Region 2 Trauma Plan

June 2017

Region 2 Trauma Plan

Region 2 Trauma Plan

1) Identification of Regional Trauma Centers Scope

The Region 2 Trauma Plan applies to all trauma patients, pre-hospital care providers, hospitals and other agencies participating in the care of trauma patients within Region 2.

10/97
Revised: 9/04
Reviewed: 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

1) Identification of Regional Trauma Centers Introduction

There are eighteen counties in Trauma Region 2 which is located in West Central Illinois. It is primarily composed of rural and small communities, with many areas having some limitation of resources. There are 25 hospitals in Region 2, with a large variation in hospital size ranging from the small community hospital to the large teaching institution. There is one Level 1 Trauma Center, seven Level II Trauma Center's and seventeen Participating Hospitals.

The Region 2 Trauma Plan is written in an attempt to organize trauma centers and existing resources in an effort to allow for continuous improvement in the provision of trauma care.

This plan is intended to operate in association with the Emergency Medical Services Systems (EMS) Act and the State of Illinois Trauma Center Code.

10/97
Revised: 9/04, 7/10
Reviewed: 3/05, 9/07, 3/10, 3/15

1) Identification of Regional Trauma Centers

Region 2 Trauma Plan

Section 515.200 Emergency Medical Services Regions

Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SECTION 515.200 EMERGENCY MEDICAL SERVICES REGIONS

Section 515.200 Emergency Medical Services Regions

Effective September 1, 1995, Emergency Medical Services Regions are designated as follows:

a) Region 1 is the following counties:
Jo Daviess, Stephenson, Winnebago, Boone, Ogle, Lee, Carroll, Whiteside, Dekalb.

b) Region 2 is the following counties:
Rock Island, Warren, Bureau, Putnam, LaSalle, Mercer, Henry, Stark, Marshall, Livingston, Henderson, Knox, Peoria, Woodford, McDonough, Fulton, Tazewell, McLean.

c) Region 3 is the following counties:
Hancock, Adams, Pike, Calhoun, Schuyler, Brown, Cass, Morgan, Scott, Greene, Jersey, Mason, Menard, Sangamon, Macoupin, Logan, Christian, Montgomery.

d) Region 4 is the following counties:
Madison, St. Clair, Monroe, Randolph, Bond, Clinton, Washington.

e) Region 5 is the following counties:
Perry, Jackson, Union, Alexander, Marion, Jefferson, Franklin, Williamson, Johnson, Pulaski, Wayne, Hamilton, Saline, Pope, Massac, Edwards, White, Gallatin, Hardin, Wabash.

f) Region 6 is the following counties:
Ford, Iroquois, DeWitt, Piatt, Champaign, Vermilion, Macon, Moultrie, Douglas, Edgar, Shelby, Coles, Cumberland, Clark, Fayette, Effingham, Jasper, Crawford, Clay, Richland, Lawrence.

g) Region 7 boundary lines:

1) North - Illinois Route 71 east from the Kendall/LaSalle county line to Illinois Route 126; east on Illinois Route 126 to the Kendall/Will county line; north on the Kendall/Will county line to the Will/DuPage county line; the Will/DuPage county line east to Naperville Road; Naperville Road South to I55; I55 north to Route 83 (Illinois Route 83 is in Region 8); Illinois Route 83 south to junction with Illinois Route 171 (Archer Avenue) (Illinois Route 171 is in Region 8); Illinois Route 171 north to the city limits of Summit; north along the Summit city limits to the Chicago city limits (Summit is in Region

7); south along the Chicago city limits to the Indiana/Illinois State line.

2) South - Grundy/Livingston county line; Kankakee/Livingston, Kankakee/Ford, and Kankakee/Iroquois county lines.

3) East - Illinois/Indiana state line for Cook, Will, and Kankakee counties.

4) West - Kendall/LaSalle county line from Route 71 south to Grundy/LaSalle county line; Grundy/LaSalle county line.

h) Region 8 boundary lines:

1) North - DuPage/Cook county line east to O'Hare International Airport (O'Hare International Airport is in Region 11); along the south and east boundary of O'Hare International Airport north of the city limits of Rosemont (Rosemont is in Region 8) to the Chicago city limits. (Norridge and Harwood Heights are in Region 8. Schiller Park is in Region 9.)

2) South - Will/DuPage county line from Kane county line east to Naperville Road, then south to Interstate 55; north on Interstate 55 to Illinois Route 83 (Illinois Route 83 is in Region 8); Illinois Route 83 south to junction with Illinois Route 171 (Archer Avenue) (Illinois Route 171 is in Region 8); Illinois Route 171 north to the city limits of Summit; north along the Summit city limits north to the Chicago city limits (Summit is in Region 7).

3) East - Chicago city limits.

4) West - DuPage/Kane county line.

i) Region 9 boundary lines:

1) North - Illinois/Wisconsin state line for McHenry County; Illinois/Wisconsin state line for Lake County from Lake/McHenry county line east to Route 83.

2) South - Route 71 north from the LaSalle/Kendall county line to Route 126; Route 126 east to the Kendall/Will county line.

3) East - Route 83 south from the Illinois/Wisconsin border to Route 173; Route 173 west to Route 59; Route 59 south to Route 60; Route 60 east to Route 83; Route 83 south to the Lake/Cook county line; Lake/Cook county line east to Milwaukee Ave.; Milwaukee Ave. south to Des Plaines River Road; Des Plaines River Road south to Central Road; Central Road east to I 294; I 294 south to Dempster Street; Dempster Street east to the Niles city limits; along the Niles city limits south to the Chicago city limits (Niles is in Region 10); along the Chicago city limits south and west to the Rosemont city limits (Park Ridge is in Region 9 and Rosemont is in Region 8); along the northern boundary of O'Hare International Airport to the DuPage/Cook county line; DuPage/Cook county line west to Cook/DuPage/Kane county line; Kane/DuPage county line south to the Kane/Kendall county line; Kendall/Will county line south to Route 126.

4) West - McHenry/Boone and McHenry/DeKalb county lines; DeKalb/Kane county line; Dekalb/Kendall county line; LaSalle/Kendall county line South to Route 71.

j) Region 10 boundary lines:

1) North - Illinois/Wisconsin state line for Lake county to Route 83.

2) South - northern Chicago city limits from Lake Michigan to the Park Ridge city limits (Park Ridge is in Region 9).

3) East - Lake Michigan south from Illinois/Wisconsin state line to Chicago city limits.

4) West - Route 83 from the Wisconsin state line south to Route 173; Route 173 west to Route 59; Route 59 south to Route 60; Route 60 east to Route 83; Route 83 south to the Lake/Cook county line; Lake/Cook county line east to Milwaukee Ave.; Milwaukee Ave. south to Des Plaines River Road; Des Plaines River Road south to Central Road; Central Road east to I 294; I 294 south to Dempster Street; Dempster Street east to the Niles city limits; along the Niles city limits south to the Chicago city limits (Niles is in Region 10).

k) Region 11 is the City of Chicago city limits.

l) Hospitals may request a waiver of the boundary lines for inclusion in a different EMS Region by submitting a request for a waiver to the Department. The Department's decision to grant or deny a waiver request will be based on:

1) Normal transfer patterns; and

2) Location of the EMS System with which the hospital is affiliated.

Reviewed: 09/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Section 515.2000 Trauma Center Designation

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SECTION 515.2000 TRAUMA CENTER DESIGNATION

Section 515.2000 Trauma Center Designation

a) *The Department shall attempt to designate trauma centers in all areas of the State. There shall be at least one Level I Trauma Center serving each EMS Region, unless waived by the Department. Level I Trauma Centers shall serve as resources for Level II Trauma Centers in the EMS Regions. The extent of such relationships shall be defined in the EMS Region plan.* (Section 3.90(b)(5) of the Act)

b) Any hospital seeking designation as a Level I or Level II Trauma Center shall submit an application form (see Section 515.Appendix A of this Part) as prescribed by the Department.

c) *Upon receipt of a completed* application, the Department shall *conduct a site visit to* determine compliance with the Act and this Part. *A report of the inspection shall be provided to the Director within 30 days of the completion of the site visit.* (Section 3.90(b)(3) of the Act) The applicant hospital shall be operational for designation within six months after the application and site survey are approved.

d) *The Department shall designate* those *applicant hospitals as Level I or Level II Trauma Centers* which *meet the* requirements *established by* the *Act* and this Part.

e) *Beginning September 1, 1997 the Department shall designate a new Trauma Center only when a local or Regional need for such a Trauma Center has been identified* by the *applicable EMS Region's Trauma Center Medical Directors Committee, with advice from the Regional Trauma Advisory Committee.* (Section 3.90(b)(4) of the Act) Department designation shall be based upon any of the following criteria justifying a need for designation of a new Trauma Center:

1) Number of expected trauma cases;

2) An estimated time of arrival to existing Trauma Centers greater than 25 minutes;

3) The number of times that surrounding Trauma Centers went on bypass status within the preceding year;

4) A recommendation by the Trauma Regional Advisory Board or Regional EMS Advisory Committee that there is an indentifiable need for additional Trauma Centers since the trauma system was implemented; and

5) Documentation of extenuating circumstances, which will be reviewed by the Department on an individual basis, where a special need exists and/or a population is not serviced by an existing Trauma Center.

f) A Trauma Center designation shall be for two years.

g) All requests for renewal of Trauma Center designations shall be filed in writing (see Section 515.Appendix B of this Part) with the Department before the designation expiration date. If the renewal request meets the requirements of this Part, the existing designation shall continue in full force and effect until a final Department decision on the renewal request has been issued.

h) Any level Trauma Center may voluntarily terminate its designation prior to its expiration date by notifying the Department in writing. Such notification shall include the anticipated date of termination, which shall not exceed 60 days after notice is received by the Department, and shall describe the procedures taken by the Trauma Center to notify the providers, hospitals, EMS systems and other Trauma Centers in the EMS Region.

i) *No facility shall use the phrase "Trauma Center" or words of similar meaning in relation to itself or hold itself out as a Trauma Center without first obtaining designation pursuant to* the Act and this Part. (Section 3.105 of the Act)

(Source: Amended at 22 Ill. Reg. 16543, effective September 8, 1998)

Reviewed: 09/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Region 2 Hospitals
Updated March 2015

Level 1 Trauma Center

OSF Saint Francis Medical Center
530 NE Glen Oak Avenue
Peoria, IL 61637
Phone: 309-655-2000

Trauma Medical Director	J. Stephen Marshall, MD	309-624-4444	smarshall@peoriasurgical.com
Pediatric Trauma Medical Director	Richard Pearl, MD	309-655-3800	Richard.H.Pearl@osfhealthcare.org
ED Medical Director	Leon Yeh, MD	309-655-2553	Leon.A.Yeh@osfhealthcare.org
EMS Medical Director	Matthew Jackson, MD	309-624-8741	Matthew.N.Jackson@osfhealthcare.org
Director of ED/CDU/Trauma	Debbie Trau, MSN	309-624-0165	Deborah.A.Trau@osfhealthcare.org
ED Manager	Gary Tupper, BSN, RN	309-624-0170	Gary.E.tupper@osfhealthcare.org
Manager of Trauma Services	Julie Matson BSN, TNS	309-655-6711	Julie.M.Matson@osfhealthcare.org
EMS Coordinator	Dale Tippett, EMT-P	309-624-3101	Edward.D.Tippett@osfhealthcare.org
Disaster Services Manager	Troy Erbentraut	309-208-0965	Troy.W.Erbentraut@osfhealthcare.org
RMERT/Disaster Coordinator	Kevin Delmastro	309-683-8363	Kevin.M.delmastro@osfhealthcare.org
Life Flight – Medical Director	Rose Haisler, DO	309-624-2306	Rose.M.Haisler@osfhealthcare.org
Life Flight – Executive Director	Brent Grady MSN, CFRN	708-927-3889	Brent.M.Grady@osfhealthcare.org
Clinical Education Scholar for Trauma	Sally Griepentrog, MSN	309-624-7760	Sally.A.Griepentrog@osfhealthcare.org

Incident Command Center
Direct Line: 309-494-2271 –
Administrative Conference room **only to be called in the event of a disaster**

Level 2 Trauma Centers

Advocate BroMenn Medical Center
1304 Franklin Ave.
Normal, IL 61761
Phone: 309-454-1400
ED Fax Number: 309-268-5784

Trauma Medical Director	Brian Gebhart, DO	309-452-1193	Brian.gebhart@advocatehealth.com
ED/EMS Medical Director	Joe Nilles, DO	309-662-1642	Joel.nilles@advocatehealth.com
Trauma Coordinator	Lori Ritter, RN	309-268-5427	Lori.ritter@advocatehealth.com
EMS Coordinator	Dylan Ferguson EMT-P		dferguson@mcleancountyems.org
ED Director	Stephanie Moore, RN	309-268-5360	Stephanie.moore@advocatehealth.com

Incident Command Center
Phone: 309-268-2468 (only active when Command Post activated)

Level 2 Trauma Centers Cont.

Galesburg Cottage Hospital
695 North Kellogg Street
Galesburg, IL 61401
Phone: 309-343-4223
ED Fax Number: 309-345-4403

Trauma Medical Director	Mark Davis, MD	309-343-7773	denise_mills@chs.net
ED Medical Director	Greg Sowards, MD	309-345-4261	jgsmdces@gmail.com
Trauma Coordinator	Alan Cooper, RN, TNS	309-345-4223	Alan_cooper@chs.net
EMS Coordinator	Richard Springer, EMT-P	309-345-4217	richard_springer@chs.net
ED Director	Mindi Lovell, RN, TNS	309-345-4578	mindi_lovell@chs.net
EMS Medical Director	Chirs Herman, MD	309-345-4223	Jaeger45@gmail.com

Incident Command Center
Direct Line 309-345-4570

Genesis Medical Center Silvis
801 Illini Drive
Silvis, IL 61282
Phone: 309-281-4000
ED Fax Number: 309-281-4079
Trauma Fax Number 309-281-4029

Trauma Medical Director	Calvin Atwell, MD	563-299-4111	
ED Medical Director	C.W. Gallops, DO	309-281-4065	Gallopsc@genesishealth.com
EMS Medical Director	C.W. Gallops, DO		dannaj@genesishealth.com
Trauma Coordinator	Danielle Hoffman, BSN, TNS	309-281-4070	Hoffmand@genesishealth.com
EMS Coordinator	Chris Webster	309-281-4038	websterc@genesishealth.com
ED Manager	Laura Carson, BSN, TNS	309-281-4293	Carsonl@genesishealth.com

Incident Command Center
Direct Line 309-281-5160
Administrative Conference room **only to be called in the event of a disaster**

Unity Point Methodist
221 NE Glen Oak Avenue
Peoria, IL 61636
Phone: 309-672-5522
ED Fax Number: 309-672-4246

Trauma Medical Director	Brian Heywood, MD	309-672-5975	Heywood@me.com
ED Medical Director's	Greg Sowards, MD	309-672-5636	James.Sowards@unitypoint.org
Director of Emergency Services	Anthony Howard, MSHA	309-671-2968	Anthony.Howard@unitypoint.org
Trauma Coordinator	Ramona Aberle, RN	309-672-5905	Ramona.Aberle@unitypoint.org
ED Nurse Manager	Michelle Guthrie, RN	309-672-4109	Michelle.Guthrie@unitypoint.org
EMS Coordinator	Tom Stecher, EMT-P	309-672-5646	Thomas.Stecher@unitypoint.org

Incident Command Center
Phone: Direct Line: 309-672-4682 (Will

roll to three other numbers)

Level 2 Trauma Centers Cont.

OSF St. Joseph Medical Center
2200 East Washington Street
Bloomington, IL 61701
Phone: 309-662-3311
ED Phone: 309-661-5111
ED Fax Number: 309-661-5109

Trauma Medical Director	John Wieland, MD	309-662-9022	
ED Medical Director	Doug Ward, MD	309-661-5129	douglas.a.ward@osfhealthcare.org
Trauma Coordinator	Michelle Smith, RN, BSN	309-661-5119	Michelle.l.smith@osfhealthcare.org
EMS Medical Director	Joel Nilles, MD	309-268-5130	Joel.nilles@advocatehealth.com
Emergency Preparedness Coordinator	Timothy Salamon	309-622-3311	Timothy.W.Salamon@osfhealthcare.org
EMS Coordinator	Dylan Ferguson EMT-P		dferguson@mcleancountyems.org
ED Manager - Interim	Michael Brantley RN BSN	309-661-5114	Micheal.R.Brantley@osfhealthcare.org
Incident Command Center	Phone: For small Event- ED 309-661-5111	Phone: For large Event 309-662-3311 Ext. 2683	

OSF St. Mary Medical Center
3333 North Seminary Street
Galesburg, IL 61401
Phone: 309-344-3161

Trauma Medical Director	Jerry Mitchell, MD	309-344-1000 ext 318	jerry.mitchell@osfhealthcare.org
ED/EMS Medical Director	Sergio Morales, MD	309-344-3161 ext 1216	moraless@uic.edu
Trauma Coordinator	Cindy Napier, RN	309-344-3161-1180	cindy.s.napier@osfhealthcare.org
EMS Coordinator	Barbara Whedbee, RN, BSN	309-344-3161-4195	Barbara.j.whedbee@osfhealthcare.org
ED Manager	Lisa Sopher, RN, BSN	309-344-3161-1164	Lisa.g.sopher@osfhealthcare.org
Incident Command Center	Small Events: 309-344-9403	Large Events: 309-344-9443	

Unity Point Trinity Rock Island
2701 17th Street
Rock Island, IL 61201
Phone: 309-779-5000
ED Fax Number: 309-779-2105

Trauma Medical Director	Daniel Johnson, MD	309-779-4400	Daniel.Johnson@unitypoint.org
ED Medical Director	Kevin Kurth, MD	309-779-3045	Kevin.Kurth@unitypoint.org
ED/Trauma Director	Sue Beswick, MSN	309-779-3839	Susan.Beswick@unitypoint.org
EMS Medical Director	Michael Barr, MD	309-779-7756	Michael.Barr@unitypoint.org
Trauma Coordinator	Emily McDowell, RN	309-779-3292	Emily.mcdowell@unitypoint.org
Disaster Preparedness Coordinator	Trent Mull, RN, EMT-P	309-779-3039	Trent.Mull@unitypoint,org
EMS Coordinator	Adam Sowells, EMT-P	309-779-7756	Adam.Sowells@unitypoint.org
Mgr ED Rock Island Trauma Center	Pamela Redpath	309-779-3890	Pamela.Redpath@unitypoint.org

Region 2 Trauma Plan

Participating Hospitals

OSF Saint Elizabeth
1100 East Norris Drive

Ottawa, IL 61350
Phone: 815-433-3100
ED Fax Number: 815-431-5387

ED/EMS Medical Director	Kathleen Papazian, MD	312-636-1903	
ED & Outpatient Director	Karen Szott RN, MS	815-431-5216	Karen.m.szott@osfhealthcare.org
EMS Coordinator	Rosemary McGinnis, RN	815-431-5359	Rosemary.t.mcginnis@osfhealthcare.org
ED Manager			
Disaster Coordinator	Jeffrey Brodbeck	815-431-5536	Jeffrey.j.brodbeck@osfhealthcare.org

Incident Command Center
NOTE: Call Hospital and ask for administrator on call at 815-433-3100

Advocate Eureka Hospital
101 S. Major Street
Eureka, IL 61530
Phone: 309-467-2371
ED Fax Number: 309-467-2963

ED Medical Director	John Kell, MD	309-304-2125	
EMS Medical Director	Joel Nilles, MD	309-454-0708 309-304-2100	Joel.nilles@advocatehealth.com
ED Manager	Ron Bartlett, RN	Ext: 48-2448	Ronald.bartlett@advocatehealth.com
EMS Coordinator			
Chief Nursing Officer	Nancy Allen, RN	309-304-2103	nallen@advocatehealth.com

Graham Hospital
210 W. Walnut Street
Canton, IL 61520
Phone: 309-647-5240
ED Fax Number: 309-649-5128

ED Medical Director	Dwayne Bernard, MD	309-647-5240	dbernard@grahamhospital.org
ED Nursing Director	Tara Shore, RN	309-647-5240 Ext 2581	tshore@grahamhospital.org

Hammond-Henry Hospital
600 N College
Geneseo, IL 61254
Phone: 309-944-6431
ED Fax Number: 309-944-9276
Incident Command Center
Phone: 309-944-5650 (changing soon)

ED Medical Director	Ann Kandis, MD		AKandis@hammondhenry.com
ED Manager	Kurtis Kruger, RN	309-944-9126	kurtkruger@hammondhenry.com

Participating Hospitals Cont.

Hopedale Medical Complex
PO Box 267, 107 Tremont Street
Hopedale, IL 61747
Phone: 309-449-3321
ED Fax Number: 309-449-4422
Incident Command Center
Direct Line: 309-449-4400

ED Medical Director	Matthew Rossi, MD	309-449-4338	mbrossi@hopedalemc.com
Chief Operating Officer	Mark Rossi	309-449-4394	mfrossi@hopedalemc.com
ED Manager	Diane Imig, RN	309-449-4232	dimig@hopedalemc.com
Disaster Coordinator	Mike Baker	309-449-4397	mdbaker@hopedalemc.com

Illinois Valley Community Hospital
925 West Street
Peru, IL 61354
Phone: 815-223-3300

ED Medical Director	Paul Bonucci, MD	815-780-3767	
EMS Medical Director	Ricardo Calderon, MD	815-220-7170	cardoivfm@msn.com
EMS Coordinator		815-780-3114	
ED Manager	Patricia Rogers	815-780-3589	patricia.rogers@ivch.org
Pediatric Quality Coordinator	Carolyn Clayton	815-780-3411	Carolyn.clayton@ivch.org

Incident Command Center
Direct Line: 815-780-3500

OSF Saint Luke Medical Center
1051 W South St, PO Box 747
Kewanee, IL 61443
Phone: 309-852-7500

ED Medical Director	Troy Cutler, MD	309-852-7606	cutlerepss@gmail.com
Director of ED/CCU/EMS Coord	Jason Bitner, RN, BSN	309-852-7605	Jason.L.Bitner@osfhealthcare.org

Incident Command Center
Direct Line - Via Switchboard:
309-852-7500

Participating Hospitals Cont.

McDonough District Hospital
525 East Grant Street
Macomb, IL 61455
Phone: 309-833-4101

Emergency Department Chairman	Jim Brown, MD	309-833-4101	
EMS Medical Director	George Roodhouse, DO	309-833-4101	gbroodhouse@mdh.org
EMS Coordinator			
Clinical Care Coordinator – Emergency Services			
Emergency Services Department Leader			

Incident Command Center
Direct Line: 309-836-3379

Mendota Community Hospital
1315 Memorial Drive
Mendota, IL 61342
Phone: 815-539-7461
ED Fax Number: 815-539-1483

ED Medical Advisor	Larry Powell, MD	815-539-1400	
EMS Medical Director	Dennis Uehara, MD	815-943-1120	
ED Manager	Michele Meyer, RN	815-539-1635	mmeyer@mendotahospital.org

Genesis Medical Center-Aledo
409 NW Ninth Avenue
Aledo, IL 61231
Phone: 309-582-5301
ED Fax Number: 309-582-3738

ED Medical Director	Julio Santiago, MD		
ED Manager	Donna Wade, RN	309-582-9150	waded@genesishealth.com

OSF Holy Family Medical Center
1000 W. Harlem Avenue
Monmouth, IL 61462
Phone: 309-734-3141
ED Fax Number: 309-734-1689

Medical Staff President	Frank Lasala, MD		Frank.T.Lasala@osfhealthcare.org
ED Medical Director	Sergio Morales, MD		Sergio.E.Morales@osfhealthcare.org
ED Manager	Shana Kennon	309-734-3141 ext 248	Shana.R.Kennon@osfhealthcare.org

Region 2 Trauma Plan

Participating Hospitals Cont.

Pekin Hospital
600 S. 13th Street
Pekin, IL 61554
Phone: 309-347-1151
ED Fax Number: 309-347-6016

ED Medical Director	Kelly Cox, MD	309-353-0255	kcox@pekinhospital.com
EMS Coordinator	Joni Barth, RN	309-353-0416	jbarth@pekinhospital.com
ED Manager	Cindy Justus, RN	309-353-0735	cjustus@pekinhospital.com

Perry Memorial Hospital
530 Park Avenue East
Princeton, IL 61356
Phone: 815-875-2811
ED Fax Number: 815-876-4471

EMS Medical Director	Rick Cernovich, MD	815-876-4411	rcemovich@perrymemorial.org
EMS Coordinator	Deb Wood, RN	815-876-4498	dwood@perrymemorial.org
Director OP Services	Delinda Leopold, MSN	815-876-2357	dleopold@perrymemorial.org
ED Coordinator	Jennifer Hoffman, RN	815-876-3363	jhoffman@perrymemorial.org

Incident Command Center
Direct Line: 815-876-2203

UnityPoint Health Proctor
5409 N. Knoxville
Peoria, IL 61614
Phone: 309-691-1000
ED Fax Number: 309-689-8627

ED Medical Director	Jim Hubler, MD	309-691-1069	hublerepss@aol.com
EMS Coordinator	Maggi Ballard	309-691-1069	Maggi.ballard@unitypoint.org
ED Manager	Faith Neuhauser, RN	309-691-1069	Faith.neuhauser@unitypoint.org

Incident Command Center
Direct Line: 309-691-1089

Region 2 Trauma Plan

OSF St. James – John W Albrecht Medical Center
2500 W Reynolds St
Pontiac, IL. 61764
815-842-2828

ED/EMS Medical Director	Benjamin Kemp, MD	646-549-0186	Benjamin.o.kemp@osfhealthcare.org
EMS Coordinator	Tonya Johnson-Wilcox EMT-P	815-842-6821	Tonya.A.Johnson-Wilcox@osfhealthcare.org
ED Supervisor	Susanna Legner, RN	815-842-4980	Susanna.k.legner@osfhealthcare.org
Executive Director of Ambulatory Services	Tim Johnson	815-842-6817	Timothy.p.johnson@osfhealthcare.org

St. Margaret's Hospital
600 East First Street
Spring Valley, IL 61362
ED Phone: 815-664-1464
ED Fax Number: 815-664-1194

ED Medical Director	Steven Parkes, MD	815-664-1464	
EMS Medical Director	Rick Calderon, MD	815-220-7170	cardoivfm@msn.com
Director of Critical Care Services	Jolene Woitynek, RN, BSN TNCC	815-664-1697	jwoitynek@aboutsmh.org

Incident Command Center
Phone: 815-664-1560 OR 815-664-1554 (Can also call hospital # 815-664-5311 and ask for ICC)

St. Mary's Hospital
111 Spring Street
Streator, IL 61364
Phone: 815-673-2311
ED Fax Number: 815-673-4616
Incident Command Center
Phone: 815-673-4566

ED Medical Director	William Maloney, MD	815-673-2311	wmaloney@infinity-meds.com
EMS Medical Director	John Massimilian, DO	815-673-4521	jmassimili@aol.com
EMS Coordinator:	Lisa Neumann, RN	815-673-4545	lneumann@sms.hshs.org
Director ED/ICU	Janis Astle, RN	815-673-4576	Janis.astle@hshs.org
Trauma Coordinator	Erin Wilson RN, TNS	815-673-4521	Erin.wilson@hshs.org

Reviewed: 10/04, 3/05, 6/07, 9/07, 5/08Revised: 11/04, 12/04, 1/05, 4/05, 5/05, 12/06, 6/07, 9/07, 5/08, 6/08, 12/08, 3/09, 5/09, 9/09, 12/09, 3/10, 7/10, 11/10, 10/11, 3/12, 8/12, 3/13, 3/15

Region 2 Trauma Plan

Region 2 Systems

HOSPITAL		TRAUMA CENTER DESIGNATION	EMSC CERTIFICATION
Advocate BroMenn Medical Center 1304 Franklin Ave. Normal, IL. 61761		Level II	EDAP
OSF St. Elizabeth Hospital 1100 East Norris Drive Ottawa, IL. 61350		Participating	EDAP
OSF Holy Family Medical Center 1000 W. Harlem Avenue Monmouth, IL. 61462		Participating	SEDP
Advocate Eureka 101 South Major Street Eureka, IL. 61530		Participating	
Galesburg Cottage Hospital 695 N. Kellogg Street Galesburg, IL. 61401		Level II	EDAP
Graham Hospital 210 West Walnut Street Canton, IL. 61520		Participating	SEDP
Hammond-Henry Hospital 210 W. Elk Street Geneseo, IL. 61254		Participating	EADP
Hopedale Medical Complex PO Box 267 Hopedale, IL. 61747		Participating	
GMC-Illini Campus 801 Illini Drive Silvis, IL. 61282		Level II	EDAP

Region 2 Trauma Plan

HOSPITAL	TRAUMA CENTER DESIGNATION	EMSC CERTIFICATION
Illinois Valley Community Hospital 925 West Street Peru, IL. 61354	Participating	EDAP
OSF Saint Luke 719 Elliot Street P.O. Box 747 Kewanee, IL. 61443	Participating	EDAP
McDonough District Hospital 525 East Grant Street Macomb, IL. 61455	Participating	EDAP
OSF Saint Paul 1315 Memorial Drive Mendota, IL. 61342	Participating	
Genesis Medical Center - Aledo 1315 NW Ninth Avenue Aledo, IL. 61231	Participating	
Unity Point Methodist 221 NE Glen Oak Avenue Peoria, IL. 61636	Level II	EDAP
Pekin Hospital 600 S 13th Street Pekin, IL. 61554	Participating	EDAP
Unity Point Proctor 5409 N. Knoxville Peoria, IL. 61614	Participating	EDAP

Region 2 Trauma Plan

Region 2 Systems Continued

HOSPITAL	TRAUMA CENTER DESIGNATION	EMSC CERTIFICATION
OSF Saint Francis Medical Center 530 NE Glen Oak Ave Peoria, IL 61637	Level I Adult and Pediatric	PCCC, EDAP
OSF St. James Hospital 610 E. Water Street Pontiac, IL. 61764	Participating	EDAP
OSF St. Joseph Medical Center 2200 E Washington Street Bloomington, IL. 61701	Level II	EDAP
St. Margaret's Hospital 600 E. First Street Spring Valley, IL. 61362	Participating	EDAP
OSF Saint Mary Medical Center 3333 North Seminary Street Galesburg, IL. 61401	Level II	EDAP
OSF CFH Streator 111 East Spring Street Streator, IL. 61364	Participating	EDAP
Unity Point Trinity Rock Island 2701 17th Street Rock Island, IL. 61201	Level II	EDAP

3/98
Revised: 10/98, 2/99, 4/02, 12/02, 12/04, 5/08, 3/10, 7/10, 3/15, 3/17
Reviewed: 9/04, 3/05, 9/07

Region 2 Trauma Plan

Region 2 Specialty Referral Hospitals

Burn

John H. Stroger, Jr., Hospital of Cook County
Sumner L. Koch Burn Center
1901 W. Harrison Street
Chicago, IL. 60612
312-864-3167
312-864-9545

Loyola University Medical Center – Burn Center
2160 S. First Ave.
Maywood, IL 60153-3304 United States
708 216-3988

Memorial Medical Center – Regional Burn Center
800 N. Rutledge St.
Springfield, IL 62781-0001 United States
217 788-3325

OSF St. Anthony Medical Center – Neuro Burn Unit
5666 E. State St.
Rockford, IL 61108-2425 United States
815 395-5313

University of Chicago Burn Center – Electrical Trauma Center
5841 S. Maryland
Chicago, IL 60637-1463 United States
773 702-6736

University of Iowa Burn Treatment Center
200 Hawkins Drive
Iowa City, Iowa 52242
319 356-2496

10/97
Reviewed: 12/02, 5/03, 8/03, 3/05, 9/07, 3/10, 3/15
Revised: 9/04, 12/04, 9/07

Region 2 Specialty Referral Hospitals Cont.

Hyperbaric Medicine

Advocate Lutheran General Hospital
1775 Dempster
Park Ridge, IL. 60068
847 723-5898

University of Iowa Hospitals & Clinics
125 South Dubuque St.
Iowa City, Iowa 52240
319 384-8999

Clarian Health
65th & 21st Street PO Box 1361
Indianapolis, Indiana 46206
317 962-5053 7:00 am – 5:30 pm
After hours page 317 962-5500 or 317 962-2000
Ask for HBO Physician on call

Reimplantation

University of Iowa Hospital and Clinics
Iowa City, Iowa 52242
Emergency Physician Consultation Service: 1-800-553-6292

SIU School of Medicine
217 782-5880

Memorial Medical Center
800 N. Rutledge St.
Springfield, IL. 62781
217 788-3000

10/97
Reviewed: 12/02, 5/03, 8/03, 3/05, 9/07, 3/15
Revised: 9/04, 9/07, 3/10

Region 2 Trauma Plan

Integration of EMSC into Region 2 Trauma Plan

Region 2 has been chosen by the Illinois Emergency Medical Services for Children (EMSC) to implement a program aimed at enhancing the care of the emergently ill/injured child. As a result, the Region 2 Pediatric Subcommittee of the Region 2 Trauma Advisory Board was developed to implement the EMSC program in Region 2. Since January, 1997 regional subcommittee meetings have been conducted to review and develop the EMSC Facility Recognition program in cooperation with the Region 2 Trauma Advisory Board, the EMSC Advisory Board, the Department of Public Health and Loyola University Medical Center Region 2 EMSC Committee will report quarterly to the Region 2 trauma Advisory Board.

The Region 2 Trauma Advisory Board has adopted the pre-hospital pediatric standing medical orders for the Region 2 EMS pediatric standing medical orders, with revisions to be completed to meet the Region's needs. In addition, the Interfacility Pediatric Trauma and Critical Care Consultation and/or Transfer Guidelines have been adopted in the Interfacility Transfer: Triage Criteria/Guidelines of the Region 2 EMS/Trauma Plan. Reference Interfacility Transfer: Triage Criteria/Guidelines.

Region 2 will continue to work in cooperation with EMSC to implement pediatric quality improvement guidelines, injury prevention programs, integration of pediatrics into disaster planning and to develop a model plan for EMSC that can be adopted throughout the state. Ongoing monitoring of the EMSC program shall be conducted in cooperation with the EMSC Advisory Board and Department of Public Health.0

10/97
Revised: 9/04
Reviewed: 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Section 515.100 Definitions

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SECTION 515.100 DEFINITIONS

Section 515.100 Definitions

For the purposes of this Part:

Act – the Emergency Medical Services (EMS) Systems Act [210 ILCS 50].

Advanced Life Support (ALS) Services – an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, cardiac monitoring, cardiac defibrillation, electrocardiography, intravenous therapy, administration of medications, drugs and solutions, use of adjunctive medical devices, trauma care, and other authorized techniques and procedures as outlined in the Advanced Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Aeromedical Crew Member or Watercraft Crew Member or Off-road SEMSV Crew Member – an individual, other than an EMS pilot, who has been approved by an SEMSV Medical Director for specific medical duties in a helicopter or fixed-wing aircraft, on a watercraft, or on an off-road SEMSV used in a Department-certified SEMSV Program.

Alternate EMS Medical Director or Alternate EMSMD – the physician who is designated by the Resource Hospital to direct the ALS/ILS/BLS operations in the absence of the EMS Medical Director.

Ambulance – any publicly or privately owned vehicle that is specifically designed, constructed or modified and equipped for, and is intended to be used for, and is maintained or operated for, the emergency transportation of persons who are sick, injured, wounded or otherwise incapacitated or helpless, or the non-emergency medical transportation of persons who require the presence of medical personnel to monitor the individual's condition or medical apparatus being used on such an individual. (Section

3.85 of the Act)

Ambulance Service Provider or Ambulance Provider – any individual, group of individuals, corporation, partnership, association, trust, joint venture, unit of local government or other public or private ownership entity that owns and operates a business or service using one or more ambulances or EMS vehicles for the transportation of emergency patients.

Associate Hospital – a hospital participating in an approved EMS System in accordance with the EMS System Program 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. The Associate Hospital must have a basic or comprehensive Emergency Department with 24-hour physician coverage. It must have a functioning Intensive Care Unit and/or a Cardiac Care Unit.

Associate Hospital EMS Coordinator – the EMT-P or Registered Nurse at the Associate Hospital who shall be responsible for duties in relation to the ALS, ILS or BLS System, in accordance with the Department-approved EMS System Program Plan.

Associate Hospital EMS Medical Director – the physician at the Associate Hospital who shall be responsible for the day-to-day operations of the Associate Hospital in relation to the ALS, ILS, or BLS System, in accordance with the Department-approved EMS System Program Plan.

Basic Emergency Department – a classification of a hospital Emergency Department where at least one physician is available in the Emergency Department at all times; physician specialists are available in minutes; and ancillary services including laboratory, x-ray and pharmacy are staffed or are "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250).

Basic Life Support (BLS) Services – a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in a Basic Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Board Eligible in Emergency Medicine – completion of a residency in Emergency Medicine in a program approved by the Residency Review Committee for Emergency Medicine or the Council on Postdoctoral Training (COPT) for the American Osteopathic Association (AOA).

Certified Registered Nurse Anesthetist or CRNA – a licensed registered professional nurse who has had additional education beyond the registered professional nurse requirements at a school/program accredited by the National Council on Accreditation, and passed the certifying exam given by the National Council on Certification, and who by participating in 40 hours of continuing education every two years, has been recertified by the National Council on Recertification.

Channel, Half-Duplex – a radio channel that transmits and receives signals, but in only one direction at a time.

CME – continuing medical education.

Comprehensive Emergency Department – a classification of a hospital Emergency Department where at least one licensed physician is available in the Emergency Department at all times; physician specialists shall be available in minutes; and ancillary services including laboratory and x-ray are staffed at all times; and pharmacy is staffed or "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250).

CPR for Healthcare Providers – a course in cardiopulmonary resuscitation that meets or exceeds the American Heart Association course "BLS for Healthcare Providers".

Department – the Illinois Department of Public Health. (Section 3.5 of the Act)

Director – the Director of the Illinois Department of Public Health or his/her designee. (Section 3.5 of the Act)

Dysrhythmia – a variation from the normal electrical rate and sequences of cardiac activity, also including abnormalities of impulse formation and conduction.

Effective Radiated Power (ERP) – the power gain of a transmitting antenna multiplied by the net power accepted by the antenna from the connected transmitter.

Electrocardiogram (EKG) – a single lead graphic recording of the electrical activity of the heart by a series of deflections that represent certain components of the cardiac cycle.

Emergency – a medical condition of recent onset and severity that would lead a prudent lay person, possessing an average knowledge of medicine

and health, to believe that urgent or unscheduled medical care is required. (Section 3.5 of the Act)

Emergency Communications Registered Nurse or ECRN – a registered professional nurse, licensed under the Nursing and Advanced Practice Nursing Act [225 ILCS 65]*, who has successfully completed supplemental education in accordance with* this Part *and who is approved by an EMS Medical Director to monitor telecommunications from and give voice orders to EMS System personnel, under the authority of the EMS Medical Director and in accordance with System protocols.* (Section 3.80 of the Act) These individuals were formerly called MICNS.

Emergency Medical Dispatcher – a person who has successfully completed a training course in emergency medical dispatching meeting or exceeding the National Curriculum of the United States Department of Transportation in accordance with this Part, *who accepts calls from the public for emergency medical services and dispatches designated emergency medical services personnel and vehicles.* (Section 3.70 of the Act)

Emergency medical dispatch priority reference system (EMDPRS) – an EMS System's organized approach to the receipt, management and disposition of a request for emergency medical services.

Emergency Medical Services (EMS) System or System *– an organization of hospitals, vehicle service providers and personnel approved by the Department in a specific geographic area, which coordinates and provides pre-hospital and inter-hospital emergency care and non-emergency medical transports at a BLS, ILS and/or ALS level pursuant to a System Program Plan submitted to and approved by the Department and pursuant to the EMS Regional Plan adopted for the EMS Region in which the System is located.* (Section 3.20 of the Act)

Emergency Medical Services System Survey – a questionnaire that provides data to the Department for the purpose of compiling annual reports.

Emergency Medical Technician-Basic or EMT-B – a person who has successfully completed a course of instruction in basic life support as prescribed by the Department, is currently licensed by the Department in accordance with standards prescribed by the *Act and* this Part *and practices within an EMS System.* (Section 3.50 of the Act)

Emergency Medical Technician-Coal Miner – for purposes of the Coal Mine Medical Emergencies Act, an EMT-B, EMT-I or EMT-P who has received training emphasizing extrication from a coal mine.

Emergency Medical Technician-Intermediate or EMT-I – a person who has

successfully completed a course of instruction in intermediate life support as prescribed by the *Act and* this Part *and practices within an Intermediate or Advanced Life Support EMS System.* (Section 3.50 of the Act)

Emergency Medical Technician-Paramedic or EMT-P – a person who has successfully completed a course of instruction in advanced life support care as prescribed by the Department, is licensed by the Department in accordance with standards prescribed by the *Act and* this Part *and practices within an Advanced Life Support EMS System.* (Section 3.50 of the Act)

EMS Administrative Director – the administrator, appointed by the Resource Hospital with the approval of the EMS Medical Director, responsible for the administration of the EMS System.

EMS Medical Director or EMSMD – the physician, appointed by the Resource Hospital, who has the responsibility and authority for total management of the EMS System.

EMS Lead Instructor – a person who has successfully completed a course of education as prescribed by the Department in this Part, *and who is currently approved by the Department to coordinate or teach education, training and continuing education courses, in accordance with* this Part. (Section 3.65 of the Act)

EMS Regional Plan – a plan established by the EMS Medical Director's Committee in accordance with Section 3.30 of the Act.

EMS System Coordinator – the designated individual responsible to the EMS Medical Director and EMS Administrative Director for coordination of the educational and functional aspects of the System program.

EMS System Program Plan – the document prepared by the Resource Hospital and approved by the Department that describes the EMS System program and directs the program's operation.

First Responder – a person who has successfully completed a course of instruction in emergency first response as prescribed by the Department, who provides first response services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the emergency first response course. (Section 3.60 of the Act)

First Response Services – a preliminary level of pre-hospital emergency care that includes cardiopulmonary resuscitation (CPR), monitoring vital signs and control of bleeding, as outlined in the First Responder curriculum of the United States Department of Transportation and any modifications to

that curriculum specified in this Part. (Section 3.10 of the Act)

Fixed-Wing Aircraft – an engine-driven aircraft that is heavier than air, and is supported in-flight by the dynamic reaction of the air against its wings.

Full-Time – on duty a minimum of 36 hours, four days a week.

Health Care Facility – a hospital, nursing home, physician's office or other fixed location at which medical and health care services are performed. It does not include "pre-hospital emergency care settings" which utilize EMTs to render pre-hospital emergency care prior to the arrival of a transport vehicle, as defined in the *Act* and this Part. (Section 3.5 of the Act)

Helicopter or Rotorcraft – an aircraft that is capable of vertical take offs and landings, including maintaining a hover.

Hospital – *has the meaning ascribed to that term in* Section 3 of the *Hospital Licensing Act* [210 ILCS 85]. (Section 3.5 of the Act)

Instrument Flight Rules or IFR – the operation of an aircraft in weather minimums below the minimums for flight under visual flight rules (VFR). (See General Operating and Flight Rules, 14 CFR 91.115 through 91.129.)

Instrument Meteorological Conditions (IMC) – meteorological conditions expressed in terms of visibility, distance from clouds and ceiling, which require Instrument Flight Rules.

Intermediate Life Support (ILS) Services – an intermediate level of pre-hospital and inter-hospital emergency care and non-emergency medical care that includes basic life support care, plus intravenous cannulation and fluid therapy, invasive airway management, trauma care, and other authorized techniques and procedures as outlined in the Intermediate Life Support National Curriculum of the United States Department of Transportation and any modifications to that curriculum specified in this Part. (Section 3.10 of the Act)

Level I Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2030 of this Part to provide optimal care to trauma patients and to provide all essential services in-house, 24 hours per day.

Level II Trauma Center – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.2040 of this Part to provide optimal care to trauma patients, to provide some essential services available in-house 24 hours per day, and to provide other essential services readily available 24 hours a day.

Limited Operation Vehicle – a vehicle which is licensed by the Department to provide basic, intermediate or advanced life support emergency or non-emergency medical services that are exclusively limited to specific events or locales. (Section 3.85 of the Act)

Local System Review Board – a group established by the Resource Hospital to hear appeals from EMTs or other providers who have been suspended or have received notification of suspension from the EMS Medical Director.

Mobile Radio – a two-way radio installed in an EMS vehicle, which may not be readily removed.

Morbidity – a negative outcome that is the result of the original trauma and/or treatment rendered or omitted.

911 – an emergency answer and response system in which the caller need only dial 9-1-1 on a telephone to obtain emergency services including police, fire, medical ambulance and rescue.

Non-emergency Medical Care – medical services rendered to patients whose condition does not meet the *Act's definition of emergency, during transportation of such patients to health care facilities for the purpose of obtaining medical or health care services which are not emergency in nature, using a vehicle regulated by* the *Act* and this Part. (Section 3.10 of the Act)

Off-Road Specialized Emergency Medical Services Vehicle or Off-Road SEMSV or Off-Road SEMS Vehicle – a motorized cart, golf cart, all-terrain vehicle (ATV), or amphibious vehicle that is not intended for use on public roads.

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.

Pediatric Trauma Patient – trauma patient from birth to 15 years of age.

Physician – any person licensed to practice medicine in all of its branches under the Medical Practice Act of 1987 [225 ILCS 90].

Pilot or EMS Pilot – a pilot certified by the Federal Aviation Administration who has been approved by an SEMSV Medical Director to fly a helicopter or fixed-wing aircraft used in a Department-certified SEMSV Program.

Portable Radio – a hand-held radio that accompanies the user during the

conduct of emergency medical services.

Pre-Hospital Care – those emergency medical services rendered to emergency patients for analytic, resuscitative, stabilizing, or preventive purposes, precedent to and during transportation of such patients to hospitals. (Section 3.10 of the Act)

Pre-Hospital Care Provider – a System Participant or any EMT-B, I, P, Ambulance, Ambulance Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN or Physician serving on an ambulance or giving voice orders over an EMS System and subject to suspension by the EMS Medical Director of that System in accordance with the policies of the EMS System Program Plan approved by the Department.

Pre-Hospital Registered Nurse or Pre-Hospital RN – a registered professional nurse, licensed under the Nursing and Advanced Practice Nursing Act, who has successfully completed supplemental education in accordance with this Part *and who is approved by an EMS Medical Director to practice within an EMS System as emergency medical services personnel for pre-hospital and inter-hospital emergency care and non-emergency medical transports.* (Section 3.80 of the Act) This individual was formerly called a Field RN.

Regional EMS Advisory Committee – a committee formed within an Emergency Medical Services (EMS) Region to advise the Region's EMS Medical Directors Committee and to select the Region's representative to the State Emergency Medical Services Advisory Council, consisting of at least the members of the Region's EMS Medical Directors Committee, the Chair of the Regional Trauma Committee, the EMS System Coordinators from each Resource Hospital within the Region, one administrative representative from an Associate Hospital within the Region, one administrative representative from a Participating Hospital within the Region, one administrative representative from the vehicle service provider which responds to the highest number of calls for emergency service within the Region, one administrative representative of a vehicle service provider from each System within the Region, one Emergency Medical Technician (EMT)/Pre-Hospital RN from each level of EMT/Pre-Hospital RN practicing within the Region, and one registered professional nurse currently practicing in an Emergency Department within the Region. Of the two administrative representatives of vehicle service providers, at least one shall be an administrative representative of a private vehicle service provider. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's EMS Advisory Committee. (Section 3.25 of the Act)

Regional EMS Coordinator – the designee of the Chief, Division of Emergency Medical Services and Highway Safety, Illinois Department of Public Health.

Regional EMS Medical Directors Committee – a group *comprised of the Region's EMS Medical Directors, along with the medical advisor to a fire department vehicle service provider. For Regions that include a municipal fire department serving a population of over 2,000,000 people, that fire department's medical advisor shall serve on the Committee. For other Regions, the fire department vehicle service providers shall select which medical advisor to serve on the Committee on an annual basis.* (Section 3.25 of the Act)

Regional Trauma Advisory Committee – a committee formed within an Emergency Medical Services (EMS) 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 EMT representing the highest level of EMT practicing within the Region, one emergency physician and one Trauma Nurse Specialist (TNS) 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. (Section 3.25 of the Act)

Registered Nurse or Registered Professional Nurse or RN – a person who is licensed as a professional nurse under the Nursing and Advanced Practice Nursing Act [225 ILCS 65].

Resource Hospital – the hospital with the authority and the responsibility for an EMS System as outlined in the Department-approved EMS System Program Plan. The Resource Hospital, through the EMS Medical Director, assumes responsibility for the entire program, including the clinical aspects, operations and educational programs. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

SEMSV Medical Control Point or Medical Control Point – the communication center from which the SEMSV Medical Director or his or her designee issues medical instructions or advice to the aeromedical, watercraft, or off-road SEMSV crew members.

SEMSV Medical Director or Medical Director – the physician appointed by the SEMSV Program 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.

SEMSV Program or Specialized Emergency Medical Services Vehicle Program – a program operating within an EMS System, pursuant to a program plan submitted to and certified by the Department, utilizing specialized emergency medical services vehicles to provide emergency transportation to sick or injured persons.

Specialized Emergency Medical Services Vehicle or SEMSV – a vehicle or conveyance, other than those owned or operated by the federal government, that is primarily intended for use in transporting the sick or injured by means of air, water, or ground transportation, that is not an ambulance as defined in the *Act. The term includes watercraft, aircraft and special purpose ground transport vehicles not intended for use on public roads.* (Section 3.85 of the Act) "Primarily intended", for the purposes of this definition, means one or more of the following:

Over 50 percent of the vehicle's operational (e.g., in-flight) hours are devoted to the emergency transportation of the sick or injured;

The vehicle is owned or leased by a hospital or ambulance provider and is used for the emergency transportation of the sick or injured;

The vehicle is advertised as a vehicle for the emergency transportation of the sick or injured;

The vehicle is owned, registered or licensed in another state and is used on a regular basis to pick up and transport the sick or injured within or from within this State; or

The vehicle's structure or permanent fixtures have been specifically designed to accommodate the emergency transportation of the sick or injured.

Standby Emergency Department – a classification of a hospital Emergency Department where at least one of the registered nurses on duty in the hospital is available for emergency services at all times; and a licensed physician is "on-call" to the Emergency Department at all times in accordance with Section 250.710 of the Hospital Licensing Requirements (77 Ill. Adm. Code 250).

Special-Use Vehicle – any public or privately owned vehicle that is

specifically designed, constructed or modified and equipped, and is intended to be used for, and is maintained or operated solely for, the emergency or non-emergency transportation of a specific medical class or category of persons who are sick, injured, wounded or otherwise incapacitated or helpless (e.g., high-risk obstetrical patients, neonatal patients). (Section 3.85 of the Act)

State EMS Advisory Council – a group that advises the Department on the administration of the Act and this Part whose members are appointed in accordance with Section 3.200 of the Act.

System Participation Suspension – the suspension from participation within an EMS System of an individual or individual provider, as specifically ordered by that System's EMS Medical Director.

Substantial Compliance – meeting requirements except for variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Substantial Failure – the failure to meet requirements other than a variance from the strict and literal performance that results in unimportant omissions or defects given the particular circumstances involved.

Sustained Hypotension – two systolic blood pressures of 90 mmHg five minutes apart or, in the case of a pediatric patient, two systolic blood pressures of 80 mmHg five minutes apart.

Telecommunications Equipment – a radio capable of transmitting and/or receiving voice and electrocardiogram (EKG) signals.

Telemetry – the transmission of data by wire, radio, or other means from remote sources to a receiving station for recording and analysis.

Trauma – any significant injury which involves single or multiple organ systems. (Section 3.5 of the Act)

Trauma Category I – a classification of trauma patients in accordance with Section 515.Appendix C and 515.Appendix F of this Part.

Trauma Category II – a classification of trauma patients in accordance with Section 515.Appendix C and 515.Appendix F of this Part.

Trauma Center – a hospital which: within designated capabilities provides care to trauma patients; participates in an approved EMS System; and is duly designated pursuant to the provisions of the *Act.* (Section 3.90 of the Act)

Trauma Center Medical Director – the trauma surgeon appointed by a Department-designated Trauma Center who has the responsibility and authority for the coordination and management of patient care and trauma services at the Trauma Center. He or she must have 24-hour independent operating privileges and shall be board certified in surgery with at least one year of experience in trauma care.

Trauma Center Medical Directors Committee – a group composed *of the Region's Trauma Center Medical Directors.* (Section 3.25 of the Act)

Trauma Coordinator – a registered nurse working in conjunction with the Trauma Medical Director. The Trauma Coordinator is responsible for the organization of service and systems necessary for a multidisciplinary approach throughout the continuum of trauma care.

Trauma Nurse Specialist or TNS – a registered professional nurse who has successfully completed education and testing requirements as prescribed by the Department, and is certified in accordance with this Part. (Section 3.75 of the Act)

Trauma Nurse Specialist Course Coordinator (TNSCC) – a registered nurse appointed by the Chief Executive Officer of a hospital designated as a TNS Training Site, who meets the requirements of Section 515.750 of this Part.

Trauma Service – an identified hospital surgical service in a Level I or Level II Trauma Center functioning under a designated trauma director in accordance with Sections 515.2030(c) and 515.2040(c) of this Part.

Unit Identifier – a number assigned by the Department for each EMS vehicle in the State to be used in radio communications.

Vehicle Service Provider – an entity licensed by the Department to provide emergency or non-emergency medical services in compliance with the *Act* and this Part *and an operational plan approved by its EMS System(s), utilizing at least ambulances or specialized emergency medical service vehicles (SEMSV).* (Section 3.85 of the Act)

Watercraft – a nautical vessel, boat, airboat, hovercraft or other vehicle that operates in, on or across water.

(Source: Amended at 27 Ill. Reg. 13507, effective July 25, 2003)

Reviewed: 09/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

2) Triage

Region 2 Trauma Plan

Field Triage

Triage has been defined as the classification of patients according to medical need. The goal of triage is prompt and appropriate treatment, at a facility with capabilities for optimal care of the individuals' injuries. Field triage requires EMS personnel to make an estimation of injury severity and match patient needs with available resources.

Based on minimum Trauma Field Triage Criteria, any Category I trauma patient shall be transported to the highest level Trauma Center, unless transport time is greater than 30 minutes to that Trauma Center. Any Category II patient will be transported to the closest Level I or Level II Trauma Center unless the transport time is greater than 30 minutes to the Trauma Center.

The field triage criteria for Region 2 will incorporate the requirements of the Illinois Emergency Medical Systems and Trauma Center Code for minimum field triage criteria. This criteria has been adopted for use in Region 2 and any patient who meets these guidelines for field triage will be considered to have entered the trauma system.

10/97
Reviewed 9/04, 3/05, 9/07, 3/10, 3/15
Revised 2/05

Region 2 Trauma Plan

Field Triage Medical Legal Considerations

1. If a patient is unconscious and meets Field Triage Guidelines for Trauma, the patient will be taken to the highest level Trauma Center available.

2. If a patient has an altered / impaired level of consciousness and meets Field Triage Guidelines for Trauma, the patient will be taken to the highest level Trauma Center available.

3. If a patient is alert and oriented to person, place and time with stable vital signs, the patient will be taken to the hospital of his/her choice, except as defined above and only after consultation with Medical Control.

4. In the absence of family member's presence, if a person at the scene of an emergency can readily prove Durable Power of Attorney for Healthcare, he/she can request that the patient be taken to a specific hospital, except as defined above. Medical Control should be contacted.

5. If a parent requests that a child less than 18 years of age, who meets Field Triage Guidelines, be taken to specific hospital, Medical Control must be contacted for the final decision.

6. If a patient requests to go to another hospital, timely contact must be made with that hospital to accept that patient.

7. Medical Control shall be contacted if there are any questions regarding the patient's status, treatment or destination.

8. It is strongly recommended that prehospital care providers advise the patient, family member/s and/or Durable Power of Attorney for Healthcare of trauma care availability and capability and that they document their choice of receiving hospital.

10/97
Reviewed: 05/03, 08/03, 09/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

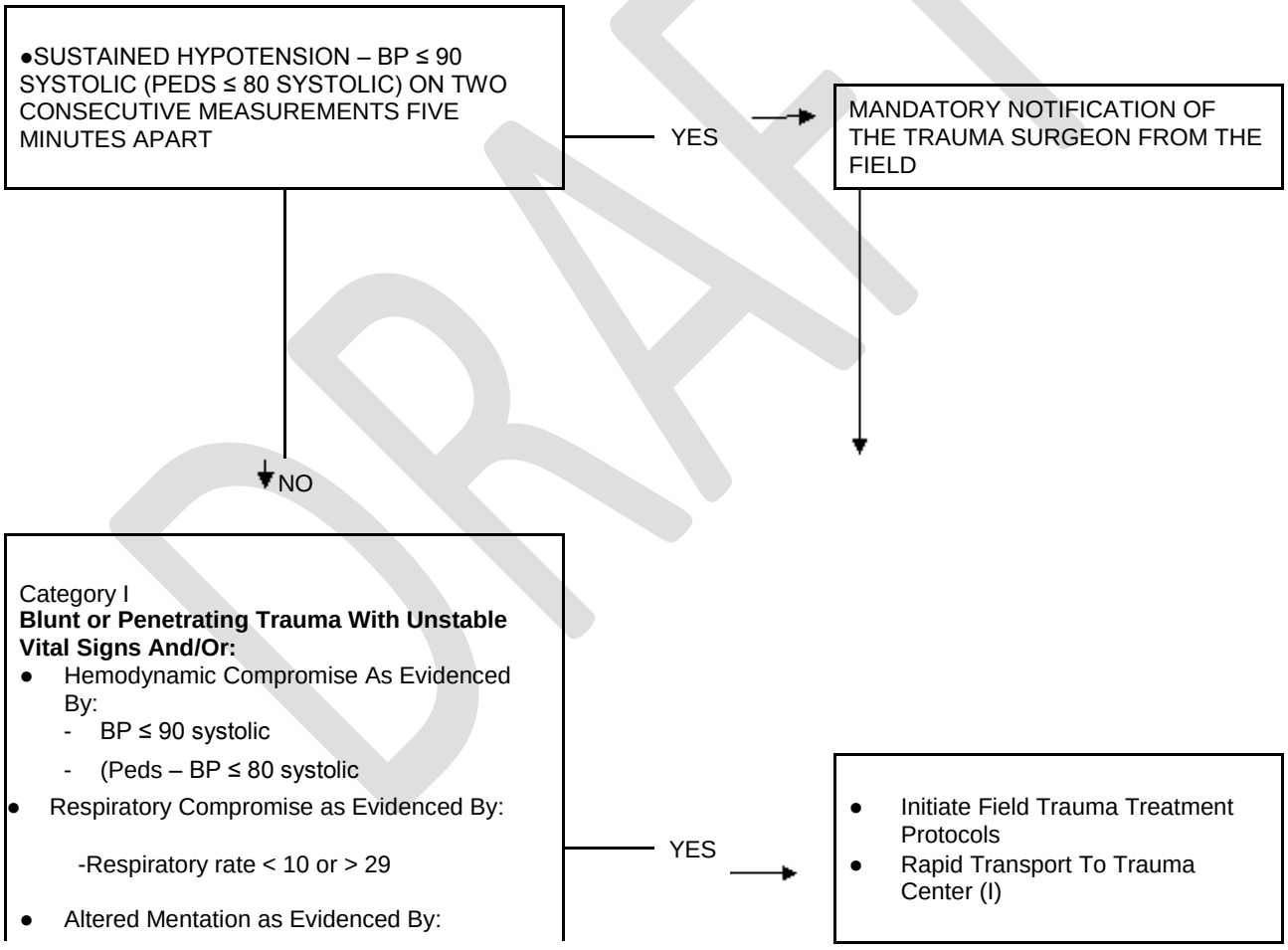
Section 515.APPENDIX C Minimum Trauma Field Triage Criteria

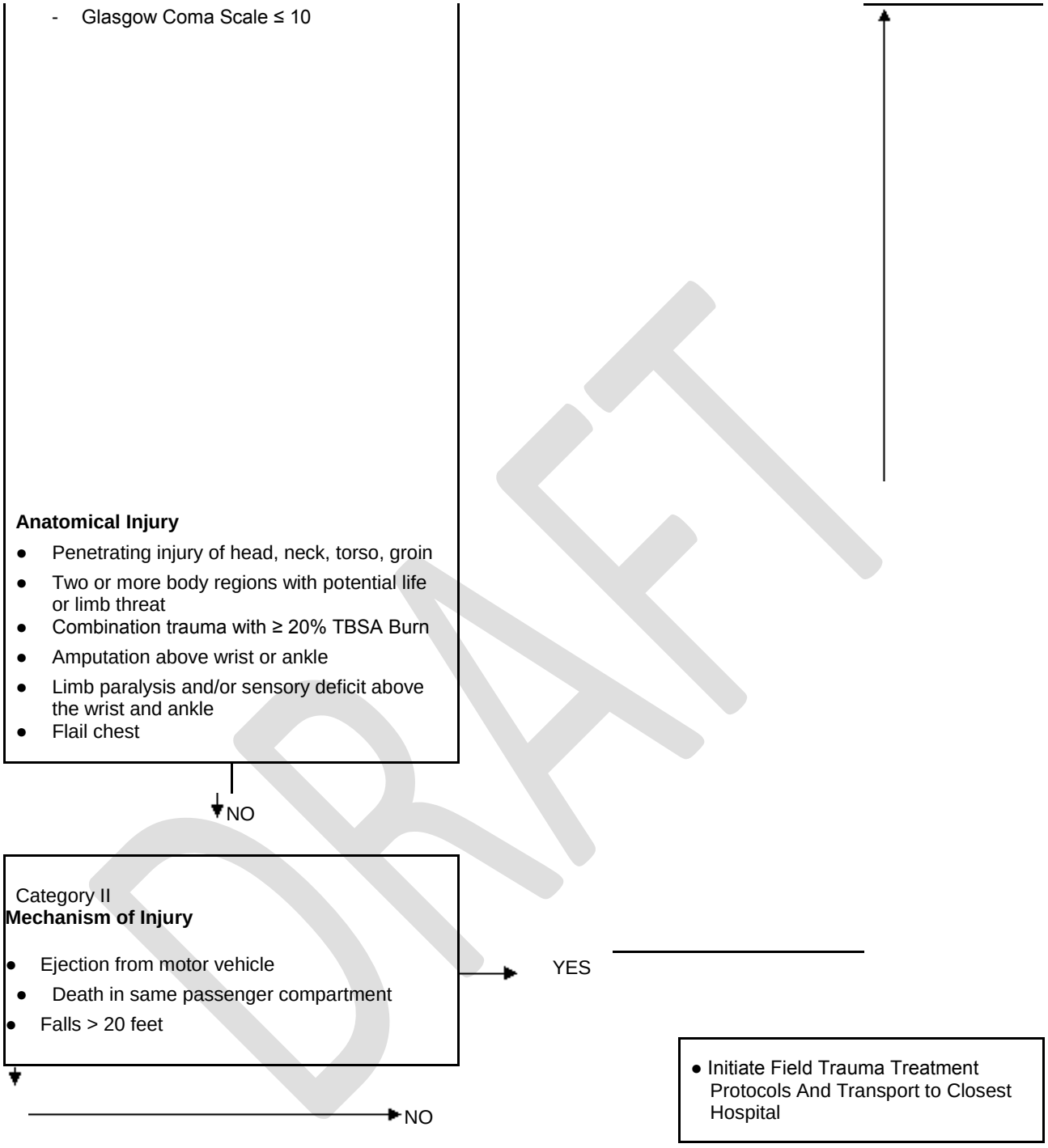
Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SECTION 515.APPENDIX C MINIMUM TRAUMA FIELD TRIAGE CRITERIA

Section 515.APPENDIX C Minimum Trauma Field Triage Criteria





(1) > 25 minutes from Trauma Center, transport to nearest participating trauma hospital.
> 30 minutes from Trauma Center or participating trauma hospital, transport to nearest hospital.
> 45 minutes from Trauma Center or participating trauma hospital in a rural area where there is no comprehensive emergency department available, transport to

the nearest hospital.

(Source: Amended at 24 Ill. Reg. 9006, effective June 15, 2000)

Reviewed: 9/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Region 2 Triage Criteria

The Trauma Service patient will be defined as any patient with significant injury that involves single or multiple organ system(s) who is at risk for loss of life or limb. The Trauma Service patient will be categorized as Category I or Category II.

Category I:

Blunt or Penetrating Trauma with Unstable Vital Signs and/or:

1. Hemodynamic Compromise as Evidenced By:
   BP $\leq$ 90 systolic
   Peds – BP $\leq$ 80 systolic

2. Respiratory Compromise as Evidenced By:
   Respiratory Rate < 10 or > 29

3. Altered Mentation as Evidenced By:
   Glasgow Coma Scale $\leq$ 10

Anatomical Injury:

1. Penetrating injury of head, neck, torso, groin
2. Two or more body regions with potential life or limb threat
3. Combination trauma with $\geq$ 20% TBSA burn
4. Amputation above wrist or ankle
5. Limb paralysis and/or sensory deficit above the wrist and ankle
6. Clinically significant flail chest
7. Two or more proximal long bone fractures
8. Transfer from another hospital receiving blood to maintain vital signs
9. At the discretion of the ED Physician

Category II:

Mechanism of Injury:

1. Ejection from motor vehicle
2. Death in same passenger compartment
3. Rollover

10/97
Reviewed: 12/02, 5/03, 8/03, 9/04, 3/05, 9/07, 3/10, 3/15

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SECTION 515.APPENDIX F TEMPLATE FOR IN-HOUSE TRIAGE FOR TRAUMA CENTERS

Section 515.APPENDIX F Template for In-House Triage for Trauma Centers

It is expected that each trauma center will expand upon the minimum triage set based on individual assessments, resources and outcomes. The criteria are consistent with the Minimum Trauma Field Triage Criteria for transport to a trauma center.

a) Patient Evaluation

1) Any EMS System transported patients who are classified under Category I in the Minimum Trauma Field Triage Criteria require rapid transport to a trauma center if less than 25 minutes from the trauma center; otherwise, follow Section 515.Appendix C. Mandatory field notification of a trauma surgeon will occur in cases of:

A) Sustained hypotension (blood pressure less than or equal to 90 Hg systolic for an adult and less than or equal to 80 Hg for a pediatric patient on two consecutive measures five minutes apart); or

B) Cavity penetration of the torso or neck.

2) Patients who are classified in the field or in any pre-hospital setting shall be evaluated by the ED's attending emergency physician or designee immediately upon arrival. (Section 515.2060(a))

3) Patients who are not classified as trauma prior to arrival shall be evaluated to assess whether they should be classified as a trauma patient within 10 minutes after arrival. (Section 515.2060(b))

4) Within the above 10 minute evaluation period, the patient must be determined to be Category I or Category II. The response periods for both categories are described below.

5) Patients may be upgraded at any time during ED treatment. The surgeon response time requirements begin at the time of upgrade.

6) Once the patient has been assigned a Category I or II status that patient cannot be downgraded until the patient is evaluated by the trauma surgeon or appropriate subspecialist.

b) Category I

The trauma center must activate its trauma team response (which includes a trauma surgeon, resident or other surgical specialty in lieu of the trauma surgeon) for patients who meet these criteria. Level II trauma centers require a 30-minute response from the time of identification of need. If a back-up surgeon is used, the 30-minute time for response is based on the trauma patient identification time, not the time of the contact to the back-up surgeon. Any patient can be made a Category I based on the ED physician's discretion.

Any patient meeting the definition of isolated injury requires consultation with the appropriate subspecialist within 60 minutes after trauma patient identification, except for neurosurgery and Level I OB/GYN, pediatric surgery and cardiovascular surgery. When neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. In a Level I trauma center, the OB/GYN, pediatric surgery or cardiovascular surgical subspecialist must arrive within 30 minutes after notification of the subspecialist that his or her services are needed at the hospital. Where specialty services are provided by transfer agreement, a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and shall be completed within two hours. An isolated injury refers to transfer of energy to a single anatomic body region with no potential for multisystem involvement.

c) Category II

Any other patient who is admitted for traumatic injury requires notification/consultation with the trauma surgeon or subspecialist at the time the decision to admit is made. The patient will be seen by the trauma surgeon or appropriate surgical subspecialist within 12 hours after emergency department arrival.

Any patient meeting the definition for isolated injury requires a telephone consultation with the appropriate subspecialist (within 60 minutes Level II and 30 minutes Level I) of identified need by the emergency department physician. When the need for neurosurgical intervention has been identified, the neurosurgeon must be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention. Where specialty services are provided by transfer agreement,

a transfer to a specialty center shall commence within 30 minutes after the patient's arrival, and the transfer shall be completed within two hours. An isolated injury refers to the transfer of energy to a single anatomic body region with no potential for multisystem involvement.

Category I criteria include at minimum but are not limited to items in the Category I box, Minimum Trauma Field Triage Criteria (Section 515.Appendix C).

Category II criteria include at minimum but are not limited to items in the Category II box, Minimum Field Triage Criteria (Section 515.Appendix C).

(Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1998)

Reviewed: 9/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

3) Region 2 Guidelines for Routine Trauma Care

Region 2 Trauma Plan

Routine Trauma Care

I. The approach to major trauma patients is divided into four phases.
- **A.** Primary Survey
  1. Rapid Assessment (60 – 90 seconds)
  2. Aimed at identifying immediate life-threatening injuries
- **B.** Resuscitation
  1. Occurs simultaneously with primary survey
  2. Basic therapy for immediate life-threatening injuries
- **C.** Secondary Survey
  1. Head-to-toe detailed assessment of trauma patient
  2. Aimed at identifying potentially lethal and non-lethal injuries
- **D.** Definitive Care
  1. Treatment of all injuries identified during primary and secondary survey
  2. Surgical and nonsurgical treatment is included in this phase.

II. Team Approach to Trauma Resuscitation
- **A.** Resuscitation of the major trauma patient requires an integrated team approach employing multiple persons.
- **B.** Personnel included in the resuscitation team:
  1. Physician(s) – emergency medicine and surgery (if in-house)
  2. Emergency Department nurse(s)
  3. Radiology technician
  4. Basic laboratory personnel (as needed)
  5. Cardiopulmonary/Respiratory Therapy
- **C.** One physician is designated as the leader of the resuscitation to coordinate the efforts of the various personnel involved.
- **D.** An attempt should be made to structure the resuscitation team, such that the various members are given specific roles and are familiar with those roles prior to the arrival of the trauma patient.
- **E.** The trauma surgeon should be involved early during the resuscitation to provide timely surgical intervention when indicated.
- **F.** Universal precautions must be utilized by all members of the resuscitative team.

III. Primary Survey and Resuscitation
- **A.** Airway patency is the first goal in the management of the major trauma victim. In all maneuvers to establish a patent airway, care must be taken to maintain cervical spine immobilization.
- **B.** The airway should be assessed by using a look, listen and feel technique to determine patency.
- **C.** The initial steps in providing a patent airway are:
  1. Manual removal of foreign bodies.
  2. Suction with a large bore tonsil tip suction.
  3. Manual maneuvers, such as a chin lift or jaw thrust, to remove the tongue from the posterior pharynx.

4. If a patent airway results from these maneuvers, it can be maintained with an oropharyngeal airway in the unconscious patient or a nasopharyngeal airway in the conscious patient. (Unless facial trauma is present.)
5. Care must be taken during these maneuvers to avoid cervical spine movement.

D. If the above manual maneuvers do not produce a patent airway, tracheal intubation will be necessary.

1. In the apneic patient, orotracheal intubation under direct vision is the procedure of choice. Care should be taken to minimize cervical spine movement through the use of in-line stabilization.
2. If these procedures fail or the patient has sustained massive facial trauma, a surgical cricothyroidotomy should be performed.
3. Formal tracheostomy is reserved for patients with airway obstruction secondary to direct trauma to the cricothyroid membrane.
4. In children less than 12 years of age, cricothyroidotomy should be replaced by percutaneous needle cricothyroidotomy using a 14-gauge catheter for airway control.

E. Once the patent airway is established, all trauma patients should receive 100% oxygen to maximize peripheral oxygenation (and ventilatory assistance with a bag/valve device or ventilator).

F. Cervical Spine Immobilization

1. Patients suspected of cervical spine injury:
   a. A patient who has sustained trauma above the clavicles.
   b. An unconscious trauma patient.
   c. A patient involved in a significant deceleration episode (i.e., motor vehicle accident, fall from height).
   d. A patient with symptoms suggesting a cervical spine injury (i.e., localized pain, spasm, palpable abnormality, peripheral neurologic symptoms.
2. Cervical spine immobilization properly applied in the field should be maintained until clearance is deemed appropriate by a physician
3. Any patient suspected of a cervical spine injury who is not immobilized in the field should be immobilized in the Emergency Department.
   a. Maintain manual stabilization of the cervical spine.
   b. The patient is placed on a long backboard.
   c. The upper torso should also be immobilized to the backboard.
   d. A blanket, towel roll, or head blocks should be placed about the head.
   e. Tape or straps are used to immobilize the head in a neutral position on the backboard.
   f. A rigid cervical collar may be used to supplement this immobilization, but should never be relied on solely for cervical immobilization.

4. A cross table lateral of the cervical spine should be obtained as soon as the primary survey is completed.

G. Breathing

1. A rapid assessment of the status of the patient's thoracic cavity should be made including:
    a. Inspection of asymmetrical movement
    b. Palpation for gross fractures
    c. Auscultation for presence and equality of breath sounds
2. Life-threatening injuries to be identified:
    a. Tension pneumothorax
    b. Open pneumothorax
    c. Massive hemothorax
    d. Flail chest
    e. Cardiac tamponade
3. Indications for chest tube insertion:
    a. Any patient with clinical evidence of a tension pneumothorax (may be preceded by needle decompression).
    b. Any patient with clinical evidence of an open pneumothorax (should be accompanied by the placement of a three sided occlusive dressing over the sucking wound).
    c. Any patient who has sustained penetrating trauma to the thoracic area and must be placed on positive pressure ventilation.
4. In the absence of the above clinical indications, a chest film should be obtained prior to the insertion of a chest tube.
5. Guidelines for emergent thoracic surgical intervention.
    a. Greater than 1500 ml of blood returned from a chest tube initially
    b. Greater than 200 ml of blood from the chest tube each hour for two to four hours.
    c. Inability to resuscitate the patient with active bleeding from the chest tube.
6. A chest film should be obtained on all trauma patients as soon as the primary survey is completed.
    a. Massive hemothorax or large amount of retained hemothorax after chest tube placement is indication for thoracotomy.

H. Circulation

1. Assessment of circulation should include:
    a. Assessment of peripheral perfusion via capillary refill
    b. Palpation of central pulses (i.e., carotid, femoral)
    c. Placement of cardiac monitor
2. All trauma patients should have two large-bore intravenous lines established (a 14 or 16-gauge IV catheter in an adult and the largest possible IV catheter in a pediatric patient).

3. If percutaneous intravenous lines cannot be established, alternative access should be obtained in the following locations:
    a. Saphenous vein at the ankle.
    b. Antecubital vein
    c. Intraosseus~~,~~
4. Central venous lines are primarily used to monitor central venous pressure but may also be used if large-bore peripheral percutaneous access cannot be achieved.
5. After the establishment of venous access, the following initial laboratory studies should be drawn(IV/IO access always takes priority, if able to draw labs at the same time then it is recommended):
    a. Hemoglobin/hematocrit
    b. Type and screen / cross-match for blood bank (amount of blood to be determined by patient's status and availability of blood)
    c. Serum/UA preg (where applicable) additional labs may be drawn
6. The initial fluid resuscitation is begun with an isotonic crystalloid solution (i.e. Lactated Ringer's solution or 0.9% normal saline).
7. If the patient's condition is stabilized, intravenous fluids should be reduced at the discretion of the physician in charge. Recurrence of hypotension at this point should be a consideration for surgical intervention.
8. If the patient's condition is not stabilized with the initial crystalloid bolus, blood products should also be initiated.
9. Pericardial tamponade must be diagnosed during this phase. Initial stabilization may be accomplished by any or all of the following:
    a. Large volume fluid resuscitation
    b. Thoracotomy (With availability of a qualified surgeon)
    c. Pericardiocentesis
10. All patients with pericardial tamponade may require surgical intervention to visualize and repair the injury.
11. External bleeding should be controlled using one of the following procedures
    a. Digital pressure
    b. A compression dressing (<u>not circumferential</u>).
    c. Tourniquets should only be utilized after all other hemorrhage control options have been exhausted. If a tourniquet has been applied pre-hospital and is adequately controlling the bleeding, take the patient to surgery as soon as possible for control of hemorrhage. If surgery is not an option, transfer the patient as quickly as possible to a level of care equipped to handle the injuries.

I. Emergency Department Thoracotomy should be considered for:

1. Any trauma patient with penetrating chest injury that was a witnessed arrest and is in PEA.

2. Airway, ventilation and intravenous access must be established prior to or concurrent with the performance of a resuscitative thoracotomy.
3. Relative contraindications:
    a. A blunt trauma victim that arrests.
    b. A penetrating trauma victim with absent vital signs with no response to initial resuscitation throughout the pre-hospital phase and a transport time of greater than 10 minutes.
    c. A patient presenting with cardiac rhythm of asystole or ventricular bradycardia < 40 beats/minute.
    d. Overwhelming head injury or a major unstable chest injury.
4. The thoracotomy should be performed by the most qualified, immediately available surgeon. An emergency department physician, with chest privileges, may perform a thoracotomy after consultation with a trauma/cardiac surgeon, and the surgeon is en route to the hospital.
5. The Emergency Department thoracotomy should be carried out in accordance with standard operative technique.
6. Any patient successfully resuscitated must be taken to the operating room.

J. Neurologic Assessment

1. A rapid assessment of the patient's neurologic condition should be made.
2. Care must be taken to document the findings.
3. Minimum assessment should be level of consciousness, pupillary findings, and motor response.
4. Any indication of increased intracranial pressure, i.e., unequal pupils, unresponsive head trauma victim, Cushing's triad (hypertension, widening pulse pressure, bradycardia), may prompt the institution of any of the following treatment(s):
    a. Intubation and ventilation
    b. Neurosurgical consultation
    c. Mannitol administration
    d. Lasix administration
5. Use the Glasgow Coma Scale to monitor neurologic function and detect deterioration.
6. Indications for CT scan of the brain(If patient is to be transferred to a higher level of care, CT scans should not be performed if it will delay transport):
    a. Unilaterally dilated pupil
    b. Altered level of consciousness
    c. Focal neurologic deficits
    d. Clinical evidence of a depressed skull fracture

IV. Secondary Survey

A. A detailed head-to-toe examination of the patient should be performed to detect all potentially life-threatening injuries.

B. All trauma patients' with significant suspicion for a c-spine injury, altered mental status, or unreliable exam should undergo C-spine clearance as deemed appropriate by a physician.

C. Any unconscious trauma patient involved in a motor vehicle accident or a significant fall should also have a film of the pelvis. Pelvic films should also be obtained for clinical indications, including hypotension and signs and symptoms of pelvic trauma.

D. Plain films should be obtained to detect potential fractures based on physical findings of pain, swelling, ecchymosis or abnormal function.

E. Pain Assessment/Management
1. Utilize individual facilities protocols/guidelines

F. Nasogastric Tubes
1. Indications for possible placement:
    a. A patient who has sustained abdominal trauma
    b. A patient who is unconscious
    c. A patient with clinical signs of a paralytic ileus or acute gastric dilatation
2. Contraindications
    a. A patient with facial trauma
    b. A patient with a suspected basilar skull fracture.
3. An orogastric tube may be placed when a nasogastric tube is contraindicated.

G. Foley Catheters
1. Indications
    a. A patient requiring large volume fluid resuscitation
    b. A patient undergoing a diagnostic peritoneal lavage
    c. A patient with potential intra-abdominal injury
2. Contraindications
    a. Any patient with evidence of blood at the meatus
    b. A patient with a pelvic fracture in which difficulty is encountered in passing the catheter
3. A freely voided urine specimen may be obtained prior to placing the Foley.

H. Abdominal evaluation in blunt injuries
1. The following are indications to perform a diagnostic test (peritoneal lavage, CT scan of the abdomen, or ultrasound) to evaluate the potential of a blunt intra-abdominal injury:
    a. Hypotension
    b. Altered level of consciousness
    c. Abdominal tenderness without peritoneal signs
    d. Injuries associated with a significant likelihood of intra-abdominal injury
        i. Lower rib fractures
        ii. Lumbar vertebral body fractures
        iii. Pelvic fractures

2. A patient who is unstable should undergo an abdominal FAST exam or peritoneal lavage to evaluate blunt abdominal trauma.
3. If peritoneal lavage is used to evaluate the abdomen, the fluid should be sent for:
    a. Red blood cell count
    b. White blood cell count
    c. Dipstick for bile
    d. Gram stain for bacteria or particulate matter
4. Consider surgical interventions for: (indications for operation require surgical judgment in all cases).
    a. Shock
    b. Peritonitis
    c. Pneumoperitoneum
    d. Retroperitoneal air
    e. Positive abdominal FAST exam
    f. Positive lavage on the basis of one of the following:
        i. Gross blood or particulate matter in the peritoneal fluid.
        ii. Red blood count greater than 100,000 cells mm3
        iii. White blood cell count greater than 500 cells mm3
        iv. Gram stain with bacteria present
    g. Positive CT scan on the basis of one of the following:
        i. Evidence of organ injury
        ii. Evidence of free air or blood in the abdomen

I. Abdominal evaluation for penetrating trauma.

1. Patients with gunshot wounds that penetrate the peritoneal cavity should undergo laparotomy.
2. Abdominal stab wounds may be explored on the basis of penetration or on the basis of visceral injury.
3. Indications for exploration in abdominal stab wounds:
    a. Systemic hypotension
    b. Peritonitis, abdominal tenderness remote from the wound
    c. Presence of gross blood per nasogastric tube, vaginal examination or rectal examination
    d. Retained impaled object
    e. Evisceration
4. In lower thoracic penetrating trauma some consideration must be given to possible diaphragmatic injury. This may be determined by:
    a. A Peritoneal lavage using more sensitive criteria than in blunt abdominal trauma (i.e., 10,000 cells mm3)
    b. Exploratory laparotomy/laparoscopy

J. Urologic Evaluation

1. A urine specimen should be obtained from all patients with potential for significant abdominal trauma.
2. Indications for CT scan with contrast:
    a. Perinephric trauma, blunt or penetrating

b. Gross hematuria (greater than 5-10 RBCs/hpf)
c. Clinical evidence suggesting a renal injury (i.e., flank hematoma or urinoma, flank tenderness)

3. Indication for cystogram:
    a. Penetrating pelvic trauma that potentially crosses the midline
    b. Gross hematuria associated with lower abdominal trauma
    c. Anterior pelvic fractures
4. Indications for retrograde urethogram:
    a. Blood at the urethral meatus
    b. High-riding prostate
    c. Perineal urinoma or hematoma
    d. Failure to easily pass a Foley catheter
5. Contraindications for cystogram:
    a. Patients suspected of having sustained a urethral injury on clinical grounds as outlined below (must be preceded by retrograde urethrogram)
    b. Unstable patient
    c. Dye allergy
6. Contraindications for retrograde urethogram:
    a. Hypovolemia
    b. Unstable patient
    c. Dye allergy

K. Proctoscopy

1. Indications
    a. Gross blood on rectal examination
    b. Penetrating pelvic trauma that potentially crosses the midline
    c. Retained foreign object

L. Arteriography

1. Indications in penetrating trauma:
    a. Any penetrating injury which crosses the path of a major vessel
    b. Physical findings suggestive of a vascular injury
2. Indications in blunt trauma:
    a. Any blunt injury associated with physical findings suggestive of a vascular injury
    b. Injuries with a high incidence of associated arterial injuries
        i. Posterior knee dislocation
        ii. Supracondylar humeral fracture
        iii. Supracondylar femoral fracture
    c. Non-visualization of one kidney on CT

V. Aortic Transection

1. Any patient involved in significant deceleration episode-should be considered at risk for aortic transection.

2. A significant deceleration episode or evidence of high impact is defined as:
    a. Falls 20 ft or more
    b. Rearward displacement of frontal axle
    c. Significant passenger compartment intrusion on opposite side of car, or deformity of car
    d. Ejection of patient
    e. Rollover
    f. Death in same passenger compartment
    g. Pedestrian hit at 20 MPH or more
3. The following chest x-ray findings are considered indications for CTA or arch arteriogram.
    a. Widened mediastinum
    b. Obliteration of the aortic knob
    c. Apical cap
    d. Obliteration of the aortopulmonary window
4. Even in the absence of these x-ray findings, a diagnostic test to determine the potential of an aortic injury should be considered in trauma patients who have sustained a significant deceleration injury.

Reviewed: 09/04, 3/05, 9/07, 3/10, 7/10
Revised: 12/04, 3/15

Region 2 Trauma Plan

Burns

I. General Guidelines

A. Stop burning process.

B. Check airway patency, especially if there are burns of the face. Pulmonary inhalational injuries, usually associated with closed space burns, may be accompanied by trivial surface burns. Look for burns of the vibrissae, soot in the pharynx or nasopharynx, obvious respiratory difficulty and coughing. Arterial blood gases with carboxyhemoglobin levels should be obtained. Oxygen should be given by nasal catheter or mask. Intubation is preferable to tracheostomy for acute respiration distress and should be performed early if there is suspicion of airway involvement. A soft cuff endotracheal or nasotracheal tube should be used.

C. Obtain vital signs and stabilize.

D. Remove clothing, rings, jewelry, contact lenses, wigs, etc.

E. Fluid Resuscitation

1. Initiate IV therapy using Lactated Ringer's and a large bore catheter. Do not use a burned area as an infusion site if possible.
2. During the EMS transport and the primary survey, IV fluids should be started at a set rate based on age.
    a. 0-5 y/o: 125mL/hr LR
    b. 6-13 y/o: 250mL/hr LR
    c. >14 y/o 500mL/hr LR
3. During the secondary survey calculate fluid replacement using the Modified Parkland Formula: 2-4 ml LR x body weight in Kg X percentage of TBSA involved.
    a. 2mL x kg x %TBSA for adults (>14 y/o or >40kg)
    b. 3mL x kg x %TBSA for pediatrics (<14 y/o or <40kg)
    c. 4mL x kg x %TBSA for adult electrical burns

    One half of this volume is to be given in the first 8 hours following injury, and the second half is to be given in the subsequent 16 hours post-burn.
3. Monitoring catheters such as Swan Ganz or conventional central venous pressure catheters are not required in the initial management of severe burns, particularly if transfer is planned. It is better that such procedures be performed after the patient has arrived at a burn unit.

F. Insert a Foley catheter and monitor urine output hourly. Regulate the IV accordingly.

Urine flow rate: 0.5 mL/kg/hr (maximum of 50mL/hr) - adults
1 mL/kg/hr – pediatrics

Electrical Burns
75-100mL/hr – adults
1-2mL/kg/hr - pediatrics

G. Insert a nasogastric tube to prevent aspiration and place to wall suction. Keep patient NPO.

H. Elevation of extremities is necessary to minimize edema. Continuous assessment of sensation and capillary circulation should be made.

I. Narcotics or pain medications should be given intravenously only. Do not give oral or IM medication. Frequent small intravenous doses of short acting narcotics should be given. Drug of choice is Morphine Sulfate, to be given in doses of 5-15 mg as necessary or in the case of children, 1 mg/kg every 2 hours prn, not to exceed adult dosing.

J. Assess patient's physical condition. Assessment should include:

1. Check for injuries other than burns, treat life threatening injuries.
2. Take brief physical history including information with regard to allergies, any changes in sensorium from time of injury, tetanus, and other medications. In the immediate post-burn, the only medications that are essential are the continuation of such medications as digitalis, anti-epileptics, and corticosteroids, etc.
3. Obtain information on how, when and where the injury occurred.
4. Estimate the percentage of the burned surface area by using the rule of nine (see chart on next page).
5. Baseline CBC, urinalysis, serum electrolytes, serum and urine osmolarity should be drawn. Chest xrays should be obtained when possible. Other xrays of long bones, abdomen, back, skull, etc. are obtained when specifically indicated.

K. Wipe off loose material from burn, and gently wash with saline (if indicated) and cover with a dry, sterile dressing. The use of topical agents should be restricted to such agents as silver sulfadiazine and should never delay transfer. After consulting with the receiving facility for guidance, if no sulfa allergy, apply silver sulfadiazine with gloved hand 1/4 of an inch thick. In no instance should a petrolatum dressing be applied to a burn. For transfer, cover wounds with a dry, sterile dressing, or as instructed by the receiving facility. For chemical burns, irrigate burn with copious amounts of water, paying attention to irrigating eyes, mouth, ears, etc.

L. Tetanus prophylaxis should be administered if the patient has not had a tetanus immunization within the last five years.

M. The use of prophylactic antibiotics in burns is not recommended and should only be used when an infection has been identified.

N. Escharotomy may be indicated to decompress extremities which have suffered circumferential burns. Disappearance of pulse, poor capillary filling, loss of position sense, altered sensation, etc., are all signs that escharotomy should be considered. This should only be done after consultation with a burn center.

O. Candidates for referral consideration to a Burn Unit include:

1. Partial thickness burn greater than 10% total body surface area (TBSA)
2. Burns that involve face, hands, feet, genitalia, perineum, or major joints

3. Third-degree burns in any age group
4. Electrical burns, including lightning injury
5. Chemical burns
6. Inhalation injury
7. Burn injury in patients with preexisting medical disorders that could complicate management, prolong recovery, or affect mortality.
8. Any patients with burns and concomitant trauma (such as fractures) in which the burn injury poses the greatest risk of morbidity or mortality. In such cases, if the trauma poses the greater immediate risk, the patient must be initially stabilized in a trauma center before being transferred to a burn unit. Physician judgment will be necessary in such situations and should be in concert with the regional medical control plan and triage protocols.
9. Burned children in hospitals without qualified personnel or equipment for the care of children.
10. Burn injury in patients who will require special social, emotional, or long-term rehabilitative interventions.

P. When transferring a patient, adequate records should be initiated, including EMTALA and sent with the patient.

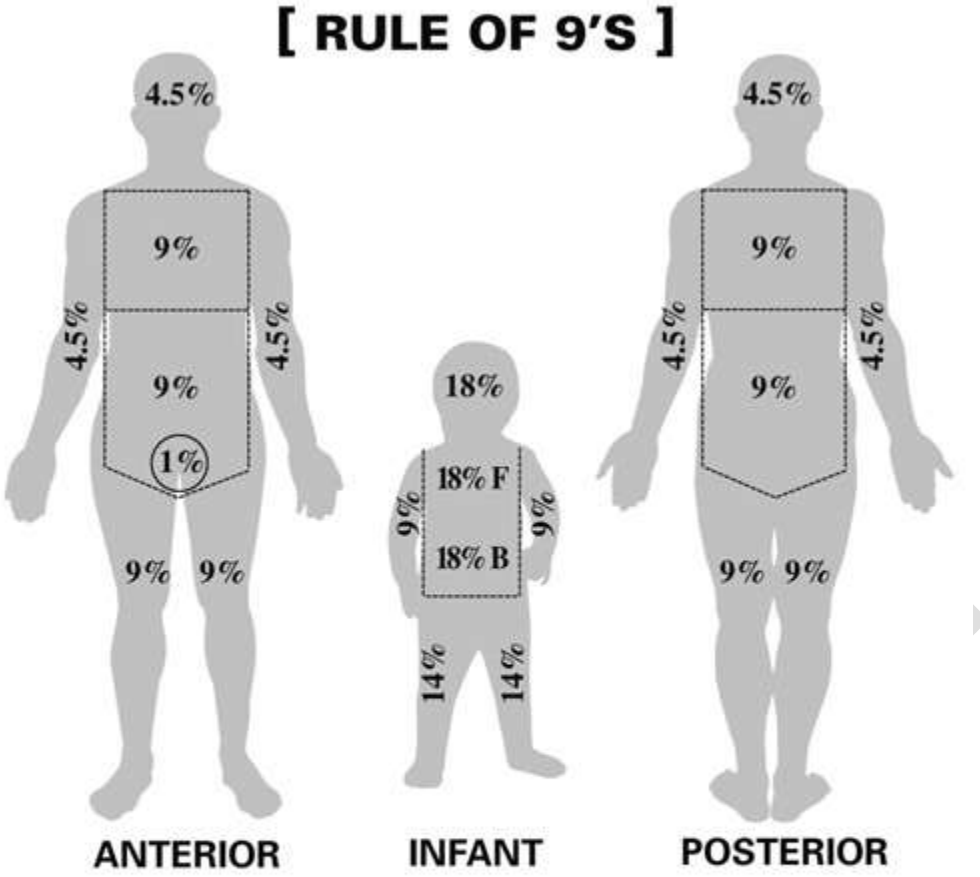
Q. Transfer to another facility should be accomplished within as short a period of time as possible after initial injury.

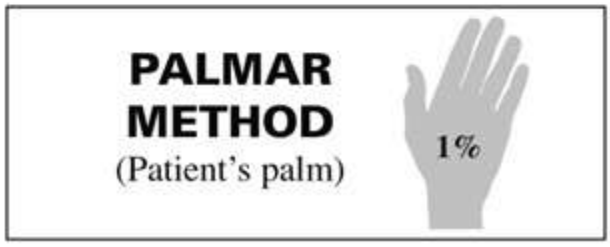
R. Adequate trained personnel should be used to transfer patients to manage intravenous routes, airways, respiratory devices, etc. Suction should be available en-route.

Revised 12/04, 7/10, 3/15
Reviewed: 3/05, 9/07, 3/10

Region 2 Trauma Plan

RULE OF NINES





Reviewed: 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

LUND AND BROWDER CHART

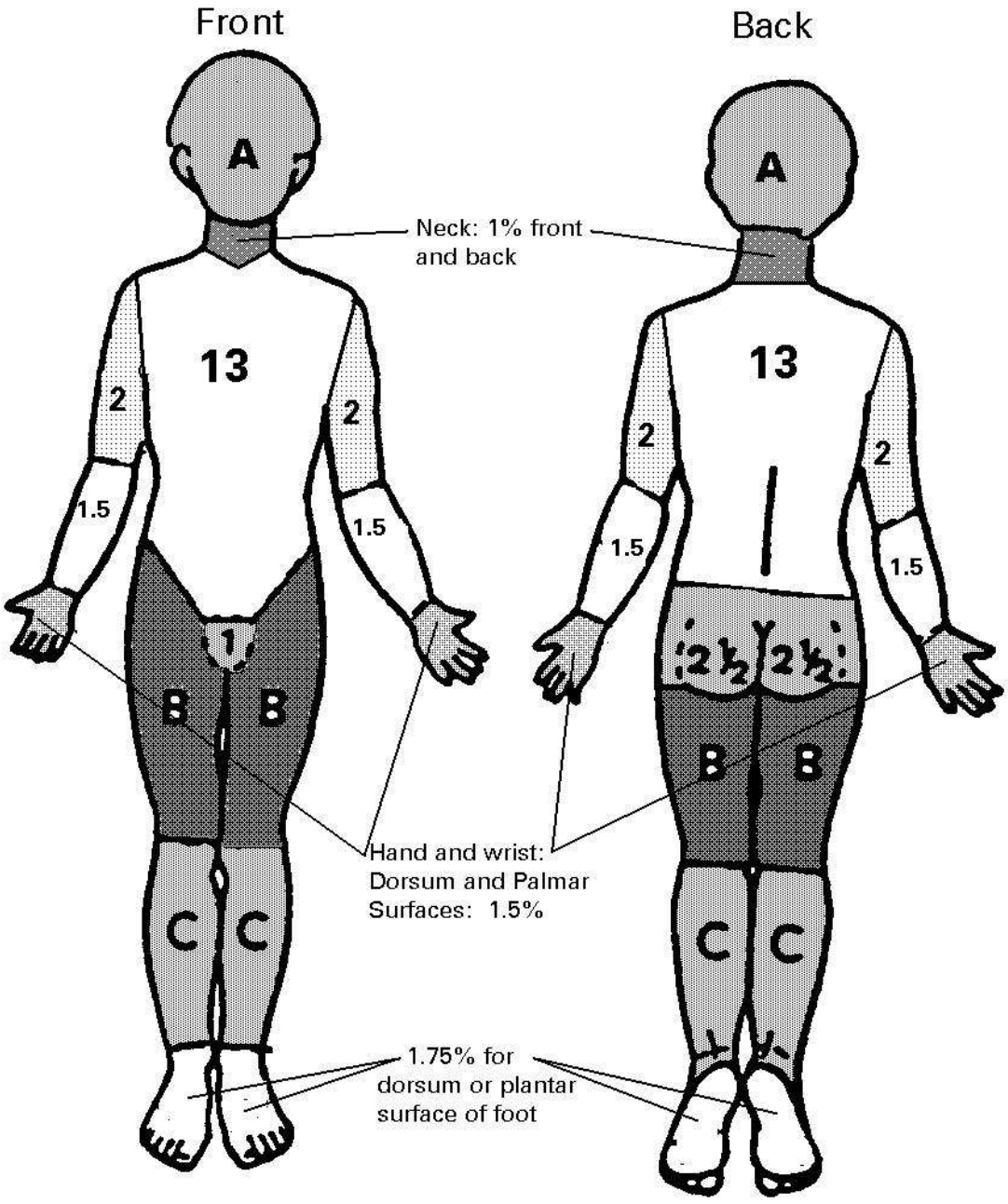


DIAGRAM AREA	AGE IN YEARS			
	0	*1*	*5*	*10*
A = ½ of Head	9.5	8.5	6.5	5.5
B= ½ of Thigh	2.75	3.25	4	4.25
C= ½ of Leg	2.5	2.5	2.75	3

Reviewed: 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Load and Go Situations

There are certain situations that require hospital treatment within minutes if the victim is to have any chance for survival. The primary survey is designed to identify these situations. When these situations are recognized, the victim should be loaded immediately onto a backboard, transferred to the ambulance and transported rapidly. Lifesaving procedures may be needed, but should be done during transport. Non-lifesaving procedures (such as splinting and bandaging) must not hold up transport. The following are critical situations that require "load and go".

1. Head injury with unconsciousness, unequal pupils or decreasing level of consciousness.
2. Airway obstruction that cannot be quickly relieved by mechanical methods such as suction, forceps or intubation.
3. Conditions resulting in possible inadequate breathing:
    a. Large open chest wound (sucking chest wound).
    b. Large flail chest.
    c. Tension pneumothorax.
    d. Major blunt chest injury.
4. Traumatic cardiopulmonary arrest.
5. Shock.
6. Signs of conditions that may rapidly lead to shock:
    a. Tender, distended abdomen.
    b. Pelvic instability.
    c. Bilateral femur fractures.
    d. Significant mechanism of injury or poor general impression.
7. Scenes that are potentially unsafe to EMS personnel (ie: family/social issues, emotionally charged situations) should be considered for emergent patient transport.

Revised: 9/04, 3/15
Reviewed: 3/05, 9/07, 3/10

Region 2 Trauma Plan

Microsurgery / Reimplantations

The following are guidelines for care of microsurgery candidates:

I. General Care
- a. Ensure patient is adequately resuscitated. (See Routine Trauma Care)
- b. Keep patient N.P.O.
- c. Ensure Tetanus prophylaxis is current.
- d. Initiate IV antibiotic therapy if requested by transferring physician.
- e. CBC – send results. (Do not hold patient just to get results – send patient and call results.)
- f. Document exact time accident occurred and exact time body part placed on ice.

II. Care of Amputated Part
- a. Pour sterile normal saline over part to wash off gross contaminates. Do **not** scrub or use detergents.
- b. Wrap part in sterile gauze lightly moistened with sterile saline – (gauze should **not** be dripping wet.)
- c. Place wrapped part in impermeable plastic bag and seal.
- d. Place plastic bag in thermal, ice-filled container and secure lid.
- e. Label container with patient's name, contents of container, and time part placed on ice. (Put information on lid and on side of container.)

III. Care of Stump
- a. Ensure hemostasis by direct pressure. (Do not use Gelfoam, cautery, or chemical coagulation.) If a large artery **must** be clamped, clamp as close to the cut end of the artery as possible.
- b. Rinse stump with sterile saline to remove gross contaminates.
- c. Wrap stump with sterile saline-soaked dressings and then with non-absorbent toweling.
- d. Elevate stump.

Insure that package containing body part is properly labeled, secured, and sent with the patient on transfer.

Reviewed: 9/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Neurology / Neurosurgery

The following are guidelines for pre-transfer care of the neurologic or neurosurgical patient.

I. General Guidelines

A. All patients with head or brain injuries have suspected spinal injuries until proven otherwise. Therefore, stabilization of the spine should be accomplished using a long spine board, rigid cervical collar, head block or rolled towel/blanket, and tape prior to transport.

B. The respiratory status of the patient should be carefully evaluated prior to transport. A patent airway must be established. Those patients with a decreasing level of consciousness or comatose patients should be intubated, with care taken to avoid hyperextension of the neck, and then ventilated.

C. An intravenous infusion of 0.09% Normal Saline should be initiated with a large bore needle and regulated to maintain a mean blood pressure of 90 mm Hg or greater.

D. Baseline documentation of the Glasgow Coma Scale is necessary to determine any changes in the patient's status.

E. Insertion of a nasogastric tube should be considered to empty stomach contents and help prevent development of an ileus. Do not insert if patient has facial injuries. Use the orogastric route instead.

F. A Foley catheter should be inserted to monitor perfusion and renal function. Do not insert if there is blood at the meatus.

G. Specific Recommendations

II. Specific Recommendations

A. Traumatic Brain Injury

a. Brain injured patients with decreasing levels of consciousness, comatose and or with a Glascow Coma Scale of less than 8 should be intubated and then ventilated to help reduce intracranial pressure.

b. Hyperventilation is no longer recommended.

c. Consult the neurosurgeon regarding the use of Mannitol and/or Decadron, but these are rarely required initially.

B. Spinal Cord Injury

a. Patients with injury to the Spinal Cord should be immobilized with a rigid cervical collar, head block or rolled towel/blanket, tape or straps and a long spine board to insure stabilization of the spinal column.

b. Careful attention is focused on the patient's level of consciousness and airway status. Deterioration of either necessitates intubation, preferably fiberoptic intubation, while maintaining cervical immobilization.

c. A nasogastric tube and foley should be inserted unless contraindicated.

d. IV fluids should be started and regulated to maintain a systolic blood pressure of 90 mm HG or greater. Hypotension in the spinal cord injured patient is usually due to neurogenic shock (bradycardia, hypotension and hypothermia) rather than hypovolemic shock. Neurogenic shock usually responds better to the administration of vasopressors than to the administration of large amounts of intravenous fluids. It is recommended to give 1-2 liters of crystalloid solution, if the patient has no obvious source of bleeding and has a suspected spinal cord injury; vasopressors should be instituted after the initial 1-2 liter bolus to maintain a systolic pressure greater than 90.
e. Methylprednisolone should be started only after consultation with a neurosurgeon (30 mg/kg initial IV bolus, followed by an intravenous infusion of 5.4 mg/kg per hour for 24 to 48 hours). If indicated, Methylprednisolone should be given within 8 hours of initial injury.

Reviewed: 09/04, 3/05, 9/07, 3/10
Revised: 7/10, 3/15

Region 2 Trauma Plan

Glasgow Coma Scale

Child / Adult		Infant / Toddler	
1. Eye Opening			
Spontaneous	_____4	Spontaneous	_____4
To Voice	_____3	To Speech	_____3
To pain	_____2	To Pain	_____2
None	_____1	None	_____1
2. Verbal Response			
Oriented	_____5	Smiles / Interacts	_____5
Confused	_____4	Consolable	_____4
Inappropriate words	_____3	Cries to Pain	_____3
Incomprehensible words	_____2	Moans to Pain	_____2
None	_____1	None	_____1
3. Motor Responses			
Obeys commands	_____6	Normal Spont Movement	_____6
Purposeful movement (pain)	_____5	Localizes	_____5
Withdraw (pain)	_____4	Withdraws	_____4
Flexion (pain)	_____3	Abd Flexion	_____3
Extension (pain)	_____2	Abn Extension	_____2
None	_____1	None	_____1
Total	_____	Total	_____

10/97
Reviewed: 12/02, 5/03, 8/03, 9/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Shock (Hypovolemia)

The following guidelines are for the initial management of the patient with hemorrhagic shock.

I. General Guidelines
- a. Establish a patent airway. Supplementary oxygen is supplied to maintain oxygen saturation >95%
- b. Control obvious hemorrhage.
  - i. Obtain adequate IV access
  - ii. Assess tissue perfusion
  - iii. Direct pressure to bleeding site of external wounds
  - iv. Pelvic stabilizers should be used for open book pelvic fractures.
  - v. Operative control of internal hemorrhage may be required
- c. Exposure with complete secondary examination, head to toe for associated injuries.
- d. Gastric decompression with Nasal Gastric tube. Gastric distention makes shock difficult to treat.
- e. Urinary catheter insertion to assess urine for hematuria and renal perfusion.

II. Vascular Access
- a. Obtain promptly
- b. Insert 2 short large-bore peripheral intravenous catheters
  - i. Forearm and antecubital veins most desirable sites in adults
  - ii. Draw blood samples from site
- c. IO access should be quickly obtained if venipuncture is unsuccessful.
- d. Central venous (femoral, jugular, or subclavian vein) access obtained if peripheral sites or IO are unsuccessful.

III. Initial Fluid Therapy
- a. Isotonic crystalloid solutions used for initial resuscitation
- b. An initial fluid bolus is given as rapidly as possible. The usual dose is 1-2 liters for an adult and 20 ml/kg for a pediatric patient.
- c. Patient's response is observed during initial fluid administration, and further therapeutic and diagnostic decisions are based on this response
- d. Amount of fluid required for resuscitation is difficult to predict on initial evaluation of the patient. Refer to the provided ATLS Estimated Fluid and Blood Losses table provided for general guidelines.
  - i. Can use 3 for 1 rule: replace each milliliter of blood loss with 3 ml of crystalloid fluid to restore plasma volume lost in the interstitial intracellular spaces
- e. Packed red blood cells, fresh frozen plasma, and platelets can be used to resuscitate the trauma patient if they do not respond to fluid therapy. Blood products should be considered after 2 liter boluses of crystalloid solution.

f. If massive bleeding is suspected, the initiation of massive transfusion is indicated per individual hospital protocols/policies.
g. Failure to respond to adequate crystalloid and blood administration dictates the need for immediate surgical intervention to control exsanguinating hemorrhage
h. Tranexamic Acid (TXA) Indications
    i. Evidence of or at risk for significant non-compressible hemorrhage
    ii. Penetrating Injury to:
        1. Head
        2. Neck
        3. Trunk
    iii. Blunt Mechanism of injury with injury patterns associated with hemorrhage.
    iv. Shock Index (heart rate/systolic blood pressure) greater than 0.7 administration of TXA should be considered and greater than 1.0 TXA is recommended.

IV. Evaluate Fluid Resuscitation

a. Observe vital signs for return to normal
b. Urinary output
    i. 0.5 ml/kg/hour in the adult patient
    ii. 1 ml/kg/hour in the pediatric patient
    iii. 2 ml/kg/hour in children under 1 year of age
c. Acid base balance
    i. Early hypovolemic shock presents with respiratory alkalosis, then mild metabolic acidosis
    ii. Severe metabolic acidosis develops with long-standing shock
    iii. Persistent acidosis usually due to inadequate resuscitation or ongoing blood loss. Treat with fluids, blood, and consideration of operative intervention for control of hemorrhage.

V. Special Considerations in the Treatment of Shock

a. Increasing blood pressure does not mean an increase in cardiac output
b. Age
    i. Hypotension secondary to blood loss is poorly tolerated by the elderly trauma patient, prompt, aggressive resuscitation and careful monitoring is required.
c. Athletes can compensate for blood loss, even significant blood loss
d. Pregnancy
    i. Physiologic maternal hypervolemia requires a greater blood loss to manifest perfusion abnormalities in the mother, which also may be reflected in decreased fetal perfusion.
e. Medications
    i. Beta-adrenergic receptor blockers and calcium channel blockers can significantly alter the patient's hemodynamic response to hemorrhage.
f. Hypothermia

i. Patients suffering from hypothermia and hemorrhagic shock do not respond normally to the administration of blood and fluid resuscitation and often develop a coagulopathy

g. Pacemaker
    i. Patients with pacemakers are unable to respond to blood loss in the expected fashion since cardiac output is directly related to heart rate
h. Anti-coagulated patients
    i. Utilize reversal agents per your hospitals policies or protocols (ie. Fresh frozen plasma, vitamin K, Kcentra, etc)

Revised: 09/04, 3/15
Reviewed: 3/05, 9/07, 3/10

4) Transfers

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SECTION 515.2060 TRAUMA PATIENT EVALUATION AND TRANSFER

Section 515.2060 Trauma Patient Evaluation and Transfer

a) Patients who are determined in the pre-hospital setting to have sustained hypotension or are victims of cavity penetration of the neck or torso or any other trauma patient as deemed by medical control shall be classified as trauma patients in the field. The trauma surgeon response time begins at the time of field classification. The patient shall be immediately evaluated upon arrival at the ED.

b) Patients who are not classified in the field must be evaluated within 10 minutes after arrival at the trauma center. This evaluation shall be conducted by the attending ED physician or designee. "Designee", for the purposes of this Section, may refer to ED staff including, but not limited to, a surgeon acting as the ED attending, resident physician, Physician Assistant, or Registered Nurse. By the time the 10 minute evaluation period has elapsed, the patient must be determined to be a Category I trauma patient (Section 515.Appendices C and F of this Part) or Category II (Section 515.Appendix C) or not to have met either Category I or II criteria. A patient cannot be downgraded once a category has been assigned. Upgrade to a Category I or II may occur at any time the patient's condition warrants. The trauma or specialty surgical response time begins at the time of upgrade.

c) EMS Regions or trauma centers may develop triage criteria that expand Category I and II criteria but may not delete any of the minimal criteria in Section 515.Appendix C of this Part.

d) The response period for trauma or specialty surgery for Category I or II patients is as specified in Section 515.2030(c), Section 515.2040(c) and Section 515.Appendix F of this Part.

e) Trauma patients being transferred to a Level I or Level II facility or to more specialized care should be enroute within two hours after arrival when stabilized within the capabilities of the referring institution.

f) The Revised Trauma Score, as specified by the American College of Surgeons, shall be used in all trauma centers. The Revised Trauma Score is determined by using the following criteria:

		Value	Points
1)	Respiratory Rate	10-29/Min	4
		>29/Min	3
		6-9/Min	2
		1-5/Min	1
		0	0
2)	Systolic Blood Pressure	greater than 89mmHg	4
		76-89mmHg	3
		50-75mmHg	2
		1-49mmHg	1
		no pulse	0

3) Glasgow Coma Scale

A) Eye Opening Response

	Points
Spontaneous	4
To Voice	3
To Pain	2
None	1

B) Best Verbal Response

Oriented	5
Confused	4
Inappropriate Words	3
Incomprehensible Sounds	2
None	1

C) Best Motor Response

Obeys Commands	6
Localizes (Pain)	5
Withdraw (Pain)	4
Flexion (Pain)	3
Extension (Pain)	1
None	1

Total GCS	Revised Trauma Points
13-15	= 4

9-12	=	3
6-8	=	2
4-5	=	1
<4	=	0

4) Revised Trauma Score = Total Points 1 + 2 + 3

g) Each EMS Region may include other criteria in addition to the Revised Trauma Score in defining a trauma patient and specifying where trauma patients should be transported according to the severity of the injury.

h) The components of Section 515.Appendix D of this Part shall be included in the trauma center policy.

(Source: Amended at 22 Ill. Reg. 11835, effective June 25, 1998)

Reviewed: 9/04, 3/05, 9/07, 3/10, 3/15

Joint Committee on Administrative Rules

ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY
PART 515 EMERGENCY MEDICAL SERVICES AND TRAUMA CENTER CODE
SECTION 515.APPENDIX M INTERFACILITY PEDIATRIC TRAUMA AND CRITICAL CARE CONSULTATION AND/OR TRANSFER GUIDELINE

Section 515.APPENDIX M Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline

Introduction
Most ill and injured children can be successfully managed by pediatricians, emergency physicians, and other community physicians in local hospitals. However, certain types of severely ill or injured children may require specialized pediatric critical care services or specialized trauma services that are not generally available in local hospitals.

Referral centers that provide specialized pediatric critical care services or specialized trauma services for pediatric patients should be identified by community hospitals and local EMS agencies and included as integral components of their pediatric emergency and critical care systems and trauma care systems. The specialized referral centers provide 24-hour telephone consultation to assist community physicians in the evaluation and management of critically ill and injured children. In addition, most of these referral centers provide pediatric inter-facility transport services to facilitate the transport of critically ill or injured children to specialized centers when indicated.

Decisions on when to seek consultation or to transfer pediatric patients need to be individualized, based on local needs and resources. However, children with certain categories of critical illness and injury are at high risk of death and disability. Early consultation with appropriate pediatric critical care or trauma specialists and rapid transport to specialized referral centers, when indicated, can improve the outcomes for these children. In particular, consultation shall be sought for pediatric medical, surgical, and trauma patients who require intensive care when it is not locally available.

The attached guidelines are intended for use in a number of ways:

- They can be used by physicians and hospitals to identify the types of critically ill or

injured children who might benefit from consultation with critical care or trauma specialists or transfer to specialized referral centers. It is recommended that hospitals and their medical staffs develop appropriate policies, procedures and staff education programs based on these guidelines. This will help to promote consultation, minimize delays, and facilitate appropriate, rapid and efficient transport of critically ill and injured children to specialty centers, when indicated.

- It is recommended that these guidelines also be used by local EMS agencies as a basis for the development of pediatric consultation and transfer guidelines based on the local needs and resources. Consultation and transfer guidelines should be integrated into local EMS agency plans for pediatric emergency, critical care, and trauma care in each region. These guidelines should become specific EMS policies and procedures in order to promote appropriate consultation and transfer of children who require specialized pediatric critical care and/or trauma services.

The following guidelines are intended to assist physicians and hospitals to identify the types of critically ill and injured children who might benefit from consultation with pediatric critical care specialists or trauma specialists and transfer to specialized pediatric critical care or trauma centers, when indicated. If an inter-facility transport is required, the referring physician, in consultation with the receiving physician, should determine the method of transport and appropriate personnel to accompany the child. The hospital shall have written pediatric inter-facility transfer guidelines/policies/procedures concerning transfer of critically ill and injured patients that include a defined process for initiation of transfer, including the roles and responsibilities of the referring facility and referral center; process for selecting the appropriate care facility; process for selecting the appropriately staffed transport service to match the patient's acuity level; process for patient transfer (including obtaining informed consent); a plan for transfer of patient medical record information, signed transport consent, and belongings; and a plan for provision of referral institution information to family.

Consultation with pediatric medical and surgical specialists at a pediatric tertiary care center or trauma specialists at a trauma center should occur as soon as possible after evaluation of the patient. It is recommended that each hospital and its medical staff develop appropriate emergency department and inpatient guidelines, policies and procedures for obtaining consultation and arranging transport, when indicated, for the following types of pediatric medical and trauma patients.

I. Guidelines for Inter-facility Consultation and/or Transfer for Evaluation of Pediatric Medical Patients (Non-trauma)

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status

2. Severe respiratory distress responding inadequately to treatment and accompanied by any one of the following:

a. Cyanosis

b. Retractions (moderate to severe)

c. Apnea

d. Stridor (moderate to severe)

e. Grunting or gasping respirations

f. Status asthmaticus

g. Respiratory failure

3. Children requiring endotrachael intubation and/or ventilatory support

4. Serious cardiac rhythm disturbances

5. Status post cardiopulmonary arrest

6. Heart failure

7. Shock responding inadequately to treatment

8. Children requiring any one of the following:

a. Arterial pressure monitoring

b. Central venous pressure or pulmonary artery monitoring

c. Intracranial pressure monitoring

d. Vasoactive medications

9. Severe hypothermia or hyperthermia

10. Hepatic failure

11. Renal failure, acute or chronic requiring immediate dialysis

B. Other Criteria

1. Near drowning with any history of loss of consciousness, unstable vital signs or respiratory problems

2. Status epilepticus

3. Potentially dangerous envenomation

4. Potentially life-threatening ingestion of, or exposure to, a toxic substance

5. Severe electrolyte imbalances

6. Severe metabolic disturbances

7. Severe dehydration

8. Potentially life-threatening infections, including sepsis

9. Children requiring intensive care

10. Any child who may benefit from consultation with, or transfer to, a pediatric critical care center

II. Guidelines for Interfacility Consultation and/or Transfer for Evaluations of Pediatric Trauma Patients

A. Physiologic Criteria

1. Depressed or deteriorating neurologic status

2. Respiratory distress or failure

3. Children requiring endotracheal intubation and/or ventilatory support

4. Shock, compensated or uncompensated

5. Injuries requiring any blood transfusion

6. Children requiring any one of the following:

a. Arterial pressure monitoring

b. Central venous pressure or pulmonary artery monitoring

c. Intracranial pressure monitoring

d. Vasoactive medications

B. Anatomic Criteria

1. Fractures and deep penetrating wounds to an extremity complicated by neurovascular or compartment injury

2. Fracture of two or more major long bones (i.e., femur, humerus)

3. Fracture of the axial skeleton

4. Spinal cord or column injuries

5. Traumatic amputation of an extremity with potential for replantation

6. Head injury when accompanied by any of the following:

   a. Cerebrospinal fluid leaks

   b. Open head injuries (excluding simple scalp injuries)

   c. Depressed skull fractures

   d. Decreased level of consciousness

7. Significant penetrating wounds to the head, neck, thorax, abdomen or pelvis

8. Major pelvic fractures

9. Significant blunt injury to the chest or abdomen

C. Other Criteria

1. Children requiring intensive care

2. Any child who may benefit from consultation with, or transfer to, a trauma center or a pediatric critical care center

D. Burn Criteria – Contact should be made with a burn center for children who meet any one of the following criteria:

1. Partial thickness burns of greater than 10% total body surface area (TBSA)

2. Third degree burns in any age group

3. Burns involving:

a. Signs or symptoms of inhalation injury

b. Respiratory distress

c. The face

d. The ears (serious full-thickness burns or burns involving the ear canal or drums)

e. The mouth and throat

f. The hands, feet, genitalia, major joints or perineum

4. Electrical burns (including lightning injury)

5. Chemical burns

6. Burns associated with trauma or complicating medical conditions

7. Burned children in hospitals without qualified personnel or equipment for the care of children

8. Burn injury in patients who will require special social, emotional, or long-term rehabilitative intervention.

(Source: Amended at 35 Ill. Reg. 20609, effective December 6, 2011)

Reviewed: 9/04, 3/05, 9/07, 3/10
Revised: 3/15

Region 2 Trauma Plan

Interfacility Transfer of Patients

Patients, pediatric or adult, with serious injury or illness may require transfer to a higher level of care beyond what is available locally.

To provide optimum patient care the following guidelines for the process of interfacility transfer of patients are stated below:

1. Patients will be transferred to another facility in accordance with EMTALA guidelines.
2. Patients will be stabilized for transfer in accordance with the Region 2 Patient Stabilization and Transfer guidelines.
3. When the decision to transfer has been made, the referring physician will confer with the receiving physician and report the patient's condition and treatment provided.
4. A trauma center will accept all trauma patient transfers meeting the field triage guidelines, subject to space and facility availability.
5. No patient will be transferred without positive acceptance by both the receiving physician and receiving institution.
6. Patient stabilization and transfer guidelines may be augmented by orders obtained from the receiving physician/s.
7. Requests of physicians and/or patients for specific receiving physicians and/or hospitals will be honored if possible.
8. Patients shall be transferred by appropriately trained personnel and vehicles properly equipped to manage problems specific to the patient's condition, whether transportation is by ground or air. Necessary provision must be made for the patient's well-being en route.
9. **Patients should be transferred to a higher level of care within two hours of arrival to referring facility** ~~decision to transfer.~~

    A. The receiving physician shall provide advice regarding options for transportation, timing of transfer, pre-transfer stabilization and additional diagnostic procedures, if necessary.

    B. Ambulances must be properly equipped with all required equipment and supplies for that ambulances' level of licensure. BLS ambulances transferring patients may require an upgrade of personnel and equipment to meet the needs of the patient.

    C. Staffing for interfacility transfers is to be determined by both the transferring and receiving hospitals, with the understanding that the transferring hospital is responsible for the care of the patient until the care is assumed by the receiving hospital.

1) If additional personnel are required, they should be trained and experienced in advanced airway management and therapeutic modalities, particularly if they will be transferring with an ambulance provider agency unable to provide advanced airway management and therapeutic modalities.
2) Personnel must have training appropriate for the type of patient they are transferring

D. Management during transport may include, but not be limited to:

1) Management of the patient's known physiologic needs.
2) Continued support of cardiorespiratory system.
3) Continued blood volume replacement.
4) Monitoring vital signs.
5) Use of appropriate medications, as ordered by the physician or as provided by written protocol.
6) Maintaining communications with a physician or facility during the transfer.
7) Maintaining accurate records during the transfer.

E. The receiving hospital may send appropriate resources and personnel to transfer the patient.

10. Diagnostic studies that are indicated based on patient presentation prior to transfer are X-rays of the pelvis, chest and extremities. These X-rays are only to be performed if medically necessary and does not delay transfer to a higher level of care. Sophisticated diagnostic studies (CT, MRI, etc.) are usually not indicated prior to patient transfer.

9. The transferring hospital should send with the patient a record of the immediate medical problem and what treatment was provided for the patient at the transferring hospital. Including but not limited to: copies of the Emergency Department Report, any diagnostic reports (lab, x-ray, ECG, CT, etc.), pre-hospital care reports, initial and subsequent trauma scores. X-ray films shall be sent.

10. An ***EMTALA*** transfer consent/form will be obtained from the patient, parent, next of kin and/or Durable Power of Attorney for Healthcare as appropriate for all transfers.

11. There may be occasions when a patient may be transferred from a Level I Trauma Center to another Level I Trauma Center or a Level II Trauma Center or a Non-Trauma hospital. There may also be occasions when a patient may be transferred from a Level II Trauma Center to another Level II Trauma Center or Non-Trauma hospital. Transfers to an equal or lower level category of Trauma hospital will be conducted based on the following criteria:

A. The patient is deemed stable by the treating physician.
B. Availability of specialty services (i.e., burns, neurology, reimplantation).
C. Reasonable request by the patient/family.

Reviewed: 09/04, 3/05, 9/07, 3/10
Revised: 3/15

Region 2 Trauma Plan

EMTALA Authorization

	OSF Saint Francis Medical Center – Peoria **EMTALA Authorization** Form No. 678-7062 (REV. 7/00) **MS** Page 1 of 1

Transferring Facility:_____ Transferring Physician:_____
Receiving Facility:_____ Receiving Physician:_____

1. **Check Those That Apply:**

- ☐ The individual has an emergency medical condition which has been stabilized such that, within reasonable medical probability, no material deterioration of the individual's emergency medical condition is likely to result from or occur during transfer; or with respect to the pregnant woman having contractions, delivery is not imminent.
- ☐ The individual does not have an emergency medical condition.
- ☐ The individual has an emergency medical condition which has not been stabilized.

2. **The Individual May Not Be Transferred Unless Each of the Following Requirements Are Met:**

- ☐ The transferring hospital provides the medical treatment within its capacity which minimizes the risk to the individual's health, and, in the case of a woman in active labor, the health of the unborn child.
- ☐ The receiving facility states that it has available space and qualified personnel for appropriate treatment of the individual.
- ☐ The receiving facility has agreed to accept the individual and to provide appropriate medical treatment.
- ☐ The receiving facility will be provided with all the medical records related to the emergency medical condition which are available at the time of transfer, the informed patient consent or certification, and the name and address of any physician who has refused or failed to appear in a reasonable amount of time.
- ☐ The patient will be transferred by qualified personnel and transportation equipment, including the use of necessary and medically appropriate life support measures.

3. **Check the Following and Fill Out Risk and Benefits on all Individuals:**

- ☐ Based upon information at the time of transfer, the medical benefits reasonably expected from the provisions of appropriate medical treatment in another facility outweigh the increased risks to the individual and, in the case of a pregnant woman in active labor, to the unborn child, which may result from or occur during the transfer.

Risks:_____ Benefits:_____
_____ _____

4. **Check the Following, if Appropriate**:

- ☐ After being informed of the hospital's obligation under the law and the risks of transfer, the individual requests transfer.
- ☐ After being informed of the hospital's obligation under the law and the risks of transfer, a legally responsible person, acting on the individual's behalf, requests transfer.

Name of Person Requesting Transfer:_____ Relationship to Patient:_____

5. **Physician Refusal:**

- ☐ On-call physician refused or failed to appear in a reasonable amount of time.

Physician Name:_____

6. **Check one of the Following**:

- ☐ Individual was offered transfer, but refused after being informed of the risks and benefits to the individual of the transfer.
- ☐ Transfer was offered but refused by legally responsible person acting on behalf, after being informed of the risks and benefits to the individual.

_____ _____
Name of Physician Authorizing Transfer Signature of Patient/Responsible Person

_____ _____
Physician's Signature Relationship to Patient

_____ _____
Person Completing Form Witness

Region 2 Trauma Plan

Interfacility Transfer: Triage Criteria/Guidelines

The following list identifies patients at a particularly high risk of dying from multiple and severe injuries. Ideally, such patients should be treated in a Trauma Center where continued exposure to such problems by multi-disciplinary team systems may afford a patient an optimum outcome.

II. Initial Insult

A. Central Nervous System

1. Head Injury
   a. Penetrating injury
   b. Depressed skull fracture
   c. Open injury
   d. Cerebrospinal fluid leak
   e. GCS score less than 15 or neurologically abnormal
   f. Lateralizing signs
2. Spinal Cord Injury
3. Major vertebral injury

B. Chest

1. Wide superior mediastinum
2. Signs suggesting great vessel injury
3. Major chest wall injury
4. Cardiac injury
5. Patients who may require *prolonged* ventilation

C. Pelvis

1. Pelvic ring disruption with any of the following:
   a. Shock
   b. Evidence of continuing hemorrhage
2. Open pelvic fracture
3. Solid organ injury

D. Extremities

1. Severe open fractures
2. Traumatic amputation with potential for re-implantation
3. Complex articular fractures
4. Major crush injury
5. Ischemia
6. Two or more long bone fractures

F. Multiple System Injury

1. Head injury with any of the following:

Interfacility Transfer: Triage Criteria/Guidelines (cont'd)

a. Severe facial injury
b. Chest injury
c. Abdominal or pelvic injury
d. Burns

2. Injury to more than two body regions
3. Major burns or burns with associated injuries

G. Comorbid Factors
1. Age greater than 55
2. Children less than 5 years of age
3. Cardiac or respiratory disease
4. Diabetes
5. Morbid Obesity
6. Pregnancy
7. Immunosuppression
8. Anti-coagulated patients

H. Secondary Deterioration
1. Patients Requiring Mechanical Ventilation
2. Sepsis
3. Single or Multiple Organ System Failure (deterioration in central nervous system, cardiac, pulmonary, hepatic, renal or hematologic systems)
4. Major tissue necrosis

III. Guidelines for Interfacility Consultation and/or Transfer for Evaluation of Pediatric Trauma Patients (in accordance with EMSC guidelines)

A. Physiologic Criteria
1. Depressed or deteriorating neurologic status
2. Respiratory distress or failure
3. Children requiring endotracheal intubation and/or ventilatory support.
4. Shock, compensated or uncompensated
5. Injuries requiring any blood transfusion
6. Children requiring any one of the following:
a. Arterial pressure monitoring
b. Central venous pressure or pulmonary artery monitoring
c. Intracranial pressure monitoring
d. Vasoactive medications

Interfacility Transfer: Triage Criteria/Guidelines (cont'd)

B. Anatomic Criteria

1. Fractures and deep penetrating wounds to an extremity compromised by neurovascular or compartment injury
2. Fractures of two or more major long bones (i.e., femur, humerus)
3. Fracture of the axial skeleton
4. Spinal cord or column injuries
5. Traumatic amputation of an extremity with potential for reimplantation.
6. Head injury when accompanied by any of the following:
   a. Cerebrospinal fluid leaks
   b. Open head injuries (excluding simple scalp injuries)
   c. Depressed skull fractures
   d. Decreased level of consciousness
7. Significant penetrating wounds to the head, neck, thorax, abdomen or pelvis.
8. Major pelvic fractures
9. Significant blunt injury to the chest or abdomen.

C. Other Criteria

1. Children requiring intensive care
2. Any child who may benefit from consultation with, or transfer to, a Trauma Center or a Pediatric Critical Care Center.

D. Burn Criteria (Thermal or Chemical) – Contact should be made with a Burn Center for children who meet any one of the following criteria:

1. Partial thickness burns of greater than 10% of the body surface area.
2. Third degree burns in any age group.
3. Burns involving:
   a. Signs or symptoms of inhalation injury
   b. Respiratory distress
   c. The face
   d. The ears (serious full-thickness burns or burns involving the ear canal or drums)
   e. The mouth and throat
   f. Burns of the hands, feet, genitalia, major joints or perineum
4. Electrical burns (including lighting)
5. Burns associated with trauma or complicating medical conditions
6. Burned children in hospitals without qualified personnel or equipment for the care of children
7. Burn injury in children who will require special social, emotional, or long term rehabilitative intervention.

Interfacility Transfer: Triage Criteria/Guidelines (cont'd)

IV. Guidelines for Inter-Facility Consultation and/or Transfer for Evaluation of Pediatric Medical Patients / Non-Trauma (in accordance with EMSC guidelines)

A. Physiologic Criteria

1. Depressed or deteriorating neurological status
2. Severe respiratory distress responding inadequately to treatment and accompanied by any one of the following:
   a. Cyanosis
   b. Retractions (moderate to severe)
   c. Apnea
   d. Stridor (moderate to severe)
   e. Grunting or gasping respirations
   f. Status asthmaticus
   g. Respiratory failure
3. Children requiring endotracheal intubation and/or ventilatory support
4. Serious cardiac rhythm disturbances
5. Status post cardiopulmonary arrest
6. Heart failure
7. Shock responding inadequately to treatment
8. Children requiring any one of the following:
   a. Arterial pressure monitoring
   b. Central venous pressure or pulmonary artery monitoring
   c. Intracranial pressure monitoring
   d. Vasoactive medications
9. Severe hypothermia or hyperthermia
10. Hepatic failure
11. Renal failure, acute or chronic, requiring immediate dialysis

B. Other Criteria

1. Near drowning with any history of loss of consciousness, unstable vital signs or respiratory problems.
2. Status epilepticus
3. Potentially dangerous envenomation
4. Potentially life threatening ingestion of, or exposure to, a toxic substance
5. Severe electrolyte imbalances
6. Severe metabolic disturbances
7. Severe dehydration
8. Potentially life threatening infections, including sepsis
9. Children requiring intensive care
10. Any child who may benefit from consultation with, or transfer to, a Pediatric Critical Care Center

Reviewed: 12/02, 5/03, 8/03, 9/04, 3/05, 9/07, 3/10
Revised: 4/15

Region 2 Trauma Plan

Transfer Agreement
Between
OSF HEALTHCARE SYSTEM,
SAINT FRANCIS MEDICAL CENTER
and
<<FACILITY>>

THIS TRANSFER AGREEMENT ("Agreement") is made and executed on the last date written below, by and between OSF HEALTHCARE SYSTEM, an Illinois not-for-profit corporation, having its Corporate Office in Peoria, Illinois, owner and operator of SAINT FRANCIS MEDICAL CENTER, located and doing business in Peoria, Illinois, (such System and Hospital are collectively referred to as "Receiving Hospital") and <<FACILITY>>, located and doing business in <<City>>, Illinois (hereinafter referred to as "Transferring Facility").

R E C I T A L S:

The Transferring Facility and the Receiving Hospital desire, by means of this Agreement, to assist physicians in the treatment of patients.

The parties hereto specifically wish to facilitate: (a) the timely transfer of patients and the medical records and other information necessary or useful for the care and treatment of patients transferred; (b) the determination as to whether such patients can be adequately cared for other than by either of the parties hereto; (c) the continuity of care and treatment appropriate to the needs of the transferred patient; and (d) the utilization of knowledge and other resources of both healthcare entities in a coordinated and cooperative manner to improve the professional healthcare of patients.

NOW, THEREFORE, in consideration of the mutual covenants contained herein, and in reliance upon the recitals, set forth above and incorporated by reference herein, the parties hereto agree as follows:

DUTIES AND RESPONSIBILITIES.

Joint Responsibilities. In accordance with the policies and procedures of the Transferring Facility and upon the recommendation of the patient's attending physician that such a transfer is medically appropriate, such patient shall be transferred from the Transferring Facility to the Receiving Hospital as long as the Receiving Hospital has bed availability, staff availability, is able to provide the services requested by the Transferring Facility, including on-call specialty physician availability, and pursuant to any other necessary criteria established by the Receiving Hospital. In such cases, the Receiving Hospital and the Transferring Facility agree to exercise best efforts to provide for prompt admission of the patient. If applicable, the parties shall comply with all EMTALA requirements with respect to such transfers. Receiving Hospital and Transferring Facility shall meet periodically to review the transfer process, of policies and procedures in order to improve the process, including efficiency, clinical care and patient safety.

Receiving Hospital. The Receiving Hospital shall accept patients in need of transfer from the Transferring Facility pursuant to the criteria set forth in Section 1.1. Further, the Receiving Hospital shall designate a person to coordinate with the Transferring Facility in order to establish acceptable and efficient transfer guidelines.

Transferring Facility. Transferring Facility shall request transfers of patients to the Receiving Hospital pursuant to the criteria set forth in Section 1.1. Further, Transferring Facility shall:

Notify the receiving Hospital as far in advance as possible of the impending transfer.

Transfer to Receiving Hospital the personal effects, including money and valuables, and information related thereto. A standard form shall be adopted and used by both parties listing such personal effects and appropriate documentation and transfer procedure.

Affect the transfer to the Receiving Hospital through qualified personnel and appropriate transfer equipment and transportation, including the use of necessary and medically appropriate life support measures.

Transfer all necessary medical records, or in the case of an emergency, as promptly as possible, transfer an abstract of the pertinent medical and other records necessary in order to continue to the patient's treatment without interruption and to provide identifying and other information, including medical, social, nursing and other care plans. Such information shall also include, without limitation and if available, current medical findings, diagnoses, advanced medical directives, rehabilitation potential, brief summary of the course of treatment at the Transferring Facility, nursing, dietary information, ambulation status and pertinent administrative and social information.

Non Discrimination. The parties hereto acknowledge that nothing in this Agreement shall be construed to permit discrimination by either party in the transfer process set forth herein based on race, color, national origin, handicap, religion, age, sex or any other characteristic protected by Illinois state laws, Title VI of the Civil Rights Act of 1964, as amended or any other applicable state or federal laws. Further, Section 504 of the Rehabilitation Act of 1973 and the American Disabilities Act require that no otherwise qualified individual with an handicap shall, solely by reason of the handicap, be excluded from participation in, or denied the benefits of, or be subjected to discrimination in a facility certified under the Medicare or Medicaid programs.

Name Use. Neither party shall use the name of the other party in any promotional or advertising material unless the other party has reviewed and approved in writing in advance such promotional and advertising material.

Standards. Receiving Hospital shall ensure that its staff provide care to patients in a manner that will ensure that all duties are performed and services provided in accordance with any standard, ruling or regulation of the Joint Commission on Accreditation of Healthcare Organizations, the Department of Health and Human Services or any other federal, state or local government agency, corporate entity or individual exercising authority with respect to or affecting Receiving Hospital. Receiving Hospital shall ensure that its professionals shall perform their duties hereunder in conformance with all requirements of the federal and state constitutions and all applicable federal and state statutes and regulations.

FINANCIAL ARRANGEMENTS.

Billing and Collection. Each party shall bill and collect for services rendered by each party pursuant to all state and federal guidelines and those set by third party payors. Neither the Transferring Facility nor the Receiving Hospital shall have any liability to the other for billing, collection or other financial matters relating to the transfer or transferred patient. Since this Agreement is not intended to induce referrals, there should be no compensation or anything of value, directly or indirectly, paid between the parties.

Insurance. Each party shall, at its expense, maintain through insurance policies, self-insurance or any combination thereof, such policies of comprehensive general liability and professional liability insurance with coverage limits of at least One Million Dollars ($1,000,000.00) per occurrence and Three Million Dollars ($3,000,000.00) annual aggregate to insure such party and its Board, officers, employees and agents acting within the scope of their duties and employment against any claim for damages arising by reason of injuries to property or personal injuries or death occasioned directly or indirectly in connection with services provided by such party and activities performed by such party in connection with this Agreement. Either party shall notify the other party thirty (30) days prior to the termination or modification of such policies.

EFFECTIVE DATE, TERM AND TERMINATION.

Effective Date and Term.. The promises and obligations contained herein shall commence as of <<Effective Date>> and shall expire on <<Expiration Date>> Subject, however, to termination under Section 3.2 herein.

Termination. This Agreement may be sooner terminated on the first to occur of the following:

Written agreement by both parties to terminate this Agreement.

In the event of breach of any of the terms or conditions of this Agreement by either party and the failure of the breaching party to correct such breach within ten (10) business days after written notice of such breach by either party, such other party may terminate this Agreement immediately with written notice of such termination to the breaching party.

In the event either party to this Agreement shall, with or without cause, at any time give to the other at least thirty (30) days advanced written notice, this Agreement shall terminate on the future date specified in such notice.

Effects of Termination. Upon termination of this Agreement, as hereinabove provided, no party shall have any further obligations hereunder, except for obligations accruing prior to the date of termination.

MISCELLANEOUS.

This Agreement constitutes the entire agreement between the parties and contains all of the terms and conditions between the parties with respect to the subject matter hereunder. Receiving Hospital and Transferring Facility shall be entitled to no benefits or services other than those specified herein. This Agreement supersedes any and all other agreements, either written or oral, between the parties with respect to the subject matter hereof.

This Agreement shall be construed and interpreted in accordance with the laws of Illinois. It may only be amended, modified or terminated by an instrument signed by the parties. This Agreement shall inure to the benefit of and be binding upon the parties, their successors, legal representatives and assigns, and neither this Agreement nor any right or interest of Receiving Hospital or Transferring Facility arising herein shall be voluntarily or involuntarily sold, transferred or assigned without written consent of the other party, and any attempt at assignment is void.

The parties are independent contractors under this Agreement. Nothing in this Agreement is intended nor shall be construed to create an employer/employee relationship or a joint venture relationship between the parties, or to allow any party to exercise control or direction over the manner or method by which any of the parties perform services herein. The waiver by either party of a breach or violation of any

provision of this Agreement shall not operate as, or be construed to be, a waiver of any subsequent breach of the same or other provisions hereof. Notices required herein shall be considered effective when delivered in person, or when sent by United States certified mail, postage prepaid, return receipt requested and addressed to:

Receiving Hospital Transferring Facility:

Dr. Michael Cruz <<First_Name>> <<Last_Name>>
Administrator <<Title>>
Saint Francis Medical Center <<Facility>>
530 N.E. Glen Oak Avenue <<Address_1>> .
Peoria, Illinois 61637 <<City>>, <<State>> <<Zip_Code>>

or to other such address, and to the attention of such other person(s) or officer(s) as a party may designate by written notice.

It is understood and agreed that neither party to this Agreement shall be legally liable for any negligent nor wrongful act, either by commission or omission, chargeable to the other, unless such liability is imposed by law and that this Agreement shall not be construed as seeking to either enlarge or diminish any obligations or duty owed by one party against the other or against a third party. The invalidity or unenforceability of any particular provision of this Agreement shall not affect the other provisions hereof, and this Agreement shall be construed in all respects as if such invalid or unenforceable provision were omitted. The section titles and other headings contained in this Agreement are for reference only and shall not affect in any way the meaning or interpretation of this Agreement.

This Agreement is a result of negotiations between the parties, none of whom have acted under any duress or compulsion, whether legal, economic or otherwise. Accordingly, the parties hereby waive the application of any rule of law that otherwise would be applicable in connection with the construction of this Agreement that ambiguous or conflicting terms or provisions should be construed against the party who (or whose attorney) prepared the executed Agreement or any earlier draft of the same.

IN WITNESS WHEREOF, the parties have hereto executed this Agreement in multiple originals as of the last date written below.

RECEIVING HOSPITAL: TRANSFERRING FACILITY:

OSF HEALTHCARE SYSTEM, <<Facility>>
an Illinois not-for-profit
corporation, owner and operator of
Saint Francis Medical Center

By:___ By:___
<<Title>>

Title:_____

Dated:_ Dated:_

10/97
Revised: 9/04
Reviewed: 3/05, 9/07, 3/10. 4/15

Region 2 Trauma Plan

Hospital Bypass

Any patient who meets the Region 2 Triage Guidelines, as defined, will be considered to have entered the trauma system.

A trauma patient may benefit from transfer directly to a Trauma Center rather than the closest geographically located hospital, unless transport time is greater than 30 minutes to the Trauma Center.

Hospital bypass is felt to be a medical decision and should be made in coordination with Medical Control. Medical control may choose to divert pre-hospital care providers to a Level I or Level II Trauma Center. Each facility/system will be responsible for developing written protocols for hospital bypass, which must be submitted to the Region 2 EMS Medical Director's Committee for review and approval, in addition to submitting to the Department.

EMS personnel will contact Medical Control with Field Triage / patient information promptly. Information that should be transmitted at the time of original communication should include data related to:

A. Physiologic factors.
B. Anatomic factors.
C. Mechanism of injury.
D. Transport time / ETA.

Medical Control should always consider time as a priority and will take such factors into consideration in any decision.

Any such decision shall always strive for the delivery of optimum patient care.

10/97
Reviewed: 9/04, 3/05, 9/07, 3/10, 4/15
Revised: 2/05

5) Quality Assurance

Region 2 Trauma Plan

Trauma Quality Assurance and Improvement

As indicated in the Illinois Emergency Medical Systems and Trauma Center Code, a program for conducting a quarterly conference will be developed that includes at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients. Trauma quality assurance and improvement will be done at each Level I and Level II trauma centers. Trends for Region 2 will be decided at the Region 2 Trauma Advisory Board Committee and all participating hospitals will be involved in any medical audits as decided by this committee. Tabulated data from such medical audits will be presented at the Region 2 Trauma Advisory Committee meetings and will be available for review upon request by IDPH.

The quality indicators may consist of, but are not limited to the following:

1. Transfers > 2 hours
2. Scene times > 20 minutes
3. Documentation of GCS < 13, and no head CT scan
4. No documentation of GCS hourly on patients with head injuries
5. Uncontrolled airway in trauma patients with head injuries
6. Laparotomy's performed > 2 hours of ED arrival
7. Delayed treatment of open orthopedic injuries > 8 hours
8. Missed injuries
9. All trauma deaths
10. 12 hour response time for trauma surgeons to level 2 trauma's

This review should exclude trauma patients who were dead on arrival. In addition, the review must include all patients who were transferred more than two hours from time of arrival at the initial institution and who meet one or more of the following criteria at the receiving trauma center:

1. Admitted to an intensive care unit
2. Admitted to a bed with telemetry monitoring
3. Went directly to the operating room
4. Went to the operating room from the emergency department
5. Discharged to a rehabilitation or skilled care facility
6. Died following arrival

10/97
Revised 10/04, 2/05, 3/15
Reviewed: 3/05, 9/07, 3/10

Region 2 Trauma Plan

Resolution of Inter-System Conflict

1. Initial resolution of Inter-System conflict shall be conducted at the Local / System level.

2. Documentation of the review and resolution will be retained by the Local EMS Systems involved and made available to the Region or State EMS Advisory Board if necessary.

3. If the conflict is unresolved at the Local level, the following shall be sent to the Region 2 EMS Medical Director's and Trauma Center Medical Director's Committee:

    A. All relevant information surrounding the conflict.

    B. A statement from each Local EMS / Trauma Medical Director supporting their position; and the name/s, phone number/s and address/es of each person who should be contacted if further information is needed.

    C. The Region 2 EMS Medical Director's and Trauma Center Medical Director's Committee will make a determination within 10 working days after receipt of the above information. The determination may be one or the other position or may be another option developed by the Committee.

4. If the conflict is unresolved at the Regional level, it will be referred to the Department Director, in accordance with Section 515.230 (refer to Region 2 Policy – Resolution of Disputes Concerning the EMS Regional Plan).

10/97
Reviewed: 10/04, 3/05, 9/07, 3/10, 3/15
Revised: 7/10

Region 2 Trauma Plan

Resolution of Disputes Concerning the Regional 2 Trauma Plan

1. In accordance with Section 515.230, if the Region 2 EMS Medical Director's and Trauma Center Medical Director's Committee have an unresolved dispute over the content of the Region 2 Trauma Plan, the following shall be sent to the IDPH Director:

    A. All relevant information surrounding the issue being disputed.

    B. A statement from the EMS Medical Director's and Trauma Center Medical Director's Committee supporting their position; and the name, phone number and address of one person who should be contacted if further information is needed.

2. The IDPH Director will make a determination within 10 working days after receipt of the above information. The determination may be one or the other position or may be another option developed by the Director of IDPH.

10/97
Revised: 10/04
Reviewed: 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Medical / Legal Considerations

In consideration of the developmental and coordinating functions of the Region 2 Trauma Plan, the following resolutions are made:

1. Region 2 Trauma Centers will follow the rules and regulations of EMTALA for transfers.

2. That the participant hospital in the Region 2 Trauma Plan shall be held harmless if following policies and procedures as outlined in this plan.

3. That any pre-hospital care provider, properly licensed and operating within the scope of their respective training and affiliated with an appropriate and properly designated Resource Hospital System plan shall be held harmless while following the policies and procedures of the Region 2 Trauma Plan.

10/97
Reviewed: 10/04, 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Written Agreements

1. Each hospital wishing to participate in the Region 2 Trauma Plan will sign an agreement to abide by the guidelines set forth in the plan. These agreements will be signed by each institutions Trauma Director and kept on file with Trauma Services at OSF Saint Francis Medical Center.

2. Hospitals outside of Region 2 who transfer trauma patients into the Region will be expected to abide by the guidelines set forth in the Trauma Region Plan.

3. Region 2 hospitals that transfer trauma patients outside the region for specialty care will abide by the specialty care guidelines set forth by the receiving hospital.

10/97
Revised: 10/04
Reviewed: 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Region 2 Trauma Agreement

_____ agrees to participate in the Region 2
(Hospital)

Trauma Plan and abide by the guidelines set forth in the Region 2 Trauma Plan.

Trauma Director Name (printed) _____

Trauma Director Signature_____

Date _____

1/98
Revised: 10/04
Reviewed: 3/05, 9/07, 3/10, 3/15, 6/17

Region 2 Trauma Plan

Region 2 Trauma Advisory Board

Region 2 will conduct quarterly conferences to discuss care of the trauma patient as well as morbidity and mortality (Section 3.30 (b) (1-9) of the ACT). The conference will include, but not be limited to, cases that have been deemed potentially preventable or preventable using ACS guidelines from "Resources for Optimal Care of the Injured Patient, 2014." All professional staff involved in the care of the trauma patient at Region 2 Trauma Centers and Participating Hospitals shall be included in this conference including Trauma Medical Directors, 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 EMT representing the highest level of EMT practicing within the Region, one Emergency Physician, and one Trauma Nurse Specialist currently practicing in a Trauma Center. Selection of cases for quality medical review shall be at the discretion of the presenting hospital. However, requests for quality medical reviews may come from any health care professional involved in the care of a trauma patient in Region 2.

Minutes from the conference will document items discussed and will be retained by the Level I trauma center and be available for IDPH review.

10/97
Reviewed: 12/02, 5/03, 8/03, 9/04, 12/04, 3/05, 9/07, 3/10
Revised: 4/15

Region 2 Trauma Plan

Trauma Centers Medical Director's Committee

Region 2 Trauma Center Medical Directors Committee shall be compromised of the Region's Trauma Center Medical Directors.

The Trauma Center Medical Directors or Trauma Center Medical Directors Committee shall address at least the following:

1. The identification of Regional Trauma Centers
2. Protocols for inter-System and inter-Region trauma patient transports, including identifying the conditions of emergency patients which may not be transported to the different levels of emergency department, based on their Department classifications and relevant Regional considerations e.g. transport times and distances)
3. Regional trauma standing medical orders
4. Trauma Patient transfer patterns, including criteria for determining whether a patient needs the specialized services of a trauma center, along with protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center which are consistent with individual System bypass or diversion protocols and protocols for patient choice or refusal
5. The identification of which types of patients can be cared for by Level I and Level II Trauma Centers
6. Criteria for inter-hospital transfer of trauma patients
7. The treatment of trauma patients in each trauma center within the Region.
8. A program for conducting a quarterly conference which shall include at a minimum a discussion of morbidity and mortality between all professional staff involved in the care of trauma patients
9. The establishment of a Regional trauma quality assurance and improvement subcommittee, consisting of trauma surgeons, which shall perform periodic medical audits of each trauma center's trauma services, and forward tabulated data from such reviews to the Department, and
10. The establishment, within 90 days of the effective date of this amendatory Act of 1996, of an internal disaster plan, which shall include, at a minimum, contingency plans for the transfer of patients to other facilities if an evacuation of the hospital becomes necessary due to a catastrophe, including but not limited to, a power failure.
11. The Region's Trauma Center Medical Directors Committees shall appoint any subcommittees concerning Region activities.
12. A Region's Trauma Center Medical Directors may choose to participate in the development of the EMS Region Plan through membership on the Regional EMS Advisory Committee, rather than through a separate Trauma Center Medical Directors Committee. If that option is selected, the Region's Trauma Center Medical Director shall also determine whether a separate Regional Trauma Advisory Committee is necessary for the Region.

13. In the event of disputes over content of the Region 2 Trauma Plan between the Region's EMS Medical Directors Committee and the Region's Trauma Center Medical Directors or Trauma Center Medical Directors Committee, whichever is applicable, the Director of the Illinois Department of Public Health shall intervene through a mechanism established by the Department through rules adopted pursuant to this Act.

Revised: 11/04
Reviewed: 3/05, 9/07, 3/10, 3/15

Region 2 Trauma Plan

Physician Credentials

Physician credentialing for general/trauma surgeons and emergency department physicians of Level I and Level II trauma centers will follow the guidelines of Section 515.APPENDIX G and H in the IDPH rules and regulations for trauma center codes under the emergency services and highway safety.

Each facility will be responsible for recording and keeping record of physician credentials according to their institutional policy.

10/04
Reviewed: 10/04, 3/05, 9/07, 3/10,
Revised: 3/15