Division of EMS & Highway Safety

5 Year Strategic Plan

September 2010

FORWARD

On September 13, 2007, the Illinois Department of Public Health (IDPH), Division of Emergency Medical Systems & Highway Safety, convened a multi disciplinary group of approximately 150 individuals representing the emergency medical systems (EMS) and trauma communities for the first of many meetings to assist in the development of a five year strategic plan. The following depicts how this group was broken down into working groups:

Trauma Sub Group

1. Administration
2. Information Systems / Evaluation / Research / Injury Prevention
3. Human Resources / Education / Definitive Care
4. Prehospital / Disaster/ Communications

EMS Sub Group

1. Administration
2. Information Systems
3. Human Resources / Education
4. Operations

On, December 15, 2008, the *Strategic Plan Draft Recommendations* document was released, containing the work of the above groups. Shortly thereafter, the Division instructed the sub groups to nominate a representative from each working group to serve on the Strategic Plan Recommendation Analysis Team (SPRAT) to work on assigning each recommendation contained in this document with a broad range timeline of short term (less than 12 months), intermediate (1 to 3 years) or long term (3 to 5 years). On March 4, 2010, an updated version of the *Strategic Plan Draft Recommendations* document was released, which contained the timelines as recommended by the SPRAT.

Upon release of the updated *Strategic Plan Draft Recommendations,* the Division began the work of transforming this document into one that accurately represents the vision of the Director of IDPH as well as one that provides a format that will allow for ease in assigning tasks and tracking progress of implementation. Several internal meetings were held with the Director to review and discuss each recommendation and associated timeline. He subsequently made a determination on each recommendation as to whether to move forward with implementation activities or to table it taking into account budget and staffing constraints, the political climate or simply his vision for the future of EMS and trauma in Illinois. The format of the goals and objectives section is structured to follow the proposed Division of EMS organizational chart. Goals may appear in more than one section as multiple program areas may be involved in the implementation of the item.

The following document represents countless hours of hard work by many passionate and dedicated individuals and organizations. Implementation of many of the activities in this document has already begun and we look forward to continuing to work in conjunction with the EMS and trauma communities in Illinois to carry out our mission.

HISTORY

By 1960, concern for the rising death rate among victims of traumatic injuries in Illinois prompted state government to begin planning to coordinate community resources for the purposes of decreasing the risk of accidents, improving the quality of emergency services and developing a comprehensive network of emergency medical services responsive to the varied needs of all the citizens of Illinois.

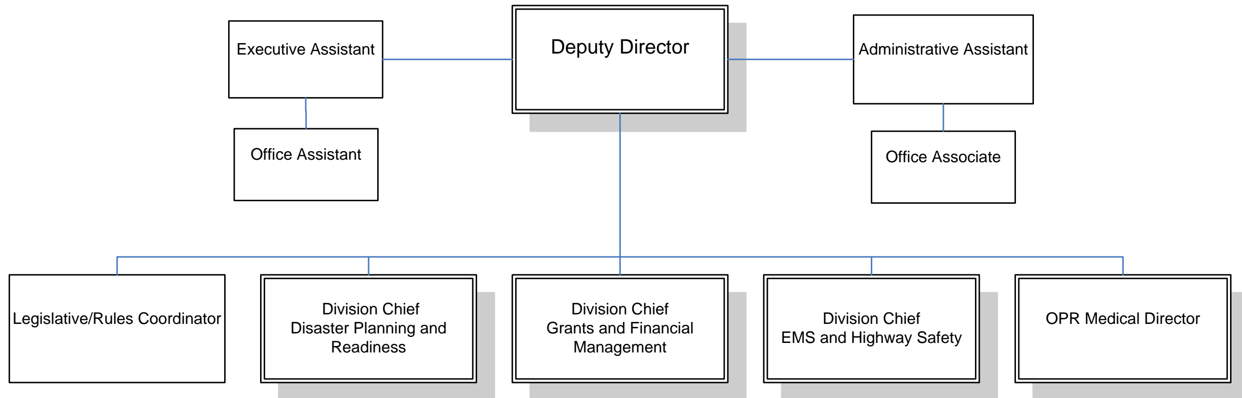
The plan was developed and, in 1971, then-Governor Richard B. Ogilvie formed a committee by executive order that worked to implement its proposals, including the establishment of training for emergency medical technicians (EMTs), physician training and a trauma nurse specialist (TNS) course.

Again by executive order, Governor Ogilvie directed the Illinois Department of Public Health (IDPH) to establish the Division of Emergency Medical Services and Highway Safety, which was authorized July 1, 1971. A cornerstone of the Division's initial efforts was a three-tiered designation system (i.e., regional, area wide and local) for trauma centers throughout the state. Local and area wide trauma centers were to direct appropriate patients to the regional centers through patient referral agreements. The fledgling program had a beneficial impact, but it would not be until later, when stronger enabling legislation was enacted, that a sophisticated trauma system emerged.

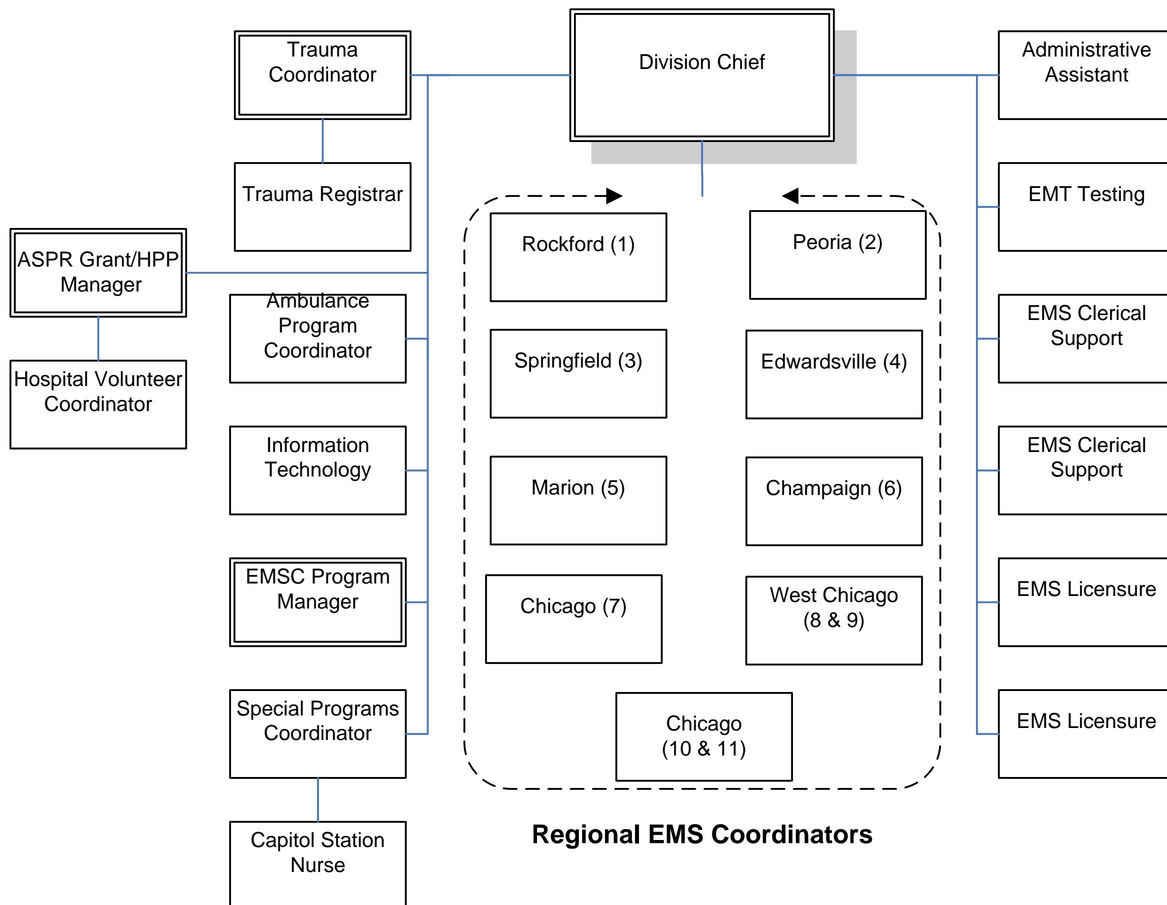
In 2004, the name of the Division was changed from Emergency Medical Services and Highway Safety to the Division of Emergency Medical Systems and Highway Safety. This small change was done to reflect our role in the overall system, and the distinction that the Division does not actually provide services.

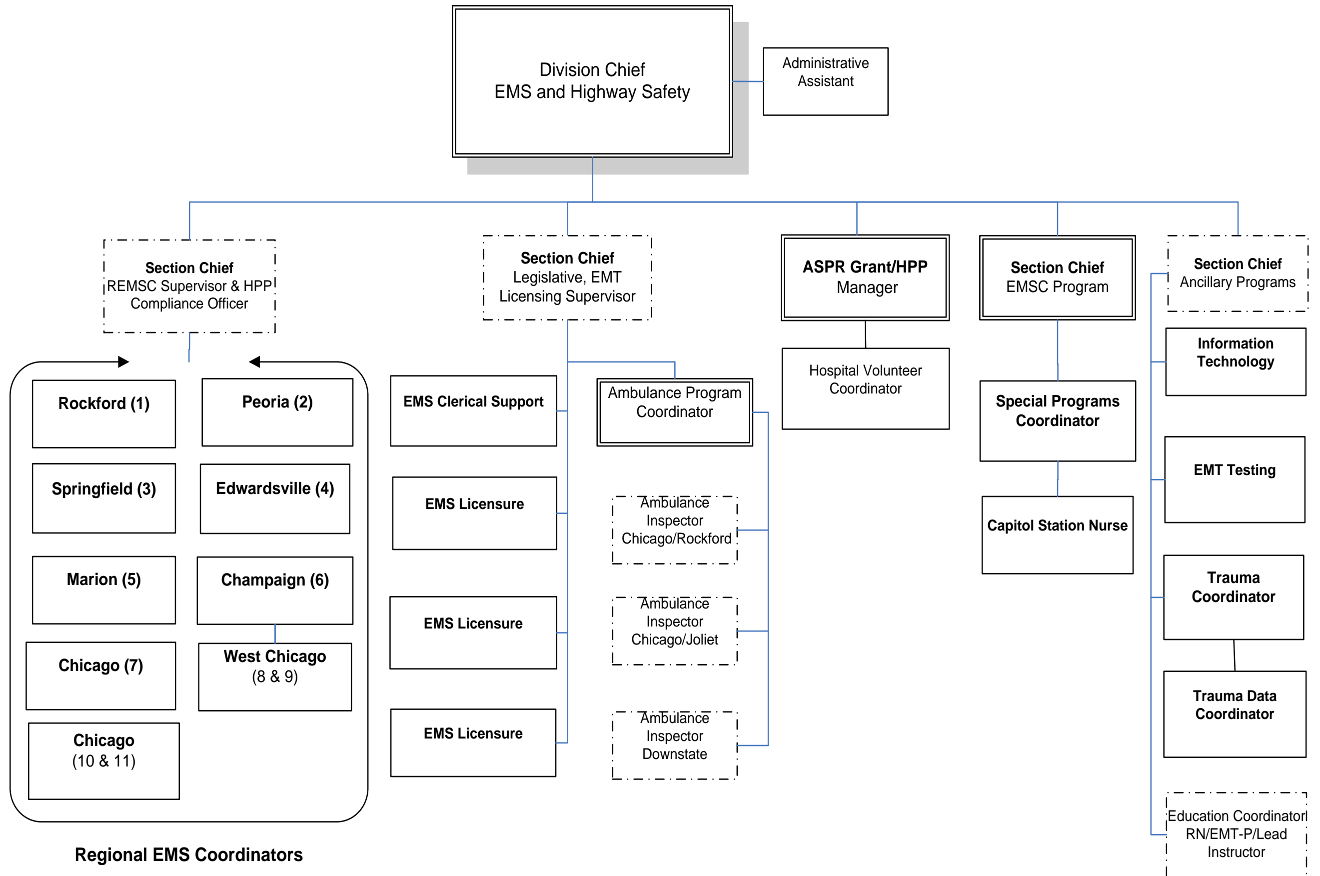
STRUCTURE

The Office of Preparedness and Response is led by Deputy Director Winfred Rawls, who was appointed in July of 2008. The Office is divided into three divisions: Division of EMS & Highway Safety, Division of Disaster Planning and Readiness and Division of Grants and Financial Management.



EMS is led by Division Chief Jack Fleeharty, who was appointed in May of 2009. The existing structure has most positions in the Division reporting directly to the Division Chief. Changes to the structure of the Division have been proposed.




Division of EMS and Highway Safety
(Proposed Structure)
Division Chief
EMS and Highway Safety
Administrative
Assistant
Section Chief
REMSC Supervisor & HPP
Compliance Officer
Section Chief
Legislative, EMT
Licensing Supervisor
ASPR Grant/HPP
Manager
Section Chief
EMSC Program
Section Chief
Ancillary Programs
Rockford (1)
Peoria (2)
Springfield (3)
Edwardsville (4)
Marion (5)
Champaign (6)
Chicago (7)
West Chicago
(8 & 9)
Chicago
(10 & 11)
Regional EMS Coordinators
EMS Clerical Support
EMS Licensure
EMS Licensure
EMS Licensure
Ambulance Program
Coordinator
Ambulance
Inspector
Chicago/Rockford
Ambulance
Inspector
Chicago/Joliet
Ambulance
Inspector
Downstate
Hospital Volunteer
Coordinator
Special Programs
Coordinator
Capitol Station Nurse
Information
Technology
EMT Testing
Trauma
Coordinator
Trauma Data
Coordinator
Education Coordinator
RN/EMT-P/Lead
Instructor

FUNDING

The Illinois Department of Public Health, Division of Emergency Medical Systems (EMS) & Highway Safety currently has two primary sources of funding in support of EMS in Illinois: State of Illinois General Revenue Fund (GRF) and the Illinois Fire Prevention Fund. However, these funding programs do not begin to cover the true cost of providing EMS and trauma care in Illinois much less the development of a system that can coordinate EMS efforts statewide.

The Division receives an annual appropriation from the General Revenue Fund as allocated by the General Assembly. This appropriation is used to fund EMS activities through the state fiscal year (SFY) beginning July 1st and ending June 30th. State EMS activities funded by the General Revenue Fund include EMS operations, personnel services, and contractual services.

In recent years, the General Assembly has made a special appropriation from the Illinois Fire Prevention Fund to the Division of EMS. The amount of the funding began at $1.4 million and is currently at $1.1 million. This funding is used to offset expenses for EMS testing, program activities, and a very limited number of EMS staff. In working with the State Fire Marshall's Office, the plan starting SFY2013 is for the Division of EMS to be self-sustaining and return all fire prevention funds to the State Fire Marshall's Office for reallocation to Illinois firefighters with the exception of half of the cost of the EMS testing contract. Today, Illinois firefighters enjoy the benefit of having the option of a state EMS test as opposed to the more expensive National Registry of EMT exam.

In addition, the Department retains 2.5% of 50% of the moneys in the Trauma Center Fund to defray the cost of administering the distributions to the Illinois hospitals that are designated as trauma centers.

On August 24, 2010, Governor Quinn signed HB 5183 into law, which becomes effective January 1, 2011. With this new law, the Division of EMS has the ability to assess fees for issuing and renewing licenses for pre-hospital personnel. The Division of EMS projects approximately $700,000 in annual revenue from these fees will be deposited into the EMS Assistance Fund to help sustain state EMS operations.

EMS SYSTEM FUNDING

While exact figures are unknown, the cost of emergent care in Illinois reaches into the tens of millions of dollars each year. EMS expenses include well maintained ambulances and medical equipment; trained and certified/licensed EMS personnel, communications capabilities, fuel, supplies, and insurance. Other expenses can include but are not limited to dispatching, administrative staffing, utilities, ambulance/supply storage, back-up/reserve vehicles, training/continuing education, and billing services. Funding for all these expenses must be available for an EMS service to survive. There are a variety of funding strategies utilized by EMS providers to finance their operations, including tax revenues, billing, subsidies, grants, and donations.

On a national level, the federal government contributes to the financing of the EMS/Trauma System through patient care reimbursement programs, such as Medicare, as well as occasional federal grant opportunities, typically for equipment and education programs. The state government contributes

through patient care reimbursement programs such as Medicaid and other programs. Generally, state programs do not provide funding for EMS/Trauma System operating costs. In fact, because EMS is not a mandated service, many communities choose to avoid the cost of providing any kind of emergency medical services, instead depending on volunteer EMS services.

MISSION STATEMENT

The overall mission of the Division of Emergency Medical Systems and Highway Safety is to assist in reducing death and disability resulting from all-hazards and function as Illinois' lead agency for a statewide EMS/Trauma System.

KEY SERVICES

Authority for the Department's regulatory responsibilities comes from the Emergency Medical Services (EMS) Systems Act, 210 ILCS 50. The Illinois EMS and Trauma Center Code 77 Ill. Adm. Code 515 was promulgated within the scope of authority delineated in the Act.

The act provides for the following:

- Designation of IDPH, Division of EMS and Highway Safety, as lead agency under the authority of the director of Public Health
- Appointment of an EMS division chief and medical consultant
- Statutory authority to regulate EMS services
- Development and adoption of EMS regulations
- Licensing/recognition and training of EMS personnel including emergency medical technicians (i.e., basic, intermediate and paramedic levels), emergency communications registered nurses, trauma nurse specialists, pre-hospital registered nurses, trauma nurse specialists, pre-hospital registered nurses, first responders and dispatchers
- Inspection and licensure of public and private transportation services including volunteer agencies and special emergency medical vehicles
- Authority to develop and regulate EMS and trauma services on a regional basis
- Appointment of an EMS Advisory Council, Trauma Advisory Council and Emergency Medical Services for Children Advisory Board
- Establishment of a Trauma Fund
- Establishment of EMS Assistance Fund grants
- Coordination of communication systems
- Statewide reporting of Pre-hospital "runs"; Trauma, Health and Spinal Cord Injury; and Violence registries
- All other EMS related activities , including research projects
- Emergency Medical Services for Children program.

VISION

Through a collaborative team approach, the Division will foster respect of our elected leadership, our agency, our peers, our state partners and those we regulate and protect.

While the mission of EMS in Illinois remains unchanged, with the evolution of disease specific protocols it is necessary for all participants in the EMS and trauma communities to continue to move towards ensuring competency of care in services and a professional workforce. The Division is poised and able to remain the statewide source of leadership as the future of EMS unfolds, providing assistance to EMS providers.

GOALS AND OBJECTIVES LEGEND

Administration (DC)

- General
- Legislation/Rules
- Councils
- Standard of Care

Licensing Section (LS)

- Prehospital
- Ambulance

Ancillary Programs Section (AP)

- Trauma (A)
  - General
  - Data
  - Prevention
- Data (B)
- Testing (C)
- Education (D)

Stroke/Stemi (SS)

Regional Section (RS)

Special Programs (SP)

- Grant Programs
- EMSC

Hospital Preparedness Program (HP)

Timeline:

S = short term (less than 12 months)

I = intermediate (1 to 3 years)

L = long term (3 to 5 years)

Administration (DC)

- General
- Legislation/Rules
- Councils
- Standard of Care

General

S Develop and coordinate with various media/public education campaigns within other state agencies to educate key populations and communities.

S Create partnerships with other allied health professionals/organizations that impact Division of EMS operations.

S Promote public awareness of 9-1-1 as THE emergency access point.

I Formally change the name of the Office of Preparedness and Response (OPR) to the Office of Preparedness and Response and Emergency Healthcare (OPREH).

I Develop a State Operations Manual/State Program based on the goals outlined in this plan and consistently apply the use of this manual across the state.

I Allocate a dedicated grant writer within the Division of EMS to investigate/secure funding for key initiatives.

I Address interoperability issues between response partners, systems and among each provider.

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 As feasible, include EMS operations in any current grant funding opportunities.

L Produce an annual report, including all sections within the Division of EMS, utilizing the previous year's statewide data acquisition.

L Collaborate with the Illinois Commerce Commission (statewide 9-1-1 agency) to ensure further development and sustainment of the enhanced 9-1-1 system.

L Develop and maintain dedicated EMS communication resources sufficient for current and future needs.

L Advocate to streamline the intake process for psychiatric patients.

Legislation/Rules

S Work with Office of Healthcare Regulation and the EMS Advisory Council to review current rules and laws governing the transport of "non-urgent" patients to Urgent Care Centers.

S Work with the EMS and Trauma Advisory Councils to review the EMS & Trauma Center Code on at least a biannual basis and develop a list of suggested updates.

S Implementation of Public Act 96-0540 (Military Education)

- Promulgate rules for implementation of the new military education law.

S Implementation of Public Act 96-0514 (Stroke)

- Work with the State Stroke Advisory Subcommittee to promulgate rules for implementation of the new primary stroke center law.

S Implementation of Public Act 96-0702 (Stretcher Vans)

- Work with the State EMS Advisory Council's Emerging Issues Subcommittee to promulgate rules for implementation of the stretcher van licensure law.

S Implementation of House Bill 5183

- Work with the State EMS Advisory Council to promulgate rules for implementation of the critical care transportation program, reserve ambulance licensure, collection of licensure/certification fees and new disciplinary provisions.

S Submit proposed rules approved by the EMSC Advisory Board to JCAR for adoption.

I Review the Division of EMS Strategic Plan on a regular interval not to exceed 4 years and present significant changes to the EMS and Trauma Advisory Councils.

I Draft legislation to amend the current distribution of Trauma Center funds to allow for the Division of EMS to retain 25% of the funds to be used for administration of the Trauma Program.

I Draft an amendment to the EMS & Trauma Center Code to mirror the federal guidelines on drug restocking and exchange.

I Draft an amendment to the EMS & Trauma Center Code to mirror the federal guidelines on equipment/supply restocking/exchange/billing.

- **I** Review the current laws, rules, policies and procedures for hospital bypass and develop a recommendation to present to the EMS Advisory Council for the modification or elimination of hospital bypass.

- **I** Modify the definition of trauma patient to reflect the most current references such as Resources for Optimal Care of the Injured Patient, CDC Triage Criteria and other key sources.

- **I** Work with the EMS Advisory Council's Emerging Issues Subcommittee to adopt the new standards outlined by NHTSA and codify with a rulemaking.

- **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 predicted on the formulation of institutional algorithms for management of certain conditions (blunt abdominal trauma, penetrating torso trauma, etc.) manually agreed upon by trauma surgeons and ED physicians.
    - These algorithms/care plans will be ultimately approved by the OPR Medical Director.

- **L** Draft an amendment to the EMS & Trauma Center Code to support and enforce full participation of trauma and pre-hospital data submission.

- **L** Review the EMS and Trauma Center Code sections regarding the CQI process for data collection and performance measures.

- **L** Formulate policies and processes that encourage EMS agencies to participate in a program whereby pre-hospital care providers conduct wellness visits/injury prevention assessments.

    - Conduct these activities in conjunction with local health departments and participating system hospitals.

- **L** Work with the EMS Advisory Council to draft any necessary amendments to the EMS Systems Act and the EMS & Trauma Center Code to coincide with the new levels and titles of EMS providers as outlined through the National Highway Traffic Safety Administration (NHTSA).

- **L** Promulgate rules to update the licensure and safety standards of the aero medical transportation program.

- **L** Work with the EMS Advisory Council's Education Subcommittee to promulgate rules to implement the new education standards and scopes of practice for pre-hospital providers.

- **L** Promulgate rules that define the process for the need and development of trauma systems 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 OPR.

- 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 All hospitals appropriate for inclusion in the trauma component of the EMS 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.

Councils

I Work with the EMS Advisory Council to lobby Legislators for a dedicated funding source to support emergency medical services in Illinois. Suggestions from the EMS community include the following:

- $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 Ask the EMS Advisory Council to convene a sub-committee to support, promote and develop a specific research agenda for the EMS in Illinois.

I Work with the EMS Advisory Council to 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 Work with the Regional EMS Advisory Committees and the EMS Advisory Council to review standard reports and trends and update laws, rules, policies and procedures as appropriate.

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

Standard of Care

S Develop guidelines for patients that are medically acceptable for Medi-car transport.

S Ensure proper medical oversight throughout all aspects of the EMS system.

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

L Encourage all agencies regulated by the Division of EMS to 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.

Licensing Section (LS)

- Pre-hospital
- Ambulance

Pre-hospital

S Develop an implementation plan for House Bill 5430 which allows for an EMS provider whose license has been lapsed for less than 36 months to renew their license without requiring the individual to complete the entire training program.

S Implementation of House Bill 5183

- Establish procedures for the processing of licensure/certification fees.
- Amend licensure/certification application to address exclusion of individuals convicted by a criminal court of Class 1, Class 2 and Class X felonies.
- Develop a waiver process for individuals convicted by a criminal court of Class 1, Class 2 and Class X felonies.
- Develop a revocation process for licensees convicted by a criminal court of Class 1, Class 2 and Class X felonies.
- Develop a procedure to track revocation cases through the administrative hearing process.

I Conduct an analysis to determine if the current four year EMS license remains adequate and acceptable.

L Develop operational agreements for the interstate transport and treatment of patients for dual licensed providers and pre-hospital care provider licenses.

Ambulance

S Critical Care Transport

- Develop an inspection form.
- Secure funding to complete changes to the current ambulance licensure database to include critical care transport requirements and the ability to print licenses.
- Develop criteria for an inspection process.
- Train staff on inspection process.

S Reserve Ambulance

- Develop an inspection form.

- Secure funding to complete changes to the current ambulance licensure database to include reserve ambulance licensure requirements and the ability to print licenses.
- Develop criteria for an inspection process.
- Train staff on inspection process.

S Stretcher Vans

- Develop an inspection form.
- Secure funding to complete changes to the current ambulance licensure database to include stretcher van requirements and the ability to print licenses.
- Develop criteria for an inspection process.
- Train staff on inspection process.

I Develop inter-regional and interstate policies for ground and air medical transport.

I Compliance with updated NHTSA requirements for ambulance licensure

- Work with the EMS Advisory Council's Emerging Issues Subcommittee to adopt the new standards outlined by NHTSA to update requirements for vehicle build specifications, safety criteria and required equipment.
- Update inspection forms.
- Secure funding to complete changes to the current ambulance licensure database to include new criteria.
- Train staff on new criteria.

I Explore the National Highway Traffic Safety Administration's recommendations for licensure and safety standards of the helicopter transportation industry.

- Work with the Division of Aeronautics and the Illinois Association of Critical Care Transportation to research and review best practices for safety in the aero medical industry.

L Develop mechanisms to assess compliance for Emergency Medical Dispatchers with current EMS regulations.

Ancillary Programs Section (AP)

- Trauma (A)
    - General
    - Data
    - Prevention
- Data (B)
- Testing (C)
- Education (D)
    - New Standards
    - Military Education
    - CEU's
    - Training Programs

Trauma (A)

General

S A structured system wide PI & E program will be developed and implemented.

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 homeostatic agents

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 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 Explore the feasibility of requiring all surgical interventions performed in the operating room of any type, on any trauma patient, at any level, require the timely presence of an attending surgeon with expertise in that operation.

S All mandatory and unique regional prehospital performance indicators are to be reported to the Division of EMS on an interval of no more than every 6 months.

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 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 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 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 Research the feasibility of adopting the new ACS Trauma Designation Guidelines.

I Work with the Trauma Advisory Council and Trauma Nurse Specialist Coordinators to amend sections of the EMS & Trauma Center Code pertaining to TNS course and testing criteria.

I Develop a system-wide protocol for the management of life threatening bleeding 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.

L Explore the feasibility of hospital systems sharing data submission requirements. Individual hospitals should be provided access to National Trauma Data Bank for comparison and benchmarking of their own data and or TQIP participation.

L A multipurpose Division of EMS web site will be created and maintained by the Division 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.

Data

S Develop capability to accept and then export data in XML standard.

S Develop a process for the resolution of trauma registry issues.

S Research the feasibility of outsourcing of state trauma registry operations and information management through an RFP process.

S Ensure the system trauma registry software is capable of allowing ad-hoc report generation by individual hospitals/providers.

S Stratify reports on a system-wide, regional and local level.

S Ensure 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 Division of EMS.

S Require trauma centers to meet the requirements of their designated level.

- Permanent waivers of any requirements or obligations will not be approved.

S Complete upgrade of the trauma registry to include WEBSPHERE Application Server 6.1.

S Complete software enhancements for ICD-9-CM codes and AIS.

S Research ability to do TQIP validation.

I Produce a formal and thorough description of the epidemiology of injury and injury mortality throughout the system resulting in the development of parallel descriptions for other emergency conditions.

I Amend laws, rules, policies and procedures to require that all trauma patients in the field be identified and assigned a unique trauma system identifier, which follows patients through the entire encounter.

L Ensure that data collected support the performance improvement processes.

L Assess and monitor data integrity and quality at the local, regional and system-wide level on a regular basis through a process to be determined.

L Construct data integrity reports and present to the Trauma Advisory Council for review comment on an annual basis.

T Add appropriate data elements relating to critical care to the Trauma Registry Data Set and Data Dictionary.

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 the Division of EMS web site “clearinghouse” page/portal (Division of EMS search engine).
- The inventory and clearinghouse initiative will eventually be expanded to other emergency illnesses/conditions (stroke, STEMI, asthma, etc.).

L Ensure that all aspects of the EMS Systems in Illinois are connected to and engaged in injury and illness prevention and wellness promotion.

L Participating system hospitals will be encouraged to conduct system-wide prevention/wellness activities as directed by the Division of EMS utilizing their Trauma System Fund allocation.

- Lack of documentation indicating credible fulfillment of these Division of EMS directed activities may be considered grounds for a site survey deficiency for failure to comply and require a plan of correction.

Data (B)

S 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.

S Improve accuracy, validity, and completeness of data being submitted and collected.

I Develop standards and procedures for obtaining, using and protecting all EMS data collected and maintained by the state.

I Adopt a single state patient tracking program to assure statewide consistency.

- Assure patient tracking coordination and interoperability among pre-hospital and hospital systems, providers and state/national repositories/rehabilitation EMS-ED-hospital-rehab.

I Achieve NEMSIS compliance at a 100% level of required data elements.

I Enter and submit data electronically via web or internet.

I The Division of EMS 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.).

L Grant 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 Division of EMS applications and information.

T Request and host a NEMSIS/NEDARC site visit.

Testing (C)

I Conduct a needs and cost benefit analysis, and provide a recommendation to EMS Advisory Council as to whether 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:

- Initiate discussion with NREMT regarding the possibility of waiving the practical examination requirements unless an individual wishes to obtain the NREMT designation.

I Work with the Trauma Advisory Council and Trauma Nurse Specialist Coordinators to amend sections of the EMS & Trauma Center Code pertaining to TNS course and testing criteria.

L Conduct a cost benefit analysis to determine the feasibility of offering computerized testing.

Education (D)

S Require each educational program to 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 Publish a listing of approved education programs on the Division of EMS webpage.

S Require EMS System plans to have an education improvement plan that intersects with a clinical performance improvement plan.

- EMS will base annual education on needs indentified during the clinical performance improvement.

S In order to promote professionalism, advocate for EMS coursework to be changed from a vocational program to an academic program with the ability to earn an Associate's degree .

S Implementation of Public Act 96-0540 (Military Education)

- Develop criteria for the comparison of military education provided through the various divisions of the armed services in comparison to the Department of Transportation national curriculum and the new education standards that will be adopted in January of 2013.

- Standardize a process in which a veteran can have his/her military training evaluated to determine at what level he/she would qualify to test within the State of Illinois for an Emergency Medical Technician license.

I Work with the EMS Advisory Council's Education Subcommittee to review current literature for best practices across the emergency health care spectrum and replicate and evaluate these practices.

I Adopt the National EMS Scope of Practice Models for all levels of EMS to serve as the minimum foundation for educational programs.

I Require each program to 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 Work with the EMS Advisory Council's Education Subcommittee to develop an EMS Educator mentoring and an auditing program for current educators.

I Require that at a minimum, all primary instructors acquire and maintain lead instructor certification.

I Work with the EMS Advisory Council's Education Subcommittee to ensure Lead Instructor and affiliate/secondary instructor training programs are offered in each region at a frequency that meets the 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 the Division of EMS.

I 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 Require paramedic training programs to be recognized by a national accreditation program.

I Work with the EMS Advisory Council's Education Subcommittee to encourage Emergency Medical Technician – Basic (EMT-B) and Advance EMT training programs to obtain national accreditation.

- EMS Systems may charge fees to cover the costs of the EMS education and credentialing process. *(Systems already have this ability as there is nothing in the EMS and Trauma Center Code that prevents this.)*

I In conjunction with the EMS System site surveys, review their education and performance improvement programs using statewide standardized criteria.

I Work with the Illinois Rural Health Association to develop innovative and non-traditional EMS education programs to achieve increased rural participation.

I Work with the EMS Advisory Council's Education Subcommittee to 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 Work with the EMS Advisory Council's Education Subcommittee to 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 Work with the EMS Advisory Council's Education Subcommittee to develop minimum requirements for all continuing education programs.

- **L** Analyze the costs, benefits and risks of transitioning EMS continuing education requirements from an hours-based to a competency-based approach.

- **L** Recognize Critical Care EMS training programs or equivalent programs that meet minimum criteria.

- **L** Evaluate the feasibility of creating a Critical Care Paramedic level of licensure.

- **L** Work with the EMS Advisory Council's Education Subcommittee to implement the new education standards and scopes of practice for prehospital providers. The target date is 1/1/2013.

Stroke/Stemi (SS)

S IDPH Division of EMS will work towards the implementation of the Public Act 96-0514 (Stroke Bill) requirements.

- Recruit, compile and review applications for appointments to the State Stroke Advisory Subcommittee. Facilitate the appointment of positions by the Director. Notify individuals selected of their appointment and term.
- Review submissions for designation of Primary Stroke Centers. Notify Primary Stroke Centers of designation.
- Develop content concerning primary stroke center designations and maintain the current listing of designation primary stroke centers to be posted on the Department's website.
- Develop application process for designation of emergent stroke-ready emergency departments.
- Evaluate applications received for designation of Emergency Stroke-Ready Emergency Departments. Notify Emergent Stroke-Ready Emergency Departments of their designation.
- Prepare the required annual report to the General Assembly.

Regional Section (RS)

S Under the aegis of the OPR Medical Director, a task force will be convened to analyze regions and report to the Division of EMS with recommendations about regional structure and advisory committees.

Special Programs (SP)

- Grant Programs
- EMSC

Grant Programs

L Develop a grant program to incorporate technology into education programs.

T Expand the current EMS Assistance Fund grant program.

EMSC

S Conduct 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.

EMSC has its own Strategic Plan. Please refer to that document.

Hospital Preparedness Program (HP)

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.

L Encourage Emergency Medical Response training throughout communities.