



**Division of Emergency Medical Systems
and
Highway Safety**

**Strategic Plan
Draft Recommendations**

**Final, 12/15/08
Updated: 03/04/10**

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Executive Summary

This document represents a significant milestone in the establishment of an optimal system to provide care to critically ill and injured persons in the State of Illinois. It describes a different approach to the development, oversight and improvement of an emergency health care system across that state. While the plan presents dozens of attributes of the evolving system a few key messages are important to summarize here.

- The Division of Emergency Medical Systems and Highway Safety will transition both in level and focus to become the Office of Emergency Health Care. Under the leadership of the new OEHC varying divisions will concentrate on specific systems of care for prehospital, trauma, stroke, cardiac conditions and the emergency needs of children. Additional activities will include the emergency care response within the hospitals and the State's ability to provide optimal medical care during a major disaster.
- Rather than having separate strategic plans, the issues pertaining to the prehospital phase of emergency care and those related to the trauma system, have been combined into a single document.
- The goals, objectives and tasks broadly outlined in this document are patient centered. The activities are also organized within a public health framework that allows the activities to be more closely linked with other units of the Department of Public Health. Some of the objectives will be difficult to obtain or unpopular with one constituent base or another. However, the attainment of these objectives will result in improved emergency health care across the State.
- This plan is not static, nor will the companion implementation plan be as it is developed. A regular review and update is essential to keeping the citizens of Illinois safe.

Please take the time to read this document in its entirety. Support its intentions which are to create an environment in which optimal emergency health care can be obtained in the personal moment where it is most needed.

Introduction

In 2007, the Illinois Department of Public Health, Division of Emergency Medical Services (EMS) and Highway Safety, empanelled an oversight group to develop a strategic plan for its Trauma and EMS functions. The oversight group was comprised of approximately 115 people representing a cross section of emergency health care providers from prehospital care, nursing, medicine and related disciplines. The oversight group was broken into Trauma and EMS subgroups. These two subgroups were further stratified into working task groups. The following table identifies the task groups and their assigned leaders.

Sub Group and Task Group Leadership	
Trauma	EMS
<i>Trauma Sub-Group Leaders</i>	<i>EMS Sub-Group Leaders</i>
Thomas J. Esposito, Chair	Mark Cichon, Chair
Paula Willoughby, Co-Chair	Gregg Scott, Co-Chair
<i>Administration Task Group</i>	<i>Administration Task Group</i>
David Schertz, Chair	George Madland, Chair
Gary Merlotti, Co-chair	Max Koensberg, Co-Chair
Ron Meadors, Recorder	Jill Pendegrass, Recorder
<i>Information Systems / Evaluation / Research / Injury Prevention Group</i>	<i>Information Systems Group</i>
Richard Fantus, Chair	Susan Fuchs, Chair
Mary Beth Voights, Recorder	Roger Holloway, Co-chair
<i>Human Resources / Education / Definitive Care Group</i>	<i>Human Resources / Education Group</i>
Glenn Aldinger, Chair	Louie Rogers, Chair
Stacy Van Vleet, Recorder	Janet Collopy, Co-chair
	Patricia J. Murphy, Recorder
<i>Prehospital / Disaster / Communications Group</i>	<i>Operations Group</i>
Bill Iversen, Chair	Cyd Gajewski, Chair
Anthony Raspati, Recorder	Mary Ann Miller, Co-chair
	Jack Whitney, Recorder

The oversight group met on a quarterly basis in various locations across the state selected to achieve maximum participation. During these meetings the oversight group initially convened as a whole to set an agenda for the day. The two main subgroups, Trauma and EMS, would then meet individually and further break into the various Task Groups. Additionally, the various Task Groups met several times between quarterly meetings by teleconference to continue their work. This plan represents many thousands of hours of volunteer effort on the part of these dedicated stakeholders.

Stellar leadership was provided to the volunteers by Walter Bradley, MD, MBA, Senior Medical Administrator of the Illinois Department of Public Health. The process was facilitated by staff from the Critical Illness and Trauma Foundation and the American College of Surgeons. Additional technical support was provided by faculty from the University of Illinois – Chicago and Southern Illinois University. Administrative support was capably provided by IDPH – Division of EMS and Highway Safety staff.

Trauma and EMS Oversight Group Charge

To develop a strategic plan with short, intermediate and long term goals that will ensure the Illinois emergency health care system will optimally meet the needs of residents of, and visitors to, the State of Illinois.

Mission

To protect the health and welfare of the citizens of Illinois by ensuring safe, effective, patient-centered, timely, efficient and equitable emergency care.

Vision

The Emergency Health Care System exists to optimize the health and well-being of the citizens of the State of Illinois. The scope of the system will span the healthcare encounter, including prevention, identification, notification, prehospital response, hospital treatment, and rehabilitation to ensure the patient's optimal outcome.

Therefore, any patient entering into the Illinois Emergency Health Care System with any acute illness or injury will be identified and treated in an effective and timely manner. The Emergency Health Care System will ensure that optimal services are consistently rendered to the patient and community at all times through continuous monitoring of outcomes and performance.

A Paradigm Shift

When Emergency Medical Services (EMS) first evolved following the publication of the National Academies of Science titled “Accidental Death and Disability: The Neglected Disease of Modern Society” in 1966, EMS was envisioned as an overarching system of care that encompassed all components of care from prevention through rehabilitation. The breadth of the EMS system was further described in 1996 in the document titled EMS: Agenda for the Future published by NHTSA. In spite of these broad visions for EMS, the public has come to identify EMS as the prehospital phase of care. The National Academies of Science, in their four volume work titled “Future of Emergency Care within the U.S. Healthcare System”, published in 2007, note that lead agencies might be better served to consider themselves, both in title and function, as Offices of Emergency Care. In doing so, EMS (both ground-based and air medical) as the prehospital care function, is more able to be fully integrated within the broader emergency health care system. Such an overarching orientation also allows for the development and oversight of the trauma system as well as other emerging, time-sensitive, disease-based response systems such as stroke and ST elevated myocardial infarction (STEMI). Additionally, such a leadership posture allows for integration of hospital-based emergency care, general and specialty needs such as pediatric, geriatric, and rural populations. It also positions the agency well for control of the medical aspects of disaster planning.

In recognition of this national shift in thinking, this report is referred to as the strategic plan for Emergency Health Care. The plans for EMS and Trauma components of the Emergency Health Care System are both included in this single document to further underscore the fact that the systems and activities are complimentary and integrated. It also provides a framework for the inclusion of stroke, STEMI and other time-sensitive, disease-based, networks of care as they evolve in the future.

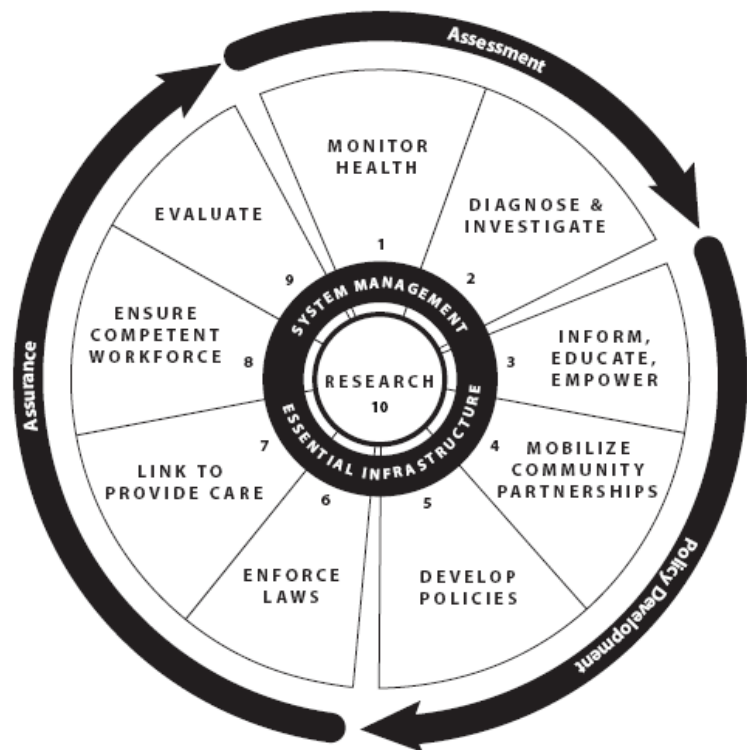


Figure 1: Public Health Framework

Recent evolutions in emergency care have included the shift away from a component-based system to one couched in a public health framework. This concept was first articulated in the Model Trauma System Planning and Evaluation document developed and published by the Health Services and Resource Administration Trauma and EMS Program in 2006. Figure 1(previous page) provides a graphic representation of the three core functions and ten essential services of the public health framework.

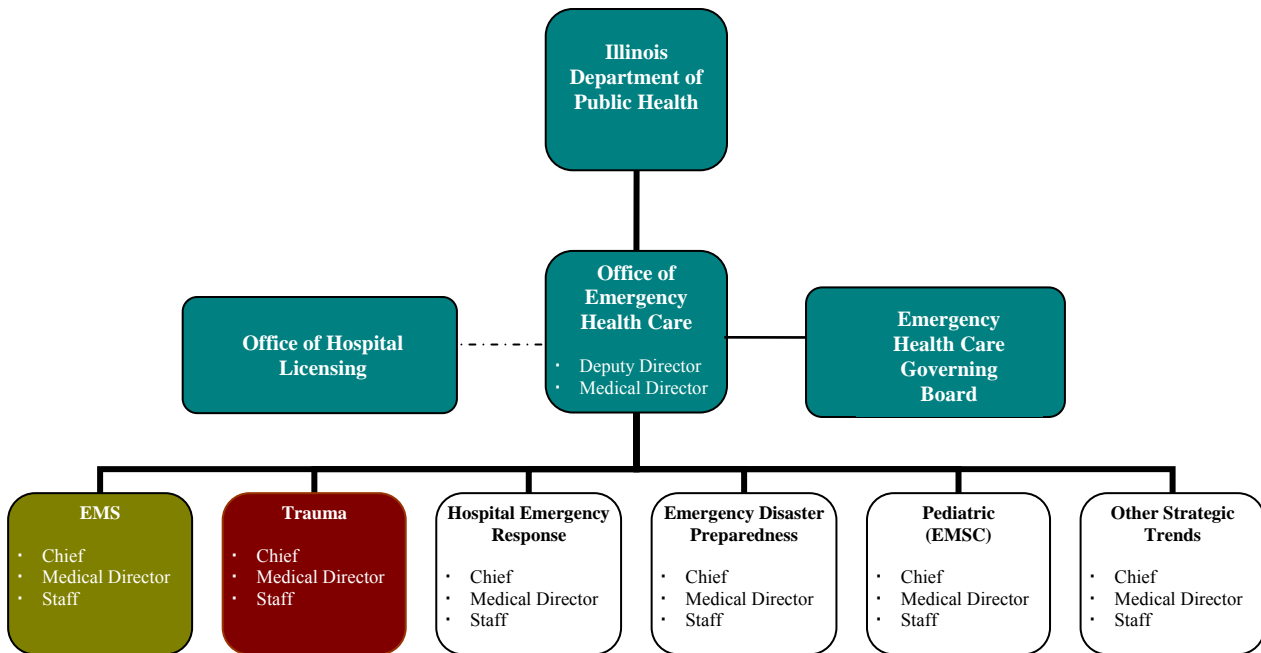
The National Association of State Emergency Medical Services Officials, in their draft Model State Emergency Medical Services System: Model, Self-Assessment, Planning and Implementation template, have embraced a similar public health oriented approach to EMS strategic planning. The Model State EMS System document begins to meld the core attributes described in the EMS Agenda for the Future (1996) and the core functions and essential services of a public health approach. To the degree practical the public health framework is used as a conceptual and organizational model for both the Trauma and EMS sections of this plan. The table on the following page cross references the core functions and essential services of the public health system with the more traditional components and attributes of the EMS and trauma systems.

Public Health Core Functions		Trauma System Components		EMS System Attributes	
CORE FUNCTION	ESSENTIAL SERVICE	1992 CORE COMPONENT	SUB-COMPONENTS	1996 CORE ATTRIBUTES	SUB-COMPONENTS
Essential Infrastructure	State Government Oversight Leadership Information Technology Finance Research				
Assessment	Monitor health Diagnose and investigate	Evaluation	Needs assessment Data collection Research	Information Systems Evaluation	
Policy Development	Inform, educate, and empower Mobilize partnerships	Public information and education Prevention	Injury prevention Trauma system committee	Public Information and Education Prevention	
	Develop policies	Legislation Regulations	Trauma system planning and operations Regulations and rules	Legislation and Regulation System Finance	
Assurance	Enforce laws		State Lead Agency	Integration of Health Services Public Access	
	Ensure links to or provision of care	Prehospital care	Communications Triage and transport, medical direction, and treatment protocols	Communication Clinical Care Medical Oversight	Resource Allocation and Utilization Disaster Preparedness
		Definitive care	Facility designation, interfacility transfer, and rehabilitation	Medical Oversight	
	Ensure competent workforce	Human resources	Workforce resources and educational preparation	Human Resources Education Systems	Medical oversight Performance Improvement
	Evaluation	Evaluation	Data collection Research Interdisciplinary Review Committee	Research	Performance Improvement

Public Health Approach

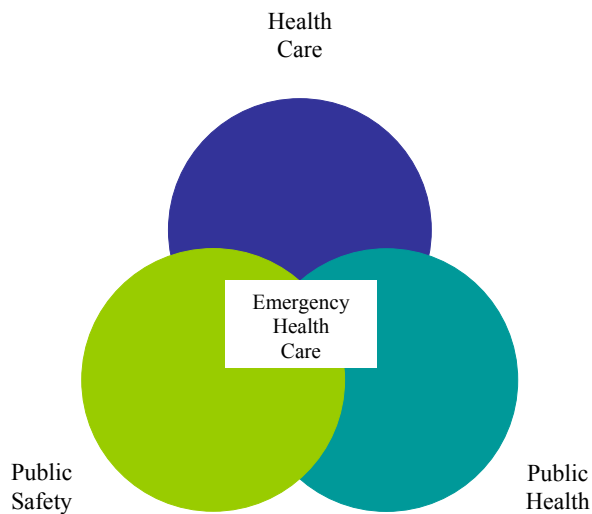
Section 1: Essential Infrastructure

In keeping with the integrated approach outlined in this report the Illinois Department of Public Health’s Division of EMS and Highway Safety should transition to become the Office of Emergency Health Care. This would enable the Office and the subsequent Divisions to provide more consistent leadership across programs and position itself for change as additional time-sensitive, disease-based systems of care evolve. The following diagram depicts the proposed oversight structure of the Office of Emergency Health Care.



The Office of Emergency Health Care would be, first and foremost, oriented to health care. However, it is noted that some overlap with public safety including: highways, fire service, disaster preparedness, health care licensing entities, etc., is essential to ensuring appropriate coordination and oversight of medical functions within these public safety entities. Additionally, there are, and could be many more, opportunities to interface with public health functions. Figure 2 on the following page illustrates this overlap.

Appropriate staffing and fiscal resources will be necessary to ensure that leadership and oversight of the Emergency Health Care System can be attained and maintained. Specific recommendations concerning the need for personnel to support all the components of emergency health care functions are contained within subsequent sections of the report. Likewise, appropriate statutory authority with sufficient resources to develop, implement and enforce necessary regulations to ensure the health and safety of the consumers of the emergency health care system is essential to the attainment of the strategies outlined in this plan. Additional detail is found in each respective section.



The Office of Emergency Health Care should rely on the input and advice of its secondary consumer base, that being the health care providers essential to the day-to-day delivery of quality emergency care. The current advisory committees and structures should be reconstituted to become the Emergency Health Care Governing Board (EHCGB) with sub-committees focusing on the specific duties of the Office of the Emergency Health Care, e.g. trauma, EMS, pediatric, etc., reporting to the main committee and subsequently through that body to the Office of Emergency Health Care.

Figure 2: Oversight Structure of the Office of Emergency Health Care

During 2009, a group of invited individuals representing a broad cross-section of EMS and trauma professionals along with IDPH staff reviewed each of the recommendations contained in the December, 2008, draft plan. Their charge was to stratify the recommendations according to how long they estimated it might take to achieve each one. They were asked to group them into short, intermediate and long term recommendations. During the first meeting it became clear that some of the recommendations were going to require additional time for reflection and discussion and that their inclusion in the current would hamper the timely discharge of the debate on the other recommendations. In this case the recommendation was tabled (T) for discussion at a later time. In some cases, the recommendations were judged to be improbable, if not impossible, to achieve in the current fiscal and health care climate. These were marked as not feasible (N). The large group was broken into four sub-groups and each given sections of the recommendations to review. A third meeting, to allow the larger group to have one final review of the individual groups' findings brought the process to a conclusion.

The draft plan, with the recommendations identified as short, intermediate, long-term will be submitted to the Director of IDPH for further review, analysis and prioritization. At a future point in time additional tactical details may be necessary to guide the attainment of some recommendations.

The recommendations are marked with the agreed upon time frame preceding each bullet where it appeared originally in the report. Additionally, a separate appendix with the recommendations stratified and grouped by time frame has been added.

S= Short Term, <12months

I= Intermediate Range, 1-3 years

L= Long Term, 3-5 years
 N= Not Feasible
 T= Table

State Government Oversight

- I ◆ The current lead agency office will be renamed: Office of Emergency Health Care and will have responsibility for administration of the following:
 - EMS
 - Trauma Care
 - Hospital Emergency Response
 - Emergency Care Response during Disaster Preparedness
 - Special Populations - Pediatric (EMSC), Geriatrics
 - Other Strategic Trends – Stroke, STEMI, Etc.

- I ◆ There will be an independent assessment by a nationally recognized organization of current lead agency operations and a resultant restructuring addressing appropriate staff size, domains of responsibility, job descriptions, appropriate credentials, performance indicators, salaries and overall cost of operation (estimated operating budget).

- I ◆ This Emergency Health Care Strategic Plan and companion Implementation Guide will be reviewed all, or in part, by the Office and EHCGB on a regular interval not to exceed 4 years.

- S ◆ EHCCGB and OEHC will review current rules/laws governing the transport of “non-urgent” patients to Urgent Care Centers.

Leadership

- L ◆ A State Emergency Health Care Governing Board will be formed and empowered to advise and direct the lead agency in regard to emergency healthcare issues. This governing board will be multidisciplinary and representative of all phases of emergency health care.
 - All section medical directors will be included.
 - Representatives from surrounding states to be included.

- I ◆ The Emergency Health Care system will have strong medical leadership at every level. Time commitments will be appropriate to the needs of the division or office.

- I ◆ There will be a full-time, salaried, EHC Medical Director. Emergency and/or trauma system management credentials will be essential for the successful candidate.

- I ◆ There will be a full-time, salaried, Trauma Medical Director. Experience in trauma surgery and trauma program management will be essential for the successful candidate.
- S ◆ Under the aegis of the EHC Medical Director, a task force will be convened to analyze regions and report to the EHCGB with recommendations about regional structure and advisory committees.
- I ◆ The role of medical director and chief in OEHC will be parallel so that medical director can make requests directly to the Director of IDPH.
- L ◆ EMS and Trauma System Advisory Council and other stakeholders will be integrated into a single EHCGB.
- S ◆ The EMS/Trauma Center Code will be initially reviewed and revised on a biannual basis with approval by EHCGB prior to introduction into legislative process.
- I ◆ A State Operations Manual/State Program Guide will be developed based on the goals outlined in this plan and consistently applied across the state.

Finances

- S ◆ Any specialty funds created to support emergency health care programs must be protected from re-allocation, and must be utilized for intended purposes as directed by EHCGB (100%).
- T ◆ Expand the current EMS Assistance Fund grant program.
- T ◆ Trauma center funds will be re-designated and re-allocated as trauma system funds with at minimum 25% dedicated to the Office of Emergency Health Care.
- L ◆ EMS operations will be included in any current grant funding opportunities.
- I ◆ Allocate a dedicated grant writer within the Office of EMS to investigate/secure funding for key initiatives.
- S ◆ A business plan will be developed for both the EHCS, and the OEHC by the OEHC staff in collaboration with the EHCGB.
- S ◆ Declare Emergency Health Care an “Essential Service”.
 - As an “Essential Service” EHC will require its own dedicated and protected revenue and funding source.
 - EHCS monies will be secured in a dedicated fund which is earmarked for the EHC operation and administrative support.

- T** ♦ Negotiations at the gubernatorial, attorneys/general and legislative level will be initiated with adjoining states, as appropriate, to assure fair and timely compensation of care to residents of those states who are treated by Illinois system providers (e.g. reciprocal public aid agreements/memorandum of understanding/policies, etc.).
- T** ♦ Disbursement of EHCS funds to participating facilities in Illinois as well as surrounding states will be contingent upon compliance with all requirements specified for a particular designation level.
- L** ♦ The proportional allocation of system funds will be determined by a disbursement calculation to be developed by the OEHC/EHCGB.
- S** ♦ The OEHC/EHCGB will have the authority to direct the use of EHCS funds disbursed to individual hospitals and regions to accomplish system region or local initiatives and improvements.
- Recipients of system funds will be accountable to the OEHC/EHCGB for use of the funds as directed and/or in a manner that directly benefits the trauma program or system.
 - A detailed report on the use of EHCS funds will be required by each recipient annually.
 - Failure to comply or use of funds deemed inappropriate will constitute grounds for sanctions and forfeiture of future fund disbursement.
- S** ♦ A mechanism to assure protection of funds dedicated to the EHCS and OEHC will be formulated and ultimately legislated.
- I** ♦ The estimated cost of operation and administration of the system is \$15 million. This is the minimum amount the fund should contain. Strategies to generate monies to be invested in the fund might include, but not be limited to:
- \$2 EHC system surcharge on all motor vehicle drivers licenses applications (new and renewal/motor vehicle and motorcycle)
 - \$2 surcharge on motor vehicle registration fees (initial and renewal).
 - A \$2 increase in the existing surcharge on DUI and speeding citations
 - A \$500 surcharge on issuance of initial and renewal liquor licenses
 - A \$500 surcharge on licenses to sell guns
 - A \$2 safety fee attached to the issuance of gun permits
 - \$1000 taxation on the purveyors of gun shows
 - \$75 tax on ATV sales
 - A 1% rebate from insurance companies on yearly motor vehicle insurance premium revenues
 - A 0.5% guaranteed allocation of state income tax revenue
 - A \$1 surcharge on the sale of fireworks
 - Revenue from trauma center designation site visits
 - Surcharge on the sale of guns and ammunition

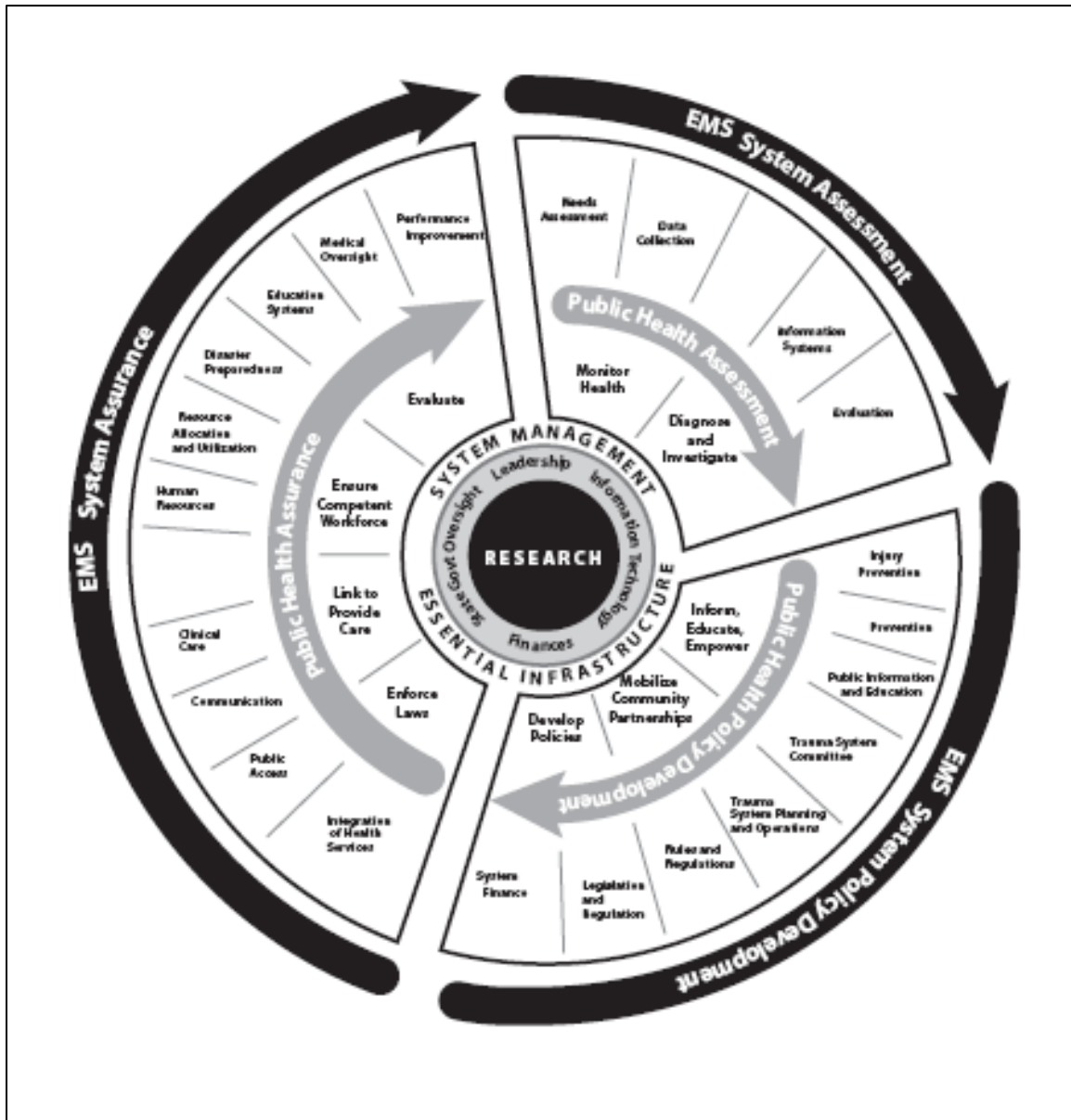
Information Technology

- S** ♦ The Office of Emergency Health Care will maintain and upgrade statewide electronic data collection systems to a status that is consistent with national standards for the purposes of supporting continuity of care, surveillance, quality improvement, public reporting and research.
- I** ♦ The Office of Emergency Health Care will be able to link, aggregate and report data from each of the various databases under its aegis, (e.g. trauma registry, prehospital, rehabilitation, etc.).

Research

- I** ♦ The OEHC will convene a sub-committee of the EHCGB to support, promote and develop a specific research agenda for the emergency health care system in Illinois.
- I** ♦ The OEHC and EHCGB will collaborate with academic units with a focus on public health and other affiliated academic entities to provide support in the development and implementation of a research agenda.
- I** ♦ The OEHC and EHCGB will review current literature for best practices across the emergency health care spectrum and replicate and evaluate these practices.
- I** ♦ The OEHC will develop standards and procedures for obtaining, using and protecting all emergency health care data collected and maintained by the state.

Section 2: EMS within the Emergency Care System



*Assessment*Information Systems

- I ♦ Adopt a single state patient tracking program to assure statewide consistency.
 - Assure patient tracking coordination and interoperability among prehospital and hospital systems, providers and state/national repositories.
- I ♦ Achieve NEMESIS compliance at a 100% level of required data elements.
- S ♦ Develop capability to accept and then export data in XML standard.
- I ♦ Enter and submit data electronically: via web, or internet.
- I ♦ Increase number of EMS agencies with access to computers..
- S ♦ Improve accuracy, validity, and completeness of data being submitted and collected.
- L ♦ Ensure that data collected support the performance improvement processes.
- T ♦ Request and host a NEMESIS/NEDARC site visit.
- L ♦ Establish a single patient identifier to track a patient throughout the entire course of emergency care (including rehabilitation EMS-ED-hospital-rehab).

Evaluation

- L ♦ The Office of Emergency Health Care shall produce an annual report that includes all divisions of emergency health care based upon the previous year's statewide data acquisition.

*Policy Development*Public Information and Education

- S ♦ Develop and coordinate with other state offices various media/public education campaigns to educate key populations and communities.

Prevention

- S ♦ Create partnerships with other allied health professionals/organizations that affect Emergency Health Care.
- L ♦ Ensure that all aspects of the EHCS in Illinois are connected to and engaged in injury and illness prevention and wellness promotion.
- I ♦ Produce a formal and thorough description of the epidemiology of injury and injury mortality throughout the system. Following from this will come parallel descriptions for other emergency conditions.
- L ♦ Formulate policies and processes that encourage EMS agencies to participate in a program whereby prehospital care providers conduct wellness visits/injury prevention assessments.
 - These activities will be conducted in conjunction with local health departments and participating system hospitals.
 - Participation in such programs will eventually become a requisite for EMS agency certification .

Legislation and Regulations

- I ♦ Drugs
 - Review, and revise as necessary, standardized policies and supporting processes related to drug restocking/exchange-based on Federal guidelines.
- I ♦ Equipment
 - Review, and revise as necessary, standardized policies and supporting processes related to equipment/supply restocking/exchange/billing-based on state and federal guidelines.
- I ♦ Develop consistent/standardized “treat and release” patient policies and supporting processes.
- L ♦ Develop policies and supporting processes for diversion/transport to specialty care centers.
- L ♦ Modify administrative rules and/or adopt policies to support and enforce full participation of Emergency Health Care data submission.

- L** ♦ Office of Emergency Health Care and the Emergency Health Care Governing Board will review and revise any required legislation and administrative code rule changes to support the levels and titles of EMS providers supported through the National Highway Traffic Safety Administration (NHTSA).
- S** ♦ Develop guidelines for patients that are medically acceptable for Medi-car transport.

System Finance

- L** ♦ OEHC will develop a grant program to incorporate technology into education programs.

*Assurance*Integration of Health Services

- I ♦ Advocate for Emergency Health Care systems and hospital-wide policies to eliminate boarding and bypass in partnership with other health care organizations.
- I ♦ Develop inter-regional and interstate policies for ground and air medical transport.
- L ♦ Develop operational agreements for the interstate transport and treatment of patients for dual licensed providers and prehospital care provider licenses.

Public Access

- L ♦ Collaborate with the statewide 9-1-1 office to ensure further development and sustainment of the enhanced 9-1-1 system.
- L ♦ Develop mechanisms to assess compliance for Emergency Medical Dispatchers with current EMS regulations.
- S ♦ Promote public awareness of 9-1-1 as THE emergency access point.

*Ensure Links to or Provisions of Care*Communication

- I ♦ Address interoperability issues between response partners, systems and among each provider.
- L ♦ Develop and maintain dedicated EMS communication resources sufficient for current and future needs.

Clinical Care

- L ♦ Require all acute care facilities with emergency departments to participate in the Illinois Facility Recognition Program as a condition of hospital licensure.
- L ♦ Develop inter-regional and interstate Emergency Health Care policies and protocols.
- L ♦ Determine and work to obtain, in collaboration with system researchers, the optimal staffing and deployment strategies for EMS in metropolitan, suburban and rural environments.

- L** ♦ Develop minimum statewide EMS protocols at all levels of providers to ensure consistent delivery of optimal care across the Emergency Health Care system, and to facilitate mobility of EMS providers between Illinois EMS Systems and agencies.

Medical Oversight

- S** ♦ Ensure proper medical oversight throughout all aspects of the Emergency Health Care system.
- S** ♦ Each EMS provider agency will be required to belong to an EMS system.
- I** ♦ The EMS System will be responsible for approval of EMS educational programs consistent with recognized state and national standards.

Resource Allocation and Utilization

- L** ♦ Allow private and public EMS provider's agencies access to Illinois Department of Public Health web portal for monitoring of the hospital bypass system and other Office of Emergency Health Care applications and information.
- I** ♦ Advocate for a streamlined process of opening additional hospital beds when surge contingency plans are activated.
- I** ♦ Develop and streamline regulations and processes for hospitals and alternate care facilities to utilize when activating their surge contingency plans.
- I** ♦ Develop inter-regional and interstate policies and EMS operational agreements for the treatment and transport of patients during times of diversions.
- L** ♦ Advocate to streamline the intake process for psychiatric patients.

Disaster

- S ♦ Incorporate nontraditional mutual aid organizations such as (PPERS) Private Provider Emergency Response System and (CHUG) Collaborative Healthcare Urgency Group into disaster planning and response.
- I ♦ Dedicate a full-time Disaster Preparedness position at each resource/associate hospital.
- L ♦ Encourage Emergency Medical Response training throughout communities.

*Ensure Competent Workforce*Human Resources

- I ♦ Conduct a needs and cost benefit analysis, and provide a report to the EHCGB determining if Illinois should continue to administer validated state EMT examinations, or utilize the National Registry of EMT examination service.
- I ♦ If the result of the above analysis reflects that the best method for initial licensure is the National Registry of EMT examination
 - o Explore an agreement with NREMT to require only the written examination.
 - o The practical examination requirements would be waived unless an individual desired to obtain the NREMT designation.
- L ♦ OEHC shall determine specific competencies required for specialty care and require such specific competencies as part of continuing education programs for all appropriate levels of providers.

Education Systems

- I ♦ OEHC will adopt the National EMS Scope of Practice Models for all levels of EMS to serve as the minimum foundation for educational programs.
- S ♦ Each educational program shall develop lesson plans that meet or exceed the national core content and the minimum recommendations for hours and patient care experiences for providers at all levels.
- I ♦ Each program shall measure competency in cognitive, psychomotor, and affective domains utilizing written examinations, site-specific practical examinations, and evaluating the behaviors specified in the National Education Standards.
- S ♦ Identify and promote acceptable emergency driving courses and identify equivalency requirements for all EMS responders.

- I ♦ Develop an EMS Educator mentoring and an auditing program for current educator.
- I ♦ At a minimum, all primary instructors will acquire and maintain lead instructor status/recognition.
- L ♦ OEHC will develop minimum requirements for any continuing education program.
- I ♦ Lead Instructor and affiliate/secondary instructor training programs will be conducted on a regional basis to meet regional needs utilizing state-approved core curriculum that will meet or exceed NAEMSE criteria.
 - The costs of these training courses will be off-set through course tuition.
 - These training programs will be conducted by EMS Systems and approved by OEHC.
- I ♦ OEHC will develop a training/education evaluation instrument; based on the National EMS Education Agenda for the future that will allow Lead Instructors to be evaluated at the end of each course.
 - Establish minimum performance criteria.
 - Provide review and remediation as indicated.
- I ♦ Each Paramedic training program shall be recognized by a national accreditation program.
 - Emergency Medical Technician – Basic (EMT-B) and Advance EMT training programs will be encouraged to obtain national accreditation.
 - EMS Systems may charge fees to cover the costs of the EMS education and credentialing process.
- I ♦ Conduct biannual site visits to each EMS Resource Hospital to review their education and performance improvement programs using statewide standardized criteria.
- S ♦ Share information about educational programs that have been approved through a web site.
- L ♦ Publish annual EMS education and EMS System best practices.
- S ♦ Conduct a state-wide EMS education seminar with various tracks (clinical, education, administrative, special response, etc.).
- I ♦ Determine the feasibility of EMS Education Centers of Excellence that will receive additional funding opportunities to enhance education programs.
- I ♦ Work with the Illinois Rural Health Association to develop innovative and non-traditional EMS education programs to achieve increased rural participation.

- I** ♦ Evaluate a model of continuing education requirements for each level of EMS provider that allows the EMS System Medical Director to determine continued competency.
- L** ♦ Analyze the costs, benefits and risks of transitioning EMS continuing education requirements from an hours-based to a competency-based approach.
- L** ♦ Develop a process for EMS providers that have had a license lapse in the last four years to renew their license without requiring the individual to complete the entire training program.
- S** ♦ EMS Systems' plans shall have an education improvement plan that intersects with a clinical performance improvement plan.
 - EMS will base annual education on needs identified during the clinical performance improvement.
- S** ♦ Recognize completion of EMS education as an academic achievement in order to promote professionalism.
- L** ♦ Recognize Critical Care EMS training programs that meet minimum criteria.
 - Evaluate the feasibility of creating a Critical Care Paramedic level of licensure.
- I** ♦ Conduct an analysis to determine if the current four year EMS license remains adequate and acceptable.

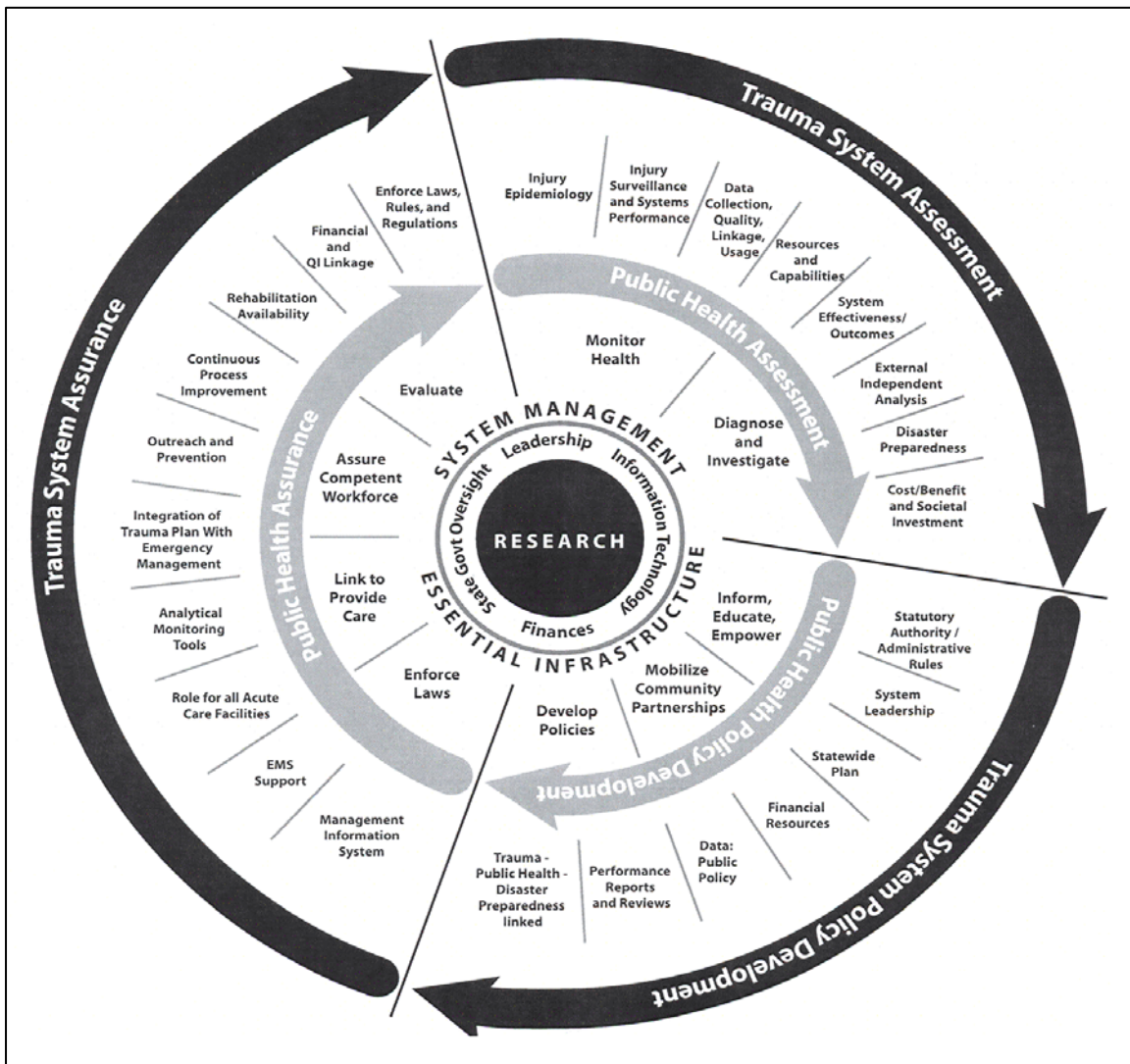
*Evaluation*Research

- L ◆ Incorporate EMS specific research that encompasses both clinical and system aspects as part of the overall Illinois EHC research agenda.

Performance Improvement

- S ◆ Establish processes that provide the best outcomes:
 - Defined as the measure/metric that has been accepted, documented, or defined for a given encounter to be of greatest value in the outcome of the patient.
- L ◆ Evaluate triage of “non-emergent” patients by 9-1-1 centers working with healthcare system oversight.
- L ◆ Ensure that all agencies have compliance plans in place and include benchmarks and an analysis of current issues of non-compliance and a process to develop strategies for performance improvement.
- I ◆ There will be a standardized process of prehospital PI across the system which will encompass cataloging, analyzing, and reporting a minimum set of performance indicators.

Section 3: Trauma within the Emergency Care System



*Assessment*Data Collection Trauma Registry, National Trauma Data Bank

- I ♦ All trauma patients will be identified in the field and assigned a unique trauma system identifier, which follows patients through the entire encounter.
- S ♦ A process for the resolution of trauma registry issues will be developed.
- S ♦ Consideration will be given to the outsourcing of state trauma registry operations and information management through an RFP process.
- I ♦ The software product and service contract with the current vendor will be re-evaluated by an independent group in conjunction with the EHCGB.
 - Recommendations pertaining to the continued use of the current software product and continuation of the service contract will be formulated and acted upon by IDPH.
- I ♦ Any new or current software used for trauma information acquisition will be compliant with the National EMS Information System, the National Trauma Data Standard/National Trauma Data Bank standard, and the Trauma Quality Improvement Program.
- S ♦ Trauma registry inclusion criteria will be defined.
- L ♦ Non-compliance with data submission requirements and system-wide PI process will be grounds for withholding or forfeiture of trauma system funding.

Injury Epidemiology

- S ♦ Produce a formal and thorough description of the epidemiology of injury and injury mortality throughout the system. Following from this will come parallel descriptions for other emergency conditions (stroke, STEMI, asthma, etc.).
 - Production of these descriptive reports and analyses will be the responsibility of various IDPH offices such as vital statistics etc., but under the direction of OEHC and EHCGB. Other entities such as non-profit organizations, universities, hospital associations, insurance associations and other agencies which acquire and maintain pertinent healthcare related data (discharge data, insurance claims data, HCUPS, FARS WISQUARS, law enforcement and judicial databases, etc.) may be solicited to participate and/or allowed proprietary data use for analysis and benchmarking.
 - This may require the formation of a data/epidemiology Task Force/Work Group of the OEHC/EHCGB.

Injury Surveillance

- I** ♦ The system trauma registry software will be capable of allowing ad-hoc report generation by individual hospitals/providers.
- L** ♦ The spinal cord/violence and brain injury registries will be abandoned and pertinent data elements will be incorporated into the trauma registry data set.
- T** ♦ A process to acquire and monitor information on injured patients who do not qualify for entry into the trauma system/trauma registry will be determined by the OEHC/EHCGB
- T** ♦ All ED's participating in the EHCS will be required to record E-codes for all injured patients both admitted as well as treated and released.

Funding to support these essential surveillance functions should come from a dedicated Trauma System Fund allocation potentially supplemented by external federal and private grant funding.

- Increase the knowledge of trauma care providers regarding the field of injury prevention.
 - Implement injury-related protocols into your organizations standard intervention, referral and treatment practices.
 - Increase trauma care provider's role in providing information on the burden of injury in the community and on prevention efforts.
 - Establish partnerships with institutions of education to strengthen research and curriculum in injury prevention.
 - Establish effective communication and collaboration with many disciplines which impact prevention and protection functions (i.e., government officials, legislators, police, fire, EMS, hospitals, trauma centers, schools, private agencies, business, industry, etc.)
- L** ♦ Some or all of Emergency Condition Surveillance activities may be "outsourced" through a RFP process.

Injury Prevention

- S** ♦ An inventory of all system-wide injury prevention activities and educational materials (public and provider) will be undertaken.
 - A clearinghouse of these programs will be developed, potentially to reside on a separate or OEHC web site "clearinghouse" page/portal (Emergency Health Care search engine).

- The inventory and clearinghouse initiative will eventually be expanded to other emergency illnesses/conditions (stroke, STEMI, asthma, etc.).
- S** ◆ A structured system wide PI & E program will be developed and implemented.
- L** ◆ Participating system hospitals will be encouraged to conduct system-wide prevention/wellness activities as directed by the OEHC utilizing their Trauma System Fund allocation.
 - Lack of documentation indicating credible fulfillment of these OEHC directed activities may be considered grounds for forfeiture of all or a portion of future system funding allocation.
- T** ◆ Discussions with the Secretary of State's office state judiciary legislative representatives, and Governor's Highway Safety office to institute a policy of mandating that DUI offenders be administered an alcohol screening test and if positive, subsequently undergo a Brief Intervention.
 - This exploratory process should also seek to substitute a similar policy of making an AUDIT screen part of the driver's license application and renewal process (much the same as a vision test).
 - Again those who screen positive should undergo a brief intervention prior to issuance of a license.

*Policy Development*Performance Reporting

- L ♦ A process of merging prehospital data with acute care and post acute care data mitigating double entry will be developed relying on the implementation of a unique system identifier number.
- S ♦ Reports will be stratified on a system-wide, regional and local level.
- S ♦ The system registry software will allow for ad-hoc report generation by individual hospitals/providers in addition sample template reports for individual hospital/provider and will be constructed and made available by the OEHC.
- I ♦ Standard reports and trends will be reviewed by the regional EMS/trauma governing boards and the state EHCGB annually for comment, recommendation and action.
- L ♦ All hospitals will be required to submit data on all trauma patients meeting TR inclusion criteria.
 - By virtue of timely and complete submission of accurate data, contributing hospitals will be entitled to share in trauma systems fund allocation.
- I ♦ The degree and nature of data sought from hospitals will vary by their level of designation, as will their trauma system fund allocation.
- L ♦ Data integrity and quality will be assessed and monitored at the local, regional and system-wide level on a regular basis through a process to be determined.
- L ♦ Data integrity reports will be constructed and presented for review, comment and action to the OEHC and EHCGB on an annual basis.
- S ♦ There will be a system-wide minimum set of performance improvement (PI) indicators and activities which will be common and standardized.
- L ♦ A standard financial report template will be created for completion by participating system hospitals.
 - This report will be submitted on a regular basis as part of the system wide performance monitoring process.
 - Data will be drawn from the trauma registry and other sources.
- I ♦ Each region and individual hospital within the system will develop their own PI plan and process which builds upon the minimum standard system activities.

- S ♦ By virtue of compliance with system data submission requirements, individual hospitals should be provided access to National Trauma Data Bank data for comparison and benchmarking of their own data as well as TQIP participation.
- L ♦ A process will be implemented to ensure the submission of complete and accurate data to the NTDB data on the required schedule.
- L ♦ All parties at OEHC, as well as at the regional and local level involved in PI activities, will be required to successfully complete an appropriate educational program.
 - Registration fees should be subsidized in whole or part by utilization of trauma system funds.
- S ♦ It will be the responsibility of the Trauma Program Manager to monitor and maintain a record of protocol compliance relating to trauma team activation, response transfer/admission and care guidelines as part of the hospital PI process.
- I ♦ There will be a full-time, salaried, Trauma Medical Director. Experience in trauma surgery and trauma program management will be essential for the successful candidate.
- L ♦ A process of monitoring and assuring quality surgical critical care and subsequent outcome at centers treating trauma patients will be developed by the EHCGB/Trauma Medical Director.
- T ♦ Appropriate data elements relating to critical care will be added to the Trauma Registry Data Set and Data Dictionary.
- L ♦ The OEHC will produce an Annual Report for public distribution encompassing information on surveillance/epidemiology, clinical outcomes and other performance indicators, financial issues, etc.
 - Benchmarking information from the NTDB or other large databases may also be included.
- L ♦ An internal OEHC report should also be produced containing information on OEHC performance and other system issues not deemed pertinent or appropriate for public scrutiny.
 - This report should be confidential and provided only to the EHCGB for review and potential action.

Public Education

- L ♦ A multipurpose EHC System web site will be created and maintained by the OEHC using trauma system funds. Separate pages for the public and system providers will contain information on prevention, education, performance, etc.

This will serve as a primary means of lead agency and provider communication as well as public information and education.

- I ♦ A structured system wide PI & E program will be developed and implemented. This may involve the use of a web site or other media tools.

Trauma Advisory Sub-Committee

- L ♦ There shall be a trauma sub-committee of the EHCGB that focuses on issues pertaining to all aspects of care of the injured patient.
 - This subcommittee shall have access to the OEHC via the trauma division medical director and through the EHCGB.
 - May include ad hoc members.

Legislation, Administrative Rules/Regulations

- I ♦ The definition of a trauma patient will be modified to reflect the most current references such as Resources for Optimal Care of the Injured Patient, CDC Triage Criteria and other key sources.
- L ♦ Require all acute care facilities with emergency departments to participate in the Illinois Trauma System as a condition of hospital licensure.
 - The structured resources and capabilities will generally correspond to those outlined in the ACS Resources for the Optimal Care of the Injured Patient (Most Current Edition).
- L ♦ Rules/Regulations will be developed that define the process for designation that assure timely access to care and appropriate facility placement and distribution
 - The trauma system will be inclusive of all hospitals with emergency departments for the purpose of patient care and data collection and submission to OEHC.
 - Levels of facility designation will be determined by:
 - Patient population (number and level of acuity)
 - Proximity to other trauma centers
 - Level of commitment
 - Ability to meet and maintain designation standards
- L ♦ OHEC will designate post acute care (rehabilitation) facilities to meet the needs of trauma patients and for the purposes of collecting outcome data.
- S ♦ A comprehensive state-wide evaluation of pediatric trauma care capabilities involving triage, transport, transfer bed availability and other resources essential to the optimal care of the pediatric patient will be conducted.

*Assurance*Enforcement of Rules/Regulations

- L** ♦ All hospitals appropriate for inclusion in the trauma component of the Emergency Health Care System will be assigned one of the following four designations based on demonstrated capacity and commitment as well as number, types and severity of injuries.
 - These will generally correspond to the ACS recommended characterizations of:
 - Level I
 - Level II
 - Level III
 - Level IV

- S** ♦ Hospitals of any level will be expected to meet the requirements of designation at that level.
 - Permanent waivers of any requirements or obligations will not be entertained or issued.

- I** ♦ Interhospital transfer criteria between different facilities dealing with neurosurgery, orthopedic, spine, hand and facial injuries or others may be set on a regional basis taking into account varying resources and other considerations.
 - All such interhospital transfer criteria will be approved by OEHC and monitored for compliance and outcome.

- I** ♦ From a conceptual and operational standpoint, each level of facility should demonstrate the capability of caring for patients with certain conditions and gradations of severity either initially or throughout the duration of acute care.
 - Transfers of patients who theoretically can be treated at a particular level of facility will be monitored and considered as a factor in determining trauma center fund allocations.

Quality of Care/Designation

- S** ♦ System-wide policies consistent and/or practice guidelines pertaining to the following, among others, will be developed and implemented.
 - Declaration of death in the field for traumatic cardiac arrest.
 - Selective spine immobilization,
 - RSI
 - Tourniquet use
 - Topical hemostatic

- S ◆ At Level I centers, a qualified general surgeon attending and/or a general surgery PGY 4 resident or higher (PGY 5 or trauma fellow) with current ATLS qualification and credentials to immediately initiate emergency surgery will respond appropriately to trauma activations.
 - When the resident or fellow functions as the “trauma surgeon” a qualified general surgery attending will be available as a back-up in a timely fashion.
- S ◆ All surgical interventions performed in the operating room of any type, on any trauma patient, at any level, center require the timely presence of an attending surgeon with expertise in that operation.
- I ◆ The ED attending physician, if appropriately credentialed, may also act as a proxy for the attending trauma surgeon in the initial evaluation and management of the trauma patient.
 - This will be predicated on the formulation of institutional algorithms for management of certain conditions (blunt abdominal trauma, penetrating torso trauma, etc.) mutually agreed upon by trauma surgeons and ED physicians.
 - These algorithms/care plans will be ultimately approved by the OEHC medical director.
- S ◆ Each level facility will present a detailed plan of response for each level of activation.
- I ◆ Appropriately credentialed residents, trauma/SCC or specialty fellows, and mid level providers may function as a proxy for the attending trauma or specialty surgeon on a contractual basis with the approval of OEHC.
- I ◆ The following patients must be seen and evaluated by a general trauma surgeon or a proxy (in some instances by OEHC approved protocol this may be an ED physician) within 15 minutes of arrival and/or qualify for the highest level of activation:
 - b) persistent BP \leq 90 and unresponsive to fluid
 - c) respiratory rate <10 or >29 on presentation
 - d) penetrating GSW/SGW to the neck/torso/proximal extremity.
- S ◆ In-house trauma surgeons may take other, non-trauma, emergency surgery cases if there is a plan for immediate trauma surgical back-up.
- S ◆ Known transfers from another facility that have been accepted by the trauma surgeon or proxy will not necessarily constitute criteria for a trauma team activation, but merely timely notification of the trauma surgeon or proxy upon patient arrival to the receiving institution.
 - Other appropriate members of the trauma team should also receive timely notification of patient arrival (respiratory therapy, OR nurses, anesthesia, etc.)

- S ♦ All interhospital trauma patient transfers must be accepted by the attending general trauma surgeon or designee.
 - Requests for transfer acceptance may be re-directed to an attending subspecialty surgeon at the discretion of the general trauma surgeon (e.g. isolated injuries such as facial fracture, extremity fracture, etc.)
- I ♦ Patients not meeting criteria for the highest level of activation will generate limited team activation.
 - These patients are to be evaluated and a disposition made by the trauma surgeon/specialty surgeon or their proxy within one hour or less.
- I ♦ All trauma activation patients admitted for observation or treatment must be admitted to an appropriate surgical service.
 - For patients with multiple injuries at Level I and Level II centers, this should be a distinct and identifiable trauma service where patients are evaluated on a daily basis by a trauma surgeon(s) and support staff (resident/PA/NP/TPM) dedicated to the overall management of trauma patients.
- I ♦ All trauma activation admissions to a non-trauma surgical or non-surgical service/attending must be cleared by a general trauma surgeon or proxy within 2 hours according to an agreed upon institutional protocol.
 - The protocol must be approved by OEHC as part of the designation process.)
- L ♦ Rates of over and under triage for each level of activation will be calculated based on system guidelines for those analyses.
- L ♦ Specific criteria for repatriation/back triage of certain patients will be formulated by the EHCGB.
 - By virtue of participation in the trauma system, compliance with sending and receiving criteria will be mandatory and trauma system fund disbursement to hospitals will be contingent upon compliance.
- L ♦ No facility of any level will be obligated/required to accept interfacility transfers of a trauma patient from another state if facilities of similar capabilities exist within that state, unless reimbursement for service and repatriation at the appropriate time is guaranteed.
- S ♦ OEHC will assist all trauma centers with processes to maximize capturing UB-92 activation funds.

- I ◆ A system-wide protocol for the management of life threatening bleeding will be developed to include a standardized Massive Transfusion Protocol (MTP), management algorithm for patients presenting with head injury (with or without lesion on brain CT) and on Coumadin with elevated INR and/or on Plavix.
 - Once such a protocol is developed and promulgated, Level II centers may be allowed to treat patients with traumatic brain bleeding and elevated INR.
 - Use of any such protocol will be closely monitored for compliance and outcome through the local and system wide PI process.

- S ◆ A system-wide algorithm for damage control operation indications and subsequent transfer to higher level facilities will be developed. This will be closely monitored for compliance and outcome through the local and system wide PI process.

- I ◆ If a Level I or Level II center is not within a 30 minute ground transport of a patient meeting criteria for transport to such a facility, then they should be transported to the highest level center within 30 minutes of the scene for initial stabilization or considered for air transport/rendezvous to the optimal level center.
 - In certain situations where the patient is hemodynamically acceptable for prolonged transport and the injury is not time critical, then direct ALS ground transport is feasible and preferable.
 - Such instances of prolonged transport will need on-line approval from medical control and be monitored and critiqued as a standing component of regional and state PI process.

- I ◆ Patients with $GCS \leq 9$ must be treated at facilities with immediate neurosurgical availability and capability of expeditious craniotomy and critical care.

Human Resources/Training/Continued Competency

- I ◆ Minimum credentialing and Maintenance of Competency (MOC) requirements for all providers will be standardized and set by the OEHC/EHCGB.

Evaluation (Process/Outcome)

- S ♦ All mandatory and unique regional prehospital performance indicators are to be reported to the OEHC and EHCGB on an interval of no more than every 6 months.
- S ♦ Specific indications for use of air medical services (field and interfacility) will be determined by the EHCGB.
- L ♦ A process of monitoring and accountability for non-compliance with prehospital destination criteria and repatriation policies will be instituted and enforced with appropriate sanctions.
- S ♦ Appropriate information regarding system performance as well as individual institutional performance will be provided to participating facilities at regular intervals for benchmarking and other purposes.

Section 4: Hospital Emergency Care within the Emergency Care System (Reserved)

Section 5: Stroke within the Emergency Care System (Reserved)

Section 6: STEMI within the Emergency Care System (Reserved)

Section 7: Special Populations within the Emergency Care System (Pediatric [EMSC] and Geriatrics) (Reserved)

Section 8: Emergency Care Response during a Disaster (Reserved)

Acronyms

AUDIT	Alcohol Use Disorders Identification Test
AHA	American Heart Association
DEMSSH	Division of EMS and Highway Safety
EHCGB	Emergency Health Care Governing Board
EHC	Emergency Health Care
EMD	Emergency Medical Dispatcher
EMR	Emergency Medical Response
EMS	Emergency Medical Services
IDPH	Illinois Department of Public Health
IRHA	Illinois Rural Health Association
MSEMSS	Model State Emergency Medical Services System: Self-Assessment, Planning and Implementation
MTSPE	Model Trauma System Planning and Evaluation
NAEMSE	National Association of EMS Educators
NEDARC	National EMSC Data Analysis Resource Center
NEMSIS	National EMS Information System
NEMSSP	National EMS Scope of Practice
NHTSA	National Highway Traffic Safety Administration
NTDS	National Trauma Data Standard
NREMT	National Registry of Emergency Medical Technicians
OEHC	Office of Emergency Health Care
STEMI	ST Elevated Myocardial Infraction
TQIP	Trauma Quality Improvement Program

Appendix

Essential Infrastructure (sorted)

- S ♦ EHCCGB and OEHC will review current rules/laws governing the transport of “non-urgent” patients to Urgent Care Centers.
- S ♦ Under the aegis of the EHC Medical Director, a task force will be convened to analyze regions and report to the EHCGB with recommendations about regional structure and advisory committees.
- S ♦ The EMS/Trauma Center Code will be initially reviewed and revised on a biannual basis with approval by EHCGB prior to introduction into legislative process.
- S ♦ Any specialty funds created to support emergency health care programs must be protected from re-allocation, and must be utilized for intended purposes as directed by EHCGB (100%).
- S ♦ A business plan will be developed for both the EHCS, and the OEHC by the OEHC staff in collaboration with the EHCGB.
- S ♦ Declare Emergency Health Care an “Essential Service”.
 - As an “Essential Service” EHC will require its own dedicated and protected revenue and funding source.
 - EHCS monies will be secured in a dedicated fund which is earmarked for the EHC operation and administrative support.
- S ♦ The OEHC/EHCGB will have the authority to direct the use of EHCS funds disbursed to individual hospitals and regions to accomplish system region or local initiatives and improvements.
 - Recipients of system funds will be accountable to the OEHC/EHCGB for use of the funds as directed and/or in a manner that directly benefits the trauma program or system.
 - A detailed report on the use of EHCS funds will be required by each recipient annually.
 - Failure to comply or use of funds deemed inappropriate will constitute grounds for sanctions and forfeiture of future fund disbursement.
- S ♦ A mechanism to assure protection of funds dedicated to the EHCS and OEHC will be formulated and ultimately legislated.
- S ♦ The Office of Emergency Health Care will maintain and upgrade statewide electronic data collection systems to a status that is consistent with national

- standards for the purposes of supporting continuity of care, surveillance, quality improvement, public reporting and research.
- I ◆ There will be a full-time, salaried, Trauma Medical Director. Experience in trauma surgery and trauma program management will be essential for the successful candidate.
 - I ◆ The current lead agency office will be renamed: Office of Emergency Health Care and will have responsibility for administration of the following:
 - EMS
 - Trauma Care
 - Hospital Emergency Response
 - Emergency Care Response during Disaster Preparedness
 - Special Populations - Pediatric (EMSC), Geriatrics
 - Other Strategic Trends – Stroke, STEMI, Etc.
 - I ◆ There will be an independent assessment by a nationally recognized organization of current lead agency operations and a resultant restructuring addressing appropriate staff size, domains of responsibility, job descriptions, appropriate credentials, performance indicators, salaries and overall cost of operation (estimated operating budget).
 - I ◆ This Emergency Health Care Strategic Plan and companion Implementation Guide will be reviewed all, or in part, by the Office and EHCGB on a regular interval not to exceed 4 years.
 - I ◆ The Emergency Health Care system will have strong medical leadership at every level. Time commitments will be appropriate to the needs of the division or office.
 - I ◆ There will be a full-time, salaried, EHC Medical Director. Emergency and/or trauma system management credentials will be essential for the successful candidate.
 - I ◆ The role of medical director and chief in OEHC will be parallel so that medical director can make requests directly to the Director of IDPH.
 - I ◆ A State Operations Manual/State Program Guide will be developed based on the goals outlined in this plan and consistently applied across the state.
 - I ◆ Allocate a dedicated grant writer within the Office of EMS to investigate/secure funding for key initiatives.
 - I ◆ The estimated cost of operation and administration of the system is \$15 million. This is the minimum amount the fund should contain. Strategies to generate monies to be invested in the fund might include, but not be limited to:

- \$2 EHC system surcharge on all motor vehicle drivers licenses applications (new and renewal/motor vehicle and motorcycle)
 - \$2 surcharge on motor vehicle registration fees (initial and renewal).
 - A \$2 increase in the existing surcharge on DUI and speeding citations
 - A \$500 surcharge on issuance of initial and renewal liquor licenses
 - A \$500 surcharge on licenses to sell guns
 - A \$2 safety fee attached to the issuance of gun permits
 - \$1000 taxation on the purveyors of gun shows
 - \$75 tax on ATV sales
 - A 1% rebate from insurance companies on yearly motor vehicle insurance premium revenues
 - A 0.5% guaranteed allocation of state income tax revenue
 - A \$1 surcharge on the sale of fireworks
 - Revenue from trauma center designation site visits
 - Surcharge on the sale of guns and ammunition
- I** ◆ The Office of Emergency Health Care will be able to link, aggregate and report data from each of the various databases under its aegis, (e.g. trauma registry, prehospital, rehabilitation, etc.).
- I** ◆ The OEHC will convene a sub-committee of the EHCGB to support, promote and develop a specific research agenda for the emergency health care system in Illinois.
- I** ◆ The OEHC and EHCGB will collaborate with academic units with a focus on public health and other affiliated academic entities to provide support in the development and implementation of a research agenda.
- I** ◆ The OEHC and EHCGB will review current literature for best practices across the emergency health care spectrum and replicate and evaluate these practices.
- I** ◆ The OEHC will develop standards and procedures for obtaining, using and protecting all emergency health care data collected and maintained by the state.
- L** ◆ A State Emergency Health Care Governing Board will be formed and empowered to advise and direct the lead agency in regard to emergency healthcare issues. This governing board will be multidisciplinary and representative of all phases of emergency health care.
- All section medical directors will be included.
 - Representatives from surrounding states to be included.
- L** ◆ EMS and Trauma System Advisory Council and other stakeholders will be integrated into a single EHCGB.
- L** ◆ EMS operations will be included in any current grant funding opportunities.

- L** ♦ The proportional allocation of system funds will be determined by a disbursal calculation to be developed by the OEHC/EHCGB.
- T** ♦ Expand the current EMS Assistance Fund grant program.
- T** ♦ Trauma center funds will be re-designated and re-allocated as trauma system funds with at minimum 25% dedicated to the Office of Emergency Health Care.
- T** ♦ Negotiations at the gubernatorial, attorneys/general and legislative level will be initiated with adjoining states, as appropriate, to assure fair and timely compensation of care to residents of those states who are treated by Illinois system providers (e.g. reciprocal public aid agreements/memorandum of understanding/policies, etc.).
- T** ♦ Disbursement of EHCS funds to participating facilities in Illinois as well as surrounding states will be contingent upon compliance with all requirements specified for a particular designation level.

EMS (sorted)

- S ♦ Develop capability to accept and then export data in XML standard.
- S ♦ Improve accuracy, validity, and completeness of data being submitted and collected.
- S ♦ Develop and coordinate with other state offices various media/public education campaigns to educate key populations and communities.
- S ♦ Create partnerships with other allied health professionals/organizations that affect Emergency Health Care.
- S ♦ Develop guidelines for patients that are medically acceptable for Medi-car transport.
- S ♦ Promote public awareness of 9-1-1 as THE emergency access point.
- S ♦ Ensure proper medical oversight throughout all aspects of the Emergency Health Care system.
- S ♦ Each EMS provider agency will be required to belong to an EMS system.
- S ♦ Incorporate nontraditional mutual aid organizations such as (PPERS) Private Provider Emergency Response System and (CHUG) Collaborative Healthcare Urgency Group into disaster planning and response.
- S ♦ Each educational program shall develop lesson plans that meet or exceed the national core content and the minimum recommendations for hours and patient care experiences for providers at all levels.
- S ♦ Identify and promote acceptable emergency driving courses and identify equivalency requirements for all EMS responders.
- S ♦ Share information about educational programs that have been approved through a web site.
- S ♦ Conduct a state-wide EMS education seminar with various tracks (clinical, education, administrative, special response, etc.).
- S ♦ EMS Systems' plans shall have an education improvement plan that intersects with a clinical performance improvement plan.
 - EMS will base annual education on needs identified during the clinical performance improvement.

- S ♦ Recognize completion of EMS education as an academic achievement in order to promote professionalism.
- S ♦ Establish processes that provide the best outcomes:
 - Defined as the measure/metric that has been accepted, documented, or defined for a given encounter to be of greatest value in the outcome of the patient.
- I ♦ Adopt a single state patient tracking program to assure statewide consistency.
 - Assure patient tracking coordination and interoperability among prehospital and hospital systems, providers and state/national repositories.
- I ♦ Achieve NEMESIS compliance at a 100% level of required data elements.
- I ♦ Enter and submit data electronically: via web, or internet.
- I ♦ Increase number of EMS agencies with access to computers..
- I ♦ Produce a formal and thorough description of the epidemiology of injury and injury mortality throughout the system. Following from this will come parallel descriptions for other emergency conditions.
- I ♦ Drugs
 - Review, and revise as necessary, standardized policies and supporting processes related to drug restocking/exchange-based on Federal guidelines.
- I ♦ Equipment
 - Review, and revise as necessary, standardized policies and supporting processes related to equipment/supply restocking/exchange/billing-based on state and federal guidelines.
- I ♦ Develop consistent/standardized “treat and release” patient policies and supporting processes.
- I ♦ Advocate for Emergency Health Care systems and hospital-wide policies to eliminate boarding and bypass in partnership with other health care organizations.
- I ♦ Develop inter-regional and interstate policies for ground and air medical transport.
- I ♦ Address interoperability issues between response partners, systems and among each provider.
- I ♦ The EMS System will be responsible for approval of EMS educational programs consistent with recognized state and national standards.

- I ◆ Advocate for a streamlined process of opening additional hospital beds when surge contingency plans are activated.
- I ◆ Develop and streamline regulations and processes for hospitals and alternate care facilities to utilize when activating their surge contingency plans.
- I ◆ Develop inter-regional and interstate policies and EMS operational agreements for the treatment and transport of patients during times of diversions.
- I ◆ Dedicate a full-time Disaster Preparedness position at each resource/associate hospital.
- I ◆ Conduct a needs and cost benefit analysis, and provide a report to the EHCGB determining if Illinois should continue to administer validated state EMT examinations, or utilize the National Registry of EMT examination service.
- I ◆ If the result of the above analysis reflects that the best method for initial licensure is the National Registry of EMT examination
 - Explore an agreement with NREMT to require only the written examination.
 - The practical examination requirements would be waived unless an individual desired to obtain the NREMT designation.
- I ◆ OEHC will adopt the National EMS Scope of Practice Models for all levels of EMS to serve as the minimum foundation for educational programs.
- I ◆ Each program shall measure competency in cognitive, psychomotor, and affective domains utilizing written examinations, site-specific practical examinations, and evaluating the behaviors specified in the National Education Standards.
- I ◆ Develop an EMS Educator mentoring and an auditing program for current educator.
- I ◆ At a minimum, all primary instructors will acquire and maintain lead instructor status/recognition.
- I ◆ Lead Instructor and affiliate/secondary instructor training programs will be conducted on a regional basis to meet regional needs utilizing state-approved core curriculum that will meet or exceed NAEMSE criteria.
 - The costs of these training courses will be off-set through course tuition.
 - These training programs will be conducted by EMS Systems and approved by OEHC.

- I ◆ OEHC will develop a training/education evaluation instrument; based on the National EMS Education Agenda for the future that will allow Lead Instructors to be evaluated at the end of each course.
 - Establish minimum performance criteria.
 - Provide review and remediation as indicated.
- I ◆ Each Paramedic training program shall be recognized by a national accreditation program.
 - Emergency Medical Technician – Basic (EMT-B) and Advance EMT training programs will be encouraged to obtain national accreditation.
 - EMS Systems may charge fees to cover the costs of the EMS education and credentialing process.
- I ◆ Conduct biannual site visits to each EMS Resource Hospital to review their education and performance improvement programs using statewide standardized criteria.
- I ◆ Determine the feasibility of EMS Education Centers of Excellence that will receive additional funding opportunities to enhance education programs.
- I ◆ Work with the Illinois Rural Health Association to develop innovative and non-traditional EMS education programs to achieve increased rural participation.
- I ◆ Evaluate a model of continuing education requirements for each level of EMS provider that allows the EMS System Medical Director to determine continued competency.
- I ◆ Conduct an analysis to determine if the current four year EMS license remains adequate and acceptable.
- I ◆ There will be a standardized process of prehospital PI across the system which will encompass cataloging, analyzing, and reporting a minimum set of performance indicators.
- L ◆ Ensure that data collected support the performance improvement processes.
- L ◆ Establish a single patient identifier to track a patient throughout the entire course of emergency care (including rehabilitation EMS-ED-hospital-rehab).
- L ◆ The Office of Emergency Health Care shall produce an annual report that includes all divisions of emergency health care based upon the previous year's statewide data acquisition.
- L ◆ Ensure that all aspects of the EHCS in Illinois are connected to and engaged in injury and illness prevention and wellness promotion.

- L ◆ Formulate policies and processes that encourage EMS agencies to participate in a program whereby prehospital care providers conduct wellness visits/injury prevention assessments.
 - These activities will be conducted in conjunction with local health departments and participating system hospitals.
 - Participation in such programs will eventually become a requisite for EMS agency certification .
- L ◆ Develop policies and supporting processes for diversion/transport to specialty care centers.
- L ◆ Modify administrative rules and/or adopt policies to support and enforce full participation of Emergency Health Care data submission.
- L ◆ Office of Emergency Health Care and the Emergency Health Care Governing Board will review and revise any required legislation and administrative code rule changes to support the levels and titles of EMS providers supported through the National Highway Traffic Safety Administration (NHTSA).
- L ◆ OEHC will develop a grant program to incorporate technology into education programs.
- L ◆ Develop operational agreements for the interstate transport and treatment of patients for dual licensed providers and prehospital care provider licenses.
- L ◆ Collaborate with the statewide 9-1-1 office to ensure further development and sustainment of the enhanced 9-1-1 system.
- L ◆ Develop mechanisms to assess compliance for Emergency Medical Dispatchers with current EMS regulations.
- L ◆ Develop and maintain dedicated EMS communication resources sufficient for current and future needs.
- L ◆ Require all acute care facilities with emergency departments to participate in the Illinois Facility Recognition Program as a condition of hospital licensure.
- L ◆ Develop inter-regional and interstate Emergency Health Care policies and protocols.
- L ◆ Determine and work to obtain, in collaboration with system researchers, the optimal staffing and deployment strategies for EMS in metropolitan, suburban and rural environments.

- L ♦ Develop minimum statewide EMS protocols at all levels of providers to ensure consistent delivery of optimal care across the Emergency Health Care system, and to facilitate mobility of EMS providers between Illinois EMS Systems and agencies.
- L ♦ Allow private and public EMS provider's agencies access to Illinois Department of Public Health web portal for monitoring of the hospital bypass system and other Office of Emergency Health Care applications and information.
- L ♦ Advocate to streamline the intake process for psychiatric patients.
- L ♦ Encourage Emergency Medical Response training throughout communities.
- L ♦ OEHC shall determine specific competencies required for specialty care and require such specific competencies as part of continuing education programs for all appropriate levels of providers.
- L ♦ OEHC will develop minimum requirements for any continuing education program.
- L ♦ Publish annual EMS education and EMS System best practices.
- L ♦ Analyze the costs, benefits and risks of transitioning EMS continuing education requirements from an hours-based to a competency-based approach.
- L ♦ Develop a process for EMS providers that have had a license lapse in the last four years to renew their license without requiring the individual to complete the entire training program.
- L ♦ Recognize Critical Care EMS training programs that meet minimum criteria.
 - Evaluate the feasibility of creating a Critical Care Paramedic level of licensure.
- L ♦ Incorporate EMS specific research that encompasses both clinical and system aspects as part of the overall Illinois EHC research agenda.
- L ♦ Evaluate triage of "non-emergent" patients by 9-1-1 centers working with healthcare system oversight.
- L ♦ Ensure that all agencies have compliance plans in place and include benchmarks and an analysis of current issues of non-compliance and a process to develop strategies for performance improvement.
- T ♦ Request and host a NEMSIS/NEDARC site visit.

Trauma (sorted)

- S ♦ A process for the resolution of trauma registry issues will be developed.
- S ♦ Consideration will be given to the outsourcing of state trauma registry operations and information management through an RFP process.
- S ♦ Trauma registry inclusion criteria will be defined.
- S ♦ Produce a formal and thorough description of the epidemiology of injury and injury mortality throughout the system. Following from this will come parallel descriptions for other emergency conditions (stroke, STEMI, asthma, etc.).
 - Production of these descriptive reports and analyses will be the responsibility of various IDPH offices such as vital statistics etc., but under the direction of OEHC and EHCGB. Other entities such as non-profit organizations, universities, hospital associations, insurance associations and other agencies which acquire and maintain pertinent healthcare related data (discharge data, insurance claims data, HCUPS, FARS WISQUARS, law enforcement and judicial databases, etc.) may be solicited to participate and/or allowed proprietary data use for analysis and benchmarking.
 - This may require the formation of a data/epidemiology Task Force/Work Group of the OEHC/EHCGB.
- S ♦ An inventory of all system-wide injury prevention activities and educational materials (public and provider) will be undertaken.
 - A clearinghouse of these programs will be developed, potentially to reside on a separate or OEHC web site “clearinghouse” page/portal (Emergency Health Care search engine).
 - The inventory and clearinghouse initiative will eventually be expanded to other emergency illnesses/conditions (stroke, STEMI, asthma, etc.).
- S ♦ A structured system wide PI & E program will be developed and implemented.
- S ♦ Reports will be stratified on a system-wide, regional and local level.
- S ♦ The system registry software will allow for ad-hoc report generation by individual hospitals/providers in addition sample template reports for individual hospital/provider and will be constructed and made available by the OEHC.
- S ♦ There will be a system-wide minimum set of performance improvement (PI) indicators and activities which will be common and standardized.
- S ♦ By virtue of compliance with system data submission requirements, individual hospitals should be provided access to National Trauma Data Bank data for comparison and benchmarking of their own data as well as TQIP participation.

- S ◆ It will be the responsibility of the Trauma Program Manager to monitor and maintain a record of protocol compliance relating to trauma team activation, response transfer/admission and care guidelines as part of the hospital PI process.
- S ◆ A comprehensive state-wide evaluation of pediatric trauma care capabilities involving triage, transport, transfer bed availability and other resources essential to the optimal care of the pediatric patient will be conducted.
- S ◆ Hospitals of any level will be expected to meet the requirements of designation at that level.
 - Permanent waivers of any requirements or obligations will not be entertained or issued.
- S ◆ System-wide policies consistent and/or practice guidelines pertaining to the following, among others, will be developed and implemented.
 - Declaration of death in the field for traumatic cardiac arrest.
 - Selective spine immobilization,
 - RSI
 - Tourniquet use
 - Topical hemostatic
- S ◆ At Level I centers, a qualified general surgeon attending and/or a general surgery PGY 4 resident or higher (PGY 5 or trauma fellow) with current ATLS qualification and credentials to immediately initiate emergency surgery will respond appropriately to trauma activations.
 - When the resident or fellow functions as the “trauma surgeon” a qualified general surgery attending will be available as a back-up in a timely fashion.
- S ◆ All surgical interventions performed in the operating room of any type, on any trauma patient, at any level, center require the timely presence of an attending surgeon with expertise in that operation.
- S ◆ Each level facility will present a detailed plan of response for each level of activation.
- S ◆ In-house trauma surgeons may take other, non-trauma, emergency surgery cases if there is a plan for immediate trauma surgical back-up.
- S ◆ Known transfers from another facility that have been accepted by the trauma surgeon or proxy will not necessarily constitute criteria for a trauma team activation, but merely timely notification of the trauma surgeon or proxy upon patient arrival to the receiving institution.
 - Other appropriate members of the trauma team should also receive timely notification of patient arrival (respiratory therapy, OR nurses, anesthesia, etc.)

- S ♦ All interhospital trauma patient transfers must be accepted by the attending general trauma surgeon or designee.
 - Requests for transfer acceptance may be re-directed to an attending subspecialty surgeon at the discretion of the general trauma surgeon (e.g. isolated injuries such as facial fracture, extremity fracture, etc.)
- S ♦ OEHC will assist all trauma centers with processes to maximize capturing UB-92 activation funds.
- S ♦ A system-wide algorithm for damage control operation indications and subsequent transfer to higher level facilities will be developed. This will be closely monitored for compliance and outcome through the local and system wide PI process.
- S ♦ All mandatory and unique regional prehospital performance indicators are to be reported to the OEHC and EHCGB on an interval of no more than every 6 months.
- S ♦ Specific indications for use of air medical services (field and interfacility) will be determined by the EHCGB.
- S ♦ Appropriate information regarding system performance as well as individual institutional performance will be provided to participating facilities at regular intervals for benchmarking and other purposes.
- I ♦ All trauma patients will be identified in the field and assigned a unique trauma system identifier, which follows patients through the entire encounter.
- I ♦ The software product and service contract with the current vendor will be re-evaluated by an independent group in conjunction with the EHCGB.
 - Recommendations pertaining to the continued use of the current software product and continuation of the service contract will be formulated and acted upon by IDPH.
- I ♦ Any new or current software used for trauma information acquisition will be compliant with the National EMS Information System, the National Trauma Data Standard/National Trauma Data Bank standard, and the Trauma Quality Improvement Program.
- I ♦ The system trauma registry software will be capable of allowing ad-hoc report generation by individual hospitals/providers.
- I ♦ Standard reports and trends will be reviewed by the regional EMS/trauma governing boards and the state EHCGB annually for comment, recommendation and action.

- I ◆ The degree and nature of data sought from hospitals will vary by their level of designation, as will their trauma system fund allocation.
- I ◆ Each region and individual hospital within the system will develop their own PI plan and process which builds upon the minimum standard system activities.
- I ◆ A structured system wide PI & E program will be developed and implemented. This may involve the use of a web site or other media tools.
- I ◆ The definition of a trauma patient will be modified to reflect the most current references such as Resources for Optimal Care of the Injured Patient, CDC Triage Criteria and other key sources.
- I ◆ Interhospital transfer criteria between different facilities dealing with neurosurgery, orthopedic, spine, hand and facial injuries or others may be set on a regional basis taking into account varying resources and other considerations.
 - All such interhospital transfer criteria will be approved by OEHC and monitored for compliance and outcome.
- I ◆ From a conceptual and operational standpoint, each level of facility should demonstrate the capability of caring for patients with certain conditions and gradations of severity either initially or throughout the duration of acute care.
 - Transfers of patients who theoretically can be treated at a particular level of facility will be monitored and considered as a factor in determining trauma center fund allocations.
- I ◆ The ED attending physician, if appropriately credentialed, may also act as a proxy for the attending trauma surgeon in the initial evaluation and management of the trauma patient.
 - This will be predicated on the formulation of institutional algorithms for management of certain conditions (blunt abdominal trauma, penetrating torso trauma, etc.) mutually agreed upon by trauma surgeons and ED physicians.
 - These algorithms/care plans will be ultimately approved by the OEHC medical director.
- I ◆ Appropriately credentialed residents, trauma/SCC or specialty fellows, and mid level providers may function as a proxy for the attending trauma or specialty surgeon on a contractual basis with the approval of OEHC.
- I ◆ The following patients must be seen and evaluated by a general trauma surgeon or a proxy (in some instances by OEHC approved protocol this may be an ED physician) within 15 minutes of arrival and/or qualify for the highest level of activation:
 - b) persistent BP \leq 90 and unresponsive to fluid
 - c) respiratory rate <10 or >29 on presentation

d) penetrating GSW/SGW to the neck/torso/proxal extremity.

- I ◆ Patients not meeting criteria for the highest level of activation will generate limited team activation.
 - These patients are to be evaluated and a disposition made by the trauma surgeon/specialty surgeon or their proxy within one hour or less.

- I ◆ All trauma activation patients admitted for observation or treatment must be admitted to an appropriate surgical service.
 - For patients with multiple injuries at Level I and Level II centers, this should be a distinct and identifiable trauma service where patients are evaluated on a daily basis by a trauma surgeon(s) and support staff (resident/PA/NP/TPM) dedicated to the overall management of trauma patients.

- I ◆ All trauma activation admissions to a non-trauma surgical or non-surgical service/attending must be cleared by a general trauma surgeon or proxy within 2 hours according to an agreed upon institutional protocol.
 - The protocol must be approved by OEHC as part of the designation process.)

- I ◆ A system-wide protocol for the management of life threatening bleeding will be developed to include a standardized Massive Transfusion Protocol (MTP), management algorithm for patients presenting with head injury (with or without lesion on brain CT) and on Coumadin with elevated INR and/or on Plavix.
 - Once such a protocol is developed and promulgated, Level II centers may be allowed to treat patients with traumatic brain bleeding and elevated INR.
 - Use of any such protocol will be closely monitored for compliance and outcome through the local and system wide PI process.

- I ◆ If a Level I or Level II center is not within a 30 minute ground transport of a patient meeting criteria for transport to such a facility, then they should be transported to the highest level center within 30 minutes of the scene for initial stabilization or considered for air transport/rendezvous to the optimal level center.
 - In certain situations where the patient is hemodynamically acceptable for prolonged transport and the injury is not time critical, then direct ALS ground transport is feasible and preferable.
 - Such instances of prolonged transport will need on-line approval from medical control and be monitored and critiqued as a standing component of regional and state PI process.

- I ◆ Patients with $GCS \leq 9$ must be treated at facilities with immediate neurosurgical availability and capability of expeditious craniotomy and critical care.

- I ◆ Minimum credentialing and Maintenance of Competency (MOC) requirements for all providers will be standardized and set by the OEHC/EHCGB.
- L ◆ Non-compliance with data submission requirements and system-wide PI process will be grounds for withholding or forfeiture of trauma system funding.
- L ◆ The spinal cord/violence and brain injury registries will be abandoned and pertinent data elements will be incorporated into the trauma registry data set.
- L ◆ Some or all of Emergency Condition Surveillance activities may be “outsourced” through a RFP process.
- L ◆ Participating system hospitals will be encouraged to conduct system-wide prevention/wellness activities as directed by the OEHC utilizing their Trauma System Fund allocation.
 - Lack of documentation indicating credible fulfillment of these OEHC directed activities may be considered grounds for forfeiture of all or a portion of future system funding allocation.
- L ◆ A process of merging prehospital data with acute care and post acute care data mitigating double entry will be developed relying on the implementation of a unique system identifier number.
- L ◆ All hospitals will be required to submit data on all trauma patients meeting TR inclusion criteria.
 - By virtue of timely and complete submission of accurate data, contributing hospitals will be entitled to share in trauma systems fund allocation.
- L ◆ Data integrity and quality will be assessed and monitored at the local, regional and system-wide level on a regular basis through a process to be determined.
- L ◆ Data integrity reports will be constructed and presented for review, comment and action to the OEHC and EHCGB on an annual basis.
- L ◆ A standard financial report template will be created for completion by participating system hospitals.
 - This report will be submitted on a regular basis as part of the system wide performance monitoring process.
 - Data will be drawn from the trauma registry and other sources.
- L ◆ A process will be implemented to ensure the submission of complete and accurate data to the NTDB data on the required schedule.
- L ◆ All parties at OEHC, as well as at the regional and local level involved in PI activities, will be required to successfully complete an appropriate educational program.

- Registration fees should be subsidized in whole or part by utilization of trauma system funds.
- L** ◆ A process of monitoring and assuring quality surgical critical care and subsequent outcome at centers treating trauma patients will be developed by the EHCGB/Trauma Medical Director.
- L** ◆ The OEHC will produce an Annual Report for public distribution encompassing information on surveillance/epidemiology, clinical outcomes and other performance indicators, financial issues, etc.
 - Benchmarking information from the NTDB or other large databases may also be included.
- L** ◆ An internal OEHC report should also be produced containing information on OEHC performance and other system issues not deemed pertinent or appropriate for public scrutiny.
 - This report should be confidential and provided only to the EHCGB for review and potential action.
- L** ◆ A multipurpose EHC System web site will be created and maintained by the OEHC using trauma system funds. Separate pages for the public and system providers will contain information on prevention, education, performance, etc. This will serve as a primary means of lead agency and provider communication as well as public information and education.
- L** ◆ There shall be a trauma sub-committee of the EHCGB that focuses on issues pertaining to all aspects of care of the injured patient.
 - This subcommittee shall have access to the OEHC via the trauma division medical director and through the EHCGB.
 - May include ad hoc members.
- L** ◆ Require all acute care facilities with emergency departments to participate in the Illinois Trauma System as a condition of hospital licensure.
 - The structured resources and capabilities will generally correspond to those outlined in the ACS Resources for the Optimal Care of the Injured Patient (Most Current Edition).
- L** ◆ Rules/Regulations will be developed that define the process for designation that assure timely access to care and appropriate facility placement and distribution
 - The trauma system will be inclusive of all hospitals with emergency departments for the purpose of patient care and data collection and submission to OEHC.
 - Levels of facility designation will be determined by:
 - Patient population (number and level of acuity)
 - Proximity to other trauma centers
 - Level of commitment

- Ability to meet and maintain designation standards
- L ♦ OHEC will designate post acute care (rehabilitation) facilities to meet the needs of trauma patients and for the purposes of collecting outcome data.
- L ♦ All hospitals appropriate for inclusion in the trauma component of the Emergency Health Care System will be assigned one of the following four designations based on demonstrated capacity and commitment as well as number, types and severity of injuries.
 - These will generally correspond to the ACS recommended characterizations of:
 - Level I
 - Level II
 - Level III
 - Level IV
- L ♦ Rates of over and under triage for each level of activation will be calculated based on system guidelines for those analyses.
- L ♦ Specific criteria for repatriation/back triage of certain patients will be formulated by the EHCGB.
 - By virtue of participation in the trauma system, compliance with sending and receiving criteria will be mandatory and trauma system fund disbursement to hospitals will be contingent upon compliance.
- L ♦ No facility of any level will be obligated/required to accept interfacility transfers of a trauma patient from another state if facilities of similar capabilities exist within that state, unless reimbursement for service and repatriation at the appropriate time is guaranteed.
- L ♦ A process of monitoring and accountability for non-compliance with prehospital destination criteria and repatriation policies will be instituted and enforced with appropriate sanctions.
- T ♦ A process to acquire and monitor information on injured patients who do not qualify for entry into the trauma system/trauma registry will be determined by the OEHC/EHCGB
- T ♦ All ED's participating in the EHCS will be required to record E-codes for all injured patients both admitted as well as treated and released.

Funding to support these essential surveillance functions should come from a dedicated Trauma System Fund allocation potentially supplemented by external federal and private grant funding.

- Increase the knowledge of trauma care providers regarding the field of injury prevention.
 - Implement injury-related protocols into your organizations standard intervention, referral and treatment practices.

 - Increase trauma care provider's role in providing information on the burden of injury in the community and on prevention efforts.

 - Establish partnerships with institutions of education to strengthen research and curriculum in injury prevention.

 - Establish effective communication and collaboration with many disciplines which impact prevention and protection functions (i.e., government officials, legislators, police, fire, EMS, hospitals, trauma centers, schools, private agencies, business, industry, etc.)
- T** ◆ Discussions with the Secretary of State's office state judiciary legislative representatives, and Governor's Highway Safety office to institute a policy of mandating that DUI offenders be administered an alcohol screening test and if positive, subsequently undergo a Brief Intervention.
- This exploratory process should also seek to substitute a similar policy of making an AUDIT screen part of the driver's license application and renewal process (much the same as a vision test).
 - Again those who screen positive should undergo a brief intervention prior to issuance of a license.
- T** ◆ Appropriate data elements relating to critical care will be added to the Trauma Registry Data Set and Data Dictionary.