Resources:

Region IX EMS Plan: Inter-system/Inter-region transports; Bypass/Diversion (Revised 12/22)

Section 515.330 EMS System Program Plan

m) *Written protocols for the bypassing of or diversion to any hospital, trauma center or regional trauma center, STEMI center,* Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital, *which provide that a person shall not be transported to a facility other than the nearest hospital, regional trauma center or trauma center*, STEMI center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital *unless the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from transport to the more distant facility, or the transport is in accordance with the System's protocols for patient choice or refusal.* (Section 3.20(c)(5) of the Act)

The bypass status policy shall include criteria to address how the hospital will manage pre-hospital patients with life threatening conditions within the hospital's then-current capabilities while the hospital is on bypass status. In addition, a hospital can declare a resource limitation, which is further outlined in the System Plan, for the following conditions:

1) There are no critical or monitored beds available in the hospital; or
2) An internal disaster occurs in the hospital; (Example, a power failure, flood, fire, or active shooter incident resulting in hospital lockdown at the time that the decision to go on bypass status was made.)

I. DEFINITIONS

A. **"Nearest hospital"** is the hospital which is closest to the scene of the emergency as determined by travel time, and which operates a full-time emergency department at the minimum level recognized by the System in its Department approved Program Plan.

B. **"Nearest Trauma Center"** is either the nearest Level I or Level II Trauma Center that can be reached within 30 minutes by ground travel time from the scene of the emergency as defined by Trauma Triage Guidelines in the SOPs.

In the event that a specialty care unit is unavailable, the ED of that institution shall be regarded as a functioning comprehensive ED without any specialty care back-up capabilities (e.g., burn unit, spinal cord unit, hyperbaric chamber, Level I Trauma Center).

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

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

E. **"Hospital bypass"**

1. Requests for bypass must only be made based on DPH criteria after a decision has been reached by medical, nursing and administrative representatives with the authority to make such a request.
2. An appropriately declared and reported bypass status will usually result in EMS patients being taken to a hospital other than the one on bypass unless an exception applies; see Section VI.

F. **"Peak Census"** occurs when a specific hospital is experiencing near capacity census with limited access to inpatient beds, critical care equipment, support resources and staffing which impact the management of patient care. The hospital surge capacity plan may have implemented patient admission to overflow space, which in turn provides a strain on available support resources and staffing.

G. "**Surge capacity"** refers to the ability to manage a sudden increase in patient volume that would severely challenge or exceed the present capacity of a facility.

II. **PURPOSE**

The purpose of this policy is to provide background and practice guidelines for all NWC EMSS hospitals, provider Agencies and EMS personnel when hospital resources are severely limited and Bypass status is being considered, has been requested, approved, and/or declared.

III. **POLICY STATEMENTS**

A. *A person shall not be transported to a facility other than the nearest hospital, regional trauma center or trauma center*, STEMI Center, Comprehensive Stroke Center, Primary Stroke Center, Acute Stroke-Ready Hospital or Emergent Stroke Ready Hospital *unless the medical benefits to the patient reasonably expected from the provision of appropriate medical treatment at a more distant facility outweigh the increased risks to the patient from transport to the more distant facility, or the transport is in accordance with the System's protocols for patient choice or refusal.* (Section 3.20(c)(5) of the Act) or (iii) another healthcare facility can provide appropriate medical treatment for that person. **CAPITALIZATION** indicates statutory language

B. A System hospital, Trauma center, STEMI Center, Stroke Center, PCI/STEMI Receiving Center, Level III NICU, and EDAP are presumed to have available resources in accordance with the provisions of its System agreement, unless such facility has notified IDPH and the Resource Hospital (NCH) that it is on bypass status.

C. **Each System hospital shall make every reasonable effort to prevent declaring bypass status.**

Bypass status should only be declared in compliance with the EMS Act and Rules and DPH and Region IX recommendations after the hospital has exhausted all internal mechanisms to relieve the limitation of resources, mitigate internal service disruptions or resolve threats/hazards requiring them to go on lockdown status (See E. below).

D. Each hospital's internal policy addressing **Peak Census/Surge procedures** shall:

1. Delineate procedures for the hospital to follow when faced with a potential or declared resource limitation that would help them to avoid bypass status.
2. Delineate procedures to monitor the status of inpatient bed occupancy as it relates to the appropriation of timely bed assignments to those patients waiting at home, in physicians' offices, in the ED, and in other areas such as the Cardiac Catheterization Lab, Day Surgery, or at other hospitals.
3. Include a list of Providers and their current contact information who customarily transport to that hospital.

E. Stricken hospitals shall implement their internal PEAK Census response plan and enter updates into the Illinois EMResource application, accessed at https://emresource.juvare.com/login .

F. **All reasonable efforts to resolve the essential resource limitation(s) shall be exhausted**, including:

1. Considering appropriately monitored beds in other areas of the hospital;
2. Limitation or cancellation of elective pt procedures and admissions to available surge pt care space and redeploy clinical staff to surge patients.
3. Actual and substantial efforts to call in appropriately trained, off-duty-staff; and
4. Urgent and priority efforts have been undertaken to restore existing diagnostic and/or interventional equipment/or backup equipment and/or facilities to availability, including but not limited to seeking emergency repair from outside vendors if in house capability is not rapidly available.

G. **If bypass is granted/declared,** the hospital shall monitor their situation carefully to determine the earliest possible time when the bypass status/lockdown can be lifted.

H. Under EMTALA provisions, Hospitals may not divert a patient without a medical screening exam once on their hospital campus (See appendix).

IV. **Section 515.315 Bypass or Resource Limitation Status IDPH Review**

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

B. The hospital shall notify the Illinois Department of Public Health, Division of Emergency Medical Services, of any bypass/resource limitation decision, at both the time of its initiation and the time of its termination, through status change updates entered into the Illinois EMResource application, accessed at https://emresource.juvare.com/login . The hospital shall document any inability to access EMResource by contacting DPH's Division of EMS during normal business hours.

C. In determining whether a hospital's decision to go on bypass/resource limitation status was reasonable, **the Department shall consider the following**:

1. The number of critical or monitored beds available in the hospital at the time that the decision to go on bypass status was made;
2. Whether an internal disaster, including, but not limited to, a power failure, had occurred in the hospital at the time that the decision to go on bypass status was made;
3. The number of staff after attempts have been made to call in additional staff, in accordance with facility policy; and
4. The approved hospital protocols for peak census, surge, and bypass and diversion at the time that the decision to go on bypass status was made, provided that the Protocols include subsections (c)(1), (2) and (3).
5. Bypass status may not be deemed reasonable if three or more hospitals in a geographic area are on bypass status or transport time by an ambulance to the nearest facility is identified in the regional bypass plan to exceed 15 minutes

D. **Hospital diversion must be based on a significant resource limitation** and may be categorized as a System of Care (STEMI or Stroke), or other EMS transports. The decision to go on bypass (or resource limitation) status shall be based on meeting the following two criteria, and compliance with Subsection (c) (3).

1. **Lack of an essential resource for a given type or class of patient** (i.e. Stroke, STEMI, etc.) Examples include, but are not limited to:
   a. No available or monitored beds within traditional patient care and surge patient care areas with appropriate monitoring for patient needs;
   b. Unavailability of trained staff appropriate for patient needs; and/or
   c. No available essential diagnostic and/or intervention equipment or facilities essential for patient needs.
2. **All reasonable efforts to resolve the essential resource limitations(s) have been exhausted** including, but not limited to:
   a. Consideration for using appropriately monitored beds in other areas of the hospital;
   b. Limitation or cancellation of elective patient procedures and admissions to make available surge patient care space and redeploy clinical staff to surge patients;
   c. Actual and substantial efforts to call in appropriately trained off duty staff; and

d. Urgent and priority efforts have been undertaken to restore existing diagnostic and/or interventional equipment/or backup equipment and/or facilities to availability, including but not limited to seeking emergency repair from outside vendors if in house capability is not rapidly available.

3. The **hospital must constantly monitor to determine when the bypass condition can be lifted**. Such monitoring and decision making shall include clinical and administrative personnel with adequate hospital authority. Efforts to resolve issues in #1 above using all available resource under #2 to come off bypass as soon as such patients can be safely accommodated.

E. **For Trauma Centers only**, a trauma center bypass policy shall identify the following situations that would constitute a reasonable decision to go on bypass status:

1. No fully staffed operating rooms are available and at least one or more of the current operative procedures is a trauma case;
2. The computated tomography (CT) scan is not working; or
3. The general bypass criteria in subsection (c).

F. **During a declared local or State disaster**, hospitals may only go on bypass status if they have received prior approval from DPH. Hospitals must complete or submit the following prior to seeking approval from DPH for bypass status:

1. EMResource must reflect current bed status;
2. Peak census policy must have been implemented 3 hours prior to the bypass request;
3. Hospital and staff surge plans must be implemented;
4. The following hospital information shall be provided when contacting ~~to~~ DPH for bypass approval:
   a. Number of hours for in-patient holds waiting for bed assignment;
   b. Longest number of hours wait time in emergency department;
   c. Number of patients in waiting area waiting to be seen;
   d. In-house open beds that are not able to be staffed;
   e. Percent of beds occupied by in-patient holds;
   f. Number of potential in-patient discharges; and
   g. Number of open ICU beds.
5. **The DPH Regional EMS Coordinator** will review the above information along with hospital status in the region and determine whether to approve bypass for 2 or 4 hours or to deny the bypass request. A hospital may be denied bypass based on regional status or told to come off bypass if an additional hospital in the geographic area requests bypass

G. **The Department may impose sanctions**, as set forth in Section 3.140 of the Act, upon a Department determination that the hospital unreasonably went on bypass status in violation of the Act. (Section 3.20(c) of the Act)

H. Each EMS System shall develop a policy addressing response to a **system-wide crisis**.

(Source: Emergency amendment at 46 Ill. Reg. 17682, effective October 23, 2022, for a maximum of 150 days)

V. **PROCEDURE: PHASE I: PRIOR TO REQUESTING BYPASS** (IDPH & Region IX recommendations)

A. "**Peak Census**" occurs when a specific hospital is experiencing near capacity census with limited access to inpatient beds, monitors, critical care equipment, support resources and staffing which impact the management of patient care. The hospital surge capacity plan may have implemented patient admission to overflow space, which in turn provides a strain on

available support resources and staffing (Region IX policy).

B. When resource limitations meet a hospital's tipping point, they shall **implement their Peak Census/surge plan** and **update their status** into the Illinois EMResource application, accessed at https://emresource.juvare.com/login to reflect Peak Census/Surge Status.

C. IDPH suggests that the following **core group should be consulted** when a hospital is on peak census status and/or is contemplating the need for bypass:

1. CEO and/or administrator on call; Chief nurse executive or designee
2. Directors of housekeeping, admitting, laboratory and transportation services
3. Nurse and physician directors of inpatient units

Hospitals are directed to the IDPH model policy for options to avoid bypass, procedures for advance admission of a pt to an inpatient area, and the five tier bed monitoring and utilization process. They are encouraged to expedite discharges; open boarding beds or overflow units, rapidly clean and prepare beds for incoming pts; and consider cancelling non-emergent surgeries and/or admissions.

D. Before a decision is made to request Bypass status, the **stricken hospital shall review the Illinois EMResource application** to determine if neighboring hospitals are also on the highest levels of peak census or bypass, ED-to-ED communication shall evaluate the possible area-wide consequences of a pending "Bypass" request.

E. EDs of stricken hospitals considering the need to request Bypass Status shall **notify their EMS Coordinator** and discuss the IDPH-recognized grounds for bypass. All Hospital EMSCs shall notify the **Resource Hospital EMS Administrative Director** who shall consider the need to implement the **System Crisis Response plan** based on the nature and extent of System-wide resource limitations.

VI. **PROCEDURE Phase II: Requesting BYPASS STATUS – See the Region IX/NWC EMSS Critical Capacity/Bypass Worksheet (11/22)**

A. System hospitals must follow IDPH Rules and EMS System/Region IX guidelines with respect to requesting and reporting bypass status.

B. **Gather the information on the Critical Capacity/Bypass worksheet** to provide justification for bypass status. (Max 2 hours for non-internal disasters)

C. If bypass is being considered, contact the following to discuss your facility's situation:

Region IX Emergency Preparedness:
Steve Baron (RHCC Coord) 224-830-5676 or Gary Brown 815-222-6358
*RHCC will review need for bypass and review EMResource for potential impact
If supported, will be given direction to contact IDPH for approval

IDPH Region IX EMSC: **IDPH Region 9 EMSC: Danielle Albinger, BSN, RN**
Email the Bypass Worksheet to: Danielle.albinger@illinois.gov
Then call her Cell: 630-200-7226

D. **NOTIFICATION procedures:**

1. **If IDPH grants approval for bypass:** Enter the change in hospital status in https://emresource.juvare.com/login
2. If experiencing an **internet connectivity issue**, first contact the hospital electronic bed tracking system administrator or others responsible for hospital reporting who may be able to change the hospital's status from a different location.
   Option #2: Contact the ED at Sherman Hospital (RHCC) to change hospital status.
   Option #3: If unsuccessful, contact Juvare Support at 877-771-0911; or via fax to the Division's Central Office at 217-557-3481.
3. The **hospital declaring bypass shall notify all surrounding hospitals** (including

NCH in all cases) that could be impacted by a bypass declaration **and EMS agencies that normally transport to that facility** through their dispatch centers or numbers provided by the agencies. This may be accomplished by phone or through a mass notification system if the process has been proven to be a reliable means of communication. Notification must include the hospital's name, reason for bypass, and estimated duration. If on **lockdown**, be very clear that **NO PATIENTS** are to be transported to that hospital.

4. **EMS AGENCIES are responsible for keeping their personnel informed** regarding Bypass Patient Redistribution plans. Provider agency policies shall specifying their way of complying with this requirement.

5. Upon notification of another hospital's bypass status, the ED charge nurse shall notify appropriate persons within their facility (based on hospital policy) regarding the potential for ED volume increases.

6. **It is expected that the hospital on bypass will return to normal operations ASAP**. They should reevaluate their status at least every four hours or more frequently if the resource limitation necessitating bypass has been resolved.

7. Notification of **BYPASS CANCELLATION** shall be promptly entered into https://emresource.juvare.com and communicated to all impacted hospitals and EMS agencies using the same notification methods used to declare bypass status.

8. Hospitals shall notify their EMSC when the Internal Peak Census/Surge plan is deactivated. Hospital EMSCs shall notify the Resource Hospital EMS Administrative Director to cancel the System Crisis Response activation that involved their facility. (Region IX Peak Census/Surge Ambulance Transport Policy)

VII. **On-line medical control (OLMC) during Bypass declarations**

EMS personnel shall follow usual and customary OLMC call patterns. Contact the nearest System hospital (or nearest non-System hospital with OLMC privileges if transport would normally go to that location) **prior to leaving the scene EVEN IF THAT HOSPITAL IS ON BYPASS**.

They will let you know if the patient will be accepted by them or routed to another facility.

EMS personnel may be directed to call **NCH (847) 259-9767** for a receiving hospital assignment.

Requests for transport to a facility other than the predetermined destination hospital outlined in the Patient Redistribution Plan **require OLMC contact PRIOR TO leaving the scene**.

If the desired receiving hospital is not a member of the System and/or does not have OLMC privileges, the Resource hospital (NCH) shall provide OLMC and shall call report to the receiving hospital.

VIII. **Patient distribution plan -** pre-established transport destinations for EMS agencies impacted by a hospital's bypass declaration.

Situations which may result in a hospital receiving patients while on bypass

A. The patient is unstable and unable to tolerate transport to a more distant comprehensive medical facility. Risks to a pt resulting from a longer transport time are judged to be greater than the benefits of transporting to a nearer hospital on bypass as long as that hospital still has a functioning Emergency Department.

Unstable patients with an immediately life-threatening condition whose "LAST CLEAR CHANCE" of survival lies in an **EXPEDITIOUS emergency evaluation or resuscitative intervention are NOT TO BE DIVERTED** and must be accepted by the closest appropriate ED regardless of Peak Census, Surge, or Bypass status **unless an internal hospital disaster is occurring and/or the hospital is on lock-down.**

UNSTABLE for the purposes of this policy is defined as: Symptoms of sufficient severity such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious

impairment to bodily functions, or serious dysfunction of bodily organs." This includes, but may not be limited to the following:

1. Persistently compromised airway/ventilations despite EMS interventions; and/or
2. Severe vascular injury with uncontrolled hemorrhage; cardiac arrest
3. Others as listed below

B. **Specific patients**

1. **Advocate LGH** will accept the following while on bypass unless experiencing an internal disaster or lockdown:
   a. Adult/pediatric Level I trauma patients
   b. **Unstable**: Adults or children with hemodynamic instability, lack of an airway, or last chance of survival per EMS judgment if ALGH is the closest appropriate hospital.
2. **ACUTE STROKE:** Transport to the closest appropriate Stroke Center regardless of peak census, surge or bypass status unless their CT scanner is unavailable, an internal hospital disaster is occurring, and/or they are on lock-down.
3. **PREGNANT PATIENTS in ACTIVE LABOR** or with **OB COMPLICATIONS:** Transport to the closest hospital with an OB unit regardless of peak census, surge, or bypass status unless an internal hospital disaster is occurring and/or they are on lock-down.
4. **Unstable PEDIATRIC PATIENTS:** Transport to the nearest EDAP regardless of peak census, surge, or bypass status unless an internal hospital disaster is occurring and/or the hospital is on lock-down.
5. **MEDIUM or LARGE SCALE MULTIPLE PATIENT INCIDENTS**: Bypass status is vacated unless an internal disaster is occurring and/or the hospital is on lock-down.

C. **Multiple hospitals simultaneously on bypass in the same geographic area**

1. Bypass status may not be honored or deemed reasonable if multiple hospitals in a geographic area are on bypass status and transport time by an ambulance to the nearest facility identified in the regional bypass plan exceeds 15 minutes (IDPH rules
2. When **two hospitals** servicing the same EMS provider agencies have simultaneously declared bypass and/or two or more hospitals simultaneously on bypass will cause other hospitals to reach the highest level of Peak Census or declare Bypass status, **the Resource Hospital shall call or page the System EMS Administrative Director**. If he or she fails to respond within 5 minutes, call the EMS MD (see below). They shall determine if the situation necessitates activation of the System's Crisis Response policy.
   a. **Bill Toliopoulos (847) 826-2285 (cell)**
   b. **Dr. Matt Jordan (847) 962-6008 (cell)**
3. Hospitals on bypass may be required to accept BLS patients to avert a System Crisis situation.
4. If **three or more hospitals** are simultaneously on bypass and are adversely impacting patient transports, the EMS MD or EMS Administrative Director will consult with the IDPH Regional EMSC. If transport time by ambulance to the next nearest approved healthcare facility exceeds 15 minutes, the hospital on bypass may be required to accept select ALS patients except in situations of internal disaster or lockdown.

   In these situations, **Resource Hospital (RH) OLMC personnel will coordinate assignment of receiving hospitals for ALS patients in rotation**. In some instances, the next nearest open facility may be a non-System hospital. If transport times are less than 15 minutes to a non-System hospital, EMS agencies may be directed to transport to that location in an effort to allow the stricken hospitals time to

recover. Notification will be sent from the RH that all communication relative to transport destinations in the stricken area will first go through them.

Attachments:

- Hospital/Provider Bypass Notice for the NWC EMSS
- NWC EMSS PEAK CENSUS / Bypass PRE-ALERT FORM
- Northwest Community EMSS Bypass Worksheet

Matthew T. Jordan, MD, FACEP
EMS System Medical Director

Vasilios Toliopoulos, BSN, RN, PHRN
EMS Administrative Director

APPENDIX

EMTALA (Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985 (42 U.S.C. §1395dd) Provisions

- The definition of a hospital campus at 42 CFR 413.65(a)(2) means the physical area immediately adjacent to the provider's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis.
- Per 42 CFR 489.24(b), "Hospital property" means the entire main hospital campus, including the parking lot, sidewalk, and driveway, but excluding other areas or structures of the hospital's main building that are not part of the hospital, such as physician offices, rural health centers, skilled nursing facilities, or other entities that participate separately under Medicare, or restaurants, shops, or other nonmedical facilities. Also, per the American Disabilities Act (ADA), hospital campuses must be accessible to individuals with disabilities.
- In addition, we know that, during the COVID-19 PHE, non-hospital properties, such as hotels, dormitories, and field hospitals at parks, are becoming extensions of hospitals, otherwise known as temporary expansion sites. This is permissible under the section 1135 waiver of the provider-based regulations at 42 CFR § 413.65 and certain requirements under the Medicare conditions of participation at 42 CFR § 482.41 and § 485.623. See description of Temporary Expansion Locations at https://www.cms.gov/files/document/covid-hospitals.pdf .
- If an ambulance arrives on any portion of a hospital's "campus" or "property", all EDs must conduct a medical screening examination for those patients and provide emergency stabilization to the best of their ability under the conditions. If an emergency medical condition exists, treatment must be provided until the emergency medical condition is resolved or stabilized. If the hospital does not have the capability to treat the emergency medical condition, an "appropriate" transfer of the patient to another hospital must be done in accordance with the EMTALA provisions.
- EMTALA defines an **emergency medical condition** as "a condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the individual's health [or the health of an unborn child] in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of bodily organs."
- The decision to admit, discharge, or transfer a patient, once stabilized, is the responsibility of the emergency physician treating the patient. Any diversions of patients that occur when the facility is not on bypass status shall be reasonable, appropriate, and compliant with Federal, state, and local laws and protocols.
- The transfer of unstable patients must be "appropriate" under the law, such that (1) the transferring hospital must provide ongoing care within it capability until transfer to minimize transfer risks, (2) provide copies of medical records, (3) must confirm that the receiving facility has space and qualified personnel to treat the condition and has agreed to accept the transfer, and (4) the transfer must be made with qualified personnel and appropriate medical equipment.
- Hospitals with specialized capabilities are obligated to accept transfers from hospitals who lack the capability to treat unstable emergency medical conditions.

Hospital/Provider Bypass Contact Information for the NWC EMSS		
Hospitals	**EMS Agencies**	**System hospitals impacted**
Ascension Alexian Brothers (ABMC) Elk Grove Village **847-952-7454** Fax: 847/ 981-2002	Northwest Central Addison Consol. DP: IFPD, WDFD DuComm: BLFD Privates	Saint Alexius Northwest Community Glen Oaks (Lutheran General)
Advent Health Glen Oaks Medical Center Glendale Heights **630/ 545-5758** Fax: 630/ 545-5722	DuComm: BLFD Privates	ABMC Northwest Community
Advocate Good Shepherd Barrington **847/ 842-4444** Fax: 847/ 842-4247	Northwest Central Lake Zurich: LZFR; Wauconda Red Center: LGFD; LRW Privates	Northwest Community Saint Alexius
Northwest Community Arlington Heights **847/ 259-9812** Fax: 847/ 618-3991	Northwest Central Lake Zurich Red Center: LG, LRWFPD PHts, Wheeling, DPFD Privates	ABMC Saint Alexius Good Shepherd (Lutheran General) Resurrection
Prime Resurrection Medical Center Chicago **773/ 792-5255** Fax: 773/ 990-7632	Privates	(Lutheran General) Northwest Community
Ascension Saint Alexius Medical Center Hoffman Estates **847-843-3508** Fax: 847/ 755-7602	Northwest Central Privates	ABMC Northwest Community Good Shepherd

EMS DISPATCH CENTERS		
AGENCY NAME	**PHONE**	**FAX**
Northwest Central Dispatch: Serving AHFD, BCFPD, BFD, BGFD, EGVFD, HEFD, INVFPD, MPFD, PFD, RMFD, SFD	**847- 590-3300**	847- 398-2498
Addison Consolidated Dispatch: WDFD & IFPD	**630- 458-4012**	630-495-1906
DuComm: BLFPD	**630- 260-7512**	630- 665-4893
Lake Zurich: Lake Zurich Fire/Rescue & Wauconda	**847- 438-2349**	847- 438-9373
Red Center: LRWFPD, LGFPD, PHTs, (Wheeling, DPFD)	**847- 724-5700**	847- 498-5968
Advantage/Elite Ambulance	**847- 413-1133**	847- 885-0002
A-TEC	**#1: 815- 477-2400** **#2: 800- 729-2780**	779- 220-9987
Superior	**630- 832-2000**	630- 903-2828

NWC EMSS Peak Census PRE-ALERT FORM	Date:

DECISION MAKERS		
ED Physician:	ED Coord:	
Supervisor:	Time called:	Present in ED:

E.D. ASSESSMENT:

Pts on ECG monitors: # Open monitored beds: # Admits holding for monitored beds:

INTERNAL ASSESSMENT: get from House Supervisor

- ☐ No monitored or ICU beds
- ☐ Unavailability of credentialed/trained staff after failed attempts to call them in
- ☐ Internal disaster or unsafe situation requires lockdown (nature):_____
- ☐ Trauma Centers: ☐ OR limitation ☐ CT down

Current census:	Step-down:	ICU:	House:

Estimate # of in-house critical or monitored beds that could be available in next 2 hours:

- ☐ Peak Census procedures completed
- ☐ Hospital Peak Census status reported to https://emresource.juvare.com..

INTERNAL STEPS TAKEN TO AVOID BYPASS: Document each of the below steps as completed:

- ☐ Consider appropriately monitored beds in other areas of the hospital; boarding and/or overflow beds opened
- ☐ Actual and substantial efforts to call in appropriately trained, off-duty-staff; staff reallocated to surge beds
- ☐ Limitation/cancellation of elective pt procedures
- ☐ Advance admission of a patient to an inpatient area where the bed is assigned and vacated, but not yet ready to be occupied
- ☐ All units advised to expedite discharges
- ☐ Environmental services notified of urgent need to rapidly clean and prepare beds for incoming patients
- ☐ Urgent efforts made to restore diagnostic and/or interventional equipment/backup equipment and/or facilities to full function, including seeking emergency repair from outside vendors if in house capability is not rapidly available.

EXTERNAL ASSESSMENT: **Check status of other hospitals in area –** Consult IDPH Daily Hospital Resource Availability Tracking system. If neighboring hospitals are also on highest levels of peak census or bypass, ED-to-ED communication shall evaluate possible consequences of a "Bypass" declaration.

Alexian Brothers	**847- 952-7454**	Time:	RN Name:
ED status/Comments:			
Glen Oaks	**630- 545-5758**	Time:	RN Name:
ED status/Comments:			
Good Shepherd	**847- 842-4444**	Time:	RN Name:
ED status/Comments:			
Lutheran General	**847- 723-5155**	Time:	RN Name:
ED status/Comments:			
Northwest Community	**847- 259-9812**	Time:	RN Name:
ED status/Comments:			
Resurrection	**773- 792-5255**	Time:	RN Name:
ED status/Comments:			
Saint Alexius	**847- 843-3508**	Time:	RN Name:
ED status/Comments:			

DECISION(S) MADE

If decision is made to request BYPASS; Initiate Critical Capacity/Bypass Worksheet to report to IDPH rep

Region IX/NWC EMSS Critical Capacity/Bypass Worksheet

Area of Focus	Comments			
Date	**Hospital name**:		City:	
Individual completing form	Name:		Phone:	
To request bypass CALL:	Time:	Steve Baron (RHCC Coord) **224-830-5676 or** Gary Brown **815-222-6358**		
If approved by above: Call IDPH rep:	Time:	e-mail this form to: Danielle.albinger@illinois.gov Call cell: **630-200-7226**		
EMS Coord. notifications	Bill Toliopoulos 847-826-2285	Hospital EMSC:		
GENERAL criteria for requesting bypass: (See policy p. 1)	Persistent limitations after surge plan activated: ☐ **No critical or monitored beds** available ☐ **Internal disaste**r (power failure, flood, fire), or active assailant resulting in hospital **lockdown** ☐ **Insufficient staff** appropriate for pt needs after attempts to call them in ☐Trauma Center: CT scan unavailable ☐Trauma Center: All staffed operating suites in use or fully implemented with on-call teams, and at least one or more of the procedures is an operative trauma case			
ED Bed/Patient Status	Total beds		ED census now:	
ED holds waiting for bed assignments/admission	Tele admits:		ICU admits:	
	Non-Tele admits:		Others:	
ED waiting room census	ED WR longest wait:		ED wait time avg.:	
	Criticality of WR pts. (ESI Level):			
Hospital bed status Alternate beds in use	CDU:	ED:	Other:	
General bed availability	Med surg.:	Tele:	ICU:	
Potential hospital discharges	Tele discharges:		Non-tele discharges:	
Transferring to other hospitals?	☐Yes ☐ No Comments:			
Surge Plan activated & strategies implemented	Plan to expand to alt. care areas		☐Y	☐N
	Modified electives?		☐Y	☐N
	Cancelled electives?		☐Y	☐N
Extra Staff Called In? Additional steps taken to supplement staffing				
Likely destination for EMS pt. diversions and that hospital's status	Hospital:	☐ Peak census ☐ Open ☐ Bypass	Hospital	☐ Peak census ☐ Open ☐ Bypass
	Hospital	☐ Peak census ☐ Open ☐ Bypass	Hospital	☐ Peak census ☐ Open ☐ Bypass
Incident Command Activation	Time:		☐Y	☐N
Peak Census level now	Level:		Time posted:	
Bypass requested by:	Print name:			
Bypass Granted by IDPH https://emresource.juvare.com.	☐ Yes ☐ No	Time of determination:		
	Time notification posted in EMResource:			
	Time duration:			
	Approved by:			

Begin log of bypass notifications and times

Created By: Region IX RHCC(NWC EMSS) Date created: 12-16-21 Updated: 11/11/22 Post Until: Updated

Northwest Community EMSS Bypass Notification Worksheet

Date:_____ Hospital:_____

Notify	Number	Alt. #	Initiated	Updated	Canceled
Northwest Central: AHFD, BCFPD, BFD, BGFD, EGV, HEFD, INVFPD, MP, Pal, RMFD, SCH	847- 590-3300				
Addison: WDFD & IFPD	630- 458-4012				
DuComm: BLFPD	630- 260-7512				
Lake Zurich: LZ & Wauconda	847- 438-2349				
Red Ctr: LRFPD, LGFD, PHts, Wheeling	847- 724-5700				
Advantage-Elite	630- 894-8484				
A-TEC	815- 477-2400				
Superior	630- 832-2000				
Alexian Brothers	847- 952-7454	847- 437-8118			
Glen Oaks	630- 545-5758	630- 545-5700			
Good Shepherd	847- 842-4444	847- 381-9525			
Lutheran General	847- 723-5155	847- 696-0743			
Northwest	**847- 259-9812**	847- 259-9767			
Resurrection	773- 792-5255	773- 774-8455			
Saint Alexius	847-843-3508	847- 490-6930			

Note: For other hospitals and phone numbers, see SOP Appendix p.117

Northwest Community EMS System

Criteria for CT Resource Limitation

If a hospital has declared bypass due to a CT scanner resource limitation –
DO NOT transport patients with the following to their location:

Indications for HEAD CT:

- Acute head injury; suspected intracranial hematoma (epidural, subdural)
- Suspected stroke, TIA, subarachnoid hemorrhage

Indications for SPINE CT:

Acute spine trauma (injury within previous 48 hours) where there is a higher than average likelihood of fracture or dislocation, bulging or herniated disc, or mechanical instability of the spine that requires spine motion restriction. Pt may c/o midline spine pain, have visible injury, or findings of neuro loss or deficit.

Indications for CHEST CT

- Chest trauma with possible pneumothorax, hemothorax, rib fractures and flail segments, pulmonary contusion, disruption to the thoracic aorta, diaphragmatic rupture

Indications for ABDOMINAL/PELVIC CT

- Acute abdominal/pelvic trauma
- Kidney and bladder trauma
- Possible Abdominal Aortic Aneurysm (AAA)