Joint Committee on Administrative Rules
ADMINISTRATIVE CODE

TITLE 77: PUBLIC HEALTH
CHAPTER I: DEPARTMENT OF PUBLIC HEALTH
SUBCHAPTER f: EMERGENCY SERVICES AND HIGHWAY SAFETY
PART 515 EMERGENCY MEDICAL SERVICES, TRAUMA CENTER, COMPREHENSIVE STROKE CENTER, PRIMARY STROKE CENTER AND ACUTE STROKE READY HOSPITAL CODE
SECTION 515.2040 LEVEL II TRAUMA CENTER DESIGNATION CRITERIA

Section 515.2040 Level II Trauma Center Designation Criteria

a) A Level II Trauma Center, under the direction of a Level II Trauma Center Medical Director, shall be responsible for providing trauma care in accordance with the EMS System Program Plan.

b) The Trauma Center Medical Director shall be a trauma surgeon, board certified in surgery, with at least two years of post-residency experience in trauma care and with 24-hour independent operating privileges.

c) The trauma center shall provide a trauma service, separate from the general surgery service, that is an identified hospital service functioning under the designated director and staffed by trauma surgeons with one year of experience in trauma, and who will arrive at the hospital to treat the trauma patient within 30 minutes after the patient's being classified as a Category I trauma patient.

1) The trauma surgeons shall have 20 hours of trauma-related CME every two years.

2) The trauma surgeon requirement may be fulfilled by residents with a minimum of four years of general surgery residency training and current ATLS verification.

3) If the resident is fulfilling the trauma surgeon requirement, the attending physician must be consulted within 30 minutes after the patient's being classified as Category I or II.

4) If the resident is fulfilling the trauma surgeon requirement, it is mandatory that an attending be present for patients undergoing operative procedures by the time the surgery begins.

5) The trauma surgeon, resident or surgical subspecialist shall be consulted when the decision is made to admit a Category II patient. The trauma

surgeon or appropriate subspecialist shall see the patient within 12 hours after ED arrival.

6) A physician with current ATLS verification or who has current competency in the initial resuscitation of the trauma patient as verified by the professional staff competency plan must be present 24 hours per day in the Level II Trauma Center to treat the trauma patient.

7) The hospital's quality improvement program shall monitor compliance with this subsection (c).

8) The trauma center shall maintain a call schedule that identifies at least a primary and back-up surgeon, each listed by surgeon's name.

9) The trauma center shall have the option of allowing the ED personnel to determine that a trauma patient with an isolated injury may be treated by one of the services listed in subsection (d) or (e) of this Section. An isolated injury refers to the transfer of energy to a single specific anatomic body region with no potential for multisystem involvement. The subspecialist must arrive within the time frame listed in subsection (d) or (e) after notification that his or her services are needed at the hospital. When the need for neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of need for operative intervention.

d) The trauma center shall have the following surgical services on call to arrive at the hospital to treat the patient within 60 minutes after notification that their services are needed:

1) Cardiothoracic; this requirement may be fulfilled by a cardiothoracic surgeon or a trauma/general surgeon with experience in cardiothoracic surgery for lifesaving procedures; the surgeon must have cardiothoracic privileges;

2) Orthopedic;

3) Urologic; and

4) Obstetrics.

e) The trauma center shall have the following surgical specialties on call to arrive at the hospital to treat the patient within 60 minutes after notification that their services are needed. When the need for neurosurgical intervention has been identified, the neurosurgeon must arrive and be available in a fully staffed operating room within 60 minutes after the identification of the need for operative intervention. The following services may be provided by written transfer agreement. These services must be provided according to subsection (c)(9) of this Section for isolated injuries when the trauma surgeon is not required to respond:

1) Neurosurgical;

2) Ophthalmologic;

3) Oral-Dental;

4) Otorhinolaryngologic;

5) Reimplantation;

6) Plastic/Maxillofacial;

7) Burn center staffed by Registered Professional Nurses trained in burn care;

8) Acute spinal cord injury management; and

9) Pediatric surgery as designated by Section 515.2045 of this Part.

f) The trauma center shall provide the following nonsurgical services within the designated times:

1) Emergency Medicine staffed 24 hours a day in the ED by:

A) A physician who has competency in trauma as demonstrated by:

i) Board certification or board eligibility by the ABEM or the AOBEM; and

ii) Ten hours per year of AMA or AOA-approved Category I or II trauma-related CME; or

B) A physician who was working in the emergency department of a trauma center prior to January 1, 2000, and who had completed 12 months of internship, followed by at least 7000 hours of hospital-based Emergency Medicine over at least a 60-month period (including 2800 hours within one 24-month period), and CME totaling 50 hours, 10 of which are trauma related for each post-internship year in which the physician completed any hospital-based Emergency Medicine Hours.

2) Anesthesiology Services:

A) Anesthesiology services shall be in compliance with the Hospital Licensing Act and the Hospital Licensing Requirements, 77 Ill. Adm. Code 250.1410. Staff shall be on call to arrive at the hospital to administer anesthesia within 30 minutes after notification that their services are needed at the hospital.

B) Direct patient care services may be performed by an anesthesiologist or a CRNA.

3) Laboratory – 24 hours a day in-house, providing the following:

A) Standard analysis of blood, urine, and other body fluids;

B) Blood typing and cross-matching;

C) Coagulation studies;

D) Comprehensive blood bank or access to a community central blood bank and adequate hospital storage facilities (see Hospital Licensing Requirements (77 Ill. Adm. Code 250.520));

E) Blood gases and pH determinations;

F) Microbiology, to include the ability to initiate aerobic and anaerobic cultures on a 24 hour per day basis; and

G) Drug and alcohol screening.

4) Radiology staffed by:

A) A technician with the ability to perform a CAT scan available within 30 minutes; and

B) A radiologist with the ability to read CAT scans and perform angiography available within 60 minutes. This requirement may be met by a PGY II radiology resident with six months experience in CAT and angiography. The radiology department shall provide a quality monitoring process to validate the resident's compliance with the time requirements and competency to read CAT scans and perform angiography. Teleradiographic equipment may be used to transmit CAT scans off site in lieu of the radiologist's response to the trauma center to read CAT scans.

5) Cardiology – 60 minutes.

6) Internal Medicine – 60 minutes.

7) Postanesthetic recovery capability staffed and available within 30 minutes may be fulfilled by ICU.

8) Intensive Care Medicine Unit having available the following:

A) A physician credentialed by the hospital and available within 30 minutes. This requirement may be fulfilled by second and third year residents who have had intensive care training and are under the

supervision of a staff physician possessing full intensive care privileges;

B) One Registered Professional Nurse per shift with two years of ICU experience and four hours of trauma-related critical care continuing education per year.

C) The following equipment:

i) Airway control and ventilation devices;

ii) Oxygen source with concentration controls;

iii) Cardiac emergency cart;

iv) Electrocardiograph-oscilloscope-defibrillator;

v) Temperature control devices;

vi) Drugs, intravenous fluids, and supplies in accordance with the Hospital Licensing Requirements (77 Ill. Adm. Code 250.1050, 250.2140, and 250.2710);

vii) Mechanical ventilator-respirators;

viii) Pulmonary function measuring devices (i.e., pulse oximeter, CO**[**2**]** monitoring); and

ix) Drugs, intravenous fluids and supplies in accordance with Hospital Licensing Requirements (77 Ill. Adm. Code 250.1050, 250.2140 and 250.2710).

9 Pediatrics – 60 minutes.

10) Acute hemodialysis capability 24 hours a day or a transfer agreement.

g) The trauma center shall meet the following professional staff requirements:

1) The ED Director shall be a physician board certified by the ABEM, or certified by the AOBEM of the AOA;

2) Each shift in the ED will be staffed by at least one Registered Professional Nurse who has completed a Trauma Nurse Specialist Course and is currently recognized in good standing as specified in Section 515.750 of this Part. The TNS will serve as a resource to the Registered Professional Nurses caring for the Category I and Category II trauma patients. For multiple concurrent trauma admissions into the ED, the nurse caring for those additional trauma patients must have a minimum of four hours of trauma-related continuing education. A back-up policy shall provide for a nurse

with experience evidenced by TNCC or 16 hours equivalent in trauma nursing education, approved by the Department, in a four-year period. A back-up schedule must be maintained unless a minimum of two TNS-trained RNs are on duty per shift;

3) A full-time Trauma Coordinator dedicated solely to the Trauma program;

4) An operating room shall be staffed and available within 30 minutes 24 hours a day; and

5) Staff shall include occupational therapy, speech therapy, physical therapy, social work, dietary, and psychiatry.

h) The trauma center shall develop a professional staff competency plan including but not limited to trauma surgeons and emergency medicine physicians treating the trauma patients. Physicians caring for trauma patients in the Level II Trauma Center must demonstrate the following:

1) Board certification/Board eligibility in their specialty;

2) Successful completion of trauma-related continuing medical education (CME) requirements as specified in this Section;

3) Ongoing clinical involvement in the care of the trauma patient as evidenced by routine participation in one or more of the following: trauma call rosters, trauma teams, and attendance at trauma rounds/trauma meetings;

4) Physician specific outcome measurements based on the frequency and acuity of procedures or other peer review measures pertinent to the facility trauma patient volume;

5) For trauma surgeons and emergency medicine physicians only, the successful completion of an ATLS provider course.

i) The trauma center shall provide and maintain the following equipment:

1) Airway control and ventilation equipment including laryngoscopes and endotracheal tubes of appropriate sizes, bag-mask, resuscitator, sources of oxygen, mechanical ventilator, pulse oximeter and CO**[**2**]** monitoring;

2) Suction device;

3) Electrocardiograph-oscilloscope-defibrillator;

4) Apparatus to establish central venous pressure monitoring;

5) All standard intravenous fluids and administration devices;

6) Sterile surgical sets of procedures standard for ED, such as cricothyrotomy, tracheostomy, thoracotomy, cut down, peritoneal lavage, and intraosseous;

7) Drugs and supplies necessary for emergency care;

8) X-ray and CAT scan capability, available within 30 minutes;

9) Spinal immobilization equipment;

10) Temporary pacemaker;

11) Temperature control device; and

12) Specialized pediatric resuscitation with measuring device cart in the emergency area.
AGENCY NOTE: Broselow**(**TM**)** Tape will meet this requirement.

j) *The trauma center* must *have helicopter landing capabilities approved by State and federal authorities.* (Section 3.100(j) of the Act) The helicopter landing capabilities shall:

1) Comply with the Aviation Safety Rules of the Illinois Department of Transportation (92 Ill. Adm. Code 14.790, 14.792 and 14.795);

2) Be covered by a favorable airspace determination letter issued by the Federal Aeronautics Administration pursuant to Sections 307 and 309 of the Federal Aviation Act of 1958, and 14 CFR 157 and 14 CFR 77, Subpart D; and

3) Be provided on the campus of the trauma center.

Out-of-state trauma centers are exempted from this subsection (j) but must comply with their state's rules that govern aviation safety.

k) The trauma center shall perform focused outcome analyses of its trauma services on a quarterly basis and shall provide all minutes related to these reviews on site or at the request of the Department. The analyses shall consist of at least:

1) Review of all patient deaths, excluding dead on arrival (DOA). Patients must be assigned a status of non-preventable death, potentially preventable death, or preventable death, or cannot be determined, using the American College of Surgeons "Performance Improvement" (Chapter 19, from "Resources for the Optimal Care of the Injured Patient, 1999"). Factors contributing to the death must be included in the review. A cumulative report of these findings shall be available on site and upon request by the Department.

2) Review of all morbidities. A morbidity is a negative outcome that is the result of the original trauma and/or treatment rendered or omitted. Factors

contributing to the morbidity must be included in the review. A cumulative report of these findings must be presented quarterly to the Region.

3) Review of audit filters. An audit filter is a clinical and/or internal resource indicator used to examine the process of care and to identify potential patient care and/or internal resource problems.

4) *All information contained in or relating to any medical audit performed of a trauma center's trauma services pursuant to* the *Act, or by an EMSMD or his designee of medical care rendered by system personnel, shall be afforded the same status as is provided information concerning medical studies in Article VIII, Part 21 of the Code of Civil Procedure.* (Section 3.110(a) of the Act)

l) Every two years the trauma center shall provide to the Department written protocols concerning the following:

1) Policies for treating patients in the trauma center, which includes Trauma Category I and Trauma Category II criteria as required in Section 515.Appendices C and F of this Part;

2) Clinical protocols for management of the trauma patient in basic resuscitation and management of specific injuries. Protocols are to be kept on site and available to the Department upon request;

3) The transfer of trauma patients to the Level I Trauma Center serving the EMS Region or a more specialized level of care;

4) A policy that blood alcohol will be drawn on a motor vehicle crash victim who is believed to have been the driver of the vehicle;

5) A suspension policy for trauma nurse specialists meeting due process requirements (see Section 515.2200).

6) A professional staff competency plan in accordance with subsection (k) of this Section.

m) Changes to the Trauma Center Plan must be approved by the Department prior to implementation.

n) The practices of the trauma center shall reflect the protocols and policies of the EMS Region and Trauma Center Plan.

o) The resuscitation care of a Trauma Category I or Trauma Category II patient must be documented on a Trauma Flow Sheet, which at minimum contains trauma category classification; time and place of classification (field or in-house); time of arrival of patient to trauma center; notification of surgical specialties and time of arrival to see patient (may exclude isolated injuries for Category II patients).

p) The trauma center shall maintain a job description for the Trauma Center Medical Director, which details his/her responsibility and authority for the coordination and management of trauma services.

q) The trauma center shall maintain a job description for the Trauma Coordinator, which details the responsibility and authority for the coordination and management of trauma services.

r) The trauma service must be identified in the facility's budget with sufficient funds dedicated to support, at a minimum, the trauma director and trauma coordinator positions and to provide for operation of the trauma registry.

s) The trauma center shall develop a policy that identifies situations that would result in trauma bypass. The hospital shall also develop a policy that identifies what measures will be taken to avoid requesting a resource limitation/bypass (see Section 515.315).

1) Such diversion must be reported to the Department by telephone if it occurs during business hours or written notification by fax of diversion must be sent within 24 hours following the diversion.

2) Both forms of notification shall include at minimum:

A) The name of the trauma center;

B) Date and time of resource limitation; and

C) The reason for resource limitation.

t) The trauma center shall develop a plan for implementing a program of public information and education concerning trauma care for adult and pediatric patients.

(Source: Amended at 25 Ill. Reg. 16386, effective December 20, 2001)