

ILLINOIS REGISTER

DEPARTMENT OF PUBLIC HEALTH

NOTICE OF EMERGENCY AMENDMENTS

TITLE 77: PUBLIC HEALTH
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SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY

PART 515
EMERGENCY MEDICAL SERVICES, TRAUMA CENTER,
COMPREHENSIVE STROKE CENTER, PRIMARY STROKE CENTER
AND ACUTE STROKE READY HOSPITAL CODE

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

SOURCE: Emergency Rule adopted at 19 Ill. Reg. 13084, effective September 1, 1995 for a maximum of 150 days; emergency expired January 28, 1996; adopted at 20 Ill. Reg. 3203, effective February 9, 1996; emergency amendment at 21 Ill. Reg. 2437, effective January 31, 1997, for a maximum of 150 days; amended at 21 Ill. Reg. 5170, effective April 15, 1997; amended at 22 Ill. Reg. 11835, effective June 25, 1998; amended at 22 Ill. Reg. 16543, effective September 8, 1998; amended at 24 Ill. Reg. 8585, effective June 10, 2000; amended at 24 Ill. Reg. 9006, effective June 15, 2000; amended at 24 Ill. Reg. 19218, effective December 15, 2000; amended at 25 Ill. Reg. 16386, effective December 20, 2001; amended at 26 Ill. Reg. 18367, effective December 20, 2002; amended at 27 Ill. Reg. 1277, effective January 10, 2003; amended at 27 Ill. Reg. 6352, effective April 15, 2003; amended at 27 Ill. Reg. 7302, effective April 25, 2003; amended at 27 Ill. Reg. 13507, effective July 25, 2003; emergency amendment at 29 Ill. Reg. 12640, effective July 29, 2005, for a maximum of 150 days; emergency expired December 25, 2005; amended at 30 Ill. Reg. 8658, effective April 21, 2006; amended at 32 Ill. Reg. 16255, effective September 18, 2008; amended at 35 Ill. Reg. 6195, effective March 22, 2011; amended at 35 Ill. Reg. 15278, effective August 30, 2011; amended at 35 Ill. Reg. 16697, effective September 29, 2011; amended at 35 Ill. Reg. 18331, effective October 21, 2011; amended at 35 Ill. Reg. 20609, effective December 9, 2011; amended at 36 Ill. Reg. 880, effective January 6, 2012; amended at 36 Ill. Reg. 2296, effective January 25, 2012; amended at 36 Ill. Reg. 3208, effective February 15, 2012; amended at 36 Ill. Reg. 11196, effective July 3, 2012; amended at 36 Ill. Reg. 17490, effective December 3, 2012; amended at 37 Ill. Reg. 5714, effective April 15, 2013; amended at 37 Ill. Reg. 7128, effective May 13, 2013; amended at 37 Ill. Reg. 10683, effective June 25, 2013; amended at 37 Ill. Reg. 18883, effective November 12, 2013; amended at 37 Ill. Reg. 19610, effective November 20, 2013; amended at 38 Ill. Reg. 9053, effective April 9, 2014; amended at 38 Ill. Reg. 16304, effective July 18, 2014; amended at 39 Ill. Reg. 13075, effective September 8, 2015; amended at 40 Ill. Reg. 8274, effective June 3, 2016; amended at 40 Ill. Reg. 10006, effective July 11, 2016; recodified at 42 Ill. Reg. 10700; amended at 42 Ill. Reg. 17632, effective September 20, 2018; amended at 43 Ill. Reg. 4145, effective March 19, 2019; emergency amendment at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days.

SUBPART A: GENERAL PROVISIONS

Section 515.100 Definitions

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

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Acute Stroke-Ready Hospital or ASRH – a hospital that has been designated by the Department as meeting the criteria for providing emergent stroke care. Designation may be provided after a hospital has been certified or through application and designation as an Acute Stroke-Ready Hospital. (Section 3.116 of the Act)

Advanced Emergency Medical Technician or A-EMT – a person who has successfully completed a course in basic and limited advanced emergency medical care as approved by the Department, is currently licensed by the Department in accordance with standards prescribed by the Act and this Part, and practices within an Intermediate or Advanced Life Support EMS System. (Section 3.50(b-5) of the Act)

Advanced Life Support Services or ALS Services – an advanced level of pre-hospital and inter-hospital emergency care and non-emergency medical services 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 National EMS Education Standards relating to Advanced Life Support and any modifications to that curriculum or those standards specified in this Part. (Section 3.10(a) of the Act)

Advanced Practice Registered Nurse or APRN – a person currently licensed as an advanced practice registered nurse under the Illinois Nurse Practice Act by the Illinois Department of Financial and Professional Regulation.

Aeromedical Crew Member or Watercraft Crew Member or Off-road Specialized Emergency Medical Services Vehicle (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 EMS MD – the physician who is designated by the Resource Hospital to direct the ALS/Advanced/ILS/BLS operations in the absence of the EMS Medical Director.

Alternate Response Vehicle – ambulance assist vehicles and non-transport vehicles as defined in Section 515.825 and Section 515.827.

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Ambulance – any publicly or privately owned on-road 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 individuals. (Section 3.85 of the Act)

Ambulance Assistance Vehicle Provider – a provider of ambulance assistance vehicles that is licensed under the Act and serves a population within the State. (Section 3.88(a) of the Act)

Ambulance Service Provider and Vehicle Service Provider Upgrades – Rural Population – a practice that allows an ambulance, alternate response vehicle, specialized emergency medical services vehicle or vehicle service provider that serves a population of 7,500 or fewer to upgrade the level of service of the provider vehicle using pre-approved System personnel and equipment.

Ambulance Service 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.

Applicant – an individual or entity applying for a Department-issued license or certification.

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 education 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 shall have a functioning Intensive Care Unit or a Cardiac Care Unit.

Associate Hospital EMS Coordinator – the paramedic or registered professional nurse at the Associate Hospital who shall be responsible for duties in relation to

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the EMS 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 EMS 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.

Basic Life Support or BLS Services – a basic level of pre-hospital and inter-hospital emergency care and non-emergency medical services that includes medical monitoring, clinical observation, airway management, cardiopulmonary resuscitation (CPR), control of shock and bleeding and splinting of fractures, as outlined in the National EMS Education Standards relating to Basic Life Support and any modifications to that curriculum or standards specified in this Part. (Section 3.10(c) 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).

Continuing Education or CE – ongoing emergency medical education after licensure that is designated to maintain, update or upgrade medical knowledge and skills.

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; who has 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.

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Child Abuse and Neglect – see the definitions of "abused child" and "neglected child" in Section 3 of the Abused and Neglected Child Reporting Act.

Child Life Specialist – a person whose primary role is to minimize the adverse effects of children's experiences by facilitating coping and the psychosocial adjustment of children and their families through the continuum of care.

Clinical Nurse Specialist – a person who is currently licensed as an APRN and who has met all qualifications for a clinical nurse specialist. For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the clinical nurse specialist shall have an unencumbered license in the state in which he or she practices.

Clinical Observation – ongoing observation of a patient's condition by a licensed health care professional utilizing a medical skill set while continuing assessment and care. (Section 3.5 of the Act)

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; ancillary services, including laboratory and x-ray, are staffed at all times; and the pharmacy is staffed or "on-call" at all times in accordance with Section 250.710 of the Hospital Licensing Requirements.

Comprehensive Stroke Center or CSC – a hospital that has been certified and has been designated as a Comprehensive Stroke Center under Subpart K. (Section 3.116 of the Act)

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

Critical Care Transport or CCT or Specialty Care Transport or SCT – *pre-hospital or inter-hospital transportation of a critically injured or ill patient by a vehicle service provider, including the provision of medically necessary supplies and services, at a level of service beyond the scope of the paramedic. When medically indicated for a patient, as determined by a physician licensed to practice medicine in all of its branches, an APRN, or a physician assistant, in compliance with Section 3.155(b) and (c) of the Act.*(Section 3.10(f-5).

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Department or IDPH – 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)

Door-to-_____ – the time from patient arrival at the health care facility until the specified result, procedure or intervention occurs.

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

Electrocardiogram or 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 layperson, 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 Nurse Practice Act 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) For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices.

Emergency Department Approved for Pediatrics or EDAP – a hospital participating in an approved EMS System and designated by the Department pursuant to Section 515.4000 of this Part as being capable of providing optimal emergency department care to pediatric patients 24 hours per day.

Emergency Medical Dispatch Priority Reference System or EMDPRS – an EMS

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System's organized approach to the receipt, management and disposition of a request for emergency medical services.

Emergency Medical Dispatcher or EMD – a person who has successfully completed a training course in emergency medical dispatching 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 Responder or EMR (AKA First Responder) – a person who has successfully completed a course of instruction for the Emergency Medical Responder as approved by the Department, who provides Emergency Medical Responder services prior to the arrival of an ambulance or specialized emergency medical services vehicle, in accordance with the level of care established in the National EMS Educational Standards for Emergency Medical Responders as modified by the Department.

Emergency Medical Responder 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 Emergency Medical Responder (EMR) curriculum of the National EMS Education standards and any modifications to that curriculum (standards) specified in this Part. (Section 3.10(d) of the Act)

Emergency Medical Services Personnel or EMS Personnel – persons licensed as an Emergency Medical Responder (EMR) (First Responder), Emergency Medical Dispatcher (EMD), Emergency Medical Technician (EMT), Emergency Medical Technician-Intermediate (EMT-I), Advanced Emergency Medical Technician (A-EMT), Paramedic, Emergency Communications Registered Nurse (ECRN), or Pre-Hospital Registered Nurse (PHRN). (Section 3.5 of the Act)

Emergency Medical Services System or 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 Region Plan adopted for the EMS Region in which the System is located. (Section 3.20(a) of the Act)

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

Emergency Medical Technician or EMT (AKA EMT-B) – a person who has successfully completed a course in basic life support as approved 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(a) of the Act)

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

Emergency Medical Technician-Intermediate or EMT-I – a person who has successfully completed a course in intermediate life support as approved by the Department, is currently licensed by the Department in accordance with the standards prescribed in this Part and practices within an Intermediate or Advanced Life Support EMS System. (Section 3.50(b) of the Act)

Emergent Stroke Care – emergency medical care that includes diagnosis and emergency medical treatment of suspected or known acute stroke patients. (Section 3.116 of the Act)

Emergent Stroke Ready Hospital – a hospital that has been designated by the Department as meeting the criteria for providing emergent stroke care as set forth in the Act and Section 515.5060. (Section 3.116 of the Act)

EMS – emergency medical services.

EMS Administrative Director – the administrator, appointed by the Resource Hospital in consultation with the EMS Medical Director, in accordance with this Part, responsible for the administration of the EMS System. (Section 3.35 of the Act)

EMSC – Emergency Medical Services for Children.

EMS Lead Instructor or LI – a person who has successfully completed a course of education as approved by the Department in this Part, and who is currently approved by the Department to coordinate or teach education, training and

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continuing education courses, in accordance with this Part. (Section 3.65(a) of the Act)

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

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 – an 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.

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 a week.

Half-Duplex Communications – a radio or device that transmits and receives signals in only one direction at a time.

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" that utilize EMS Personnel 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.

Helicopter Shopping – the practice of calling various operators until a helicopter emergency medical services (HEMS) operator agrees to take a flight assignment, without sharing with subsequent operators that the previously called operators declined the flight, or the reasons why the flight was declined.

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

Hospitalist – a physician who primarily provides unit-based/in-hospital services.

In-Field Service Level Upgrade – a practice that allows the delivery of advanced care from a lower level service provider by a licensed higher level of care ambulance, alternate response vehicle, or specialized emergency medical services vehicle according to a pre-approved written plan approved by the local EMS Medical Director.

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

Intermediate Life Support Services or ILS Services – an intermediate level of pre-hospital and inter-hospital emergency care and non-emergency medical services 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 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 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.

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Licensee – an individual or entity to which the Department has issued a license.

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 EMS Personnel or other providers who have been suspended or have received notification of suspension from the EMS Medical Director.

Medical Monitoring – the performance of medical tests and physical exams to evaluate an individual's on-going exposure to a factor that could negatively impact that person's health. This includes close surveillance or supervision of patient's liable to suffer deterioration in physical or mental health and checks of various parameters such as pulse rate, temperature, respiration rate, the condition of the pupils, the level of consciousness and awareness, the degree of appreciation of pain, and blood gas concentrations such as oxygen and carbon dioxide. (Section 3.5 of the Act)

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 medical or trauma condition 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 or mobile device to obtain emergency services, including police, fire, medical ambulance and rescue.

Non-emergency Medical Care – medical care, clinical observation, or medical monitoring rendered to patients whose conditions do not meet the Act's definition of emergency, before or during transportation of such patients to or from health care facilities visited for the purpose of obtaining medical or health care services that are not emergency in nature, using a vehicle regulated by the Act and this Part. (Section 3.10(g) of the Act)

Nurse Practitioner – a person who is currently licensed as an APRN and who has met all qualifications for a nurse practitioner. For out-of-state facilities that have

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Illinois recognition under the EMS, trauma, or pediatric program, the nurse practitioner shall have an unencumbered license in the state in which he or she practices.

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.

Paramedic or EMT-P – a person who has successfully completed a course in advanced life support care as approved by the Department, is currently 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)

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 Critical Care Center or PCCC – a hospital participating in an approved EMS System and designated by the Department as being capable of providing optimal critical and specialty care services to pediatric patients, and of providing all essential services either in-house or readily available 24 hours per day.

Pediatric Patient – patient from birth through 15 years of age.

Physician – any person licensed to practice medicine in all of its branches under the Illinois Medical Practice Act of 1987. For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the physician shall have an unencumbered license in the state in which he or she practices.

Physician Assistant or PA – a person who is licensed under the Physician Assistant Practice Act. For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the PA shall have an unencumbered license in the state in which he or she practices.

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.

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Police Dog – a specially trained dog owned or used by a law enforcement department or agency in the course of the department's or agency's official work, including a search and rescue dog, service dog, accelerant detection canine, or other dog that is in use by a county, municipal, or State law enforcement agency for official duties. (Section 3.55(e) of the Act)

Practitioner Order for Life-Sustaining Treatment on POLST or Do Not Resuscitate or DNR – an authorized practitioner order that reflects an individual's wishes about receiving cardiopulmonary resuscitation (CPR) and life-sustaining treatments, including medical interventions and artificially administered nutrition.

Pre-Hospital Advanced Practice Registered Nurse or PHAPRN – an APRN, with an unencumbered APRN license in Illinois, who has successfully completed supplemental education in accordance with this Part and who is approved by an Illinois EMS Medical Director to practice within an EMS System for pre-hospital and inter-hospital emergency care and non-emergency medical transports.

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

Pre-Hospital Care Participants – Any EMS Personnel, Ambulance Service Provider, EMS Vehicle, Associate Hospital, Participating Hospital, EMS Administrative Director, EMS System Coordinator, Associate Hospital EMS Coordinator, Associate Hospital EMS Medical Director, ECRN, Resource Hospital, Emergency Dispatch Center or physician serving on an ambulance or non-transport vehicle or giving voice orders for an EMS System and who are 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 Physician Assistant or PHPA – a graduate PA, with an unencumbered Illinois Physician Assistant License, who has successfully completed supplemental education in accordance with this Part and who is approved by an Illinois EMS Medical Director to practice within an EMS System for pre-hospital and inter-hospital emergency care and non-emergency medical transports.

Pre-Hospital Registered Nurse or PHRN – a registered professional nurse, with

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an unencumbered registered professional nurse license in the state in which he or she practices who has successfully completed supplemental education in accordance with this Part and who is approved by an Illinois EMS Medical Director to practice within an EMS System for pre-hospital and inter-hospital emergency care and non-emergency medical transports. (Section 3.80 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices.

Primary Stroke Center or PSC – a hospital that has been certified by a Department-approved, nationally recognized certifying body and designated as a Primary Stroke Center by the Department. (Section 3.116 of the Act)

Provisional EMR – a person who is at least 16 years of age, who has successfully completed a course of instruction for emergency medical responders as prescribed by the Department and passed the exam, and who functions within an approved EMS System pursuant to Section 515.715.

Regional EMS Advisory Committee – a committee formed within an Emergency Medical Services 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 individual from each level of license provided by the Act, one pre-hospital registered nurse 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)

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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 Stroke Advisory Subcommittee – a subcommittee formed within each Regional EMS Advisory Committee to advise the Director and the Region's EMS Medical Directors Committee on the triage, treatment, and transport of possible acute stroke patients and to select the Region's representative to the State Stroke Advisory Subcommittee. (Section 3.116 of the Act) The composition of the Subcommittee shall be as set forth in Section 3.116 of the Act.

Regional Trauma Advisory Committee – a committee formed within an Emergency Medical Services Region, to advise the Region's Trauma Center Medical Directors Committee, consisting of at least the Trauma Center Medical Directors and Trauma Coordinators from each trauma center within the Region, one EMS Medical Director from a Resource Hospital within the Region, one EMS System Coordinator from another Resource Hospital within the Region, one representative each from a public and private vehicle service provider which transports trauma patients within the Region, an administrative representative from each trauma center within the Region, one EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN, or PHRN representing the highest level of EMS Personnel practicing within the Region, one emergency physician and one trauma nurse specialist currently practicing in a trauma center. The Department's Regional EMS Coordinator for each Region shall serve as a non-voting member of that Region's Trauma Advisory Committee. (Section 3.25 of the Act)

Registered Nurse or Registered Professional Nurse or RN – a person who is licensed as an RN under the Illinois Nurse Practice Act. For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the registered professional nurse shall have an unencumbered license in the state in which he or she practices.

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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 education programs. This hospital agrees to replace medical supplies and provide for equipment exchange for participating EMS vehicles.

Rural Ambulance Service Provider – an ambulance service provider licensed under the Act that serves a rural population of 7,500 or fewer inhabitants. (Section 3.87(a) of the Act)

Rural In-Field Service Level Upgrade – a practice that allows the delivery of advanced care for a lower level service provider that serves a rural population of 7,500 or fewer inhabitants, through use of EMS System approved EMS personnel.

Rural Vehicle Service Provider – an entity that serves a rural population of 7,500 or fewer inhabitants and is licensed by the Department to provide emergency or non-emergency medical services in compliance with the Act, this Part and an operational plan approved by the entity's EMS System, utilizing at least an ambulance, alternate response vehicle as defined by the Department in this Part, or specialized emergency medical services vehicle. (Section 3.87(a) of the Act)

Screening – a preliminary procedure or assessment, such as a test or examination, to detect the most characteristic sign or signs of a disorder or condition that may require further investigation (for example, assessing for potential abuse or neglect through interview responses and behavioral/physical symptom clues).

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

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submitted to and certified by the Department, using specialized emergency medical services vehicles to provide emergency transportation to sick or injured persons.

Special-Use Vehicle – any publicly 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)

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 (i.e., 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 RNs on duty in the hospital is available for

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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.

Standby Emergency Department Approved for Pediatrics or SEDP – a hospital participating in an approved EMS System and designated by the Department, pursuant to Section 515.4010, as being capable of providing optimal standby emergency department care to pediatric patients and to have transfer agreements and transfer mechanisms in place when more definitive pediatric care is needed.

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.

Stretcher Van – a vehicle used by a licensed stretcher van provider to transport non-emergency passengers in accordance with the Act and this Part.

Stretcher Van Provider – an entity licensed by the Department to provide non-emergency transportation of passengers on a stretcher in compliance with the Act and this Part, utilizing stretcher vans. (Section 3.86 of the Act)

Stroke Network – a voluntary association of hospitals, including a hospital with a board eligible or board certified neurosurgeon or neurologist, that may, among other activities, share stroke protocols; provide medical consultations on possible or known acute stroke patients or on inter-facility transfers of possible or known acute stroke patients; or provide education specific to improving acute stroke care. Participating hospitals in a stroke network may be in-state or out-of-state.

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.

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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.

Telecommunications Equipment – a communication system capable of transmitting and receiving voice and electrocardiogram (EKG) signals.

Telemetry – the transmission of data through a communication system to a receiving station for recording, interpretation 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 Appendix C and Appendix F.

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

Trauma Center – a hospital which: within designated capabilities provides optimal 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 or Trauma Center MD – 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 – an RN 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.

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Trauma Nurse Specialist or TNS – an RN licensed under the Nurse Practice Act who has successfully completed supplemental education and testing requirements as prescribed by the Department, and is licensed in accordance with this Part. (Section 3.75 of the Act) For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices.

Trauma Nurse Specialist Course Coordinator or TNSCC – an RN appointed by the Chief Executive Officer of a hospital designated as a TNS education site, who meets the requirements of Section 515.750.

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).

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 Systems, utilizing at least ambulances or specialized emergency medical service vehicles (SEMSV). (Section 3.85(a) of the Act)

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

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

SUBPART C: EMS SYSTEMS

Section 515.315 Bypass Status Review
EMERGENCY

- a) *The Department shall investigate the circumstances that caused a hospital in an EMS System to go on bypass status to determine whether that hospital's decision to go on bypass status was reasonable. (Section 3.20(c) of the Act)*

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- b) The hospital shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, of any bypass decision, at both the time of its initiation and the time of its termination, through status change updates entered into the Illinois EMResource application, accessed at <https://emresource.juvare.com/login>. The hospital shall document any inability to access EMResource by contacting IDPH Division of EMS during normal business hours.
- c) In determining whether a hospital's decision to go on bypass status was reasonable, the Department shall consider the following:
- 1) The number of critical or monitored beds available in the hospital at the time that the decision to go on bypass status was made;
 - 2) Whether an internal disaster, including, but not limited to, a power failure, had occurred in the hospital at the time that the decision to go on bypass status was made;
 - 3) The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and
 - 4) The approved Regional Protocols for bypass and diversion at the time that the decision to go on bypass status was made, provided that the Protocols include subsections (c)(1), (2) and (3).
- d) For Trauma Centers only, the following situations constitute a reasonable decision to go on bypass status:
- 1) All staffed operating suites are in use or fully implemented with on-call teams, and at least one or more of the procedures is an operative trauma case;
 - 2) The CAT scan is not working; or
 - 3) The general bypass criteria in subsection (c).
- e) *The Department may impose sanctions, as set forth in Section 3.140 of the Act, upon a Department determination that the hospital unreasonably went on bypass status in violation of the Act. (Section 3.20(c) of the Act)*

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- f) Each EMS System shall develop a policy addressing response to a system-wide crisis.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

Section 515.460 Fees
EMERGENCY

- a) The following fees shall be submitted to the Department at the time of application for examination, initial licensure, licensure renewal, duplicate license, or reciprocity:
- 1) EMT licensure: \$45
 - 2) EMT renewal: \$20
 - 3) EMT examination: \$20
 - 4) A-EMT or EMT-I licensure: \$45
 - 5) A-EMT or EMT-I renewal: \$30
 - 6) A-EMT or EMT-I examination: \$30
 - 7) Paramedic licensure: \$60
 - 8) Paramedic renewal: \$40
 - 9) Paramedic examination: \$40
 - 10) Trauma Nurse Specialist licensure: \$50
 - 11) Trauma Nurse Specialist renewal: \$25
 - 12) Trauma Nurse Specialist examination: \$25 (see Section 515.750(f))
 - 13) Emergency Communications Registered Nurse licensure: \$55

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- 14) Emergency Communications Registered Nurse renewal: \$20
- 15) Emergency Medical Dispatcher licensure: \$30
- 16) Emergency Medical Dispatcher renewal: \$20
- 17) Pre-Hospital RN licensure: \$30
- 18) Pre-Hospital RN renewal: \$20
- 19) Pre-Hospital PA licensure: \$30
- 20) Pre-Hospital PA renewal: \$20
- 21) Pre-Hospital APRN licensure: \$30
- 22) Pre-Hospital APRN renewal: \$20
- 23) Lead Instructor licensure: \$40
- 24) Lead Instructor renewal: \$20
- 25) EMR licensure: \$55
- 26) EMR renewal: \$20
- 27) Duplicate license: \$10
- 28) Reciprocity application processing fee: \$50
- 29) Fees for a reciprocity license or reinstatement of a license will be equal to the amount of the initial license fee.
- 30) License status verification documentation for out-of-state or organizational requests: \$25
- 31) License renewal late fee during lapse period: \$50

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- b) *An EMR, EMD, EMT, EMT-I, A-EMT, Paramedic, ECRN or PHRN who is a member of the Illinois National Guard or an Illinois State Trooper or who exclusively serves as a volunteer for units of local government with a population base of less than 5,000 or as a volunteer for a not-for-profit organization that serves a service area with a population base of less than 5,000 in this State may submit an application to the Department for a waiver of the fees for the EMS Personnel examination, licensure and license renewal on a form prescribed by the Department. (Section 3.50(d-5) of the Act) The fee waiver application shall be submitted to the Department and approved prior to examination, licensure or renewal. No fees will be refunded.*
- c) Fees shall be paid on-line or by certified check or money order made payable to the Department. Personal checks or cash will not be accepted.
- d) If a candidate does not achieve a passing grade on the written examination, the fee for the retest is the same as for initial examination.
- e) All fees submitted for licensure examinations are not refundable.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

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

Section 515.730 Pre-Hospital Registered Nurse, Pre-Hospital Physician Assistant, Pre-Hospital Advanced Practice Registered Nurse
EMERGENCY

- a) To be approved and licensed as a PHRN, PHPA, PHAPRN:
 - 1) An individual shall:
 - A) Be a licensed RN, PA or APRN in good standing and in accordance with all requirements of the Illinois Department of Financial and Professional Regulation;

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- B) Complete a supplemental education curriculum, formulated by an EMS System and approved by the Department, that consists of:
 - i) at least 40 hours of classroom and psychomotor education and measurement of competency equivalent to the entry level Paramedic program;
 - ii) practical education, including, but not limited to, advanced airway techniques, ambulance operations, *extrication, telecommunications, and pre-hospital cardiac and trauma care* of both the adult and pediatric population (Section 3.80(c)(1)(A) of the Act); and
 - iii) the EMS System's policies, protocols and standing orders; and
 - C) Complete a minimum of 10 ALS runs supervised by a licensed EMS System, physician, an approved System PHRN, PHPA, PHAPN or a Paramedic, only as authorized by the EMS MD, and shall successfully complete a Paramedic examination approved by the Department.
- 2) New applicants completing course work after January 1, 2018 and before April 1, 2020 shall successfully pass the State of Illinois Paramedic licensure examination. New applicants completing course work after April 1, 2020 shall successfully pass the National Registry of EMT's Paramedic cognitive assessment exam; and
 - 3) The EMS MD shall electronically submit to the Department, using the Department's Electronic Transaction Form, a recommendation for licensure for a PHRN, PHPA, PHAPN candidate who has completed and passed all components of the PHRN, PHPA, PHAPN education program and passed the final examination. The application will include demographic information, social security number, child support statement, felony conviction statement, and applicable fees and shall require EMS System authorization.
- b) To apply for a four year renewal, the PHRN, PHPA, PHAPN shall comply with

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Section 515.590.

- c) Inactive Status
- 1) Prior to the expiration of the current license, a PHRN, PHPA, PHAPN may request to be placed on inactive status as outlined in Section 515.600. The request shall be made in writing to the EMS MD.
 - 2) A PHRN, PHPA, PHAPN who wants to restore his or her license to active status shall follow the requirements set forth in Section 515.600.
 - 3) If the PHRN, PHPA, PHAPN inactive status period exceeds 48 months, the licensee shall redemonstrate competencies and successfully pass the State Paramedic examination.
 - 4) The EMS MD shall notify the Department in writing of a PHRN's, PHPA's, PHAPN's approval, reapproval, or granting or denying of inactive status within 10 days after any change in a PHRN's, PHPA's, PHAPN's approval status.
- e) A PHRN, PHPA, PHAPN shall notify the Department within 30 days after any change in name or address. Notification may be in person, or by mail, phone, fax, or electronic mail. Addresses may be changed through the Department's online system: <https://emslicensing.dph.illinois.gov/Clients/ILDOHEMS/Private/AddressChange/AddressLogin.aspx>. Names and gender changes require legal documents, i.e., marriage license or court documents.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

SUBPART F: VEHICLE SERVICE PROVIDERS

Section 515.830 Ambulance Licensing Requirements
EMERGENCY

- a) Vehicle Design
- 1) Each new vehicle used as an ambulance shall comply with the criteria established by the Federal Specifications for Ambulance, KKK-A-1822F,

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United States General Services Administration, with the exception of Section 3.16.2, Color, Paint and Finish.

- 2) *A licensed vehicle shall be exempt from subsequent vehicle design standards or specifications required by the Department in this Part, as long as the vehicle is continuously in compliance with the vehicle design standards and specifications originally applicable to that vehicle, or until the vehicle's title of ownership is transferred.* (Section 3.85(b)(8) of the Act)
- 3) The following requirements listed in Specification KKK-A-1822F shall be considered mandatory in Illinois even though they are listed as optional in that publication:
 - A) 3.7.7.1 Each vehicle will be equipped with either a battery charger or battery conditioner (see 3.15.3 item 7).
 - B) 3.8.5.2 Patient compartment checkout lights will be provided (see 3.15.3 item 9).
 - C) 3.12.1 An oxygen outlet will be provided above the secondary patient (see 3.15.4 M9).
 - D) 3.15.4M3 Electric clock with sweep second hand will be provided.
- b) Equipment Requirements – Basic Life Support Vehicles Each ambulance used as a Basic Life Support vehicle shall meet the following equipment requirements, as determined by the Department by an inspection:
 - 1) Stretchers, Cots, and Litters
 - A) Primary Patient Cot
Shall meet the requirements of sections 3.11.5, 3.11.8.1 of KKK-A-1822F.
 - B) Secondary Patient Stretcher
Shall meet the requirements of sections 3.11.5, 3.11.5.1, 3.11.8.1 of KKK-A-1822F.

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- 2) Oxygen, Portable
Shall meet the operational requirements of section 3.12.2 of KKK-A-1822-F.
- 3) Suction, Portable
 - A) Shall meet the operational requirements of section 3.12.4 of KKK-A-1822F.
 - B) A manually operated suction device is acceptable if approved by the Department.
- 4) Medical Equipment
 - A) Squeeze bag-valve-mask ventilation unit with adult size transparent mask, and child size bag-valve-mask ventilation unit with child, infant and newborn size transparent masks
 - B) Lower-extremity traction splint, adult and pediatric sizes
 - C) Blood pressure cuff, one each, adult, child and infant sizes and gauge
 - D) Stethoscopes, two per vehicle
 - E) Pneumatic counterpressure trouser kit, adult size, optional
 - F) Long spine board with three sets of torso straps, 72" x 16" minimum
 - G) Short spine board (32" x 16" minimum) with two 9-foot torso straps, one chin and head strap or equivalent vest type (wrap around) per vehicle; extrication device optional
 - H) Airway, oropharyngeal – adult, child, and infant, sizes 0-5
 - I) Airway, nasopharyngeal with lubrication, sizes 14-34F

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- J) Two adult and two pediatric sized non-rebreather oxygen masks per vehicle
 - K) Two infant partial re-breather oxygen masks per vehicle
 - L) Three nasal cannulas, adult and child size, per vehicle
 - M) Bandage shears, one per vehicle
 - N) Extremity splints, adult, two long and short per vehicle
 - O) Extremity splints, pediatric, two long and short per vehicle
 - P) Rigid cervical collars – one pediatric, small, medium, and large sizes or adjustable size collars per vehicle. Shall be made of rigid material to minimize flexion, extension, and lateral rotation of the head and cervical spine when spine injury is suspected
 - Q) Patient restraints, arm and leg, sets
 - R) Pulse oximeter with pediatric and adult probes
 - S) AED or defibrillator that includes pediatric capability
- 5) Medical Supplies
- A) Trauma dressing – six per vehicle
 - B) Sterile gauze pads – 20 per vehicle, 4 inches by 4 inches
 - C) Bandages, soft roller, self-adhering type, 10 per vehicle, 4 inches by 5 yards
 - D) Vaseline gauze – two per vehicle, 3 inches by 8 inches
 - E) Adhesive tape rolls – two per vehicle
 - F) Triangular bandages or slings – five per vehicle

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- G) Burn sheets – two per vehicle, clean, individually wrapped
- H) Sterile solution (normal saline) – four per vehicle, 500 cc or two per vehicle, 1,000 cc plastic bottles or bags
- I) Thermal absorbent blanket and head cover, aluminum foil roll or appropriate heat reflective material – minimum one
- J) Obstetrical kit, sterile – minimum one, pre-packaged with instruments and bulb syringe
- K) Cold packs, three per vehicle
- L) Hot packs, three per vehicle, optional
- M) Emesis basin – one per vehicle
- N) Drinking water – one quart, in non-breakable container; sterile water may be substituted
- O) Ambulance emergency run reports – 10 per vehicle, on a form prescribed by the Department or one that contains the data elements from the Department-prescribed form as described in Section 515. Appendix E or electronic documentation with paper backup
- P) Pillows – two per vehicle, for ambulance cot
- Q) Pillowcases – two per vehicle, for ambulance cot
- R) Sheets – two per vehicle, for ambulance cot
- S) Blankets – two per vehicle, for ambulance cot
- T) Opioid antagonist, including, but not limited to, Naloxone, with administration equipment appropriate for the licensed level of care
- U) Urinal

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- V) Bedpan
 - W) Remains bag, optional
 - X) Nonporous disposable gloves
 - Y) Impermeable red biohazard-labeled isolation bag
 - Z) Face protection through any combination of masks and eye protection and field shields
 - AA) Suction catheters – sterile, single use, two each, 6, 8, 10, 12, 14 and 18F, plus three tonsil tip semi-rigid pharyngeal suction tip catheters per vehicle; all shall have a thumb suction control port
 - BB) Child and infant or convertible car seats
 - CC) Current equipment/drug dosage sizing tape or pediatric equipment/drug age/weight chart
 - DD) Flashlight, two per vehicle, for patient assessment
 - EE) Current Illinois Department of Transportation Safety Inspection sticker in accordance with Section 13-101 of the Illinois Vehicle Code
 - FF) Illinois Poison Center telephone number
 - GG) Department of Public Health Central Complaint Registry telephone number posted where visible to the patient
 - HH) Medical Grade Oxygen
 - II) Ten disaster triage tags
 - JJ) State-approved Mass Casualty Incident (MCI) triage algorithms (START/JumpSTART)
- c) Equipment Requirements – Intermediate and Advanced Life Support Vehicles

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Each ambulance used as an Intermediate Life Support vehicle or as an Advanced Life Support vehicle shall meet the requirements in subsections (b) and (d) and shall also comply with the equipment and supply requirements as determined by the EMS MD in the System in which the ambulance and its crew participate. Drugs shall include both adult and pediatric dosages. These vehicles shall have a current pediatric equipment/drug dosage sizing tape or pediatric equipment/drug dosage age/weight chart.

- d) **Equipment Requirements – Rescue and/or Extrication**
The following equipment shall be carried on the ambulance, unless the ambulance is routinely accompanied by a rescue vehicle:
- 1) Wrecking bar, 24"
 - 2) Goggles for eye safety
 - 3) Flashlight – one per vehicle, portable, battery operated
 - 4) Fire Extinguisher – two per vehicle, ABC dry chemical, minimum 5-pound unit with quick release brackets. One mounted in driver compartment and one in patient compartment
- e) **Equipment Requirements – Communications Capability**
Each ambulance shall have reliable ambulance-to-hospital radio communications capability and meet the requirements provided in Section 515.400.
- f) **Equipment Requirements – Epinephrine**
An EMT, EMT-I, A-EMT or Paramedic who has successfully completed a Department-approved course in the administration of epinephrine shall be required to carry epinephrine (both adult and pediatric doses) with him or her in the ambulance or drug box as part of the EMS Personnel medical supplies whenever he or she is performing official duties, as determined by the EMS System within the context of the EMS System plan. (Section 3.55(a-7) of the Act)
- g) **Personnel Requirements**
- 1) Each Basic Life Support ambulance shall be staffed by a minimum of one System authorized EMT, A-EMT, EMT-I, Paramedic or PHRN, PHPA,

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PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses.

- 2) Each ambulance used as an Intermediate Life Support vehicle shall be staffed by a minimum of one System authorized A-EMT, EMT-I, Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses.
- 3) Each ambulance used as an Advanced Life Support vehicle shall be staffed by a minimum of one System authorized Paramedic or PHRN, PHPA, PHAPN and one other System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician on all responses.

h) Alternate Rural Staffing Authorization

- 1) A Vehicle Service Provider *that serves a rural or semi-rural population of 10,000 or fewer inhabitants and exclusively uses volunteers, paid-on-call personnel or a combination* to provide patient care may apply for alternate rural staffing authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle to be staffed by one EMS Personnel licensed at or above the level at which the vehicle is licensed, plus one EMR when two licensed EMTs, A-EMTs, EMT-Is, Paramedics, PHRNs, PHPAs, PHAPNs or physicians are not available to respond. (Section 3.85(b)(3) of the Act)
- 2) The EMS Personnel licensed at or above the level at which the ambulance is licensed shall be the primary patient care provider in route to the health care facility.
- 3) The Vehicle Service Provider shall obtain the prior written approval for alternate rural staffing from the EMS MD. The EMS MD shall submit to the Department a request for an amendment to the existing EMS System plan that clearly demonstrates the need for alternate rural staffing in accordance with subsection (h)(4) and that the alternate rural staffing will not reduce the quality of medical care established by the Act and this Part.
- 4) A Vehicle Service Provider requesting alternate rural staffing authorization shall clearly demonstrate all of the following:

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- A) That it has undertaken extensive efforts to recruit and educate licensed EMTs, A-EMTs, EMT-Is, Paramedics, or PHRNs, PHPAs, PHAPNs;
 - B) That, despite its exhaustive efforts, licensed EMTs, A-EMTs, EMT-Is, Paramedics or PHRNs, PHPAs, PHAPNs are not available; and
 - C) That, without alternate rural staffing authorization, the rural or semi-rural population of 10,000 or fewer inhabitants served will be unable to meet staffing requirements as specified in subsection (g).
- 5) The alternate rural staffing authorization and subsequent authorizations shall include beginning and termination dates not to exceed 48 months. The EMS MD shall re-evaluate subsequent requests for authorization for compliance with subsections (h)(4)(A) through (C). Subsequent requests for authorization shall be submitted to the Department for approval in accordance with this Section.
 - 6) Alternate rural staffing authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate rural staffing authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate rural staffing authorization presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing.
 - 7) Vehicle Service Providers that cannot meet the alternate rural staffing authorization requirements of this Section may apply through the EMS MD to the Department for a staffing waiver pursuant to Section 515.150.
- i) Alternate Response Authorization
 - 1) A Vehicle Service Provider that exclusively uses volunteers or paid-on-call personnel or a combination to provide patient care who are not required to be stationed with the vehicle may apply to the Department for

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alternate response authorization to authorize the ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department to travel to the scene of an emergency staffed by at least one licensed EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician.

- 2) A Vehicle Service Provider operating under alternate response authorization shall ensure that a second licensed EMS Personnel is on scene or in route to the emergency response location.
 - 3) Unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h), the Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported with:
 - A) fewer than two EMTs, Paramedics or PHRNs, PHPAs, PHAPNs;
 - B) a physician; or
 - C) a combination, at least one of whom shall be licensed at or above the level of the license for the vehicle.
 - 4) Alternate response authorization may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization presents an immediate threat to the health or safety of the public. After summary suspension, the licensee shall have the opportunity for an expedited hearing (see Section 515.180).
- j) Alternate Response Authorization – Secondary Response Vehicles
- 1) A Vehicle Service Provider that uses volunteers or paid-on-call personnel or a combination to provide patient care, and staffs its primary response vehicle with personnel stationed with the vehicle, may apply for alternate response authorization for its secondary response vehicles. The secondary or subsequent ambulance, Non-Transport Vehicle, Special-Use Vehicle, or Limited Operation Vehicle licensed by the Department at the BLS, ILS or

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ALS level, when personnel are not stationed with the vehicle, may respond to the scene of an emergency when the primary vehicle is on another response. The vehicle shall be staffed by at least one System authorized licensed EMT, A-EMT, EMT-I, PHRN, PHPA, PHAPN or physician.

- 2) A Vehicle Service Provider operating under the alternate response authorization shall ensure that a second System authorized licensed EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA, PHAPN or physician is on the scene or in route to the emergency response location, unless the Vehicle Service Provider is approved for alternate rural staffing authorization, in which case the second individual may be an EMR or First Responder.
 - 3) Unless the Vehicle Service Provider is approved for alternate rural staffing authorization under subsection (h), the Vehicle Service Provider shall demonstrate to the Department that it has written safeguards to ensure that no patient will be transported without at least one EMT who is licensed at or above the level of ambulance, plus at least one of the following: EMT, Paramedic, PHRN, PHPA, PHAPN or physician.
 - 4) Alternate response authorization for secondary response vehicles may be suspended or revoked, after an opportunity for hearing, if the Department determines that a violation of this Part has occurred. Alternate response authorization for secondary response vehicles may be summarily suspended by written order of the Director, served on the Vehicle Service Provider, if the Director determines that continued operation under the alternate response authorization for secondary vehicles presents an immediate threat to the health or safety of the public. After summary suspension, the Vehicle Service Provider shall have the opportunity for an expedited hearing (see Section 515.180).
- k) Operational Requirements
- 1) An ambulance that is transporting a patient to a hospital shall be operated in accordance with the requirements of the Act and this Part.
 - 2) A licensee shall operate its ambulance service in compliance with this Part, 24 hours a day, every day of the year. Except as required in this subsection (k), each individual vehicle within the ambulance service shall

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not be required to operate 24 hours a day, as long as at least one vehicle for each level of service covered by the license is in operation at all times. An ALS vehicle can be used to provide coverage at either an ALS, ILS or BLS level, and the coverage shall meet the requirements of this Section.

- A) At the time of application for initial or renewal licensure, and upon annual inspection, the applicant or licensee shall submit to the Department for approval a list containing the anticipated hours of operation for each vehicle covered by the license.
 - i) A current roster shall also be submitted that lists the System authorized EMTs, A-EMTs, EMT-Is, Paramedics, PHRNs, PHPAs, PHAPNs or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license number, license expiration date and telephone number, and shall state whether the person is scheduled to be on site or on call.
 - ii) An actual or proposed four-week staffing schedule shall also be submitted that covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift.
- B) Licensees shall obtain the EMS MD's approval of their vehicles' hours of operation prior to submitting an application to the Department. An EMS MD may require specific hours of operation for individual vehicles to assure appropriate coverage within the System.
- C) A Vehicle Service Provider that advertises its service as operating a specific number of vehicles or more than one vehicle shall state in the advertisement the hours of operation for those vehicles, if individual vehicles are not available 24 hours a day. Any advertised vehicle for which hours of operation are not stated shall be required to operate 24 hours a day. (See Section 515.800(j).)

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- 3) For each patient transported to a hospital, the ambulance staff shall, at a minimum, measure and record the information required in Appendix E.
 - 4) A Vehicle Service Provider shall provide emergency service within the service area on a per-need basis without regard to the patient's ability to pay for the service.
 - 5) A Vehicle Service Provider shall provide documentation of procedures to be followed when a call for service is received and a vehicle is not available, including copies of mutual aid agreements with other ambulance providers. (See Section 515.810(h).)
 - 6) A Vehicle Service Provider shall not operate its ambulance at a level exceeding the level for which it is licensed (basic life support, intermediate life support, advanced life support), unless the vehicle is operated pursuant to an EMS System-approved in-field service level upgrade or ambulance service upgrades – rural population.
 - 7) The Department will inspect ambulances each year. If the Vehicle Service Provider has no violations of this Section that threaten the health or safety of patients or the public for the previous five years and has no substantiated complaints against it, the Department will inspect the Vehicle Service Provider's ambulances in alternate years, and the Vehicle Service Provider may, with the Department's prior approval, self-inspect its ambulances in the other years. The Vehicle Service Provider shall use the Department's inspection form for self-inspection. Nothing contained in this subsection (k)(7) shall prevent the Department from conducting unannounced inspections.
- l) A licensee may use a replacement vehicle for up to 10 days without a Department inspection, provided that the EMS System and the Department are notified of the use of the vehicle by the second working day.
 - m) *Patients, individuals who accompany a patient, and EMS Personnel may not smoke while inside an ambulance or SEMSV. The Department of Public Health shall impose a civil penalty on an individual who violates this subsection (m) in the amount of \$100. (Section 3.155(h) of the Act)*

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- n) Any provider may request a waiver of any requirements in this Section under the provisions of Section 515.150.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

Section 515.860 Critical Care Transport
EMERGENCY

- a) Critical care transport *may be provided by:*
- 1) *Department-approved critical care transport providers, not owned or operated by a hospital, utilizing EMT-Paramedics with additional training, nurses, or other qualified health professionals; or*
 - 2) *Hospitals, when utilizing any vehicle service provider or any hospital-owned or operated vehicle service provider. Nothing in the Act requires a hospital to use, or to be, a Department-approved critical care transport provider when transporting patients, including those critically injured or ill. Nothing in the Act shall restrict or prohibit a hospital from providing, or arranging for, the medically appropriate transport of any patient, as determined by a physician licensed to practice medicine in all of its branches, an APRN, or a PA. (Section 3.10(f-5) of the Act)*
- b) *All critical care transport providers must function within a Department-approved EMS System. Nothing in this Part shall restrict a hospital's ability to furnish personnel, equipment, and medical supplies to any vehicle service provider, including a critical care transport provider. (Section 3.10(g-5) of the Act)*
- c) For the purposes of this Section, "expanded scope of practice" includes the accepted national curriculum plus additional education, experience and equipment (see Section 515.360) as approved by the Department pursuant to Section 3.55 of the Act. Tier I transports are considered "expanded scope of practice".
- d) For the purposes of this Section, CCT plans are defined in three tiers of care. Tier II and Tier III are considered Critical Care Transports.
- e) Tier I

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Tier I provides a level of care for patients who require care beyond the Department-approved Paramedic scope of practice, up to but not including the requirements of Tiers II and III. Tier I transport includes the use of a ventilator, the use of infusion pumps with administration of medication drips, and maintenance of chest tubes.

- 1) Personnel Staffing and Licensure
 - A) Licensure
 - i) Licensed Illinois Paramedic, PHRN, PHPA or PHAPN;
 - ii) Scope of practice more comprehensive than the national EMS scope of practice model approved by the Department in accordance with the EMS System plan (see Sections 515.310 and 515.330); and
 - iii) Approved to practice by the Department in accordance with the EMS System plan.
 - B) Minimum Staffing
 - i) System authorized EMT, A-EMT, EMT-I, Paramedic, PHRN, PHPA or PHAPN as driver; and
 - ii) System authorized expanded scope of practice Paramedic, PHRN, PHPA, PHAPN or physician who shall remain with the patient at all times.
- 2) Education, Certification and Experience
 - A) Initial Education. Documentation of initial education and demonstrated competencies of expanded scope of practice knowledge and skills as required by Tier I Level of Care and approved by the Department in accordance with the EMS System plan.
 - B) CE Requirements

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- i) Annual competencies of expanded scope of practice knowledge, equipment and procedures shall be completed; and
 - ii) The EMS vehicle service provider shall maintain documentation of competencies and provide documentation to the EMS Resource Hospital upon request.
 - C) Certifications. Tier I personnel shall maintain all of the following renewable certifications and credentials in active status:
 - i) Advanced Cardiac Life Support (ACLS);
 - ii) Pediatric Education for Pre-Hospital Professionals (PEPP) or Pediatric Advance Life Support (PALS);
 - iii) International Trauma Life Support (ITLS) or Pre-Hospital Trauma Life Support (PHTLS); and
 - iv) Any additional educational course work or certifications required by the EMS MD.
 - D) Experience
 - i) Minimum of one year of experience functioning in the field at an ALS level or as a physician in an emergency department; and
 - ii) Documentation of education and demonstrated competencies of expanded scope of practice knowledge and skills required for Tier I Level of Care, approved by the Department and included in the EMS System plan.
- 3) Medical Equipment and Supplies
- A) Ventilator; and
 - B) Infusion pumps.

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- 4) Vehicle Standards
Any vehicle used for providing expanded scope of practice care shall comply at a minimum with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for expanded scope of practice transport shall be equipped with an onboard alternating current (AC) supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.
- 5) Treatment and Transport Protocols shall address the following:
 - A) EMS MD or designee present at established Medical Control;
 - B) Communication points for contacting System authorized Medical Control and a written Expanded Scope of Practice Standard;
 - C) Written operating procedures and protocols signed by the EMS MD and approved for use by the Department in accordance with the System plan; and
 - D) Use of a ventilator, infusion pumps with administration of medication drips, and maintenance of chest tubes.
- 6) Quality Assurance Program
 - A) The Tier I transport provider shall develop a written Quality Assurance (QA) plan approved by the EMS System and the Department in accordance with subsection (e)(6)(D). The provider shall provide quarterly QA reports to the assigned EMS Resource Hospitals for the first 12 months of operation.
 - B) The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.

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- C) An EMS MD or a SEMSV shall oversee the QA program.
- D) The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:
 - i) Review of transferring physician orders and evidence of compliance with those orders;
 - ii) Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;
 - iii) Documentation of any side effects/complications, including hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;
 - iv) Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;
 - v) Review of any Medical Control contact for further direction;
 - vi) Documentation that any unusual occurrences were promptly communicated to the EMS System; and
 - vii) A root cause analysis of any event or care inconsistent with standards. The EMS System educator shall assess and carry out a corrective action plan.
- E) The QA plan shall be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).
- f) Tier II

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Tier II provides a level of care for patients who require care beyond the Department-approved national EMS scope of practice model and expanded scope of practice ALS (Paramedic) transport program, and who require formal advanced education for ALS Paramedic staff. Tier II transport includes the use of a ventilator, infusion pumps with administration of medication drips, maintenance of chest tubes, and other equipment and treatment, such as, but not limited to: arterial lines; accessing central lines; medication-assisted intubation; patient assessment and titration of IV pump medications, including additional active interventions necessary in providing care to the patient receiving treatment with advanced equipment and medications.

- 1) Personnel Staffing and Licensure
 - A) Licensure – Licensed Illinois Paramedic, PHRN, PHPA or PHAPN:
 - i) Expanded scope of practice more comprehensive than the national EMS scope of practice model and Tier I Level as approved by the Department; and
 - ii) Approved to practice by the EMS System and the Department in accordance with the EMS System plan.
 - B) Minimum Staffing:
 - i) System authorized Paramedic, PHRN, PHPA or PHAPN; and
 - ii) System authorized Paramedic, PHRN, PHPA, PHAPN or physician who is critical care prepared and who shall remain with the patient at all times.
- 2) Education, Certification and Experience
 - A) Initial Advanced Formal Education.
 - i) At a minimum, 80 didactic hours of established higher collegiate education or equivalent critical care education based on nationally recognized program models; and

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- ii) Demonstrated competencies, as documented by the EMS MD or SEMSV MD and approved by the Department.
 - B) CE Requirements
 - i) The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures;
 - ii) The following current credentials, as a minimum, shall be maintained: ACLS, PEPP or PALS, ITLS or PHTLS;
 - iii) A minimum of 40 hours of critical care level education shall be completed every four years;
 - iv) The EMS provider shall maintain documentation of compliance with subsections (f)(2)(B)(i) through (iii) and shall provide documentation to the EMS Resource Hospital upon request; and
 - v) Nationally recognized critical care certifications shall be maintained and renewed based on national recertification criteria.
 - C) Experience. Minimum of two years experience functioning in the field at an ALS level for Paramedics and PHRNs and one year experience in an emergency department for physicians.
- 3) Medical Equipment and Supplies
- A) Ventilator; and
 - B) Infusion pumps.
- 4) Vehicle Standards
- Any vehicle used for providing critical care transport shall comply at a minimum with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920

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(SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for CCT shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.

- 5) Treatment and Transport Protocols shall address the following:
 - A) EMS MD or designee present at established Medical Control communication points and a written Expanded Scope of Practice Standard Operating Procedure signed by the EMS MD and approved for use by the Department in accordance with the System plan;
 - B) The use of a ventilator, infusion pumps with administration of medication drips, maintenance of chest tubes, and other equipment and treatment, such as, but not limited to: arterial lines, accessing central lines, and medication-assisted intubation; and
 - C) Patient assessment and titration of IV pump medications, including additional active interventions necessary in providing care to the patient receiving treatment with advanced equipment and medications.

- 6) Quality Assurance Program
 - A) The Tier II transport provider shall develop a written QA plan approved by the EMS System and the Department in accordance with subsection (f)(6)(D). The participating provider shall provide quarterly reports to the assigned EMS Resource Hospitals for the first 12 months of operation.
 - B) The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.
 - C) An EMS MD or SEMSV MD shall oversee the QA program.

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- D) The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:
- i) Review of transferring physician orders and evidence of compliance with those orders;
 - ii) Documentation of vital signs and frequency, and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;
 - iii) Documentation of any side effects or complications, including, but not limited to, hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status and/or changes in neurological examination, and evidence that interventions were appropriate for those events;
 - iv) Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;
 - v) Review of any Medical Control contact for further direction;
 - vi) Documentation that unusual occurrences were promptly communicated to the EMS System; and
 - vii) A root cause analysis shall be completed for any event or care inconsistent with standards. The EMS MD or the SEMSV MD shall recommend and implement a corrective action plan.
- E) The QA plan shall be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).
- g) Tier III

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Tier III provides the highest level of ground transport care for patients who require nursing level treatment modalities and interventions.

- 1) Minimum Personnel Staffing and Licensure
 - A) EMT, A-EMT, EMT-I or Paramedic (as driver); and
 - B) Two critical care prepared providers, who shall remain with the patient at all times:
 - i) Paramedic, PHRN, PHPA or PHAPN; and
 - ii) RN, PHRN, PHPA or PHAPN.
- 2) Education, Certification, and Experience: Paramedic, PHRN, PHPA or PHAPN
 - A) Initial Advanced Formal Education
 - i) Approval to practice by EMS System and the Department in accordance with the EMS program plan;
 - ii) At a minimum, 80 didactic hours of established higher collegiate education or equivalent critical care education nationally recognized program models;
 - iii) Demonstrated competencies, as documented by EMS MD and SEMSV MD and approved by the Department; and
 - iv) Expanded scope of practice more comprehensive than the national EMS scope of practice model and Tier II level as approved by the Department.
 - B) CE Requirements
 - i) The EMS System shall document and maintain annual competencies of expanded scope of practice knowledge, equipment and procedures;

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- ii) The following valid credentials, at a minimum, shall be maintained: ACLS, PEPP or PALS, ITLS or PHTLS;
 - iii) A minimum of 40 hours of critical care level CE shall be completed every four years;
 - iv) The EMS provider shall maintain documentation of compliance with subsection (g)(2)(B)(i) and shall provide documentation to the EMS Resource Hospital upon request; and
 - v) Nationally recognized critical certifications shall be maintained and renewed based on national recertification criteria.
- C) Experience
- i) Minimum of two years experience functioning in the field at an ALS Level;
 - ii) Documented demonstrated competencies; and
 - iii) Completion of annual competencies of expanded scope knowledge, equipment and procedures.
- 3) Education, Certification and Experience – Registered Professional Nurse
- A) CE Requirements
- i) A minimum of 48 hours of critical care level education shall be completed every four years;
 - ii) The EMS provider shall maintain documentation of compliance with subsection (g)(3)(A)(i) and shall provide documentation to the EMS Resource Hospital upon request; and
 - iii) Annual competencies of expanded scope of practice knowledge, equipment and procedures shall be completed.

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- B) Certifications
Tier III personnel shall maintain the following valid critical care certifications and credentials:
 - i) ACLS;
 - ii) PALS, PEPP or ENPC;
 - iii) ITLS, PHTLS, TNCC or TNS; and
 - iv) ECRN or equivalent.
 - C) Advanced Certifications Preferred but not Required
 - i) Certified Emergency Nurse (CEN);
 - ii) Critical Care Registered Nurse (CCRN);
 - iii) Critical Care Emergency Medical Technician-Paramedic (CCEMT-P);
 - iv) Certified Registered Flight Nurse (CFRN); and
 - v) Certified Transport Registered Nurse (CTRN).
 - D) Experience
 - i) Two years of experience with demonstrated competency in a critical care setting; and
 - ii) Documented demonstrated EMT System competencies.
- 4) Medical Equipment and Supplies
Tier III transport requires nursing level treatment modalities and interventions as agreed upon by the sending physician and the accepting physician at the receiving facility. If either physician is not available for consult, the EMS MD or SEMSV MD or designee shall direct care.

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- 5) Vehicular Standards
Any vehicle used for providing CCT shall comply, at a minimum, with Section 515.830 (Ambulance Licensing Requirements) or Sections 515.900 (Licensure of SEMSV Programs – General) and 515.920 (SEMSV Program Licensure Requirements for All Vehicles) regarding licensure of SEMSV Programs and SEMSV vehicle requirements, including additional medical equipment and ambulance equipment as defined in this Section. Any vehicle used for CCT shall be equipped with an onboard AC supply capable of operating and maintaining the AC current needs of the required medical devices used in providing care during the transport of a patient.
- 6) Treatment and Transport Protocols shall address the following:
 - A) Paramedic, PHRN, PHPA or PHAPN: EMS MD or designee present at established Medical Control communication points and written Critical Care Standard Operating procedure signed by the EMS MD and approved for use by the Department in accordance with the System plan;
 - B) Registered Professional Nurse: The provider's EMS MD or SEMSV Critical Care MD may establish standing medical orders for nursing personnel, or the RN may be approved to accept orders from the sending physician or receiving physician.
- 7) Quality Assurance Program
 - A) The Tier III transport provider shall have a written QA plan approved by the EMS System and the Department, in accordance with subsection (g)(7)(D). The provider shall provide quarterly reports to the assigned EMS Resource Hospitals for the first 12 months of operation.
 - B) The EMS System shall establish the frequency of quality reports after the first year if the System has not identified any deficiencies or adverse outcomes.
 - C) An EMS MD or SEMSV MD shall oversee the QA program.

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- D) The QA plan shall evaluate all expanded scope of practice activity for medical appropriateness and thoroughness of documentation. The review shall include:
 - i) Review of transferring physician orders and evidence of compliance with those orders;
 - ii) Documentation of vital signs and frequency and evidence that abnormal vital signs or trends suggesting an unstable patient were appropriately detected and managed;
 - iii) Documentation of any side effects or complications, including, but not limited to, hypotension, extreme bradycardia or tachycardia, increasing chest pain, dysrhythmia, altered mental status or changes in neurological examination, and evidence that interventions were appropriate for those events;
 - iv) Documentation of any unanticipated discontinuation of a catheter or rate adjustments of infusions, along with rationale and outcome;
 - v) Review of any medical control contact for further direction;
 - vi) Prompt communication of unusual occurrences to the EMS System;
 - vii) A root cause analysis shall be completed for any event or care inconsistent with standards. The EMS MD or the SEMSV MD shall recommend and implement a corrective action plan.
- E) The QA plan will be subject to review as part of an EMS System site survey and as deemed necessary by the Department (e.g., in response to a complaint).
- h) The Department will approve vehicle service providers for CCT when the provider demonstrates compliance with an approved EMS System's CCT program

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plan for Tier II or Tier III transports. Only Department-approved agencies may advertise as CCT providers.

- i) The Department will suspend a vehicle service provider's approval for critical care transport if any part of the provider's QA plan is not followed or if a situation exists that poses a threat to the public health and safety. The Department will provide a notice of suspension of CCT approval and an opportunity for hearing. If the vehicle service provider does not respond to the notice within 10 days after receipt, approval will be revoked.
- j) The Director may summarily suspend any licensed provider's authorization to perform CCT under this Part if the Director or designee determines that continued CCT by the provider poses an imminent threat to the health or safety of the public. Any order for suspension will be in writing and effective immediately upon service of the provider or its lawful agent. Any provider served with an order of suspension shall immediately cease accepting all CCT cases and shall have the right to request a hearing if a written request is delivered to the Department within 15 days after receipt of the order of suspension. If a timely request is delivered to the Department, then the Department will endeavor to schedule a hearing in an expedited manor, taking into account equity and the need for evidence and live witnesses at the hearing. The Department is authorized to seek injunctive relief in the circuit court if the Director's order is violated.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

SUBPART J: EMERGENCY MEDICAL SERVICES FOR CHILDREN

Section 515.4000 Facility Recognition Criteria for the Emergency Department Approved for Pediatrics (EDAP)
EMERGENCY

- a) Professional Staff: Physicians
 - 1) Qualifications
Twenty-four hour coverage of the emergency department (excluding designated areas utilized to care for minor illnesses or injuries, i.e., fast track, urgent care) shall be provided by one or more physicians

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responsible for the care of all children. Each physician shall hold one of the following qualifications:

- A) Certification in emergency medicine by the American Board of Emergency Medicine (ABEM) or American Osteopathic Board of Emergency Medicine (AOBEM) or residency trained/board eligible in emergency medicine and in the first cycle of the board certification process; or
- B) Sub-board Certification in pediatric emergency medicine by the American Board of Pediatrics or the ABEM or residency trained/board eligible in pediatric emergency medicine and in the first cycle of the board certification process; or
- C) Certification by one of the following boards and current American Heart Association – American Academy of Pediatrics (AHA-AAP) Pediatric Advanced Life Support (PALS) recognition or American College of Emergency Physicians – American Academy of Pediatrics (ACEP-AAP) Advanced Pediatric Life Support (APLS) recognition. PALS and APLS courses shall include both cognitive and practical skills evaluation.
 - i) Certification in family medicine by the American Board of Family Medicine (ABFM) or American Osteopathic Board of Family Medicine (AOBFM); or
 - ii) Certification in pediatrics by the ABP or American Osteopathic Board of Pediatrics (AOBP); or
 - iii) Residency trained/board eligible in either family medicine or pediatrics and in the first cycle of the board certification process; or
- D) Alternate Criteria. The physician has worked in the emergency department prior to January 1, 2018 and has completed 12 months of internship followed by at least 7000 hours of hospital-based emergency medicine, including pediatric patients, over the last 60-month period (including at least 2800 hours within one continuous 24-month period), certified in writing by the hospitals at which the

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internship and subsequent hours were completed. The physician shall have current AHA-AAP PALS or ACEP-AAP APLS recognition and have completed at least 16 hours of pediatric CME within the past two years.

- 2) **Continuing Medical Education**
All full- and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of completion of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.
- 3) **Physician Coverage**
At least one physician meeting the requirements of subsection (a)(1) shall be on duty in the emergency department 24 hours a day.
- 4) **Consultation**
Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation can be with an on-staff physician or in accordance with Appendix M.
- 5) **Physician Backup**
A backup physician whose qualifications and training are equivalent to subsection (a)(1) shall be available in person to the EDAP within one hour after notification to assist with critical situations, increased surge capacity or disasters.
- 6) **On-Call Physicians**

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Guidelines shall be established that address on-site response time for all on-call specialty physicians.

- b) Professional Staff: Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant
This subsection (b) pertains to nurse practitioners, clinical nurse specialists, and PAs working within their scope of practice, and credentialed as defined by the hospital.

1) Qualifications

A) Nurse practitioners shall:

i) Either:

- Successfully complete a nurse practitioner program with a focus on the pediatric patient. The following are programs that qualify as focused on pediatric patients: acute care pediatric nurse practitioner program, primary care pediatric nurse practitioner program, pediatric critical care nurse practitioner program, emergency nurse practitioner program, or family practice nurse practitioner program; or
- Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department or acute care as a nurse practitioner over the last 24-month period that includes the care of pediatric patients. This must be certified in writing by the hospitals at which the hours were completed.

- ii) Hold a current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the nurse practitioner shall have an unencumbered license in the state in which he or she practices.

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- iii) Provide credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient, as defined by the hospital credentialing process.
- B) Clinical nurse specialists shall:
- i) Complete a clinical nurse specialist program that includes pediatrics;
 - ii) Maintain pediatric clinical nurse specialist certification through a nationally recognized organization (American Association of Critical Care Nurses (AACN), American Nurses Credentialing Center (ANCC), or an equivalent national organization);
 - iii) Hold a current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the clinical nurse specialist shall have an unencumbered license in the state in which he or she practices; and
 - iv) Provide credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient, as defined by the hospital credentialing process.
- C) Physician Assistants shall:
- i) Hold a current Illinois Physician Assistant License. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the PA shall have an unencumbered license in the state in which he or she practices; and
 - ii) Provide credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient, as defined by the hospital credentialing process.

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- 2) Continuing Education
 - A) All full- or part-time nurse practitioners, clinical nurse specialists, and PAs caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS, or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.
 - B) All full- or part-time nurse practitioners, clinical nurse specialists, and PAs caring for children in the emergency department and fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.
- c) Professional Staff: Nursing
 - 1) Qualifications
 - A) At least one RN on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:
 - i) AHA-AAP PALS;
 - ii) ACEP-AAP APLS; or
 - iii) ENA ENPC.
 - B) All emergency department nurses shall successfully complete and maintain the current recognition required in subsection (c)(1)(A) within 24 months after employment. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.
 - 2) Continuing Education

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All nurses assigned to the emergency department shall have documentation of a minimum of eight hours of pediatric emergency or critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; or publications. These continuing education hours can be integrated with other existing continuing education requirements, provided that the content is pediatric specific.

- d) Guidelines, Policies and Procedures
 - 1) Inter-facility Transfer
 - A) The hospital shall have current written transfer agreements that cover pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.
 - B) The hospital shall have written pediatric inter-facility transfer guidelines, policies or procedures concerning transfer of critically ill and injured patients, which include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a 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 hospital information to family. Incorporating the components of Appendix M into the emergency department transfer policy/procedure will meet this requirement.
 - 2) Suspected Child Abuse and Neglect

The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to

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the Department of Children and Family Services (DCFS) of victims of suspected child abuse and neglect in accordance with State law.

- 3) **Emergency Department Treatment Guidelines**
The hospital shall have emergency department pediatric specific treatment guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).
 - 4) **Latex-Allergy Policy**
The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.
 - 5) **Disaster Preparedness**
The hospital shall integrate pediatric components into its hospital Disaster Plan or Emergency Operations Plan.
- e) **Quality Improvement**
- 1) **Multidisciplinary Quality Activities Policy**
 - A) Pediatric emergency medical care shall be included in the EDAP's emergency department or section quality improvement (QI) program and reported to the hospital Quality Committee.
 - B) Multidisciplinary quality improvement (QI) processes/activities shall be established (e.g., committee).
 - C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all emergency department:
 - i) Pediatric deaths;
 - ii) Pediatric inter-facility transfers;

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- iii) Child abuse and neglect cases;
 - iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure); and
 - v) Pediatric quality and safety priorities of the institution.
- D) *All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC's, EDAP's or SEDP's pediatric services pursuant to this Section shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure.* (Section 3-110(a) of the Act)
- 2) **Pediatric Physician Champion**
The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.
- 3) **Pediatric Quality Coordinator**
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital. This individual may be employed in an area other than the emergency department provided he or she has a minimum of 3600 hours of pediatric critical care experience or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator shall include:
- A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department staff in accordance with subsections (a), (b) and (c).

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- B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)).
 - C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.
 - D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.
 - E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)
- f) Equipment, Trays and Supplies
See Appendix L.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

Section 515.4010 Facility Recognition Criteria for the Standby Emergency Department Approved for Pediatrics (SEDP)
EMERGENCY

- a) Professional Staff: Physicians
 - 1) Qualifications
 - A) All physicians shall have training in the care of pediatric patients through residency training, clinical training, or practice.
 - B) All physicians shall successfully complete and maintain current recognition in the AHA-AAP PALS or the ACEP-AAP APLS. Physicians who are board certified or eligible in emergency medicine (ABEM or AOBEM) or in pediatric emergency medicine (ABP/ABEM) are excluded from this requirement. PALS and APLS shall include both cognitive and practical skills evaluation.

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- 2) **Continuing Medical Education**
All full and part-time emergency physicians caring for children in the emergency department or fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing medical education (AMA Category I or II) in pediatric emergency topics every two years. CME hours shall be earned by, but not limited to, verified attendance at or participation in formal CME programs (i.e., Category I) or informal CME programs (i.e., Category II), all of which shall have pediatrics as the majority of their content. The CME may be obtained from a pediatric specific program/course or may be a pediatric lecture/presentation from a workshop/conference. To meet Category II, teaching time needs to have undergone review and received approval by a university/hospital as Category II CME. The Illinois Department of Financial and Professional Regulation can provide guidance related to criteria for acceptable Category I or II credit.
- 3) **Coverage**
At least one physician meeting the requirements of subsection (a)(1), or a nurse practitioner, clinical nurse specialist, or PA meeting the requirements of subsection (b)(1), shall be on duty in the emergency department 24 hours a day or immediately available in person. A policy shall define when a physician is to be consulted or called in at times when the emergency department is covered by one of these clinicians.
- 4) **Consultation**
Telephone consultation with a physician who is board certified or eligible in pediatrics or pediatric emergency medicine shall be available 24 hours a day. Consultation may be with an on-call physician or in accordance with Appendix M.
- 5) **Physician, Nurse Practitioner, Clinical Nurse Specialist, Physician Assistant Backup**
A backup physician, nurse practitioner, clinical nurse specialist, or PA whose qualifications and training are equivalent to that required by subsections (a) and (b) shall be available in person to the SEDP, within one hour after notification, to assist with critical situations, increased surge capacity or disasters.

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- 6) On-Call Physicians
Guidelines shall address response time for on-call physicians.

- b) Professional Staff: Nurse Practitioner, Clinical Nurse Specialist and Physician Assistant
This subsection (b) pertains to nurse practitioners, clinical nurse specialists, and PAs working within their scope of practice, and credentialed as defined by the hospital.
 - 1) Qualifications
 - A) Nurse practitioners shall:
 - i) Successfully Complete a Nurse Practitioner Program with a Focus on the Pediatric Patient. The following are programs that qualify as focused on pediatric patients: acute care pediatric nurse practitioner program, primary care pediatric nurse practitioner program, pediatric critical care nurse practitioner program, emergency nurse practitioner program, or family practice nurse practitioner program; or
 - ii) Alternate Criteria: The nurse practitioner worked in the emergency department prior to January 1, 2018 and has completed at least 2000 hours of hospital-based emergency department experience or acute care experience as a nurse practitioner over the last 24-month period that includes the care of pediatric patients. This must be certified in writing by the hospitals at which the hours were completed.
 - iii) Current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the nurse practitioner shall have an unencumbered license in the state in which he or she practices.
 - iv) Credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric

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emergency patient, as defined by the hospital credentialing process.

- B) Clinical nurse specialists shall:
 - i) Complete a clinical nurse specialist program that includes pediatrics;
 - ii) Maintain pediatric clinical nurse specialist certification through a nationally recognized organization (American Association of Critical Care Nurses (AACN), American Nurses Credentialing Center (ANCC), or an equivalent national organization);
 - iii) Hold a current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the clinical nurse specialist shall have an unencumbered license in the state in which he or she practices; and
 - iv) Provide credentialing that reflects orientation, ongoing training, and specific competencies in the care of the pediatric emergency patient, as defined by the hospital credentialing process.
 - C) Physician Assistants shall:
 - i) Hold a current Illinois Physician Assistant License. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices.
 - ii) Provide credentialing that reflects orientation, ongoing training and specific competencies in the care of the pediatric emergency patient as defined by the hospital credentialing process.
- 2) Continuing Education

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- A) All full- and part-time nurse practitioners, clinical nurse specialists, and PAs caring for children in the emergency department shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the Emergency Nurses Association (ENA) Emergency Nursing Pediatric Course (ENPC). PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.
 - B) All full- and part-time nurse practitioners, clinical nurse specialists, and PAs caring for children in the emergency department and fast track/urgent care area shall have documentation of a minimum of 16 hours of continuing education in pediatric emergency topics every two years that are approved by an accrediting agency.
- c) Professional Staff: Nursing
- 1) Qualifications
At least one RN on duty each shift who is responsible for the direct care of the child in the emergency department shall successfully complete and maintain current recognition in one of the following courses in pediatric emergency care:
 - A) AHA-AAP PALS;
 - B) ACEP-AAP APLS; or
 - C) ENA ENPC.
 - 2) Continuing Education
At least one RN on duty on each shift who is responsible for the direct care of the child in the emergency department shall have documentation of a minimum of eight hours of pediatric emergency or critical care continuing education every two years. Continuing education may include, but is not limited to, PALS, APLS or ENPC; CEU offerings; case presentations; competency testing; teaching courses related to pediatrics; and publications. The continuing education hours may be integrated with other existing continuing education requirements, provided that the

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content is pediatric specific. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

- d) Policies and Procedures
 - 1) Inter-facility Transfer
 - A) The hospital shall have current written transfer agreements that cover pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.
 - B) The hospital shall have written pediatric inter-facility transfer guidelines, policies, or procedures concerning transfer of critically ill and injured patients, which include a defined process for initiation of transfer, including the roles and responsibilities of the referring hospital and referral center; a process for selecting the appropriate care facility; a process for selecting the appropriately staffed transport service to match the patient's acuity level; a 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 hospital information to family. Incorporating the components of Appendix M into the emergency department transfer policy/procedure will meet this requirement.
 - 2) Suspected Child Abuse and Neglect

The hospital shall have policies/procedures addressing child abuse and neglect. These policies/procedures shall include, but not be limited to: the identification (including screening), evaluation, treatment and referral to DCFS of victims of suspected child abuse and neglect in accordance with State law.
 - 3) Emergency Department Treatment Guidelines

The hospital shall have emergency department pediatric specific treatment guidelines, order sets or policies and procedures addressing initial

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assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).

- 4) Latex-Allergy Policy
The hospital shall have a policy addressing the assessment of latex allergies and the availability of latex-free equipment and supplies.
 - 5) Disaster Preparedness
The hospital shall integrate pediatric components into its Disaster Plan or Emergency Operations Plan.
- e) Quality Improvement
- 1) Multidisciplinary Quality Activities Policy
 - A) Pediatric emergency medical care shall be included in the SEDP's emergency department or section QI program and reported to the hospital Quality Committee.
 - B) Multidisciplinary quality improvement processes/ activities shall be established (e.g., committee).
 - C) Quality monitors shall be documented that address pediatric care within the emergency department, with identified clinical indicators, monitor tools, defined outcomes for care, feedback loop processes and target timeframes for closure of issues. These activities shall include children from birth up to and including 15 years of age and shall consist of, but are not limited to, all emergency department:
 - i) Pediatric deaths;
 - ii) Pediatric inter-facility transfers;
 - iii) Child abuse and neglect cases;
 - iv) Critically ill or injured children in need of stabilization (e.g., respiratory failure, sepsis, shock, altered level of consciousness, cardio/pulmonary failure; and

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- v) Pediatric quality and safety priorities of the institution.
- D) *All information contained in or relating to any medical audit/quality improvement monitor performed of a PCCC's, EDAP's or SEDP's pediatric services pursuant to this Section shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure.* (Section 3.110(a) of the Act)
- 2) **Pediatric Physician Champion**
The emergency department medical director shall appoint a physician to champion pediatric quality improvement activities. The pediatric physician champion shall work with and provide support to the pediatric quality coordinator.
- 3) **Pediatric Quality Coordinator**
A member of the professional staff who has ongoing involvement in the care of pediatric patients shall be designated to serve in the role of the pediatric quality coordinator. The pediatric quality coordinator shall have a job description that includes the allocation of appropriate time and resources by the hospital. This individual may be employed in an area other than the emergency department provided he or she has a minimum of 3600 hours of pediatric critical care experience or emergency department experience. Working with the pediatric physician champion, the responsibilities of the pediatric quality coordinator shall include:
 - A) Working in conjunction with the ED nurse manager and ED medical director to ensure compliance with and documentation of the pediatric continuing education of all emergency department professional staff in accordance with subsections (a), (b) and (c).
 - B) Coordinating data collection for identified clinical indicators and outcomes (see subsection (e)(1)(C)).
 - C) Reviewing selected pediatric cases transported to the hospital by pre-hospital providers and providing feedback to the EMS Coordinator/System.

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- D) Participating in regional QI activities, including preparing a written QI report and attending the Regional QI subcommittee meetings. These activities shall be supported by the hospital. One representative from the Regional QI subcommittee shall report to the EMS Regional Advisory Board.
- E) Providing QI information to the Department upon request. (See Section 3.110(a) of the Act.)
- f) Equipment, Trays, and Supplies
See Appendix L.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

Section 515.4020 Facility Recognition Criteria for the Pediatric Critical Care Center (PCCC)
EMERGENCY

Any facility seeking PCCC level recognition shall meet requirements for both the EDAP and PCCC levels.

- a) Facility Requirements
A facility recognized as a PCCC Center shall provide the following:
 - 1) An EDAP-recognized emergency department;
 - 2) A distinct Pediatric Intensive Care Unit (PICU);
 - 3) A PICU Committee established as a standing (interdisciplinary) committee within the hospital with membership that includes, at a minimum, one physician, one RN, one respiratory therapist, and other specialties as determined by the hospital;
 - 4) Helicopter landing capabilities approved by State and federal authorities;
 - 5) Computerized axial tomography (CAT) scan availability 24 hours a day;
 - 6) Laboratory 24 hours a day in-house, providing:

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- A) Standard analysis of blood, urine and body fluids;
 - B) Blood typing and cross-matching;
 - C) Coagulation studies;
 - D) Comprehensive blood bank or an agreement with a community central blood bank;
 - E) Blood gases and pH determinations;
 - F) Microbiology, including the ability to initiate aerobic and anaerobic cultures on site; and
 - G) Drug and alcohol screening;
- 7) Hemodialysis capabilities or a transfer agreement;
 - 8) Staff, including a child life specialist, occupational therapy, speech therapy, physical therapy, social work, dietary, psychiatry and child protective services;
 - 9) Hospital support staff to act as a resource and participate in multidisciplinary regional pediatric critical care education;
 - 10) A plan for implementing a program of public information/education concerning emergency care services for pediatrics; and
 - 11) Support for active institutional and collaborative regional research.
- b) PICU Medical Director Requirements
A Medical Director shall be appointed, and a record of appointment and acceptance shall be in writing.
 - 1) Qualifications
The PICU shall have a dedicated Medical Director who is:

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- A) Board certified in Pediatrics by the ABP or the AOBP, and Board certified or in the process of certification in Pediatric Critical Care Medicine by ABP, or Pediatric Intensive Care by AOBP;
 - B) Board certified in Pediatrics by the ABP or the AOBP, and Board certified in a pediatric subspecialty with at least 50% practice in pediatric critical care. In this situation, a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director;
 - C) Board certified in Anesthesiology by the American Board of Anesthesiology (ABA), or the American Osteopathic Board of Anesthesiology (AOBA), with practice limited to infants and children and with a subspecialty certification in Critical Care Medicine. In this situation, a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director; or
 - D) Board certified in Pediatric Surgery by the American Board of Surgery (ABS) with a subspecialty certification in Surgical Critical Care Medicine by the ABS. In this situation (ABS), a physician who meets the criteria in subsection (b)(1)(A) shall be appointed as Co-director.
- 2) The Medical Director or Co-Director shall achieve certification within seven years after his/her initial acceptance into the certification process for pediatric critical care or intensive care medicine, and shall maintain certification.
- c) PICU Medical Staff Requirements
- 1) Qualifications
 - A) The PICU shall have 24-hour in-hospital coverage provided by a board certified pediatric intensivist, certified by ABP or AOBP, or board eligible pediatric intensivist in the process of certification by ABP or AOBP, who is responsible for the supervision of the physicians listed in subsections (c)(1)(A)(i) and (ii), and who is available within 30 minutes in-house after the determination is made that he or she is needed. If the intensivist is not in-house, then one of the following shall be available in-house:

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- i) Board certified pediatrician certified by ABP or AOBP, or board eligible in pediatrics and in the process of board certification; or
 - ii) A resident of PGY-2 or greater under the auspices of a Pediatric Training Program, in the unit, with a PGY-3 in-house.
 - B) All physicians listed in subsection (c)(1)(A) shall successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.
- 2) Physician Specialist Availability
- If the applying hospital is a Pediatric Trauma Center, the applicable requirements for physician response times that meet Sections 515.2035 and 515.2045 shall be followed.
- A) Attending level physician specialists shall be on staff and are required to have the following:
 - i) Pediatric proficiency as defined by the hospital credentialing process;
 - ii) Board/sub-board certification in their specialty. If residency trained/board prepared in their specialty, physicians shall achieve certification within seven years after initial acceptance into the board/sub-board certification process, and maintain certification; and
 - iii) 10 hours per year of pediatric CME (category I or II) in his/her specialty.
 - B) The following on-call surgeons with pediatric proficiency shall be available in-house within 60 minutes after the determination is made that they are needed:
 - i) Surgeon; and

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- ii) Neurosurgeon, or transfer agreement with another facility.
- C) On-call attending anesthesiologists with pediatric proficiency shall be available in-house within 60 minutes after the determination is made that they are needed. CRNAs with pediatric proficiency may initiate appropriate procedures as identified in hospital by-laws.
- D) On-staff subspecialists with the following pediatric proficiency shall be available to the institution or by phone for consultation within 60 minutes after the determination is made that they are needed:
 - i) Cardiologist;
 - ii) Neonatologist;
 - iii) Nephrologist;
 - iv) Neurologist;
 - v) Orthopedic surgeon;
 - vi) Otolaryngologist; and
 - vii) Radiologist.
- E) The following physician specialists shall be available in the hospital or by consultation or transfer agreement with another hospital:
 - i) Allergist or immunologist;
 - ii) Cardiothoracic surgeon;
 - iii) Craniofacial (plastic) surgeon;
 - iv) Endocrinologist;

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- v) Gastroenterologist;
 - vi) Hand surgeon;
 - vii) Hematologist-oncologist;
 - viii) Infectious disease;
 - ix) Micro-vascular surgeon;
 - x) Obstetrics/gynecology;
 - xi) Ophthalmologist;
 - xii) Oral surgeon;
 - xiii) Physiatrist (physical medicine & rehabilitation);
 - xiv) Psychiatrist/psychologist;
 - xv) Pulmonologist; and
 - xvi) Urologist.
- d) PICU Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant Qualifications
- 1) Nurse practitioners shall:
 - A) Successfully complete a Pediatric Nurse Practitioner program or Pediatric Critical Care Nurse Practitioner Program and certification as an acute care pediatric nurse practitioner.
 - B) Hold a current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the nurse practitioner shall have an unencumbered license in the state in which he or she practices.

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- C) Provide credentialing that reflects orientation, ongoing training, and specific demonstrated competencies in the care of the critically ill and injured pediatric patient, as defined by the hospital credentialing process.
- 2) Clinical nurse specialists shall:
- A) Successfully complete a clinical nurse specialist program that includes pediatrics.
 - B) Maintain pediatric clinical nurse specialist certification through a nationally recognized organization (AACN, ANCC or an equivalent national organization).
 - C) Hold a current Illinois APRN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the clinical nurse specialist shall have an unencumbered license in the state in which he or she practices.
 - D) Provide credentialing that reflects orientation, ongoing training, and specific demonstrated competencies in the care of the critically ill and injured pediatric patient, as defined by the hospital credentialing process.
- 3) PA shall:
- A) Hold a current Illinois Physician Assistant License. For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the professional shall have an unencumbered license in the state in which he or she practices.
 - B) Provide credentialing that reflects orientation, ongoing training and specific demonstrated competencies in the care of the critically ill and injured pediatric patient as defined by the hospital credentialing process.
- 4) All full- and part-time nurse practitioners, clinical nurse specialists, and PAs shall successfully complete and maintain current recognition in one of

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the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.

- 5) All full- and part-time nurse practitioners, clinical nurse specialists, and PAs shall have documentation of a minimum of 50 hours of continuing education in pediatric topics every two years that included a minimum of 25 hours in pediatric critical care, and that are approved by an accrediting agency.
- e) PICU Nursing Staff Requirements
- 1) Nurse manager. The PICU shall have a designated nurse manager who shall:
 - A) Be licensed as an RN;
 - B) Have the equivalent of three years full-time clinical critical care experience, with a minimum of one year in clinical pediatric care; and
 - C) Successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.
 - 2) Pediatric Clinical Nurse Expert. The PICU shall have a designated pediatric clinical nurse expert who is a member of the unit leadership and who facilitates the development, provision and conduction of clinical education, quality improvement, and policy development aimed at promoting pediatric evidence-based best practices. This nurse shall:
 - A) Successfully complete:
 - i) An acute Care or Primary Care Pediatric Nurse Practitioner Program and hold certification as an acute care or primary care pediatric nurse practitioner;
 - ii) A Pediatric Clinical Nurse Specialist Program and hold certification as a pediatric clinical nurse specialist; or

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- iii) A masters or doctorate and hold certification as a certified pediatric nurse (CPN), certified critical care registered nurse in pediatrics (CCRN-P), or certified critical care registered nurse in pediatrics – knowledge professional (CCRN-K).

 - B) Hold a current Illinois RN license. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the RN shall have an unencumbered license in the state in which he or she practices;

 - C) Successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS or ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation; and

 - D) Provide documentation of a minimum of 50 hours of continuing education in pediatric topics every two years that include a minimum of 25 hours in pediatric critical care and that are approved by an accrediting agency.
- 3) Nursing Patient Care Services
All RNs engaged in direct patient care activities shall:
- A) Successfully complete a documented hospital and unit orientation according to hospital guidelines before assuming full responsibility for patient care;

 - B) Complete a yearly competency review of high-risk, low-frequency therapies;

 - C) Successfully complete and maintain current recognition in one of the following courses: the AHA-AAP PALS, the ACEP-AAP APLS or the ENA ENPC. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation; and

 - D) Complete a minimum of 16 hours of pediatric emergency/critical care continuing education hours every two years. Continuing

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education may include, but is not limited to, CEU offerings, case presentations, competency testing, teaching courses related to pediatrics or publications.

- f) PICU Policies, Procedures, and Treatment Protocols
The PICU will include, but not be limited to, having the following age-specific policies/protocols in place:
- 1) Admission and discharge criteria;
 - 2) A staffing policy that addresses nursing shift staffing patterns based on patient acuity;
 - 3) A policy for managing the psychiatric needs of the PICU patient; and
 - 4) Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses.
- g) Inter-facility Transfer/Transport Requirements
A PCCC shall:
- 1) Provide necessary consultation to those hospitals with which a transfer agreement is established; accept pediatric transfers from those hospitals; provide feedback as well as quality review to those hospitals on the transfer and management process;
 - 2) Have or be affiliated with a transport system and team to assist referral hospitals in arranging safe pediatric patient transport; and
 - 3) Have a transfer/transport policy that addresses the special needs of the pediatric population during transport.
- h) Quality Improvement Requirements
- 1) Each PCCC shall have members from the PICU, including the Medical Director, and from the Pediatric Department who serve on the Multidisciplinary Pediatric Quality Improvement Committee, which will include, but not be limited to: emergency department, pediatric department, respiratory, laboratory, social service and radiology staff.

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- 2) The Multidisciplinary Pediatric Quality Improvement Committee shall perform focused outcome analyses of its PICU and other pediatric inpatient unit services on a quarterly basis that consist of a review of at least the following:
 - A) All pediatric deaths;
 - B) All pediatric inter-facility transfers;
 - C) All pediatric morbidities or negative outcomes that are a result of treatment rendered or omitted;
 - D) Pediatric quality metrics that examine the process of care and identify potential patient care and internal resource problems;
 - E) Child abuse and neglect cases unless review is performed by another committee in the hospital;
 - F) All re-admissions within 48 hours after discharge from the emergency department or inpatient care that result in admission to the PICU; and
 - G) Review of all potential and unanticipated adverse outcomes.
- i) PICU Equipment (See Appendix O)

The PCCC shall meet all equipment requirements as outlined in Appendix O. In addition, a specialized pediatric resuscitation cart with measuring device shall be readily available on each pediatric unit, containing the required equipment.
- j) Pediatric Inpatient Care Service Requirements
 - 1) Physician Requirements
 - A) The Chair of Pediatrics or the Pediatric Inpatient Director shall have certification in pediatrics by the ABP or the AOBP.
 - B) All hospitalists, credentialed by their hospital to provide pediatric unit care, shall successfully complete and maintain current

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recognition in one of the following courses: the AHA-AAP PALS or the ACEP-AAP APLS. PALS and APLS shall include both cognitive and practical skills evaluation.

- C) The Medical Director of the PICU, or his/her designee, shall be available on call and for consultation for all pediatric in-house patients who may require critical care.

2) Nurse Manager Requirements

The nurse manager shall:

- A) Be licensed as an RN. For out-of-state facilities that have Illinois recognition under the EMS, trauma, or pediatric program, the RN shall have an unencumbered license in the state in which he or she practices;
- B) Have the equivalent of three years full-time pediatric experience; and
- C) Complete and maintain current recognition in one of the following courses: AHA-AAP PALS, the ACEP-AAP APLS or the ENA ENPC. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation.

3) Nursing Patient Care Services

All nurses engaged in direct patient care activities shall:

- A) Be licensed as an RN. For out-of-state facilities with Illinois recognition under the EMS, trauma, or pediatric program, the RN shall have an unencumbered license in the state in which he or she practices;
- B) Complete a documented hospital and unit orientation according to hospital guidelines before assuming full responsibility for patient care;
- C) Complete a yearly competency review of high-risk, low-frequency therapies based on patient population;

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- D) Complete and maintain current recognition in one of the following courses: AHA-AAP PALS, the ACEP-AAP APLS or the ENA ENPC. PALS, APLS and ENPC shall include both cognitive and practical skills evaluation; and
 - E) Complete a minimum of 16 hours of pediatric continuing education hours every two years. Continuing education may include, but is not limited to, CEU offerings, case presentations, competency testing, teaching courses related to pediatrics, or publications.
- k) Hospital General Pediatric Department Policies, Procedures and Treatment Protocols. The pediatric department shall have, but not be limited to:
- 1) A policy or scope of services that outlines the pediatric department services, ages of patients served, and admission guidelines;
 - 2) A staffing policy that addresses nursing shift staffing patterns based on patient acuity;
 - 3) A safety and security policy for the patient in the unit;
 - 4) An inter-facility transport policy that addresses safety and acuity;
 - 5) An intra-facility transport policy that addresses safety and acuity;
 - 6) A latex allergy policy;
 - 7) A pediatric organ procurement/donation policy;
 - 8) An isolation precautions policy that incorporates appropriate infection control measures;
 - 9) A disaster policy that addresses the specific medical and psychosocial needs of the pediatric population;
 - 10) Protocols, order sets, pathways or guidelines for management of high-risk and low-frequency diagnoses;

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- 11) A pediatric policy that addresses the resources available to meet the psychosocial needs of patients and family and appropriate social work referral for the following indicators:
 - A) Child death;
 - B) Child has been a victim of or witness to violence;
 - C) Family needs assistance in obtaining resources to take the child home;
 - D) Family needs a payment resource for their child's health needs;
 - E) Family needs to be linked back to their primary health, social service or educational system;
 - F) Family needs support services to adjust to their child's health condition or the increased demands related to changes in their child's health conditions; and
 - G) Family needs additional education related to the child's care needs to care for the child at home.

- 12) A discharge planning policy or protocol that includes the following:
 - A) Documentation of appropriate primary care/specialty follow-up provisions;
 - B) Mechanism to access a primary care resource for children who do not have a provider;
 - C) Discharge summary provision to appropriate medical care provider, parent/guardian, which includes the following:
 - i) Information on the child's hospital course;
 - ii) Discharge instructions and education; and
 - iii) Follow-up arrangements;

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- D) Appropriate referral of patients to rehabilitation or specialty services for children who may have any of the following problems:
 - i) Require the assistance of medical technology;
 - ii) Do not exhibit age-appropriate activity in cognitive, communication or motor skills, behavioral, or social/emotional realms;
 - iii) Additional medical or rehabilitation needs that may require specialized care, such as medication, hospice care, physical therapy, home health, or speech/language services;
 - iv) Brain injury – mild, moderate or severe;
 - v) Spinal cord injury;
 - vi) Seizure behavior exhibited during acute care or a history of seizure disorder and is not currently linked with specialty follow up;
 - vii) Submersion injury, such as a near drowning;
 - viii) Burn (other than a superficial burn);
 - ix) Pre-existing condition that experiences a change in health or functional status;
 - x) Neurological, musculoskeletal or developmental disability; or
 - xi) Sudden onset of behavioral change, for example, in cognition, language or affect.

- 1) Quality Improvement Requirements
Representatives from the pediatric unit shall participate in the multidisciplinary Pediatric Quality Improvement Committee (see subsection (h)).

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- m) Equipment Requirements (See Appendix O)
The PCCC shall meet all equipment requirements as outlined in Appendix O. In addition, a specialized pediatric resuscitation cart with measuring device shall be readily available on each pediatric unit, containing the required equipment.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

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**Section 515.APPENDIX K Application for Facility Recognition for Emergency
Department with Pediatrics Capabilities**
EMERGENCY

FACILITY RECOGNITION
Emergency Department with Pediatric Capabilities

Application Instructions

Follow these instructions to initiate the process to obtain recognition as an Emergency Department Approved for Pediatrics (EDAP) or Standby Emergency Department for Pediatrics (SEDP):

- 1) Complete the application form and obtain the appropriate signatures.
- 2) Using the Emergency Department Pediatric Plan Guideline and the EDAP or SEDP requirements, complete an Emergency Department Pediatric Plan. Attach all requested supporting documentation (credentialing forms, schedules, policies, procedures, protocols, guidelines, plans, etc.).
- 3) Submit the original signed application form plus three additional copies of the signed application form and four copies of the Emergency Department Pediatric Plan (including supporting documentation) to:

Chief, Division of EMS & Highway Safety
Illinois Department of Public Health
422 S. 5th Street
Springfield IL 62701

- 4) The Emergency Department Pediatric Plan shall follow the format outlined in the Emergency Department Pediatric Plan Guideline in this Appendix K and include all required documentation. The plan shall also address how each of the EDAP/SEDP requirements is currently being or will be met. The Pediatric Plan shall be developed through interaction and collaboration with all other appropriate disciplines.
- 5) Any submitted requests for equipment waivers shall include the criteria by which compliance is considered to be a hardship and demonstrate that there will be no reduction in the provision of medical care.

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- 6) The application should be submitted in a single-sided format and unstapled.
- 7) Appendix M provides additional resource information related to pediatric inter-facility transfer and consultation and can be used in the development of the Emergency Department Pediatrics Plan.
- 8) For questions regarding the application process, specific requirements, or supporting documentation, please contact the Division of EMS & Highway Safety at 217-785-2080.

RECOGNITION OF EMERGENCY DEPARTMENT
PEDIATRIC CAPABILITIES
APPLICATION FORM

- 1) Name and address of hospital (typed)

- 2) Specify the recognition level for which your hospital is applying:

- a) Emergency Department Approved for Pediatrics (EDAP) _____
- b) Standby Emergency Department Approved for Pediatrics (SEDP) _____

- 3) The above-named hospital certifies that each requirement in this Request for Recognition is met and will be in operation by the date of recognition.

Typed name – CEO/Administrator

Signature – CEO/Administrator

Date

Typed name – Medical Director of Emergency Services

Signature – Medical Director of Emergency Services

Date

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Contact person – Typed name, credentials and title

Contact person – Phone number, fax number and email

EMERGENCY DEPARTMENT PEDIATRIC PLAN
GUIDELINE

Emergency Department Pediatric Plan (Please follow this guideline carefully. It provides information on the components that must be included in the submitted plan. Please include any applicable supplemental documentation.)

A. Emergency Department Organizational Structure

1. Provide a hospital Organizational Table identifying the administrative relationships among all departments in the hospital, especially as they relate to the emergency department. The table must include, but is not limited to, the following:
 - a. Board of Directors
 - b. Chief Executive Officers
 - c. Emergency Department
 - d. Department of Pediatrics
 - e. Trauma Service (if applicable)
 - f. Department of Radiology
2. In addition, provide a separate Emergency Department Organizational Structure table showing the organization structure of the emergency department, including the relationship of the physician, nursing and ancillary services. Include the reporting structure for the ED Medical Director (to whom he/she reports).

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B. Emergency Department Services

1. Description of the emergency department services

- Provide a scope of services or policy outlining emergency department services, emergency department level, a description of the population served, types of pediatric patients seen, and annual emergency department visits that involve the pediatric patient.
- Identify the age range that the hospital uses to define the pediatric patient, i.e., 0-15.
- Provide information on participation/status in EMS system and trauma system as appropriate.

2. Description of the emergency department patient flow

- Provide a narrative description or algorithm of patient path/flow from point of entry through disposition.
- Provide any policies/guidelines that identify triaging/urgency categorization of patients.
- Identify whether pediatric patients are seen in the general emergency department or in a separate area/bed space allocated for the pediatric patient.
- If an emergency department fast-track area exists, provide triage criteria for this area and information on physician and nursing staffing/qualifications for assignment to the fast-track area.

3. Description of emergency medical services communication with identification of dedicated phone line, radio, and telemetry capabilities

- Provide a policy or narrative description of the emergency services dedicated phone/telemetry radio communication capabilities.
- Provide a policy outlining staffing qualifications to access and use such equipment.

4. Description of social service availability and capabilities

- Provide a scope of services or policy that defines the services, capabilities and availability of social service department/personnel to the emergency department.

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- Describe typical mechanism and response by social worker to emergency department requests (i.e., handle over the phone, respond directly to the emergency department, follow-up consult/appointment made).

C. Pediatric Department Services

1. Description of the pediatric department services

- Identify whether there is a dedicated pediatric inpatient unit, dedicated pediatric inpatient beds and pediatric intensive care unit.
- Provide a scope of services/policy outlining pediatric department services.

2. Description of the pediatric staffing and availability

- Provide policy or scope of services outlining pediatric unit shift nursing staffing patterns based on patient acuity and any pediatric continuing education requirements/competencies verification.
- If pediatric patients are admitted for care to an adult inpatient unit, provide documentation that identifies unit pediatrician staffing/coverage for such patients and how RNs are assigned to the inpatient pediatric patient, i.e., only RNs who have completed the PALS course.

3. Documented description of pediatric inpatient capabilities with identification of PICU and/or pediatric general floor bed availability and unit resources

- Provide policy or scope of services that identifies what types of pediatric patients are typically admitted, i.e., types of conditions/diagnoses. Are there guidelines in place that define pediatric patients specifically by age parameters or diagnoses?
- If a PICU is present, then a description of services, unit resources, and capabilities is needed. If a PICU is not present, then a description of where patients requiring such care are transferred, established relationships with pediatric tertiary care center, etc., is needed.

D. Professional Staff

1. Emergency Department Director

- a. Copy of curriculum vitae

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- Provide a printed curriculum vitae.
 - Identify any board certification as outlined in the Facility Recognition Criteria (Sections 515.4000 and 515.4010).
- b. Document Board Certification, as identified in the Facility Recognition Criteria, on the Emergency Department Credentialing Form.
2. Emergency Department Physicians
Documentation of the ability to meet recognition requirements in Section 515.4000 or Section 515.4010.

Hospital Recognition Requirement – Section 515.4000(a)(1) or 515.4010(a)(1)

- Provide a policy or description of emergency department physician staffing, coverage and availability (including fast track/urgent care area).
- Provide a completed Department approved credentialing form for emergency department physician staff and a credentialing form for fast track/urgent care physicians.
- Provide a one-month staffing schedule/calendar, including fast track/urgent care area (schedule should be from within the three month time period previous to the application submission).
- Provide documentation of a plan to maintain PALS or APLS recognition.
- Provide a policy that incorporates Section 515.4000(a)(1) or 515.4010(a)(1).

Hospital Recognition Requirement – Section 515.4000(a)(2) or 515.4010(a)(2)

- Provide a copy of the emergency department physician continuing education policy.
- Provide a description of how physician continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours (these hours can be integrated into the overall CME tracking process).
- Provide a policy that incorporates Section 515.4000(a)(2) or 515.4010(a)(2).

Hospital Recognition Requirement – Section 515.4000(a)(3) or 515.4010(a)(3)

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- Provide a staffing policy that incorporates Section 515.4000(a)(3) or 515.4010(a)(3).

Hospital Recognition Requirement – Section 515.4000(a)(4) or 515.4010(a)(4)

- Provide a one-month on-call schedule that identifies availability of a board certified/prepared pediatrician or pediatric emergency medicine physician for telephone consultation (schedule should be from within the three month time period previous to the application submission).

Hospital Recognition Requirement – Section 515.4000(a)(5) or 515.4010(a)(5)

- Provide a copy of a policy that identifies physician back-up availability to assist with critical situations, increased surge capacity or disasters.

Hospital Recognition Requirement – Section 515.4000(a)(6) or 515.4010(a)(6)

- Provide a protocol/policy/bylaws that identifies maximum response time for all specialty on-call physicians.

3. Emergency department nurse practitioner, clinical nurse specialist, and PA
Note – Complete this section only if nurse practitioners, clinical nurse specialists, or PAs practice in the emergency department and participate in the care of pediatric patients.

Provide documentation of the ability to meet hospital recognition requirements in Section 515.4000(b) or 515.4010(b).

Requirement – Section 515.4000(b)(1) or 515.4010(b)(1)

- Provide a policy of emergency department nurse practitioner, clinical nurse specialist, and PA staffing, coverage, availability, responsibilities and credentialing process.
- Provide a completed Department approved credentialing form for all emergency department fast track nurse practitioner, clinical nurse specialist, and PA staff.
- Provide a copy of a one-month staffing schedule/calendar (schedule should be from within the three month time period previous to the

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- application submission).
- Provide documentation of a plan to maintain PALS, APLS or ENPC recognition.
- Provide a policy that incorporates Section 515.4000(b)(1) or 515.4010(b)(1).

Requirement – Section 515.4000(b)(2) or 515.4010(b)(2)

- Provide a copy of the emergency department and fast track nurse practitioner, clinical nurse specialist, and PA continuing education policy.
- Provide a description of how nurse practitioner, clinical nurse specialist, and PA continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours (these hours can be integrated into overall continuing education tracking process).
- Provide a policy that incorporates Section 515.4000(b)(2) or 515.4010(b)(2).

4. Emergency Department Registered Nurses
Provide documentation of the ability to meet hospital recognition requirements in Section 515.4000(c) or 515.4010(c).

Requirement – Section 515.4000(c)(1) or 515.4010(c)(1)

- Provide a policy/documentation outlining current nursing shift staffing plan/patterns.
- Provide a Department approved credentialing form for all emergency department nursing staff.
- Provide a copy of a one-month nursing staffing schedule/calendar (schedule should be from within the three month time period previous to the application submission).
- Provide documentation of a plan to maintain PALS, APLS or ENPC recognition.
- Provide a policy that incorporates Section 515.4000(c)(1) or 515.4010(c)(1).

Requirement – Section 515.4000(c)(2) or 515.4010(c)(2)

- Provide a policy identifying continuing education requirements and

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- competency testing for emergency department nursing staff.
- Provide a description of how continuing education is currently tracked.
- Provide documentation of an implementation plan for attaining and tracking of pediatric specific continuing education hours.
- Provide a policy that incorporates Section 515.4000(c)(2) or 515.4010(c)(2).

E. Policies and Procedures

1. Policy/procedure for inter-facility transfer as identified in Section 515.4000(d)(1) or 515.4010(d)(1).
 - Provide a written transfer agreement with a Pediatric Critical Care Center and identification of facilities to which the hospital typically transfers pediatric patients. The transfer agreements shall include a provision that addresses communication and quality improvement measures between the referral and receiving hospitals, as related to patient stabilization, treatment prior to and subsequent to transfer, and patient outcome.
 - Provide a transfer policy that incorporates the physiologic/other criteria identified in Appendix M: EMSC Inter-facility Pediatric Trauma and Critical Care Consultation and/or Transfer Guideline.
2. Policy/procedure for suspected child abuse and neglect as identified in Section 515.4000(d)(2) or 515.4010(d)(2).
 - Provide a policy that includes age-specific identification, assessment, evaluation and management measures for the suspected child abuse and neglect patient.
3. Pediatric treatment guidelines as identified in Section 515.4000(d)(3) or 515.4010(d)(3).
 - Provide copies of pediatric specific treatment guidelines as described.
 - The hospital shall have emergency department pediatric specific treatment guidelines, order sets or policies and procedures addressing initial assessment and management for its high-volume and high-risk pediatric population (i.e., fever, trauma, respiratory distress, seizures).
4. Policy for latex allergy as identified in Section 515.4000(d)(4) or 515.4010(d)(4).

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- Provide a policy that addresses assessment of latex allergies and the availability of latex-free equipment and supplies.

F. Quality Improvement

1. Describe and document the ongoing emergency department program for conducting outcome analysis or quality improvement and how pediatrics is integrated into the process.

- Provide a policy/guideline that outlines the emergency department quality improvement program, i.e., describe the quality improvement process, required clinical indicators, "loop closure" and target time frames for closure of issues.
- Provide documentation outlining current and planned pediatric monitoring activities.

2. Document the ability to meet facility recognition requirements in Section 515.4000(e) or 515.4010(e).

Requirement – Section 515.4000(e)(1) or 515.4010(e)(1)

- Define the composition of the multidisciplinary QI committee (recommend broadening composition of committee beyond physician/nursing to include other essential disciplines such as pediatric, social services, respiratory therapy), frequency of committee meetings and reporting structure.
- Provide a copy of the emergency department quality improvement plan, including QI policy, pediatric indicators, feedback loop and target time frames for closure of issues. If implementation of pediatric monitoring activities is pending, define implementation plan and time frame.

Requirement – Section 515.4000(e)(2) or 515.4010(e)(2)

- Provide a curriculum vitae for the physician who will assume the pediatric physician champion role.
- Provide the name and title of the individual who will assume the pediatric quality coordinator role.
- Provide a job description that addresses allocation of time and resources to

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the role and includes each of the requirements outlined in Section 515.4000(e)(2) or 515.4010(e)(2) that will be carried out by the pediatric quality coordinator.

- G. Equipment
- Using the equipment list provided in Appendix L, place an "X" next to each equipment item that is currently available (as appropriate for the level applied for). If equipment/supply items are not available, a plan for securing the items shall be identified, i.e., submission of a purchase order to assure that the item is on order, or equipment waiver shall be submitted for each item.

Requests for equipment waivers shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

Site Survey Procedure

- 1) Within four to six weeks following receipt of the Application Form and supporting documents (schedules, policies, procedures, protocols, guidelines, etc.), the hospital will be informed as to the status of the application. If all documentation is in order, a site visit will be scheduled.
- 2) The site visit will include a survey of the emergency department and pediatric unit (including intensive care, if applicable), and a meeting with the following individuals:
 - a) The hospital's chief administrative/executive officer or designee
 - b) The chief nursing executive/director of nursing or designee
 - c) The chief of pediatrics or, if the hospital does not have a pediatric department, the designated pediatric consultant
 - d) The nursing director or nursing manager of the pediatric unit, if applicable
 - e) The emergency department medical director or pediatric emergency department medical director
 - f) The emergency department nursing director or nursing manager

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- g) The administrator of emergency services
 - h) The administrator of pediatric services, if applicable
 - i) The pediatric quality coordinator
 - j) The hospital quality improvement director or designee
 - k) The hospital emergency management/disaster preparedness coordinator
 - l) Nurse practitioner, clinical nurse specialist, or PA, for those hospitals that use these clinicians in their emergency department
 - m) For EMS Resource or Associate Hospitals only: the EMS Medical Director and EMS Coordinator
- 3) In preparation for the site visit, hospital personnel shall prepare evidence to verify adherence to the hospital recognition requirements.

Site Survey Team

The EMSC program within the Division of EMS & Highway Safety will appoint the survey team. Site survey teams will be composed of a physician/nurse (or two nurse) team along with a representative from the Illinois Department of Public Health. All team members shall have attended formal training in the responsibilities, expectations, process and assessment of facility recognition.

Following the Site Survey

- 1) Within four to six weeks following the site visit, the Department will provide the hospital with the results of the survey. Those hospitals meeting all requirements will receive a formal "recognition" for their emergency department pediatric capabilities.
- 2) Hospitals may appeal the results of the survey by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.
- 3) Re-recognition shall occur every four years, with site visits scheduled as necessary.

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(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

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Section 515.APPENDIX L Pediatric Equipment Requirements for Emergency Departments
EMERGENCY

The following list identifies pediatric equipment items that are required for the two emergency department facility recognition levels. Equipment items are classified as "essential" (E) and "need to be stocked in the emergency department" (ED).

	EDAP	SEDP
Monitoring Devices		
Blood glucose measurement device (i.e., chemistry strip or glucometer)	E (ED)	E (ED)
Continuous end-tidal PCO ₂ monitor and pediatric CO ₂ colorimetric detector (disposable units may be substituted)	E (ED)	E (ED)
Doppler ultrasound blood pressure device (neonatal-adult thigh cuffs)	E (ED)	E (ED)
ECG monitor-defibrillator/cardioverter with pediatric and adult sized paddles, or pads, with pediatric dosage settings and pediatric and adult pacing electrodes	E (ED)	E (ED)
Hypothermia thermometer (Note: with a range of 28-42°C)	E (ED)	E (ED)
Pediatric monitor electrodes	E (ED)	E (ED)
Otoscope/ophthalmoscope/stethoscope	E (ED)	E (ED)
Pulse oximeter with pediatric and adult probes	E (ED)	E (ED)
Sphygmomanometer with cuffs (neonatal-adult thigh)	E (ED)	E (ED)
Vascular Access Supplies and Equipment		
Arm boards (sized infant through adult)	E (ED)	E (ED)
Blood gas kits	E (ED)	E (ED)

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Butterfly-type needles (19-25 g)*	E (ED)	E (ED)
Catheter-over-needle devices (16-24 g)*	E (ED)	E (ED)
Central venous catheters (stock one small and one large size)	E (ED)	E (ED)
Infusion pumps, syringe pumps, or devices with microinfusion capability using appropriate tubing & connectors	E (ED)	E (ED)
Intraosseous needles or bone marrow needles (13-18 g size range; stock one large/one small bore) or IO device (pediatric and adult sizes)	E (ED)	E (ED)
IV extension tubing, stopcocks, and T-connectors	E (ED)	E (ED)
IV fluid/blood warmer	E (ED)	E (ED)
IV solutions: standard crystalloid solutions (D10W, D5/.2 NS, D5/.45 NS, D5/.9 NS and 0.9 NS)	E (ED)	E (ED)
Syringes (1 mL through 20 mL)	E (ED)	E (ED)
Tourniquets	E (ED)	E (ED)
Umbilical vein catheters (3.5 and 5 Fr; the same size feeding tube may be used for 5 Fr)*	E (ED)	E (ED)
Respiratory Equipment and Supplies		
Bag-valve-mask device, self-inflating infant/child and adult (1000 ml) with O ₂ reservoir and clear masks (neonatal through large adult sizes)*; PEEP valve	E (ED)	E (ED)
Manometer	E (ED)	E (ED)
Bulb syringe	E (ED)	E (ED)
Endotracheal tubes:*		

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Cuffed or Uncuffed (sizes 2.5, 3.0, 3.5, 4.0, 4.5, 5.0, 5.5, 6.0, 6.5, 7.0, 7.5 and 8.0)	E (ED)	E (ED)
Stylets for endotracheal tubes (pediatric and adult)	E (ED)	E (ED)
Laryngoscope handle (pediatric and adult)	E (ED)	E (ED)
Laryngoscope blades (curved 2, 3; straight or Miller 0, 1, 2, 3)*	E (ED)	E (ED)
Magill forceps (pediatric and adult)	E (ED)	E (ED)
Meconium aspirator	E (ED)	E (ED)
Nasopharyngeal airways (sizes 14, 16, 20, 24, 28, 30 Fr)*	E (ED)	E (ED)
Nebulized medication, administration set with pediatric and adult masks	E (ED)	E (ED)
Oral airways (sizes 0, 1, 2, 3, 4, 5 or size 50 mm, 60 mm, 70 mm, 80 mm, 90 mm, 100 mm)*	E (ED)	E (ED)
Oxygen delivery device with flow meter and tubing	E (ED)	E (ED)
Oxygen delivery adjuncts:		
Tracheostomy collar	E (ED)	E (ED)
Standard masks, clear (pediatric and adult sizes)	E (ED)	E (ED)
Partial-non-rebreather or non-rebreather masks, clear (pediatric and adult sizes)	E (ED)	E (ED)
Nasal cannula (infant, pediatric and adult)	E (ED)	E (ED)
Peak flow meter	E (ED)	E (ED)
Supplies/kit for patients with difficult air way conditions (must have one of the following):	E (ED)	E (ED)
• Supraglottic airway devices (sizes 1, 1.5, 2, 2.5, 3, 4 and 5; or sizes appropriate for a neonate through adult);		
• Cricothyrotomy kit (pediatric size); or		

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- Cricothyrotomy capabilities (i.e., 10 g needle and 3.5 mm ET tube adapter or 14 g needle and 3.0 mm ET tube adapter)

Suction capability (wall)	E (ED)	E (ED)
Suction capability (portable)	E (ED)	E (ED)
Suction catheters (sizes 5/6, 8, 10, 12, 14, 16, 18 Fr and Yankauer-tip catheter)*	E (ED)	E (ED)
Tracheostomy tubes (sizes PED* 3.0, 3.5, 4.0, 4.5, 5.0, 5.5)* (correspond to PT 00, 0, 1, 2, 3, 4, in old schematization)	E (ED)	---
Tube thoracostomy tray and water seal drainage capacity with chest tubes (sizes 12-32 Fr)*	E (ED)	---

Medications (unit dose, prepackaged)

Access to the Illinois Poison Center 1-800-222-1222 through posting of phone number in ED	E (ED)	E (ED)
Activated charcoal (consider with and without Sorbitol)	E (ED)	E (ED)
Adenosine	E (ED)	E (ED)
Amiodarone	E (ED)	E (ED)
Antiemetics	E (ED)	E (ED)
Antimicrobial agents (parenteral and oral)	E (ED)	E (ED)
Antipyretics	E (ED)	E (ED)
Atropine	E (ED)	E (ED)
Barbiturates, e.g., Phenobarbital, Pentobarbital	E (ED)	E (ED)
Benzodiazepines, e.g., Lorazepam, Midazolam, Diazepam	E (ED)	E (ED)

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Beta agonist for inhalation (Albuterol, Levalbuterol)	E (ED)	E (ED)
Beta blockers, e.g., Propranolol, Metoprolol	E (ED)	E (ED)
Calcium (chloride or gluconate)	E (ED)	E (ED)
Corticosteroids, e.g., Dexamethasone, Hydrocortisone, Methylprednisolone	E (ED)	E (ED)
Dextrose (25% and 50%)	E (ED)	E (ED)
Diphenhydramine	E (ED)	E (ED)
Dobutamine	E (ED)	---
Dopamine	E (ED)	---
Epinephrine (1 mg/mL and 0.1mg/mL)	E (ED)	E (ED)
Epinephrine (Racemic)	E (ED)	E (ED)
Fosphenytoin or Phenytoin	E (ED)	E (ED)
Furosemide	E (ED)	E (ED)
Glucagon or Glucose Paste	E (ED)	E (ED)
Insulin, regular	E (ED)	E (ED)
Lidocaine 1%	E (ED)	E (ED)
Magnesium Sulfate	E (ED)	E (ED)
Mannitol	E (ED)	E (ED)
Narcotics	E (ED)	E (ED)

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Neuromuscular blocking agents (i.e., succinylcholine, rocuronium, vecuronium)	E (ED)	E (ED)
Ocular anesthetics	E (ED)	E (ED)
Poison Specific Antidotes		
Acetylcysteine	E (ED)	E (ED)
Cyanide antidote (Sodium Thiosulfate with or without Sodium Nitrite therapy; or Hydroxocobalamin single agent therapy)	E (ED)	E (ED)
Flumazenil	E (ED)	E (ED)
Naloxone	E (ED)	E (ED)
Sodium bicarbonate – 8.4% and 4.2%	E (ED)	E (ED)
Sedative/Hypnotic (e.g., Ketamine, Etomidate)	E (ED)	E (ED)
Tetanus Immune Globulin (Human)	E (ED)	E (ED)
Tetanus Vaccines (single or in combination with other vaccines)	E (ED)	E (ED)
Topical Anesthetics	E (ED)	E (ED)
Miscellaneous Equipment		
Dosing device – length or weight based system for dosing and equipment	E (ED)	E (ED)
Dosing/equipment chart by weight	E (ED)	E (ED)
EMS communication equipment (i.e., telemetry, MERCI, cellular or dedicated phone)	E (ED)	E (ED)
Examination gloves, disposable	E (ED)	E (ED)
Fluorescein (eye strips)	E (ED)	E (ED)
Infant formulas, dextrose in water with various nipple sizes	E (ED)	E (ED)
Lubricant, water soluble	E (ED)	E (ED)

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Nasogastric tubes 8 through-18 Fr* (may substitute feeding tubes 5F and 8F)	E (ED)	E (ED)
Oral rehydrating solution	E (ED)	E (ED)
Pain scale assessment tools appropriate for age	E (ED)	E (ED)
Pediatric emergency/crash cart or bag with defined list of contents attached to bag/cart	E (ED)	E (ED)
Restraining device/methods (e.g., papoose, distraction devices, comfort hold, swaddling)	E (ED)	E (ED)
Resuscitation board	E (ED)	E (ED)
Urinary catheters (8-22 Fr)*	E (ED)	E (ED)
Warming devices, age appropriate	E (ED)	E (ED)
Weighing scales (in kilograms only) for infants and children	E (ED)	E (ED)
Woods lamp (blue light)	E (ED)	E (ED)
Specialized Pediatric Trays		
Lumbar puncture tray, including a selection of needle sizes (size 18-22 g, 1½-3 inch needle)	E (ED)	E (ED)
Minor surgical instruments and sutures	E (ED)	E (ED)
Newborn kit/OB kit (including umbilical clamp, bulb syringe, towel). Maintain newborn resuscitation equipment/supplies together for easy access (as outlined in this equipment list: warming device, feeding tubes, neonatal mask, meconium aspirator).	E (ED)	E (ED)
Fracture Management Devices		

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Extremity splints	E (ED)	E (ED)
Femur splint (child and adult)	E (ED)	E (ED)
Semi-rigid neck collars (child through adult) or cervical immobilization equipment suitable for children	E (ED)	E (ED)
Spinal immobilization board	E (ED)	E (ED)

* Shall minimally stock a range of each commonly available size noted or comparable sizes.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

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Section 515.APPENDIX N Pediatric Critical Care Center (PCCC)/Emergency Department Approved for Pediatrics (EDAP) Recognition Application
EMERGENCY

Application Instructions

Follow these instructions to initiate the process to request recognition as a Pediatric Critical Care Center (PCCC) and Emergency Department Approved for Pediatrics (EDAP). The Pediatric Plan shall be developed through interaction and collaboration with all appropriate disciplines:

1. Complete the Request for Recognition of Pediatric Critical Care Center and Emergency Department Approved for Pediatrics Status Application Form and obtain the appropriate signatures.
2. Using the Pediatric Critical Care Center Plan Application Guideline and the PCCC/EDAP requirements, complete a PCCC and EDAP Pediatric Plan. The Pediatric Plan should follow the Pediatric Critical Care Center Plan Application Guideline checklist format provided in this application and include all requested supporting documentation, including, but not limited to, scope of services/care, credentialing forms, policies (both administrative and department specific), procedures, protocols, guidelines, flow charts, rosters, calendars, schedules, etc.
3. Complete and obtain signatures on the Department-approved physician, nurse practitioner, clinical nurse specialist, physician assistant, and nursing credentialing forms.
4. Complete the EDAP, PICU and Pediatric Unit Equipment Checklists.
5. Submit four copies of the hospital's Pediatric Plan (an original signed copy plus three additional copies) that each contain the following:
 - a. Signed Request for Recognition of Pediatric Critical Care Center and Emergency Department Approved for Pediatrics Status Application Form;
 - b. Completed PCCC Plan and EDAP Plan (including supporting documentation);
 - c. Completed physician, nurse practitioner, clinical nurse specialist, physician assistant, and nursing credentialing forms;
 - d. Completed EDAP, PICU and Pediatric Inpatient Unit Equipment Checklists.

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6. Submit these documents (including all supporting documentation) in the order listed in this application to: Division of EMS & Highway Safety, Illinois Department of Public Health, 422 S. 5th Street, Springfield IL 62701.
7. The Pediatric Plan shall be submitted in a single-sided format and unstapled.
8. Any submitted requests to waive any of the EDAP or PCCC equipment requirements shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

Site Survey Procedure

1. Within four to six weeks following the Department's receipt of the PCCC Pediatric Plan and supporting documents, the hospital will be informed as to the status of the application. If all documentation is in order, a site visit will be scheduled.
2. In preparation for the site visit, hospital personnel shall prepare evidence to verify adherence to the facility recognition requirements.
3. The site visit will include a survey of the Emergency Department, Pediatric Intensive Care Unit, Pediatric Units and a meeting with the following individuals:
 - a. chief administrative/executive officer or designee
 - b. chief of pediatrics
 - c. medical director of the pediatric intensive care services
 - d. medical directors of the pediatric units
 - e. medical director of pediatric ambulatory care
 - f. nursing director or nurse manager of the pediatric intensive care services
 - g. nursing director or nurse manager of the pediatric units
 - h. administrator of pediatric services

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- i. administrator of emergency services
- j. pediatric quality coordinator
- k. hospital quality improvement department director or designee
- l. emergency department medical director and the pediatric emergency department medical director
- m. emergency department nurse manager and the pediatric emergency department nurse manager
- n. hospital emergency management/disaster preparedness coordinator
- o. transport team medical director
- p. transport team nurse coordinator
- q. Clinical nurse specialist, nurse practitioner or physician assistant for those facilities that use these clinicians
- r. For EMS Resource or Associate Hospitals: The EMS MD and EMS coordinator

Site Survey Team

The EMSC program within the Division of EMS & Highway Safety will appoint the site survey team. Site survey teams will be composed of a physician/nurse team along with a representative from the Illinois Department of Public Health. All team members will attend formal training in the site survey responsibilities, expectations and process.

Following the Site Survey

1. Within four to six weeks following the site visit, the hospital shall receive the results of the survey from the Department. Those hospitals meeting all requirements will receive a formal recognition of their Pediatric Critical Care capabilities.
2. Hospitals that do not meet the requirements will receive a letter from the Illinois Department of Public Health outlining the areas of non-compliance. The Department shall deny a request for recognition if findings show failure to substantially comply with

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the EDAP and PCCC requirements. Hospitals may appeal the denial by submitting a written request to the Illinois Department of Public Health, Division of EMS & Highway Safety.

3. Re-recognition shall occur every three years, with site visits scheduled as necessary.

ILLINOIS EMSC
FACILITY RECOGNITION

Request for Recognition of Pediatric Critical Care Center (PCCC) and
Emergency Department Approved for Pediatrics (EDAP) Status

Application Form

Name of hospital and address (typed)

The above-named hospital is requesting PCCC and EDAP recognition. In addition, the above-named hospital certifies that each requirement in this Request for Recognition is met.

Typed name – CEO/Administrator

Signature – CEO/Administrator

Date

Typed name – Chairman of the Department of Pediatrics

Signature – Chairman of the Department of Pediatrics

Date

Typed name – Medical Director of Emergency Services

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Signature – Medical Director of Emergency Services

Date

Contact Person – Typed name, credentials and title

Contact Person – Phone number, fax number and email

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)

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Section 515.APPENDIX O Pediatric Critical Care Center Plan
EMERGENCY

I. PEDIATRIC CRITICAL CARE CENTER PLAN

Application Checklist

Instructions: Please follow and complete this checklist carefully. It outlines the components that must be included in the submitted plan. Please include any applicable supplemental documentation.

A. Organizational Structure

1. Enclosed is an organizational table identifying the administrative relationships among all departments in the hospital, especially as they relate to the pediatrics department. The table shall include, but is not limited to, the following:

- board of directors
- chief executive officers
- emergency department
- department of pediatrics
- pediatric ambulatory care
- trauma service
- department of radiology
- laboratory services
- transport service team
- social services

2. Enclosed is an organizational table showing the organizational structure of the department of pediatrics, including the relationship of the physician, nursing and ancillary services for both the PICU and pediatric units. Include the reporting structure for the pediatric chairman (to whom he/she reports).

- Department of Pediatrics Organizational Structure (Table)

3. Enclosed is an organizational table showing the organizational structure of the emergency department, including the relationship of the physician, nursing and ancillary services. Include the reporting structure for the emergency department director (to whom he/she reports).

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- Emergency Department Organizational Structure (Table)

EDAP Checklist

Review the criteria in Section 515.4000(a)(1) and (2) for the physician staff qualifications and continuing medical education and submit each of the following:

- A policy or medical staff bylaws that incorporate the physician qualifications and CME requirements.
- A completed Credentials of Emergency Department Physicians form
- A completed Credentials of Fast Track Physicians form
- The curriculum vitae for the ED medical director
- A current one-month physician schedule for the ED

Review the criteria in Section 515.4000(a)(3) for the ED physician coverage and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(a)(4) for ED consultation and submit a one-month on-call schedule identifying availability of board certified/board prepared pediatricians or pediatric emergency medicine physicians.

Review the criteria in Section 515.4000(a)(5) for ED physician back-up and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(a)(6) for all on-call specialty physician response time and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(b)(1) and (2) for nurse practitioner and physician assistant qualifications and continuing medical education and submit the following (as applicable):

- A policy(s) that incorporates the mid-level provider qualifications and continuing education requirements
- A completed Credentials of Emergency Department and Fast Track Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant form
- A current one-month schedule for the emergency department and fast track area as applicable.

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Review the criteria in Section 515.4000(c)(1) and (2) for nursing qualifications and continuing education and submit the following:

- A policy that incorporates the nursing qualifications and CE requirements
- A completed Credentials of Emergency Department Nursing Staff form
- A one-month nurse staffing schedule for the emergency department

Review the criteria in Section 515.4000(d)(1) for inter-facility transfer and submit the following:

- An inter-facility transfer policy that addresses pediatric transfers
- A copy of current pediatric-specific transfer agreements with hospitals that provide pediatric specialty services, pediatric intensive care and burn care not available at your facility

Review the criteria in Section 515.4000(d)(2) for suspected child abuse and neglect and submit a policy that addresses this requirement.

Review the criteria in Section 515.4000(d)(3) for treatment protocols and submit all pediatric treatment protocols.

Review the criteria in Section 515.4000(d)(4) for latex allergy policy and submit a policy that addresses latex allergies and the availability of latex-free equipment and supplies.

Review the criteria in Section 515.4000(d)(5) for disaster preparedness and submit a completed pediatric disaster preparedness checklist.

Review the criteria in Section 515.4000(e)(1) for quality improvement activities and the multidisciplinary quality improvement committee and submit the following:

- A quality improvement plan, including a QI policy, pediatric indicators, feedback loop and target time frames for closure of issues
- The composition of the multidisciplinary QI committee

Review the criteria in Section 515.4000(e)(2) and (3) for the pediatric physician champion and the pediatric quality coordinator responsibilities and submit the following:

- A curriculum vitae for the pediatric physician champion
- A curriculum vitae and job description for the pediatric quality coordinator

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- Documentation detailing the participation of the pediatric quality coordinator in regional QI activities and how that has affected pediatric quality care in the ED

Review the criteria in Section 515.4000(f) for the list of emergency department equipment requirements and submit a completed checklist indicating the availability of all equipment.

Indicate in the pediatric plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order) or an equipment waiver request shall be submitted for each item. Requests for waiver shall include the criteria by which compliance is considered to be a hardship and demonstrate that there will be no reduction in the provision of medical care.

B. PCCC Checklist

1. Hospital Requirements

Review the criteria in Section 515.4020(a) of the PCCC requirements as related to hospital resources and submit documentation identifying the ability to meet each of the following:

- A scope of services/policy outlining PICU services, unit resources and capabilities. Include any guidelines that outline pediatric admission criteria based on age parameters and diagnoses
- A list of the members of the PICU Committee, as well as their disciplines, to meet subsection (a)(3)
- Documentation to substantiate that Section 515.4020(a)(4) (Helicopter landing) is met
- A statement regarding 24-hour availability to meet Section 515.4020(a)(5) (CAT scan)
- A statement regarding the ability to meet Section 515.4020(a)(6) (Laboratory)
- A statement of availability or transfer agreement to meet Section 515.4020(a)(7) (Hemodialysis capabilities)
- A statement or scope of service from each program identifying the availability of staff as required in Section 515.4020(a)(8) (Other staffing/services)
- A list of professional pediatric critical care educational trainings that staff have provided in the past year to meet Section 515.4020(a)(9) (include information on trainings held within the facility, within the region or surrounding geographic area)
- A list of pediatric emergency care classes that staff have provided in the past year to meet Section 515.4020(a)(10) (i.e., CPR, first aid, health fairs, etc., conducted

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for the patient population and the community, region or surrounding geographic area)

- Documentation of any pediatric research the facility has been engaged in during the past year to meet Section 515.4020(a)(11) (include the research project abstract, summary of projects or listing of research activities)

II. PICU SERVICE REQUIREMENTS

A. Professional Staff

1. PICU Medical Director

Review the criteria in Section 515.4020(b) for the Medical Director and Co-Director requirements and submit each of the following:

- A curriculum vitae for the appointed PICU medical director
- A copy of board certification or verification of board certification
- A curriculum vitae and board certification for the co-director (as applicable – see Section 515.4020(b)(1))

2. PICU Medical Staff Requirements

Review the criteria in Section 515.4020(c) and submit each of the following:

PICU Medical Staff

- A policy outlining PICU physician staffing, coverage, availability, and CME requirements that incorporates Section 515.4020(c)(1)(A) and (B)
- A completed Credentials of PICU Physicians form that includes the medical director (and co-director as applicable)
- A one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)

Physician Specialist Availability (Section 515.4020(c)(2))

- A policy or by-laws that address the response time and on-call scheduling of pediatric surgeons
- A policy/process outlining board or sub-board certification or board preparedness for all specialist physicians
- A policy/process outlining how pediatric proficiency is defined and assuring that all specialist physicians maintain 10 hours of pediatric CME per year

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- A policy/process outlining anesthesiologist on-call staffing and response time, subspecialty training in pediatric anesthesiology or pediatric proficiency as defined by institution, and 10 hours of pediatric CME per year; for Certified Registered Nurse Anesthetists, provide a copy of the by-laws that address their responsibilities and back up
 - On-call schedules from the last month that list physician availability to meet Section 515.4020(c)(2)(C) and (D)
3. PICU Nurse Practitioner, Clinical Nurse Specialist, or Physician Assistant Requirements

NOTE – Complete this section only if physician assistants, clinical nurse specialists, or nurse practitioners practice in the PICU.

Review the criteria in Section 515.4020(d) and submit each of the following:

Nurse Practitioner (Section 515.4020(d)(1))

- A policy outlining PICU nurse practitioner staffing, coverage, availability, responsibilities and credentialing process
- A copy of a one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)
- A completed Credentials of PICU Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant form

Clinical Nurse Specialist (Section 515.4020(d)(2))

- A policy outlining PICU clinical nurse specialist staffing, coverage, availability, responsibilities and credentialing process
- A copy of a one-month staffing schedule or calendar (schedule should be from within the three-month time period previous to the application submission)
- A completed Credentials of PICU Nurse Practitioner, Clinical Nurse Specialist and Physician Assistant form

Physician Assistant (Section 515.4020(d)(3))

- A policy outlining PICU physician assistant staffing, coverage, availability, responsibilities and credentialing process
- A copy of a one-month staffing schedule/calendar (schedule should be from within the three-month time period previous to the application submission)
- A completed Credentials of PICU Nurse Practitioner, Clinical Nurse Specialist, and Physician Assistant form

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Education (Section 515.4020(d)(4) and (54))

- A policy that incorporates APLS, PALS or ENPC (Section 515.4020(d)(3))
- A copy of the PICU nurse practitioner, clinical nurse specialist, and physician assistant continuing education policy that incorporates Section 515.4020(d)(4)

4. PICU Nursing Staff Requirements

Review the criteria in Section 515.4020(e) and submit each of the following:

PICU Nurse Manager

- A curriculum vitae for the PICU manager
- A policy or job description that incorporates Section 515.4020(e)(1)(C)

PICU Pediatric Clinical Nurse Expert

- A policy or job description of the role and responsibilities of the pediatric clinical nurse expert in the PICU
- A resume of the PICU pediatric clinical nurse expert
- A policy that incorporates Section 515.4020(e)(2)(C) and (D)

Nursing Patient Care Services

- A policy/documentation outlining current nursing shift staffing plan/patterns
- A completed Credentials of PICU Nursing Staff form that includes the PICU nurse manager and PICU pediatric clinical nurse expert
- A policy or job description for the PICU nurse that outlines the orientation process to the unit responsibilities and requirements of the Department (Section 515.4020(e)(3)(C) and (D))
- A copy of a one-month nurse staffing schedule/calendar (schedule shall be from within the three-month time period previous to the application submission)
- A policy reflecting yearly competency review requirements for the PICU staff

D. Policies, Procedures and Treatment Protocols

Review the criteria in Section 515.4020(f) and submit each of the following:

- An admission and discharge criteria policy
- A staffing policy that addresses nursing shift staffing patterns based on patient acuity
- A policy for managing the psychiatric needs of the PICU patient

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- Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses

E. Inter-facility Transfer/Transport Requirements

Review the criteria in Section 515.4020(g) and submit each of the following:

- A copy of the last annual report containing the number of annual transfers to the facility from transferring institutions
- A policy outlining the feedback process to transferring hospitals on the status of the referral patient and the methods for quality review of the transfer process
- Documentation outlining the pediatric inter-facility transport system capabilities and resources
- A transfer policy that addresses pediatric inter-facility transfers

F. Quality Improvement Requirements

Review the criteria in Section 515.4020(h) and submit each of the following:

- A list of the members of the Multidisciplinary Pediatric Quality Improvement Committee and their respective positions/disciplines
- An institutional Quality Improvement Organizational Chart
- The PICU outcome analysis plan and pediatric monitoring activities that meet Section 515.4020(h)(2) (minutes from the past year that reflect the activities of the Multidisciplinary Pediatric Quality Improvement Committee will be requested at the time of site survey)

G. Equipment

Review the criteria in Section 515.4020(i) and submit the following:

Indicate in the Pediatric Plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order); if the item is not on order, an equipment waiver request shall be submitted for each item. Requests for an equipment waiver shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

III. PEDIATRIC INPATIENT CARE SERVICE REQUIREMENTS

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A. Professional Staff

1. Pediatric Unit Physician Requirements

Review the criteria in Section 515.4020(j) and submit each of the following:

- A curriculum vitae and a copy of board certification for the pediatric inpatient director
- A policy or a scope of services for the pediatric unit that defines responsibility for medical management of care
- If pediatric hospitalists are used, documentation that defines their scope of service, including their responsibilities to other attending physicians
- A completed Credentials of Pediatric Unit Hospitalists form
- A policy that incorporates Section 515.4020(j)(1)(B)
- A policy or scope of services outlining the responsibility of the PICU medical director or his/her designee as being available on call and for consultation on all pediatric in-house patients who may require critical care

2. Pediatric Unit Nurse Manager Requirements

Review the criteria in Section 515.4020(j)(2) and submit each of the following:

- A curriculum vitae for the pediatric unit manager
- A job description or policy incorporating Section 515.4020(j)(2)(C)

3. Pediatric Unit Nursing Care Services

Review the criteria in Section 515.4020(j)(3) and submit each of the following:

- A policy/documentation outlining current nursing shift staffing plan/patterns
- A policy describing annual competency review requirements for the pediatric nursing staff (Section 515.4020(j)(3)(B))
- A policy or job description for the pediatric unit nurse that outlines the orientation process to the unit responsibilities and requirements of the Department that address Section 515.4020(j)(3)(A) through (D)
- A copy of a one-month nursing staffing schedule/calendar (schedule shall be from within the three-month time period previous to the application submission)

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- A completed Credentials for the Pediatric Unit Nursing Staff form that includes the Pediatric Unit Nurse Manager

B. Policies, Procedures and Treatment Protocols

Review the criteria in Section 515.4020(k) and submit each of the following:

- A policy or scope of services that outlines the pediatric department services, ages of patients served and admission guidelines
- A staffing policy that addresses nursing shift staffing patterns based on patient acuity
- A safety and security policy for the patient in the unit
- An inter-facility transport policy that addresses safety and acuity
- An intra-facility transport policy that addresses safety and acuity
- A latex allergy policy
- A pediatric organ procurement/donation policy
- An isolation precautions policy that incorporates appropriate infection control measures
- A disaster policy that addresses the specific medical and psychosocial needs of the pediatric population
- Protocols, order sets, pathways or guidelines for management of high- and low-frequency diagnoses
- A pediatric policy that addresses the resources available to meet the psychosocial needs of patients and family, and appropriate social work referral for the following indicators (see Pediatric Bill of Rights in Appendix N):
- Child death
 - Child has been a victim of or witness to violence
Family needs assistance in obtaining resources to take the child home
 - Family needs a payment resource for their child's health needs
Family needs to be linked back to their primary health, social service or educational system
 - Family needs support services to adjust to their child's health condition or the increased demands related to changes in their child's health condition
 - Family needs additional education related to the child's care needs to care for the child at home
- A discharge planning policy or protocol that includes the following:
1. Documentation of appropriate primary care/specialty follow-up provisions
 2. Mechanism to access a primary care resource for children who do not have a provider

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3. Discharge summary provision to appropriate medical care provider, parent/guardian, that includes:
 - Information on the child's hospital course
 - Discharge instructions and education
 - Follow-up arrangements
4. Appropriate referral of patients to rehabilitation or specialty services for children who may have any of the following problems:
 - Require the assistance of medical technology
 - Do not exhibit age-appropriate activity in cognitive, communication or motor skills, behavioral or social/emotional realms
 - Have additional medical or rehabilitation needs that may require specialized care, such as medication, hospice care, physical therapy, home health or speech/language services
 - Have a brain injury – mild, moderate or severe
 - Have a spinal cord injury
 - Exhibit seizure behavior during an acute care episode or have a history of seizure disorder and are not currently linked with specialty follow-up
 - Have a submersion injury, such as a near drowning
 - Have a burn (other than a superficial burn)
 - Have a pre-existing condition that experiences a change in health or functional status
 - Have a neurological, musculoskeletal or developmental disability
 - Have a sudden onset of behavioral change, for example, in cognition, language or affect

C. Quality Improvement Requirements

Review the criteria in Section 515.4020(l) and submit the following:

- The titles of the pediatric unit representatives that serve on the Multidisciplinary Pediatric Quality Improvement Committee

D. Equipment Requirements

Review the criteria in Section 515.4020(m) and submit the following:

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Indicate in the Pediatric Plan whether each item is currently available. If equipment/supply items are not available, a plan for securing the items shall be identified (e.g., submission of a purchase order to assure that the item is on order); if the item is not on order, an equipment waiver request shall be submitted for each item. Requests for an equipment waiver shall include the criteria by which compliance is considered to be a hardship and shall demonstrate that there will be no reduction in the provision of medical care.

(Source: Amended by emergency rulemaking at 44 Ill. Reg. _____, effective _____, for a maximum of 150 days)