I. Requirements while operating under Conventional capacity: Personnel and staffing

A. It is assumed through this section that the spaces, staff, and supplies used are consistent with usual and customary daily practices within the System fully meeting all laws, rules, guidelines, policies and procedures.

B. Each EMS provider agency that operates an emergency transport vehicle shall ensure through written agreement with the EMS System that the agency providing emergency care at the scene and en route to a hospital meets or exceeds the requirements of the IDPH Rules and System Policy. (Section 515.830 of the EMS Rules Amended at 42 Ill. Reg. 17632, effective September 20, 2018 amended by emergency rulemaking at 46 Ill. Reg. 1173, effective December 27, 2021, for a maximum of 150 days) and System policy.

> **Levels of acuity:** Source document: National EMS Core Content: An acuity level is essential for identifying care priorities in the EMS setting. They are coded to NEMSIS standards and should be documented as such in the ePCR. Critical pts are TIME-SENSITIVE with black box notations throughout the SOPs.
>
> **Critical:** Symptoms of a life threatening illness or injury with a high probability of mortality if immediate intervention is not begun to prevent further airway, respiratory, hemodynamic and/or neurologic instability.
>
> **Emergent:** Symptoms of illness or injury that may progress in severity or result in complications w/ a high probability for morbidity if treatment is not begun quickly. These may be identified as time-sensitive on a case by case basis.
>
> **Lower Acuity:** Symptoms of an illness or injury that have a low probability of progression to more serious disease or development of complications.

C. **NWC EMSS Policy**: Patients requiring **ALS services and determined to be critical, emergent, and/or unstable**, as defined by IDPH, the EMS Act and/or Rules, and System SOPs and/or policy, will be cared for by a minimum of **two licensed EMS personnel with ALS privileges** (paramedic, Pre-hospital RN [PHRN], Pre-hospital Advanced Practice RN [PHAPRN,] or Pre-Hospital Physician Assistant [PHPA]) with NWC EMSS privileges awarded through the full System entry credentialing process unless an exemption applies or a variance has been granted by the EMS MD.

D. Patient requiring **ALS services who are stable and determined to be of a lower acuity rating** shall be cared for by **one licensed ALS practitioner** and one other EMT with NWC EMSS privileges awarded through the full System entry credentialing process.

E. All patients requiring **Basic Life Support services** as defined by IDPH, the EMS Act and/or Rules, and System SOPs and/or policy will be cared for by a minimum of two licensed EMTs or EMS practitioners with a higher level of licensure with NWC EMSS privileges while at the scene and en route to the receiving destination.

F. This policy is driven by the level of care required by the patient, not the level at which a vehicle is licensed. Agencies have options for how they will get adequately licensed individuals and/or vehicles licensed and stocked at the ALS level to the scene if ALS care is required. It also only pertains to an agency's first response capabilities within their primary response area as identified in their EMS System Plan agreement. It **DOES NOT** pertain to second simultaneous calls requiring dispatch of reserve vehicles or mutual aid companies. The System expects EMS agencies to dispatch the highest level of care **available** once all primary response transport vehicles are committed, pending a request for mutual aid.

G. All mutual aid ALS transport vehicles sent by NWC EMS Provider agencies to other NWC EMSS agencies will be staffed with two licensed ALS personnel.

H. At the time of application for initial or renewal licensure, the applicant or licensee shall submit to IDPH and the System for approval a list containing the anticipated hours of operation for each vehicle covered by the license.

1. A current roster shall also be submitted, which lists the EMTs, paramedics, PHRNs, PHAPRNs, PHPAs, and/or physicians who are employed or available to staff each vehicle during its hours of operation. The roster shall include each staff person's name, license level, license number, expiration date, and contact information (e-mail address or phone number), and shall state whether such person is generally scheduled to be on site or on call.
2. An actual or proposed four-week staffing schedule shall also be submitted, which covers all vehicles, includes staff names from the submitted roster, and states whether each staff member is scheduled to be on site or on call during each work shift. (EMS Rules Section 515.830(k2A).

I. **Special Considerations under Conventional Capacity**

1. **Dissent to care/Refusal of service calls:** Situations involving patients with legal and decisional capacity who required ALS monitoring and/or interventions and are now stable, non-emergent, and refusing further care and/or transport and the first responding EMS vehicle was staffed with one ALS practitioner and one other EMT: If the patient meets eligibility criteria to dissent to care and the refusal is not contested by EMS, the ALS practitioner on scene may process and execute the refusal per System policy while on scene.
2. **Private ambulance EMS personnel in need of ALS assistance may do one of the following:**
   a. **Weigh the risk/benefit to the patient** of waiting for a mutual aid ALS team or rapidly transporting to the nearest hospital for care. Call OLMC for a determination.
   b. **If the patient is determined to be Critical or Emergen**t: Call their dispatch center and request help from the local 911 EMS provider, giving the location, patient condition and rendezvous point or call 911 for mutual aid from the municipality through which they are traveling.
   c. Under no circumstances should a BLS team wait on scene longer for an ALS vehicle from their own agency to respond than the local municipal ALS agency could respond for a patient categorized as Critical or Emergent under the SOPs.
   d. If the patient is determined to be lower acuity, but requires ALS assessment and/or care, a BLS team can call their own agency dispatch center and ask for a vehicle staffed and approved at the ALS level.
3. **Transfer of care from one agency to another:** Any EMS Agency assuming responsibility for a patient from another agency must receive a verbal handover report from personnel who are relinquishing responsibility for the patient noting the chief complaint, presenting S&S, vital signs, any treatment rendered, and the patient's responses. The originally responding agency must complete a PCR documenting the assessments and care provided up to the time of patient transfer and forward a copy of their complete PCR to the receiving hospital within two hours. See System policy D4: Data collection and submission.
4. **Paramedic students** are recognized under the law as an EMT and cannot fulfill paramedic staffing requirements. The only **EXCEPTION** to this policy is a **TEMPORARY VARIANCE** authorized by the EMS MD or designee during the later

portion of the Field internship capstone experience or in the last semester of class (EMS 216) after the student has demonstrated competency as a paramedic team leader. A variance must be requested by the Provider Agency in writing, accompanied by a description of the staffing hardship necessitating the variance. It must be reviewed on a case by case basis for each student as stated in System Policy V-1. If approved, the agency may use a current paramedic preceptor and the approved paramedic student as an ALS response team for patients determined to have a lower acuity, non-urgent condition. The student must drive the ambulance and the licensed paramedic shall provide direct patient care.

II. **Requirements while operating under Contingency capacity**

A. **Contingency capacity:** Staffing shortages are imminent, and if action is not taken will interrupt EMS operations. Contingency strategies are used to mitigate staffing shortages. The spaces, staff, and supplies used are not consistent with usual and customary daily practices. Spaces or practices may be repurposed, used temporarily during a declared emergency event or on a more sustained basis when the demands of the incident exceed hospital, agency, and/or community resources. Contingency plans may include, but not be limited to the following: changes in staffing, work redeployment, temporary emergency practice privileges for EMS and ECRN personnel, brief deferrals of non-emergency travel, meetings, classes, or services, change in responsibilities, and documentation as defined by the Contingency Capacity declaration. This results in functionally equivalent or modified education and/or patient care practices meeting defined standards.

B. EMS providers shall monitor their resources on an ongoing basis. If their workforce is decimated by the effects of the emergency and conventional capacity ALS staffing cannot be achieved. EMS agencies are authorized to operate at minimum IDPH staffing levels per the EMS Rules on all patients. For ALS calls, this includes **one licensed ALS personnel** and one other EMT with NWC EMSS privileges.

C. Notify the EMS Administrative Director by email of the change in staffing per vehicle and estimate the length of time that the alternate staffing will need to be in effect. Alternate staffing plans meeting minimum state standards will not be authorized after the state of emergency is lifted and/or EMS members are safely returned to the workforce.

D. **Temporary staffing resources and CONTINGENCY practice privileges**:

1. NWC EMSS agencies may immediately share licensed EMS practitioners in good standing with other NWC EMSS agencies with no additional requirements other than to notify the Resource Hospital and to activate them within their agency's Image Trend roster so they are accurately noted on the ePCR.

2. NWC EMSS agencies may temporarily use licensed PMs in good standing working for EMS agencies in Region 9 and approved agencies in Region 8 based on Intra- and Inter-Region agreements.

   These ALS practitioners may petition for temporary Contingency EMS Privileges by providing written recommendation from their current EMS MD to the Resource Hospital stating that they are qualified and in good standing to practice at the Paramedic level. They shall be added temporarily to the agency's Image Trend Roster so they can be listed on the ePCR. See limitations of Contingency Practice Privileges below.

3. Agencies who are hiring licensed ALS practitioners from outside of Region 9 during Contingency Operation and suspension of System Entry testing and/or labs may petition for Contingency practice privileges after the licensee opens a file and submits required documents per usual System Entry processes, submits a letter of good standing from the current EMS System, and submits the SOP and Policy Manual Self-assessments scored as acceptable.

4. IDPH shall permit immediate reciprocity to all EMS personnel from other states who hold an unencumbered National Registry of Emergency Medical Technicians certification for EMTs, AEMTs, or Paramedics, allowing such individuals to operate in an EMS System under a provisional system status until an Illinois license is issued:

   a. To operate on an EMS System transport or non-transport IDPH licensed Vehicle under provisional system status, an individual must have applied for licensure with the Department and meet all requirements under the Act. All Dept-required application materials for submission must be provided to the EMS System for review prior to system provisional reciprocity approval.

   b. The EMS System has the responsibility for validating National Registry Certification of each individual.

   c. An individual with a Class X, Class 1 or Class 2 felony conviction or out-of-state equivalent offense, as described in Section 515.190, is not eligible for provisional system status.

   (Source: Amended by emergency rulemaking at 46 Ill. Reg. 1173, effective December 27, 2021, for a maximum of 150 days)

5. **Contingency privileges are temporary** and shall only be awarded while Contingency operation continues. These individuals shall serve in a support role alongside at least one other licensed ALS practitioner with full NWC EMSS privileges. They shall not perform assessments or procedures using devices or equipment for which they have not been educated, competencied, or credentialed. When the state of Contingency is lifted, those hired by NWC EMSS Agencies must complete the full System Entry testing and credentialing process per System Policy.

III. CRISIS CAPACITY STAFFING

A. Staffing shortages already exist, and crisis strategies are used in order to continue operations at a safe level. Staffing, equipment, and supply resources are insufficient even after adaptations and allowances made for Contingency capacity. **Crisis operation provides for the best proportionate response possible in the setting of severe resource limitations**, catastrophic disease, or disaster given the circumstances and resources available. It allows the flexibility to improvise, loosens usual requirements, and balances risk against benefit to provide the greatest good for the greatest number (Utilitarianism). The System must make known to IDPH and all its member dispatch centers, Provider Agencies; and Hospitals that it is operating under CRISIS capacity standards of care.

B. **Source authority:** Temporary Waiver for Certain Requirements for EMT and Paramedics Pursuant to authority granted to IDPH by 210 ILCS 50/3.185, the Department will consider a special temporary waiver for certain requirements for EMT and Paramedic Licensure for applicants whose IDPH issued EMS license is expired for less than 60 months, as of 3/23/20.

C. If the nature of the emergency makes operating at minimum IDPH staffing levels impossible, the EMS MD will consider declaring a state of CRISIS CAPACITY. This declaration must be submitted to IDPH if it is anticipated to last longer than 72 hours. An agency's crisis capacity staffing plan must be submitted to the Resource Hospital who will also forward to the IDPH Regional EMS Coordinator (REMSC).

D. No Crisis Capacity staffing plan will be granted for longer than 90 days without a re-evaluation of the request.

E. If Crisis Capacity staffing is invoked, a QA process must be put in place by the System to have the Agency evaluate at least five calls during the duration of the request to ensure there were no preventable deficiencies in care due to the staffing change. This information shall be provided to and retained by the System and made available to IDPH upon request.

F. **Options to support staffing during Crisis Capacity operation**

1. Submit a waiver to the Resource Hospital to allow one licensed practitioner at the level of care required by the patient and consistent with the drugs and supplies available on the vehicle and one other individual to drive the ambulance with CPR certification. If approved, the System will forward to the REMSC for approval.

2. Currently licensed EMS practitioners and ECRNs and currently credentialed MILITARY Medics may petition the System for temporary CRISIS privileges by forwarding a copy of a photo ID, their current license and a letter of good standing from their current EMS System or Commanding Officer to the EMS Administrative Director. If approved, no further actions are needed for temporary Crisis Privileges.

3. **CRISIS privileges are temporary** and shall only be awarded while CRISIS operations continue. Whenever possible, these individuals shall serve in a support role alongside at least one other licensed practitioner with full NWC EMSS privileges. They shall not perform assessments or procedures using devices or equipment for which they have not been educated, competencied, or credentialed. When the state of CRISIS is lifted, those who wish to retain NWC EMSS privileges must complete the full System Entry testing and credentialing process per System Policy.

4. Per IDPH authorization, the System shall create an educational and testing plan for reinstating retired or expired EMS practitioners to attain temporarily Crisis EMS privileges to work in the System per the following restrictions.

   a. General requirements for all special licensees issued under this temporary special waiver:

      (1) The applicant's IDPH EMS license has been expired for less than 60 months, and must have been in good standing at the time it expired, i.e. not suspended or revoked.

      (2) The applicant must not have been suspended from any Illinois EMS system as of the IDPH license expiration date.

      (3) The applicant must hold current CPR for healthcare provider certification from the AHA.

      (4) Any licensee granted a temporary license under this special waiver shall only practice with another System-approved licensee with full practice privileges at or above the level of the licensee. Two licensees granted a temporary (Crisis) license under this special waiver shall not practice together and must be paired with a System approved licensee with full practice privileges.

      (5) The applicant must submit a written application for the level of license sought, which may be downloaded from the Department's website at: http://www.dph.illinois.gov/topics-services/emergency-preparedness-response/ems. The application must demonstrate and comply with all of the following for the level of license sought:

         (a) For applicants seeking a paramedic license, the applicant must demonstrate all of the following:

            (i) That the applicant has either: (i) Completed all CE as required by the EMS MD OR (ii) successfully completed an EMS System exam demonstrating competence with all current Paramedic protocols required with respect to the EMS System in which the applicant seeks to practice.

(ii) Regardless of (i) and (ii) above, the applicant must also have the written recommendation from a current Illinois EMS System MD stating that the applicant is: (i) qualified to practice at the Paramedic level; and (ii) will be accepted into that EMS MD's EMS system.

(b) For applicants seeking to practice at the EMT level:

(i) That the applicant has either: (i) Completed all Continuing Medical Education as currently required by the EMS System; OR (i) successfully completed an EMS System examination demonstrating competence with all current EMT protocols required with respect to the EMS System in which the applicant seeks to practice, and

(ii) Regardless of (i) and (ii) above, the applicant must also have the written recommendation from a current Illinois EMS System MD stating that the applicant: (i) is qualified to practice at the EMT level; and (ii) will be accepted into that EMS MD's EMS System.

(6) For licenses expired less than 60 months as of 3/23/20:

(a) The applicant must submit a complete application for the level of license sought; demonstrate successful completion of system entrance requirements to function at the level of the expired license, e.g. expired Paramedic successfully completes system entrance requirements for the ALS level, may function at the PM level.

(b) If they cannot successfully complete the system entrance exam for the level of licensure requested, then may function at the level of entrance requirements they can successfully pass, e.g. a person with an expired Paramedic license can only successfully complete the EMT entrance requirements, then may only function at the EMT level.

(c) All temporary licenses for those reinstating their status under this special waiver (EMT and Paramedic) shall **automatically expire 6 months** after being issued. License renewal shall require full compliance with all: IDPH and EMS system requirements.

b. The EMS MD is responsible for all approvals and at what level they may function.

c. NCH Paramedic students in EMS 216 who are already employees of an ALS Provider Agency within the NWC EMSS may be given Crisis ALS privileges if they have been declared competent by completing EMS 215 - EMS Field Internship.

d. "Function" requirements: Expired and student EMS personnel may only function with a licensed EMS practitioner at or above the level of licensure that they are seeking as approved by the EMSMD.

e. Required documentation:

(1) System plan amendment presented to IDPH for approval

(2) System submits a roster with names of expired licensed personnel who successfully complete the system entrance requirements.

(3) The roster will include:

(a) Name of expired licensee, expired license number, phone number, social security#, level of function approved by EMS system for this individual, and date approved

(b) Name of student, class site code, phone number, social security # level of function approved by EMS system for this individual and date approved

(c) Name, system number, EMS MD signature

IV. **Alternative Staffing for Private Ambulance Providers, Excluding Local Government Employers**

A. An ambulance provider may request approval from IDPH to use an alternative staffing model for interfacility transfers for a maximum of one year in accordance with the requirements for Vehicle Service Providers in 210 ILCS 50/3.85 of the Act and may be renewed annually.

1. An ambulance provider requesting alternative staffing for BLS ambulance(s) for interfacility transfers will provide the following to IDPH:

a. Assurance that an EMT will remain with the patient at all times and an EMR will act as driver.

b. Certificate of completion of a defensive driver course for the EMR and validation that the EMT has one year of pre-hospital experience.

c. A system plan modification form stating this type of transport will only be for identified interfacility transports or medical appointments excluding dialysis.

d. Dispatch protocols for properly screening and assessing patients appropriate for transports utilizing the alternative staffing models.

e. A quality assurance plan which must include monthly review of dispatch screening and outcome.

2. The EMSMD and the Department shall not approve any request for out of state deployment for any EMS provider utilizing an alternative staffing model.

3. The System modification form and program plan shall be submitted to the EMSMD for approval and forwarded to the REMSC for review and approval. The provider shall not implement the alternative staffing plan until approval by the EMSMD and the Department.

4. Within 30 days, each EMS System must develop an EMS Workforce Development and Retention Committee. In the NWC EMSS, the System Advisory Board shall also serve as the EMS Workforce Development and Retention Committee as it meets the IDPH requirements for representation as stated below:

a. The Committee shall be representative of the following:

(1) At least one individual representing each private ambulance provider.
(2) At least one individual representing each municipal provider;
(3) Two individuals representing the Associate Hospitals
(4) Two individuals representing the Participating Hospitals
(5) One individual representing the Resource Hospital; and
(6) The EMS System Medical Director

b. The committee shall:

(1) Assess whether there are EMS staffing shortages within the System and the impact of any staffing shortage on response times and other relevant metrics.

(2) Develop recommendations to address such staffing shortages, including, but not limited to, alternative staffing models including the use of EMRs.

c. The EMSMD shall submit a final report to the Department along with any proposed system modifications to address the staffing shortages of the System.

d. Under the approval of the EMSMD, private ambulance providers may submit a plan for alternative staffing models.

(1) The alternative staffing model would include expanded scopes of practice as determined by the EMSMD and approved by the Department.

(2) This may include the use of an EMR at the BLS, AEMT/ILS, or ALS levels of care.

(3) If an EMSMD proposes an expansion of the scope of practice for EMRs, such expansion shall not exceed the education standards prescribed by IDPH.

(4) No expanded scopes of practice for EMTs or EMRs are needed in the NWC EMSS at the present time.

e. The alternative staffing plan shall be renewed annually if the following criteria are met:

(1) All system modification forms and supportive planning documentation are submitted, validated, and approved by the EMSMD who shall submit to the Department for final approval.

(2) All plans must demonstrate that personnel will meet the training and education requirements as determined by IDPH for expanding the scope of practice for EMRs, testing to assure knowledge and skill validation, and a quality assurance plan for monitoring transports utilizing alternative staffing models that include EMRs.

(3) This plan shall be submitted to the REMSC for review and approval.

(4) This plan shall not be implemented without Department approval, which shall not be unreasonably withheld.

B. Deference shall be given to the EMSMD's approval of the plan.
(Source: Amended by emergency rulemaking at 46 Ill. Reg. 1173, effective December 27, 2021, for a maximum of 150 days)

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