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# Title 48
# PUBLIC HEALTH—GENERAL
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## Chapter 181. General Provisions

**§18101. Scope**

A. These rules are adopted by the Louisiana Emergency Network (hereinafter LERN) Board (hereinafter board) to effectuate the provisions of R.S. 40:2841 et seq.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:649 (April 2008).

## Chapter 183. Louisiana Emergency Response Network (LERN)

**§18301. Board Officers of Louisiana Emergency Response Network (LERN) Board**

A. The chairman and vice-chairman, and any other officers that the board shall deem necessary, shall be elected for a two-year term at the first meeting held following January 1 of each even numbered year.

B. In the case of a vacancy in the office of chairman, the vice-chairman shall serve the remainder of the vacated term, and in the case of a vacancy in the office of vice-chairman, the board shall elect a new vice-chairman who shall serve the remainder of the vacated term.

C. The chairman shall:

1. preside at all meetings of the board;

2. determine necessary subcommittees and working group and appoint members to each subcommittee and working groups;

3. direct activities of staff between board meetings;

4. provide direction on behalf of board between meetings to all regional commissions;

5. designate the date, time and place of board meetings;

6. enter into confidentiality agreements on behalf of the board regarding pertinent data to be submitted to board and board staff which contain individually identifiable health or proprietary information;

7. perform all other duties as may be assigned by the board.

D. Should the chairman become unable to perform the duties of chairman, the vice-chairman shall act in his stead.

E. A ground for removal of a board officer includes conviction of a felony.

AUTHORITY NOTE: Promulgated in accordance with R.S. 48:2844(H) and 40:2846(A).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

**§18303. Quorum**

A. Eight members of the board shall constitute a quorum for all purposes.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2844(H) and 40:2846(A).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

**§18305. Grounds for Removal of Board Members**

A. Grounds for removal of board members include conviction of a felony.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2844(H) and 40:2846(A).
HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

## Chapter 185. Regional Commissions; Membership; Officers; Meetings; Duties and Responsibilities

**§18501. Regional Commission Membership**

A. Selection of Regional Commission Membership by Louisiana Emergency Response Network (LERN) Board

1. The process for selecting the regional commission members is as follows:

a. the LERN Board Chairman shall request in writing the name of a nominee to serve on each regional commission from each of the legislatively identified state organizations;

b. in the event there is more than one organization, state association or entity, each entity shall be requested to name a nominee and, once constituted, the commission shall choose from among the nominees; and

c. if no state or local organization exists in a category, but multiple nominees are identified in that category, the selection of the representative to serve on the regional commission will be determined by that category's group of nominees.

2. Once documentation is received from each organization or group, the compiled list of nominees is submitted to the board for ratification. The board shall appoint those selected by the various organizations.

B. Voting members of the regional commission may be added through a process employing the following steps:

1. majority vote of a quorum of voting members of the commission;

2. formal written request to LERN Board to add specified voting member, with reasons for adding. Such

addition must represent a group which would enhance the working of the regional commission;

3. majority vote by LERN Board members at a meeting. If such a vote fails, the regional commission may appear in person at the following LERN Board meeting, where the subject will be revisited;

4. once an additional voting member is approved for one region, in order for other regions to add a member representing the same group, only a letter detailing the requirements of Paragraphs 1 through 3 above will be necessary to add the particular member. Board approval will not require an additional vote.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

**§18503. Regional Commission Officers**

A. Each regional commission shall select a chairman and vice chairman.

B. The chairman and vice-chairman, and any other officers that the commission shall deem necessary, shall be elected for a two-year term at the first meeting held following January 1 of each even numbered year.

C. In the case of a vacancy in the office of chairman, the vice-chairman shall serve as chairman for the remaining vacated term; and in the case of a vacancy in the office of vice-chairman, the regional commission shall elect a new vice-chairman who shall serve until the expiration of the vacated term.

D. The chairman shall:

1. preside at all meetings of the commission;

2. determine necessary ad hoc committees, appoint a commission member to chair each such committee, and provide for the commission as a whole to name the membership of the committee;

3. provide direction to the commission to implement the mandates of the LERN Board;

4. direct that a record of all meetings of the commission shall be kept and such records shall be retained as permanent records of the transactions of the commission; and

5. perform all other duties pertaining to the office of chairman of the commission or as may be assigned by the commission.

E. Should the chairman become unable to perform the duties of chairman, the vice-chairman shall act in his stead.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:650 (April 2008).

**§18505. Regional Commission Meetings**

A. Meetings of the commission shall be noticed, convened and held not less frequently than quarterly during each calendar year and otherwise at the call of the chairman or on the written petition for a meeting signed by not less than the number of members which would constitute a quorum of the commission. Meetings shall be held on such date and at such time and place as may be designated by the chairman.

B. One third of the currently serving members of the commission shall constitute a quorum for all purposes. All actions which the commission is empowered by law to take shall be effected by vote of not less than a majority of the members present at a meeting of the commission at which a quorum is present.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:651 (April 2008).

**§18507. Regional Commission Duties and Responsibilities**

A. Each regional commission shall:

1. develop a written system plan for submission to LERN Board, which plan shall:

a. identify all resources available in the region for emergency and disaster preparedness and response;

b. be based on standard guidelines for comprehensive system development;

c. include all parishes within the region unless a specific parish portion thereof has been aligned within an adjacent region;

d. give an opportunity to all health care entities and interested specialty centers opportunity to participate in the planning process; and

e. address the following components:

i. injury prevention;

ii. access to the system;

iii. communications;

iv. pre-hospital triage criteria;

v. diversion policies;

vi. bypass protocols;

vii. regional medical control;

viii. facility triage criteria;

ix. inter-hospital transfers;

x. planning for the designation of trauma facilities, including the identification of the lead facility(ies); and

xi. a performance improvement program that evaluates processes and outcomes from a system perspective;

2. upon approval of the board, implement the system plan to include:

a. education of all entities about the plan components;

b. on-going review of resource, process, and outcome data; and

c. if necessary, revision and re-approval of the plan or plan components by LERN Board;

3. annually complete a regional needs assessment and conduct education and training within the region to meet the needs identified in the annual needs assessment;

4. develop and implement a regional performance improvement (PI) program plan;

5. develop and implement a regional injury prevention program;

6. at least quarterly, submit evidence of on-going activity, including meeting notices and minutes, to LERN Board; and

7. Annually submit a report to LERN Board which describes progress toward system development and demonstrates on-going activity;

B. Regional commission may request technical assistance from the LERN Board at any time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2845(A)(3)(a) and 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network Board, LR 34:651 (April 2008).

# Chapter 187. Requirements for Louisiana Stroke Center Recognition

### §18701. Stroke Center Recognition

A. The Louisiana Emergency Response Network Board (LERN) and the Louisiana Department of Health recognize the following six levels of stroke facilities:

1. CSC: comprehensive stroke center (formerly designated as level 1);

2. TSC: thrombectomy capable stroke center;

3. PSC-E: primary stroke center with endovascular capability;

4. PSC: primary stroke center (formerly designated as level 2);

5. ASRH: acute stroke ready hospital (formerly designated as level 3); and

6. stroke bypass hospital (formerly designated as level 4).

B. Participation in Louisiana stroke center recognition is voluntary and no hospital shall be required to participate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 40:2590 (December 2014), amended by the Department of Health, Emergency Response Network LR 46:1088 (August 2020).

### §18703. Stroke Center Criteria

A. Each facility participating in stroke center recognition shall meet the following criteria.

1. CSC: a comprehensive stroke center (CSC) will meet the requirements specified by the joint commission or other board approved accrediting/certification body approved by LERN for comprehensive stroke center certification. Attestation as a CSC is only allowed after verification by the joint commission or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the CSC standards.

2. TSC: a thrombectomy capable stroke center (TSC) will meet the requirements specified by the joint commission or other board approved accrediting/certification body approved by LERN for thrombectomy capable stroke center certification. Attestation as a TSC is only allowed after verification by the joint commission or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the TSC standards.

3. PSC-E: a primary stroke center (PSC-E) shall meet the requirements specified by the joint commission, healthcare facilities accreditation program (HFAP), or other LERN approved accrediting/certification body for Primary Stroke Center verification. Attestation as a PSC-E is only allowed after verification by the joint commission, HFAP, or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the PSC standards. In addition to PSC requirements, a PSC-E must have physician(s) credentialed to perform mechanical thrombectomy and must update resource management portal of endovascular availability at all times. If a physician credentialed to perform endovascular capability is not available, the PSC-E must notify all EMS providers in the region when endovascular resources are not available. The PSC-E must collect and submit quarterly to LERN the same data the joint commission requires the Thrombectomy Stroke Capable centers to collect and any other data as required by LERN.

4. PSC: a primary stroke center (PSC) shall meet the requirements specified by the joint commission, healthcare facilities accreditation program (HFAP), or other LERN approved accrediting/certification body for primary stroke center verification. Attestation as a PSC is only allowed after verification by the joint commission, HFAP, or other LERN approved accrediting/certification body that the facility meets all requirements set forth in the PSC standards.

5. ASRH: an acute stroke ready hospital (ASRH) will provide timely access to stroke care but may not meet all

criteria for a CSC, TSC, or a PSC or a PSC-E facility. An ASRH will provide acute stroke care in urban and rural areas where transportation and access are limited. An ASRH is intended to recognize models of care delivery that have shown utility, including "drip-and-ship" and telemedicine. An ASRH must meet requirements adopted by LERN and submit quarterly data as required by LERN. LERN approved requirements are based on national best practice guidelines.

6. Stroke bypass hospital: a stroke bypass hospital should not receive patients exhibiting signs or symptoms of stroke except for instances when the clinical situation requires stopping at the closest emergency department. A stroke bypass hospital must have:

a. transfer protocol in place for transfer to higher levels of care through written and agreed upon relationship with a CSC, TSC, PSC, PSC-E or ASRH stroke center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 40:2590 (December 2014), amended by the Department of Health, Emergency Response Network LR 46:1088 (August 2020), amended by the Department of Health, Emergency Response Network LR 50:220 (February 2024).

**§18705. Attestation for Stroke Center Recognition**

A. A hospital seeking CSC, TSC, PSC-E, ASRH or stroke bypass recognition will submit an affidavit of the hospital CEO to LERN detailing compliance with the requirements designated herein.

1. A center or hospital seeking CSC recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

2. A center or hospital seeking TSC stroke center recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission, HFAP, or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

3. A center or hospital seeking PSC-E stroke center recognition which submits a copy of PSC certification by a LERN-recognized organization, such as the joint commission, HFAP, or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition. In addition to a copy of the certification, the CEO must also attest to meeting the additional board approved requirements.

4. A center or hospital seeking PSC stroke center recognition which submits a copy of that level of certification by a LERN-recognized organization, such as the joint commission, HFAP, or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition.

5. A center or hospital seeking ASRH recognition must submit data which, at a minimum, meets door to needle metric for ASRH recognition for the two consecutive quarters immediately preceding the submission date. Although a center or hospital seeking ASRH stroke center recognition is not required to obtain certification by an external certifying body, a hospital which submits a copy of ASRH certification by a LERN-recognized organization, such as the joint commission, HFAP or other LERN approved accrediting/certification body, shall be assumed to meet the requirements for recognition. Hospitals must all meet LERN ASRH requirements and approved data submission requirements.

6. Each center or hospital shall submit proof of continued compliance every two years by submission of an affidavit by its CEO. The CEO may submit a revised attestation at any point during the two year period, as appropriate, when a change in resources or certification occurs.

B. A hospital or center which fails to meet the requirements as attested, or which no longer chooses to maintain state Stroke Facility level recognition, shall immediately notify LERN and local EMS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 40:2590 (December 2014), amended by the Department of Health, Emergency Response Network LR 46:1089 (August 2020), amended by the Department of Health, Emergency Response Network, LR 50:220 (February 2024).

**§18706. Stroke Center Data Submission Requirements**

A. All stroke centers, whether CSC, TSC, PSC-E, PSC or ASRH are required to submit certain data to the board on a quarterly basis.

B. The requirements of and for data submission are posted on the LERN website, http://lern.la.gov/lern-stroke-system/stroke-data-collection.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 46:1089 (August 2020).

**§18708. Failure to Submit Stroke Data to LERN**

A. Acute stroke ready hospitals not submitting data for one quarter or not submitting the required action plan and/or mock code, if applicable, will result in automatic probation, which will generate a warning letter to the CEO. The letter will communicate LERN board expectation for data and (action plan and/or mock code, if applicable) submission for the missed quarter and the following quarter.

B. For an ASRH not submitting data to the board for two consecutive quarters, the hospital will automatically be demoted to a stroke bypass hospital.

C. Once an ASRH demotes to a stroke bypass hospital for non-adherence with submission requirement, the hospital CEO cannot re-attest until the hospital has submitted two consecutive quarters of data meeting standards.

D. If an ASRH fails to meet the performance metrics after two quarters of participation in data review, the board appointed stroke committee may temporarily demote the facility to a stroke bypass hospital until the next board meeting, when the board appointed stroke subcommittee will present the blinded data to the board for a vote on demotion to stroke bypass hospital versus continued remediation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 46:1089 (August 2020), amended by the Department of Health, Emergency Response Network, LR 50:220 (February 2024).

# Chapter 189. Requirements for Louisiana STEMI Receiving/Referral Centers

### §18901. STEMI Center Recognition

A. The Louisiana Emergency Response Network Board (LERN), and the Louisiana Department of Health and Hospitals recognize the following types of facilities for the treatment of ST elevated myocardial infarction (STEMI):

1. STEMI receiving center; and

2. STEMI referral center.

B. Participation in the Louisiana STEMI center recognition is voluntary and no hospital shall be required to participate.

C. A facility seeking STEMI receiving center recognition shall meet the STEMI receiving center requirements adopted by LERN. LERN approved requirements are based on national best practice guidelines.

D. A hospital with an emergency room not meeting criteria for a STEMI receiving center will automatically default to a STEMI referral center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

### §18903. Attestation for STEMI Center Recognition

A. A hospital seeking STEMI Center recognition will submit an affidavit of the hospital CEO to LERN detailing compliance with LERN Approved STEMI Receiving center requirements.

1. Those hospitals which submit a copy of certification by a LERN-recognized organization such as The American Heart Association Mission:Lifeline, Society of Cardiovascular Patient Care or other LERN approved accrediting/certification body shall be assumed to meet the requirements for recognition.

2. Each center or hospital shall submit proof of continued compliance every two years by submission of an affidavit of its CEO.

B. A hospital or center which fails to meet the criteria for a STEMI receiving center or which no longer choose to maintain state STEMI receiving center recognition, shall immediately notify LERN and local EMS.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), 48:2845(A)(7) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

### §18905. STEMI Center Listing

A. LERN will publish a list on its website of hospitals or centers attesting to STEMI center criteria for recognition as either a STEMI receiving center or STEMI referral center. This list shall be made available to the LERN regional commissions for facilitation of EMS transportation plans.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 40:2846(A) and 48:2845(A)(7).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

### §18907. Hospital Destination/STEMI System Transport:

A. These rules are not intended to prevent any hospital or medical facility from providing medical care to any patient but rather to serve as a guideline to facilitate the timely and appropriate delivery of STEMI patients to the most appropriate care site for the definitive treatment of STEMI.

B. Knowledge of STEMI capabilities and the use of a STEMI pre-hospital destination protocol will enable providers to make timely decisions, promote appropriate utilization of the STEMI care delivery system, and ultimately save lives.

AUTHORITY NOTE: Promulgated in accordance with La. R.S. 40:2846(A), 48:2845(A)(7) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 40:2591 (December 2014).

# Chapter 191. Trauma Protocols

### §19101. Entry Criteria and Region 4 LERN LCC Destination Protocol

A. On November 15, 2007, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated “LERN Entry Criteria” and "LERN Region 4 LCC Destination Protocol" for region 4 of the Louisiana Emergency Response Network (R.S. 40:2842(3)), which region includes the parishes of Acadia, Evangeline, Iberia, Lafayette, St. Martin, St. Landry, and Vermilion, as follows.

1. LERN Entry Criteria

| LERN Entry Criteria | | |
|---|---|---|
| □ Unmanageable Airway<br>□ Tension Pneumothorax<br>□ Traumatic cardiac arrest<br>□ Burn patient without patent airway<br>□ Burn patient >40% BSA without IV | YES→ | Call LCC |
| Neurologic Trauma | | |
| □ GCS <14 + one or more of the following:<br>□ Penetrating head injury or depressed | YES→ | Call LCC |

| LERN Entry Criteria | | |
|---|---|---|
| skull fracture<br>□ Open head injury with or without CSF leak<br>□ Deterioration of the GCS<br>□ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) | | |
| Physiologic | | |
| □ SBP <90 (adults and > 9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>□ RR <10 or >29 (adults and > 9 y/o)<br><15 or >30 (age 1 to 8)<br><25 or >50 (<12 m/o) | YES→ | Call LCC |
| Anatomic | | |
| □ All penetrating injuries to neck, torso and extremities proximal to elbow and knee<br>□ Flail Chest<br>□ 2 or more proximal long-bone fractures<br>□ Crush, degloved or mangled extremity<br>□ Amputation proximal to wrist and ankle<br>□ Pelvic Fracture<br>□ Hip fractures (hip tenderness, deformity, lateral deviation of foot)<br>□ Major joint dislocations (hip, knee, ankle, elbow)<br>□ Open Fractures<br>□ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.) | YES→ | Call LCC |
| Mechanism | | |
| □ Falls > 20 ft. (adults)<br>> 10 ft. (child) or 2 to 3 times height<br>□ High-risk auto crash<br>Intrusion > 12 in. occupant site:<br>>20 in. any site<br>□ Ejection, partial or complete from automobile<br>□ Death in same passenger compartment<br>□ Auto vs. pedestrian/bicyclist thrown, run over or >5 MPH impact<br>□ Motorcycle crash >20 MPH | YES→ | Call LCC |
| Special | | |
| □ Pregnancy >20 weeks<br>□ Burns (will follow ABA guidelines) | YES→ | Call LCC |
| Other | | |
| □ Age ≥55 y/o or <8 y/o<br>□ Anticoagulation and bleeding disorders<br>□ End stage renal disease<br>□ Transplant patients | YES→ | Call LCC |

2. LERN Region 4 LCC Destination Protocol

| LERN Region 4 LCC Destination Protocol | | |
|---|---|---|
| □ Unmanageable Airway<br>□ Tension Pneumothorax<br>□ Traumatic cardiac arrest<br>□ Burn patient without patent airway<br>□ Burn patient >40 percent BSA without IV | YES→ | Closest ED |
| NO<br>↓ | | |
| Neurologic Trauma | | |
| □ GCS <14 + one or more of the following:<br>□ Penetrating head injury or depressed skull fracture<br>□ Open head injury with or without CSF leak | YES→ | LERN Level II |
| □ Deterioration of the GCS<br>□ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) | | |
| NO<br>↓ | | |
| Physiologic | | |
| □ SBP <90 (adults and > 9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>□ RR <10 or >29 (adults and ≥ 9 y/o)<br><15 or >30 (age 1 to 8)<br><25 or >50 (<12 m/o) | YES→ | LERN Level II or III |
| NO<br>↓ | | |
| Anatomic | | |
| □ All penetrating injuries to neck, torso and extremities proximal to elbow and knee<br>□ Flail Chest<br>□ 2 or more proximal long-bone fractures<br>□ Crush, degloved or mangled extremity<br>□ Amputation proximal to wrist and ankle<br>□ Pelvic Fracture<br>□ Hip fractures (hip tenderness, deformity, lateral deviation of foot)<br>□ Major joint dislocations (hip, knee, ankle, elbow)<br>□ Open Fractures<br>□ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.) | YES→ | LERN Level II or III |
| ↓ | | |
| Mechanism | | |
| □ Falls > 20 ft. (adults)<br>> 10 ft. (child) or 2 to 3 times height<br>□ High-risk auto crash<br>□ Intrusion > 12 in. occupant site:<br>>20 in. any site<br>□ Ejection, partial or complete from automobile<br>□ Death in same passenger compartment<br>□ Auto vs. pedestrian/bicyclist thrown, run over or >5 MPH impact<br>□ Motorcycle crash >20 MPH | YES→ | LERN Level II or III |
| NO<br>↓ | | |
| Special | | |
| □ Pregnancy >20 weeks<br>□ Burns (will follow ABA guidelines) | YES→ | LERN |
| NO<br>↓ | | |
| Other | | |
| □ Age ≥ 55 y/o or <8 y/o<br>□ Anticoagulation and bleeding disorders<br>□ End stage renal disease<br>□ Transplant patients | YES→ | LERN Level II, III or IV |

B. On June 26, 2008, the Louisiana Emergency Response Network Board passed a resolution allowing any region of the Louisiana Emergency Response Network which agreed to use the foregoing "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol" to begin operating using the "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol" set forth above.

C. This protocol was published at LR 35:1181-1183 (June 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:138 (January 2015).

**§19103. Region 7 LERN Entry and Destination Protocols**

A. On November 15, 2007, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated "Region 7 LERN Entry and Destination Protocol" for region 7 of the Louisiana Emergency Response Network [R.S. 40:2842(3)], which region includes the parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster, as follows.

1.a. Traumatic patients who meet the following criteria will be entered to LERN call center and should be transported directly to LSUHSC in Shreveport, Louisiana, if possible:

i. airway compromise (intubated, apneic, or obstructed airway);

ii. penetrating wound of head, neck, chest, abdomen, groin, or buttocks;

iii. blood pressure ≤ 100 or signs of shock;

iv. GCS 12 or less;

v. new onset neurological deficit associated with traumatic event;

vi. extremity wound with absent pulse or amputation proximal to foot or hand.

b. Trauma patients who meet the following criteria, and are located outside the city limits of Shreveport and Bossier City, should be taken to nearest hospital for immediate stabilization followed by continued rapid transport to LSUHSC Shreveport per the LERN hospital protocol:

i. unable to establish and maintain adequate airway/ventilation;

ii. hypotension unresponsive to crystalloids (no more than 2 L);

iii. patients who meet trauma center criteria but have a transport time > 60 minutes;

iv. traumatic arrest.

B. On May 8, 2008, the Louisiana Emergency Response Network Board (R.S. 40:2842(1)) amended and promulgated, as amended, "Region 7 LERN Entry and Destination Protocol" for region 7 of the Louisiana Emergency Response Network (R.S. 40:2842(3)), which region includes the parishes of Bienville, Bossier, Caddo, Claiborne, DeSoto, Natchitoches, Red River, Sabine and Webster, which protocol was originally adopted and promulgated on November 15, 2007, so that the "Region 7 Louisiana Emergency Response Network Entry and Destination Protocol," as amended, effective May 8, 2008, is as follows.

1.a. Traumatic patients who meet the following criteria will be entered to LERN call center and should be transported directly to LSUHSC in Shreveport, if possible:

i. airway compromise (intubated, apneic, or obstructed airway);

ii. penetrating wound of head, neck, chest, abdomen, groin, or buttocks;

iii. blood pressure ≤ 100 or signs of shock;

iv. GCS 12 or less;

v. new onset neurological deficit associated with traumatic event;

vi. extremity wound with absent pulse or amputation proximal to foot or hand;

vii. burn patients as identified following ABA guidelines;

viii. *healthcare provider discretion*—patients evaluated by hospitals may be entered into LERN if the evaluating hospitals medical personnel determines the patient has a medical condition requiring immediate surgical evaluation and/or intervention and the transferring hospital does not have these services immediately available at that facility (*Healthcare provider discretion* does not include orthopedic injuries.).

b. Patients that have been entered into LERN but will require greater than 60 minute transport time from the field should stop at local area hospitals for stabilization. These patients should still be entered into LERN from the field but will require transport to local area hospitals for stabilization. LERN will facilitate the movement of these patients from the local hospital once stabilizing measures are completed.

i. The following are conditions requiring immediate stabilization by local area hospitals:

(a). unable to establish and maintain adequate airway/ventilation;

(b). hypotension unresponsive to crystalloids (no more than 2 L);

(c). patients who meet trauma center criteria but have a transport time > 60 minutes;

(d). traumatic arrest.

C. The following will be routed directly to the LSUHSC Burn Unit from local area hospitals or from the field:

1. partial-thickness and full thickness burns greater than 10 percent of the total body surface area (TBSA) in patients younger than 10 years of age or older than 50 years of age;

2. partial-thickness and full thickness burns greater than 20 percent of the total body surface area (TBSA) in other age groups;

3. partial-thickness and full thickness burns involving the face, eyes, ears, hands, feet, genitalia, perineum, or skin overlying major joints;

4. full-thickness burns greater than 5 percent TBSA in any age group;

5. electrical burns, including lightning injury;

6. chemical burns;

7. patients with inhalation injury;

8. burn injury in patients with pre-existing illnesses that could complicate management, prolong recovery, or adversely affect mortality risk;

9. any burn patient in whom concomitant trauma poses an increased risk of morbidity or mortality may be treated initially in a trauma center until stable before transfer to a burn center;

10. children with burns seen in hospitals without qualified personnel or equipment for their care;

11. burn injury in patients who will require special social and emotional or long-term rehabilitative support, including cases involving suspected child abuse or neglect.

D. These protocols were published at LR 35:1183-1184 (June 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:139 (January 2015).

### §19105. Standard LERN Entry Criteria; Standard Destination Protocol

A. On June 18, 2009, the Louisiana Emergency Response Network Board (R.S. 40:2842(1)) adopted and promulgated "Standard LERN Entry Criteria" and "Standard Destination Protocol" for use in all regions, except region 7, of the Louisiana Emergency Response Network (R.S. 40:2842(3)), replacing the "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol," adopted and promulgated November 15, 2007, as follows.

1. Standard LERN Entry Criteria—Pre-Hospital and Hospital Triage Protocol

| **Standard LERN Entry Criteria** | | |
|---|---|---|
| **Pre-Hospital and Hospital Triage Protocol** | | |
| ☐ Unmanageable Airway<br>☐ Tension Pneumothorax<br>☐ Traumatic cardiac arrest<br>☐ Burn patient without patent airway<br>☐ Burn patient >40 percent BSA without IV | YES→ | Call LCC |
| Neurologic Trauma | | |
| ☐ GCS <14 + one or more of the following:<br>☐ Penetrating head injury or depressed skull fracture<br>☐ Open head injury with or without CSF leak | YES→ | Call LCC |
| ☐ Deterioration of the GCS<br>☐ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) | | |
| Physiologic | | |
| ☐ SBP <90 (adults and > 9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>☐ RR <10 or >29 (adults and > 9 y/o)<br><15 or >30 (age 1 to 8)<br><25 or >50 (<12 m/o) | YES→ | Call LCC |
| Anatomic | | |
| ☐ All penetrating injuries to neck, torso and extremities proximal to elbow and knee<br>☐ Flail Chest<br>☐ 2 or more proximal long-bone fractures<br>☐ Crush, degloved or mangled extremity<br>☐ Amputation proximal to wrist and ankle<br>☐ Pelvic Fracture<br>☐ Hip fractures (hip tenderness, deformity, lateral deviation of foot)<br>☐ Major joint dislocations (hip, knee, ankle, elbow)<br>☐ Open Fractures<br>☐ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.) | YES→ | Call LCC |
| Mechanism | | |
| ☐ Falls > 20 ft. (adults)<br>> 10 ft. (child) or 2 to 3 times height<br>☐ High-risk auto crash<br>Intrusion > 12 in, occupant site:<br>>18 in. any site<br>• Ejection, partial or complete from automobile<br>• Death in same passenger compartment<br>☐ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>☐ Motorcycle crash >20 MPH | YES→ | Call LCC |
| Special | | |
| ☐ Pregnancy >20 weeks<br>☐ Burns (will follow ABA guidelines) | YES→ | Call LCC |
| Other | | |
| ☐ Age ≥ 55 y/o or <8 y/o<br>☐ Anticoagulation and bleeding disorders<br>☐ End stage renal disease<br>☐ Transplant patients | YES→ | Call LCC |

2. Standard Destination Protocol

| **Standard Destination Protocol** | | |
|---|---|---|
| ☐ Unmanageable Airway<br>☐ Tension Pneumothorax<br>☐ Traumatic cardiac arrest<br>☐ Burn patient without patent airway<br>☐ Burn patient >40 percent BSA without IV | YES→ | Closest ED |
| NO<br>↓ | | |
| Neurologic Trauma | | |

| Standard Destination Protocol | | |
|---|---|---|
| ☐ GCS <14<br>☐ Penetrating head injury or depressed skull fracture<br>☐ Open head injury with or without CSF leak<br>☐ Deterioration of the GCS<br>☐ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) | YES→ | LERN Level I or II |
| NO ↓ | | |
| Physiologic | | |
| ☐ SBP <90 (adults and >9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>☐ RR <10 or >29 (adults and >9 y/o)<br><15 or >30 (age 1 to 8)<br><25 or >50 (<12 m/o) | YES→ | LERN Level I, II or III |
| NO ↓ | | |
| Anatomic | | |
| ☐ All penetrating injuries to neck, torso and extremities proximal to elbow and knee<br>☐ Flail Chest<br>☐ 2 or more proximal long-bone fractures<br>☐ Crush, degloved or mangled extremity<br>☐ Amputation proximal to wrist and ankle<br>☐ Pelvic Fracture<br>☐ Hip fractures (hip tenderness, deformity, lateral deviation of foot)<br>☐ Major joint dislocations (hip, knee, ankle, elbow)<br>☐ Open Fractures<br>☐ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.) | YES→ | LERN Level I, II or III |
| NO ↓ | | |
| Mechanism | | |
| ☐ Falls >20 ft. (adults)<br>>10 ft. (child) or 2 to 3 times height<br>☐ High-risk auto crash<br>• Intrusion >12 in. occupant site:<br>• >18 in. any site<br>• Ejection, partial or complete from automobile<br>• Death in same passenger compartment<br>☐ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>☐ Motorcycle crash >20 MPH | YES→ | LERN Level II or III |
| NO ↓ | | |
| Special | | |
| ☐ Pregnancy >20 weeks<br>☐ Burns (will follow ABA guidelines) | YES→ | LERN Level II or III |
| NO ↓ | | |
| Other | | |
| ☐ Age ≥ 55 y/o or <8 y/o<br>☐ Anticoagulation and bleeding disorders<br>☐ End stage renal disease<br>☐ Transplant patients | YES→ | LERN Level II, III or IV |

B. These protocols were published at LR 35:1409 (July 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:140 (January 2015).

### §19107. Interregional Transfer Protocol

A. On June 18, 2009, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated "Interregional Transfer Protocol" for the Louisiana Emergency Response Network [R.S. 40:2842(3)], as follows.

1. The LERN interregional transfer protocol only applies to those regions and (hospitals/EMS) that are participating in the LERN network.

2. The interregional transfer protocol will be tested over a 90 day period. At the end of the 90 days all interregional transfers will be reviewed for compliance with protocols, quality, patient safety and standards of care. This information will be shared with commissions of the regions participating as well as the LERN board and the "design the system group". Decisions regarding the interregional transfer protocol will be made at the end of the 90 days trial period.

3. Interregional Transfer Protocol

a. All patients whose condition exceeds the regionally available resources provided by local area hospitals may be transferred from one region to another following LERN interregional transfer protocol. Destination to the definitive care hospital in the receiving region will follow the LERN standard protocol (all laws regarding EMTALA apply).

b. Only regions operating with the LERN standard protocol will be involved in the LERN interregional transfer protocol.

c. Patients being transferred via the LERN interregional transfer protocol must:

i. be assessed at a local area hospital for treatment and stabilized by a physician and meet the entry criteria as determined by LERN standard protocol;

ii. treating physician will call LERN to request a transfer to another hospital;

iii. LCC (LERN call center) will determine the closest and most appropriate facility available following LERN standard protocol;

iv. if there are no available resources in the region then the LCC will locate an appropriate facility outside the region, and an interregional transfer will be considered. (All LERN interregional transfers will be reviewed by LERN medical directors and data will be collected for QI/PI.)

d. Exceptions

i. EMS requesting LERN for patients located on or close to borders between two regions will and can be directed to either region based on the patient needs and available resources.

ii. Air-med at the scene that is able to mitigate the time of transfer of long distances will and can be directed to hospitals outside the region they originate from based on patients needs and available resources.

iii. LERN medical directors will be involved in the decision making (real time) in all patients that fall into the exception category.

B. On August 20, 2009, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] adopted and promulgated the amended "Interregional Transfer Protocol" for the Louisiana Emergency Response Network [R.S. 40:2842(3)], as follows.

1. The LERN interregional transfer protocol only applies to those regions, hospitals and pre-hospital providers that are participating in the LERN network.

2. The interregional transfer protocol will be tested over a 90 day period, at the end of which all interregional transfers will be reviewed for compliance with protocols, quality, patient safety and standards of care. This information will be shared with regional commissions, LERN Board, and LERN design the system work group. Decisions regarding the Interregional Transfer Protocol will be made at the end of the 90-day trial period.

3. Interregional Transfer Protocol

a. All patients whose conditions exceed the regionally available resources provided by local area hospitals may be transferred from one region to another following LERN interregional transfer protocol. Destination to the definitive care hospital in the receiving region will follow the LERN standard protocol. All laws regarding EMTALA apply.

b. Only regions operating with the LERN standard protocol will be involved in the LERN interregional transfer protocol.

c. Patients transferred via the LERN interregional transfer protocol must:

i. be assessed at a local area hospital for treatment, be stabilized by a physician, and meet the entry criteria as determined by LERN standard protocol; and

ii. have a treating physician call LERN to request a transfer to another hospital.

d. The LERN call center (LCC) will determine the closest and most appropriate facility available following LERN standard protocol.

e. If there are no available resources in the region, the LCC will locate an appropriate facility outside the region, and a interregional transfer will be considered.

f. All LERN interregional transfers will be reviewed by LERN medical directors and data will be collected for QI/PI.

g. Exceptions

i. Pre-hospital providers requesting LERN for patients located on or close to borders between regions will and can be directed to either region based on the patient needs and available resources.

ii. Air-med at the scene able to mitigate the time of transfer of long distances will and can be directed to hospitals outside the region they originate from, based on patient needs and available resources.

iii. LERN medical directors will be involved in the decision making for all patients in the exception category.

C. These protocols were published at LR 35:2109-2110 (September 20, 2009).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:141 (January 2015).

### §19109. Standard LERN Entry and Destination Criteria

A. On October 21, 2010, the Louisiana Emergency Response Network Board [R.S. 40:2842(1)] revised, adopted and promulgated "Standard LERN Entry Criteria" and "Standard Destination Protocol" for use in all regions, except region 7, of the Louisiana Emergency Response Network [R.S. 40:2842(3)], replacing the "LERN Entry Criteria" and "LERN Region 4 LCC Destination Protocol," adopted and promulgated June 18, 2009, as follows.

1. Standard LERN Entry Criteria—Pre-Hospital and Hospital Triage Protocol

| **Standard LERN Entry Criteria** | | |
|---|---|---|
| **Pre-Hospital and Hospital Triage Protocol** | | |
| □ Unmanageable Airway<br>□ Tension Pneumothorax<br>□ Traumatic cardiac arrest<br>□ Burn patient without patent airway<br>□ Burn patient >40 percent BSA without IV | YES→ | Call LCC |
| Neurologic Trauma | | |
| □ GCS <14 + one or more of the following:<br>□ Penetrating head injury or depressed skull fracture<br>□ Open head injury with or without CSF leak<br>□ Deterioration of the GCS<br>□ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) | YES→ | Call LCC |
| Physiologic | | |
| □ SBP <90 (adults and > 9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>□ RR <10 or >29 (adults and ≥ 9 y/o)<br><15 or >30 (age 1 to 8)<br><25 or >50 (<12 m/o) | YES→ | Call LCC |
| Anatomic | | |
| □ All penetrating injuries to neck, torso and extremities proximal to elbow and knee<br>□ Flail Chest<br>□ 2 or more proximal long-bone fractures<br>□ Crush, degloved or mangled extremity<br>□ Amputation proximal to wrist and ankle<br>□ Pelvic Fracture<br>□ Hip fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip | YES→ | Call LCC |

| Standard LERN Entry Criteria<br>Pre-Hospital and Hospital Triage Protocol | | |
|---|---|---|
| fractures from same level falls<br>□ Major joint dislocations (hip, knee, ankle, elbow)<br>□ Open Fractures<br>□ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.) | | |
| Mechanism | | |
| □ Falls >20 ft. (adults)<br>>10 ft. (child) or 2 to 3 times height<br>□ High-risk auto crash<br>Intrusion >12 in. occupant site:<br>>18 in. any site<br>• Ejection, partial or complete from automobile<br>• Death in same passenger compartment<br>□ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>□ Motorcycle crash >20 MPH | YES→ | Call LCC |
| Special | | |
| □ Pregnancy >20 weeks<br>□ Burns (will follow ABA guidelines) | YES→ | Call LCC |
| Other | | |
| □ Age ≥ 55 y/o or <8 y/o<br>□ Anticoagulation and bleeding disorders<br>□ End stage renal disease<br>□ Transplant patients | YES→ | Call LCC |

2. Standard Destination Protocol

| Standard Destination Protocol | | |
|---|---|---|
| □ Unmanageable Airway<br>□ Tension Pneumothorax<br>□ Traumatic cardiac arrest<br>□ Burn patient without patent airway<br>□ Burn patient >40 percent BSA without IV | YES→ | Closest ED |
| NO<br>↓ | | |
| Neurologic Trauma | | |
| □ GCS <14<br>□ Penetrating head injury or depressed skull fracture<br>□ Open head injury with or without CSF leak<br>□ Deterioration of the GCS<br>□ Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit) | YES→ | LERN Level I or II |
| NO<br>↓ | | |
| Physiologic | | |
| □ SBP <90 (adults and >9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>□ RR <10 or >29 (adults and ≥9 y/o)<br><15 or >30 (age 1 to 8)<br><25 or >50 (<12 m/o) | YES→ | LERN Level I, II or III |
| NO<br>↓ | | |
| Anatomic | | |
| □ All penetrating injuries to neck, torso and extremities proximal to elbow and knee<br>□ Flail Chest<br>□ 2 or more proximal long-bone fractures<br>□ Crush, degloved or mangled extremity<br>□ Amputation proximal to wrist and ankle<br>□ Pelvic Fracture<br>□ Hip fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip | YES→ | LERN Level I, II or III |

| Standard Destination Protocol | | |
|---|---|---|
| fractures from same level falls<br>□ Major joint dislocations (hip, knee, ankle, elbow)<br>□ Open Fractures<br>□ Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture, etc.) | | |
| NO<br>↓ | | |
| Mechanism | | |
| □ Falls >20 ft. (adults)<br>>10 ft. (child) or 2 to 3 times height<br>□ High-risk auto crash<br>• Intrusion >12 in. occupant site:<br>• >18 in. any site<br>• Ejection, partial or complete from automobile<br>• Death in same passenger compartment<br>□ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>□ Motorcycle crash >20 MPH | YES→ | LERN Level II or III |
| NO<br>↓ | | |
| Special | | |
| □ Pregnancy >20 weeks<br>□ Burns (will follow ABA guidelines) | YES→ | LERN Level II or III |
| NO<br>↓ | | |
| Other | | |
| □ Age ≥ 55 y/o or <8 y/o<br>□ Anticoagulation and bleeding disorders<br>□ End stage renal disease<br>□ Transplant patients | YES→ | LERN Level II, III or IV |

B. These protocols were published at LR 36:2743-2745 (November 20, 2010).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:142 (January 2015).

### §19111. Interregional Transfer Protocol

A. On January 20, 2011, the Louisiana Emergency Response Network Board (R.S. 40:2842(1) and (3)) adopted and promulgated "LERN Hospital Interregional Transfer Guidelines" and "LERN Hospital Interregional Transfer Protocol", replacing "Interregional Transfer Protocol" adopted June 18, 2009, as follows.

1. LERN Hospital Interregional Transfer Guidelines

a. All patients whose conditions exceed the regionally available resources provided by local area hospitals may be transferred from one region to another following LERN interregional transfer protocol.

b. The LERN hospital interregional transfer protocol only applies to hospitals that are participating in the LERN network.

c. Regions or individual parishes that have MOU's (which include medical control and destination guidelines), between an ACS verified level 1 trauma center and a local

parish medical society(ies) will be incorporated into the LCC standard operating procedure for the effected region(s).

2. LERN Hospital Interregional Transfer Protocol

a. Patients transferred via the LERN hospital interregional transfer protocol must:

i. meet LERN standard entry criteria that requires resources and/or capabilities not available in that region;

ii. be assessed and stabilized to the best of their ability at a local area hospital prior to transport to the closest appropriate hospital;

iii. the treating physician/nurse must contact LERN to request a transfer. The LERN communications center (LCC) will determine the closest and most appropriate facility available following the LERN standard destination protocol.

B. These guidelines and protocols were published at LR 37:751 (February 20, 2011).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:143 (January 2015).

### §19113. LERN Entry Criteria: Trauma; LERN Destination Protocol: Trauma

A. On January 20, 2011, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN ENTRY CRITERIA: Trauma; Pre-Hospital and Hospital Triage Protocol" and "LERN DESTINATION PROTOCOL: Trauma" replacing the "Standard LERN Entry Trauma Criteria" and "Standard LERN Entry Trauma Criteria Destination Protocol" adopted and promulgated January 20, 2011, as follows.

1. LERN Entry Criteria: Trauma

a. Pre-Hospital and Hospital Triage Protocol

| **Call LERN Communications Center for:** |
|---|
| • Unmanageable Airway<br>• Tension Pneumothorax<br>• Traumatic cardiac arrest<br>• Burn Patient without patent airway<br>• Burn patient >40 percent BSA without IV |
| Physiologic |
| • GCS <14<br>• SBP <90 (adults and > 9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8 y/o)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>• RR <10 or >29 (adults & ≥ 9 y/o)<br><15 or >30 (age 1 to 8 y/o)<br><25 or >50 (<12 m/o) |
| Anatomic |
| • Open or depressed skull fractures<br>• Open head injury with or without CSF leak<br>• Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)<br>• All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee<br>• Flail Chest<br>• 2 or more proximal long-bone fractures |
| **Call LERN Communications Center for:** |
| • Crush, degloved or mangled extremity<br>• Amputation proximal to wrist and ankle<br>• Pelvic Fractures<br>• Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls<br>• Major joint dislocations (hip, knee, ankle, elbow)<br>• Open Fractures<br>• Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture) |
| Mechanism |
| • Falls >20 ft. adults<br>>10 ft. (child) or 2 to 3 times height<br>• Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>• Motorcycle crash >20 MPH<br>• High-risk auto crash<br>• Intrusion >12 in, occupant site<br>>18 in. any site<br>• Ejection, partial or complete from automobile<br>• Death in same passenger compartment |
| Other |
| • Pregnancy >20 weeks<br>• Burns (follow ABA guidelines)<br>• Age ≥ 55 y/o or <8 y/o<br>• Anticoagulation and bleeding disorders<br>• End stage renal disease<br>• Transplant patients |
| Multi/Mass Casualty Incident (MCI) |

2. LERN Destination Protocol: Trauma

| **LERN Destination Protocol: Trauma** | | |
|---|---|---|
| • Unmanageable Airway<br>• Tension Pneumothorax<br>• Traumatic cardiac arrest<br>• Burn patient without patent airway<br>• Burn patient >40 percent BSA without IV | YES→ | Closest ED |
| Physiologic | | |
| • GCS < 14<br>• SBP <90 (adults and > 9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>• RR <10 or >29 (adults and > 9 y/o)<br><15 or >30 (age 1 to 8)<br><25 or >50 (< 12 m/o) | YES→ | LERN Level I, II, or III |
| Anatomic | | |
| • Open or depressed skull fractures<br>• Open head injury with or without CSF leak<br>• Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)<br>• All penetrating injuries to neck, torso and extremities proximal to elbow and knee<br>• Flail Chest<br>• 2 or more proximal long-bone fractures<br>• Crush, degloved or mangled extremity<br>• Amputation proximal to wrist and ankle<br>• Pelvic Fracture<br>• Hip fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls<br>• Major joint dislocations (hip, knee, ankle, elbow)<br>• Open Fractures<br>• Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture | YES→ | LERN Level I, II, or III |

| LERN Destination Protocol: Trauma | | |
|---|---|---|
| Mechanism | | |
| ☐ Falls > 20 ft. (adults)<br>> 10 ft. (child) or 2 to 3 times height<br>☐ High-risk auto crash<br>Intrusion > 12 in. occupant site:<br>>18 in. any site<br>☐ Ejection, partial or complete from automobile<br>☐ Death in same passenger compartment<br>☐ Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>☐ Motorcycle crash >20 MPH | YES→ | LERN Level II, or III |
| Other | | |
| • Pregnancy > 20 weeks<br>• Burns (follow ABA guidelines)<br>• Age >55 y/o or <8 y/o<br>• Anticoagulation and bleeding disorders<br>• End stage renal disease<br>• Transplant patients | YES→ | LERN Level II, III, or IV |
| MULTI/MASS CASUALTY INCIDENT (MCI) | YES→ | LERN Level I, II, III, or IV |

B. These protocols were published at LR 37:1466-1468 (April 20, 2011).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:143 (January 2015).

### §19115. LERN Destination Protocol: TRAUMA

A. On April 26, 2012, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: Trauma" replacing the "LERN Destination Protocol: Trauma" adopted and promulgated April 21, 2011, as follows.

| | | |
|---|---|---|
| • Unmanageable Airway<br>• Tension Pneumothorax<br>• Traumatic cardiac arrest<br>• Burn Patient without patent airway<br>• Burn patient >40 percent BSA without IV | → | Closest ED |
| Physiologic | | |
| • GCS <14<br>• SBP <90 (adults and > 9 y/o)<br><70 + 2 [age (yrs)] (age 1 to 8 y/o)<br><70 (age 1 to 12 months)<br><60 (term neonate)<br>• RR <10 or >29 (adults and ≥ 9 y/o)<br><15 or >30 (age 1 to 8 y/o)<br><25 or >50 (<12 m/o) | → | Level I, II, or III* |
| Anatomic | | |
| • Open or depressed skull fractures<br>• Open head injury with or without CSF leak<br>• Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)<br>• All penetrating injuries to head, neck, torso, & extremities proximal to elbow & knee<br>• Flail Chest<br>• 2 or more proximal long-bone fractures<br>• Crush, degloved or mangled extremity<br>• Amputation proximal to wrist & ankle<br>• Pelvic Fractures<br>• Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures | → | Level I, II, or III* |
| from same level falls<br>• Major joint dislocations (hip, knee, ankle, elbow)<br>• Open Fractures<br>• Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture) | | |
| Mechanism | | |
| • Falls >20 ft. adults<br>>10 ft. (child) or 2 to 3 times height<br>• High-risk auto crash<br>• Intrusion > 12 in. occupant site<br>> 18 in. any site<br>• Ejection, partial or complete from automobile<br>• Death in same passenger compartment<br>• Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>• Motorcycle crash >20 MPH | → | Level I, II, or III* |
| Other | | |
| • Pregnancy >20 weeks<br>• Burns (follow ABA guidelines)<br>• Age ≥ 55 y/o or <8 y/o<br>• Anticoagulation and bleeding disorders -patients w/ head injuries are at high risk for rapid deterioration | → | Level II, or III* |
| MULTI/MASS CASUALTY INCIDENT (MCI) | → | Level I, II, or III* |

*Refers to ACS Verified Level Trauma Center—Where trauma center not available, patient will be routed to facility with appropriate resource which may not need be the highest level facility.

B. This protocol was published at LR 38:1462-1463 (June 20, 2012).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:144 (January 2015).

### §19117. LERN Destination Protocol: Trauma

A. On November 21, 2013, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: TRAUMA" replacing the "LERN Destination Protocol: Trauma" adopted and promulgated April 26, 2012, and repealing "LERN ENTRY CRITERIA, Trauma Pre-Hospital and Hospital Triage Protocol" adopted and promulgated April 21, 2011, as follows.

1. Call LERN Communication Center at (866) 320-8293 for patients meeting the following criteria.

| | | |
|---|---|---|
| • Unmanageable airway<br>• Tension pneumothorax<br>• Traumatic cardiac arrest<br>• Burn patient without patent airway<br>• Burn patient > 40 percent BSA without IV | → | Closest ED/Trauma Center |
| NO<br>↓ | | |

| | | |
|---|---|---|
| Physiologic | | |
| • GCS < 14<br>• SBP < 90 (adults and > 9 y/o)<br>< 70 + 2 [age (yrs)] (age 1 to 8 y/o)<br>< 70 (age 1 to 12 months)<br>< 60 (term neonate)<br>• RR < 10 or > 29 (adults & ≥ 9 y/o)<br>< 15 or > 30 (age 1 to 8 y/o)<br>< 25 or > 50 (< 12 m/o) | → | To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center |
| NO<br>↓ | | |
| Anatomic | | |
| • Open or depressed skull fractures<br>• Open head injury with or without CSF leak<br>• Lateralizing signs or paralysis (i.e., one-sided weakness, motor, or sensory deficit)<br>• All penetrating injuries to head, neck, torso, and extremities proximal to elbow and knee<br>• Flail Chest<br>• 2 or more proximal long-bone fractures<br>• Crush, degloved or mangled extremity<br>• Amputation proximal to wrist and ankle<br>• Pelvic Fractures<br>• Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls<br>• Major joint dislocations (hip, knee, ankle, elbow)<br>• Open Fractures<br>• Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture) | → | To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center |
| NO<br>↓ | | |
| Mechanism | | |
| • Falls >20 ft. adults<br>>10 ft. (child) or 2 to 3 times height<br>• High-risk auto crash<br>• Intrusion >12 in. occupant site<br>>18 in. any site<br>• Ejection, partial or complete from automobile<br>• Death in same passenger compartment<br>• Auto vs. pedestrian/bicyclist thrown, run over or significant (>20 MPH) impact<br>• Motorcycle crash >20 MPH | → | To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center |
| NO<br>↓ | | |
| Other | | |
| • Pregnancy >20 weeks<br>• Burns (follow ABA guidelines)<br>• Age ≥ 55 y/o or <8 y/o<br>• Anticoagulation and bleeding disorders - patients w/ head injuries are at high risk for rapid deterioration | → | To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center |
| MULTI/MASS CASUALTY INCIDENT (MCI) | → | To Appropriate Trauma Center or Hospital as Determined by LERN Communication Center |

B. This protocol was published at LR 40:190-191 (January 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Louisiana Emergency Response Network, LR 41:145 (January 2015).

### §19119. Destination Protocol: TRAUMA

A. On November 20, 2014, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "Destination Protocol: Trauma" to be effective January 1, 2015, and replacing the "LERN Destination Protocol: Trauma" adopted and promulgated November 21, 2013, as follows.

1. Call LERN communication center at (866) 320-8293 for patients meeting the following criteria.

| | | |
|---|---|---|
| • Unmanageable airway<br>• Tension pneumothorax<br>• Traumatic cardiac arrest<br>• Burn patient without patent airway<br>• Burn patient > 40 percent BSA without IV | Yes→ | Closest ED/ Trauma Center |
| ↓ No | | |
| Measure vital signs and level of consciousness | | |
| • GCS ≤13<br>• SBP <90mmHg<br>• RR <10 or >29 breaths per minute, or need for ventilator Support (<20 in infant aged <1 year) | Yes⟶ | Transport to Trauma Center/ Trauma Program<br>These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program.<br>** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.* |
| ↓ No | | |
| Assess anatomy of injury | | |
| • All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee<br>• Chest wall instability or deformity (e.g. flail chest)<br>• Two or more proximal long-bone fractures<br>• Crushed, degloved, mangled, or pulseless extremity<br>• Amputation proximal to wrist or ankle<br>• Pelvic fractures<br>• Open or depressed skull fracture<br>• Paralysis<br>• Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture) | Yes→ | Transport to Trauma Center/ Trauma Program<br>These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program.<br>** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.* |
| ↓ No | | |
| Assess mechanism of injury and | | |

| | | |
|---|---|---|
| evidence of high-energy impact | | |
| • Falls<br>- Adults: >20 feet (one story is equal to 10 feet)<br>- Children: >10 feet or two or three times the height of the child<br>• High-risk auto crash<br>- Intrusion, including roof: > 12 inches occupant site;<br>> 18 inches any site<br>- Ejection (partial or complete) from automobile<br>- Death in the same passenger compartment<br>- Vehicle telemetry data consistent with a high risk of injury<br>• Auto vs. pedestrian/bicyclist/ ATV thrown, run over, or with significant (>20 mph) impact<br>• Motorcycle crash >20mph | Yes→ | Transport to Trauma Center/Trauma Program which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital. |
| ↓ No | | |
| Assess special patient or system considerations | | |
| • Older Adults<br>- Risk of injury/death increases after age 55 years<br>- SBP <110 may represent shock after age 65<br>- Low impact mechanisms (e.g. ground level falls) may result in severe injury<br>• Children<br>- Should be triaged preferentially to pediatric capable trauma centers<br>• Anticoagulants and bleeding disorders<br>- Patients with head injury are at high risk for rapid deterioration<br>• Burns<br>- With trauma mechanism: triage to trauma center<br>• Pregnancy >20 weeks<br>• Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls<br>• Major joint dislocations (hip, knee, ankle, elbow)<br>• Open Fractures<br>• EMS provider judgment | Yes→ | Transport to Trauma Center/Trauma Program which, depending upon the defined trauma system, need not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital. |
| ↓ No | | |
| Multi/Mass Casualty Incident | No→ | Transport according to protocol |

2. When in doubt, transport to a trauma center.

B. This protocol was published at LR 40:2710 (December 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:950 (May 2015).

## §19121. LERN Destination Protocol: TRAUMA

A. On December 10, 2015, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: TRAUMA", which replaces the "LERN Destination Protocol: TRAUMA" found in §19121 adopted and promulgated November 20, 2014, as follows.

1. Call LERN communication center at (866) 320-8293 for patients meeting the following criteria.

| | | |
|---|---|---|
| • Unmanageable airway<br>• Tension pneumothorax<br>• Traumatic cardiac arrest<br>• Burn patient without patent airway<br>• Burn patient > 40 percent BSA without IV | Yes→ | **Closest ED/Trauma Center** |
| No<br>↓ | | |
| **Measure vital signs and level of consciousness** | | |
| • GCS ≤13<br>• SBP <90mmHg<br>• RR <10 or >29 breaths per minute, or need for ventilator<br>Support (<20 in infant aged <1 year) | Yes→ | **Transport to Trauma Center/ Trauma Program**<br>These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program.<br>** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.* |
| No<br>↓ | | |
| **Assess anatomy of injury** | | |
| • All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee<br>• Chest wall instability or deformity (e.g. flail chest)<br>• Two or more proximal long-bone fractures<br>• Crushed, degloved, mangled, or pulseless extremity<br>• Amputation proximal to wrist or ankle<br>• Pelvic fractures<br>• Open or depressed skull fracture<br>• Paralysis<br>• Fractures with neurovascular compromise (decreased peripheral pulses or prolonged capillary refill, motor or sensory deficits distal to fracture) | Yes→ | Transport to Trauma Center/ Trauma Program<br>These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program.<br>** If distance or patient condition impedes transport to trauma facility, consider transport to most appropriate resourced hospital.* |
| No<br>↓ | | |
| Assess mechanism of injury and evidence of high-energy impact | | |
| • **Falls**<br>- Adults: >20 feet (one story is equal to 10 feet)<br>- Children: >10 feet or | Yes→ | **Transport to Trauma Center/Trauma Program** which, depending upon the defined trauma system, need |

| | | |
|---|---|---|
| two or three times the height of the child<br>• **High-risk auto crash**<br>- Intrusion, including roof: > 12 inches occupant site;<br>> 18 inches any site<br>- Ejection (partial or complete) from automobile<br>- Death in the same passenger compartment<br>- Vehicle telemetry data consistent with a high risk of injury<br>• **Auto vs. pedestrian/bicyclist/ATV thrown, run over, or with significant (>20 mph) impact**<br>• **Motorcycle crash >20mph** | | not be the highest level trauma center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital. |
| No<br>↓ | | |
| **Assess special patient or system considerations** | | |
| • **Older Adults**<br>- Risk of injury/death increases after age 55 years<br>- SBP <110 may represent shock after age 65<br>- Low impact mechanisms (e.g. ground level falls) may result in severe injury<br>• **Children**<br>- Should be triaged preferentially to pediatric capable trauma centers<br>• **Anticoagulants and bleeding disorders**<br>- Patients with head injury are at high risk for rapid deterioration<br>• **Burns**<br>- With trauma mechanism: triage to trauma center<br>• **Pregnancy >20 weeks**<br>• Hip Fractures (hip tenderness, deformity, lateral deviation of foot) excluding isolated hip fractures from same level falls<br>• Major joint dislocations (hip, knee, ankle, elbow)<br>• Open Fractures<br>• EMS provider judgment | Yes→ | **Transport to Trauma Center/Trauma Program** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control. |
| No<br>↓ | | |
| **Multi/Mass Casualty Incident** | No→ | Transport according to protocol |

2. When in doubt, transport to a trauma center.

B. This protocol was published at LR 42:169 (January 2016).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 42:904 (June 2016).

### §19123. LERN Destination Protocol: TRAUMA

A. On August 18, 2022, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: TRAUMA", and replacing the "LERN Destination Protocol: TRAUMA" adopted and promulgated December 10, 2015, as follows:

1. Call LERN Communication Center at (866) 320-8293 for patients meeting the following criteria.

| | | |
|---|---|---|
| **Assess for Extremis** | | |
| • Unmanageable airway<br>• Tension pneumothorax<br>• Traumatic cardiac arrest<br>• Burn patient without patent airway<br>• Burn patient > 40 percent BSA without IV or IO Access | **Yes→** | **Closest ED/Trauma Center** |
| **No↓** | | |
| **Measure vital signs and Mental Status** | | |
| • Unable to follow commands (Motor GCS < 6)<br>• RR <10 or > 29 breaths per minute (<20 in infant aged <1 year)<br>• Respiratory distress or need for support<br>• Room air pulse oximetry <90%<br>• Age 0-9: SBP <70 mmHG + (2 x age in years)<br>• Age 10-64: SBP <90 mmHG or HR > SBP<br>• Age ≥ 65: SBP <110 mmHG or HR > SBP | **Yes→** | **Transport to Trauma Center/ Trauma Program**<br>These patients should be transported to the highest level of care within the defined trauma system. This is a Level 1 or a Level 2 Trauma Center or Trauma Program.<br>* If distance or patient condition impedes transport to Level 1 or 2, consider transport to a Level 3 Trauma Center/Trauma Program or most appropriate resourced hospital. |
| **No↓** | | |
| **Assess Injury Patterns** | | |
| • All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee<br>• Chest wall instability or deformity or suspected flail chest<br>• Suspected fracture of two or more proximal long-bones<br>• Crushed, de-gloved, mangled, or pulseless extremity<br>• Amputation proximal to wrist or ankle<br>• Suspected pelvic fracture<br>• Skull deformity or suspected skull fracture<br>• Suspected spinal injury with new motor or sensory loss<br>• Active bleeding requiring a tourniquet or wound packing with continuous pressure | **Yes→** | **Transport to Trauma Center/ Trauma Program**<br>These patients should be transported to the highest level of care within the defined trauma system. This is a Level I or a Level 2 Trauma Center or Trauma Program.<br>* If distance or patient condition impedes transport to Level 1 or 2, consider transport to a Level 3 Trauma Center/Trauma Program or most appropriate resourced hospital |
| **No↓** | | |
| **Assess mechanism of injury** | | |
| • Falls from height >10 feet (all ages)<br>• High-risk auto crash<br>-- Intrusion, including roof: | **Yes→** | **Transport to Trauma Center/Trauma Program** which, depending upon the defined trauma system, need not be the highest level trauma |

| | | |
|---|---|---|
| –12 inches occupant site;<br>–18 inches any site;<br>–need for extrication for patient entrapped<br>- Ejection (partial or complete) from automobile<br>- Death in the same passenger compartment<br>- Child (Age 0-9)unrestrained or in unsecured child safety seat<br>- Vehicle telemetry data consistent with a high risk of injury<br>• Auto vs. pedestrian/bicyclist thrown, run over, or with significant (>20 mph) impact<br>• Rider separated from transport vehicle with significant impact (ex: motorcycle, ATV, Horse, etc.) | | center/program. If no Trauma Center/Trauma Program in the region, LCC may route to the most appropriate resourced hospital. |
| **No↓** | | |
| **Assess special patient or system considerations** | | |
| • Older Adults<br>- Age ≥ 65 with evidence of traumatic injury<br>- Fall from any height with evidence of significant head impact<br>- Use of anticoagulant or antiplatelet drugs<br>• Children<br>- Age ≤ 5 with evidence of traumatic injury<br>- Fall from any height with evidence of significant head impact<br>• Burns<br>- In conjunction with trauma<br>- High voltage electrical injuries<br>• Pregnancy >20 weeks<br>• Major joint dislocations (hip, knee, ankle, elbow)<br>• EMS provider judgment | **Yes→** | **Transport to Trauma Center/Trauma Program** or hospital capable of timely and thorough evaluation and initial management of potentially serious injuries. Consider consultation with medical control. |
| **No↓** | | |
| **Multi/Mass Casualty Incident** | **No→** | Transport according to protocol |

2. When in doubt, transport to a trauma center.

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

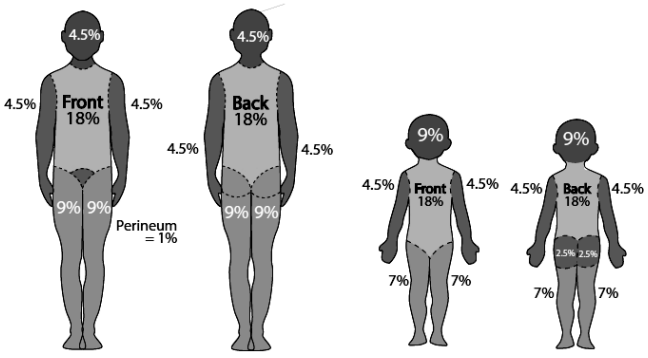
HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 49:265 (February 2023).

# Chapter 192. Burn Protocols

## §19201. LERN Destination Protocol: BURN

A. Call LERN Communication Center at 1-866-320-8293 for patients meeting the following criteria.

| | | |
|---|---|---|
| Burn Patient with Trauma | Yes⟶ | See LERN Trauma Destination Protocol |
| ↓ No | | |
| • Burn patient without patent airway<br>• Patients with facial / airway burns or anticipated airway compromise<br>• Burn patient with > 40 % BSA without IV or IO access | Yes⟶ | Transport to Closest ED |
| ↓ No | | |
| 2nd and 3rd degree burns involving:<br>• > 10% BSA<br>• Face, hands, feet, genitalia, perineum, or major joints<br>• Circumferential Burns<br>• Electrical burns, including lightning injury<br>• Chemical burns<br>Or<br>• Inhalation injury<br>• All Third Degree Burns | Yes→ | Transport to Closest Burn Center<br>** If distance or patient condition impedes transport to burn center, consider transport to most appropriate resourced hospital.* |
| ↓ No | | |
| Transport per Local EMS Protocols | | |
| • In the event of a burn disaster, each burn center should immediately contact LERN. LERN Call Center (LCC) will conduct a bed poll.<br>• In the event of a burn disaster and excess beyond capacity, the next geographically closest burn center should be alerted immediately by LERN. | | |




AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 45:911 (July 2019).

# Chapter 193. Stroke Protocols

## §19301. LERN Destination Protocol: Stroke

A. On November 21, 2013, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: STROKE," as follows.

1. The following protocol applies to patients with suspected stroke.

| | | |
|---|---|---|
| Compromise Of:<br>• Airway<br>• Breathing<br>• Circulation | → | Closest ED |
| NO<br>↓ | | |
| • All other patients with suspected stroke Patients with seizure with focal deficit, extended window (4-8 hrs from onset), and patients with unknown onset may benefit from evaluation at Level I or II hospital with on-site stroke expertise. | → | Transport to LERN Stroke Level I, II, or III |
| NO<br>↓ | | |
| Terminally Ill or Palliative Care Patient | → | Transport to LERN Stroke Level I, II, III, or IV |
| Guiding principles:<br>• Time is the critical variable in acute stroke care.<br>• Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate primary destination efficiency.<br>• Treatment with intravenous tPA is the only FDA approved acute therapy for stroke.<br>• EMS should identify the geographically closest facility capable of providing tPA treatment.<br>• Transfer patient to the nearest hospital equipped to provide tPA treatment.<br>• Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients. | | |

B. This protocol was published at LR 40:189-190 (January 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:146 (January 2015).

## §19303. LERN Destination Protocol: Stroke

A. On April 21, 2017, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "LERN Designation Protocol: Stroke", amending and replacing the previous "LERN Designation Protocol: Stroke" adopted on November 21, 2013 and set out in Section 19301, as follows.

**LERN Destination Protocol: Stroke**
**LERN Call Center: (866) 320-8293**

The following protocol applies to patients with suspected stroke:

**Compromise Of:**
- Airway
- Breathing
- Circulation

→ Closest ED for stabilization and then triage to closest appropriate hospital

NO

**All other patients with suspected stroke, determine time last seen normal (LSN) and screen for large vessel occlusion (LVO)**

| **LSN < 6 hours* AND screen for LVO is positive** | **LSN > 6 hours OR screen for LVO is negative** |
|---|---|
| **Transport to LERN Stroke Level I, II, or III Center** | **Transport to LERN Stroke Level I, II, or III Center** |
| If < 15 minutes of additional transport time to reach Level I or endovascular capable Level II Center, transfer to the Level I or endovascular capable Level II Center | If > 15 minutes of additional transport time to reach Level I, II, or III Center than to reach stroke capable Off Site ED, it is acceptable to transport to a stroke capable Off Site ED |

* The LSN < 6hrs should include patients without a definite time of LSN, but who could reasonably be assumed to be within 6 hrs of onset, including patients who wake-up with stroke symptoms.

**Guiding Principles:**
- Time is the critical variable in acute stroke care
- Protocols that include pre-hospital notification while en route by EMS should be used for patients with suspected acute stroke to facilitate initial destination efficiency.
- Treatment with intravenous tPA is the only FDA approved medication therapy for hyperacute stroke.
- EMS should identify the geographically closest hospital capable of providing tPA treatment.
- Transfer patient to the nearest hospital equipped to provide tPA treatment.
- Secondary transfer to facilities equipped to provide tertiary care and interventional treatments should not prevent administration of tPA to appropriate patients.

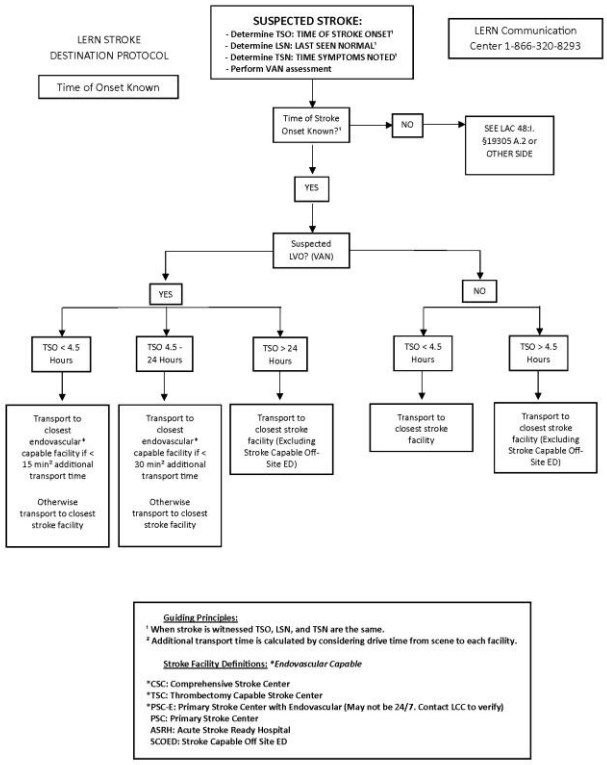
AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 43:1758 (September 2017).

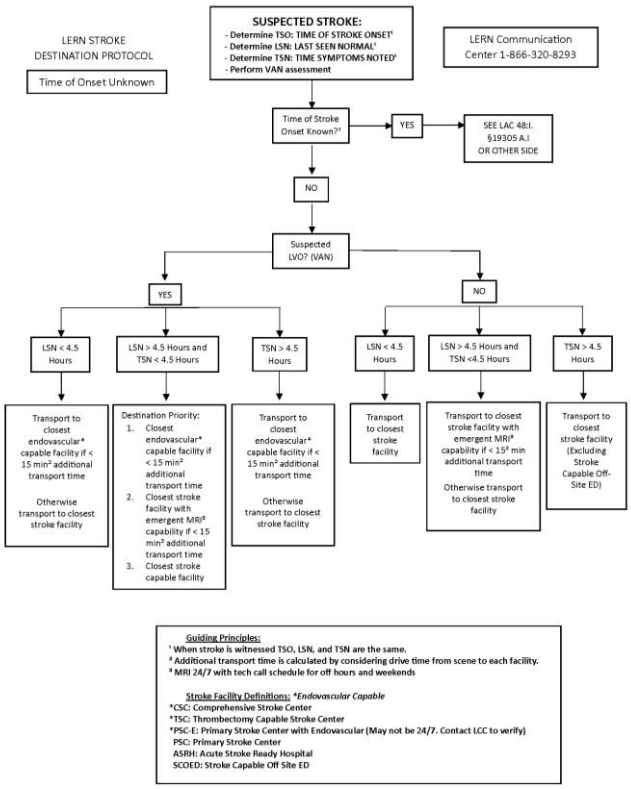
## §19305. LERN Destination Protocol: Stroke

A. On November 17, 2023, to be effective January 1, 2024, the Louisiana Emergency Response Network Board [R,S, 40:2842(1) and (3)] adopted and promulgated "LERN Destination Protocol: Stroke", amending and replacing the previous "LERN Destination Protocol: Stroke" adopted on April 21, 2017, and set out in Section 19303, as follows:

1. LERN Destination Protocol: Stroke for Known Time of Stroke Onset



2. LERN Destination Protocol: Stroke for Unknown Time of Stroke Onset




AUTHORITY NOTE: Promulgated in accordance with R.S. 9:21798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 50:687 (May 2024).

# Chapter 195. STEMI Protocols

## §19501. STEMI Triage Protocol for Pre-Hospital Providers

A. On November 21, 2013, the Louisiana Emergency Response Network Board [R.S. 40:2842(1) and (3)] adopted and promulgated "STEMI Triage Protocol for Pre-Hospital Providers," as follows.

| | | |
|---|---|---|
| Acute coronary symptoms ≥ 15 minutes and < 12 hours<br>AND<br>12 lead ECG criteria of 1 mm ST elevation in 2 or more contiguous leads<br>OR<br>LBBB NOT KNOWN to be present in the past<br><br>EMS ECG interpreted or transmitted to hospital for MD consult for bypass and activation | | |
| ↓ | | |
| STEMI-Receiving Center with medical contact-to-device (PCI) ≤ 90 minutes (by ground or air)? | YES→ | Transport to nearest STEMI-Receiving Center with pre-hospital notification/activation<br><br>Goal medical contact to device (PCI) time of 90 minutes or less |
| NO<br>↓ | | |
| Transport to closest STEMI-Referral Hospital with Pre-hospital notification/activation Goal medical contact to fibrinolytic needle time of 30 minutes or less | → | Transport to nearest STEMI-Receiving Center for subsequent PCI |

*O'Gara PT, Kushner FG, Ascheim DD, et all. 2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infraction: A Report of the American College of Cardiology Foundation/American Heart Association Task Force on Practice Guidelines. Journal of the American College of Cardiology. 2013;61(4):e78.

B. This protocol was published at LR 50:192 (January 20, 2014).

AUTHORITY NOTE: Promulgated in accordance with R.S. 9:2798.5 and R.S. 40:2846(A).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Emergency Response Network, LR 41:146 (January 2015).

# Chapter 197. Trauma Program Recognition

## §19701. Generally

A. The goal of the Louisiana Emergency Response Network Board is to establish a trauma system that includes one verified trauma center in each region of the state. Trauma program recognition in excess of this goal will be determined utilizing a needs based assessment. The LERN communication center coordinates access to the trauma system by providing accurate and professional routing of patients experiencing time sensitive illness to the definitive care facility, which includes trauma programs recognized according to these rules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1931 (November 2016).

## §19703. Purpose

A. LERN recognizes the opportunity to reduce the morbidity and mortality of trauma patients in Louisiana in areas without an existing level I or level II trauma center or an existing level II or level III trauma program through this process which recognizes the achievement of specific benchmarks in hospitals actively pursuing levels II or III trauma center verification through the American College of Surgeons (ACS).

B. The purpose of this Chapter is to define the qualifications, procedure, and requirements for hospitals seeking trauma center verification by the ACS to be recognized by LERN as achieving the core components of a trauma program and thus qualified for recognition as a trauma program.

C. The criteria for trauma program recognition are drawn from *Resources for Optimal Care of Injured Patient 2014* published by the ACS.

D. Trauma program recognition is distinct and different from the trauma center certification by the state. To be certified as a trauma center, a hospital must satisfy the requirements of R.S. 40:2172 and 2173.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1931 (November 2016).

**§19705. Qualifications for LERN Trauma Program Recognition**

A. The hospital must be located in a LERN region that does not have an existing ACS verified level I or level II trauma center.

B. A hospital providing care to trauma patients in a LERN region without an existing ACS verified level I or level II trauma center or without an existing level II or level III trauma program is eligible for trauma program recognition upon meeting the requirements of this rule.

C. If there is an existing LERN recognized level II or Level III trauma program in the LERN region, the hospital must complete the most current version of the ACS needs based assessment of trauma systems tool (ACS NBATS). If the number of trauma centers allocated by the tool is less than or equal to the number of existing trauma programs in the region, the hospital is not eligible for trauma program recognition.

D. A hospital must be in the process of working toward ACS verification to be eligible for trauma program recognition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1932 (November 2016).

**§19707. Procedure for Trauma Program Recognition**

A. A hospital must complete the LERN approved form, "application for recognition of trauma program".

B. The hospital CEO must complete and sign the LERN approved trauma program checklist/attestation for the applicable trauma program level.

1. By this attestation, the hospital CEO ensures 24/7/365 availability of the resources listed.

2. The attestation must be validated by a site visit by LERN staff.

3. Upon CEO attestation and/or site visit, if it is determined by the LERN executive committee in conjunction with the LERN trauma medical director, that the required benchmarks are not in place the hospital will not be eligible for trauma program verification.

C. After satisfying the requirements of A. and B. above, the hospital will be recognized as a trauma program and such recognition will be added to the LERN resource management screen for the purpose of routing trauma patients.

D. To maintain trauma program recognition, the hospital must request an ACS verification or consultation site visit at the time of the attestation or within 30 days thereafter, with the consultation or survey to occur within 12 months of the attestation or as close to 12 months as the ACS schedule allows. Written documentation of the request and scheduling must be submitted to LERN.

1. If an ACS verification or consultation site visit is not requested within 30 days and does not occur within 12 months or as close to 12 months as the ACS schedule allows, the trauma program indicator on LERN resource management screen will be removed.

E. After a consultation visit for the desired trauma level, the hospital has 30 days to schedule the verification survey by the ACS to occur within 12 months of the consultation or as close to 12 months as the ACS schedule allows. Written documentation of the request and scheduling must be submitted to LERN.

1. If documentation of scheduling per required parameters is not submitted to LERN and the ACS verification survey is not scheduled to occur within 12 months of the consultation or as close to 12 months as the ACS schedule allows, the trauma program indicator will be removed on the LERN resource management screen.

2. If the hospital fails the ACS verification visit and a focused review visit, the hospital will lose trauma program status. The trauma program indicator will be removed on the LERN resource management screen.

F. After loss of trauma program status for failing the ACS verification visit and focused review visit, trauma program status may be regained provided the following conditions are met:

1. a LERN designee and either the LERN trauma medical director or a trauma surgeon must review the deficiencies and findings of the ACS at a site visit;

2. the hospital must develop a remediation plan and apply to the LERN board for approval of trauma program status;

3. the LERN board will review the LERN team assessment of deficiencies and the hospital's remediation plan;

4. the LERN board must vote to approve the trauma program status request.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2846(A), R.S. 40:2845(A)(1) and R.S. 9:2798.5.

HISTORICAL NOTE: Promulgated by the Department of Health, Emergency Response Network, LR 42:1932 (November 2016), amended LR 44:63 (January 2018), LR 45:436 (March 2019), repromulgated LR 45:573 (April 2019).