patient care area near a casualty collection point.
   c. In the event of an incident beyond an EMS Plan 3, the SEMSV EMS Bus may be used for appropriate patient transport, as defined in this policy.

## IV. PRIMARY UTILIZATION – PLANNED SPECIAL EVENTS

A. Staffing

1. At a minimum, two paramedics will be assigned to the unit for patient care.

2. Additional EMS personnel may be assigned as needed.

B. Patient Flow

1. All individuals requesting or potentially needing medical evaluation or treatment are considered patients and require a full assessment and documentation on a patient care report.

2. If a patient that is initially evaluated on the SEMSV EMS Bus needs additional medical care or hospital transport, the EMS personnel on the SEMSV EMS Bus will request an ambulance and transfer patient care.

C. Medical Direction

1. The SEMSV shall be listed on the IDPH Special Event form for review by the EMS System.

2. Patient contacts should be assessed and treated, with the appropriate contact with Online Medical Control, per Region 11 Policy.

## V. SECONDARY UTILIZATION – LARGE INCIDENT RESPONSE

A. Staffing

1. At a minimum, two paramedics will be assigned to the unit for patient care.

2. As the incident evolves, additional EMS personnel may be added to maintain adequate patient staffing.

3. There will be one paramedic for every two yellow patients and one paramedic for every four green patients. Patients that are triaged red should be prioritized for treatment and transport by ambulance.

B. Patient Flow

1. The SEMSV EMS Bus may be staged near a casualty collection point for stationary patient care.

2. All patients should receive a primary triage based on the Region 11 Modified START/JumpSTART Triage Algorithm. Triage is a dynamic process and the initially assigned triage category may change subsequent to additional patient assessment.

   a. Red “Immediate”: Obvious threat to life or limb and requires immediate medical attention.
   b. Yellow “Delayed”: Condition in need of definitive medical care, but is not likely to decompensate rapidly if care is delayed, these patients may not be ambulatory.
   c. Green “Minimal”: Minor injuries and can tolerate extended delays in treatment without increasing the risk of mortality, these patients are ambulatory.
   d. Black “Deceased”: No respirations following basic airway maneuvers.

3. SMART triage tags should be used for patient identification and tracking.

4. Patients that have a primary triage category of green or yellow may be moved from the Casualty Collection Point (CCP) to the SEMSV EMS Bus. Patients that have a primary triage category of red will move from the CCP to an ambulance for transport.

5. Patients that enter the SEMSV EMS Bus can be assessed in seats or supine in litters.

6. Each patient should have a secondary triage with a complete assessment in the SEMSV EMS Bus.

7. Patients should be assessed for any Trauma Field Triage Criteria (per Trauma Patient Destination Policy).

8. Patients that meet any of the Region 11 Trauma Field Triage Criteria or on reassessment require an upgrade in care should be transferred to an ambulance for transport to the hospital.

9. Documentation of the initial vital signs, assessment, and interventions should be on SMART triage tags or verbally provided to another equal or higher level EMS provider if there is a transfer of patient care.

C. Transport Considerations

1. Trauma Patients should have the Trauma Field Triage Criteria applied (per policy) to identify critical patients requiring transport to a Level 1 Trauma Center.

   a. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged “Red” and be transported to the appropriate Level 1 Trauma Center.
   b. Patients that meet **Mechanism of Injury** or **High-Risk Populations** criteria should be triaged “Yellow” and be transported to the appropriate Level 1 Trauma Center.

2. Patients that meet Region 11 Trauma Field Triage Criteria should be transported by ambulance to Level 1 Trauma Centers.

3. In the event of an EMS Plan 3, the SEMSV EMS Bus may be used as a transportation resource for yellow or green tag patients that are ambulatory and do not meet Region 11 Trauma Field Triage Criteria, and require transportation to the closest appropriate hospital.

D. Medical Direction

1. The ranking EMS Chief on scene will determine the need to use the SEMSV EMS Bus as a transportation resource as per this policy.

2. The Command Hospital for the incident will be notified on the use of the EMS Bus by the EMS Chief or the EMS Communications Officer on scene.

3. The EMS Communications Officer or highest-ranking paramedic on the EMS Bus will provide a brief report of individual patient information including assessment findings, treatment provided, and triage category to the Command Hospital.

4. The Command Hospital, in consultation with the EMS Communications Officer or highest-ranking paramedic on the EMS Bus and/or the Regional Hospital Coordinating Center (RHCC) as indicated, will determine transport destination.

5. Patient distribution from the EMS Bus will optimally be divided between the two most appropriate hospitals for low acuity patients to not overwhelm one hospital.

6. The Command Hospital will provide an initial notification to the receiving hospital(s) regarding the SEMSV EMS Bus transport, including patient information and estimated time of arrival.

7. The highest-ranking transporting paramedic will provide the receiving hospital with a brief, updated pre-notification report of the patients transported to that facility, stating that the patients are from an EMS Plan response.

8. The highest-ranking transporting paramedic will contact the Command Hospital as required for any changes in patient condition during transport.

## VI. EQUIPMENT AND MEDICATIONS

A. Patient Stations: There are 11 individual patient stations which include:

1. Supine litter with two safety belts (10) or secured stretcher (1) with safety belts

2. Oxygen wall unit

3. Suction canister with tubing and catheters

4. Cardiac monitoring:

   a. Each station has an AED Pro with 4 lead cables
   b. Each unit with adult and pediatric pads

5. Vital sign assessment:

   a. Blood pressure cuff
   b. Stethoscope
   c. Pulse oximeter

B. Patient Assessment Area: There are 2 seats near the rear of the EMS Bus used for patient assessment and monitoring only and not for transport which include:

1. Oxygen wall unit
2. Suction canister with tubing and catheters
3. Cardiac monitor/defibrillator
4. Vital sign assessment

C. Equipment/Supplies

1. Quick Response Bags (QRB):

   a. Four adult bags
   b. Two pediatric bags

2. Large Traumatic Injury (TTI) Bag

3. Cabinets with additional supplies:

   a. Oxygen administration
   b. Hemorrhage control
   c. Splinting
   d. Cervical collars

D. Medications

1. Six complete medication boxes, per Region 11 ALS list.

2. Three secured boxes for controlled substances.

E. Conveyance Devices

1. Each litter is removable from the wall brackets.
2. One stretcher is secured inside the bus for conveyance of patients inside and out of the EMS Bus.

## VII. PATIENT TREATMENT PROTOCOLS AND POLICIES

A. Patient care on the SEMSV EMS Bus shall follow all Region 11 EMS Protocols, Policies, and Procedures as defined in this section.

B. Patient Age:

1. The SEMSV EMS Bus can treat patients of all ages.

2. Prior to transportation, all patients must be secured appropriately with safety belts.

C. Management of Multiple Patient Incidents (MPI) Policy

1. For large incidents, each patient should have a primary and secondary triage assessment performed and a triage tag applied.

2. **EMS Plan Response**: The number of patients exceeds routine operational capacity of a Multiple Patient Incident, wherein dispatch of additional resources is required to **provide normal levels of care and transportation**. This shall be used to prioritize the on-scene evaluation and treatment of multiple patients based on a primary triage category with the expectation that there is a subsequent complete assessment and patient care per Region 11 Protocols and Policies.

3. The SEMSV EMS Bus may be used as an additional transport vehicle resource for low acuity and ambulatory patients at an EMS Plan 3 or larger incident.

4. **Mass Casualty Incident**: The number of patients or type of situation has overwhelmed the operational ability of the provider, wherein the number of patients and nature of their injuries make the normal prehospital level of stabilization and care unachievable, and/or available resources are insufficient to manage the scene under normal operating procedures.

D. Trauma Patient Destination Policy

1. Patients shall have a full assessment performed prior to transport.

2. Patients transported on the SEMSV EMS Bus shall not meet any Region 11 Trauma Field Triage Criteria.

E. Conveyance of Patients Policy

1. Patients should be appropriately conveyed into the EMS Bus by stair chair or stretcher, up the ramp and into the rear door of the vehicle.

2. Patients should be carefully transferred to the litters, maintaining any spinal motion restriction as indicated.

3. Patients should be secured with safety belts prior to transport.

4. Paramedics should be seated with safety belts prior to transport.

F. Spinal Care Protocol and Spinal Motion Restriction (SMR) Procedure

1. Patients should be assessed for spinal injury as per Spinal Care Protocol.

2. Patients requiring spinal motion restriction should be secured to and transported to an ambulance stretcher or litter with cervical collar in place.

G. Controlled Substance Requirements Policy

1. Controlled substances will be stored at EMS Logistics.

2. On deployment of the SEMSV EMS Bus, the controlled substance box will be moved to a locked cabinet on the bus.

3. When the controlled substances are removed from the locked cabinet, the medications should always remain under the Paramedic's direct supervision.

H. Consent and Refusal of EMS Service Policy

1. Patients should be assessed for decision making capacity.

2. Refusals should be called into Online Medical Control, per regional policy.

I. Medical Records Documentation and Reporting Policy

A. An individual patient care report shall be completed for each patient that receives medical care from EMS personnel on the SEMSV EMS bus.

## VIII. TRAINING

A. EMS personnel will receive training on this Region 11 Policy and any corresponding Chicago Fire Department policy on the SEMSV EMS Bus 8-8-12.

B. Only personnel that have completed the training shall perform patient care on the SEMSV EMS Bus.

## IX. QUALITY ASSURANCE

A. Each deployment of the SEMSV EMS bus will be reviewed by the MARC Division, EMS Operations, and the SEMSV/EMS System Medical Director.

B. For every time the SEMSV EMS Bus is deployed, a QA/QI report will be completed post deployment and submitted to the EMS System and IDPH. The report will include the number of patients, patient symptoms, treatment provided, disposition, issues and resolutions, and identified opportunities for improvement and training.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: School Incidents with Minor Patients |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# SCHOOL INCIDENTS WITH MINOR PATIENTS

I. In situations of a report of suspicious illnesses (multiple ill or injured children, i.e., fumes, food poisoning) at a school facility, EMS personnel will assess and treat patients as follows:

A. **Category I:** Patients in facility with actual exposure and one or more children having complaints of illness and/or injury

1. Patients will be assessed and treated according to the Region 11 EMS Protocols with each individual having a completed patient care report.

2. Patients without complaints will be managed as in Category II.

B. **Category II**: Patients in facility with potential exposure/actual exposure and no complaints

1. Document on PCR.

2. The school representative will assume responsibility for the minor patients in absence of the parent/legal guardian and sign a refusal of transport.

C. **Category III**: Patients in facility with no direct exposure and/or complaints

1. Document on PCR.

2. The school representative will assume responsibility for the minor patients in absence of the parent/legal guardian and sign a refusal of transport.

II. In situations of a motor vehicle collision involving a school bus with children on board, EMS personnel will assess and treat patients as follows:

A. **Category I:** A significant mechanism of injury occurred where one or more children have injuries

1. Injured patients will be assessed and treated according to the Region 11 EMS Protocols with each individual having a completed patient care report.

2. Patients without injuries will be managed as in Category III.

B. **Category II:** No mechanism of injury exists that can be reasonably expected to cause significant injuries. There may be patients with minor injuries.

1. Injured patients will be assessed and treated according to Region 11 EMS Protocols with each individual having a completed patient care report.

2. Patients without complaints will be managed as in Category III.

C. **Category III:** No mechanism of injury exists that can be reasonably expected to cause injury and the patients have no complaints

1. Document on PCR.

2. The school representative and/or bus driver will assume responsibility for the minor patients in absence of the parent/legal guardian and sign a refusal of transport.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Termination of Resuscitation |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 1, 2022 |

# TERMINATION OF RESUSCITATION

I. Termination of Resuscitation may be considered in the following circumstances:

A. Adult (≥ 18 years of age) patient in cardiac arrest (unresponsive, pulseless, apneic)

1. Excludes traumatic arrest, possible hypothermia, and pregnant patients.

2. No other reversible cause of cardiac arrest identified.

3. No return of spontaneous circulation has been achieved after at least 20 minutes of prehospital resuscitation as per Cardiac Arrest Management (ICCA) Protocol – BLS/ALS.

B. Initial rhythm is asystole or pulseless electrical activity (PEA).

1. Confirmed in two different leads.

2. For patients in PEA, bradycardic rhythms with a wide QRS complex are more consistent with terminal cardiac rhythms. Faster, narrow QRS complex rhythms may indicate ROSC.

C. IV or IO access is established.

1. Epinephrine 1 mg IV every 5 minutes.

2. 3 total doses of Epinephrine have been administered.

D. Advanced airway established.

1. Supraglottic airway or endotracheal tube.

E. End Tidal CO2 (ETCO2) capnography attached with number and waveform reading.

1. ETCO2 values persistently less than 10 mmHg or decreasing (downward trend) of more than 25% despite resuscitation indicate a poor prognosis.

II. If all of the above criteria are met:

A. Contact Medical Control

B. Request termination of resuscitation from ECP or ECRN.

C. If order for termination approved, terminate resuscitation

D. If order for termination not approved, continue resuscitation or plan for transport as per

discussion with ECP or ECRN.

III. If the order for termination is approved and the deceased is in ***a home or private residence*:**

A. Notify family members of death and provide grief counseling as appropriate per Death Notification Procedure – BLS/ALS, using the GRIEV_ING method.

B. Contact Chicago Police Department (if not already present on scene).

C. Give relevant information to the police officer on scene.

D. Police will assume custody of body and arrange body aftercare with either the Cook County Medical Examiner or with the family and a private funeral home.

IV. If the order for termination is approved and the deceased is in ***a public place or unsafe scene, CPD should be called to take custody of the body.*** *In the rare circumstance where* transport is needed, transport the patient to the closest comprehensive emergency department. The base station should notify the receiving hospital that they are receiving a patient whose resuscitation was terminated in the field.

V. If the order for termination is approved and the deceased is ***in a healthcare facility*** (i.e. nursing home, hospice, rehabilitation hospital), no transport is required and body aftercare will be assumed by the facility.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Use of Latex-Free Supplies |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# USE OF LATEX-FREE SUPPLIES

## I. PURPOSE

To define use of latex-free supplies during EMS patient care.

## II. DEFINITIONS:

A. Latex: Refers to natural rubber latex, the product manufactured from a milky fluid derived from the rubber tree, *Hevea brasiliensis*.

B. Latex Allergy: A reaction to certain proteins in latex rubber.

## III. POLICY:

A. Many medical products or devices such as catheters, gloves, adhesive tape, and syringes are made of latex and can trigger an allergic reaction in sensitive individuals.

B. When possible, EMS should use latex free products including gloves.

C. Ask patients about latex allergy or check medical alert bracelets.

D. Latex allergy symptoms range from skin irritation to life-threatening anaphylaxis.

E. Treat latex allergy as per the Anaphylaxis and Allergic Reaction Protocol.

Reference: Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health (NIOSH), Latex Allergy A Prevention Guide, https://www.cdc.gov/niosh/docs/98-113/

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Watercraft SEMSV Program |
|---|---|
| | Section: Patient Care |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# WATERCRAFT SEMSV PROGRAM

## I. PURPOSE

A. To ensure safety for responders and patients during a water response.

## II. DEFINITIONS

A. SEMSV**:** A "Specialized Emergency Medical Services Vehicle" (SEMSV) is a vehicle or conveyance that is not an ambulance as defined in the EMS Act but is primarily intended to provide emergency care and transportation to ill or injured patients by means of air, water, or ground transportation.

B. Watercraft: A specialized vessel used by a Watercraft SEMSV Program for water-based emergency response and patient transport.

## III. POLICY

A. Watercraft SEMSV Programs operate as a licensed watercraft-based emergency response program under IDPH Administrative Code, Section 515.965, *Watercraft Requirements*.

B. Watercrafts shall meet requirements of Article IV of the Boat Registration and Safety Act.

C. Watercrafts are licensed by IDPH as Specialized Emergency Medical Services Vehicles (SEMSVs).

D. Watercrafts are maintained and operated by the EMS Agency, which is responsible for daily inventory, maintenance, and restocking of medical equipment and supplies.

E. Watercraft will be operated by a qualified Watercraft Operator and crewed by licensed EMS personnel, meeting IDPH staffing regulations.

F. Watercraft Operator and EMS crew will have all required Illinois licensing and certifications, including marine safety training as per IDPH Section 515.965.

G. Watercraft SEMSV Programs should have a map that defines service area of operations.

## IV. WATERCRAFT SEMSV PROGRAM

A. Staffing

1. The Watercraft SEMSV Program and EMS System should maintain a current roster of watercraft crew members including EMS license and required training.

2. All crew members assigned to a watercraft shall be approved by the EMS MD.

3. An ALS watercraft must have a minimum of one licensed Paramedic and one licensed EMT on each watercraft, in addition to the watercraft operator.

4. In an ALS watercraft response, the paramedic shall be the primary clinician responsible for patient care until handoff to another EMS crew.

B. Watercraft Activation

1. Requests for a watercraft response may come through multiple channels:

   a. Direct to the U.S. Coast Guard Marine Safety Station
   b. The International Hailing and Distress frequency (Channel 16)
   c. The Office of Emergency Management and Communication (OEMC)
   d. Direct civilian contact

2. All requests are routed through the OEMC for situational awareness and to ensure an appropriate level of response.

3. Watercraft may also self-dispatch to active emergencies observed while on patrol.

C. Patient Flow

1. An on-water watercraft response may have multiple agencies respond including:

   a. Chicago Fire Department (CFD)
   b. Chicago Police Department (CPD)
   c. United States Coast Guard (USCG)

2. On-water medical responses

   a. When a non-medical watercraft (CPD and USCG) responds to a medical incident, the on-board personnel shall consider a medical watercraft intercept of patients and/or personnel and equipment to a CFD watercraft to initiate emergency medical care versus an expeditious transport to shore.
   b. Considerations for requesting a medical watercraft response include:
      - Environmental conditions on Lake Michigan and other bodies of water;
      - Patient assessment and medical condition;
      - Maintaining responder and patient safety.

3. Transfer of patient care on land

   a. Watercraft personnel will transfer the patient safely to EMS personnel on land.
   b. Patient handoff should occur from the on-water response personnel to the paramedics on land.

D. Medical Direction

1. EMS personnel on the Watercraft SEMSV should contact Online Medical Control (OLMC) per the Field to Hospital Communication Policy.

## V. EQUIPMENT AND MEDICATIONS

A. Medications

1. Each ALS watercraft will carry medications, equipment, and supplies as defined on the Region 11 ALS non-transport list.

B. Additional Equipment/Supplies

1. Watercraft specific equipment per IDPH Section 515.970.

2. Additional equipment specific to watercrafts operating on Lake Michigan.

C. Communication Equipment

1. For contact of Online Medical Control through cellular phone.

2. For contact with law enforcement agencies.

3. For communication with dispatch center.

## VI. PATIENT TREATMENT PROTOCOLS AND POLICIES

A. Patient care on the watercraft follows Region 11 EMS Protocols, Policies, Procedures.

B. For on-water responses, conditions may limit the medical care provided in this environment, however it is expected that patient care begins at the point of contact and appropriate treatment is initiated, including ALS level care when indicated and safe.

## VII. EDUCATION AND TRAINING

A. Each watercraft crew member will complete a boat safety course conducted pursuant to Section 5-18 of the Boat Registration and Safety Act [625 ILCS 45].

B. Records of education or training completion should be maintained by the EMS Agency and by the EMS System

## VIII. QUALITY ASSURANCE

A. All patient care run reports are reviewed by the EMS System and the EMS Agency.

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## TRANSPORTATION

Burn Patient Destination
Cardiac Arrest Patient Destination
Critical Airway
Ebola Virus Disease – Viral Hemorrhagic Fever (EVD-VHF) Patient Destination
EMS Transport of Law Enforcement Dogs
EMS Transport of Service/Support Animals
Helicopter EMS (HEMS) Utilization
Hospital Diversion/Ambulance Bypass or Resource Limitation
Interfacility Transfer
Patient Destination
Pediatric Patient Destination
Perinatal (Obstetric/Neonatal) Patient Destination
Response to a System-Wide Crisis
Securing a Weapon Prior to Transport
STEMI Patient Destination
Stroke Patient Destination
Suspected COVID-19 Patient Triage and Transport
Systems of Care
Trauma Patient Destination
Ventricular Assist Device (VAD) Patient Destination
Veteran Patient Destination

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Burn Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: July 10, 2024 |

# BURN PATIENT DESTINATION

## I. PURPOSE

1. Identify patients with significant or complex burns and transport to a Burn Center.

2. Identify patients with burns and trauma and transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.

## II. DEFINITIONS

**Burn Center**: Hospitals that provide high quality patient care to burn patients from the time of injury through rehabilitation.

## III. BURN PATIENT DESTINATION CRITERIA

A. Patients with the following criteria should preferentially be transported to a Burn Center:

1. Thermal Burns
   a. Full thickness burns
   b. Partial thickness burns with Total Body Surface Area (TBSA) 10% or more
   c. Partial or full thickness burn involving the face, hands, genitalia, feet, perineum, or over any joints
   d. Patients with burns and other comorbidities (including pre-existing medical condition)
   e. Circumferential burns
2. Inhalation injury
3. Pediatric burns (age less than 16 years old)
4. Chemical injuries
5. Electrical injuries
   a. High voltage ( $\geq$ 1000 V) electrical injuries
   b. Lightning injury

B. Patients with the following criteria should be transported to most appropriate Level 1 Trauma Center:
   a. Patients with burns and concomitant traumatic injuries

C. For situations where there concern for an impending loss of the airway or worsening clinical condition, transport patient to the closest Emergency Department. Contact Online Medical Control (OLMC) as needed for destination questions.

## IV. HOSPITAL COMMUNICATION

A. Online Medical Control is required for all burn patients.

B. Document time of hospital notification.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Burn Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: July 10, 2024 |

# BURN CENTERS

John H. Stroger, Jr. Hospital of Cook County*****
Loyola University Medical Center
UChicago Medicine

***** Current status of Burn Capable

Updated: 11/14/23

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Cardiac Arrest Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 1, 2022 |

# CARDIAC ARREST PATIENT DESTINATION

I. Patients in cardiac arrest from a medical cause should have field resuscitation following the Cardiac Arrest Management (ICCA) Protocol – BLS/ALS.

II. OLMC contact should be made during ongoing resuscitation from the scene. The following options should be discussed with the ECP or ECRN:

A. Continue field resuscitation for a defined period/task achievement and re-contact base station.

B. Transport of patient with Return of Spontaneous Circulation (ROSC).

C. Transport of patient with ongoing resuscitation.

D. Termination of resuscitative efforts (age ≥ 18 years).

III. EMS Field providers and base station physicians should make every effort to achieve ROSC before transporting the patient to the hospital with ongoing resuscitation. This recognizes the fact that ongoing resuscitation in the back of a moving ambulance is sub-optimal.

IV. Termination of Resuscitation may be considered for all adult (non-traumatic) cardiac arrest patients with initial rhythms of either asystole or pulseless electrical activity (PEA) who do not respond to field resuscitative efforts (see Termination of Resuscitation Policy).

V. Patients with ROSC should be treated according to the Adult and Pediatric Post-ROSC Care Protocol - ALS.

VI. Adult patients with ROSC, or any adult patient where the decision is made to transport to the hospital with ongoing resuscitation (only after discussion with OLMC), should be transported to the closest STEMI Center (see STEMI Patient Destination Policy for a list of STEMI Centers).

VII. Pediatric patients with ROSC, or any patient where the decision is made to transport to the hospital with ongoing resuscitation (only after discussion with OLMC), should be transported to the closest EDAP certified emergency department (see Pediatric Patient Destination Policy for list of EDAP hospitals).

VIII. Pregnant patients greater than 20 weeks gestation or with a visibly gravid abdomen should be transported to the closest STEMI Center that is also a Level III Perinatal Center (see Perinatal (Obstetric/Neonatal) Patient Destination Policy for a list of Level III Perinatal Centers).

IX. Ventricular assist device (VAD) patients should only be transported to a VAD Center (see Ventricular Assist Device (VAD) Patient Destination Policy for a list of VAD Centers).

X. In the event that the closest STEMI Center, EDAP hospital, Level III Perinatal Center or VAD Center is on ALS bypass, the “T+5 minute” rule should be followed, i.e. if the transport time to

the next closest appropriate specialty center is greater than an additional 5 minutes, the patient should be transported to the appropriate specialty center on ALS bypass (see Hospital Diversion / Ambulance Bypass or Resource Limitation Policy).

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Critical Airway |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: January 6, 2014 |

# CRITICAL AIRWAY

I. All Region 11 Participating Hospitals collectively contribute to the safety of patients transported by EMS providers. In rare circumstances it may be necessary for EMS providers to require a Participating Hospital to assist in the emergency airway stabilization of patients being transported to another Participating Hospital.

II. **NON-TRAUMA AIRWAY POLICY (STEMI OR STROKE TRANSPORTS):**

A. In the event that a patient under EMS care cannot be intubated or effectively ventilated using either supraglottic airway or bag mask ventilation, the transporting ambulance may use discretion in revising the transport destination. In these rare "cannot ventilate" scenarios, the Paramedic should contact online medical control, to determine the closest appropriate facility for emergency airway stabilization and further care.

III. **TRAUMA AIRWAY POLICY:**

A. In the event a trauma patient cannot be ventilated effectively by EMS providers during transport to a Trauma Center, EMS providers should contact online medical control to determine if diverting to another non-trauma center hospital for airway assistance/stabilization is advised. Whenever possible, the transporting EMS providers/base station should notify the non-trauma center hospital of the need for trauma airway stabilization in advance of arrival.

B. In the event that a trauma patient is diverted to a non-trauma center for emergency airway stabilization, the transporting ambulance will remain with the patient and will continue the transport to the intended/closest trauma center upon stabilization of the airway by the participating non-trauma center hospital. The non-trauma center hospital should notify the receiving Trauma Center of the airway stabilization provided. The EMS providers must also re-contact the assigned Resource Hospital base station with an update to ensure that the receiving Trauma Center is also notified by the Resource Hospital of airway stabilization, transport delay, and revised ETA.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Ebola Virus Disease – Viral Hemorrhagic Fever (EVD-VHF) Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EBOLA VIRUS DISEASE – VIRAL HEMORRHAGIC FEVER (EVD-VHF) PATIENT DESTINATION

I. The Centers for Disease Control and Prevention (CDC) and the Chicago Department of Public Health (CDPH) issue specific guidance for screening, care and transport of patients who present with Ebola Viral Disease or Viral Hemorrhagic Fever (EVD-VHF) symptoms.

II. Patients who are considered "high risk" for EVD-VHF **MUST MEET THE FOLLOWING CRITERIA:**

A. Recent travel from a country with widespread EVD-VHF transmission, as noted by the CDC, IDPH and/or CDPH.

**AND**

B. At least one of the following symptoms:

1. Fever
2. Abdominal pain
3. Diarrhea
4. Vomiting
5. Unusual bleeding (from the eyes, nose, gums)
6. Muscle pain (myalgia)
7. Headache
8. Feeling weak or tired

III. Any patient who meets BOTH of the above criteria for a suspect EVD-VHF should be transported to a hospital designated as a "Specialized Pathogen Treatment Center (SPTC)" for confirmatory testing ONLY after the proper infection control precautions are established.

IV. For any patient with travel history and symptoms as above, EMS personnel should notify their EMS supervisor who will communicate with the Resource Hospital, RHCC, and CDPH to safely coordinate and plan transportation of the patient to a Specialized Pathogen Treatment Center.

V. **Proper PPE use and training is critical to protect EMS personnel and prevent the spread of infection. Refer to the EMS Guidelines for Infection Control Policy for specific details on PPE, patient care and transport considerations, and ambulance decontamination.**

VI. EMS personnel may directly contact the Base Station of the Specialized Pathogen Treatment Center with the positive screening criteria and pertinent patient information.

VII. Any invasive procedure (i.e. glucometer, IV start, advanced airway) should not be performed unless required for patient stabilization.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Transport of Law Enforcement Dogs |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS TRANSPORT OF LAW ENFORCEMENT DOGS

## I. DEFINITIONS

A. Law Enforcement Dog**:** A dog owned or used by a law enforcement department or agency in the course of the department or agency's work which includes the following:

1. Search and rescue dog
2. Service dog
3. Accelerant detection canine
4. Other dog that is in use by a county, municipal, or state law enforcement agency

B. Canine Handler: A professional who provides training and care for canines and is responsible for the dog during routine operations and when injured.

## II. EMS RESPONSIBILITIES

A. Law Enforcement Dogs

1. **EMS personnel should not attempt to handle or treat a conscious law enforcement dog without a trained canine handler or agency representative to assist with the animal.**
2. Ask the canine handler to apply the dog's muzzle if available.
3. Under normal conditions, agency or department canine handlers or supervisors have vehicles equipped to transport an ill or injured canine to an appropriate veterinary facility.
4. In the rare event this is not available, an EMT or Paramedic may transport a law enforcement dog that has been injured in the line of duty to a veterinary clinic or similar facility if there are no persons requiring medical attention or transport at that time.
5. **When transporting a law enforcement dog in an ambulance, the dog's handler, another canine handler, or a representative from the agency who owns the canine should accompany the canine during transport to the veterinary emergency facility.**
6. EMS personnel may provide basic level first aid and supportive care to an injured law enforcement dog. The provision of ALS care is not authorized and is not permitted unless the individual EMS provider is also appropriately licensed under the Illinois Veterinary Medicine and Surgery Practice Act (225 ILCS 115).

a. Oxygen and Ventilatory Support: If available, an appropriately sized facemask with oxygen may be applied for a canine with respiratory distress or apnea.
   i. Small canine mask: 3-5 liters
   ii. Large canine mask: 5-7 liters
b. Hemorrhage control: Apply direct pressure and pressure dressing as needed.

7. Each law enforcement department or agency should maintain a list of appropriate and available veterinary emergency facilities with agreements for canine care. Designated local veterinary facilities that will provide emergency treatment of injured law enforcement dogs include:

   a. Partner & Paws (560 Ogden Ave, Lisle, IL 60532)
   b. MedVet (3305 N. California, Chicago, IL 60618)
   c. Bloomingdale Animal Hospital (290 Glen Ellyn Road, Bloomingdale, IL 60108)
   d. Blue Pearl (1050 Bonaventure Dr. Elk Grove Village, IL 60007)

8. Following the transport of a law enforcement dog, EMS personnel should ensure proper and complete decontamination and sterilization of the interior of the ambulance or other EMS vehicle including stretchers, the patient compartment, and all contaminated medical equipment before returning to service.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMS Transport of Service and Support Animals |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS TRANSPORT OF SERVICE AND SUPPORT ANIMALS

## I. DEFINITIONS

A. ADA Requirements - Service Animals**:** The Department of Justice published revised final regulations implementing the Americans with Disabilities Act (ADA) in 2010 which contain updated requirements, including the 2010 Standards for Accessible Design.

B. Service Animal**:** Any dog that is individually trained to do work or perform tasks for the benefit of an individual with a disability, including a physical, sensory, psychiatric, intellectual, or other mental disability. Examples of service animal tasks include:

1. A person who uses a wheelchair may have a dog that is trained to retrieve objects for them.

2. A person with depression may have a dog that is trained to perform a task to remind them to take their medication.

3. A person with PTSD may have a dog that is trained to lick their hand to alert them to an oncoming panic attack.

4. A person who has epilepsy may have a dog that is trained to detect the onset of a seizure and then help the person remain safe during the seizure.

C. Support Animal**:** An emotional support animal is any animal that provides emotional support alleviating one or more symptoms or effects of a person's disability. Emotional support animals provide companionship, relieve loneliness, and sometimes help with depression, anxiety, and certain phobias, but do not have special training to perform tasks that assist people with disabilities. Emotional support animals are not limited to dogs.

## II. EMS RESPONSIBILITIES

### A. Service Animals

1. Under the Americans with Disabilities Act (ADA), if a person with a disability requires transportation in an ambulance, accommodations must be made to allow the service animal to accompany the patient to the hospital.

2. A service animal must be under the control of its handler. Under the ADA, service animals must be harnessed, leashed, or tethered, unless the individual's disability prevents using these devices or these devices interfere with the service animal's safe, effective performance of tasks. In that case, the individual must maintain control of the animal through voice, signal, or other effective controls.

3. When it is not obvious what service an animal provides, only limited inquiries are allowed. EMS Personnel may ask two questions:

   a. Is the dog a service animal required because of a disability?
   b. What work or task has the dog been trained to perform?

4. EMS Personnel cannot ask about the person's disability, require medical documentation, require a special identification card or training documentation for the dog, or ask that the dog demonstrate its ability to perform the work or task.

5. In addition to the provisions about service dogs, the Department of Justice's ADA regulations have a separate provision about miniature horses that have been individually trained to do work or perform tasks for people with disabilities and permitting these animals when reasonable.

6. EMS Personnel are not required to provide care for or supervision of a service animal.

**B. Support Animals**

1. Dogs whose sole function is to provide comfort or emotional support do not qualify as service animals under the ADA.

2. Support dogs have not been trained to perform a specific job or task and therefore do not qualify as service animals under the ADA.

3. There is no federal legal obligation to allow emotional support dogs to accompany a patient in the ambulance.

4. The decision to allow the patient and dog to remain together is based on the patient's need and ability to control the animal, as well as the crew's ability to transport the dog safely.

**C. Transport of Service and Support Animals**

1. EMS personnel should notify the receiving hospital that they are transporting a patient with a service or support animal.

2. Following the transport of a service or support animal, EMS personnel should ensure proper and complete decontamination and sterilization of the interior of the ambulance including stretchers, the patient compartment, and all contaminated medical equipment before returning to service.

**D. References**

1. US Department of Justice, Civil Rights Division: ADA Requirements: Service Animals | ADA.gov

2. Illinois Attorney General, Service Animals: Illinois Attorney General - Service Animals guide (state.il.us)

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Helicopter Emergency Medical Services (HEMS) Utilization |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# HELICOPTER EMERGENCY MEDICAL SERVICES (HEMS) UTILIZATION

## I. PURPOSE

A. To minimize loss of life and disability by ensuring timely air medical resources for Region 11.

B. To define the scope in which the Region 11 EMS System will use HEMS for emergency transport of critically injured patients.

C. To provide for safe and coordinated air medical operations with ground responders and hospital resources.

## II. POLICY

### A. Availability of HEMS

1. HEMS response shall be made available to critically injured persons in Region 11 whenever it is safe, appropriate, and necessary to optimize the care of the patient.

2. The pilot in command of the HEMS aircraft shall have the full authority to abort or decline response to any request for service when mechanical, geographic, weather, or flight conditions might endanger the crew or others.

### B. Authorization of HEMS service providers

1. All HEMS operators routinely offering service to or from hospitals located within Region 11 should follow local policies and protocols for patient transport.

2. The closest providers include UCAN (University of Chicago Aeromedical Network) and Lifestar Joliet.

### C. Medical Crew Requirements

1. All members of a HEMS medical flight crew must meet training requirements and continuing education as defined in the State of Illinois Administrative Code Section 515.940 “Aeromedical Crew Member Training Requirements.”

### D. Ground Crew Requirements

1. All providers operating in the vicinity of helicopters must be trained in helicopter safety operations.

2. Any scene requesting HEMS activation shall have an identified Incident Commander to coordinate the response.

**E. Patient Management**

1. Ground patient management should follow Region 11 policies and protocols until care is transferred to the flight crew.

2. Medical control for the flight crew members shall be supplied by the HEMS program's Medical Director.

3. Helicopters that do not have a medical flight crew should not transport patients outside of search and rescue operations.

**F. HEMS Aircraft Requirements**

1. All HEMS aircraft should follow State of Illinois Administrative Code in regards to licensure (515.900, 515.920), medical oversight requirements (515.930), vehicle specifications and operations (515.945), aircraft medical equipment and drugs (515.950).

2. EMS pilot specifications should be in accordance with section 515.935.

**G. Authorized Landing Sites**

1. HEMS aircrafts shall only land at landing sites meeting one of the following criteria:

    a. Heliports permitted by the Illinois Department of Transportation.
    b. Emergency helispots (landing zones) near the scene of a multi-casualty incident, disaster, or other critical incident. The Incident Commander (IC) shall designate appropriate landing zones at emergency scenes.

**H. Communication Policy**

1. HEMS should maintain the capacity to communicate with Landing Zone Operations, OLMC, and Receiving Hospital.

2. The designated CFD fire tactical frequency to be used to maintain contact with Landing Zone Operations during an incident will be Ops Channel 8.

    a. Ops Channel 8 is a simplex local tactical channel, which is limited to the proximity of the incident.

## III. PROCEDURE

### A. There are two field situations which may potentially require HEMS response:

1. Scene response with a critically injured patient (such as prolonged extrication). Activation criteria must include ALL of the following:

   a. Patient meeting Level 1 Trauma triage criteria.
   b. Estimated ground transport time > 25 minutes OR inaccessibility to ground transport.
   c. Anticipation that the transport time would pose additional risk to life or limb.

2. Multiple patient incident

   a. Situations involving multiple patients with severe trauma or burns where the closest receiving centers or local EMS resources are overwhelmed.

### B. Initiating HEMS Response

1. The ranking EMS Chief may activate HEMS for a scene response involving a critically injured patient meeting all activation criteria.

2. During a multiple patient incident, the Incident Commander is in charge of all emergency operations on scene. The decision to request EMS aircraft is based on both:

   a. The advice of on-scene ranking EMS Chief in consultation with the Resource Hospital or Regional Hospital Coordinating Center (RHCC); and
   b. The suitability of the scene for helicopter operations.

### C. Requesting HEMS

1. The ranking EMS Chief or Incident Commander on scene identifies the need for air medical transport.

2. The OEMC is contacted with the request for HEMS and provided with the scene information.

3. The OEMC will contact the HEMS agency with the response request.

4. EMS field crews shall not call for HEMS directly.

**D. Activation**

1. The primary air medical response will be the University of Chicago Aeromedical Network (UCAN).

2. If UCAN is unavailable, the UCAN communications center will immediately call Lifestar to determine their availability and connect the OEMC to their dispatch center.

3. The Incident Commander will be notified of the responding helicopter.

**E. Required HEMS Request Information**

1. The following information must be provided to the OEMC by the Incident Commander (IC) or designee:

   a. Location of incident: Intersection, landmarks, latitude/longitude
   b. Location of anticipated landing zone
   c. Ground contact and designated tactical frequency
   d. EMS Resource Hospital (medical control of scene)
   e. Brief (A MINI) patient report (if the situation permits) that includes the following:
      i. Age of patient(s)
      ii. Mechanism of injury
      iii. Injuries (known or suspected)
      iv. Neurological findings /vital signs
      v. Intervention (intubation, IVs, etc.)

**F. Mobilization**

1. HEMS will respond within a 15 minute call to arrival time interval. If a 15 minute ETA is not possible, the OEMC will be notified.

2. When HEMS is mobilized, the OEMC will notify the ground crew.

**G. Ground Crew Deployment**

1. For scenes requesting HEMS, the Incident Commander will determine and activate appropriate ground crew deployment.

2. The Incident Commander will coordinate the Landing Zone (LZ) support.

3. The Incident Commander or designee shall communicate with HEMS on Ops Channel 8 once in the proximity of the incident.

4. The ground crew should maintain the landing zone perimeter and not enter unless accompanied by the HEMS flight crew. After landing the helicopter, the HEMS crew

will bring their equipment and stretcher to the ambulance. EMS will provide a patient report and transfer the patient to the HEMS crew's equipment and stretcher

**H. Destination**

1. Determined by the HEMS crew as the closest appropriate trauma or specialty center that is capable of receiving helicopter transports.

2. The EMS aircraft will contact the receiving hospital with pertinent patient information.

**I. Air-to-Ground Communications**

1. The OEMC will contact the UCAN Communications center with HEMS request.

2. Landing zone operations to/from EMS aircraft will be by the designated tactical frequency (based on the proximity to the incident) identified by Incident Commander.

**J. Standby Request**

1. For field situations potentially needing HEMS activation, a ‘standby request’ can be made. This allows for early determination of aircraft availability, weather check, and a prompt response.

2. The OEMC or Ranking EMS Chief may place HEMS on standby.

**K. Quality Improvement**

1. Activation of HEMS is a sentinel event and the M.A.R.C. office will notify the Region 11 EMSMD Continuous Quality Improvement (CQI) Committee for case review.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Hospital Diversion / Ambulance Bypass or Resource Limitation |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# HOSPITAL DIVERSION/ AMBULANCE BYPASS OR RESOURCE LIMITATION

## I. BACKGROUND

A. Hospital diversion of ambulances (bypass) must be based on a significant resource limitation, disaster event, or active threat.

B. Each hospital should have a protocol that addresses peak census, surge, and hospital diversion/ambulance bypass and current status should be updated in EMResource.

C. The decision to go on diversion/bypass or resource limitation should be based on meeting the following criteria per IDPH:

1. Lack of an Essential Resource: All reasonable efforts to resolve the essential resource limitation have been exhausted including, but not limited to:

   a. Consideration for using appropriately monitored beds in other areas of the hospital;
   b. Limitation or cancellation of elective patient procedures and admissions to make available surge patient care space and redeploy clinical staff to surge patients;
   c. Actual and substantial efforts to call in appropriately trained off-duty staff; AND
   d. Urgent and priority efforts have been undertaken to restore existing diagnostic and/or interventional equipment or backup equipment and/or facilities to availability, including but not limited to seeking emergency repair from outside vendors if in house capability is not rapidly available.

D. Bypass status may NOT be deemed reasonable if hospitals in a geographic area are on peak census or bypass status or transport time by an ambulance to the nearest facility is identified to exceed 15 minutes.

E. When a hospital is on bypass, the next geographically closest hospital without a declared resource limitation/disaster will be considered the “closest” hospital for EMS transport destination.

F. In a situation where diverting an ALS patient adds 5 or more additional minutes of transport time to the closest hospital not on bypass, that patient may be transported to the closest hospital on ALS bypass, barring extenuating circumstances.

## II. MONITOR AND REVIEW

A. The hospital must constantly monitor to determine when the hospital diversion/ambulance bypass or Resource Limitation condition can be lifted. Such monitoring and decision making

shall include clinical and administrative personnel with adequate hospital authority. Efforts to address hospital issues using all available resources to resolve bypass as soon as such patients can be safely accommodated.

B. The Illinois Department of Public Health (IDPH) can remove or override a hospital's bypass status at any time.

C. IDPH shall investigate the circumstances that caused a hospital in an EMS System to go on bypass status to determine whether that hospital's decision to go on bypass status was reasonable.

D. Ambulance service providers will be responsible for assuring their EMS personnel are kept informed of existing hospital diversion/ambulance bypass and resource limitations in the EMS system.

E. Hospitals shall update their bypass status/resource limitation every 2 hours in the EMResource system and make every effort to manage resources efficiently. **If a hospital finds it necessary to stay on bypass for longer than 2 hours, the IDPH EMS Regional Coordinator must be contacted directly for review at 312-636-0241.**

## III. REASON/ELIGIBILITY FOR RESOURCE LIMITATION OR DIVERSION/BYPASS STATUS

A. **Resource Limitation**: Systems of care patients including Stroke and STEMI. This is not a bypass status, but a notification and request to the EMS System.

1. No available or monitored beds within traditional patient care and surge patient care areas with appropriate monitoring for patient needs;

2. Unavailability of trained staff appropriate for patient needs; or

3. No available essential diagnostic and/or intervention equipment or facilities essential for patient needs.

B. **ALS Bypass:** In determining whether a hospital's decision to go on bypass/resource limitation status is reasonable, the following should be considered:

1. The number of critical or monitored beds available in the hospital at the time that the decision to go on bypass status was made;

2. The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and

3. The approved hospital protocols for peak census, surge, and bypass at the time that the decision to go on bypass status was made.

4. Note that BLS transports are not diverted for ALS bypass

C. **Trauma Bypass: For Level 1 Trauma Centers or Level 1 Pediatric Trauma Centers**

1. No fully staffed operating rooms are available, and at least one or more of the current operative procedures is a trauma case;

2. The CT scan is not working; or

3. The general bypass criteria listed above.

D. **Bypass Override**: Can override the above for bypass

1. At the discretion of Online Medical Control, participating hospitals may still receive patients when on resource limitation or bypass. This may occur if it is determined that such a triage decision is in the best interest of a particular patient or the community at large. Situations that might (but do not automatically) warrant such a decision include:

   a. Life threatening situations requiring the patient to be transported to the closest hospital because the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility DO NOT outweigh the increased risks to the patient from the transport to a more distant facility.
   b. Incident requiring a multiple ambulance response (i.e., EMS Plans, Mass Casualty Events, etc.).

E. **Internal Disaster**

1. An internal disaster (including but not limited to fire, flood, power failure, active threat) has occurred in the hospital at the time that the decision to go on bypass status was made;

2. ALS and BLS transports are diverted.

3. Hospitals with a declared bypass status due to an internal disaster will not have their status over-ridden to accept any patient by EMS.

F. **System-Wide Crisis**

1. In the event of a system-wide crisis, refer to the Response to a System-Wide Crisis Policy and notify the Regional Hospital Coordinating Center (RHCC).

G. **Declared Local or State Disaster**

1. During a declared local or State disaster, hospitals may only go on bypass status if they have received prior approval from IDPH. Hospitals must complete or submit the following prior to seeking approval from IDPH for bypass status:

   a. EMResource must reflect current bed status;
   b. Peak census policy must have been implemented 3 hours prior to the bypass request;
   c. Hospital and staff surge plans must be implemented;
   d. The following hospital information shall be provided to IDPH:
      - Number of hours for in-patient holds waiting for bed assignment;
      - Longest number of hours wait time in emergency department;
      - Number of patients in waiting area waiting to be seen;
      - In-house open beds that are not able to be staffed;
      - Percent of beds occupied by in-patient holds;
      - Number of potential in-patient discharges;
      - Number of open ICU beds; and
      - Additional steps taken to address the challenges.
   e. The IDPH Regional EMS Coordinator will review the above information along with hospital status in the region and determine whether to approve bypass for 2 hours, 4 hours, or an appropriate length of time as determined by the IDPH Regional EMS Coordinator, or to deny the bypass request. A bypass request may be extended based on continued assessment of the situation, including status of surrounding hospitals, with the IDPH Regional EMS Coordinator and communication with the requesting hospital. A hospital may be denied bypass based on regional status or told to come off bypass if an additional hospital in the geographic area requests bypass.

## IV. NOTIFICATION PROCESS

A. Notification of Hospital Status Change: The hospital shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, of any bypass/resource limitation decision, at both the time of its initiation and the time of its termination, through status change updates entered into the Illinois EMResource application, accessed at https://emresource.juvare.com/login.

1. Submit status update through EMResource including initial, continuing or resolution of bypass/diversion status. This will alert IDPH and all Region 11 and surrounding region hospitals of the status change.

   a. If unable to access EMResource, contact your hospital EMResource administrator to address the issue.

2. Notify Chicago Office of Emergency Communications (OEMC)/911 Center.

3. Notify respective Resource Hospital Base Station (for Participating and Associate hospitals; Resource Hospitals notify geographical next closest Resource Hospital).

4. Alert private ambulance services that normally service the facility

5. Ambulance service providers will be responsible for assuring their EMS personnel are kept informed of existing resource limitations in the system.

6. If a hospital finds it necessary to stay on bypass for longer than 2 hours, the IDPH EMS Regional Coordinator must be contacted directly for review at 312-636-0241.

B. The hospital shall document any inability to access EMResource by contacting their Resource Hospital EMS Coordinator, Chicago Department of Public Health, and IDPH Division of EMS during normal business hours.

## V. IDPH SANCTIONS FOR HOSPITAL DIVERSION/AMBULANCE BYPASS

A. IDPH may impose sanctions upon determination that the hospital unreasonably went on bypass status in violation of the EMS Act as set forth in Section 3.140 of the Act, upon IDPH determination that the hospital unreasonably went on bypass status in violation of the EMS Act.

B. Reference: *IDPH EMS Administrative Code Section 515.315 Bypass or Resource Limitation Status Review*

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Interfacility Transfer |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# INTERFACILITY TRANSFER

## I. PURPOSE

To define the EMS responsibilities for patient transport in an interfacility transfer.

## II. DEFINITION

A. Interfacility Transfer: Any transfer, after initial assessment and stabilization, from and to a health care facility. Examples would include hospital to hospital; clinic to hospital; hospital to rehabilitation; and hospital to long-term care.

B. EMTALA (Emergency Medical Treatment and Labor Act): Federal law that requires hospitals with Emergency Departments to provide emergency medical care to everyone who needs it, regardless of ability to pay or insurance status and governs how patients may be transferred from one hospital to another.

## III. POLICY

### A. Patient Care

1. Federal legislation clearly requires the transferring facility and physician to be responsible for arranging the proper mode and level of transport with the appropriate level of EMS personnel.

2. In Region 11, EMS personnel must follow the EMS Protocols, Policies, and Procedures that are approved by the EMS Medical Director and are credentialed at their level of licensure.

3. Once patient care is initiated, EMS personnel are to maintain ongoing patient care until responsibility is assumed by equal or higher level personnel at the receiving facility.

### B. Scope of Practice

1. Interfacility transfers of patients that require medication or equipment outside of the defined Region 11 EMT or Paramedic EMS Scope of Practice Policy shall require appropriate facility staff to accompany the patient during transport.

2. Additional healthcare personnel assisting in the transport of a patient in an ambulance that are not employed by the EMS provider agency, including but not limited to a Registered Nurse, Physician or technician are acting under the responsibility and liability of the transferring facility.

### C. Level of Care

1. **BLS (Basic Life Support)** – Basic emergency care including oxygen, monitoring of

vital signs and saline lock.

2. **ALS (Advanced Life Support)** – Advanced emergency care including oxygen, monitoring of vital signs, intravenous fluids, intravenous medication including pain medications, cardiac rhythm monitoring, advanced airway management and capnography monitoring, advanced assessment and interpretation skills, cardiac arrest management.

3. **CCT (Critical Care Transport)** – Advanced scope of paramedic care including ventilator management, vasoactive and continuous infusion medication management, blood product management, chest tube management, central and arterial line management.

## D. Hospital Communication

1. Transports to the Emergency Department require a pre-notification call.

2. Online Medical Control must be contacted in the following circumstances:

   a. Acute deterioration in patient status enroute;
   b. Medical-legal issues needing immediate clarification;
   c. Concerns between transferring physician orders and established Region 11 Policies, Protocols and Procedures.

## E. Documentation

1. Follow the Medical Records Documentation and Reporting Policy for any patient care provided by EMS personnel.

2. When a transport team is involved and no patient care is provided by EMS personnel, a brief description of the reason for transport is required.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PATIENT DESTINATION

## I. PURPOSE

To define the destination of a patient and selection of the receiving facility.

## II. DEFINITION

A. Closest Appropriate Facility: Closest facility with the capability to care for that patient and in the patient's best interest which is based on Systems of Care criteria, established medical care, or patient preference.

## III. POLICY

### A. Determination of Patient Destination

1. In any emergency situation, the patient should be transported by ambulance to the closest appropriate facility, as defined in the EMS Act.

2. After patient assessment, EMS should determine the closest appropriate facility for transport based on the following:

    a. Patient meets criteria for hospital destination per Systems of Care Policy, including STEMI and Cardiac Arrest, Stroke, Trauma, VAD, Perinatal, and Pediatrics;
    b. Patient has established medical care at a facility to maintain continuity of care; and
    c. Patient preference

3. Patient preference and/or patient medical home may be taken into consideration if it does not conflict with Systems of Care criteria, if the patient is unstable, or if it is potentially detrimental to EMS system operations.

4. If the closest appropriate facility is on bypass or diversion status, EMS should follow the Hospital Diversion / Ambulance Bypass or Resource Limitation Policy.

5. Online Medical Control may be contacted for any questions or issues in determining the closest appropriate hospital.

6. If the patient/legal guardian refuses transport to the closest appropriate facility, EMS providers must follow these guidelines:

    a. Make sure the patient/legal guardian is notified of and understands the risks and benefits of their decision to be transported to a facility other than the closest appropriate facility.
    b. Document the patient/legal guardian's refusal of transport to the closest appropriate facility.
    c. If the patient requires additional emergency care, remain with the patient at the

scene until additional EMS providers are available to transport the patient.

d. The patient will be cared for at the highest level of care to meet their needs. The level of care is not downgraded due to the patient's refusal to be transported to the closest appropriate facility.

B. **Destination Facilities**

1. EMS may transport to EMS System approved locations including:

   a. Hospitals with Comprehensive Emergency Department services (see Participating Hospital Responsibilities Policy)
   b. Alternate destinations under pilot program status or as an interfacility transfer
      i. Licensed mental health facilities
      ii. Urgent or immediate care
   c. Other field treatment locations, as approved, for special events

2. Patient destination location should be documented on the patient care report.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Pediatric Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PEDIATRIC PATIENT DESTINATION

## I. PURPOSE

A. Identify pediatric patients with complex conditions that require transport to a designated Pediatric Critical Care Center (PCCC).

B. Identify pediatric patients with emergency conditions that require transport to a designated Emergency Department Approved for Pediatrics (EDAP).

C. For pediatric trauma criteria and Level 1 Pediatric Trauma Centers, refer to the Trauma Patient Destination Policy.

## II. PEDIATRIC CENTERS

### A. Pediatric Critical Care Center (PCCC)

1. Hospitals that have a pediatric intensive care unit (PICU) and can provide specialty inpatient services for the pediatric patient.

2. All PCCC level centers must also maintain EDAP status.

### B. Emergency Department Approved for Pediatrics (EDAP)

1. Hospitals that can provide comprehensive emergency services and meet pediatric emergency care requirements.

2. Pediatric emergency care requirements include appropriately trained staff, effective processes (policies, guidelines, training requirements, and quality improvement initiatives), and resources (medications, supplies, and equipment) to care for children who present to the emergency department (ED).

### C. Emergency Department Without Pediatric Designation

1. Hospitals that can stabilize and may transfer pediatric patients.

## III. PEDIATRIC DESTINATION CRITERIA

A. **Pediatric Critical Care Center (PCCC)**

1. Pediatric stroke

2. Other complex conditions that require specialty care in consultation with online medical control

B. **Emergency Department Approved for Pediatrics (EDAP)**

1. Pediatric cardiac arrest (preferentially PCCC)
2. Status epilepticus
3. Brief Resolved Unexplained Event (BRUE)
4. Abandoned newborn

C. **Emergency Department Without Pediatric Designation**

1. Low acuity conditions

## IV. HOSPITAL COMMUNICATION

A. All pediatric patient transports are considered Systems of Care patients and require contact with Online Medical Control.

B. When possible, preferential transport to the pediatric patient's medical home can facilitate timely and efficient care.

C. Region 11 Hospitals that are Base Stations with PCCC capabilities may be contacted preferentially for Online Medical Control including refusals.

1. Ann & Robert H. Lurie Children's Hospital of Chicago
2. UChicago Medicine Comer Children's Hospital

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Pediatric Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PEDIATRIC CENTERS

## PEDIATRIC CRITICAL CARE CENTER (PCCC)

Advocate Christ Medical Center
Advocate Lutheran General Hospital
Ann & Robert H. Lurie Children's Hospital of Chicago*
Loyola University Medical Center
Rush University Medical Center
UChicago Medicine Comer Children's Hospital*
UI Health

## EMERGENCY DEPARTMENT APPROVED FOR PEDIATRICS (EDAP)

Advocate Illinois Masonic Medical Center
Ascension Saint Joseph Hospital - Chicago
Endeavor Health Swedish Hospital
John H. Stroger, Jr. Hospital of Cook County*
Loyola MacNeal Hospital
Mount Sinai Hospital
Northwestern Memorial Hospital
OSF Little Company of Mary Medical Center
Prime Healthcare Saint Francis Hospital
Prime Healthcare Saint Mary of Nazareth Hospital
Saint Anthony Hospital
West Suburban Medical Center

The following Region 11 Emergency Departments are **NOT** designated by the Illinois Department of Public Health Emergency Medical Services for Children (EMSC) program as having the essential resources and capabilities in place to meet the emergency and critical care needs of seriously ill children:

Advocate Trinity Hospital
Prime Healthcare Resurrection Medical Center
Community First Medical Center
Holy Cross Hospital
Humboldt Park Health
Insight Hospital and Medical Center
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Administration Medical Center
Loretto Hospital
Provident Hospital of Cook County
Roseland Community Hospital
Saint Bernard Hospital & Health Care Center
South Shore Hospital
Thorek Memorial Hospital

***Region 11 Pediatric Level I Trauma Centers**

Updated 1/12/26

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Perinatal (Obstetric/Neonatal) Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# PERINATAL (OBSTETRIC/NEONATAL) PATIENT DESTINATION

## I. PURPOSE

1. Define a Perinatal Center as a hospital that provides high-quality maternal-fetal and neonatal care services.

2. Identify pregnant patients over 20 weeks through the immediate postpartum period (28 days after childbirth) and transport to the closest Level 2 or Level 3 Perinatal Center.

3. Evaluate pregnant patients for high-risk criteria and transport to a Level 3 Perinatal Center.

## II. PERINATAL CENTERS

A. Level 3 Perinatal Center: Hospitals designated by IDPH that provide care for pregnant patients and newborns of high risk that require complex care and operate a Neonatal Intensive Care Unit (NICU).

B. Level 2 Perinatal Center: Hospitals designated by IDPH that provide care to pregnant patients and newborns of moderate risk (32 weeks or more) and operate immediate care nurseries.

C. Level 0: Hospitals designated by IDPH with no obstetric services available.

## III. PERINATAL (OBSTETRIC/NEONATAL) PATIENT DESTINATION CRITERIA:

A. Level 3 Perinatal Center Criteria

1. Patients between 20-32 weeks gestation with any complaint.

2. Pregnant patients that are "high risk" category based on either of the following:
   a. Patients have been told they are high risk in the current pregnancy
   b. EMS judgement that the patient is high risk based on lack of prenatal care, abnormal vitals, or pregnancy complication.

3. Any prehospital delivery.

B. Level 2 Perinatal Center Criteria

1. None of the Level 3 criteria are met.

2. Patients are 32 weeks or more gestation with any complaint.

C. All other pregnant or postpartum patients

1. Less than 20 weeks estimated gestational age may be transported to the closest emergency department.

2. Patients within immediate postpartum period (28 days after childbirth) should be transported to a Perinatal Center.

## IV. HOSPITAL COMMUNICATION

A. All Perinatal patients including pregnant or post-partum woman and newborn patients with a prehospital delivery are considered Systems of Care patients and require contact with Online Medical Control.

B. When possible, transport to the patient's medical home to facilitate timely and efficient care after discussion with Online Medical Control.

Attachment 1: Perinatal Centers

Attachment 1

# PERINATAL CENTERS

## LEVEL 3 PERINATAL CENTERS

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Ascension Saint Joseph Hospital, Chicago
John H. Stroger, Jr. Hospital of Cook County
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
Rush University Medical Center
UChicago Medicine
UI Health

## LEVEL 2 PERINATAL CENTERS

Advocate Trinity Hospital
Prime Healthcare Resurrection Medical Center
Prime Healthcare Saint Mary of Nazareth Hospital
Endeavor Health Swedish Hospital
Humboldt Park Health
Loyola MacNeal Hospital
OSF Little Company of Mary Medical Center
Roseland Community Hospital
Saint Anthony Hospital

## NO OBSTETRIC SERVICES AVAILABLE

Ann & Robert H. Lurie Children's Hospital of Chicago
Prime Healthcare Saint Francis Hospital
Community First Medical Center
Edward Hines, Jr. Veterans Affairs Hospital
Holy Cross Hospital
Insight Hospital & Medical Center
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Affairs Medical Center
Loretto Hospital
Provident Hospital of Cook County
South Shore Hospital
St. Bernard Hospital
Thorek Memorial Hospital
West Suburban Medical Center

Updated: 8/25

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Response to a System-Wide Crisis |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# RESPONSE TO A SYSTEM-WIDE CRISIS

I. A variety of crises may occur that create intense demand for EMS and Emergency Department resources within the Region 11 Chicago EMS Systems. Such crises may include a mass casualty incident, a heat emergency, a respiratory infection surge or pandemic, or a terrorist act involving a nuclear, biological, chemical or industrial agent which overloads Emergency Department resources.

II. **When faced with an impending or actual system-wide crisis, the following procedure should be followed**:

A. Any EMS System participant suspecting or knowing of an event that could precipitate a system-wide crisis should contact the Resource Hospital. Awareness of a system-wide crisis may originate with any EMS system participant, including an ambulance service provider (e.g., mass casualty incident), EMS personnel (e.g., heat emergency), or a participating hospital (e.g., respiratory infection surge).

B. The Resource Hospital EMS Coordinator and EMS Medical Director will assess the information and seek confirmation prior to declaring a system-wide crisis.

C. Once a system-wide crisis is confirmed, the Resource Hospital will:

1. Notify the following:

a. Other EMS Coordinators and EMS Medical Directors in Region 11
b. Regional Hospital Coordinating Center (RHCC) Coordinator
c. The RHCC will notify IDPH
d. The RHCC will notify CDPH
e. Region 11 ambulance service providers, as indicated
f. The RHCC will notify adjacent RHCC Coordinators

2. Assure that participating hospitals within the EMS System are informed of the crisis, and request that steps be taken to avoid hospital diversion/ambulance bypass, and alert them to the possibility of having to mobilize additional staff and resources and/or implement internal surge plans.

3. Provide ongoing monitoring of the situation and assist with communication between the hospitals, ambulance service providers, and appropriate governmental agencies.

III. System-Wide Crisis Response Coordination

A. The Regional Hospital Coordinating Center (RHCC) serves as the lead entity responsible for coordinating health and medical emergency response in its region as part of the regional health care coalition.

B. Regional health care coalitions may also be involved, which are groups of hospitals, local health departments, and emergency management personnel that serve a pivotal role in assisting during a pandemic or disaster response and are a crucial resource to hospitals when they are experiencing surges or resource limitations.

C. The RHCC, in coordination with the regional health care coalition, may coordinate distribution of resources during a public health emergency to hospitals and health care providers.

D. The Resource Hospital EMS Coordinator, EMS Medical Director, and RHCC Coordinator, together with the OEMC and the CFD Deputy Fire Commissioner, will closely monitor the overall EMS System operational impact.

E. CFD may request the help of private ambulance service providers as well as activate additional staff and equipment.

IV. Syndromic Surveillance of Patients with Similar Symptoms

A. If a participating hospital is noting a trend of increased frequency of similar symptoms, including potential drug overdoses, the Resource Hospital EMS Coordinator or EMS Medical Director shall be notified.

B. The Resource Hospital EMS Coordinator and RHCC Coordinator will monitor the situation and, if necessary, notify IDPH, CDPH and ambulance service providers.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Securing A Weapon Prior To Transport |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# SECURING A WEAPON PRIOR TO TRANSPORT

## I. PURPOSE

1. To define the process for securing a weapon by licensed EMS personnel within Region 11.

2. To safely assess and provide medical care for individuals carrying a weapon or firearm.

## II. DEFINITIONS

A. Weapon**:** A firearm or other object that is designed or used for inflicting bodily harm or physical damage.

B. Firearm Concealed Carry Act**:** An Illinois law that allows individuals with a license to legally carry a firearm except in defined prohibited areas.

## III. EMS RESPONSIBILITIES

### A. Safety

1. If there is any concern of scene safety, EMS personnel should retreat to a safe zone and call for law enforcement.

2. EMS personnel should not attempt to unload or render the firearm safe; this is the responsibility of law enforcement.

### B. Securing the Firearm

1. Prior to transport, the individual should leave the firearm or weapon appropriately secured at home.

2. If this is not possible, law enforcement should be contacted to secure the firearm or weapon prior to transport.

3. If law enforcement is not immediately available, the firearm or weapon should ideally be secured in a locked location in the ambulance prior to transport.

### C. Hospital Communication

1. During the pre-notification call to the receiving hospital, the paramedic should state “I have a firearm (or weapon) secured on board” and ask to notify hospital security or the public safety team prior to arrival.

2. Upon arrival in the Emergency Department and after patient care is transferred, the weapon should be transferred to hospital security or the public safety team.

3. Under the Illinois Firearm Concealed Carry Act, a licensee may not knowingly carry a firearm into prohibited areas which include a public or private hospital or hospital affiliate, mental health facility, or nursing home.

## IV. LAW ENFORCEMENT OFFICERS

A. If assisting EMS with patient care in an ambulance, a law enforcement officer should maintain custody of their firearm.

B. If a law enforcement officer is the patient in an ambulance, another officer shall take custody of their firearm.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: STEMI Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: March 6, 2025 |

# STEMI PATIENT DESTINATION

## I. PURPOSE

A. Identify patients with suspected ST Elevation Myocardial Infarction (STEMI) or dysrhythmias that require transport to a STEMI Center.

B. Transport cardiac arrest patients with Return of Spontaneous Circulation (ROSC) or ongoing resuscitation to a STEMI Center.

## II. DEFINITIONS

A. STEMI Center: A hospital that provides percutaneous coronary intervention (PCI) and post-resuscitation services as designated by Region 11 EMS Medical Directors.

## III. STEMI CENTER DESTINATION CRITERIA

A. ST-Elevation Myocardial Infarction (STEMI) criteria on 12-lead ECG:

1. Computer interpretation of 12-lead is any of the following:

   a. ***STEMI***

   b. ***ACUTE MI***

2. Paramedic interpretation of 12-lead ECG as STEMI (ST elevation of 1 mm in at least two contiguous leads).

3. Base station ECP interpretation of transmitted 12-lead ECG as STEMI.

B. Suspected acute coronary syndrome without STEMI on ECG, that require the capabilities of a STEMI center based on Paramedic or Base Station judgement.

C. Cardiac Arrhythmias:

1. Wide complex tachycardia

2. Narrow complex tachycardia requiring synchronized cardioversion

3. Symptomatic bradycardia with high grade AV block (2nd or 3rd degree heart block)

4. Symptomatic bradycardia requiring transcutaneous pacing

D. Cardiac arrest patients with ROSC or if/when decision is made to transport to the hospital with ongoing resuscitation.

## IV. HOSPITAL COMMUNICATION

A. Online Medical Control contact is required for all patients meeting STEMI Center destination criteria.

1. Document time of hospital contact.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: STEMI Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: March 6, 2025 |

# STEMI CENTERS

## HOSPITAL NAME

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
Advocate Trinity Hospital
Ascension Saint Joseph Hospital - Chicago
Community First Medical Center
Endeavor Health Swedish Hospital
Humboldt Park Health
John H. Stroger, Jr. Hospital of Cook County
Loyola MacNeal Hospital
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
OSF Little Company of Mary Medical Center
Prime Healthcare Resurrection Medical Center
Prime Healthcare Saint Francis Hospital
Prime Healthcare Saint Mary of Nazareth Hospital
Rush University Medical Center
UChicago Medicine
UI Health
West Suburban Medical Center

Updated: 8/8/25

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Stroke Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: November 6, 2024 |

# STROKE PATIENT DESTINATION

## I. PURPOSE

A. Identify patients with symptoms of stroke based on a stroke screening scale (CPSS) and stroke severity scale (3I-SS).

B. Transport patients to a Primary Stroke Center (PSC), Thrombectomy Stroke Center (TSC), or Comprehensive Stroke Center (CSC) based on last known well time and stroke severity.

## II. STROKE CENTERS

A. Primary Stroke Center (PSC)**:** Ability to care for patients with acute ischemic stroke with intravenous thrombolytic therapy and inpatient care.

B. Thrombectomy Stroke Centers (TSC): Ability to concurrently provide endovascular therapy (EVT) for treatment of acute ischemic stroke associated large vessel occlusions including neurointerventional team, neurointensive care unit, advanced neuroimaging, and the ability to collect and review data on reperfusion therapy. There are three designations that hospital accrediting bodies may use under the Illinois state law.

1. Thrombectomy Capable Stroke Center
2. Thrombectomy Ready Stroke Center
3. Primary Plus Stroke Center

C. Comprehensive Stroke Center (CSC): Ability to provide complex treatments of other cerebrovascular disease including endovascular therapy.

## III. STROKE SCALES

### A. Cincinnati Prehospital Stroke Scale (CPSS) - Stroke Screening

**Facial Droop** - Have patient show teeth or smile
- Normal = Both sides of the face move equally
- Abnormal = One side of the face does not move at all

**Arm Drift** - Have patient close eyes and hold arms out for 10 seconds with palms up
- Normal = Both arms move equally or not at all
- Abnormal = One arm drifts compared to the other

**Speech** - Have patient say, “You can’t teach an old dog new tricks”
- Normal = Patient uses correct words with no slurring
- Abnormal = Slurred or inappropriate words or mute

**B. 3-Item Stroke Scale (3I-SS) - Stroke Severity**

*The 3I-SS is scored 0-6. Assign a score from 0 to 2 for each of the three parts of the assessment. Add each section for the total score.*

**Level of Consciousness (AVPU)**
0 = Alert
1 = Arousable to voice only
2 = Arousable to noxious stimuli only, or unresponsive

**Gaze Preference**
0 = Normal eye movements
1 = Prefers to look to one side, but can move eyes to both sides
2 = Eyes are fixed in one direction

**Motor Function**
0 = Normal strength in arms and legs
1 = Can lift arm or leg, but cannot hold arm/leg up for 10 seconds
2 = None or minimal movement of arm or leg

## IV. STROKE DESTINATION CRITERIA

A. Patients with stroke symptoms are screened with the Cincinnati Prehospital Stroke Scale (CPSS).

B. Patients with an abnormal CPSS or a suspected stroke will be assessed for stroke severity with the 3 Item Stroke Scale (3I-SS).

C. Patients with a 3I-SS score of 4 or more and have a last known well time of less than 24 hours OR an unknown last known well time shall be transported to the closest Thrombectomy Stroke Center (TSC) or Comprehensive Stroke Center (CSC)

D. Patients with a 3I-SS score of 3 or less shall be transported to the closest stroke center.

E. Patients with a 3I-SS score of 4 or more and a last known well time greater than 24 hours shall be transported to the closest stroke center.

## V. HOSPITAL COMMUNICATION

A. Online Medical Control contact is required for all suspected stroke patients.

B. Document time of hospital notification.

# STROKE CENTERS

## PRIMARY STROKE CENTERS (PSC)

Advocate Trinity Hospital
Ascension Saint Joseph Hospital - Chicago
Community First Medical Center
Endeavor Health Swedish Hospital
Holy Cross Hospital
Humboldt Park Health
Insight Hospital & Medical Center
John H. Stroger, Jr. Hospital of Cook County
Loyola MacNeal Hospital
Mount Sinai Hospital
OSF Little Company of Mary Medical Center
Prime Healthcare Saint Francis Hospital
Prime Healthcare Saint Mary of Nazareth Hospital
Saint Anthony Hospital
West Suburban Medical Center

## THROMBECTOMY STROKE CENTERS (TSC)

Advocate Illinois Masonic Medical Center

## COMPREHENSIVE STROKE CENTERS (CSC)

Advocate Christ Medical Center
Advocate Lutheran General Hospital
Loyola University Medical Center
Northwestern Memorial Hospital
Prime Healthcare Resurrection Medical Center
Rush University Medical Center
UChicago Medicine
UI Health

Updated: 8/8/25

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Suspected COVID-19 Patient Triage and Transport |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: April 3, 2020 |

# SUSPECTED COVID-19 PATIENT TRIAGE AND TRANSPORT

## I. PURPOSE

A. Identify patients that require emergency medical care and those that are appropriate for non-transport to a hospital during the COVID-19 pandemic in order to accomplish the following:

1. Provide EMS services to critically ill or high risk populations
2. Minimize disease transmission to the community
3. Protect first responders and healthcare personnel
4. Preserve healthcare system functioning when the system is overwhelmed
5. Ensure proper follow-up and education of patients that are not transported by EMS

## II. SUSPECTED COVID-19 TRIAGE AND TRANSPORT

A. COVID-19 should be suspected in patients with history of fever with symptoms of **viral syndrome illness** (cough, nasal/chest congestion, sore throat, body aches).

B. Follow “Suspected COVID-19 Protocol” for initial assessment and treatment.

C. Continue to treat the patient per Region 11 EMS System Protocol and Policies.

D. Triage the patient acuity based on the following established categories (see algorithm attachment)

1. “Red” (Immediate)
   a. Abnormal vital signs
   b. Presence of emergency condition
2. “Yellow” (Delayed)
   a. High risk due to age or comorbidities
   b. Unsafe home situation
3. “Green” (Minor)
   a. Minimal symptoms
   b. Requesting testing
   c. COVID-19 exposure
4. “Black” (Deceased)
   a. Cardiac arrest

b. Not covered on this algorithm

E. Evaluate each COVID-19 patient with a complete assessment including the following criteria:

1. **Age**:
   a. Adult patients are > 18 years old and included in the algorithm
   b. Pediatric patients are not covered on this algorithm

2. **Vital Signs (if YES to any triage "RED")**:
   a. Respiratory rate < 8 or > 24
   b. Oxygen saturation < 94%
   c. Heart rate > 110 bpm
   d. Systolic blood pressure < 100 or > 180 mmHg
   e. Temperature > 100.4 degrees F (if available)

3. **Emergency Condition (if YES to any triage "RED"):**
   a. Chest pain, other than mild with coughing
   b. Shortness of breath with activity
   c. Altered mental status
   d. Syncope
   e. Diaphoresis
   f. Cyanosis

4. **High Risk Factors (if YES to any triage "YELLOW")**:
   a. Age > 60 years old
   b. Diabetes
   c. Pregnant
   d. Chronic heart, lung, or kidney disease
   e. Immunocompromised

5. **Home Criteria (if <u>NO</u> to any triage "YELLOW"):**
   a. Appropriate caregivers are available if needed
   b. Patient has decision making capacity
   c. Patient consents to non-transport
   d. Access to food, water, and other necessities

F. Determine triage category and transport decision

1. Patients with vital sign abnormalities or emergency conditions should be triaged "Red" and transported to the closest Emergency Department with Pre-Notification.

2. Patients with significant risk factors or without appropriate home criteria should be triaged "Yellow" and transported to the closest Emergency Department with Pre-Notification.

3. For any situations where transport is indicated, but the patient refuses transport, consult Online Medical Control while on scene with the patient.

4. Patients that do not meet criteria for vital sign abnormalities, emergency conditions, or risk factors and do meet all of the home criteria should be triaged “Green” and are appropriate for non-transport.

G. Prior to non-transport, the following criteria are mandatory:

1. Online Medical Control is required

2. Follow-Up Plan Established
   a. Primary care provider follow-up available
   b. Referral to Community Health Center if no primary care provider
   c. Provided with CDPH COVID Information Line (312-746-4835)
   d. Instructions to seek medical care if symptoms worsen

3. COVID-19 Resource Packet provided
   a. COVID Educational forms from CDPH that may include and be updated (https://www.chicago.gov/city/en/sites/covid-19/home/resources.html)
      1. What to do if you have COVID-19?
      2. What to do if you have been exposed to someone with COVID-19?
      3. What to do if you have been diagnosed with COVID-19?
      4. What to do if you don’t have health insurance?
      5. Tips on managing anxiety about COVID-19?

4. Refusal form signed by patient

# Region 11 Chicago EMS Guidelines for Suspected COVID-19 Patient Triage and Transport

For adult patients with history of fever and symptoms of **viral syndrome illness** (cough, nasal/chest congestion, sore throat, body aches)

## VITAL SIGNS

- Respiratory rate < 8 or > 24
- Oxygen saturation < 94%
- Heart rate > 110 bpm
- Systolic blood pressure < 100 or > 180 mmHg
- Temperature > 100.4 °F (if available)

YES → **Transport to closest appropriate Emergency Department with Pre-Notification**

NO

## EMERGENCY CONDITION

- Chest pain, other than mild with coughing
- Shortness of breath with activity
- Altered mental status
- Syncope
- Diaphoresis
- Cyanosis

YES → **Transport to closest appropriate Emergency Department with Pre-Notification**

NO

## RISK FACTORS

- Age > 60 years old
- Diabetes
- Pregnant
- Chronic heart, lung, or kidney disease
- Immunocompromised

YES → **Transport to closest appropriate Emergency Department with Pre-Notification**

NO

## HOME CRITERIA

- Appropriate caregivers are available if needed
- Patient has decision making capacity
- Patient consents to non-transport
- Access to food, water, and other necessities

NO → **Transport to closest appropriate Emergency Department with Pre-Notification**

YES

**Patient is appropriate for non-transport**

**Online Medical Control is required**

**Follow-Up Plan Established**

**COVID Resource Packet Provided**

**For any situation where transport is indicated, but the patient refuses transport, consult Online Medical Control**

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Systems of Care |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# SYSTEMS OF CARE

## I. PURPOSE

A. To define the Systems of Care for patients transported by EMS to hospitals participating in the Region 11 Chicago EMS Systems.

B. To deliver the right resources to the right patient in the right place at the right time.

## II. DEFINITIONS

A. System of Care**:** Regionalized care for a patient with a time-critical or specialty condition from EMS assessment to definitive care at a designated hospital facility.

B. Designation: Recognition of a hospital facility to have the capability to provide specialty care services by a state or regional authority.

C. Destination Criteria**:** Defined criteria for EMS to identify patients that should be directly transported to a designated hospital as part of a System of Care.

## III. SYSTEMS OF CARE

A. The established Systems of Care with specialty hospital designations for Region 11 are listed below. Refer to each individual policy for specific patient destination criteria.

1. STEMI and Out of Hospital Cardiac Arrest (OHCA) Patient Destination

   a. STEMI Center

2. Stroke Patient Destination

   a. Primary Stroke Center (PSC)
   b. Thrombectomy Stroke Center (TSC)
   c. Comprehensive Stroke Center (CSC)

3. Trauma Patient Destination

   a. Level 1 Trauma Center
   b. Level 1 Pediatric Trauma Center

4. Burn Patient Destination

   a. Burn Center

5. Ventricular Assist Device (VAD) Patient Destination

   a. VAD Center

6. Perinatal (Obstetric/Neonatal) Patient Destination

   a. Level 3 Perinatal Hospital
   b. Level 2 Perinatal Hospital
   c. No obstetrical services (Level 0)

7. Pediatric Patient Destination

   a. Pediatric Critical Care Center (PCCC)
   b. Emergency Department Approved for Pediatrics (EDAP)
   c. Emergency Department without pediatric designation

## IV. OTHER PATIENT DESTINATION CONSIDERATIONS

A. Patients that self-identify as veterans can be transported to a Veterans Affairs Medical Center (VAMC) per policy.

B. Veteran patient transports are preferred for medical care coordination, but it is not a System of Care.

## V. FACILITY RECOGNITION

A. IDPH Administrative Code and relevant Subparts.

B. Additional accrediting organizations.

## VI. HOSPITAL COMMUNICATION

A. Online Medical Control contact is required for all Systems of Care patients.

B. Document time of hospital notification.

## VII. DOCUMENTATION

A. Documentation should include “Systems of Care” as a reason for the destination.

B. The hospital designation or capability should be documented as the reason for transport to that facility.

# REGION 11 EMS SYSTEMS OF CARE - HOSPITAL DESIGNATIONS

| Hospital | Burn | Pediatrics | Perinatal (Obstetric & Neonatal) | STEMI & Out of Hospital Cardiac Arrest (OHCA) | Stroke | Trauma | Ventricular Assist Device (VAD) |
|---|---|---|---|---|---|---|---|
| Advocate Christ Medical Center | | PCCC | Level 3 | STEMI Center | CSC | Level 1 | VAD Center |
| Advocate Illinois Masonic Medical Center | | EDAP | Level 3 | STEMI Center | TSC | Level 1 | |
| Advocate Lutheran General Hospital | | PCCC | Level 3 | STEMI Center | CSC | Level 1 | |
| Advocate Trinity Hospital | | | Level 2 | STEMI Center | PSC | | |
| Ann & Robert H. Lurie Children's Hospital of Chicago | | PCCC | NO OB SERVICES | | | Level 1 Pediatric | |
| Ascension Saint Joseph Hospital - Chicago | | EDAP | Level 3 | STEMI Center | PSC | | |
| Community First Medical Center | | | NO OB SERVICES | STEMI Center | PSC | | |
| Edward Hines, Jr. Veterans Affairs Hospital | | | NO OB SERVICES | | | | |
| Endeavor Health Swedish Hospital | | EDAP | Level 2 | STEMI Center | PSC | | |
| Holy Cross Hospital | | | NO OB SERVICES | | PSC | | |
| Humboldt Park Health | | | Level 2 | STEMI Center | PSC | | |
| Insight Hospital & Medical Center | | | NO OB SERVICES | | PSC | | |
| Jackson Park Hospital & Medical Center | | | NO OB SERVICES | | | | |
| Jesse Brown Veterans Affairs Medical Center | | | NO OB SERVICES | | | | |
| John H. Stroger, Jr. Hospital of Cook County | Burn Capable | EDAP | Level 3 | STEMI Center | PSC | Level 1<br>Level 1 Pediatric | |
| Loretto Hospital | | | NO OB SERVICES | | | | |
| Loyola MacNeal Hospital | | EDAP | Level 2 | STEMI Center | PSC | | |
| Loyola University Medical Center | Burn Center | PCCC | Level 3 | STEMI Center | CSC | Level 1 | VAD Center |
| Mount Sinai Hospital | | EDAP | Level 3 | STEMI Center | PSC | Level 1 | |
| Northwestern Memorial Hospital | | EDAP | Level 3 | STEMI Center | CSC | Level 1 | VAD Center |
| OSF Little Company of Mary Medical Center | | EDAP | Level 2 | STEMI Center | PSC | | |
| Prime Healthcare Resurrection Medical Center | | | Level 2 | STEMI Center | CSC | | |
| Prime Healthcare Saint Francis Hospital | | EDAP | NO OB SERVICES | STEMI Center | PSC | Level 1 | |
| Prime Healthcare Saint Mary of Nazareth Hospital | | EDAP | Level 2 | STEMI Center | PSC | | |
| Provident Hospital of Cook County | | | NO OB SERVICES | | | | |
| Roseland Community Hospital | | | Level 2 | | | | |
| Rush University Medical Center | | PCCC | Level 3 | STEMI Center | CSC | | VAD Center |
| Saint Anthony Hospital | | EDAP | Level 2 | | PSC | | |
| South Shore Hospital | | | NO OB SERVICES | | | | |
| St. Bernard Hospital & Health Care Center | | | NO OB SERVICES | | | | |
| Thorek Memorial Hospital | | | NO OB SERVICES | | | | |
| UChicago Medicine | Burn Center | | Level 3 | STEMI Center | CSC | Level 1 | VAD Center |
| UChicago Medicine Comer Children's Hospital | | PCCC | Level 3 | | | Level I Pediatric | |
| UI Health | | PCCC | Level 3 | STEMI Center | CSC | | |
| West Suburban Medical Center | | EDAP | NO OB SERVICES | STEMI Center | PSC | | |

PCCC: Pediatric Critical Care Center
EDAP: Emergency Department Approved for Pediatrics

CSC: Comprehensive Stroke Center
TSC: Thrombectomy Stroke Center
PSC: Primary Stroke Center

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Trauma Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: July 10, 2024 |

# TRAUMA PATIENT DESTINATION

## I. PURPOSE

A. Identify patients with significant injury based on the Region 11 Trauma Field Triage Criteria:

1. Injury Patterns
2. Mental Status & Vital signs
3. Mechanism of Injury
4. High-Risk Populations

B. Patients meeting any criteria in the four categories will be transported to the appropriate Level 1 Trauma Center or Level 1 Pediatric Trauma Center.

## II. TRAUMA CENTERS

A. Level I Trauma Center – A hospital participating in an approved Emergency Medical Services System and designated by the Illinois Department of Public Health to provide optimal care to all trauma patients. Level 1 Trauma Centers provide all essential services in-house, 24 hours a day.

B. Level 1 Pediatric Trauma Center - A hospital participating in an approved Emergency Medical Services System and designated by the Illinois Department of Public Health to provide optimal care to pediatric trauma patients. Level 1 Pediatric Trauma centers provide all essential **pediatric specialty services** in-house, 24 hours a day.

## III. TRAUMA DESTINATION

A. Adult patients: Region 11 EMS defines the adult trauma patient as an injured person aged 16 years and older. Adult patients meeting any trauma criteria using the trauma field triage decision algorithm should be transported to the closest Level I Trauma Center.

B. Pediatric patients: Region 11 EMS defines the pediatric trauma patient as an injured person aged 15 years or less. Pediatric patients meeting trauma criteria using the trauma field triage decision algorithm should be **preferentially** transported to the closest Level I Pediatric Trauma Center.

## IV. MULTIPLE PATIENT INCIDENT (MPI) EVENTS

A. During a MPI (Multiple Patient Incident) injured patients should have the Trauma Field Triage Criteria applied to identify critical patients requiring transport to a Level 1 Trauma Center or Level 1 Pediatric Trauma Center.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Trauma Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: July 10, 2024 |

1. Patients that meet **Injury Pattern** or **Mental Status & Vital Signs** criteria should be triaged “Red” and be transported to the appropriate Level 1 Trauma Center.

2. Patients that meet **Mechanism of Injury** or **High Risk Populations** criteria should be triaged “Yellow” and be transported to the appropriate Level 1 Trauma Center.

Attachments:
1. Region 11 Trauma Field Triage Criteria
2. Trauma Centers

# REGION 11 TRAUMA FIELD TRIAGE CRITERIA

**Patients meeting any criteria will be transported to the closest appropriate Level I Trauma Center**

## Injury Patterns

- Penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee
- Skull deformity, suspected skull fracture
- Suspected spinal injury with new motor or sensory loss
- Chest wall instability, deformity, or suspected flail chest
- Suspected pelvic fracture
- Suspected fracture of two or more proximal long bones
- Crushed, degloved, mangled, or pulseless extremity
- Amputation proximal to wrist or ankle
- Active bleeding requiring a tourniquet or wound packing with continuous pressure

## Mental Status & Vital Signs

**All Patients**
- Unable to follow commands (motor GCS < 6)
- RR < 10 or > 29 breaths/min
- Respiratory distress or need for respiratory support
- Room-air pulse oximetry < 90%

**Age 0-9 Years**
- SBP < 70mm Hg + (2 x age in years)

**Age 10-64 Years**
- SBP < 100 mmHg or
- HR > SBP

**Age ≥ 65 Years**
- SBP < 110 mmHg or
- HR > SBP

**Patients meeting these criteria are categorized as "Red"**

## Mechanism of Injury

- High-Risk Auto Crash
  - – Partial or complete ejection
  - – Significant intrusion (including roof)
    - > 12 inches occupant site OR
    - > 18 inches any site OR
    - Need for extrication of entrapped patient
  - – Death in passenger compartment
  - – Child (age 0-9 years) unrestrained or in unsecured child safety seat
  - – Vehicle telemetry data consistent with severe injury
- Rider separated from transport vehicle with significant impact (e.g., motorcycle, electric powered device, ATV, horse, etc.)
- Pedestrian/bicycle rider thrown, run over, or with significant impact
- Hanging/Strangulation
- Fall from height > 10 feet (all ages)

## High Risk Populations

**Children**
- All children ≤ 15 years meeting criteria for transport to a Trauma Center should go to a Level I Pediatric Trauma Center
- Low level falls (age ≤ 5 years) with significant head impact or obvious injury
- Suspicion of traumatic injury secondary to child abuse

**Older Adults (Age ≥ 65 Years)**
- Low level falls with significant head impact or obvious injury

**Other**
- Anticoagulant use or bleeding disorder with significant head impact or obvious injury
- Burns in conjunction with trauma
- Pregnancy > 20 weeks should be preferentially transported to a Level I Trauma Center with Level III Perinatal Center capabilities
- EMS or base station judgement

**Patients meeting these criteria are categorized as "Yellow"**

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Trauma Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: July 10, 2024 |

Attachment 2

# TRAUMA CENTERS

**(Pediatric patients are defined as less than 16 years old)**

I. **Level I Trauma Centers**:

Advocate Christ Medical Center
Advocate Illinois Masonic Medical Center
Advocate Lutheran General Hospital
John H. Stroger Hospital of Cook County
Loyola University Medical Center
Mount Sinai Hospital
Northwestern Memorial Hospital
Prime Healthcare Saint Francis Hospital
UChicago Medicine

II. **Level I Pediatric Trauma Centers:**

Ann & Robert H. Lurie Children's Hospital of Chicago
John H. Stroger Hospital of Cook County
UChicago Medicine - Comer Children's Hospital

Updated: 3/6/25

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Ventricular Assist Device (VAD) Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: February 24, 2020 |

# VENTRICULAR ASSIST DEVICE (VAD) PATIENT DESTINATION

I. Patients with a Ventricular Assist Device experiencing VAD-related complications or cardiovascular problems should be transported to a VAD center.

II. Patients with a VAD and a non-cardiovascular-related problem should still preferentially be transported to a VAD center if less than 25 minutes transport time.

III. When possible, patients should be transported to the center that placed the VAD (if less than 25 minutes transport time).

IV. Bring all VAD equipment to the hospital.

V. Follow the Ventricular Assist Device protocol when caring for VAD patients.

## VAD CENTERS

**As of February 24, 2020**

Advocate Christ Medical Center
Loyola University Medical Center
Northwestern Memorial Hospital
Rush University Medical Center
UChicago Medicine

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Veteran Patient Destination |
|---|---|
| | Section: Transportation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# VETERAN PATIENT DESTINATION

## I. PURPOSE

To define the transport of patients that self-identify as veterans to facilities in the Veterans Affairs Healthcare System that participate in the EMS System.

## II. DEFINITIONS

A. Veteran: A person who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable.

## III. POLICY

A. Patients who are military veterans may request to obtain their medical care at facilities within the Veterans Affairs (VA) Healthcare System.

B. Veterans should self-identify their status; no further confirmation is necessary by EMS personnel.

C. There are two facilities under the Veterans Affairs Healthcare System that are Participating Hospitals in Region 11 Chicago EMS:

1. Jesse Brown Department of Veterans Affairs Medical Center

2. Edward Hines, Jr. Veterans Affairs Hospital

D. Both of these facilities are licensed as Comprehensive Emergency Departments under IDPH.

E. Patients that meet criteria set forth in the Systems of Care Policy **should not be** transported to a Veterans Affairs Healthcare facility.

F. Additional determination of the veteran patient destination should be according to the Patient Destination Policy.

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## DOCUMENTATION

Medical Records Documentation and Reporting
Patient Confidentiality and Release of Information/Health Insurance Portability and Accountability Act (HIPAA)

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Medical Records Documentation and Reporting |
|---|---|
| | Section: Documentation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# MEDICAL RECORDS DOCUMENTATION AND REPORTING

## I. PURPOSE

To define the minimum data elements and reporting requirements for medical records documentation of an EMS patient care report.

## II. DEFINITIONS

A. NEMSIS (National EMS Information System): The National EMS Information System or NEMSIS is a national system to collect, store, and share EMS data in the United States. NEMSIS develops and maintains a national standard for how patient care information resulting from prehospital EMS activations is documented.

B. Illinois Prehospital Data Program: Required electronic data file information about the EMS incident (reason for call, scene location, outcome, etc.), provider/unit/crew member identifiers, unit utilization descriptors (e.g., times and locations), patient information (limited demographics, injury/illness characterization, assessment results), and treatment details (medications, procedures) submitted to the state of Illinois database and exported to NEMSIS.

## III. POLICY

### A. Data Collection and Submission

1. EMS personnel on Illinois licensed transport vehicle service provider agencies shall complete and provide an electronic or paper patient care report (PCR) to the receiving facility at the time of transport for every interfacility transport and prehospital emergency call, regardless of the ultimate outcome or disposition of the call.

2. The PCR shall be submitted to the receiving hospital emergency department or health care facility **before leaving the facility.**

3. The EMS System shall designate or approve the patient care report to be used by all of its transport vehicle providers. The report shall contain the minimum requirements as defined by the Illinois Prehospital Data Program and NEMSIS.

4. Region 11 approved short patient care forms must include at minimum the following data elements:

   a. Name of patient
   b. Age
   c. Vital Signs
   d. Chief complaint
   e. List of current medications
   f. List of allergies
   g. All treatment and interventions
   h. Date
   i. Time

5. EMS personnel on non-transport vehicles and non-transport EMS units shall document all medical care provided and shall submit the documentation electronically at the end of the incident. The EMS System shall have access to the documentation of all medical care provided by non-transport vehicles and provide a report to IDPH upon request.

6. Patient Care Data Reporting

   a. Transport vehicle providers shall submit patient care report data to the EMS System.
   b. When an EMS System is unable to import data from one or more providers, those providers may, with EMS System approval, submit their patient care report data directly to IDPH.
   c. IDPH will make the patient care report data available to the EMS System upon request.
   d. Every EMS System and EMS provider approved to submit data directly shall electronically submit all patient care report data to IDPH by the 15th day of each month.
   e. The monthly report shall contain the previous month's patient care report data and shall be submitted to IDPH no later than the 15th of the following month.
   f. IDPH shall make information about the data errors available to data submitters within one day or receipt of each patient's care report submissions.
   g. Data submitters shall correct all data errors within 14 days of original data submission date.

**B. Documentation Requirements**

1. The patient care report is an **OFFICIAL LEGAL DOCUMENT** and must be reviewed and signed by all EMS personnel participating in the care of the patient.

2. All assessments, procedures, and medications must be documented in the patient care report.

3. Cardiac rhythm and capnography monitoring data shall be uploaded to the electronic patient care report when the monitor is applied to the patient including, but not limited to, the following situations: cardiac arrest, STEMI, 12 lead ECG, advanced airway, cardioversion, defibrillation, and pacing.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Patient Confidentiality and Release of Information / Health Insurance Portability and Accountability Act (HIPAA) |
|---|---|
| | Section: Documentation |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PATIENT CONFIDENTIALITY AND RELEASE OF INFORMATION / HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

## I. DEFINITIONS

A. HIPAA Law: Emergency Medical Services (EMS) follows the Health Insurance Portability and Accountability Act (HIPAA) of 1996 Privacy Rule. The HIPAA Privacy Rule standards address the use and disclosure of individuals' health information, also known as “protected health information”, by organizations subject to the Privacy Rule, who are also be referred to as "covered entities," as well as standards for individuals' privacy rights to understand and control how their health information is used.

B. Protected Health Information (PHI): The HIPAA Privacy Rule protects all "individually identifiable health information" held or transmitted by a covered entity or its business associate, in any form or media, whether electronic, paper, or oral. The HIPAA Privacy Rule calls this information "protected health information (PHI").

C. Individually Identifiable Health Information: Information, including demographic data, that relates to:

1. The individual's past, present or future physical or mental health or condition;

2. The provision of healthcare services to the individual;

3. The past, present, or future payment for the provision of health care to the individual; and

4. Information that identifies the individual OR for which there is a reasonable basis to believe that it can be used to identify the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birth date, Social Security Number).

## II. DISCLOSURE OF PHI UNDER THE HIPAA PRIVAVCY RULE

A. When participating in treatment, payment, or operations activities, EMS providers may use or disclose PHI that is necessary to conduct those activities without patient authorization. EMS providers should use or disclose only the minimum amount of PHI necessary to accomplish the required task.

B. The HIPAA Privacy Rule generally does not apply to law enforcement officers, so they cannot violate HIPAA. Necessary PHI can generally be released to law enforcement when

related to a crime or where required by state law. EMS agency policies regarding this should be followed.

III. **SAFEGUARDING EMS PATIENT CONFIDENTIALITY**

A. The confidentiality of information pertaining to a patient must be safeguarded by all EMS system participants, per the law and in compliance with hospital and/or ambulance service provider policy at all times.

B. The confidentiality of patient record information should include, but not be limited to, the names of the patients and their medical status.

C. The patient may request, in writing, a copy of the patient care report through the respective ambulance service provider. Receiving hospitals shall not turn over a copy of the ambulance run report to the patient or a patient's family member.

D. Copies of prehospital audio records, log sheets, and patient care reports must be provided by system participants to the Resource Hospital on request.

E. During a multiple patient incident or multiple patient transport, confidentiality must be maintained when collecting individual patient information.

Reference: U.S. Department of Health and Human Services, Summary of the HIPAA Privacy Rule, https://www.hhs.gov/hipaa/for-professionals/privacy/laws-regulations/index.html

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## EMS EDUCATION

EMS Competency Testing
EMS Continuing Education (CE) Relicensure Requirements
EMS Lead Instructor
EMT Continuing Education
Paramedic Continuing Education
EMT Initial Education Programs
Paramedic Initial Education Programs
EMT and Paramedic Licensure
EMT and Paramedic Testing

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Competency Testing |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# EMS COMPETENCY TESTING

## I. REQUIREMENTS

A. Region 11 EMS providers will complete EMS education and skill testing as required by the EMS Medical Director's Consortium.

B. Successful completion of EMS Competency Testing is a minimum score of 75 percent.

## II. CONTENT OF EMS COMPETENCY TESTING

A. Written questions will be focused on Region 11 EMS System Protocols, Policies, and Procedures with content following the National EMS Education Standards.

B. Skill testing will follow the EMS scope of practice per licensure level under Region 11.

## III. NOTIFICATION OF TEST RESULTS

A. Exam scores will be provided on the day of testing or it may be reviewed at a later date by the Resource Hospital.

## IV. FAILURE OF EXAM

A. Any portion of the exam that is not successfully completed after the first attempt will be reviewed by the Resource Hospital EMS Coordinator or designee with the EMS provider.

B. The exam review and retesting must be scheduled with the Resource Hospital EMS Coordinator or designee. It is the responsibility of EMS personnel to schedule this review.

C. Exam review and retesting shall be completed within 60 days from the date of the initial failure.

D. The retest will be administered by the EMS Coordinator or the EMS Medical Director (or designee) of the respective Resource Hospital and graded immediately upon completion.

E. Upon completion of the exam, EMS personnel will be notified verbally of the examination results and will subsequently receive written confirmations.

F. If a passing grade is not achieved, notification of failure on the retest will be sent by regular mail and email. This will include a notification that failure of a third test will result in suspension of medical privileges. Employers of these individuals will be notified of retest examination failures and possibly of suspension of medical privileges within four weeks.

G. The third test shall be accomplished within the subsequent four-week period. It is the responsibility of the EMS personnel to schedule the retest with the Resource Hospital EMS Coordinator or designee.

H. It is the responsibility of the EMS personnel to review relevant content and prepare for the third and final exam.

I. The third test will be administered by the EMS Coordinator or EMS Medical Director (or designee) of the respective Resource Hospital and graded immediately upon completion.

J. EMS personnel will immediately be notified verbally of the examination results and will subsequently receive written confirmation.

K. In the event of failure of the third test, the EMS personnel's medical privileges shall be suspended. The respective employer will be notified immediately regarding the individual's status upon completion of the third test.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Continuing Education Relicensure Requirements |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMS CONTINUING EDUCATION RELICENSURE REQUIREMENTS

## I. PURPOSE

To define EMS Continuing Education activity and core content requirements for license renewal of EMTs and Paramedics under the Region 11 Chicago EMS Systems.

## II. POLICY

A. Definitions

1. In-System CE: Continuing Education (CE) given by or approved by the Resource Hospital for the EMS System within Region 11.

2. Out-of-System CE: Any other CE courses.

B. Continuing Education applications and credits must meet the requirements as listed in the EMT Continuing Education Policy and Paramedic Continuing Education Policy.

## III. EMS CONTINUING EDUCATION (CE) ACTIVITIES

**A. Region 11 accepts the following EMS Continuing Education activities:**

1. National Courses

   a. As listed on the Standardized Course Guide per National Registry
   b. Attached course list and link National Continued Competency Program (NCCP) Model 2025 Reference Document

2. EMS Seminar or Conference

   a. With valid IDPH site code OR
   b. CAPCE (Commission on Accreditation for Prehospital Continuing Education) approval number

3. Local EMS CE course approved by the EMS System with IDPH site code.

4. Health related college courses with transcript as approved by the EMS System.

5. Other EMS Continuing Education as approved by the EMS System.

**B. Other CE must be reviewed and approved by the EMS System.**

## IV. CORE CONTENT CATEGORIES

A. EMS License Categories and Components

1. **EMT Core Content**: Minimum, per 4-year license period (total 80 hours):

   a. Airway (8 hours)
   b. Cardiology (10 hours)
   c. Trauma (6 hours)
   d. Medical (12 hours)
   e. Operations (4 hours)
   f. Pediatrics (8 hours)
   g. Elective (32 hours)

   *No more than 20% per main category (16 hours max each) – not counting elective*

2. **Paramedic Core Content**: Minimum, per 4-year license period (total 120 hours):

   a. Airway (12 hours)
   b. Cardiology (14 hours)
   c. Trauma (10 hours)
   d. Medical (16 hours)
   e. Operations (8 hours)
   f. Pediatrics (12 hours)
   g. Elective (48 hours)

   *No more than 20% per main category (24 hours max each) – not counting elective*

B. **Pediatric core content category** must include a skills-based course as defined by one of the following options per four-year license renewal cycle:

1. Pediatric Advanced Life Support (PALS)
2. Advanced Pediatric Life Support (APLS)
3. Pediatric Education for Prehospital Professionals (PEPP)
4. Pediatric Emergency Assessment, Recognition and Stabilization Course (PEARS)
5. Emergency Pediatric Care (EPC)
6. Neonatal Resuscitation Program (NRP)
7. Other EMS System approved “Pediatric Skills” course with psychomotor component.

## V. SUBMISSION OF CE ON VECTOR SOLUTIONS

A. All EMS CE should be uploaded into the appropriate core content category by the EMT or Paramedic into their Vector Solutions – EMS Medical Directors Consortium profile.

B. The EMS System Coordinator will review all CE submissions and validate per policy.

C. Additional hours to the required number per core content category will overflow into the "Elective" category.

## VI. EMS CE CERTIFCATE REQUIREMENTS

A. Course name

B. Date

C. Participant name

D. Number of hours

E. Course instructor name and signature

F. Training site location

G. Education format: online or in-person

H. Core content category (if approved within Region 11)

I. IDPH site code number or CAPCE approval

## VII. OTHER EMS LICENSE CE

A. Region 11 EMS does not offer continuing education for A-EMT or EMT-I license level.

B. EMR continuing education requirements are listed in the Region 11 Emergency Medical Responder (EMR) Policy.

# NCCP Model 2025

## National EMS Certifications

- Total credits required in the National Continued Competency Program (NCCP) 2025 Model (National + Local + Individual) vary by level. EMR = 16, EMT = 40, AEMT = 50, Paramedic = 60
- 10% of your total National Component credits must be in pediatric content

| National Component Requirement by Level | | Airway | Cardiology | Trauma | Medical | Operations | Total National Component Credits |
|---|---|---|---|---|---|---|---|
| NREMR | Emergency Medical Responder | 1.5 | 2 | 1 | 2.5 | 1 | 8 |
| NREMT | Emergency Medical Technician | 4 | 5 | 3 | 6 | 2 | 20 |
| NRAEMT | Advanced Emergency Medical Technician | 5 | 6 | 4 | 7 | 3 | 25 |
| NRP | Paramedic | 6 | 7 | 5 | 8 | 4 | 30 |

As part of The National Continued Competency Program (NCCP), the National Registry accepts different types of education including academic courses, initial EMS programs, continuing education credits, and refresher courses. In addition, you also may use the maximum credits the National Registry allows for any of the standardized courses listed below. All education must be approved by your state EMS office, or CAPCE-accredited and directly related to EMS patient care.

## Standardized Course Guide

**To recertify with the National Registry of Emergency Medical Technicians, you may take classes that are accepted by your state EMS office, or CAPCE-accredited and directly related to EMS patient care. While the National Registry recognizes that CAPCE or State Offices/Organizations may provide a number of credits, the National Registry sets a maximum number of credits as indicated below. Only that number will be allowed for recertification, re-entry, and state-licenced entry. Ex. If CAPCE allows 4 credits, and our maximum is 2 credits, then only 2 credits will be allowed.**

**Note:** A ✓ indicates that the course can be assigned under that broad topic domain in the application.

| Cardiology | | Airway | Cardiology | Trauma | Medical | Operations | Course Max.Credit |
|---|---|---|---|---|---|---|---|
| CPR- HCP | CPR - Healthcare Professional | ✓ | ✓ | | ✓ | | 4 |
| ACLS | Advanced Cardiac Life Support | ✓ | ✓ | ✓ | ✓ | | 10 |
| ALS | Advanced Life Support | ✓ | ✓ | ✓ | ✓ | | 10 |

| Medical | | Airway | Cardiology | Trauma | Medical | Operations | Course Max.Credit |
|---|---|---|---|---|---|---|---|
| AMLS | Advanced Medical Life Support | ✓ | ✓ | ✓ | ✓ | ✓ | 16 |
| EMPACT | Emergency Medical Patients: Assessment, Care and Transport | ✓ | ✓ | ✓ | ✓ | ✓ | 16 |
| ABLS | Advanced Burn Life Support | ✓ | | ✓ | ✓ | | 7 |
| ASLS | Advanced Stroke Life Support | ✓ | ✓ | ✓ | ✓ | | 8 |
| ENLS | Emergency Neurological Life Support | ✓ | ✓ | ✓ | ✓ | | 15 |

| Special Populations | | Airway | Cardiology | Trauma | Medical | Operations | Course Max.Credit |
|---|---|---|---|---|---|---|---|
| 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 | ✓ | ✓ | ✓ | ✓ | | 12 |
| EPC | Emergency Pediatric Course | ✓ | ✓ | ✓ | ✓ | | 16 |
| GEMS | Geriatric Education for EMS | ✓ | ✓ | ✓ | ✓ | | 8 |

| Trauma | | Airway | Cardiology | Trauma | Medical | Operations | Course Max.Credit |
|---|---|---|---|---|---|---|---|
| ITLS | International Trauma Life Support | ✓ | ✓ | ✓ | ✓ | ✓ | 16 |
| PHTLS | Prehospital Trauma Life Support | ✓ | ✓ | ✓ | ✓ | ✓ | 16 |
| TCCC | Tactical Casualty Combat Care | | | | | | N/A |
| | *Tactical Casualty Combat Care - MP (Military Personnel) | ✓ | ✓ | ✓ | ✓ | ✓ | 16 |
| | *Tactical Casualty Combat Care -CMC (Corpsman) | ✓ | ✓ | ✓ | ✓ | ✓ | 63 |
| | *Tactical Casualty Combat Care - CLS (Combat Lifesaver) | ✓ | ✓ | ✓ | ✓ | ✓ | 40 |
| | *Tactical Casualty Combat Care - ASM (All Service Members) | ✓ | ✓ | ✓ | ✓ | ✓ | 7 |
| TECC | Tactical Emergency Combat Care (Civilian) | ✓ | ✓ | ✓ | ✓ | ✓ | 16 |
| ATLS | Advanced Trauma Life Support | ✓ | ✓ | ✓ | ✓ | ✓ | 16 |

| Operations | | Airway | Cardiology | Trauma | Medical | Operations | Course Max.Credit |
|---|---|---|---|---|---|---|---|
| EMS Safety | EMS Safety | | | | | ✓ | 8 |
| EVOC | Emergency Vehicle Operator Course / Safety Course | | | | | ✓ | 8 |
| TIMS | Traffic Incident Management | | | | | ✓ | 4 |
| HAZMAT | HAZMAT | | | | | | N/A |
| | *Hazardous Materials Technician | | | | ✓ | ✓ | 20 |
| | *Hazardous Materials Operations | | | | ✓ | ✓ | 20 |
| | *Hazardous Materials Awareness | | | | ✓ | ✓ | 8 |
| | *All Hazards Disaster Life Support | | | | ✓ | ✓ | 8 |
| BDLS | Basic Disaster Life Support | | | ✓ | ✓ | ✓ | 7.5 |
| ADLS | Advanced Disaster Life Support | | | ✓ | ✓ | ✓ | 15 |
| IS 100 | An Introduction to the Incident Command System, ICS 100 | | | | ✓ | ✓ | 2 |
| IS 200 | An Introduction to the National Incident Management System | | | | ✓ | ✓ | 4 |
| IS 300 | ICS 300: Intermediate Incident Command System for Expanding Incidents | | | | ✓ | ✓ | 21 |
| IS 400 | ICS 400: Advanced Incident Command System for Command and General Staff-Complex Incidents | | | | ✓ | ✓ | 15 |
| IS 700 | IS-700.B: An Introduction to the National Incident Management System | | | | ✓ | ✓ | 4 |
| IS 800 | IS-800.D: National Response Framework, An Introduction | | | | ✓ | ✓ | 3 |

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Lead Instructor (LI) |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMS LEAD INSTRUCTOR (LI)

## I. LEAD INSTRUCTOR (LI) INITIAL LICENSE APPLICATION

A. **In the Region 11 Chicago EMS Systems, and per IDPH, all education, training, and Continuing Education (CE) courses for EMTs, Paramedics, ECRNs, EMRs and EMDs shall be coordinated by at least one approved Illinois EMS Lead Instructor (LI). A program that includes education, training or CE for more than one type of EMS Personnel may use one EMS LI to coordinate the program. A single EMS LI may simultaneously coordinate more than one program or course.**

B. To be eligible for an Illinois EMS LI license, the applicant shall meet at least the following minimum experience and education requirements:

1. A current Illinois license as an EMD, EMT, Paramedic, RN, or physician;

2. A minimum of four years of experience in EMS or emergency care;

3. At least two years of documented teaching experience (CPR, ACLS, PALS, PHTLS, EMT or Paramedic etc.);

4. Documented EMS classroom teaching experience with a recommendation for LI licensure by an EMS MD or licensed LI;

5. Documented successful completion of the Illinois EMS Instructor Education Course or equivalent to the National Standard Curriculum for EMS Instructors (NAEMSE Lead 1 Course) as approved by IDPH.

C. The LI applicant shall complete the Region 11 EMS Lead Instructor Application that describes the above requirements and details regarding their teaching experience (available online at https://chicagoems.org/lead-instructor/). This includes course dates and roles in the course teaching and administration. This application and copy of the successful Course Completion Certificate of the Lead Instructor course should be sent to the Resource Hospital.

D. Once the criteria are met to the standards of the Resource Hospital, the EMS Medical Director signs the IDPH Lead Instructor Initial/Renewal EMS Medical Director Authorization Form.

E. The candidate is responsible for completing the IDPH EMS Systems Renewal Notice/Child Support/Personal History Statement (available online at https://chicagoems.org/lead-instructor/) and submitting it to their Resource Hospital.

F. The Resource Hospital is responsible for completing the Transaction Card for the license.

G. The Resource Hospital will submit the complete application packet to IDPH.

H. Once the complete application packet is received by IDPH, they will notify the LI applicant with instructions for online payment.

I. Once issued, the EMS Lead Instructor license should be added as a credential to the Vector Solutions platform to track CE hours and renewal.

## II. LEAD INSTRUCTOR (LI) LICENSE RENEWAL APPLICATION

A. All LI license renewal applicants will receive a renewal letter from IDPH 60 days prior to their expiration date. The letter will contain information for renewal and a PIN ID number required for online payment.

B. All EMS LIs shall attend an IDPH approved review course whenever revisions are made to the national EMS education standards.

C. To apply for license renewal, the EMS LI shall submit the following to their Resource Hospital at least 60, but no more than 90 days prior to the LI's license expiration:

1. A letter of support or electronic authorization from the EMS MD indicating that the LI has satisfactorily coordinated programs for the EMS System at any time during the four-year period.

2. Documentation of at least 40 total hours of continuing education.

   a. There should be at least 20 hours of “Instructor Related Education” which is related to the development, delivery, and evaluation of education programs.
   b. There should be at least 20 hours related to the “Classroom Time” as documented on a course roster or verification letter.

3. Documentation of attendance at an IDPH-approved national EMS education standards update course, if applicable

4. Completed IDPH EMS Systems Renewal Notice/Child Support/Personal History Statement (available online at https://chicagoems.org/lead-instructor/).

5. Once the criteria are met, the EMS Medical Director signs the IDPH Lead Instructor Initial/Renewal EMS Medical Director Authorization form.

6. The Resource Hospital will submit to IDPH the Lead Instructor Initial/Renewal EMS Medical Director Authorization Form and a new license will be issued to the individual.

D. A LI that has not been recommended for relicensure shall be provided with a written statement from the EMS MD stating the reason for the withholding of the endorsement.

1. The license of a LI who has failed to complete the renewal application requirements for the EMS System and IDPH shall be invalid on the expiration date of the license. An individual shall not function as an EMS LI on an expired license.

2. A LI whose license has expired may, within 60 days after the expiration of the license, submit all relicensure requirements and the required fees, including a late fee, online or by certified check or money order.

3. A LI whose license has expired after 60 days of expiration should follow the process for a new license application.

## III. LEAD INSTRUCTOR (LI) LICENSE SUSPENSION AND EXPECTATIONS

A. IDPH may suspend, revoke, or refuse to issue or renew the approval of an EMS LI license, after an opportunity for a hearing, when findings show one or more of the following:

1. The EMS LI has failed to conduct a course in accordance with the curriculum of the Region 11 EMS Systems;

2. The EMS LI has failed to comply with protocols and polices of the Region 11 EMS Systems.

B. The EMS LI shall be responsible for the following:

1. Understanding the process and requirements for site code applications in the Region 11 EMS Systems;

2. Ensuring that no EMS education course begins until after IDPH issues its formal written pre-approval, which shall be in the form of a numeric site approval code; and

3. Ensuring that all materials presented to participants comply with National EMS Education Standards, as modified and approved by Region 11 and IDPH. Methods of assessment or intervention that are not approved by both the EMS System and the Department shall not be presented.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMT Continuing Education |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMT CONTINUING EDUCATION

## I. EMT CONTINUING EDUCATION APPLICATION

A. A complete Continuing Education (CE) site code application should be completed by a licensed EMS Lead Instructor and sent to the EMS System for review at least 90 days prior to the anticipated start date.

B. Continuing education classes, seminars, or other types of programs shall be approved by IDPH before being offered to EMTs.

C. An application for approval shall be submitted by the EMS System to IDPH on a site code form prescribed, prepared, and furnished by IDPH, at least 60 days prior to the scheduled event. The application will include, but not be limited to, the following:

1. Name of applicant, agency, and address;
2. Lead Instructor's name, license number, address and contact information, including e-mail address;
3. Name and signature of the EMS MD and the EMS System Coordinator;
4. Type of education program;
5. Dates, times, and location of the education program (submit course schedule);
6. Goals and objectives at or above the license level;
7. Methods and materials, textbooks, and resources, when applicable;
8. Content consistent with the National EMS Education Standards;
9. Description of evaluation instruments; and
10. Requirements for successful completion, when applicable.

D. Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the national EMS education standards, as modified by IDPH. Upon approval, IDPH will issue a site code for the course, seminar, workshop, or program.

E. An EMS System may apply to IDPH for a single System site code to cover CE activities conducted or approved by the System for System EMTs when an urgent education need arises that requires immediate attention or when other appropriate education opportunities present outside of the scheduled approved offerings. Activities conducted under the System site code shall not require individual approval by IDPH. The single System site code is not intended to replace the routine CE pre-approvals required by IDPH and is identified in the EMS System education program plan.

## II. EMT CONTINUING EDUCATION CREDITS

A. An EMT functioning within an EMS System shall submit written proof of CE attendance to the EMS System Coordinator pursuant to EMS System policy (EMS Continuing Education Relicensure Requirements Policy). An EMT not functioning within an EMS System shall submit written proof of CE attendance to the IDPH Regional EMS Coordinator upon licensure renewal request.

B. The EMS MD or designee of the EMS System of the EMT's primary affiliation, or IDPH's designee for independent EMTs, shall verify whether specific CE hours meet requirements for educational credit towards active status or renewal purposes.

C. An EMS System that requires continuing clinical education shall specify in the System Program Plan the number of hours required and the manner in which those hours shall be earned, submitted, and verified.

D. An EMT shall maintain copies of all documentation concerning CE programs that he or she has completed for a period of not less than four years.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Paramedic Continuing Education |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# PARAMEDIC CONTINUING EDUCATION

## I. PARAMEDIC CONTINUING EDUCATION APPLICATION

A. A complete Continuing Education (CE) site code application should be completed by a licensed EMS Lead Instructor and sent to the EMS System for review at least 90 days prior to the anticipated start date.

B. Continuing education classes, seminars, or other types of programs shall be approved by IDPH before being offered to Paramedics.

C. An application for approval shall be submitted to IDPH by an EMS Medical Director, on a site code form prescribed, prepared, and furnished by IDPH, at least 60 days prior to the scheduled event. The application will include, but not be limited to, the following:

1. Name of applicant, agency, and address;
2. Lead Instructor's name, license number, address, and contact information, including e-mail address;
3. Name and signature of the EMS MD and the EMS System Coordinator;
4. Type of education program;
5. Dates, times, and location of the education program (submit course schedule);
6. Goals and objectives at or above the license level;
7. Methods and materials, textbooks, and resources, when applicable;
8. Content consistent with the National EMS Education Standards for the appropriate license level;
9. Description of evaluation instruments; and
10. Requirements for successful completion, when applicable.

D. Approval will be granted provided the application is complete and the content of the program is based on topics or materials from the National EMS Education Standards, as modified by IDPH. Upon approval, IDPH will issue a site code to the course, seminar, or program.

E. An EMS System may apply to IDPH for a single System site code to cover CE activities conducted or approved by the System solely for System Paramedics when an urgent education need arises that requires immediate attention or when other appropriate education opportunities present outside of the scheduled approved offerings. Activities conducted under the System site code shall not require individual approval by IDPH. The single System site code is not intended to replace routine CE pre-approvals.

## II. PARAMEDIC CONTINUING EDUCATION CREDITS

A. A Paramedic functioning within an EMS System shall submit written proof of CE attendance to the EMS System Coordinator pursuant to EMS System policy (EMS Continuing Education Relicensure Requirements Policy). A Paramedic not functioning within an EMS System shall submit written proof of CE attendance to the IDPH Regional EMS Coordinator upon licensure renewal request.

B. The EMS MD or designee of the EMS System Paramedic's primary affiliation shall verify whether specific CE hours meet the criteria for educational credit towards active status or renewal purposes.

C. An EMS System that requires clinical CE shall specify in the System Program Plan the number of hours required, and the manner in which those hours must be earned, submitted, and verified.

D. A Paramedic shall maintain copies of all documentation concerning CE programs or activities that he or she has completed for a period of not less than four years.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMT Initial Education Programs |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMT INITIAL EDUCATION PROGRAMS

*An EMS education program shall only be conducted by an EMS System or an academic institution under the direction of the EMS System*

## I. EMT EDUCATION PROGRAM APPLICATION

A. Applications for pre-approval of EMT education programs shall be filed with IDPH on forms prescribed by IDPH. The applications shall contain, at a minimum:

1. Name of the applicant, agency, and address;
2. Lead Instructor's name, license number, address and contact information;
3. Name and signature of the EMS MD and EMS System Coordinator;
4. Type of education program;
5. Dates, times, and location of the education program, including course schedule;
6. Goals, objectives, and course outline;
7. Methods, materials and text books;
8. Content and time consistent with the national EMS education standards and additional course curricula required by IDPH. Initial or modified course syllabi shall be approved by IDPH;
9. Description of the clinical and field requirements;
10. Description of evaluation tools (student, clinical units, faculty, and programs); and
11. Requirements for successful completion.

B. Applications for pre-approval, including a copy of the course schedule and syllabus, shall be submitted no less than 60 days before the first scheduled class.

1. Initial or revised education programs require full submission of all curriculum related educational documents for IDPH pre-approval.
2. Education programs previously approved by IDPH without changes to curricula or content require submission of the course schedule and syllabus only.

C. The EMS MD shall attest on the application form that the education program will be conducted according to the national EMS education standards, including modifications required by IDPH. The course hours shall include, at a minimum, 125 hours of didactic education and 25 hours of clinical experience, which includes hospital or alternate health care facility and field internship experience. The clinical experience shall include minimum patient care contacts, competency evaluation, and measurement, as defined in

the standards and approved by the EMS MD.

## II. EMT EDUCATION PROGRAM REQUIREMENTS

A. The EMS MD and the EMS System Coordinator, in cooperation with the educational institution, shall be responsible for oversight, quality assurance and outcome measurement for the EMT education program.

B. The Lead Instructor for the course shall be responsible for ensuring that no EMT course begins until after IDPH issues its formal, written pre-approval, which shall be in the form of a numeric site code.

C. The Lead Instructor for the course shall be responsible for ensuring that all materials presented to EMT students conform to all curriculum requirements of both IDPH and the EMS System granting its approval. Methods of assessment or intervention that are not approved by both IDPH and the EMS System shall not be taught or presented. All course Lead Instructors shall be approved by the EMS MD.

D. Any change in the EMT program's EMS MD, EMS System Coordinator or Lead Instructor, or change in the minimum approved program, shall require an amendment to be filed with IDPH by the EMS System.

E. Before a candidate is accepted into the program, documentation shall be submitted that a BLS EMS System vehicle will be available to accommodate field internship needs.

F. Each EMS Lead Instructor shall verify a student's qualification to take an IDPH-approved licensure examination upon the successful completion of the education program and shall submit a student roster on a form approved by IDPH. The EMS MD or designee may approve students through an on-line verification system.

G. EMT candidates may test for licensure through the NREMT. For EMT candidates who have completed and passed the EMT program, and passed the NREMT examination, the EMS MD or EMS System Coordinator shall submit to IDPH an electronic transaction provided by IDPH.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Paramedic Initial Education Programs |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# PARAMEDIC INITIAL EDUCATION PROGRAMS

*An accredited Paramedic program shall be conducted only by an EMS System or an academic institution whose curriculum has been approved by the EMS System.*

## I. PARAMEDIC EDUCATION PROGRAM APPLICATION

A. Applications for pre-approval of Paramedic education programs shall be filed with IDPH on forms prescribed by IDPH. The applications shall contain, at a minimum:

1. Name of the applicant, agency, and address;
2. Lead Instructor's name, license number, address and contact information;
3. Name and signature of the EMS MD and EMS System Coordinator;
4. Type of education program;
5. Dates, times, and location of the education program, including course schedule;
6. Goals, objectives, and course outline;
7. Methods, materials and text books;
8. Content and time consistent with the national EMS education standards and additional course curricula required by IDPH. Initial or modified course syllabi shall be approved by IDPH;
9. Description of the clinical and field requirements;
10. Description of evaluation tools (student, clinical units, faculty, and programs); and
11. Requirements for successful completion.

B. Applications for pre-approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days before the first scheduled class.

1. Initial or revised education programs require full submission of all curriculum related educational documents for IDPH pre-approval.
2. Education programs previously approved by IDPH without changes to curricula or content require submission of the course schedule and syllabus only.

C. The EMS MD of the EMS System shall attest on the application form that the education program will be conducted according to the national EMS education standards, including all modifications required by IDPH. The course hours shall minimally include 500 hours of didactic education and 500 hours of clinical experience, which includes hospitals plus alternate care facilities and field internship experience,

including minimum patient care contacts and competency evaluation and measurement as defined in the standards and approved by the EMS MD.

## II. PARAMEDIC EDUCATION PROGRAM REQUIREMENTS

A. Oversight, quality assurance and outcome measurement for the Paramedic education program shall be the responsibility of the EMS MD and the EMS System Coordinator, with cooperation of the educational institution.

B. The Lead Instructor for the course shall be responsible for ensuring that no Paramedic class begins until after IDPH issues its formal written pre-approval, which shall be in the form of a numeric site code.

C. The Lead Instructor for the course shall be responsible for ensuring that all materials presented to Paramedic students conform to all curriculum requirements of both IDPH and the EMS System granting its approval. Methods of assessment or intervention that are not approved by both IDPH and the EMS System shall not be taught or presented. All course Lead Instructors must be approved by the EMS MD.

D. Any change in the Paramedic program's EMS MD, EMS System Coordinator or Lead Instructor, or change in the minimum approved program, shall require an amendment to be filed with IDPH.

E. A candidate for a Paramedic education program shall have an active Illinois EMT, A-EMT or EMT-I license. All program participants shall maintain their qualifying license throughout completion of the program and successful completion of the licensure examination.

F. Before a candidate is accepted into the program, documentation shall be submitted that an ALS or Critical Care Transport EMS System vehicle will be available to accommodate field internship needs.

G. Each education program shall verify a student's qualification to attempt an IDPH-approved licensure examination upon the successful completion of the education program and shall submit a student roster on a form approved by IDPH. The EMS MD or designee may approve students through an on-line verification system.

H. Paramedic candidates may test for licensure via the NREMT examination (NREMT requires successful completion from an accredited academic institution recognized by NREMT). For Paramedic candidates who have completed and passed all components of the program, and passed the NREMT examination, and who are applying for Illinois licensure, the EMS MD shall submit to IDPH an electronic transaction form provided by IDPH. No electronic transaction form is required for candidates taking the state licensure examination.

I. All approved programs shall maintain course and student records for seven years, in compliance with the affiliated academic institution requirements as applicable. The course and student records shall be made available to the EMS System or IDPH upon request.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMT and Paramedic Licensure |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMT AND PARAMEDIC LICENSURE

## I. EMT AND PARAMEDIC LICENSURE REQUIREMENTS

A. To be licensed by IDPH as an EMT or Paramedic, an individual must pass the NREMT examination.

B. Within 24 months of NREMT certification, the applicant shall apply for initial licensure to IDPH through the EMS System that sponsored the education program, using forms specified by IDPH. The application will include demographic information, social security number, child support statement, felony conviction statement, and applicable fees, and will require EMS System authorization.

C. An EMS license will specify the level of licensure, i.e., EMT or Paramedic, and will be effective for a period of four years.

D. An EMT or Paramedic shall notify IDPH within 30 days after any change in name or address. Notification may be in person or by mail, phone, fax, or electronic mail. Addresses may be changed through IDPH's on-line system. Name and gender changes require certified copies of court orders, i.e., marriage license or court documents.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMT and Paramedic Testing |
|---|---|
| | Section: EMS Education |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMT AND PARAMEDIC TESTING

## I. EMT AND PARAMEDIC TESTING REQUIREMENTS

A. All candidates shall hold a high school diploma or high school equivalency certificate and be 18 years of age or older to be licensed.

B. After completion of an approved education program and a recommendation to test by the EMS MD or designee, candidates shall take the NREMT cognitive examination, and an EMS System approved psychomotor examination.

C. Candidates qualifying for licensure examinations may register for examinations through the NREMT. Application information may be found on the NREMT website. All candidates for licensure examinations shall be approved by the EMS System. Candidates shall register to take a licensure examination within 90 days after course completion, including all clinical and field requirements.

D. A failure rate per course of 30 percent or greater on the licensure examination will subject the particular education program to review by the EMS System or IDPH.

E. Candidates shall follow the NREMT policy for initial licensure examination within 12 months after initial authorizations to test.

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## EMS PERSONNEL

Alternate Response Vehicle
Ambulance Licensing Requirements
Community Paramedic
Emergency Medical Dispatcher (EMD)
Emergency Medical Responder (EMR)
EMS Mandatory Continuing Education
EMS Personnel Licensing Requirements and Renewals
EMS Personnel Reinstatement
EMS Preceptor
EMS Provider Impairment and Substance Abuse
EMS Reciprocity
EMS Scope of Practice
EMS System Entry
EMS System Inventory Requirements
EMS System Participation Suspension
EMS System Review Board
Evaluation and Recognition of Military Experience
Inactive Status
Occupational Exposure to an Infectious Disease
Paramedic Field Internship Program
Prehospital Registered Nurse (PHRN), Prehospital Physician Assistant (PHPA) and Prehospital Advanced Practice Registered Nurse (PHAPRN)
Primary and Secondary EMS System
Vaccine Administration
Vehicle Service Provider Licensure

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Alternate Response Vehicle |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# ALTERNATE RESPONSE VEHICLE

## I. PURPOSE

To define the scope in which the Region 11 Chicago EMS Systems will utilize alternate response vehicles.

## II. DEFINITIONS

A. Alternate Response Vehicle: Ambulance assistance vehicles and other non-transport vehicles.

B. Ambulance Assistance Vehicle: Vehicles that are dispatched simultaneously with an ambulance and assist with patient care prior to the arrival of the ambulance. Ambulance assistance vehicles include fire engines, trucks, squad cars, supervisor cars, or chief's cars that contain the staff and equipment required under the EMS System Plan.

C. Non-Transport Vehicle: Vehicles that are dispatched prior to the dispatch of a transporting ambulance. Non-transport vehicles include fire engines and trucks that contain the staff and equipment required under the EMS System Plan.

## III. AMBULANCE ASSISTANCE VEHICLES

A. Ambulance assistance vehicles shall not function as assist vehicles if the staff and equipment required under the EMS System Plan are not available. The EMS agency shall identify ambulance assistance vehicles as a program plan amendment outlining the type and level of response that is planned.

B. The ambulance assistance vehicle shall not transport or be a primary response vehicle, but a supplementary vehicle to support EMS services. The ambulance assistance vehicle shall be dispatched only if needed. Ambulance assistance vehicles shall be classified as either:

1. Advanced ambulance assistance vehicles and shall be staffed with a minimum of one Paramedic, PHRN, or physician and shall have all the required equipment;

2. Basic ambulance assistance vehicles shall be staffed with a minimum of one EMT, Paramedic, PHRN, or physician and shall have all the required equipment.

## III. NON-TRANSPORT VEHICLES

A. Non-transport vehicles shall be staffed 24 hours per day, every day of the year. The vehicle service provider shall identify non-transport vehicles as a program plan amendment outlining the type and level of response that is planned.

1. ALS Non-Transport Vehicles shall have a minimum of either one System authorized Paramedic or one PHRN, and one additional System authorized Paramedic, PHRN, or physician, and shall have all the required equipment; and

2. BLS Non-Transport vehicles shall be staffed by two System authorized personnel unless the provider is functioning within IDPH's ambulance licensing requirements. The vehicle shall be staffed by an EMT or higher on all responses and shall have all the required equipment.

## IV. ADDITIONAL ALTERNATE RESPONSE VEHICLE REQUIREMENTS

A. Equipment Requirements

1. Each vehicle used as an alternate response vehicle shall meet the equipment requirements, per Section 515.825.

B. Registration of Non-Transport Provider Agencies

1. Each non-transport provider shall complete and submit to IDPH either the EMS non-transport provider application or EMS non-transport application for an existing transport provider, available on IDPH's Division of EMS website.

C. Inspection of Non-Transport EMS Providers

1. IDPH will schedule initial inspections. Thereafter, non-transport ambulance assist providers shall perform annual self-inspections, using forms provided by IDPH and Region 11, and shall submit the forms to the EMS System for submission to IDPH upon completion of the inspection. IDPH and the Region will perform inspections randomly or as the result of a complaint.

D. Issuance and Renewal of License for Non-Transport Providers

1. Upon payment of the appropriate fee, qualifying non-transport providers shall be issued a provider license that lists a number for each level of care approved. Licenses will not be issued for individual Non-Transport Vehicles. Providers shall inform the EMS System and IDPH of any modifications to the application, using the System Modification forms (sys-mod). Licenses will be issued for one year and will be renewed upon completion of the self-inspection.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Ambulance Licensing Requirements |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# AMBULANCE LICENSING REQUIREMENTS

## I. PURPOSE

To establish ambulance licensing requirements for EMS agencies participating in Region 11 Chicago EMS.

## II. VEHICLE DESIGN

A. Each new vehicle used as an ambulance shall comply with the current criteria established by nationally recognized standards such as National Fire Protection Association, Ground Vehicle Standards for Ambulances, the Federal Specifications for the Star of Life Ambulance, or the Commission on Accreditation of Ambulance Services (CAAS) Ground Vehicle Standard for Ambulances.

B. A licensed vehicle shall be exempt from subsequent vehicle design standards or specifications required by IDPH, as long as the vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until the vehicle's title of ownership is transferred.

## III. EQUIPMENT REQUIREMENTS

A. All ambulances and non-transport units functioning in Region 11 Chicago EMS shall meet equipment requirements as determined by IDPH and the EMS Medical Director and in alignment with the current approved Region 11 Medication, Equipment and Supply Inventory List.

1. Specific requirements for ambulances and non-transport units (ALS and BLS) functioning in Region 11 Chicago EMS can be found on the Chicago EMS website.

B. Any medications carried on the ambulance shall include both adult and pediatric doses.

C. All ambulances shall have an EMS Medical Director approved current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart

D. Each ambulance shall have reliable ambulance-to-hospital communications capability including radio and cellular phone (See EMS System Communications Policy for further details).

## IV. OPERATIONAL REQUIREMENTS

A. Personnel requirements are defined in the EMS Staffing Policy.

B. An ambulance that transports a patient to a hospital shall be operated in accordance with the requirements of the EMS Systems Act (210 ILCS 50) and its Rules and Regulations.

C. A licensee shall operate its ambulance service 24 hours a day, every day of the year. Each individual vehicle within the ambulance service shall not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS or BLS level, and the coverage shall meet the ambulance licensing requirements set forth by IDPH.

1. At the time of application for initial or renewal licensure, and upon annual inspection, the applicant or licensee shall submit to IDPH for approval a list containing the anticipated hours of operation for each vehicle covered by the license.

    a. A current roster shall also be submitted that lists the System authorized EMTs, Paramedics, PHRNs, or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, license expiration date, and telephone number, and shall state whether the person is scheduled to be on site or on call.
    b. An actual or proposed four-week staffing schedule shall also be submitted that covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.

2. Licensees shall obtain the EMS Medical Director's approval of their vehicles' hours of operation prior to submitting an application to IDPH. The EMS Medical Director may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.

3. A vehicle service provider that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day.

D. For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required as listed in the IDPH National Emergency Medical Services Information System (NEMSIS) Prehospital Dataset.A vehicle service provider shall provide emergency service within the service area on a per- need basis without regard to the patient's ability to pay for the service.

E. A vehicle service provider shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers.

F. A vehicle service provider shall not operate its ambulance at a level exceeding the level for which it is licensed.

G. IDPH will inspect ambulances each year. If the vehicle service provider has no violations of IDPH ambulance licensing requirements that threaten the health of safety of patients or the public for the previous five years and has no substantiated complaints against it, IDPH will inspect the vehicle service provider's ambulances in alternate years, and the vehicle service provider may, with IDPH's prior approval, self-inspect its ambulances in the other years. The vehicle service provider shall use IDPH's inspection form for self-inspection. This does not prevent IDPH from conducting unannounced inspections.

H. A licensee may use a replacement vehicle for up to 10 days without an IDPH inspection, provided that the EMS System and IDPH are notified of the use of the vehicle by the second working day.

I. Patients, individuals who accompany a patient, and EMS Personnel may not smoke while inside an ambulance or Specialized EMS Vehicle (SEMSV). IDPH may impose a civil penalty on an individual who violates this rule.

J. Any EMS provider agency may request a waiver of any requirements found in the provisions of Section 515.150.

## V. EMS SYSTEM PROGRAM PLAN

A. Each licensed EMS vehicle (ambulance and non-transport units) operates under an EMS System as defined in the EMS System Program Plan.

B. EMS vehicle administrative assignments for the Region 11 EMS Systems are listed on Attachment 1 – Region 11 EMS System Administrative Assignments.

# Region 11 EMS System
# Administrative Assignments

**Chicago North EMS System #1103**

- **CFD ALS Ambulances:** 2-6-7-13-16-20-26-31-32-39-40-46-47-48-56-59-61-73
- **CFD ALS Companies:** E9-E10-E11-E12-E55-E59-E71-E78-E79-E83-E91-E102-E108-E124-E125-T12-T55-T58-TL63
- **CFD BLS Companies:** E7-E56-E69-E70-E86-E89-E94-E106-E110-E112-E119-T9-T13-T22-T25-T38-T44-T47-T53- T56-T57-TL21-TL23-SQ2-SQ7-HAZMAT 512
- **LifeLine Ambulance**

**Chicago South EMS System #1113**

- **CFD ALS Ambulances:** 5-9-14-22-24-25-29-30-36-37-38-49-50-51-55-57-60-70-71-72-76-79
- **CFD ALS Companies:** E46-E47-E54-E60-E62-E72-E73-E74-E82-E84-E93-E97-E115-E116-E122-E120-E126- MC8812
- **CFD BLS Companies:** E45-E63-E75-E80-E81-E104-T17-T20-T27-T30-T34-T37-T42-T49-T51-T61-T62-TL16-TL24- SQ5
- **CFD Mobile Integrated Healthcare (MIH) Unit**
- **ATI Ambulance**
- **Black Fire Brigade EMS**
- **Hawthorne Race Track Ambulance**
- **LifeLine Ambulance**
- **UCAN**
- **Vandenburg Ambulance**

**Chicago Central EMS System #1108**

- **CFD ALS Ambulances:** 1-3-4-11-19-28-35-41-42-43-44-53-62-65-66-68-74
- **CFD ALS Companies:** E1-E2-E4-E8-E13-E18-E19-E23-E26-E29-E30-E39-E43-E49-E50-E57-E98-E123-T2-T29 -688-689 (seasonal)
- **CFD BLS Companies:** E5-E14-E28-E51-E16-E22-E35-E42-E45-E103-T1-T3-T4-T6-T7-T8-T11-T15-T18-T19-T28 T33- TL5-TL10-TL39-AT8-SQ1-DIVE Truck 687-HAZMAT 511
- **Chicago Police Department Marine & SWAT Units**
- **Event Medical Solutions**
- **MASE**
- **OEMC Dispatchers including O'Hare and Midway Airports**

**Chicago West EMS System #1178**

- **CFD ALS Ambulances:** 8-10-12-15-17-18-21-23-27-33-34-45-52-54-58-63-64-67-69-75-77-78-80
- **CFD ALS Companies:** E34-E38-E64-E68-E76-E88-E95-E99-E113 -E117-E127-E129-T32-T36-T40-T41-T45-T60
- **CFD BLS Companies:** E15-E32-E44-E65-E92-E96-E101-E107-E109-E121-T26-T31-T35-T46-T48-T31-T50-T52-T59 TL14-TL54
- **CFD Surge Ambulances:** 150-151-152-153-154-155-156-157-158-159
- **CFD Reserve Ambulance:** 101-102-103-104-105-106-107-108-109-110-111-112-113-114-115-116-117-118-119-120-121-122-123-124-125-126-127-128-129-130-131-132-133-134
- **CFD Mobile Medical Response Team (MMRT) Bikes and Carts**
- **Cook County Sheriff's Department SWAT**
- **Hatzalah**

Revised: October 2025

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Community Paramedic |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 11, 2020 |

# COMMUNITY PARAMEDIC

## I. PURPOSE:

To define the role of the Community Paramedic (CP) within a Mobile Integrated Healthcare (MIH) Program in the Region 11 EMS System.

## II. DEFINITION:

A Community Paramedic (CP) is a licensed Paramedic that completes a standardized Community Paramedic education program through an approved college or university and operates as an advanced paramedic in the provision of health education, monitoring and services beyond the roles of traditional emergency care and transport. Community Paramedic education programs using the North Central EMS Institute Community Paramedic curriculum are recognized by the Region 11 EMS System.

## III. ROLE:

The Community Paramedic will assist individuals in overcoming healthcare barriers by identifying and mitigating gaps in their health and wellness needs and evaluation of specific disease processes. The Community Paramedic coordinates with community resources to support relationships between the patient and medical and social services. Community Paramedics are credentialed by the Region 11 EMS System to work in an IDPH approved Mobile Integrated Healthcare Program.

## IV. CREDENTIALING:

To be credentialed as a Community Paramedic by the Region 11 EMS System, the candidate must:

A. Maintain a current IDPH Paramedic license;

B. Have two years minimum of field experience as a Paramedic;

C. Successfully complete a Community Paramedic education program with certificate from a Region 11 approved program that includes clinical experience provided under the supervision of the EMS Medical Director;

D. Submit a letter of interest to the EMS Medical Director;

E. Submit a letter of recommendation in support of the candidate from a mentor that supports the recommended qualities as listed below;

F. Attend a Region 11 EMS orientation session for the MIH Program;

G. Practice in accordance with the Region 11 Community Paramedic Protocols;

H. Complete an additional 12 hours of Continuing Education every year at the Paramedic level that is focused on Community Paramedic topics.

## V. MOBILE INTEGRATED HEALTHCARE (MIH) PROGRAM PARAMEDIC SELECTION:

Community Paramedics are advanced Paramedics that require a specialized knowledge base and essential characteristics to ensure success in the role. Community Paramedics credentialed within Region 11 are eligible to participate in an approved Mobile Integrated Healthcare (MIH) Program as defined by the EMS Agency, the EMS System, and IDPH. The following are recommended qualities that Community Paramedics should display:

A. Proficient patient assessment skills;

B. The ability to work collaboratively as a member of a healthcare team;

C. Good communication and social skills;

D. Empathy;

E. Acceptable EMS System and EMS Agency personnel file upon review.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Emergency Medical Dispatcher (EMD) |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMERGENCY MEDICAL DISPATCHER (EMD)

## I. EMD LICENSURE

A. To apply for licensure as an EMD, the individual shall request that the EMS System submit the following to IDPH:

1. A completed electronic transaction form recommending initial licensure as an EMD; and

2. Documentation of successful completion of a training course in emergency medical dispatching that meets or exceeds the national curriculum of the United States Department of Transportation for EMS Dispatchers or its equivalent.

B. Reciprocity shall be granted to an individual who is licensed as an EMD in another state and who meets IDPH requirements.

C. An individual who is certified or recertified by a national certification agency shall be licensed as an EMD if he or she meets IDPH requirements.

D. The EMD license shall be valid for a period of four years.

E. A licensed EMD shall notify IDPH within 30 days after any changes in name or address. Notification may be in person or by mail, phone, fax or electronic mail. Addresses may be changed through IDPH's online system. Name and gender changes require legal documents (i.e. marriage license or court documents).

F. A person may not represent himself or herself, nor may an agency or business represent an agent or employee of that agency or business, as an EMD unless licensed by IDPH as an EMD.

## II. EMD PROTOCOLS

A. The EMD shall use the IDPH-approved emergency medical dispatch priority reference system (EMDPRS) protocol selected for use by his or her agency and approved by the EMS Medical Director. Pre-arrival support instructions shall be provided in a non-discriminatory manner and in accordance with the EMDPRS established by the EMS Medical Director of the EMS System in which the EMD operates.

B. EMD protocols shall include:

1. Complaint-related question sets that query the caller in a standardized manner;

2. Pre-arrival instructions associated with all question sets;

3. Dispatch determinants consistent with the design and configuration of the EMS System and the severity of the event as determined by the question sets; and

4. Post-dispatch instructions with all question sets.

5. Informing the caller requesting an emergency vehicle of the estimated time of arrival when this information is requested by the caller.

C. If the dispatcher operates under the authority of an Emergency Telephone System Board established under the Emergency Telephone System Act, the protocols shall be established by the Board in consultation with the EMS Medical Director.

D. The EMD shall provide pre-arrival instructions in compliance with protocols selected and approved by the system's EMS Medical Director and approved by IDPH.

E. IDPH and the EMS Medical Director shall approve EMDPRS protocols that meet or exceed the requirements set forth by IDPH and the National Highway Traffic Safety Administration (NHTSA) Emergency Medical Dispatch: National Standard Curriculum.

## III. EMD RELINCENSURE

A. To apply for relicensure, the EMD shall submit the following to IDPH no less than 30 days before the licensure expiration date:

1. An approval signed by the EMS Medical Director recommending recertification; and

2. Proof of completion of at least 12 hours annually of medical dispatch continuing education.

B. The EMD shall file a written or electronic application for renewal with IDPH no less than 30 days before the license expiration date. Incomplete license applications submitted less than 30 days before the expiration of the license may not be processed by the expiration date and will be subject to a late fee.

C. An EMD whose license has expired may, within 60 days after the license expiration date, complete all relicensure requirements and submit relicensure fees, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met and there are no pending or sustained disciplinary actions against the EMD, IDPH will relicense the EMD.

D. An EMD who has not been recommended for relicensure by the EMS Medical Director shall independently submit to IDPH an application for recertification. The EMS Medical Director shall provide the EMD with a copy of the appropriate form to be completed.

## IV. EMD EDUCATION PROGRAMS

A. IDPH-approved emergency medical dispatch training programs shall be conducted in accordance with the standards of the National Highway Traffic Safety Administration Emergency Medical Dispatch: National Standard Curriculum or equivalent.

B. Applications for approval of EMD education programs shall be filed with IDPH on IDPH-approved forms. The application shall contain, at a minimum, the name of the applicant, agency and address, type of education program, Lead Instructor's name and address, and dates of the education program.

C. Applications for approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days in advance of the first scheduled class. A description of the text book being used and passing score for the course shall be included with the application. The application shall be made on a form provided by IDPH and will include, but not be limited to, the following:

1. Name of applicant, agency and address;
2. Lead Instructor's name, license number, address and contact information;
3. Name and signature of the EMS Medical Director and the EMS System Coordinator;
4. Type of education program;
5. Dates, times and location of the education program (submit course schedule);
6. Goals, objectives and course outline;
7. Methods, materials and text books;
8. Content and time consistent with the National Highway Traffic Safety Administration Emergency Medical Dispatch: National Standard Curriculum and additional course curricula required by IDPH. Initial or modified course syllabi shall be approved by IDPH;
9. Description of evaluation instruments (student, clinical units, faculty and programs); and
10. Requirements for successful completion, when applicable.

D. All EMD education, training, and CE courses shall be coordinated by at least one approved EMS Lead Instructor. The EMS Lead Instructor shall be approved by IDPH.

E. EMD training programs shall be conducted by instructors licensed by IDPH as an EMT or Paramedic who:

1. Are, at a minimum, licensed as emergency medical dispatchers;
2. Have completed am IDPH-approved course on methods of instruction;
3. Have previous experience in a medical dispatch agency; and

4. Have demonstrated experience as an EMS instructor.

F. Any change in the EMD education program's EMS Lead Instructor shall require that an amendment to the application be filed with IDPH.

G. Questions for all quizzes and tests to be given during the EMD education program shall be prepared by the EMS Lead Instructor and available for review by IDPH upon request.

H. All approved programs shall maintain course and student records for seven years. The records shall be made available to IDPH for review upon request.

## V. EMERGENCY MEDICAL DISPATCH AGENCY CERTIFICATION

A. To apply for certification as an emergency medical dispatch agency, the person, organization or government agency that operates an emergency medical dispatch agency shall submit the following to IDPH:

1. A completed emergency medical dispatch agency certification form that includes name and address;

2. Documentation of the use on every request for medical assistance of an emergency medical dispatch priority reference system (EMDPRS) that complies with IDPH requirements and is approved by the EMS Medical Director.

3. Documentation of the establishment of a continuous quality improvement (CQI) program under the approval and supervision of the EMS Medical Director. The CQI program shall include, at a minimum, the following:

a. A quality assistance review process used by the agency to identify EMD compliance with the protocol;
b. Random case review;
c. Regular feedback of performance results to all EMDs;
d. Availability of CQI reports to IDPH upon request; and
e. Compliance with the confidentiality provisions of the Medical Studies Act.

B. A person, organization, or government agency shall not represent itself as an emergency medical dispatch agency unless the person, organization, or government agency is certified by IDPH as an emergency medical dispatch agency.

## VI. EMERGENCY MEDICAL DISPATCH AGENCY RECERTIFICATION

A. To apply for recertification, the emergency medical dispatch agency shall submit an application to IDPH at least 30 days prior to the certification expiration date. The application shall document continued compliance with Section V above.

## VII. REVOCATION OR SUSPENSION OF EMD OR EMERGENCY MEDICAL DISPATCH AGENCY CERTIFICATION

A. The EMS Medical Director shall report to IDPH whenever an action has taken place that may require the revocation or suspension of a license issued by IDPH.

B. Revocation or suspension of an EMD license or emergency medical dispatch agency certification shall be in accordance with rules and regulations set forth by IDPH.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Emergency Medical Responder (EMR) |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMERGENCY MEDICAL RESPONDER (EMR)

## I. EMERGENCY MEDICAL RESPONDER EDUCATION PROGRAMS

A. An Emergency Medical Responder (EMR) education program shall be pre-approved by IDPH and conducted only by an EMS System or a community college under the direction of the EMS System.

B. Applications for approval of EMR education programs shall be filed with IDPH on forms prescribed by IDPH. The application shall contain, at a minimum, name of applicant, agency and address, type of training program, dates of training program, and names and signatures of the EMS MD and EMS System Coordinator.

C. Applications for approval, including a copy of the course schedule and syllabus, shall be submitted at least 60 days in advance of the first scheduled class.

D. The EMS MD of the EMS System shall attest on the application form that the education program will be conducted according to the national EMS education standards. The EMR education program shall include all components of the national EMS education standards, including all modifications required by IDPH. The course hours shall minimally include 52 hours of didactic education.

E. The EMR education program shall designate an EMS Lead Instructor who shall be responsible for the overall management of the education program and shall be approved by IDPH.

F. CE classes, seminars, workshops, or other types of programs shall be approved by IDPH before being offered to EMR candidates. An application for approval shall be submitted to IDPH at least 60 days prior to the scheduled event.

G. Approval will be granted provided that the application is complete and the content of the program is based on topics or materials from the national EMS education standards for the EMR.

H. All approved programs shall maintain course and student records for seven years, which shall be made available to IDPH upon request.

## II. EMERGENCY MEDICAL RESPONDER LICENSURE

A. The EMS MD shall authorize the electronic submission-of licensure application documents to IDPH for an EMR candidate who is at least 18 years of age and has completed and passed all components of the education program, has successfully passed the final examination, and has paid the appropriate initial licensure fee.

B. EMRs who are not affiliated with an EMS System shall have equipment immediately available to provide the standard of care established by the national EMS education standards for the EMR.

C. Region 11 Chicago EMS Systems does not recognize provisional licensure of Emergency Medical Responders.

## III. EMERGENCY MEDICAL RESPONDER LICENSURE RENEWAL

A. To renew an EMR license, the applicant shall submit the following to IDPH at least 60 days, but no more than 90 days, before the license expiration.

1. The submission of an electronic transaction by the EMS MD will satisfy the renewal application requirement for an EMR who has been recommended for re-licensure by the EMS MD.

2. The licensee shall file a written or electronic application for renewal with IDPH no less than 30 days before the license expiration date. Incomplete license applications submitted less than 30 days before the license expiration may not be processed by the expiration date and will be subject to a late fee.

3. EMRs whose licenses have expired may, within 60 days after license expiration, submit all relicensure requirements and submit the required relicensure fees, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and there are no pending disciplinary actions against the EMR, IDPH will relicense the EMR.

4. An EMR who has not been recommended for relicensure by the EMS MD shall independently submit to IDPH an application for renewal. The EMS MD shall provide the EMR with a copy of the application form.

D. A written recommendation signed by the EMS MD shall be provided to IDPH regarding completion of the following requirements:

1. 24 hours of CE every four years. The System shall define in the EMS Program Plan the number of CE hours to be accrued each year for re-licensure; and

2. The licensee shall have current CPR for Healthcare Providers recognition that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

E. EMRs shall be responsible for submitting written proof of CE attendance to the EMS System Coordinator or, for independent renewals, to the IDPH Regional EMS Coordinator. The EMS System Coordinator or IDPH Regional EMS Coordinator shall verify whether specific CE hours submitted by the EMR qualify for renewal.

F. EMRs shall maintain copies of all documentation concerning CE programs that he or she has completed.

G. EMRs whose licenses have expired may, within 60 days after license expiration, submit all relicensure requirements and submit the required relicensure fees, including a late fee, online or in the form of a certified check or money order. Cash or personal check will not be accepted. If all relicensure requirements have been met, and there are no pending disciplinary actions against the EMR, IDPH will relicense the EMR.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMS Mandatory Continuing Education |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# EMS MANDATORY CONTINUING EDUCATION

I. It is the responsibility of the EMS provider to complete any mandatory Region 11 EMS CE assignment as directed by the EMS Medical Directors. Specific details of EMS Mandatory Continuing Education are detailed in memo format by the EMS Medical Directors. EMS Continuing Education can be in the form of "Online CE Assignments" or "In-Person CE Modules".

A. Mandatory Online CE Assignments

1. Mandatory CE assignments will be assigned through the Vector Solutions – EMS Medical Directors Consortium site.

2. EMS providers in Region 11 must complete all mandatory CE assignments within the specified date and time written in the accompanying memo from the EMS Medical Directors.

3. EMS providers that do not achieve a 75% score after three attempts on the quiz will not receive credit for the assignment and must contact their Resource Hospital for review.

4. For an EMS provider to be considered complete, a passing score of 75% and a certificate of completion from the assignment must be obtained.

5. In situations where there is a failure to complete the mandatory CE requirements, the process is detailed below.

B. Mandatory In-Person CE Modules

1. There will be no make-up dates upon completion of a module.

2. If the EMS provider fails to attend the mandatory scheduled module without prior notice and approval by the EMSMD or EMS System Coordinator, they must schedule time with the EMS Coordinator to complete the mandatory CE module.

3. This will be scheduled based on the availability of the EMS System Coordinator.

4. In situations where there is a failure to complete the mandatory CE requirements, the process is detailed below.

II. Failure to Complete Mandatory CE Requirements

A. At the conclusion of a mandatory CE assignment or module, the EMS provider will receive written notification from the EMS System Coordinator via the email associated with their Vector Solutions – EMS Medical Directors Consortium site. This email serves as an official notification of the failure to comply with deadline requirements and includes the intent to suspend from System Participation. The EMS provider employer agency will be copied on

the email notification.

B. Failure to complete a mandatory assignment or module by the deadline, will result in an administrative fee of $100/CE credit hour.

C. After the deadline of the mandatory assignment or module, there is a 15 day grace period to complete the CE requirements and arrange payment of the administrative fee with the EMS provider's assigned EMS System Coordinator (per the profile in Vector Solutions).

D. Failure to complete requirements of the mandatory CE and administrative fee payment within the 15 day grace period, will result in suspension of System Participation in Region 11.

E. This grace period serves as an opportunity for the EMS provider to have due process prior to suspension of System Participation in Region 11. Refer to the Region 11 EMS System Participation Suspension Policy for additional details.

F. The suspension of EMS System Participation will continue until the EMS provider completes all the requirements as noted above.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMS Personnel License Requirements and Renewals |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMS PERSONNEL LICENSE REQUIREMENTS AND RENEWALS

## I. EMS SYSTEM PERSONNEL LICENSE RESPONSIBILITIES

A. EMS personnel are individually responsible for maintaining Continuing Education (CE) certificates as required by IDPH and the EMS System for the license renewal process.

B. EMTs and Paramedics that are active in the Chicago EMS Systems (Region 11) are required to maintain a Vector Solutions account on the EMS Medical Directors Consortium site to maintain EMS CE records. This allows the Resource Hospital to track, verify, and assign CE.

C. EMS personnel should maintain current address, email, and phone number with their EMS System and IDPH. In the event of a change of address, a written notification to IDPH, the EMS System, and the employer must be submitted within 30 days. EMS personnel must also simultaneously update their profile on the Vector Solutions – Region 11 EMS Medical Directors Consortium site.

D. At the time of initial licensure or renewal, all license holders shall fully disclose any new felony convictions. All EMS licensees should report all new felony convictions in writing to the EMS System and IDPH within seven days after the conviction.

E. EMS personnel must carry a copy of their license and photo identification while on duty.

F. Upon receipt of a renewed EMS license, a copy should be uploaded to the Vector Solutions – Region 11 EMS Medical Directors Consortium site to the corresponding EMS license located under the credential section.

G. IDPH licensed EMS personnel that are credentialed to work in another EMS System should designate their status with the Resource Hospital on their Vector Solutions profile noting their “Primary EMS System” for CE and license renewal and any “Secondary EMS System.”

H. As an EMS System participant, all Region 11 EMS personnel must report to the EMS Medical Director (EMSMD) or EMS Coordinator when requested for a patient care run review.

## II. IDPH EMS LICENSE RENEWAL PROCESS

A. Within 90 days of license renewal, IDPH will mail a “Renewal Form” to EMS personnel at their respective **home address**. This form will provide a **PIN number** and the **IDPH EMS Licensing website address.**

B. Using the “EMS Licensing Online Fee Payment” link on the IDPH EMS Licensing website, EMS personnel must complete the ***EMS Systems Renewal Notice/Child Support/Personal History*** statement and answer all the prompts.

1. During this process, you must select your current Resource Hospital EMS System number:

a. Advocate Illinois Masonic Medical Center (#1103)
b. John H. Stroger, Jr., Hospital of Cook County (#1178)
c. Northwestern Memorial Hospital (#1108)
d. University of Chicago Medicine (#1113)

C. The online form submission will notify your EMS System that you are applying for renewal. The Resource Hospital in the EMS System must then verify that submitted CE hours are valid, the required amount of hours for license renewal are completed, the Child Support Statement and Felony Conviction Statement are submitted and approve EMS personnel for license renewal in the IDPH database.

D. EMS personnel that do not meet all the IDPH requirements within the four-year license period (i.e. the required amount of continuing education hours, not current with CPR certification, have not completed an approved Dementia continuing education, or have NOT completed the IDPH EMS web license renewal requirement) will not be recommended for license renewal.

E. **It is solely the responsibility of EMS personnel to follow the IDPH instructions for license renewal**. EMS personnel should contact their respective Resource Hospital with questions regarding their submission of the online application for license renewal and to review the required amount of continuing education content and hours.

F. If all renewal requirements have not been met, the EMS license will lapse.

G. If all renewal requirements have not been met after 60 days, the EMS license will expire.

H. License renewal fees will be assessed and paid online to IDPH.

## III. IDPH EMS LICENSE RENEWAL REQUIREMENTS

A. To be relicensed, the licensee shall file an application for renewal at least 30 days prior to the license expiration date. Incomplete license applications submitted to IDPH less than 30 days before the expiration may not be processed by the expiration date and may be subject to a late fee.

1. In addition to completion of the renewal application and payment of the renewal fee, a licensee who functions within an EMS System shall submit documentation of completion of CE requirements to his or her EMS System of primary affiliation at least 30 days before the expiration of his or her license.

2. A licensee who does not function within an EMS System, and who seeks independent renewal, shall submit documentation of completion of CE requirements to IDPH at least 30 days before the expiration of his or her license.

3. A licensee who has not been recommended for license renewal by the EMS MD shall independently submit an application to IDPH. The EMS MD shall provide a written statement stating the reason for the denial of license renewal to the licensee and IDPH. The application for independent renewal may be found on the IDPH's Division of EMS website.

B. **EMS System CE Requirements**. Proof of valid continuing education hours satisfying IDPH and EMS System requirements over a 4-year license period must be reviewed and verified by the Resource Hospital prior to license renewal. The EMS MD or designee shall provide an electronic authorization to IDPH regarding completion of the following minimum requirements:

1. **Continuing Education (CE) Hour Requirements**:

   a. EMTs must complete 20 hours of EMS system-approved CE per year, for a total of 80 hours per license period.
   b. Paramedics must complete 30 hours of EMS system-approved CE per year, for a total of 120 hours per license period.
   c. It is the responsibility of the EMS personnel to complete all mandatory Region 11 EMS CE assignments, as directed by the EMS Medical Directors Consortium (refer to EMS Mandatory Continuing Education Policy).

2. **Continuing Education (CE) Hour Content:**

   a. All EMS CE shall consist of EMS System-approved courses, IDPH-recognized college health care courses, online CE courses, seminars, workshops, addressing adult and pediatric care.
   b. EMS CE should be in core content category hours as defined in the EMS Continuing Education Relicensure Requirements Policy.
   c. No more than 20 percent of those CE hours may be in the same subject.
   d. Each continuing education course may only be submitted once per licensure period.

3. **CPR Certification**: The licensee shall have proof of current CPR for Healthcare Providers that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

4. **Dementia Course**: For license renewals occurring on or after January 1, 2023, EMS personnel must complete at least one one-hour course of training on the diagnosis, treatment, and care of individuals with Alzheimer's disease or other dementias per license renewal period. This training shall include, but not be limited to, assessment and diagnosis, effective communication strategies, and management and care planning. EMS courses on dementia can be found in the Vector Solutions Learning Management Systems (LMS) library.

5. **Pediatric Skills**: For license renewals occurring on or after July 1, 2026, EMS personnel must participate in a Pediatric Core Content Course with a psychomotor skills component at minimum once per license renewal period as defined in the EMS Continuing Education Relicensure Requirements Policy

C. The license of EMS personnel who have failed to file a completed application for renewal on time shall be invalid on the day following the expiration date shown on the license. EMS personnel shall not function on an expired license.

D. IDPH shall require the licensee to certify on the renewal application form, under penalty of perjury, that he or she is not more than 30 days delinquent in complying with a child support order.

## IV. EMS PERSONNEL LICENSURE DOWNGRADES AND UPGRADES

A. At any time prior to the expiration of the current license, an EMT or Paramedic may downgrade to EMT or EMR status for the remainder of the license period. The EMT or Paramedic shall make this request in writing to the EMS MD of his or her System of primary affiliation along with a signed renewal notice and his or her original EMS license and duplicate license fee. The EMS MD or designee shall verify that the license is current with CE hours and forward the approved applications to IDPH. To relicense at the EMT or EMR level, the individual must meet the license renewal requirements for that downgraded level.

B. EMS personnel who have downgraded to EMT status may subsequently upgrade to his or her original Paramedic license held at the time of the downgrade upon the recommendation of an EMS MD who has verified that the individual's knowledge and psychomotor skills are at the level of the licensure being requested. The individual shall complete any education or testing deemed necessary by the EMS MD for resuming Paramedic activities and submit a duplicate license fee. EMS personnel cannot upgrade from the EMR level.

## V. EXPIRED EMS LICENSES

A. EMS personnel whose licenses have expired may, within 60 days after license expiration, submit all license renewal requirements and submit the required fees, including a late fee, online or by certified check or money order. Cash or personal check will not be accepted. If all license renewal requirements have been met, and no disciplinary actions are pending against the EMS personnel, IDPH will relicense the EMS personnel.

B. EMS personnel whose licenses have expired for a period of more than 60 days shall be required to reapply for licensure, complete the education program, pass an IDPH-approved licensure examination, and pay the fees as required for initial licensure. Within 36 months after expiration of a license, an individual may qualify for reinstatement.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMS Personnel Reinstatement |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# EMS PERSONNEL REINSTATEMENT

## I. REINSTATEMENT

A. A IDPH licensed EMD, EMR, EMT, Paramedic or ECRN whose license has been expired for less than 36 consecutive months, and had been active in Region 11 under an EMS System, may submit an application for reinstatement by IDPH by completion of the following:

1. Submit proof of completion of CE hours.

2. Receive a positive recommendation in writing from the EMS Medical Director verifying competency of all skills at the level of licensure.

3. Successfully complete an IDPH approved test for the level of EMS license to be reinstated, in accordance with Section 515.530.

4. A fee will be assessed as per IDPH and may be assessed by the Resource Hospital.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Preceptor |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# EMS PRECEPTOR

## I. DEFINITION

A. The EMS preceptor is a clinical role model, mentor and evaluator for EMS students in the field setting.

B. The EMS preceptor must have thorough knowledge of the Region 11 EMS Protocols, Policies, and Procedures.

## II. PREREQUISITES

A. Required:

1. One year experience as a licensed Paramedic within Region 11 EMS or alternate experience.
2. No sustained complaints in the Paramedic's file within the past 12 months.
3. Professional references.
4. Recommendation by the Paramedic's EMS Coordinator and EMS Medical Director.
5. Approval by the EMS Medical Directors Consortium.

B. Preferred:

1. EMS teaching experience (CPR, initial or continuing EMT or Paramedic education courses)
2. CPR instructor certification
3. ACLS certification
4. ITLS or PHTLS certification
5. PEPP or PALS certification
6. Licensed IDPH Lead Instructor or National Association of EMS Educators (NAEMSE) Instructor Course 1 (IC1) certificate.
7. Regularly performing direct EMS patient care or responsible for ensuring quality patient care.

C. Preceptors are reviewed annually by the EMS Medical Director’s Consortium.

## III. CONTINUING EDUCATION HOURS FOR CLINICAL PRECEPTING OF AN EMS STUDENT

A. Preceptors must attend an annual Preceptor Workshop

1. Curriculum includes educational theory, strategies, and development.

2. Content is specific to the EMS education program hosting the EMS Preceptor.

3. Continuing education (CE) hours are provided for successful completion of the Preceptor Workshop.

B. Preceptors that have been approved by Region 11 may earn additional continuing education (CE) hours for clinical precepting of an EMS student if there is both:

1. An assigned EMS student for field internship; and

2. Completion of EMS student evaluations.

C. Preceptors may earn 6 hours of EMS CE each year in the elective core content category for this role.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Provider Impairment and Substance Abuse |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS PROVIDER IMPAIRMENT AND SUBSTANCE ABUSE

## I. PURPOSE

To ensure patient and coworker safety through the rapid identification of prehospital personnel who are impaired or displaying signs and symptoms of a substance abuse disorder and removing them from the patient care environment.

## II. DEFINITIONS

A. Impairment: A condition where any of the body's sensory, cognitive, or motor functions or capabilities are altered, diminished, or affected due to the use of alcohol and/or drugs.

B. Substance Abuse Disorder: A pattern of harmful use of any substance for mood altering purposes. This can include the use of alcohol, prescription and over-the-counter drugs, illegal drugs, and controlled substances.

## III. POLICY

A. Region 11 Chicago EMS recognizes that substance abuse as a health-related disorder. However, EMS system providers and patients may suffer adverse effects in the presence of providers whose work performance is below acceptable standards due to alcohol or drug use or impairment. Therefore, any EMS provider found to be under the influence of drugs and/or alcohol shall be deemed unfit to work and relieved of duty until the situation is investigated.

B. This policy does not prohibit EMS providers from possessing, using or being under the influence of medication that a physician had prescribed for them as long as the medications are used for prescribed purpose, in prescribed dosages, and do not compromise the EMS provider's professional duty and patient care.

C. The use, sale, or distribution of drugs and alcohol while representing the Region 11 Chicago EMS System, or reporting to work under the influence drugs and/or alcohol is grounds for disciplinary action up to and including suspension under the EMS System Participation Suspension Policy.

D. The use, sale, purchase, transfer, theft, or possession of an illegal drug is a violation of the federal law. This includes, but is not limited to, illegal drug and prescription medications or controlled substances not being used for the prescribed purpose, by the correct person, or using the correct dose.

E. Anyone in violation of illegal drug activities while on or off duty will be referred to law enforcement, the EMS System Medical Director, and IDPH by the employer agency.

**F. Impaired EMS Providers**

1. All employers and EMS agencies with EMS personnel in the Region 11 EMS System must have a policy to address EMS personnel who are suspected to be impaired while on duty.

2. Whenever an EMS provider is suspected to be under the influence of drugs and/or alcohol, the provider shall be relieved from duty and the incident should be immediately reported to the EMS System Medical Director, as well as the provider's supervisor. Findings will be forwarded to IDPH by the Resource Hospital. Concerns of this nature are confidential.

3. Prior to returning to duty, any individual removed from duty by his/her employer for documented reasons of impairment, must have documentation forwarded to the EMS System Medical Director that he/she is medically and psychologically capable of resuming EMS System participation.

**G. EMS Provider Substance Abuse**

1. All employers and EMS agencies with EMS personnel in the Region 11 EMS System must have a policy addressing substance abuse by EMS System personnel while on duty.

2. If EMS providers with suspected substance abuse disorder do not attempt to correct problems related to their drug and/or alcohol use, they will be subject to disciplinary action up to and including suspension in accordance with the EMS System Suspension Policy. Findings will be forwarded to IDPH by the Resource Hospital.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMS Reciprocity |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMS RECIPROCITY

## I. PURPOSE

To allow for an EMD, EMR, EMT or Paramedic licensed or certified in another state, territory or jurisdiction of the United States seeking licensure in Illinois to apply to IDPH for licensure by reciprocity, using an IDPH-approved form and available on the IDPH website: https://dph.illinois.gov/content/dam/soi/en/web/idph/files/forms/emsreciprocityapplication.pdf

## II. DEFINITION

Reciprocity: Allows EMDs, EMRs, EMTs and Paramedics who are licensed in another state, the military, and/or certified by the National Registry of Emergency Medical Technicians (NREMT) to apply for licensure in Illinois using a streamlined process.

## III. STATE TO STATE RECIPROCITY

A. The reciprocity application shall contain the following information:

1. Verifiable proof of current state, territory or jurisdiction licensure or certification, or current registration with NREMT;

2. A written statement of satisfactory completion of an education program that meets or exceeds the requirements of IDPH;

3. A letter of recommendation from the EMS Medical Director of the EMS System in the state, territory, or jurisdiction from which the individual is licensed. The letter should include a statement that the applicant is currently in good standing and up to date with continuing education (CE) hours; and

4. A current CPR for Healthcare Providers card that covers didactic and psychomotor skills that meet or exceed American Heart Association guidelines.

B. IDPH will review requests for reciprocity to determine compliance with the applicable provisions of IDPH Section 515.610. CE hours from the state of current licensure will be prorated based on the expiration date of the current license.

C. Individuals who meet the requirements for licensure by reciprocity will be State licensed consistent with the expiration date of their current license but not to exceed a period of four years.

D. Following licensure by reciprocity, the individual must comply with the requirements of IDPH Section 515.590 for relicensure.

## IV. NREMT RECIPROCITY AND PROVISONAL SYSTEM STATUS

A. IDPH shall permit immediate reciprocity to all EMS personnel who hold an unencumbered National Registry of Emergency Medical Technicians (NREMT) certification for EMTs or Paramedics, allowing such individuals to operate in an EMS System under a provisional system status until an Illinois license is issued.

B. To operate on an EMS System transport or non-transport IDPH licensed vehicle under provisional system status, an individual must have applied for licensure with IDPH and meet all requirements under the Act. All IDPH-required application materials for submission must be provided to the EMS System for review prior to system provisional reciprocity approval.

C. The EMS System has the responsibility for validating National Registry Certification of each individual.

D. An individual with a Class X, Class 1 or Class 2 felony conviction or out-of-state equivalent offense, as described in IDPH Section 515.190, is not eligible for provisional system status.

## V. REGION 11 CHICAGO EMS

This policy applies specifically to EMDs, EMRs, EMTs and Paramedics, as Region 11 Chicago EMS does not recognize the A-EMT licensure levels within their EMS Systems.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS Scope of Practice |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS SCOPE OF PRACTICE

## I. PURPOSE

To define the EMS scope of practice for licensed health care personnel at the level of Emergency Medical Responder (EMR), Emergency Medical Technician (EMT), and Paramedic within Region 11.

## II. DEFINITION

Scope of Practice: A legal description of the distinction between licensed health care personnel and the lay public as well as among the different levels of licensed health care professionals.

## III. FRAMEWORK

The National EMS Scope of Practice Model establishes a framework that determines the range of skills and roles that an individual possessing a State of Illinois EMS license is authorized to do in an EMS System. This is based on the fact that education, certification, licensure, and credentialing are four separate, but related activities.

A. **Education**: Includes all cognitive, psychomotor, and affective learning that individuals have undergone including initial EMS education, continuing education, and informal learning.

B. **Certification**: An external verification of competencies that an individual has achieved to assure safe and effective patient care and involves an examination process (example: National Registry certification).

C. **Licensure**: Represents legal authority granted by the State of Illinois for an individual to practice patient care at a certain level of EMS practitioner (example: IDPH license for EMR, EMT, Paramedic).

D. **Credentialing**: Clinical determination of a physician EMS Medical Director for an EMS practitioner to work in an EMS System (example: EMS system entry and competency testing).

## IV. EMS SCOPE OF PRACTICE:

As defined in the National EMS Scope of Practice Model and shown below, an individual may only perform a skill or role for which that person is:

A. Educated (has been trained to perform the skill or role); AND

B. Certified (has demonstrated competence in that skill or role); AND

C. Licensed (has legal authority issued by the State of Illinois to perform the skill or role); AND

D. Credentialed (has been authorized by the EMS Medical Director to perform that skill or role).

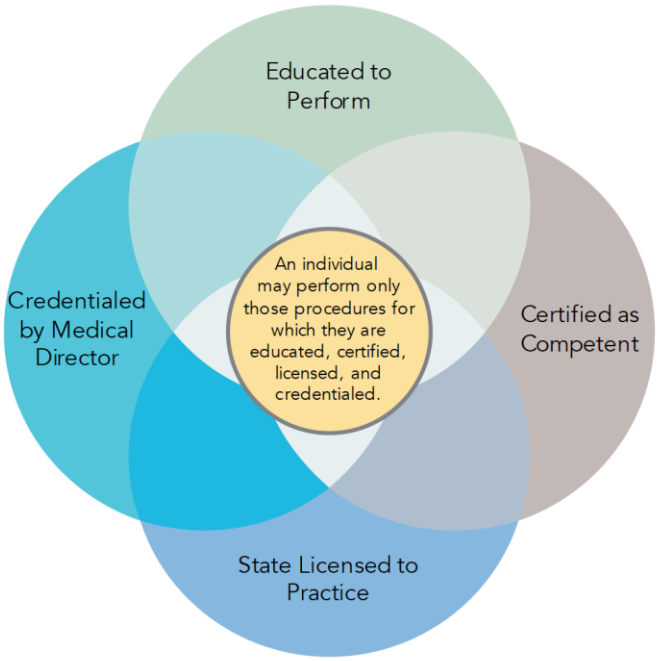


Image adapted from 2019 National EMS Scope of Practice Model, National Highway Traffic Safety Administration Office of EMS - https://www.ems.gov/national-ems-scope-of-practice-model/

## V. DESCRIPTION OF EMS LICENSURE LEVELS

A. **Emergency Medical Responder (EMR):** An out-of-hospital practitioner whose primary focus is to initiate immediate lifesaving care to patients while ensuring patient access to the Emergency Medical Services (EMS) system. EMRs possess the basic knowledge and skills necessary to provide lifesaving interventions while awaiting additional EMS response or working with higher-level medical personnel.

B. **Emergency Medical Technician (EMT):** A health professional whose primary focus is to respond to, assess, and triage emergent, urgent, and non-urgent requests for medical care, and apply the basic knowledge and skills necessary to provide patient care and medical transportation to and from an emergency or other health care facilities.

C. **Paramedic:** A health professional whose primary focus is to respond to, assess, and triage emergent, urgent, and non-urgent requests for medical care, and apply the basic and advanced knowledge and skills necessary to determine patient physiologic, psychological, and psychosocial needs, administer medications, interpret and use diagnostic findings to

implement treatment, provide complex patient care, and facilitate referrals and/or access to a higher level of care when the needs of the patient exceed the capability level of the paramedic. Paramedics commonly facilitate medical decisions at an emergency scene and during transport.

D. While the Illinois EMS Act recognizes EMT-Is and A-EMTs as additional EMS licensure levels, Region 11 Chicago EMS does not recognize them in their EMS Systems.

## VI. REGION 11 CHICAGO EMS

A. Region 11 Chicago EMS is comprised of 4 EMS System Medical Directors (collectively "Chicago EMS") that credential EMRs, EMTs, and Paramedics to work under defined regional EMS Protocols, Policies, and Procedures.

1. **EMS Protocols**: Patient care guidelines written for all levels of EMS practitioners.

2. **EMS Policies**: Scene management and destination guidelines written for all levels of EMS practitioners.

3. **EMS Procedures:** Defines the procedures authorized by level of EMS licensure.

## VII. IDPH REGULATIONS

A. Any person currently licensed as an EMT or Paramedic may only perform emergency and non-emergency medical services in accordance with his or her level of education, training and licensure, the standards of performance and conduct prescribed in IDPH Section 515.550, and the requirements of the EMS System in which he or she practices, as contained in the approved System Polices and Protocols. IDPH may, by written order, temporarily modify individual scopes of practice in response to public health emergencies for periods not to exceed 180 days.

B. EMS Personnel who have successfully completed an IDPH-approved course in automated external defibrillator operation, and who are functioning within an IDPH-approved EMS System, may use an automated external defibrillator according to the standards of performance and conduct prescribed by IDPH in Section 515.550, and the requirements of the EMS System in which they practice, as contained in the approved System Policies and Protocols.

C. An EMT or Paramedic who has successfully completed an IDPH-approved course in the administration of epinephrine shall be required to carry epinephrine with him or her as part of the EMS Personnel medical supplies whenever he or she is performing official duties, as determined by the EMS System.

D. An EMR, EMT, or Paramedic may only practice as an EMR, EMT, or Paramedic or utilize his or her EMR, EMT, or Paramedic license in pre-hospital or inter-hospital emergency care settings or non-emergency medical transport situations, under the written or verbal direction

of the EMS Medical Director. For purposes of this section, a "pre-hospital emergency care setting" may include a location that is not a health care facility, which utilizes EMS Personnel to render pre-hospital emergency care prior to the arrival of a transport vehicle. The location shall include communication equipment and all of the portable equipment and drugs appropriate for the EMT or Paramedic's level of care, and the protocols of the EMS Systems, and shall operate only with the approval and under the direction of the EMS Medical Director.

E. This does not prohibit an EMR, EMT, or Paramedic from practicing within an emergency department or other health care setting for the purpose of receiving continuing education or training approved by the EMS Medical Director. This also does not prohibit an EMT or Paramedic from seeking credentials other than his or her EMT or Paramedic license and utilizing such credentials to work in emergency departments or other health care settings under the jurisdiction of that employer.

F. A student enrolled in an IDPH-approved EMS Personnel program, while fulfilling the clinical training and in-field supervised experience requirements mandated for licensure or approval by the EMS System and IDPH, may perform prescribed procedures under the direct supervision of a physician licensed to practice medicine in all of its branches, a qualified RN or a qualified EMS Personnel, only when authorized by the EMS Medical Director.

## VIII. REFERENCES

A. National EMS Scope of Practice Model 2019: (https://www.ems.gov/pdf/National_EMS_Scope_of_Practice_Model_2019.pdf)

# REGION 11 CHICAGO EMS SCOPE OF PRACTICE

| | Emergency Medical Responder (EMR) | EMT (BLS) | Paramedic (ALS) |
|---|---|---|---|
| **Skill: Patient Assessment / Management** | | | |
| Blood Glucose Monitoring | | X | X |
| Medical Patient Assessment | | X | X |
| Neurologic Patient Assessment | | X | X |
| Patient Restraint | | X | X |
| Pediatric Assessment | | X | X |
| Stroke Patient Assessment | | X | X |
| Trauma Patient Assessment | | X | X |
| **Skill: Airway / Ventilatory Management** | | | |
| Airway – Nasal | | X | X |
| Airway – Oral | | X | X |
| Airway Opening (head tilt-chin lift, jaw thrust) | | X | X |
| Bag Valve Mask (BVM) | | X | X |
| Capnography (monitoring and interpretation) | | | X |
| CPAP | | | X |
| Endotracheal Intubation | | | X |
| Foreign Body Removal (Magill forceps) | | | X |
| I-gel Supraglottic Airway | | X | X |
| Oxygen Therapy | | X | X |
| Suction Upper Airway | | X | X |
| **Skill: Cardiac Management** | | | |
| Cardiac Arrest Management (ICCA) | | X | X |
| Cardiac Monitoring (12 lead Electrocardiogram (ECG) acquisition and transmission) | | | X |
| Cardiac Monitoring (4 lead) | | | X |
| Death Notification | | | X |
| Defibrillation (automatic) | X | X | X |
| Manual Defibrillation | | | X |
| Synchronized Cardioversion | | | X |
| Transcutaneous Pacing | | | X |
| **Skills: Trauma Management** | | | |
| Cervical Collar Application | | X | X |
| Chest Seal Application (HyFin Vent) | | X | X |
| Hemorrhage Control (direct pressure) | | X | X |

| | | | |
|---|---|---|---|
| Hemorrhage Control (pressure dressing) | | X | X |
| Hemorrhage Control (tourniquet) | | X | X |
| Hemorrhage Control (wound packing) | | X | X |
| Joint Splinting | | X | X |
| Long Bone Splinting | | X | X |
| Pleural (Chest) Decompression | | | X |
| Spinal Motion Restriction (SMR) | | X | X |
| START / JumpSTART triage | | X | X |
| Traction Splinting | | X | X |
| **Skills: Medication Administration/Access** | | | |
| Access Indwelling Catheters and Central IV Ports | | | X |
| Buretrol | | | X |
| Inhaled | | X | X |
| Intramuscular (Autoinjector) | | X | X |
| Intramuscular (IM) | | X | X |
| Intranasal (IN) | | X | X |
| Intraosseous (IO) Insertion | | | X |
| Intravenous (IV) Insertion | | | X |
| Intravenous Medication Administration | | | X |
| Medication Administration Cross Check (MACC) | | X | X |
| Mucosal / Sublingual | | | X |
| Nebulized (aerosolized) | | X | X |
| Oral | | | X |
| Vaccine Administration | | | X |
| **Skills: Obstetric / Pediatric Management** | | | |
| Assisted Delivery (childbirth) | | X | X |
| Neonatal Resuscitation | | X | X |
| Pediatric Measuring Tape / Medication Dosing | | | X |

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS System Entry |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS SYSTEM ENTRY

## I. PREREQUISITES

A. EMS System Entry is the process of education, written testing, and skill verification of an applicant to the Region 11 EMS Protocols, Policies and Procedures in order to be credentialed to provide prehospital patient care under the EMS Medical Director.

B. A licensed EMS provider, prior to entering Region 11, is considered an "applicant" to the EMS system.

C. Applicants are required to have a current CPR certification and an IDPH EMS license as below:

1. Emergency Medical Dispatcher (EMD)
2. Emergency Medical Responder (EMR)
3. Emergency Medical Technician (EMT)
4. Paramedic
5. Emergency Communications Registered Nurse (ECRN)

D. Applicants are required to work for an EMS agency within Region 11.

E. Additional requirements:

1. Current and valid government issued identification.
2. Letter of good standing from the last EMS system in which the applicant worked.

## II. EMS SYSTEM ENTRY PROCESS

A. EMS System Entry Orientation

1. The EMS agency will schedule a date for EMS System Entry with the Resource Hospital EMS Coordinator.
2. The initial EMS System Entry orientation session with the Resource Hospital EMS Coordinator, EMS Medical Director or designee will include:
   a. Overview of Region 11 EMS Protocols, Policies, and Procedures
   b. Review materials for studying
   c. Details of the EMS System Entry exam

d. Instructions for creating a Vector Solutions – EMS Medical Directors Consortium account (for EMTs and Paramedics)
e. Expectations on EMS continuing education tracking and IDPH relicensure
f. Process for scheduling the EMS System Entry exam within two weeks of the initial orientation

B. EMS System Entry Exam

1. EMS System Entry testing will consist of a written examination and skills validation.

2. All EMS System Entry testing must be completed within 21 calendar days, unless prior arrangements have been made.

3. The minimum passing score is 75% on both the written examination and skill validation. A score of less than 75% on either section requires a retest within two weeks.

4. It is the responsibility of the EMS provider to review the failed exam or skill and perform focused self-education prior to retesting.

5. There will be two retesting opportunities to complete EMS System Entry. Applicants that fail retesting may repeat the EMS System Entry process after 3 months with proof of re-education during that time.

## III. EMS PROVIDER STATUS

A. Individuals that are able to maintain continuing education requirements are considered to remain “participating” in the EMS System.

B. Individuals that are not able to maintain continuing education requirements for a period of <u>less than twelve months</u> due to a medical leave, change in EMS system, or change in employer are considered to be “not participating” in the EMS System and will be required to successfully complete any mandatory EMS Continuing Education assignments prior to returning to EMS System Participation.

C. Individuals that are not able to maintain continuing education requirements for a period of <u>twelve months or greater</u> due to a medical leave, change in EMS system, or change in employer are considered to be “not participating” in the EMS System will be required to complete the full EMS System Entry process including any mandatory EMS Continuing Education assignments prior to returning to EMS System Participation.

D. It is the responsibility of the EMS provider and their employer to notify the Resource Hospital EMS System Coordinator in these situations.

## IV. CREDENTIALING

A. After successful completion of EMS system entry requirements, the licensed EMS provider will be credentialed to provide medical care within Region 11.

B. In order to maintain credentials, EMS providers must complete all mandatory EMS education and skills requirements as defined by the EMS System Medical Director.

C. EMTs and Paramedics must maintain a Vector Solutions – EMS Medical Directors Consortium account in order to remain credentialed in Region 11.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMS System Inventory Requirements |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS SYSTEM INVENTORY REQUIREMENTS

## I. PURPOSE

To define the responsibilities of the EMS provider and the EMS agency in maintaining drugs, equipment and supplies as defined by the EMS System and managed by the EMS agency.

## II. POLICY

A. Each EMS personnel is responsible for completing a daily inventory review and report on **all licensed EMS vehicles involved with delivering patient care.**

B. A daily inventory form will be completed on a daily basis and available for review to the Resource Hospitals on a 24/7 basis.

C. A monthly report will be available for review by the Resource Hospital to verify compliance of daily inventory and weekly supply inventory.

D. Only medication, equipment, and supplies as listed on the Region 11 Drug, Equipment, and Supply list or otherwise approved by the Resource Hospital can be used for patient care.

E. The daily inventory inspections must include the following components:

1. Medications will be inspected on a daily basis and inventory form completed.

2. All airway equipment, cardiac equipment, and response bags will be inspected on a daily basis and inventory form completed.

3. It is the responsibility of the EMS provider to notify their supervisor for any expiring medication or supplies within one month of expiration.

4. It is the responsibility of the EMS agency to internally manage and replace the stock of expiring medication and equipment in advance of the expiration date.

5. It is the responsibility of the EMS agency to internally manage and replace the stock of expiring medication (with the exception of Controlled Substances as detailed below) and equipment in advance of the expiration date.

## III. CONTROLLED SUBSTANCES

A. Controlled substances should be carefully inspected daily and an inventory form should be signed and dated by each ALS company as per the Controlled Substance Requirements Policy.

B. Expiring Controlled Substances should be replaced within seven calendar days at the assigned Resource or Associate Hospital as defined in the Controlled Substance Requirements Policy.

C. Any damage, loss, tampering or expired controlled substances should be immediately brought to the attention of the Resource Hospital EMS Coordinator and the EMS agency supervisor in verbal and written format. Findings will be forwarded to IDPH.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: EMS System Participation Suspension |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# EMS SYSTEM PARTICIPATION SUSPENSION

I. An EMS MD may suspend from participation within the EMS System any EMS Personnel, EMS Lead Instructor (LI), individual, individual provider or other participant considered not to be meeting the requirements of the Program Plan of that approved EMS System (Section 3.40(a) of the EMS Act).

**II. EMS System Participation Suspensions are based on one or more of the following:**

A. Failure to meet the education or relicensure requirements as defined by IDPH or the EMSMD;

B. Violation of the EMS Act or any rule or regulation under the Act;

C. Failure to comply with the Region 11 EMS System Protocols, Policies, and Procedures;

D. Violation of the EMS System's standards of care;

E. Failure to maintain proficiency in the level of skills for which he or she is licensed;

F. During the provision of emergency services, engaging in dishonorable, unethical, or unprofessional conduct of a character likely to deceive, defraud or harm the public;

G. Intoxication or use of illegal drugs while on duty including controlled substances or other drugs or stimulants that adversely affect the delivery, performance or activities of patient care;

H. Intentional falsification of any medical documents or reports, or making misrepresentations involving patient care;

I. Abandoning or neglecting a patient requiring emergency care;

J. Unauthorized use or removal of narcotics, drugs, supplies, or equipment from any ambulance, health care facility or other work place location;

K. Performing or attempting emergency care, techniques or procedures without proper permission, licensure, training or supervision;

L. Discrimination in rendering emergency care because of race, sex, creed, religion, national origin or ability to pay;

M. Medical misconduct or incompetence or a pattern of continued or repeated medical misconduct or incompetence in the provision of emergency care;

N. Physical impairment to the extent the individual cannot physically perform the emergency care for which the individual is licensed, as verified by a physician, unless the person is on inactive status pursuant to Illinois Department of Public Health (IDPH) regulations;

O. Mental impairment to the extent that the individual cannot exercise the appropriate judgment, skill and safety for performing the emergency care for which the individual is licensed, as verified by a physician, unless the person is on inactive status pursuant to IDPH regulations;

P. Conviction of an Illinois Class X, Class 1 or Class 2 felony or out-of-state equivalent; or

Q. Failure to report a felony conviction to the assigned Resource Hospital within seven days after the conviction.

## III. EMS System Participation Suspension Process

A. Except in cases of immediate suspension, the EMS MD shall provide the individual, individual provider or other participant with a written explanation of the reason for the suspension; the terms, length and condition of the suspension; and the date the suspension will commence, unless a hearing is requested. The procedure for requesting a hearing within 15 days through the Local System Review Board shall be provided.

B. EMS System Participation Suspensions related to failure to successfully complete a mandatory Continuing Education assignment or module, as defined in accompanying memo by the EMS Medical Directors, shall be accompanied by written notice emailed to the suspended participant from the EMSMD. Refer to the Region 11 EMS Mandatory Continuing Education Policy for further details.

C. The suspended participant shall have the opportunity to request a review of the suspension by a board designated by the System, or directly to the State EMS Disciplinary Review Board for immediate suspensions.

D. The EMS provider's employer will be notified of an EMS System Participation Suspension (see Region 11 System Review Board Policy).

E. If the licensed EMS Personnel is known to have dual participation with another EMS System, that EMS System will be notified of the system suspension.

## IV. Immediate EMS System Participation Suspension

A. An EMS MD may immediately suspend an EMR, EMD, EMT, Paramedic, ECRN, PHRN, PHAPRN, PHPA, LI, or other individual or entity if he or she finds that the continuation in practice by the individual or entity would constitute an imminent danger to the public. The suspended individual or entity shall be issued an immediate verbal notification, followed by a written suspension notice by the EMS MD that states the length, terms and basis for the suspension (Section 3.40(c) of the Act).

1. Within 24 hours following the commencement of the suspension, the EMS MD shall deliver to IDPH, by email, a copy of the suspension notice and copies of any written materials that relate to the EMS MD's decision to suspend the individual or entity.

2. Within 24 hours following the commencement of the suspension, the suspended individual or entity may deliver to IDPH, by email, a written response to the suspension notice and copies of any written materials that the individual or entity feels are appropriate.

3. Within 24 hours following receipt of the EMS MD's suspension order or the individual entity's written response, whichever is later, the IDPH Director or the Director's designee, shall determine whether the suspension should be stayed (put off) pending an opportunity for a hearing or review in accordance with the Act, or whether the suspension should continue during the course of that hearing or review. The IDPH Director or the Director's designee, shall issue this determination to the EMS MD, who shall immediately notify the suspended individual or entity. The suspension shall remain in effect during this period of review by the IDPH Director or the Director's designee.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS System Review Board |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# EMS SYSTEM REVIEW BOARD

I. Upon receipt of a Notice of EMS System Participation Suspension from the EMS Medical Director, the EMS personnel or ambulance service provider, or other system participant shall have fifteen days to request a hearing before the System Review Board, by submitting a written request to the EMS Medical Director and EMS System Coordinator via e-mail. Failure to request a hearing within fifteen days shall constitute a waiver of the right to a Local System Review Board Hearing. The decision of the EMSMD shall be considered final and the EMS System Participation Suspension shall commence.

II. The Resource Hospital shall designate the Local System Review Board for the purposes of conducting a hearing to the individual or entity participating within the EMS System that has received the Suspension Notice. The Local System Review Board will consist of at least three members, one of whom is an Emergency Department Physician with the knowledge of EMS, and one of whom is an EMT or Paramedic, and one of whom is of the same professional category as the individual EMS personnel, individual ambulance service provider, or other EMS System participant requesting the hearing.

III. The hearing shall commence as soon as possible but within at least 21 days after receipt of a written request. The suspended participant shall be notified by e-mail of the date, time and place of the hearing and shall receive a copy of this policy. For good cause, the hearing may be changed upon advance request by one of the parties.

IV. The Board shall review and consider any testimony and documentation related to the suspension which is offered by either the EMSMD or the suspended party.

V. The EMSMD and the suspended party may both elect to have legal counsel representation.

VI. A hearing held by the System need not be formal in legal terms, nor need it adhere to established rules of evidence. The hearing shall be conducted in a fair and objective manner under procedures outlined:

A. Each party to the proceedings shall have the right to select a person to represent him/her and be present at the hearing at his/her own expense. Any rights of participation, review or commentary extended to the counsel for the EMS System will be similarly extended to the same degree to the representative for the suspended participant.

B. At the hearing, the EMSMD or the counsel for the EMS System shall present such witnesses and evidence, as they deem appropriate to uphold the suspension. The suspended participant or his/her representative may present such witnesses and evidence, as the suspended participant deems appropriate. The System Review Board will direct questions to all concerned parties in order to gather all of the facts and pertinent information.

C. The System Review Board shall review and consider any testimony and documentation related to the issue at hand which is offered by either party to the suspension issue. Only current allegation may be presented unless previous information illustrates a pattern of

behavior or practice. Each party shall have the right to submit evidence explaining or refuting the charges as well as the right to question the witnesses.

D. The EMSMD shall arrange for a certified shorthand reporter to make a stenographic record of the hearing. A copy of the hearing transcription shall be made available to any involved party so requesting at the party's expense. The transcript, all documents or materials received as evidence during such hearing, and the System Review Board's written decision shall be retained in the custody of the Resource Hospital EMS office and shall be maintained in confidence.

E. The suspended participant, the EMSMD and/or legal counsel(s) shall be allowed to listen to all testimony, but shall not be allowed admittance to the discussion and decision process of the System Review Board. However, they may be present after the decision is reached, and the System Review Board's recommendations are announced, if the decision can be reached immediately.

F. Witnesses may only be present during their testimony or when making their statement, and shall be instructed not to discuss the situation with any other witness.

VII. The Board shall state, in writing, its decision to affirm, modify or reverse the suspension including a statement detailing the duration and grounds for the decision. Such decision shall be sent via email to the EMSMD and the EMS personnel, ambulance service provider or other system participant within five business days after the conclusion of the hearing.

VIII. The EMSMD shall notify the Chief of the Division of EMS and Highway Safety at the Illinois Department of Public Health (IDPH), in writing, of a decision by the System Review Board to either uphold, reverse or modify the EMSMD's suspension of an EMS personnel, ambulance service provider or other system participant from participation within the EMS System, within five business days after the System Review Board's decision is received.

IX. The EMS System shall implement a decision of the System Review Board unless that decision has been appealed to the State EMS Disciplinary Review Board.

X. A request for review by the State EMS Disciplinary Review Board shall be made in writing by email to the Chief of the Division of EMS and Highway and Safety at IDPH, within ten business days after receiving the System Review Board's decision. A copy of the System Review Board's decision shall be enclosed. Requests for review shall only be made by an EMS System participant whose suspension order was affirmed or modified by the System Review Board. If reversed or modified, the EMSMD can request a review.

XI. Upon receipt of a valid request for review, the Chief of the Division of EMS and Highway Safety at IDPH shall convene a State EMS Disciplinary Review Board to review the decision of the System Review Board.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Evaluation and Recognition of Military Experience and Education |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EVALUATION AND RECOGNITION OF MILITARY EXPERIENCE AND EDUCATION

## I. PURPOSE

To evaluate EMS Personnel licensure applications for honorably discharged members of the armed forces and ensure that a candidate's military emergency medical training, emergency medical curriculum completed, and clinical experience are recognized.

## II. POLICY

A. The Illinois Department of Public Health (IDPH) will review applications for EMS Personnel licensure from honorably discharged members of the armed forces of the United States with military emergency medical training.

B. IDPH will provide application forms. Applications shall be filed with IDPH within one year after military discharge and shall contain the following:

1. Documentation that the application is being filed within one year after military discharge;

2. Proof of successful completion of military emergency medical training or National Registry certification;

3. A detailed description of the emergency medical curriculum completed, including official documentation demonstrating basic coursework and curriculum; and

4. A detailed description and official documentation of the applicant's clinical experience or current National Registry certification.

C. IDPH may request additional and clarifying information and supporting documentation, if necessary, to verify the information provided above.

D. IDPH shall evaluate the application, including the applicant's training and experience, and ensure that it is consistent with IDPH Standards, to determine if the applicant qualifies for the licensure level for which the applicant has applied.

E. If the application clearly demonstrates that the training and experience meets IDPH Standards, IDPH shall offer the applicant the opportunity to complete a Department-approved EMS Personnel examination for the license level that the applicant is qualified.

F. Upon the applicant's passage of an examination and having paid all required fees, IDPH shall issue a license that shall be subject to all provisions of the EMS Act and the level of EMS Personnel license issued.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Inactive Status |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# INACTIVE STATUS

## I. INACTIVE STATUS

A. Prior to the expiration of their current license, EMS personnel may request to be placed on inactive status.

B. This request must be made in writing by the EMS personnel to the respective Resource Hospital EMS Medical Director (EMSMD) and shall include the individual's name and contact information, current license level and number with expiration date, and circumstances requiring inactive status using the IDPH approved form, "EMS Inactive Request".

C. All CE requirements must be up to date prior to granting the inactive status.

D. If the EMSMD approves, the request will be submitted to the Illinois Department of Public Health that the individual be placed on inactive status.

E. For independent license holders, IDPH will review and confirm that relicensure requirements have been met by the date of the application for inactive status.

F. IDPH will review requests for inactive status and notify the EMSMD in writing of its decisions.

G. During Inactive Status, the individual shall not perform at any level of EMS provider.

## II. RETURN TO ACTIVE STATUS

A. When EMS personnel request to return to active status, they **MUST REACTIVATE** in the EMS System that put them on inactive status.

B. EMS personnel requesting reactivation must complete the following:

1. Submit a letter of intent.

2. Successfully complete all components of the Region 11 EMS System Entry Policy.

3. Meet as determined by the EMS Coordinator to set timelines for and monitor progress toward completion of all system entry requirements.

4. Complete all mandatory modules held during the individual's inactive status and any others deemed necessary by the EMSMD or EMS Coordinator.

C. A reactivation fee will be assessed by the Resource Hospital based upon the amount of CE necessary.

D. After completion of the required CE, the EMS MD shall confirm that the applicant has been examined (physically and mentally) and found capable of functioning within the EMS System; that the applicant's knowledge and psychomotor skills are at the active EMS level for that individual's license; and that the applicant has completed any education and evaluation deemed necessary by the EMS MD and approved by the Department. If the inactive status was based on a disability, the EMS MD shall also verify that the applicant can perform all critical functions of the requested license level.

E. EMS Personnel whose inactive status period exceeds 48 months shall pass an IDPH approved licensure examination for the requested level of license upon recommendation of an EMS MD.

F. Upon review, IDPH may reinstate the individual to active status and establish a new licensing period.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Occupational Exposure to an Infectious Disease |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# OCCUPATIONAL EXPOSURE TO AN INFECTIOUS DISEASE

## I. PURPOSE

To define methods to protect EMS personnel from significant or high-risk occupational exposure to an infectious disease and notification of the EMS agency designated infection control officer (DICO) after exposure.

## II. POLICY

### A. OCCUPATIONAL EXPOSURE TO INFECTIOUS DISEASE

1. Initial and ongoing training in the types of available PPE and demonstrated proficiency in donning and doffing of PPE is critical to EMS personnel safety.

2. Prevention of exposures is critical. Extraordinary care should be used to prevent exposures from needles and other sharp instruments.

3. Per OSHA, best practices for preventing sharps and needlestick injuries include:

    a. Plan safe handling and disposal before any procedure.
    b. Use safe and effective needle alternatives when available.
    c. Use needles with engineered sharps injury protection (SESIPs).
    d. Always activate the device's safety features.
    e. Do not pass used sharps between workers.
    f. Do not recap, shear, or break contaminated needles.
    g. Immediately dispose of contaminated needles in properly secured, puncture-resistant, closable, leak-proof, labeled sharps containers.
    h. Complete Bloodborne Pathogens training.

4. Appropriate barrier precautions should be used when cleaning, disinfecting, or disposing of contaminated equipment, supplies, and ambulance surfaces.

5. EMS personnel who have any areas of open skin from any cause shall have these areas covered with a moisture proof covering prior to any patient contact.

6. Significant blood or body fluid exposures for EMS personnel include blood, bloody saliva or urine, or amniotic fluid exposure to eyes, mucous membranes, non-intact skin or by needle stick or bites.

7. The exposed area should be irrigated or flushed with large amounts of water or saline.

8. The blood borne pathogen exposure (BBPE) should be reported to the EMS personnel's immediate supervisor as soon as possible

9. When significant exposures have occurred, the involved EMS personnel should be evaluated by a physician **at the same Emergency Department where the source patient was transported**.

10. EMS personnel should be assessed regarding possibility of post-exposure prophylaxis or treatment depending on the agent and exposure. Post-exposure prophylaxis is seldom indicated with the exception of direct contact with patients confirmed to have Neisseria meningitidis or after a needle stick or other high-risk exposure to an HIV positive source patient. Prophylaxis may be considered in unprotected exposures to special pathogens in consultation with infectious disease experts.

11. EMS agencies should standardize pre-exposure immunization requirements for personnel in accordance with public health vaccination recommendations. It is recommended that EMS personnel have appropriate immunizations or knowledge of prior illness to the following: hepatitis B, measles, mumps, rubella, pertussis/whooping cough, chicken pox, tetanus, diphtheria, and polio.

12. Each EMS agency shall have a policy addressing infectious disease exposures. The policy should be available for review by the EMS Medical Director and the Illinois Department of Public Health (IDPH).

13. Each EMS agency should follow OSHA's Bloodborne Pathogens Standard (29 CFR 1910.1030) as amended pursuant to the 2000 Needlestick Safety and Prevention Act, which is a regulation that prescribes safeguards to protect workers against health hazards related to bloodborne pathogens.

## B. NOTIFICATION OF POTENTIAL EXPOSURE TO AN INFECTIOUS DISEASE

1. EMS personnel are considered "Emergency response employees (EREs)" and are at risk of exposure to potentially life-threatening infectious diseases through contact with patients during emergencies. Part G of the Ryan White HIV/AIDS Treatment Extension Act of 2009 requires that medical facilities provide EREs with notification of when they may have been exposed to potentially life-threatening infectious diseases while transporting or serving patients in an emergency.

2. NIOSH (**National Institute for Occupational Safety and Health)** has developed a list of potentially life-threatening diseases, including emerging infectious diseases, to which EREs may be exposed while transporting or serving emergency patients taken to a medical facility (Table 1).

3. Medical facilities that receive and treat patients in an emergency or ascertain the cause of death are responsible for routinely notifying and responding to requests pertaining to any determinations that a patient in an emergency has a listed potentially life-threatening infectious disease, as described in the NIOSH guidelines.

4. When a medical facility determines that a patient in an emergency has a potentially life-threatening disease to which the ERE may have been exposed to (see Table 1 below), the medical facility shall, in writing, notify the ERE agency's designated infection control officer (DICO) no later than 48 hours after a confirmed diagnosis (in accordance with the Illinois Hospital Licensing Act, 210 ILCS 85/6.08)

5. If an ERE believes he or she has been exposed to any potentially life-threatening disease on the NIOSH list, and has transported, attended, treated, or assisted the

patient pursuant to the emergency, the ERE may initiate a request for notification from the medical facility to which the patient was transported.

Table 1: NIOSH List of Potentially Life-Threatening Infectious Diseases to Which Emergency Response Employees May Be Exposed, by Exposure Type (https://www.cdc.gov/niosh/topics/ryanwhite/#table1)

| ROUTINELY TRANSMITTED BY CONTACT OR BODY FLUID EXPOSURES | ROUTINELY TRANSMITTED THROUGH AEROSOLIZED AIRBORNE MEANS[1] | ROUTINELY TRANSMITTED THROUGH AEROSOLIZED DROPLET MEANS[1] | CAUSED BY AGENTS POTENTIALLY USED FOR BIOTERRORISM OR BIOLOGICAL WARFARE |
|---|---|---|---|
| • Anthrax, cutaneous (*Bacillus anthracis*)<br>• Hepatitis B (HBV)<br>• Hepatitis C (HCV)<br>• Human immunodeficiency virus (HIV)<br>• Rabies (Rabies virus)<br>• Vaccinia (Vaccinia virus)<br>• Viral hemorrhagic fevers (Lassa, Marburg, Ebola, Crimean-Congo, and other viruses yet to be identified)[5] | • Measles (Rubeola virus)<br>• Tuberculosis (*Mycobacterium tuberculosis*)—infectious pulmonary or laryngeal disease; or extrapulmonary (draining lesion)<br>• Varicella disease (Varicella zoster virus)—chickenpox, disseminated zoster | • Diphtheria (*Corynebacterium diphtheriae*)<br>• Novel influenza A viruses as defined by the Council of State and Territorial Epidemiologists (CSTE)[6]<br>• Meningococcal disease (*Neisseria meningitidis*)<br>• Mumps (Mumps virus)<br>• Pertussis (*Bordetella pertussis*)<br>• Plague, pneumonic (*Yersinia pestis*)<br>• Rubella (German measles; Rubella virus)<br>• SARS-CoV<br>• COVID-19 (SARS-CoV-2) | These diseases include those caused by any transmissible agent included in the HHS Select Agents List [4].[5]<br>Many are not routinely transmitted human to human but may be transmitted via exposure to contaminated environments<br>The HHS Select Agents List is updated regularly and can be found on the National Select Agent Registry Web site: http://www.selectagents.gov/ |

## C. ADMINISTRATION OF AN INITIAL OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (OSHA) RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

1. This is decided and managed by the EMS employer agency.

2. See Section 515.330 for additional requirements.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Paramedic Field Internship Program |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# PARAMEDIC FIELD INTERNSHIP PROGRAM

I. Paramedic students functioning in this capacity do so under contractual agreement between the Chicago Fire Department (CFD), the Resource Hospital(s), and the sponsoring institution (Malcolm X College) hosting the paramedic training program.

II. For the field internship, the paramedic student is assigned to a CFD Paramedic Preceptor that is approved by Region 11.

III. Paramedic students must follow all Protocols, Policies and Procedures under the sponsoring institution training program, the Chicago Fire Department and Region 11 EMS.

IV. A waiver of liability must be completed and on file with CFD and MXC prior to start of internship.

V. Upon successful completion of the field internship, and the student has completed their paramedic training, they will be deemed eligible to take the National Registry Paramedic examination and can apply for Illinois state licensure upon obtaining the NREMT certification

VI. Paramedic students attending an outside Region 11 training program, but are from EMS Employer Agencies within Region 11 may be allowed to complete their field internship requirements as outlined by their program if approved by CFD and the Region 11 EMS Employer Agency's assigned Resource Hospital. The outside training program shall communicate with the Region 11 Resource Hospital and EMS Employer Agency regarding the student's progress. An affiliation agreement is required to be completed and kept on file with the Region 11 EMS Employer Agency, the assigned Region 11 Resource Hospital, and the initial training program located outside of Region 11.

   A. Priority ride time scheduling remains with the Region 11 initial training paramedic program and shall not be affected by outside Region 11 initial training programs.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Prehospital Registered Nurse, Prehospital Physician Assistant, and Prehospital Advanced Practice Registered Nurse |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PREHOSPITAL REGISTERED NURSE (PHRN), PREHOSPITAL PHYSICIAN ASSISTANT (PHPA) AND PREHOSPITAL ADVANCED PRACTICE REGISTERED NURSE (PHAPRN)

I. While the Illinois EMS Act recognizes Prehospital Physician Assistants (PHPA) and Prehospital Advanced Practice Registered Nurses (PHAPRN) as approved licensure levels, Region 11 Chicago EMS does not recognize them in their EMS Systems.

**II. To be approved and licensed as a "Prehospital Registered Nurse" (Prehospital RN) an individual shall:**

A. Be a licensed RN in good standing and in accordance with the Illinois Department of Financial and Professional Regulation.

B. Have two years of full time clinical practice in Emergency or Critical Care nursing.

C. Have current CPR certification.

D. Complete a supplemental educational curriculum, formulated by the EMS System and approved by IDPH, that consists of:

1. At least 40 hours of classroom and psychomotor education and measurement of competency equivalent to an entry level Paramedic program;

2. Practical education, including but not limited to: advanced airway techniques, ambulance operations, extrication, telecommunications, and prehospital cardiac and trauma care of both the adult and pediatric population; and

3. The Region 11 EMS System Protocols, Policies, and Procedures.

E. Complete a minimum of 10 ALS runs supervised by a licensed EMS System physician or an approved EMS System PHRN or Paramedic only as approved by the EMS Medical Director.

F. Successfully complete the National Registry of EMTs (NREMT) paramedic cognitive examination.

G. After submission of the above components to the Resource Hospital, the transaction form and recommendation for licensure will be submitted to IDPH. The application will include demographic information, social security number, child support statement, felony conviction statement, applicable fees and shall require EMS System authorization.

## III. PHRN LICENSE RENEWAL

A. To apply for a four-year license renewal:

1. Submit documentation of CE requirements to the EMS System at minimum 30 days prior to license expiration.

   a. PHRNs shall have a minimum of 120 system approved CE hours in the same core content areas as required for paramedics.
   b. All Region 11 mandatory CE assignments are required.

2. Maintain current CPR certification on file with the Resource Hospital.

3. Maintain current RN License within the State of Illinois on file with Resource Hospital.

## III. INACTIVE STATUS

A. Prior to the expiration of the current license, a PHRN may request to be placed on inactive status. The request shall be made in writing to the EMS MD.

B. A PHRN who wants to restore their license to active status shall follow the requirements set forth in Section 515.600.

C. If the PHRN inactive status period exceeds 48 months, the licensee shall re-demonstrate competencies and successfully pass the NREMT Paramedic examination.

D. The EMS MD shall notify the Department in writing of a PHRN's approval, re-approval, or granting or denying of inactive status within 10 days after any change in a PHRN's approval status.

## IV. CHANGE IN NAME OR ADDRESS

A. A PHRN shall notify the Department within 30 days after any change in name or address. Notification may be in person, or by mail, phone, fax, or electronic mail.

B. Addresses may be changed through the Department's online system: https://emslic.dph.illinois.gov/glsuiteweb/clients/ildohems/private/shared/onlineservices.aspx

C. Names and gender changes require legal documents (marriage license or court documents).

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Primary and Secondary EMS Systems |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# PRIMARY AND SECONDARY EMS SYSTEMS

## I. PURPOSE

To define the responsibilities of EMS personnel that work in more than one EMS System.

## II. DEFINITIONS

A. Primary EMS System: The EMS System in which the EMS personnel primarily works and renews their EMS license.

B. Secondary EMS System: The EMS System in which the EMS personnel works in a secondary or part-time role and does not renew their EMS license.

## III. POLICY

A. It is the responsibility of the EMS personnel to define their Primary and any Secondary EMS System for renewal of EMS licensure to the Resource Hospital(s) at system entry and/or with employment change.

B. For EMS personnel in Region 11, this status should be on record with their Resource Hospital and entered under their Vector Solutions profile.

C. Any EMS personnel with Primary or Secondary EMS System status in Region 11 must complete all mandatory EMS Continuing Education (CE) as per policy.

D. For any status changes in Primary or Secondary EMS System, the EMS personnel should notify the Resource Hospital.

E. If a licensed EMS personnel has dual participation with another EMS System, the Resource Hospital will notify the other EMS System of a system suspension.

F. EMS personnel that do not actively work under an EMS System are considered independent for renewal of licensure.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Vaccine Administration |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 11, 2020 |

# VACCINE ADMINISTRATION

I. **PURPOSE:**

This policy outlines the guidelines for licensed Paramedics within the Region 11 Chicago EMS System to administer vaccines in order to assist state and local partner agencies with mass vaccination efforts as per IDPH (Illinois Department of Public Health) policies.

II. **DEFINITION**:

Vaccines include any vaccines under an IDPH mass vaccination plan.

III. **ROLE:**

Vaccine administration is part of the additional Paramedic scope of practice per IDPH under an approved EMS System Plan.

IV. **TRAINING PROGRAM:**

Training programs shall be approved by the Resource Hospital and include the following components that are specific to the vaccine administered under an approved Vaccination Program.

A. Vaccine Education

1. Pharmacology of vaccine

2. Administration

a. Storage and handling of vaccine
b. Dosage and route of administration
c. Indication or eligibility for administration
d. Contraindication for administration

3. Vaccine side effects or adverse reactions

4. Emergency treatment for vaccine reactions

5. Vaccine Information Statement (VIS)

B. Vaccine Administration Record (VAR) documentation

C. Reporting of possible adverse effects to the Vaccine Adverse Events Reporting System (VAERS)

D. Vaccine Administration procedure skills validation

E. Roster of Paramedics that have completed the training

V. **REPORTING**:

There should be communication between the EMS Agency and the Resource Hospital regarding the site and date that Paramedics are performing vaccine administration.

VI. **QUALITY ASSURANCE:**

A quality assurance plan must be in place for tracking and documenting the use of paramedics performing vaccine administration.

VII. **CONTINUING EDUCATION:**

Annual continuing education is required for paramedics performing vaccine administration.

# Paramedic Vaccination Tracking Form

This form must be filled out and sent in to the EMS System after the vaccination event.

Please email this completed form to the Resource Hospital EMS System Coordinator.

| | |
|---|---|
| *EMS Agency Name:* | |
| *EMS Agency Address:* | |
| *Contact Name:* | *Contact Phone Number:* |

| | | |
|---|---|---|
| *Vaccine Manufacturer.* | *Lot Number:* | *Expiration Date:* |

The following paramedics have been approved to administer vaccines in the Region 11 Chicago EMS System. All paramedics listed have gone through Just-In-Time or annual vaccination training for an approved Vaccination Program.

| *Paramedic Name* | *Paramedic License #* | *# of Vaccines Administered* |
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*Signature of Contact:* _____ *Date:* _____

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Vehicle Service Provider Licensure |
|---|---|
| | Section: EMS Personnel |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# VEHICLE SERVICE PROVIDER LICENSURE

## I. PURPOSE

To establish vehicle service provider licensure requirements for EMS agencies participating under the Region 11 Chicago EMS Systems.

## II. POLICY

A. An application for a vehicle service provider license shall be submitted on a form prescribed by the Illinois Department of Public Health (IDPH). The application shall include, but not be limited to, licensee name, address, email address, and telephone number; and, for each vehicle to be covered by the license, include the make, model, year, vehicle identification number (VIN), state vehicle license number and level of service (BLS or ALS).

B. Each application shall be accompanied by a fee of $35 for each vehicle included in the initial license application and due at the time of each annual inspection for up to 100 individual vehicles. A fee of $3,500 shall be submitted for initial applications and due at annual inspections for providers with 100 or more vehicles. Inspection fees not paid after 30 days from the documented annual inspection date will incur a late fee of $25 per vehicle for up to 100 vehicles.

C. An application for license renewal shall be submitted to IDPH in accordance with at least 60 days, but no more than 90 days prior to license expiration.

D. IDPH shall issue a license valid for four years. The license will remain valid if, after annual inspection, all fee requirements are paid and IDPH finds that the vehicle service provider is in full compliance with EMS administrative rules and regulations. If IDPH finds that the vehicle service provider is not in full compliance, in addition to all other actions authorized under EMS administrative rules and regulations, IDPH may issue a license for a shorter interval.

E. IDPH shall have the right to make inspections and investigations as necessary to determine compliance with EMS administrative rules and regulations. Pursuant to any inspection or investigation, a licensee shall allow IDPH access to all records, equipment and vehicles licensed under the EMS Act.

F. Each license is issued to the licensee for the vehicles identified in the application. The licensee shall notify IDPH, in writing, within 10 days after any changes in the information on the application. Additional vehicles shall not be put in service until an application is submitted with the proper fee, and an inspection is conducted. The licensee shall notify IDPH to change a vehicle's level of service.

G. IDPH will approve each vehicle covered by an ambulance service provider license to operate at a specific level of service (BLS or ALS). To change the level of service for a specific vehicle:

1. The licensee shall submit a written request to the EMS MD;

2. The EMS MD shall submit a copy of that request to IDPH, along with written verification that the licensee meets the equipment and staffing requirements of IDPH and the EMS System Plan for the requested level of service;

3. IDPH will then amend the provider's license and vehicle certificate to reflect the new level of service.

H. All vehicle service providers shall function within an EMS System.

I. A vehicle service provider utilizing ambulances shall have a primary affiliation with an EMS System within the EMS Region in which its primary service area is located. This does not apply to vehicle service providers that exclusively utilize limited operation vehicles.

J. A vehicle service provider is prohibited from advertising, identifying its vehicles, or disseminating information in a false or misleading manner concerning the provider's type and level of vehicles, location, primary service area, response times, level of personnel, licensure status, or EMS System participation.

K. A vehicle service provider, whether municipal, private, or hospital owned, is prohibited from advertising itself as a critical care transport provider unless it participates in an IDPH- approved EMS System critical care transport plan and provides critical care transport services at a Tier II or Tier III level of care.

L. All vehicle service providers shall have a designated Pediatric Emergency Care Coordinator (PECC) who assists in ensuring that their agency and personnel are prepared to care for ill and injured children. Training and education can be validated by conducting activities such as confirming the availability of pediatric equipment and supplies, ensuring that personnel follow pediatric protocols and participate in pediatric education, and promoting family-centered care. Each vehicle service provider shall submit the name of the licensed personnel serving as the PECC to their EMS System Coordinator. For additional details and prehospital pediatric resources, please refer to the IDPH EMS for Children (EMSC) Pediatric Readiness website.

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## HOSPITAL

Base Station Cardiac Arrest Guidelines
ECP Recognition
ECRN Licensure
Hospital Preparedness Program
Resource Hospital Base Station Override

# BASE STATION CARDIAC ARREST GUIDELINES

Patient age, Comorbidities?
Witnessed arrest? Bystander or EMS?
If unwitnessed, is downtime known?
Bystander CPR?
First cardiac rhythm?

Current cardiac rhythm?
Ensure high quality CPR
Advanced airway with ETCO2
**Epinephrine IV/IO every 5 minutes**

**PULSELESS ELECTRICAL ACTIVITY**

Evaluate rhythm
- Wide and Slow: Possible terminal rhythm
- Narrow and Fast: Possible ROSC

For dialysis and/or renal failure with possible hyperkalemia, consider **Calcium chloride** and **Sodium Bicarbonate IVP**

For possible opioid overdose, consider **Naloxone**

Consider other reversible causes (H's/T's)

**ASYSTOLE**

Ensure asystole in multiple leads
Evaluate corresponding ETCO2[1] value

**PULSELESS VTACH OR VFIB**

Defibrillation every 2 minutes

**Amiodarone 300 mg**
(peds 5mg/kg) after 3rd shock

**Amiodarone 150 mg**
(peds 5mg/kg) after 4th shock

Attempt to achieve ROSC
before patient movement/transport

Response to treatment?

**NO ROSC / PERSISTENT LOW OR DECREASING ETCO2**

**Consider field Termination of Resuscitation Criteria**
- Adult patient at least 18 years of age
- Non-traumatic cardiac arrest
- No hypothermia or pregnancy
- No reversible cause identified
- No ROSC at any point during minimum 20 minute resuscitation
- Initial cardiac rhythm is non-shockable (Asystole or PEA)
- IV/IO access with at least 3 rounds of Epinephrine
- Advanced airway established with ETCO2[1] capnography

**Other prognostic factors that may be considered include:**
- Unwitnessed arrests have a lower predicted survival
- A shockable rhythm at any point during resuscitation increases chance of survival
- ETCO2[1] value should be consider in the context of other arrest criteria and should not be used as the sole determining factor in termination vs. transport

**ROSC / PERSISTENT HIGH OR INCREASING ETCO2**

Transport to a STEMI Center[2,3,4]

- Monitor closely for re-arrest
- Initiate post arrest care
- Check blood glucose
- **12 lead ECG**
- Adults: Maintain SBP ≥ 90 mmHg with fluid bolus Pediatrics: Maintain blood pressure at or above normal for age with 20 ml/kg fluid bolus (see Region 11 Pediatric Resuscitation Card)
- For adults with GCS ≤ 8 initiate targeted temperature management with cold packs

Response to treatment?

**YES**

**NO**

For persistent shockable rhythms, consider continued field resuscitation or transport to a STEMI Center[2,3,4] with ongoing resuscitation

**1 – Interpretation of ETCO2 Values in Cardiac Arrest**

ETCO2 measures ventilation and is a surrogate marker of cardiac output:
- < 10 mmHg may indicate low quality CPR or provider fatigue
- 10-30 mmHg indicates high quality CPR
- Evaluate ETCO2 values and trends such as:
  - Sudden rise in ETCO2 or persistent reading > 30 mmHg may indicate ROSC
  - Values decreasing more than 25% during resuscitation indicate poor prognosis
  - Values persistently < 10 mmHg, despite high quality CPR indicate poor prognosis

**3 - Pediatric Considerations**

- On scene resuscitation where the patient is encountered should take precedence with the goal of obtaining ROSC before patient movement/transport.
- Field termination of resuscitation is not considered for patients under the age of 18.
- Pediatric patients should be transported to an Emergency Department Approved for Pediatrics (EDAP) (see Pediatric Patient Transport Policy).

**2- Obstetric Considerations**

For pregnant patients > 20 weeks gestation or with a visibly gravid abdomen:
- Complete the following code tasks on scene: High quality CPR, defibrillation when indicated, IV/IO access with ACLS drug administration and advanced airway placement with ETCO2 monitoring.
- Plan for expedited hospital transport with ongoing resuscitation to the closest STEMI Center that is also a Level III Perinatal Center.
- Contact receiving Level III Perinatal Center and inform them of arrival of pregnant cardiac arrest patient.

**4 – Ventricular Assist Device (VAD) Patients**

- Should be transported to a VAD Center per Transport of Patients With a Ventricular Assist Device (VAD) Policy.

**Effective: December 1, 2022**
**Chicago Region 11 EMS Medical Directors Consortium**

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: ECP Recognition |
|---|---|
| | Section: Hospital |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# ECP RECOGNITION

## I. GUIDELINES FOR EMERGENCY COMMUNICATION PHYSICIAN (ECP) RECOGNITION IN REGION 11:

A. To obtain recognition as an ECP, an individual shall:

1. Be a physician currently licensed in Illinois and regularly involved in online medical control at a Base Station.

2. Complete the Region 11 ECP Base Station Course or equivalent as determined by the EMSMD.

B. To maintain ECP recognition, the physician must review any EMS System Continuing Education updates and remain in good standing with the EMS System.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: ECRN Licensure |
|---|---|
| | Section: Hospital |
| | Approved: EMS Medical Directors Consortium |
| | Effective: June 1, 2023 |

# ECRN LICENSURE

## I. Emergency Communications Registered Nurse (ECRN) Licensure

A. Initial licensure:

1. To be licensed as an ECRN, an individual shall:

   a. Be a registered nurse in accordance with the Nurse Practice Act with a minimum of six months Emergency Department nursing experience or appropriate equivalent as approved by the EMS Medical Director (EMSMD)
   b. Current CPR certification
   c. Current ACLS certification
   d. Successfully complete an education curriculum formulated by an EMS System and approved by IDPH, which consists of at least 40 hours of classroom (32 hours) and practical (8 hours field experience on an ambulance supervised by a paramedic) education for both the adult and pediatric population, including telecommunications, and EMS System Protocols, Policies and Procedures.
   e. Complete an orientation conducting EMS radio calls with a licensed ECRN under the supervision of the EMS Coordinator at that hospital.
   f. Meets all requirements mandated by the IDPH Rules and Regulations.

2. The Resource Hospital will submit to IDPH the electronic transaction form and recommendation for initial licensure of an ECRN candidate who has completed and passed all components of the education program and passed the final examination.

B. ECRN Relicensure: The ECRN should submit proof of the following to their hospital EMS Coordinator 90 days prior to license expiration date.

1. Is a registered nurse with an unencumbered license in Illinois.

2. Has completed 32 hours of EMS System approved Continuing Education in a four-year period.

3. Has successfully completed all mandatory Region 11 EMS continuing education.

4. Remains active as an ECRN in the EMS System under Region 11.

5. Completed the IDPH Child Support Form.

6. If the above are completed, the Resource Hospital will submit the ECRN for relicensure with IDPH.

C. Inactive status:

1. Prior to the expiration of the current license, the ECRN may request to be placed on

inactive status. The request shall be made in writing to the EMS Medical Director and shall contain the following information:

a. Name of individual;
b. Date of approval;
c. Circumstances requiring inactive status;
d. A statement that recertification requirements have been met by the date of the application for inactive status;
e. ECRN license number

2. The EMS Medical Director will review and grant or deny requests for inactive status.

3. For the ECRN to return to active status, the EMS Medical Director must document that the ECRN has been examined and found capable of functioning within the EMS System, that the ECRN's knowledge and clinical skills are at the active ECRN level, and that the ECRN has completed any refresher training deemed necessary by the EMS System. If the inactive status was based on a temporary disability, the EMS System shall also verify that the disability has ceased.

4. During inactive status, the individual shall not function as an ECRN.

5. The EMS Medical Director shall notify IDPH in writing of the ECRN's approval, re-approval, or granting or denying inactive status within 10 days after any change in an ECRN's approval status.

## II. ECRN Functioning and System Entry

A. A licensed ECRN who is currently functioning in another Region 11 Resource or Associate Hospital or has been active within the last six months and receives a letter of good standing from his/her EMS Coordinator shall meet with his/her current EMS Coordinator or EMSMD for approval and orientation prior to resuming ECRN function.

B. Licensed ECRNs from hospitals outside Region 11 should request a letter of good standing from that hospital and submit it to their Region 11 Resource Hospital and request to take the ECRN System Entry examination.

C. Additional educational requirements may be required by the EMSMD.

## III. ECRN Requirements

A. An ECRN shall notify IDPH within 30 days after any change in name or address. Notification may be in person, or by mail, phone, fax or electronic mail. Addresses may be changed through IDPH's online system.

B. To maintain ECRN Licensure, the nurse must complete any EMS System Continuing Education updates and remain in good standing with the EMS System.

C. An ECRN may be suspended as per the Region 11 EMS System Participation Suspension Policy.

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: Hospital Preparedness Program |
|---|---|
| | Section: Hospital |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# HOSPITAL PREPAREDNESS PROGRAM

## I. DEFINITIONS

A. Regional Hospital Coordinating Center (RHCC): The lead hospital in a specific Public Health and Medical Services Response Region (PHMSRR) / EMS region responsible for coordinating disaster medical response upon the activation of the IDPH Emergency Support Function (ESF-8) Plan.

## II. HOSPITAL PREPAREDNESS PROGRAM REQUIREMENTS

A. Illinois Department of Public Health (IDPH) shall distribute federal grant funds as available to hospitals and as identified by IDPH. The Chicago Public Health Department (CDPH) is a separately funded jurisdiction in the federal Hospital Preparedness Program (HPP) and works directly with the Region 11 RHCC to ensure the preparedness of all Chicago hospitals. This coordination happens primarily through the regional healthcare coalition: The Chicago Healthcare System Coalition for Preparedness and Response (CHSCPR).

B. All hospitals regardless of whether they receive federal funds are required to meet the appropriate tier level classification, participate in IDPH's preparedness activities, and comply with IDPH rules. Each hospital shall meet the minimum disaster/all-hazards requirements outlined in one of the tiers below.

## II. HOSPITAL PREPAREDNESS PROGRAM TIERS AND RESPONSIBILITIES

### A. Tier Level 3 – Participating Hospitals

1. Designate a contact person for disaster/all-hazards preparedness. This person should be registered with the CHSCPR (https://chscpr.org/) and listed in EMResource (https://emresource.juvare.com/login)

2. Participate in disaster/all-hazards planning and disaster/all-hazards exercises on a regional basis.

3. Have reference information on treatment of biological agents on site or post the phone number of Illinois Poison Center (IPC).

4. Implement the System-Wide Crisis Policy and the IDPH ESF-8 Plan and provide ongoing education to staff on both.

5. Have functional medical emergency radio communication of Illinois (MERCI) radio and redundant hospital to hospital communication.

6. Develop a plan to identify, receive, and distribute the National Pharmaceutical Stockpile and/or the State Pharmaceutical Stockpile to hospital staff.

7. Make training in the recognition and treatment of weapons of mass destruction available to the hospital staff.

8. Maintain disaster bags and supplies as outlined in the IDPH ESF 8 Plan.

**B. Tier Level 2 - Non-Regional Hospital Coordinating Centers**

*This level includes all hospitals that are not Regional Hospital Coordinating Centers (RHCC) as identified in the IDPH ESF 8 Plan. These hospitals include Resource Hospitals, Associate Hospitals and/or trauma centers as designated by IDPH.*

1. Meet all Tier Level 3 capabilities as outlined above.

2. Have communication capability with prehospital care personnel.

3. Assist with disaster planning and exercises.

4. Provide list of staff to a RHCC as part of a Regional Emergency Medical Response Team (REMRT), if available.

5. Resource Hospitals Only – Act as a resource for disaster planning and actively participate in the development, education, and implementation of the Regional Response Plan. The Regional Response Plan is developed by the Regional EMS Advisory Committee. In Region 11, CHSCPR maintains an Emergency Operations Plan (EOP) and hazard specific annexes complementary of Region 11 EMS response plans and the IDPH EST-8 Plan. EMS stakeholders are engaged in EOP review and approval.

**C. Tier Level 1 – Regional Hospital Coordinating Centers (RHCC)**

*A Tier Level 1 hospital is the highest level for a preparedness hospital. A Tier Level 1 hospital shall be an IDPH-designated RHCC hospital as identified in the IDPH ESF8 Plan. The Region 11 IDPH-designated hospital is Advocate Illinois Masonic Medical Center (AIMMC).*

1. Meet all the requirements of Tier Level 3 and Tier Level 2 capabilities as outlined above.

2. Identify a disaster preparedness coordinator to work with the State coordinator for planning and response. As Chicago is a separately funded jurisdiction, in Region 11 the RHCC identifies a coordinator to work with the CDPH HPP coordinator. CDPH and the State work collaboratively on state and regional response plans and during response activations, as appropriate.

3. Perform as the lead hospital in a regional or State preparedness exercise.

4. Perform as the lead in planning and developing a Regional Response Plan, including but not limited to the following: inter-hospital transfers; intra-region transfers; medical surge; disaster bags; medical response teams; and the dissemination of information as it pertains to EMS system activities and the reporting and feedback of such information for EMS providers and emergency departments within the region. Identify members of the regional healthcare coalition committee, including, at a minimum:

   a. Emergency Physicians
   b. EMS Coordinators from Resource & Associate Hospitals

c. Designated contact disaster person at Participating Hospitals
d. Local health department representative
e. Hospital administrator
f. Hospital security representative
g. Physician specializing in pediatrics, trauma, and obstetrics
h. Representative from a specialized hospital/rehabilitation center
i. Representative from police, fire, and EMS (public and private providers)
j. ED Nurse Manager
k. Infectious disease physician or registered nurse
l. Legal representative

5. Maintain regional response equipment and identify staff for a REMRT as available.

6. Support training and educational programs for health professional staff in region.

## III. SELECT EMERGENCY PLANS REFERENCED

A. Region 11 EMS

1. System Wide Crisis Policy

B. CHSCPR

1. Emergency Operations Plan

a. Communications Annex
b. Medical Surge Annex (Including Burn and Pediatrics)

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Hospital Preparedness Program |
|---|---|
| | Section: Hospital |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# REGION 11 HOSPITAL PREPAREDNESS PROGRAM TIERS

***This list includes only hospitals located within the City of Chicago***

## TIER LEVEL 1 – REGIONAL HOSPITAL COORDINATING CENTERS (RHCC)

Advocate Illinois Masonic Medical Center (Region 11)

## TIER LEVEL 2 - NON-REGIONAL HOSPITAL COORDINATING CENTERS

Advocate Trinity Hospital
Ann & Robert H. Lurie Children's Hospital of Chicago
Ascension Saint Joseph Hospital - Chicago
Community First Medical Center
Holy Cross Hospital
John H. Stroger, Jr. Hospital of Cook County
Mount Sinai Hospital
Northwestern Memorial Hospital
Prime Healthcare Resurrection Medical Center
Prime Healthcare Saint Mary of Nazareth Hospital
Rush University Medical Center
UChicago Medicine

## TIER LEVEL 3 – PARTICIPATING HOSPITALS

Endeavor Health Swedish Hospital
Humboldt Park Health
Insight Hospital & Medical Center
Jackson Park Hospital & Medical Center
Jesse Brown Veterans Affairs Medical Center
Loretto Hospital
Provident Hospital of Cook County
Roseland Community Hospital
Saint Anthony Hospital
South Shore Hospital
St. Bernard Hospital & Health Care Center
Thorek Memorial Hospital
UI Health

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Resource Hospital Base Station Override |
|---|---|
| | Section: Hospital |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# RESOURCE HOSPITAL BASE STATION OVERRIDE

## I. PURPOSE

To establish a process to contact the Resource Hospital for medical direction to qualify orders from any other source other than the Resource Hospital.

## II. DEFINTION

Resource Hospital Override: Situations in which medical direction or orders from an Associate Hospital are requested to be reviewed by the Resource Hospital

## III. POLICY

A. To allow EMS personnel to contact a Region 11 Resource Hospital, if in the judgement of the EMS provider, the medical direction or orders for patient treatment:

1. Vary significantly from the approved Region 11 Protocols and Policies;
2. Could result in unreasonable or medically inaccurate treatment causing potential harm to the patient; and/or
3. When there is no response from the Associate Hospital after three attempts to contact.

B. The EMS provider should first clarify the medical direction or order with the ECRN/ECP and advise that it deviates significantly from approved protocols or policies.

C. If there is no resolution, the EMS provider should inform the Associate Hospital that they will contact the Resource Hospital regarding the situation.

D. When calling the Resource Hospital, the EMS provider should inform the ECRN that this is a “Resource Hospital Override” and the ECP should be consulted.

E. The Resource Hospital ECP may consult the EMS Medical Director as needed.

F. After resolution, the Resource Hospital should communicate the decision and outcome to the Associate Hospital.

G. The Resource Hospital EMS Coordinator should be immediately notified and a Request for Clarification (RFC) or Complaint Form is to be completed on the incident.

H. The Resource Hospital EMS Medical Director and the EMS Coordinator will review the incident with all involved individuals, including the Associate Hospital EMS Medical Director and EMS Coordinator in a timely manner.

# REGION 11
# CHICAGO EMS SYSTEM
# POLICIES

## QUALITY IMPROVEMENT

EMS System Quality Improvement/Quality Assurance (QI/QA) Plan
IDPH Waiver Provision
Medical Device Malfunction Reporting
Request for Clarification (RFC)/Complaint Investigation
Resolving Regional or System Conflict

| REGION 11 CHICAGO EMS SYSTEM POLICY | Title: EMS System Quality Improvement / Quality Assurance (QI/QA) Plan |
|---|---|
| | Section: Quality Improvement |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# EMS SYSTEM QUALITY IMPROVEMENT /QUALITY ASSURANCE (QI/QA) PLAN

## I. PURPOSE

To define the responsibilities of the Emergency Medical Dispatch (EMD) agency, EMS agencies, and EMS System to ensure Quality Improvement/Quality Assurance (QI/QA) in Region 11 EMS.

## II. POLICY

### A. EMD Agency

1. Each Emergency Medical Dispatch (EMD) Agency is required to be certified by IDPH and must have:

    a. An established continuous quality improvement (CQI) program under the approval and supervision of the EMS Medical Director. The CQI program shall include, at a minimum, the following:
        - A quality assurance review process used by the agency to identify EMD compliance with the protocol;
        - Random case review;
        - Regular feedback of performance results to all EMDs.
    b. Availability of CQI reports to IDPH upon request; and
    c. Compliance with the confidentiality provisions of the Medical Studies Act.

### B. EMS Agency

1. Each EMS Agency participating within the Region 11 EMS System must have an established continuous quality improvement (CQI) program under approval and supervision by the EMS Medical Director. The CQI program shall include, at a minimum, the following:

    a. A quality assurance review process used by the agency to identify patient care gaps and compliance with EMS protocols and policies;
    b. Peer review;
    c. Regular feedback of performance results;
    d. Special event after action reports.
    e. Availability of CQI reports to IDPH upon request.

2. All CQI reports must be submitted to the respective Resource Hospital on a quarterly basis.

3. An annual CQI report that reviews continuous quality improvement (CQI) program goals and performance measures will be submitted to the Resource Hospital within one month following the end of the year.

**C. EMS System**

1. Quality improvement measures for the EMS System are selected and agreed upon by the EMS Medical Directors, which may include various patient care and operational quality measures based on system need.

2. There will be a quarterly review of the quality improvement measures.

3. Educational activities will be monitored to ensure that the instruction and materials are consistent with National EMS Education Standards.

4. Findings from quality reviews will be used to inform process improvement and will be communicated to system participants through EMS continuing education (CE) updates.

5. Findings from quality reviews will be made available to IDPH upon request.

6. EMS Program Implementation and Medical Oversight: Any new or pilot program implemented within the EMS System will have a QA/QI review for the first year following implementation. Reports will be submitted to the EMS Medical Director on a monthly basis. Refer to the Approval of Additional Pilot Programs, Medications, and Equipment Policy for additional details.

7. New Medication, Equipment or Procedure: Any new medication, equipment, or procedure will have a QA/QI review of all related patient encounters for a minimum period of six months. Reports will be submitted to the EMS Medical Director on a monthly basis. Refer to the Approval of Additional Pilot Programs, Medications, and Equipment Policy for additional details.

**D. Systems of Care**

1. Pediatrics: Regional Pediatric Quality Improvement Subcommittee - Hospitals within Region 11 that are designated as an SEDP, EDAP or PCCC shall have their Pediatric Quality Coordinator (PQC) participate in the Region 11 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.

2. Stroke: Regional Stroke Advisory Subcommittee (RSAS) – A subcommittee that functions under the Regional EMS Advisory Committee to make recommendations to the Region's EMS Medical Directors Committee on the triage, treatment, and transport of possible acute stroke patients to the appropriate stroke hospitals. The Regional Stroke Advisory Subcommittee shall collect and evaluate de-identified stroke care data from regional stroke network hospitals and EMS Systems to evaluate and make recommendations to the EMS Medical Directors Committee for improvement in regional stroke systems of care. Hospitals

designated as Primary Stroke Center, Thrombectomy Stroke Center, or Comprehensive Stroke Center within Region 11 must participate in the RSAS Subcommittee.

3. STEMI: Regional STEMI/Heart Attack Systems of Care Subcommittee – A subcommittee that functions under the Regional EMS Advisory Committee to make recommendations to the Region's EMS Medical Directors Committee on the triage, treatment, and transport of STEMI patients to the appropriate STEMI centers. The Regional STEMI Subcommittee shall collect and evaluate de-identified STEMI care data from regional STEMI network hospitals and EMS Systems to evaluate and make recommendations to the EMS Medical Directors Committee for improvement in regional STEMI systems of care. Hospitals designated as STEMI Centers within Region 11 must participate in the Regional STEMI Subcommittee.

4. Trauma: Regional Trauma Advisory Committee – A committee formed within an Emergency Medical Services Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each trauma center within the Region, one EMS Medical Director from a Resource Hospital within the Region, one EMS System Coordinator from another Resource Hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative representative from each trauma center within the Region, one EMR, EMD, EMT, Paramedic, ECRN, or PHRN representing the highest level of EMS Personnel practicing within the Region, one emergency physician and one trauma nurse specialist currently practicing in a trauma center. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's Trauma Advisory Committee.

**E. IDPH**

1. Monitors EMD agency, EMS agency, and EMS System QI/QA.

2. May perform unannounced inspection of pre-hospital services.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: IDPH Waiver Provisions |
|---|---|
| | Section: Quality Improvement |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# IDPH WAIVER PROVISIONS

I. The Illinois Department of Public Health (IDPH) may grant a waiver to any provision of the EMS Act or its Rules and Regulations for a specified period of time that they determine to be appropriate. IDPH may grant a waiver when it can be demonstrated that there will be no reduction in standards of medical care as determined by the EMS MD or IDPH. Waivers shall be valid only for the length of time determined by the Department. For either a single or multiple waiver request, the burden of proof as to the factual basis supporting any waiver shall be on the applicant.

II. Any entity may apply in writing to IDPH for a waiver to specific requirements or standards for which it considers compliance to be a hardship. The application shall contain the following information:

A. The applicant's name, address, and license number (if applicable);

B. The Section of the EMS Act or its Rules and Regulations for which the waiver is being sought;

C. An explanation of why the applicant considers compliance to be a unique hardship, including:

1. A description of how the applicant has attempted to comply with the requirement;

2. The reasons for non-compliance; and

3. A detailed plan for achieving compliance. The detailed plan shall include specific timetables.

D. The period of time for which the waiver is being sought;

E. An explanation of how the waiver will not reduce the quality of medical care established by the EMS Act and it's Rules and Regulations; and

F. If the applicant is a system participant, the applicant's EMS MD shall state in writing whether he or she recommends or opposes the application for waiver, the reason for the recommendation or opposition, and how the waiver will or will not reduce the quality of medical care established by the EMS Act and it's Rules and Regulations. The applicant shall submit the EMS MD's statements along with the application for waiver. If the EMS MD does not provide written statements within 30 days after the applicant's request, the EMS MD will be determined to be in support of the application, and the application may be submitted to IDPH.

III. An EMS MD may apply to IDPH for a waiver on behalf of a system participant by submitting an application that contains all of the information required above, along with a statement signed by the system participant requesting or authorizing the EMS MD to make the application.

IV. IDPH will grant the requested waiver if it finds the following:

A. The waiver will not reduce the quality of medical care established by the EMS Act and it's Rules and Regulations;

B. Full compliance with the statutory or regulatory requirement at issue is or would be a unique hardship on the applicant;

C. For EMS Personnel seeking a waiver to extend a relicensure date in order to complete relicensure requirements:

1. The EMS provider has previously received no more than one extension since his or her last relicensure; and

2. The EMS provider has not established a pattern of seeking extensions (e.g., waivers sought based on the same type of hardship in two or more previous license periods);

D. For an applicant other than EMS providers seeking a waiver:

1. The applicant has previously received no more than one waiver of the same statutory or regulatory requirement during the current license or designation period;

2. The applicant has not established a pattern of seeking waivers of the same statutory or regulatory requirement during previous license or designation period; and

3. IDPH finds that the hardship preventing compliance with the particular statutory or regulatory requirement is unique and not of an ongoing nature;

E. For a hospital requesting a waiver to participate in a System other than that in which the hospital is geographically located:

1. Documentation that transfer patterns support the request; and

2. Historic patterns of patient referrals support the request.

IV. When granting a waiver, IDPH will specify the statutory or regulatory requirement that is being waived, any alternate requirement that the waiver applicant shall meet, and any procedures or timetable that the waiver applicant shall follow to achieve compliance with the waived requirement.

V. IDPH will determine the length of any waiver that it grants, based on the nature and extent of the hardship and will consider the medical needs of the community or areas in which the waiver applicant functions.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Medical Device Malfunction Reporting |
|---|---|
| | Section: Quality Improvement |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# MEDICAL DEVICE MALFUNCTION REPORTING

## I. PURPOSE

To define the medical device reporting requirements by EMS personnel for the Food and Drug Administration (FDA) under the Safe Medical Devices Act of 1990.

## II. DEFINITIONS

A. Medical Device: Any instrument, apparatus or other article that is used to prevent, diagnose, mitigate or treat a disease or to affect the structure or function of the body. This includes, but is not limited to ventilators, cardiac monitors, electronic equipment, patient restraints, syringes, catheters, diagnostic test kits and reagents, disposables, components, parts, or accessories.

B. Malfunction: Failure of a device to meet its performance specifications or to perform as intended.

C. Medical Device Reporting (MDR) Regulation of 1995: Contains mandatory requirements for manufacturers, importers, and device user facilities (includes hospital and EMS) to report device related serious injury or death within 10 business days to the manufacturer and/or the Food and Drug Administration (FDA).

D. MDR Reportable Event: An event about which a user facility becomes aware of information that reasonably suggests that a device has or may have caused or contributed to a death or serious injury.

E. MDR Authority: The Food and Drug Administration (FDA) has criminal and civil penalty to enforce MDR requirements.

## III. POLICY

A. Any individual who witnesses, discovers, or otherwise becomes aware of information that reasonably suggests that a medical device has caused or contributed to the morbidity and mortality of the patient or EMS personnel is responsible to:

1. Report the incident to their immediate supervisor; and

2. Complete a Request for Clarification (RFC) within 24 hours.

B. Medical device malfunction is a mandatory reportable event by the EMS personnel and/or the EMS agency to the Resource Hospital EMS Coordinator and EMS Medical Director.

C. Incident investigation information will be used to complete the FDA Med Watch mandatory or voluntary reporting of adverse events form.

Reference: U.S. Food and Drug Administration, Medical Device Safety, https://www.fda.gov/medical-devices/medical-device-safety.

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Request for Clarification (RFC) / Complaint Investigation |
|---|---|
| | Section: Quality Improvement |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 17, 2025 |

# REQUEST FOR CLARIFICATION (RFC) / COMPLAINT INVESTIGATION

## I. PURPOSE

To define the process to review issues or concerns regarding prehospital patient care within the EMS System.

## II. DEFINITION

A. Request for Clarification (RFC): When a system participant requests Resource Hospital review of an incident.

B. Complaint: Problems related to the care and treatment of a patient. For the purposes of this policy, "complaint" means a report of an alleged violation of the EMS Act or its rules and regulation by any system participant, EMS provider, or member of the public.

## III. POLICY

A. Any person or system participant may submit a Request for Clarification (RFC) or a complaint regarding an incident.

B. Submitting a RFC/complaint:

1. EMS Providers and EMS System Participants: RFCs/complaints should be submitted to the Resource Hospital on the attached form, but may also be submitted by phone, email, or verbal report with the required information.

2. Patients and Members of the Public: Complaints should be submitted to the IDPH Central Complaint Registry Hotline by calling 800-252-4343 (Monday-Friday 8:30 am – 4:30 pm). For additional information regarding how to file a health care complaint, please visit https://dph.illinois.gov/topics-services/health-care- regulation/complaints.html.

C. Examples of common RFCs/complaints include, but are not limited to:

1. Deviations in EMS protocols or policies;

2. Direction or orders given by Online Medical Control; and/or

3. Problems or incidents related to the care and treatment of a patient

D. The Resource Hospital EMS System Coordinator and EMS Medical Director will review submitted RFC/complaints and obtain information needed to investigate the incident.

E. The name of the complainant shall not be disclosed unless the complainant consents in writing to that disclosure.

F. IDPH may conduct a joint investigation with the EMS Medical Director and EMS Coordinator if a death or serious injury has occurred or there is imminent risk of death or serious injury, or

if the complainant alleges action or conditions that could result in a denial, non-renewal, suspension, or revocation of licensure or designation.

G. The EMS Medical Director shall forward the results of any investigation with disciplinary action to IDPH.

H. Documentation of the investigation shall be retained at the hospital in accordance with the Resource Hospital record retention policy and shall be available to IDPH upon request. The investigation file shall be considered privileged and confidential in accordance with the Medical Studies Act [735 ILCS 5/8 -2101], except that IDPH and the involved EMS System may share information. IDPH's final determination shall be public information.

I. IDPH will determine whether the Act or which part is being violated based upon information submitted by the complainant and the results of the investigation conducted in accordance with section F.

1. IDPH will have final authority in the disposition of a complaint investigation. Complaint investigations will be classified as valid, invalid, or undetermined.

2. IDPH will inform the complainant and the System Participant or provider of the complaint results within 20 days after its determination.

3. An EMS System participant or provider who is dissatisfied with the determination or investigation by IDPH may request reconsideration by IDPH within seven business days of the determination.

J. The attached Request for Clarification (RFC) or Complaint Form should be copied and made available to the public and participants of the EMS system. It should be made accessible at the Resource and Associate Hospital EMS offices and Participating Hospital Emergency Departments.

# REGION 11 EMS
# REQUEST FOR CLARIFICATION (RFC) OR COMPLAINT FORM

**CONFIDENTIAL**

THIS IS A CONFIDENTIAL QUALITY IMPROVEMENT DOCUMENT.
DO NOT COPY OR MAKE REFERENCE TO ITS COMPLETION IN THE MEDICAL RECORD/PATIENT CARE REPORT.

Date and Time of Occurrence:

EMS Agency and Unit Number: Event or Incident Number:

Hospital or Facility Where the Patient Was Transported:

Hospital Log or Report Number:

EMS Personnel Name(s):

Names of the Patient, Entities, Family Members, and Other Persons Involved:

Relationship of the Complainant to the Patient or the Provider:

Patient Condition and Status:

Details of the Situation:

Name of Person(s) Submitting Form:

Form Submitted To:

Date Form Submitted:

**CONFIDENTIAL**

| REGION 11<br>CHICAGO EMS SYSTEM<br>POLICY | Title: Resolving Regional or System Conflict |
|---|---|
| | Section: Quality Improvement |
| | Approved: EMS Medical Directors Consortium |
| | Effective: December 6, 2023 |

# RESOLVING REGIONAL OR SYSTEM CONFLICT

I. The EMS Medical Directors of the EMS systems involved will review and develop a plan of action to resolve the conflict.

II. Unresolved issues will be referred to IDPH for review and recommendations.

III. If IDPH determines that a dispute exists between an EMS System, vehicle service provider, Advisory Committee, hospital, 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 IDPH shall have the authority to resolve those disputes, if one party to the dispute requests IDPH intervention in writing. If IDPH 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. IDPH shall have the authority to hear oral arguments and testimony based upon the written submissions. Any decision by IDPH shall be issued in writing and state the basis for the decision, which shall be final and binding upon all parties to the dispute. IDPH will endeavor to issue a written decision within 30 days after receipt of all written submissions and verbal testimony, if verbal testimony is permitted.

IV. This dispute resolution process is not applicable to EMS personnel or members of the public. This process is not applicable to any EMS System Suspension, Local Board of Review, or action by the State EMS Disciplinary Review Board or IDPH.

V. The IDPH Practice and Procedure in Administrative Hearings (77 Ill. Adm. Code 100) shall govern all proceedings.

VI. All final administrative decisions of IDPH hereunder shall be subject to judicial review pursuant to the provisions of the Administrative Review Law [35 ILCS 5/Art. III]. A decision by IDPH 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.