

**NORTH CENTRAL REGION
EMERGENCY MEDICAL SERVICES
& TRAUMA SYSTEM**

S T R A T E G I C P L A N

July 2009 - June 2013

Submitted by the North Central Region EMS and Trauma Care Council
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EXECUTIVE SUMMARY

Introduction

System Leadership

In the North Central Region, there has not been a focused region wide effort to provide resources for leaders to enhance their knowledge or leadership skills within the system. We are not aware of what leadership training prehospital agency leads have had the opportunity to participate in, but we know the regional and local council boards have not had formal leadership or system development training.

Leadership is an integral component of the dynamic and evolving system of Emergency Medical Services and Trauma Care. The coming years are going to challenge our EMS system and require a much more sophisticated method of planning, communicating with stakeholders and utilization of funds to maximize efficiencies. It is important our region develop the necessary skills sets within the administration of our EMS system to ensure future viability of services at the local level. This plan addresses the need for:

- Council membership to be aligned with system representation needs
- Board Succession Plan Development

System Development

The North Central Region has local county MPD coordinated EMS run review QI process and a hospital based CQI process to assist in the reduction of inappropriate and inadequate patient care. The system that currently exists lacks established regional benchmarks and the ability to retain accurate data from the QI process.

The development of a strong, efficient, well-coordinated EMS & Trauma System is vital in reducing the inappropriate and inadequate trauma care and emergency medical services to minimize human suffering and the costs associated with preventable injuries and death. The challenge to the EMS & Trauma System is to ensure that progress is made in a systematic and measured way. This plan addresses the need for:

- Successful integration of a quality philosophy in all aspects of the EMS & Trauma System
- Implementation of objectives and strategies that move the region toward the accomplishment of identified local, regional and state goals

System Public Information and Education

In the North Central Region, we have recognized the need for comprehensive and region wide information & education distribution. Currently, information about the EMS and Trauma system is communicated informally. There is limited consistent distribution of information & communication between regional EMS agencies, regional healthcare facilities and the public at large.

There is a growing need to ensure the public as a whole is engaged and invested in Emergency Medical Services and the ongoing need for quality emergency medical care. Ongoing system evaluation and feedback from the public perspective is essential to identifying how to better serve our customers, and will help to identify gaps in public knowledge regarding the system. There is a need now more than ever to establish partnerships between EMS and the communities they serve by vesting the community in the system.

This plan addresses the need for:

- Development and implementation of a regional public information plan.

- Evaluation of the public information plan effectiveness and modification as indicated

System Finance

In the North Central Region, we have identified existing gaps in our current system that impact leadership management and the ability to identify true costs of providing patient care. We recognize these gaps must be addressed in order to garner sufficient resources to continue support of planning, implementation, delivery and ongoing management of administrative and clinical components in delivering quality patient care to the community.

Providing our local agencies leadership and administrative development tools are an essential component to creating a viable, sustainable system. This plan addresses the need for:

- Developing a process for providing information to prehospital agencies on funding
- Establishing ongoing funding for the work of the Regional Council

Injury Prevention and Control

The North Central Region has made great progress in developing a comprehensive network of injury prevention partners and establishing partner coalitions. Our target areas for continued emphasis are childhood injuries and senior falls prevention.

By supporting regional networks of Safe Kids coalitions, Traffic Safety Coordinators, Tribal & Public Health partners, Aging & Adult Care and Retired Senior Volunteer Program, the North Central Region council is building a sustainable injury prevention network. This plan addresses the need for:

- Continuing support of established injury prevention groups and their efforts to reduce unintentional injuries through best practice programs
- Continuing regional participation in state IPPE meetings

Participating in the Statewide Injury Prevention project

Pre-Hospital Care

MPD QI is done on a county by county basis. Region wide prehospital CQI does not currently exist. Creating region wide prehospital CQI would allow for integration of what is currently thought of as Regional Hospital QI (Regional QI) with the prehospital system in the future.

BLS OTEP is coordinated regionally in our system. The regional Training and Education CQI program must address key performance indicators and review progress. This plan addresses the need for:

- Developing and evaluating a region wide prehospital CQI process
- Prehospital Cardiac PCPs

Continued support of prehospital education and training based on standardized procedure

Acute Hospital Care

The North Central Region has 11 designated trauma care services that provide a network of patient care for trauma. Central Washington Hospital is the highest designated trauma facility as a Level III and is centrally located in the region.

The regional trauma services network continues to strive for highest quality patient care through collaboration by establishing interfacility transfers in accordance with established guidelines from DOH and ACS, as well as participating in CQI and regional meetings identifying trauma services needs of the region. This plan addresses the need for:

- Continuing region wide stakeholder involvement in trauma designation
- Reviewing interfacility transfer guidelines in accordance with DOH & ACS criteria

Pediatric Care

There are limited pediatric specialists within our system regionally; Central Washington Hospital is our only Pediatric Trauma Designated facility. Our region must identify the most sufficient means to accomplish the task of ensuring quality appropriate care for pediatric patients.

Our system must define the best way to accomplish the task of caring for pediatric patients by taking advantage of evidenced based care models, utilizing technology and resources outside of our region, and ensuring we have adequate supplies and equipment to care for pediatric patients. We must ensure timely transfers to the most appropriate facility happen consistently. This plan addresses the need for:

- Adoption of evidenced based prehospital pediatric protocols in the region
- Provision of Pediatric equipment and supplies on BLS and ALS response units to AAP/ACEP standards
- Implementation of DOH Pediatric Consultation and Transfer Guidelines in hospitals

Trauma Rehabilitation

The North Central Region has one Level II Trauma Rehabilitation facility located at Wenatchee Valley Medical Center in Wenatchee. Currently, repatriation of trauma patients back to Wenatchee for trauma rehabilitation from Level I & II trauma centers needs improvement. This plan addresses the need for:

- Determining Regional Rehabilitation Referral needs
- Developing and disseminating public and professional information on rehabilitation in the region.

System Evaluation

Currently the North Central Region does not have consistent, comprehensive EMS data submittal from all EMS agencies and has not established region wide system evaluation & improvement components.

The ability of continuous system improvement hinges upon individual organizations within the system to collect data, evaluate data, monitor trends and identify outliers. A formal system evaluation process that includes performance improvement measures for clinical care, operations and customer satisfaction across the Emergency Medical System is essential for our region to make system improvements. Making this model a part of our systems culture is essential to ensuring that response, treatment and transport, acute care and rehabilitation are the best they can be within the confines and limitations of our system. This plan addresses the need for:

- Continuous system improvement involving data collection, data evaluation, monitoring of trends and identifying outliers
- A multidisciplinary CQI program that can evaluate the entire system of care for trauma patients

REGIONAL SYSTEM
GOALS – OBJECTIVES – STRATEGIES
JUNE 2009 – JULY 2012

ADMINISTRATIVE COMPONENTS

SYSTEM LEADERSHIP

Introduction

Leadership is an integral component to the dynamic and evolving system of Emergency Medical Services. From agency directors, to mid-level managers and patient care providers, an intimate understanding of leadership is integral to the success of both individuals and organizations. An organization with great leadership will be more effective, more cost efficient and have better employee morale at all levels, all of which are important components of any successful organization.

In the North Central Region we do not have a comprehensive leadership training component established. We are not aware of what leadership training prehospital agency leads have had the opportunity to participate in, but we know the regional and local council boards have not had formal leadership or system development training.

The coming years are going to challenge our EMS system and require a much more sophisticated method of planning, communicating with stakeholders and utilization of funds to maximize efficiencies. Strong leadership and well coordinated system development will be integral to the success of this region in the future. It is essential our local and Regional Council Boards are structured to guarantee a mix of representation that will ensure success at all levels of the EMS system in our region. Our system leadership and administration must evolve in order to meet the challenges of now and the future in an effective and efficient manner.

The EMS & Trauma System is provided for by legislative authority in RCW 70.168.100 through RCW 70.168.130 and WAC 246.976.960. The system is in its adolescence and now the need for skilled and knowledgeable leaders in EMS is immense. Leaders must deal with not only normal leadership issues such as conflict resolution, leader-follower relationships and fiscal responsibilities, they must also be familiar with laws regarding patient care and billing, appropriate system status management, and how to lead the unique followers that comprise an EMS organization. To be a successful leader in EMS, one must be intimately familiar with current leadership practices and the issues confronting EMS organizations.

We see it as essential that we are able to develop the necessary skills sets within the administration of our EMS system to ensure future viability of services at the local level. We believe that this development will have a cascading effect on the leadership development within our local and Regional Council Board in the future.

This plan addresses the need for:

- **Council membership to be aligned with system representation needs**
- **Board Succession Plan development**

- Goal #1 -	
There are viable, active local and regional EMS and trauma care councils comprised of multi-disciplinary, EMS and trauma system representation.	
<p>Objective 1. By June 2011 Regional & Local Councils will review & revise their respective memberships to ensure compliance with RCW 70.168.120 and current system representation needs.</p>	<p>Strategy 1. By December 2009, the North Central Region EMS & Trauma Care Council will, during a regular meeting, review & revise as needed their current board structure and positions to reflect system representation needs.</p>
	<p>Strategy 2. By September 2010, each of the Local Councils will review & revise as needed board/membership positions to reflect, at least RCW 70.168.120; as reflected in Goal 2, Objective 1, Strategy 1, the Regional Council will have an existing Partnership Workgroup to guide membership</p>
	<p>Strategy 3. By April 2010, the North Central Region EMS & Trauma Care Council will solicit new members as needed to reflect a balance of membership as described in RCW 70.168.120 and meet other system wide representation needs</p>
	<p>Strategy 4. By June 2011, each of the Local Councils will solicit new members to reflect a balance of membership as described in RCW 70.168.120</p>
<p>Objective 2. By February 2013 the Regional Council will develop and implement a regional board succession plan.</p>	<p>Strategy 1. By June 2011, the Regional Council Chair will appoint a workgroup to develop a succession plan for implementation by the Regional Council Board.</p>
	<p>Strategy 2. At the August and December 2011 regional council meetings, the appointed succession plan workgroup will provide regional council with updates on progress of succession plan project.</p>
	<p>Strategy 3. By February 2013, the Succession Plan Workgroup will present a completed succession plan to the Regional Council Board for approval and implementation.</p>

SYSTEM LEADERSHIP

- Goal #2 -

Multi-disciplinary coalitions of private/public health care providers are fully engaged in regional and local EMS and trauma systems.

<p>Objective 1. By March 2010, Regional Council Board will identify regional council plan workgroups and engage key partners with specific skill sets to participate in the workgroup.</p>	<p>Strategy 1. By October 2009, the Regional Council Chair will appoint a member from the council as a lead for each established plan workgroup.</p>
	<p>Strategy 2. By February 2010 each plan workgroup will provide workgroup timelines with member solicitation list to local and regional councils.</p>
<p>Objective 2. By June 2013, Regional Council Staff will engage stakeholders to enroll in the Information Distribution Network.</p>	<p>Strategy 1. By June 2011, Regional Council board will invite stakeholders to enroll in our Information Distribution Network.</p>
	<p>Strategy 2. On an ongoing basis, the Regional Council Board will disseminate specific information requested by each enrollee through the Information Distribution Network.</p>
<p>Objective 3. By December 2012, Regional Council Staff will evaluate the adequacy of the Information Distribution System and make adjustments to address needs identified in the evaluation process.</p>	<p>Strategy 1. By December 2011, the Regional Council Staff will review current enrollment in the Information Distribution System as compared to identified partners identified in Goal 2 – Objective 1.</p>
	<p>Strategy 2. By October 2012, the Regional Council Staff will complete an enrollee perception survey to measure customer satisfaction and establish current expectations of the Information Distribution System.</p>
	<p>Strategy 3. By December 2012, the Regional Council Staff will construct a System Status report of the Information Distribution Network and submit it to the Regional Council Board with recommendations.</p>
	<p>Strategy 4. By December 2012, the Regional Council Staff will make adjustments to Information Distribution System to meet needs identified in the evaluation process.</p>

SYSTEM LEADERSHIP

- Goal #3 -

Each of the services under the EMS and Trauma System has active, well trained and supported leadership.

<p>Objective 1. By January 2013, the Regional Council Board will utilize information from the focus group survey and on-going contact to determine methods to prepare Emergency Medical Service Administrators and Leadership for the challenges that face the system now and in the future.</p>	<p>Strategy 1. By January 2010 the Regional Council Board will conduct EMS agency director focus group meetings in each county to determine needs of regional agencies.</p>
	<p>Strategy 2. By February 2010, focus group report will be presented to Regional Council Board.</p>
	<p>Strategy 3. By April 2010 the Regional Council Board will identify methods of supporting leadership training for EMS agency directors.</p>
	<p>Strategy 4. By July 2010 through December 2012 the Regional Council Board will continue to survey agency directors to assist with on-going evaluation of agency director leadership needs.</p>
	<p>Strategy 5: By January 2013, the Regional Council Board will utilize information from the continued contact and survey of EMS agency directors for use in the development of objectives for the 2013-2017 regional plan.</p>

SYSTEM DEVELOPMENT

Introduction

Currently the North Central Region has local county EMS run review QI process coordinated by each county MPD and a hospital based CQI process to assist in the reduction of inappropriate and inadequate patient care. The system that currently exists lacks established regional benchmarks and the ability to retain accurate data from the QI process.

The development of a strong, efficient, well-coordinated EMS & Trauma System is vital in reducing the inappropriate and inadequate trauma care and emergency medical services to minimize human suffering and the costs associated with preventable injuries and death. The challenge to the EMS & Trauma System is to ensure that progress is made in a systematic and measured way. To that end, the North Central Region EMS & Trauma Care Council has identified two areas that will be implemented and monitored.

This plan addresses the need for:

- **Successful integration of a quality philosophy in all aspects of the EMS & Trauma System**
- **Implementation of objectives and strategies that move the region toward the accomplishment of identified local, regional and state goals**

- Goal #4 -

There is a strong, efficient, well-coordinated region-wide EMS and Trauma System to reduce the incidence of inappropriate and inadequate trauma care and emergency medical services and to minimize the human suffering and costs associated with preventable mortality and morbidity.

<p>Objective 1. By June 2013, the Regional Council Board in collaboration with MPDs, and the Regional QI Committee will identify system benchmarks for EMS and trauma and implement their use.</p>	<p>Strategy 1. By January 2013, the Regional Council Board will utilize Outcomes TAC benchmarks to incorporate in regional system evaluations.</p> <p>Strategy 2. By June 2013 the Regional Council Board will select system benchmarks and determine and implement the system benchmarking process.</p>
<p>Objective 2. By June 2012, the Regional Council Board and other system stakeholders will use the system</p>	<p>Strategy 1. Regional Council Board and staff will use DOH and other reports by June 2012 and assist the regional plan development group in using them in developing objectives for the 2013-2017 North Central</p>

benchmarking data from Objective 1 for the 2013-2017 regional planning process.	Region EMS and Trauma Care System Strategic Plan.
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SYSTEM DEVELOPMENT

- Goal #5 -

The Regional Plan is congruent with the statewide strategic plan and utilizes standardized methods for identifying resource needs.

<p>Objective 1. By May, 2012 the Regional Council Board will utilize Washington State DOH standardized methodologies to determine min/max numbers for verified service types in each county.</p>	<p>Strategy 1. By January 2011, the Regional Council Board will provide Washington State standardized methodologies to local councils and provide assistance in determining min/max numbers, levels and types of prehospital verified service</p>
	<p>Strategy 2. By March 2011, The Regional Council Board will utilize recommendations from each Local Council for min/max updates to verified service numbers, levels and types in the 2013-2017 Regional Plan.</p>
<p>Objective 2. By May 2012 the Regional Council Board will utilize Washington State DOH standardized methodologies to determine trauma designated service levels, distribution and numbers region wide.</p>	<p>Strategy 1. By January 2010, the Regional Council Board will provide Washington State standardized methodologies to regional hospitals and provide assistance in determining trauma designated service levels, distribution, and numbers.</p>
	<p>Strategy 2. By March 2012, The Regional Council Board will utilize recommendations from Regional Hospitals for trauma designated service levels, distribution, and numbers in the 2013-2017 Regional Plan.</p>
<p>Objective 3. Annually by June stakeholders involved in regional plan development will review the Regional Plan for alignment with State EMS and Trauma System Strategic Plan work and develop recommendations to the Regional Council Board for enacting Regional Plan changes to maintain congruency with the State Plan</p>	<p>Strategy 1. By May annually Regional Council Board staff will provide a summary report on the work of the State Plan being carried out by the State EMS and Trauma Steering Committee Technical Advisory Committees and present it to stakeholders involved in regional plan development</p>
	<p>Strategy 2. By June annually the stakeholder group will develop recommendations to the Regional Council Board for their action in making plan changes.</p>

SYSTEM DEVELOPMENT

- Goal #6 -

The Regional EMS and trauma care system has multiple distribution channels (methods, routes etc.) for timely dissemination of information on emerging issues that have been identified by the Steering Committee

Objective 1.

By December annually Regional and Local Councils will use existing regional website for use in timely distribution of Steering Committee & TAC information to regional stakeholders on emerging issues and will develop, implement and update an information distribution process.

Strategy 1. By December of 2009 the emerging issues information dissemination process will be implemented within the regional system.

Strategy 2. By December annually, as needed, other emerging issues will be included in the established regional distribution process & distribution list of recipients updated.

SYSTEM DEVELOPMENT

- Goal #7 -

The Regional EMS and Trauma System interfaces with emergency preparedness/disaster planning, bioterrorism and public health.

Objective 1. From July 2009 through June 2013, the Region 7 Healthcare Coalition will maintain multi disciplinary membership from across the region.

Strategy 1. By January, and June annually the Region 7 Healthcare Coalition will review rosters to identify gaps in maintaining a multidisciplinary membership across the region.

Strategy 2. By February and July annually Region 7 Healthcare Coalition will invite representatives from across the region to fill gaps identified in membership.

Objective 2. By December 2009, the Regional Council Board will appoint a council position to attend monthly Region 7 Healthcare Coalition meetings.

Strategy 1. By December 2009, the Regional Council Board structure will identify a Healthcare Coalition representative and the Regional Council Chair will make the appointment.

SYSTEM DEVELOPMENT

- Goal #8 -

Region-wide interoperable communications are in place for emergency responders and hospitals.

Objective 1. By July 2012 the focus group project stakeholders will use information to provide input on developing objectives for the 2013-2017 regional plan.

Strategy 1. By June 2012 Regional Council Board staff will provide the reports to the regional plan development group

Strategy 2. By July 2012 the regional plan development group will develop draft objectives to address any identified gaps in existing prehospital to prehospital, prehospital to hospital, and hospital to hospital communications.

SYSTEM PUBLIC INFORMATION & EDUCATION

Introduction

In the North Central Region, we have recognized the need for comprehensive and region wide information & education distribution. Currently, there is limited consistent distribution of information & communication between regional EMS agencies, regional healthcare facilities and the public at large.

There is a growing need to ensure the public as a whole is engaged and invested in Emergency Medical Services and the ongoing need for quality emergency medical care. EMS systems must be able to assess the needs of the general public. Ongoing system evaluation and feedback from the public perspective is essential to identifying how to better serve our customers, and will help to identify gaps in public knowledge regarding the system. There is a need now more than ever to establish partnerships between EMS and the communities they serve by vesting the community in the system. By providing the Public Information Plan, EMS agencies have the ability to communicate the measurable differences they make in their communities to legislators, local government, the general public and other partners throughout the health care and public service sectors.

This plan addresses the need for:

- **Development and implementation of a regional public information plan.**
- **Evaluation of the public information plan effectiveness and modification as indicated**

- Goal #9 -

There is a regional public information plan consistent with the state public information plan to educate the public about the EMS and Trauma Care System. The purpose of this plan is to inform the general public, decision-makers and the health care community about the role and impact of the Regional EMS and Trauma Care System.

<p>Objective 1. By August 2010 the Regional Council Board will develop a Regional Public Information Plan that parallels the State PIP.</p>	<p>Strategy 1. By October 2009, the Regional Council Chair will appoint a Public Information Plan Workgroup.</p>
	<p>Strategy 2. By February 2010, the Public Information Plan Workgroup will develop a work plan for the Region Public Information Plan.</p>
	<p>Strategy 3. By June 2010, the Public Information Plan Workgroup will draft a Regional Public Information Plan and present it to the Regional Council Board for approval.</p>
	<p>Strategy 4: By August 2010 the Regional Council Board will finalize a Regional Public Information Plan.</p>
<p>Objective 2. By July 2011, Public Information Plan Workgroup will fully implement Public Information Plan across the Region according to Regional Public Information Work Plan.</p>	<p>Strategy 1. By October 2010, the Public Information Plan Workgroup will begin to roll out the Public Information Plan to regional stakeholders through the regional website.</p> <p>Strategy 2: By July 2011, the Regional Public Information Plan will be rolled out to all identified recipients.</p>

There is no Regional Plan goal #10

SYSTEM FINANCE

Introduction

In the North Central Region, we have identified existing gaps in our current system that impact leadership management and the ability to identify true costs of providing patient care. We recognize these gaps must be addressed in order to garner sufficient resources to continue support of planning, implementation, delivery and ongoing management of administrative and clinical components in delivering quality patient care to the community.

Developing administrative skills and leadership at the local agency level is essential to maintaining a viable system financially. The ability for the Emergency Medical Services

System to report on benchmarks may directly affect the ability to sustain reimbursement for services.

The system has to be able to communicate the value of Emergency Medical Services to the general public, to state and local elected officials and to other parts of the healthcare system in order to ensure that Emergency Medical Services is supported financially by its partners and end users. We must be able to determine the measurable difference we make in the community and communicate that to decision makers in a way that they can understand. Future funding will depend on our ability to function with this level of system evaluation and feed back and the ability to communicate the value to others.

The system must be able to identify the true cost and resources necessary to deliver Emergency Medical Care; they must have accurate accounting systems and programmatic reports that document the essential nature of the services provided in order to maintain adequate funding sources

Many of our hospitals currently have at least a limited ability to perform system evaluation through a CQI program and make system adjustments as well as report on established benchmarks. Our Prehospital Emergency Medical Service Organizations are not currently capable of this. We have identified that this is a system gap that could lead to barriers in the near future for these organizations to maintain their current reimbursement of Medicare and Medicaid funding.

Within the July 2009 – June 2012 North Central Region Plan, we have identified many system weaknesses, and strategies for accomplishing measurable improvement in these areas. Current funding for the Regional Council to commence the work of the plan now and in the future is growing inadequate to provide the coordination, facilitation and oversight within the system and ensure efficiency and meaningful progress. It will become imperative to identify and secure further funding sources to continue to have positive impact on regional system weaknesses and gaps. Pursuing other funding sources will require regional network partners within the whole system of EMS and Trauma Care to continue to provide services to the public.

This plan addresses the need for:

- **Developing a process for providing information to prehospital agencies on funding**
- **Establishing ongoing funding for the work of the Regional Council**

- Goal #11 -	
There is consistent and sustainable funding to ensure a financially viable regional EMS and Trauma Care System.	
Objective 1. By January 2010, the Regional Council Board will establish an on-	Strategy 1. By December 2009, the Regional Council will determine how to use regional website for distributing information regarding prehospital and

<p>going system distributing information about prehospital EMS and Trauma system funding.</p>	<p>trauma system funding.</p>
<p>Objective 3. By August 2011, The Regional Council Board will develop a long term funding plan to support Regional EMS & Trauma Council work.</p>	<p>Strategy 2. By January 2010 the regional website will include information about EMS and Trauma System funding.</p>
	<p>Strategy 1. By December 2009, the Regional Council Chair will appoint a Funding Plan Workgroup to explore long term needs and recommend a plan for securing long term funding.</p>
	<p>Strategy 2. By February 2010, the Funding Plan Workgroup will explore the use of professional grant writer(s) to support regional council work.</p>
<p>Strategy 3: By August 2011, the Funding Plan Workgroup will develop a Funding Plan to present to the Regional Council Board.</p>	

CLINICAL COMPONENTS

INJURY PREVENTION & CONTROL

Introduction

The North Central Region has made great strides in developing a comprehensive network of injury prevention partners and establishing partner coalitions. Our target areas for continued emphasis are childhood injuries and senior falls prevention.

Each county in our region has an active and vital Safe Kids coalition/chapter that are addressing the child passenger safety, water safety/drowning prevention and educating parents on best practice prevention methods. Through these Safe Kids networks, North Central Region has 15 PFD loaner boards, 3 active Child Passenger Safety teams and involve public health, private healthcare facilities, law enforcement, marine patrols, fire, EMS, traffic safety coordinators, Tribal and community health as well as local community volunteers to assist in implementing these comprehensive safety and injury prevention programs.

Senior Falls Prevention has expanded rapidly in our region with the formation of community coalitions and education efforts. Chelan & Douglas County is served by the Lifetime Wellness Coalition and Grant County has the Get Health, Get Fit coalition to address wellness and falls prevention in the senior population. These coalitions provide community education forums to our senior populations; Stay Active and Independent for Life exercise classes and continue to increase participant numbers as quickly as new instructors are added. The coalitions include partners from healthcare facilities, assisted living and full time nursing facilities, EMS, community foundations, public health and Retired Senior Volunteer Program (RSVP) of NCW. RSVP of NCW through their dedicated VISTA position for senior falls, are actively gathering Okanogan county partners to further the emphasis in our northern county.

This plan addresses the need for:

- **Continuing support of established injury prevention groups and their efforts to reduce unintentional injuries through best practice programs**
- **Continuing regional participation in state IPPE meetings**

Participating in the Statewide Injury Prevention project

- Goal #12 -

INJURY PREVENTION AND CONTROL:

Preventable/premature death and disability due to injury is reduced through targeted injury prevention activities and programs.

<p>Objective 1. Annually, as funding is available, the Regional Council Board will contract with regional Safe Kids and Senior Falls Prevention coalitions to provide injury prevention programs.</p>	<p>Strategy 1. By October annually, Regional Council staff will contact injury prevention partners to secure contract agreements.</p>
	<p>Strategy 2. Bi-annually, contracted injury prevention partners will provide Regional Council staff with program activities reports and accomplishments.</p>
<p>Objective 2. During July 2009 – June 2013, Regional Council IPPE Coordinator will implement the statewide IPPE PI&E project in the region.</p>	<p>Strategy 1: During July 2009 – June 2013, the Regional Council IPPE Coordinator will distribute IP&E information and templates provided by Washington State DOH to regional IPPE partners in participation of statewide IP&E project.</p>

PREHOSPITAL

Introduction

Region wide prehospital CQI does not currently exist. MPD QI is done on a county by county basis. No patient care benchmarks have been set and MPD QI revolves mostly around run review. We need to develop the ability for current practices to be measured against benchmarks and evaluated continuously to ensure progress towards set system goals. The ability to adjust practices appropriately in order to achieve set goals for patient outcomes is essential in the further development of prehospital care.

Adjustment of training programs, patient care protocols, and regional Patient Care Procedures and County Operating Procedures based upon identified system needs for improvement and benchmarking for success would drastically change the ability to affect patient care in an effective and measurable way. We need to create region wide prehospital CQI to better allow for integration of what is currently thought of as the Regional Hospital QI (Regional QI) with the prehospital system in the future.

BLS OTEP is coordinated regionally in our system. There is currently no feedback loop that allows for us to measure the effectiveness of the training and whether or not the

expected outcomes of the program are achieved. We will work over these next few years to improve our Training and Education CQI to be able to provide continuous feedback on prescribed measures for success and allow us to make adjustments to the program in a timelier manner in order to be achieving program success on an ongoing basis.

Historically, the Regional Council has provided funds within the budget to ensure that there is access to ongoing training, specifically for rural-volunteer providers throughout the North Central Region. The Regional Council feels it is important to continue to assess training and education needs and determine how to most effectively and efficiently support ongoing education for prehospital providers in our region. The Regional Council Board will continue to support this component in our system, but in the coming years will better utilize our annual Prehospital agency survey in conjunction with a system analysis, to help determine how these funds can make the most meaningful impact on our system through training and education.

This plan addresses the need for:

- **Developing and evaluating a region wide prehospital CQI process**
- **Prehospital Cardiac PCPs**

Continued support of prehospital education and training based on standardized procedure

- Goal #13 -	
There is a sustainable region-wide prehospital EMS system utilizing standardized, evidence- based procedures and performance measures that address both trauma and medical emergencies.	
Objective 1. County Medical Program Directors (MPD's) will use Continuous Quality Improvement to make county level system adjustments that improve patient outcomes by January 2013.	Strategy 1. By April 2011 County MPD's will have access to County wide WEMIS data to determine their local county system status on an ongoing basis
	Strategy 2. By October 2011, MPD's will use appropriate state Outcomes TAC benchmarks in the local county system.
	Strategy 3. By January 2013, MPD's will be using available local data to measure performance against benchmarks.
Objective 2. By May 2013, the Regional Council Board will establish a CQI program for BLS OTEP sponsored by the North Central Region.	Strategy 1. By December 2010, regional Training & Education Committee members, regional EMS evaluators will coordinate and provide one (1) skills check off event in each county of the region.
	Strategy 2. By March 2012, the regional Training & Education Committee will provide MPD's with a report identifying areas of weakness assessed at the county skills check off event.
	Strategy 3. By June 2012, the regional Training & Education Committee will develop an action plan for

	<p>areas of weakness identified at the county skills check off events.</p> <p>Strategy 4. Quarterly from June 2012 through May 2013, the Training and Education Committee will report to the Regional Council Board and County MPD's on BLS OTEP training and skills event.</p>
	<p>Strategy 5: By April 2013, the Training and Education Committee will review adequacy of current CQI strategies and determine the plan for future CQI</p>
<p>Objective 3. By October annually, the Regional council will determine its education & training focus and allocate funding, as available, to support prehospital education and training within the regional system that is based on its standardized procedure.</p>	<p>Strategy 1. By April, annually the Regional Council Board will survey agencies to determine perceived training and education needs.</p> <p>Strategy 2. By July, annually the Training and Education Committee will review system needs based upon current system analysis and present a recommendation for the most efficient and effective way to support prehospital training and education throughout the region.</p> <p>Strategy 3. By October, annually the Regional Council Board will determine funding allocation for Prehospital Training and Education support within the fiscal year budget.</p>

ACUTE HOSPITAL

Introduction

The North Central Region has 11 designated trauma care services that provide a network of patient care for trauma. Central Washington Hospital is the highest designated trauma facility as a Level III and is centrally located in the region in Wenatchee. Patients requiring specialty trauma care that is unavailable (certain methods of orthopedic injury fixation, burn care, head injuries and spinal cord injury) are transferred to either the Level II facilities in Spokane or the Level I facility in Seattle.

The identified gaps in the provision of trauma care services within the North Central Region are: lack of access to timely critical care transport, both air and ground; lack of availability of skills maintenance/education courses for rural hospital staff; and lack of neurosurgery services. Unfortunately, the gaps of neurosurgery and critical care transport are not feasible for the North Central Region to adequately address. These gaps will

continue to be of consideration when establishing transfer guidelines and trauma patient care procedures.

At this time, the min/max number of designated trauma services has not been met. The North Central Region is in need of one Level II trauma facility, one Level III trauma facility and currently has two more level IV facilities than what has been approved.

LEVEL	STATE APPROVED		CURRENT STATUS
	MIN	MAX	
II	1	1	0
III	2	2	1
IV	4	7	6
V	3	3	3
IIP	0	0	0
IIIP	1	1	1

The Regional Trauma Continuous Quality Improvement Committee, led by Central Washington Hospital provides the forum for pre-hospital providers, medical program directors, trauma directors and trauma physicians to discuss and address on-going emergency service and trauma system needs in the North Central Region.

Reflected in the objectives and strategies listed, this trauma services network continues to strive for highest quality patient care through collaboration by establishing interfacility transfers in accordance with established guidelines from Department of Health and American College of Surgeons, increasing rural pre-hospital and hospital provider skill levels through training, as well as participating in and sharing information from CQI and regional meetings identifying trauma system needs of the region.

This plan addresses the need for:

- **Continuing region wide stakeholder involvement in trauma designation**
- **Reviewing interfacility transfer guidelines in accordance with DOH & ACS criteria**

Continuing Regional Continuous Quality Improvement Committee involving pre-hospital agencies and hospital facilities.

Establishing an information distribution system for trauma care issues.

- Goal #14 -	
There is a sustainable region-wide system of designated trauma services that provides appropriate capacity and distribution of resources to support high-quality trauma patient care	
Objective 1. Annually by December, the Regional Council will collaborate with Central Washington Hospital	Strategy 1. Annually, by October the Regional Council in partnership with Central Washington Hospital will invite all appropriate parties to a trauma designation and trauma care needs meeting.

<p>to host a Trauma Summit meeting that brings together hospital administrators, designees and interested parties to discuss trauma care designation and trauma care needs through out the region.</p>	<p>Strategy 2. Annually by December, conduct the Trauma Summit meeting at the identified location in the region.</p> <p>Strategy 3. Annually by January, a comprehensive report of needs identified at the Trauma Summit meeting will be distributed to regional CQI committee members and other stakeholders.</p>
<p>Objective 2. Annually by December, Regional CQI Committee will review interfacility transfer guidelines between all regional designated trauma facilities to provide guidance in ensuring that agreements meet current Department of Health and American College of Surgeon Guidelines through review and providing models if needed.</p>	<p>Strategy 1. Annually by June the Regional CQI Committee will facilitate the review and update of interfacility guidelines agreements in concert with the Regional CQI Plan.</p> <p>Strategy 2. Annually by December, the Regional Council will review and update the current Patient Care Procedure for Interfacility Transfer to ensure it is consistent with Department of Health and American College of Surgeon Guidelines.</p>
<p>Objective 3. By December annually, regional CQI Committee will identify facility staff training needs and partner with Regional Council to provide training opportunities to meet identified needs.</p>	<p>Strategy 1. By December annually, Central Washington Hospital and the Regional Council will partner to provide a combined hospital facility trauma personnel and EMS provider training.</p>

PEDIATRIC

Introduction

There are limited pediatric specialists within our system regionally. In light of this, our region must define the best way to accomplish the task of ensuring appropriate and quality care for pediatric patients.

Creating a system that takes advantage of available resources in order to care for pediatric patients in the most appropriate and efficient manner is a challenge in our rural system. This requires taking advantage of evidenced based care models, utilizing technology and resources outside of our region, and ensuring that we have adequate supplies and equipment to care for pediatrics in the prehospital and primary care facility setting. These things must be in place prior to transferring them to the most appropriate facility for definitive care in the timeliest manner.

This plan addresses the need for:

- **Adoption of evidenced based prehospital pediatric protocols in the region**
- **Provision of pediatric equipment and supplies on BLS and ALS response units to AAP/ACEP standards**
- **Implementation of DOH Pediatric Consultation and Transfer Guidelines in hospitals**

- Goal #15 -

There is a sustainable region-wide EMS and Trauma Care System that integrates pediatric care into the system continuum (prevention, prehospital, hospital, rehabilitation and system evaluation).

<p>Objective 1. By July 2011, County MPD's will update BLS and ALS Pediatric Protocols to be consistent with the evidence based "model" pediatric guidelines developed by the State of WA DOH Pediatric TAC.</p>	<p>Strategy 1. By June 30, 2011 Medical Program Directors will evaluate current prehospital ALS pediatric care protocols to identify inconsistencies between existing protocols and "model" evidence-based prehospital guidelines established by the State of Washington.</p>
<p>Objective 2. By June 2012, all regional BLS & ALS agencies will receive updated information on required</p>	<p>Strategy 2. By July, 2011 ALS Pediatric Care Protocols will be updated by the Medical Program Directors to be consistent with evidence based "model" prehospital guidelines as established by the WA State DOH Pediatric TAC.</p>
<p>Objective 2. By June 2012, all regional BLS & ALS agencies will receive updated information on required</p>	<p>Strategy 1. By June 2012, the updated WAC will be disseminated through regional website.</p>

pediatric equipment and supplies as outlined in WAC.	
Objective 3. By June 2010, Designated Trauma Facilities will integrate the WA DOH Pediatric Consultation and Transfer Guidelines	Strategy 1. By June 2010, The Regional QI Committee will conduct a formal introduction of Pediatric Consultation and Transfer Guidelines.
	Strategy 2. By April 2009, all Designated Trauma Facilities in the North Central Region will review their current Pediatric Transfer Guidelines for compliance with the WA DOH Pediatric Consultation and Transfer Guidelines Template
	Strategy 3. By June 2010, all designated trauma facilities in the North Central Region will provide evidence to the Regional CQI Committee that current Pediatric Transfer Guidelines are consistent with the WA DOH Pediatric Consultation and Transfer Guidelines Template

TRAUMA REHABILITATION

Introduction

The North Central Region has one Level II Trauma Rehabilitation facility located at Wenatchee Valley Medical Center in Wenatchee. Currently, there is an perceived issue of repatriation back to Wenatchee for trauma rehabilitation from Level I & II trauma centers is Rehabilitation needs have not yet been explored as part of regional system planning.

Information about the trauma rehabilitation component of the regional system is not widely disseminated to system participants or stakeholders. Prehospital education and training does not include information about the role or benefits of trauma rehabilitation. Information on the role of Rehabilitation in the continuum of trauma care is not routinely available for communicated to the public.

This plan addresses the need for:

- **Determining Regional Rehabilitation Referral needs**
- **Developing and disseminating public and professional information on rehabilitation in the region.**

- Goal #16 - There is a sustainable region-wide system of designated trauma rehabilitation services that provides adequate capacity and distribution of resources to support high-quality trauma rehabilitation care.	
Objective 1. By October 2010, the Regional Council	Strategy 1. By October 2009, Regional Council Chair will establish a Rehabilitation Workgroup.

will establish a Rehabilitation Workgroup to assess regional needs and current referral patterns of Trauma Rehabilitation patients.	Strategy 2. Regional council will identify a regional representative to attend the State Rehabilitation TAC meetings.
	Strategy 3. By October 2010, Regional Rehabilitation workgroup will report to Regional Council on regional rehabilitation issues.
Objective 2. By June 2012 the Rehabilitation Workgroup will develop public and professional education information on the benefits of trauma rehabilitation in the North Central Region EMS and Trauma Care System for dissemination in the region	Strategy 1. By January 2012, the Rehabilitation Workgroup will develop an educational component for prehospital and trauma facility distribution, and present it to the Regional Council Board for distribution via the Information Distribution System.
	Strategy 2. By March 2012, the Rehabilitation Workgroup will develop public education materials on trauma rehabilitation for distribution to both public and private entities and present it to the Regional Council Board. Strategy 3. By June 2012, Rehabilitation Workgroup will distribute trauma rehabilitation information via the Information Distribution System.

SYSTEM EVALUATION

Introduction

Currently the North Central Region does not have consistent, comprehensive EMS data submittal from all EMS agencies and has not established region wide system improvement. The ability of continuous system improvement hinges upon individual organizations within the system to collect data, evaluate data, monitor trends and identify outliers. A formal system evaluation process that includes performance improvement measures for clinical care, operations and customer satisfaction across the Emergency Medical System is essential for our region to make system improvements that result in measurable improvements for patients across the region. Making this model a part of our systems culture is essential to ensuring that response, treatment and transport, acute care and rehabilitation are the best they can be within the confines and limitations of our system.

This plan addresses the need for:

- **Continuous system improvement involving data collection, data evaluation, monitoring of trends and identifying outliers**
- **A multidisciplinary CQI program that can evaluate the entire system of care for trauma patients**

- Goal #17 -

The Regional EMS and Trauma Care System has data management capabilities to support evaluation and improvement.

<p>Objective 1. By June 2013, increase by 80% the licensed EMS agencies in our region submitting data to WEMISIS.</p>	<p>Strategy 1. By December 2009, the Regional Council will survey existing data regarding current WEMISIS participants to determine agencies who are not currently submitting data to WEMISIS.</p>
	<p>Strategy 2. By February 2010, utilize existing WEMISIS mentors to further remove barriers to participation and educate agencies who are not currently participating.</p> <p>Strategy 3. By June 2011, the Regional Council will survey existing data regarding current WEMISIS participants and use information in development of 2012-2017 Plan objectives.</p> <p>Strategy 3. By June 2012 the Regional Council will survey existing data regarding current WEMISIS participants and use information in development of 2013-2017 Plan objectives.</p>
	<p>Strategy 3. By June 2012, the Regional Council will survey existing data regarding current WEMISIS participants and use information in development of 2013-2017 plan objectives.</p>

SYSTEM EVALUATION

- Goal #18 -

The EMS and Trauma Care System has comprehensive, data-driven quality improvement (QI) processes at the local and regional levels.

<p>Objective 1. By March 2012, the Regional Council will develop Region specific system performance measures or adopt state system performance measures to implement them to monitor regional system performance.</p>	<p>Strategy 1. By March 2011, Regional Council committees will review available state developed system performance measures and determine if any can be adopted for use in the regional system.</p>
	<p>Strategy 2. By January 2011, the Regional Council committees will develop system performance measures specific to the regional system as needed.</p>
	<p>Strategy 3. By March 2012, the Regional Council will select initial system performance measures and implement them to begin to monitor the system performance of the regional system.</p>

EMERGENCY CARDIAC & STROKE SYSTEM

- Goal #19 -

Regional systems of care are coordinated with the statewide emergency cardiac and stroke system to improve and enhance emergency cardiac and stroke care, and to minimize the human suffering and costs associated with preventable mortality and morbidity.

<p>Objective 1. By June 2011, the regional council in collaboration with regional MPDs will develop and implement regional patient care procedures for emergency cardiac and stroke care based on the Washington State Prehospital Acute Coronary Syndrome Triage Destination Procedure.</p>	<p>Strategy 1. By October 2010, the regional council will develop PCPs for regional MPDs to review.</p>
	<p>Strategy 2. By December 2010, the regional council will review comments on the PCP's and make necessary revisions.</p>
	<p>Strategy 3. By March 2011, the regional council will present the ACS PCP to DOH.</p>
	<p>Strategy 4. By June 2011, ACS PCPs will be rolled out and implemented in North Central Region.</p>

APPENDICIES

Appendix 1. Approved Min/Max of Verified Trauma Services

Approved Min/Max numbers of Verified Trauma Services by Level and Type by County (repeat for each county)

Chelan County:

Chelan County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	4	6	5
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	2	4	2
	Amb – ILS	0	0	0
	Amb - ALS	4	4	4

Douglas County:

Douglas County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	1	5	1
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	3	4	3
	Amb – ILS	0	0	0
	Amb - ALS	0	0	0

Grant County:

Grant County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	4	11	5
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	4	8	5
	Amb – ILS	0	5	1
	Amb - ALS	1	4	4

Okanogan County:

Okanogan County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (Total # Verified for each Service Type within the whole county)
	Aid – BLS	1	5*	4
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	3	4**	3
	Amb – ILS	0	1	1
	Amb - ALS	1	2	2

*Aid – BLS target area Enias Valley

**Amb – BLS target area Tonasket

Appendix 2. Trauma Response Areas

Trauma response areas by county

Chelan County

Chelan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that can be mapped and encompass the entire trauma response area – may use GIS as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	#1	Current Boundaries of Chelan County Fire District #1 Proper	A1, F2
	#2	Current Boundaries of Chelan County Fire District #3 Proper	A1, F3
	#3	Current Boundaries of Chelan County Fire District #4 Proper	F3
	#4	Current Boundaries of Chelan County Fire District #6 Proper	A1, F3
	#5	Current Boundaries of Chelan County Fire District #8 Proper	D1, F3
	#6	Current Boundaries of Chelan County PHD #2 Proper	F1
	#7	Current Boundaries of City limits of Cashmere Proper	D1, F2
	#8	Current Boundaries of City limits of Wenatchee proper	A1, F2
	#9	Town of Stehekin and surrounding wilderness area	F2
	U-1	East border encompasses NF7340, NF7322. NW Border encompasses Colchuck Lake, 8 Mile Lake and westerly riverbed. Northern most border includes NF7601, NF11 and borders the Southern border of trauma response area U-2. Northeastern border follows the southwestern border of trauma response area #4. Eastern border, borders western border of U-17, encompassing Sand Creek Road, the westerly border of trauma response area U-19, including Devils Gulch Trail.	F3

	U-2	Western border includes Trout Lake heading North to Donell Lakes. Northern border includes trauma response area U-4's southern border, Chwaukum Lake, Winton Road, Carl Road, Hill Street. Eastern Borders include the Western boundary of trauma response area #2 and trauma response area #3, including Alder Street.	A1, F3
	U-3	Southwest border follows trauma response area U-2 Northwest boundary, including NF125, and Derby Canyon. Northwest border encompasses trauma response area U-5 SE border, including NF020, NF 7503 NF 7500. Eastern Border includes trauma response area U-10 Western border, including Ollala Canyon road, NF7410.	A1, F3
	U-4	Western border includes upper Mill Creek Road, Yodelin Place, Smithbrook Road, North to the eastern end of the Little Wenatchee River Bed, encompassing NF400. Northwestern border includes 65 Road, NF6506, NF6400, NF6200, Eastern border includes NF1408. Southeastern border includes NF1409, Chikamin Ridge Road, and includes Northwestern boundary of trauma response areas U-6 and trauma response area U-9. Southeastern boundary includes NF6208, NF6102, NF300 and borders the trauma response area U-12 Northwestern boundary. Southern boundary includes CR22, Bretz Road, Riche Road and borders the trauma response area U-2 North Boundary.	F3
	U-5	Western Boundary follows the trauma response area #2 and trauma response area #3 eastern boundaries. Northern boundary includes NF6103 eastern boundary borders the western trauma response area U-12 boundary, including NF315, NF7801, NF7502. Southern boundary includes NF7502, NF7500, NF7503, NF7401 and borders the trauma response area U-3 NW Boundary.	F3

	U-6	West boundary includes NF1409, and borders the NE trauma response area U-4 boundary. Northern boundary includes the northern Entiat River bed, encompasses NF5100, Hope Ridge Road, NF1433, NF112 and the trauma response area U-16 southern border. Eastern border includes NF1443, NF116, NF1448, NF211, Johnson Creek Road and borders the west trauma response area U-7 border and the trauma response area #5 west border. South border includes north border of trauma response area U-8 and NF5300, NF5320, NF114. The Southwestern border encompasses the bordering northern section of trauma response area #4, to include NF5390, NF312, NF5503.	F3
	U-7	Western border includes NF8410, NF118, NF114, Shady Pass Road, and the trauma response area U-6 eastern border. North border includes Shady Pass Road, NF5900, NF127 and the SE corner of trauma response area U-16, Eastern border includes NF127. NF233, and the western border of trauma response area #6. Southern border includes NF1448, and the southeastern border of trauma response area U-6.	F1
	U-8	Western border encompasses the section of NE trauma response area #4, including NF5305, NF5310, County Road 287. The Northern border includes trauma response area U-6 southern border, NF114, NF5320, Mudd Creek Road and County Road 63. Eastern Border includes trauma response area #5's western border from County road 63 to Tiny Canyon Road. Southern border follows the NE section of trauma response area #4, including Tiny Canyon Road, NF302.	D1, F2
	U-9	Southwest border encompasses NF500 and the trauma response area U-12 NE border, Western border encompasses Mad Lake and The trauma response area U-4 NE border. Northern border includes the trauma response area U-6 S border and eastern border is the NW section of the trauma response area #4, including NF5702, NF5700, NF400, NF800.	D1, F2

U-10	West Border includes the east border of trauma response area U-3, NF7410, Ollala Canyon Road, North Fork Road, Northern border encompasses a portion of the trauma response area U-12 south border, including NF11. Eastern border, borders trauma response area U-11 West border, NF5200, Orchid Street and the northwestern section of trauma response area #7. South border includes the north section of trauma response area #7 including Hay Canyon and NF7410.	D1, F2
U-11	West border includes the east border of trauma response area #7, NF7415, Orchid Street, North border includes NF6210, South border of trauma response area U-12 and northern section of trauma response area #4, including Mills Canyon Road. Eastern border is the west boundary of trauma response area #4, including Swakane Road. Southern border includes northern trauma response area #8, including Burch Mtn Road.	A1, D1, F2
U-12	Western border includes east border of trauma response area U-5, NF6102, NF300, NF6104. North border is the south boundary of trauma response area U-9, including NF5700. Eastern border includes the western boundary of trauma response area #4 including Mad River road, NF110, Roaring Creek Road. Southern border includes the North boundary of trauma response area U-11 and trauma response area U-10, including NF6210.	D1, F2
U-13	West border is the trauma response area #5 east border. North border is the trauma response area #6 south border, including Foot Trail. East border follows the western border of trauma response area #6. South border is the northern border of trauma response area #5.	F1
U-14	West border is the eastern shore of Lake Chelan from the North section of trauma response area #6 to the south border of trauma response U-15. NW border includes the trauma response area U-15 border and NF8200. NE border is the County Line, including NF8220, NF3107, NF430, NF3107, NF8210. South border is the north section of trauma response area #6 including NF8045	F1

	U-15	West and southwest border is the eastern shore of Lake Chelan from trauma response area U-14 NW border, encompassing the entire trauma response area #9. The Western border follows the Northern shores of Lake Chelan. The Northwest and North borders encompass trauma response area #9. The North and Eastern borders follow the Okanogan County Line encompassing the Sawtooth wilderness area in Chelan County. The Southern border is the Northern border of trauma response area U-14.	F1
	U-16	Western border is the eastern border of ARCA#1. The Northwestern border encompasses Lyman Lake, continues north to the NW corner of trauma response area U-15. The Northern border includes Battalion Lake and the NW border of trauma response area U-15. Eastern border is the south shore of Lake Chelan, including NF112, the southern border includes the northern borders of trauma response area U-7 and trauma response area U-6.	F1
	U-17	Western border includes Sand Creek Road, Tripp Canyon Road, and the eastern border of trauma response area U-1. Northern and eastern border is the southern and western borders of trauma response area #7. Southern border includes GR11 and the SE border of trauma response area #7.	D1, F2
	U-18	Western borders area the eastern boundary of trauma response area #7, including Mission Creek Road, Northern borders area the southern borders of trauma response area #7, including Yaksum Canyon Road. The eastern border is the southern border of trauma response area #7. The Southern borders are the northern border of trauma response area U-19, including Horse Lake Road.	D1, F2
	U-19	Western border includes NF9712, Devils Gulch and the Eastern border of trauma response area U-1. Northern border includes the southern border of trauma response area U-18 and the southern border of trauma response area #7. Eastern border includes the western border of trauma response area #1 and trauma response area #8, NF7101, upper reservoir loop road, Stemilt Loop Road, Upper Hedges Road, Jump Off Road, the southern borders are the county line, including Ingersoll Road, Schaller Road, and Naneum Ridge Road as well as NF330, NF9712.	A1, F2

*Key: For each level the type and number should be indicated

Aid-BLS = A
Aid-ILS = B
Aid-ALS = C

Ambulance-BLS = D
Ambulance-ILS = E
Ambulance-ALS = F

Explanation: The *type and number* column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the **total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a county; it may be a larger number in Trauma Response Area table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

Douglas County:

Douglas County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that can be mapped and encompass the entire trauma response area – may use GIS as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	# 1	Current Boundaries of Douglas County Fire District #1 Proper	D1, F1
	#2	Current Boundaries of Douglas County Fire District #2 Proper	A1, F2
	#3	Current Boundaries of Douglas County Fire District #3 Proper	D2
	#4	Current Boundaries of Douglas County Fire District #4 Proper	A1, F3
	#5	Current Boundaries of Douglas County Fire District #5 Proper	D1, F1
	#6	Current Boundaries City of Bridgeport Proper	D1, F1
	U-1	Encompassed by response area #1 to the West, North and East borders. Southern border is the north west border of trauma response area U-9 including the south Jamison Lake Road.	D1, F2
	U-2	Western and Southern border is the east border of trauma response area U-3, North border is the south border of trauma response area #6, East border is the west border of trauma response area #3,	D1
	U-3	West border is the Douglas County Line, including Bailey Way. North border is the South border of U-10, including CR73960, Grange Road NE, Moe Road NE. East border is the county line and west border of trauma response area #6. Southern border is the north border of trauma response area #5, including CR72300	E1
	U-4	Southwest and North borders area encompassed by trauma response area #1. The east border is encompassed by trauma response area U-9.	None

	U-5	West border is the east border of trauma response area U-6. North border is the south border of trauma response area #1, including Pondosa Drive. Northern border is encompassed by trauma response area #1 and trauma response area U-9. The East border is the southwest trauma response area U-9 boundary, and includes Road C SE. The South border is the North border of trauma response area #10 and the north border of trauma response area U-8, including Road 12 SE, Douglas/Grant Shared and Grant County Route.	D1, F1
	U-6	Southwest border is the NE boundary of trauma response area U-7. North border is the South border of trauma response area #1. East border is the west trauma response area U-5 border. South border is the north border of trauma response area U-8, including Road 24 NW.	D1, F1
	U-7	Southwest border is the NE border of trauma response area #2. NW border is the SE border of trauma response area #1. NE Border is the SW border of trauma response area U-6, and the SE border is the NW border of trauma response area #1.	D1, F2
	U-8	West border is the east border of trauma response area U-7. North border is the south border of trauma response area U-6 and trauma response area U-5 including Road 24 NW. The east border is the northwest border of trauma response area #10. The south border is the north border of trauma response area #1.	D1, F1
	U-9	West border includes Road C SE, and the west borders of trauma response area U-5, trauma response area U-4 and trauma response area U-1. The North border includes the southern border of trauma response area #5, including Road 6 NE, St Andrews West road NE, St. Andrews East Road NE, Road O NE. The East and SE borders are the Grant County Line, including Road 6 SE. South border follows the Grant County Line, including Road 24 NW.	D1

	U-10	To the West, East and North borders the Okanogan County Line, including Chambers Road. South border follows the North border of trauma response area U-3, including CR74690 and CR73960.	E1
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*Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Explanation: The *type and number* column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the **total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a county; it may be a larger number in Trauma Response Area table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

Grant County:

Grant County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	#1	The current boundaries of Grant County Fire District #3 proper	A1, D2, F2
	#2	The current boundaries of Grant County Fire District #4 proper	A1, E1, F1
	#3	The current boundaries of Grant County Fire District #5 proper	D1, E1, F1
	#4	The current boundaries of Grant County Fire District #6 proper	D3
	#5	The current boundaries of Grant County Fire District #7 proper	A1, D2, E1, F1
	#6	The current boundaries of Grant County Fire District #8 proper	D1, E1, F1
	#7	The current boundaries of Grant County Fire District #10 proper	A1, F1
	#8	The current boundaries of Grant County Fire District #11 proper	D1, E1, F1
	#9	The current boundaries of Grant County Fire District #12 proper	D2, E1, F1
	#10	The current boundaries of Grant County Fire District #13 proper	D1, E1, F1
	#11	The current boundaries of Grant County Fire District #14 proper	D1, E1, F1
	#12	The current boundaries of Grant County Fire District #15 proper	D1, E1, F1
	#13	The current boundaries of City Limits of Coulee City proper	D1, E1, F1
	#14	The current boundaries of City Limits of Ephrata proper	F1
	#15	The current boundaries of City Limits of Grand Coulee proper	D1, E1, F1
	#16	The current boundaries of City Limits of Moses Lake proper	E1, F1

	#17	Port district boundaries, Grant County International Airport & Surrounding Industries	A1, E1, F1
	U-1	Northrup Canyon area between Grant County Fire District #14 South & Grant County Fire District #6 East	D1
	U-2	Banks Lake North, South of Grant County Fire District #14 – Section 16 North, West of Grant County Fire District #6, North of Million Dollar Mile.	D1
	U-3	Banks Lake South of Coulee City Area, Section 26: Township 26N: Range 28E, South and West of Grant County Fire District #6 to Douglas County Line.	D1
	U-4	Sun Lakes West and North, west to Grant County Fire District #7 – Over to County Line; West of Park Lake, West of Blue Lake	A1, D2, E1, F1
	U-5	West Lake Lenore.	A1, D2, E1, F1
(3 Devils Grade Area)	U-6	North of Grant County Fire District #7 boundary, along shoreline of Lake Lenore, Along Grant County Fire District #7 boundary, over to county line.	A1, D2, E1, F1
	U-7	South of Road 24 NW West to County line. 1 mile south, 2 miles west, 1 mile south, 4 miles east to Grant County Fire District #13 boundary. West 2 miles to County Line (Road 24 NW)	A2, F1
	U-8	Between Grant County Fire District #7 and Grant County Fire District #13: North of Road 20 NE	D2, E1, F1
	U-9	East of Grant County Fire District #7; North of Grant County Fire District #13; Canal Bank NE; South of Road 19NE; South of E SW;	D2, E1, F1
	U-10/10A	South and East of Grant County Fire District #12 to County Line. North of Grant County Fire District #5, North of Road 12 NE; West of County Line; North to Road 16 NE over to V NE, 1 mile north – 1 mile west – 3 miles south – 2 miles west – south to Road 12 NE.	D2, E1, F1

	U-11	East of Grant County Fire District #5, North of Grant County Fire District #13, East of Grant County Fire District #3, West of Potholes Reservoir, West Potholes Reservoir edge to 4 miles, One Piece is North and East of Grant County Fire District #11/East of Potholes. West – 3 miles south.	D1, E1, F1
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*Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D

Aid-ILS = B Ambulance-ILS = E

Aid-ALS = C Ambulance-ALS = F

Explanation: The *type and number* column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the **total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a county; it may be a larger number in Trauma Response Area table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

Okanogan County:

Okanogan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that can be mapped and encompass the entire trauma response area – may use GIS as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	#1	The current boundaries of Okanogan County Fire District #1 proper	D1
	#2	The current boundaries of Okanogan County Fire District #2 proper	D2
	#3	The current boundaries of Okanogan County Fire District #3 proper	A1, F1
	#4	The current boundaries of Okanogan County Fire District #4 proper	D1
	#5	The current boundaries of Douglas/Okanogan County Fire District #15 proper	E1
	#6	The current boundaries of Aero Methow Rescue Response area	A1, F1
	#7	The current boundaries of Okanogan County Fire District #7 proper	A1, F1
	#8	The current boundaries of Okanogan County Fire District #8 proper	A1, D1, E1, F1
	#9	The current boundaries of Okanogan County Fire District #9 proper	A1, F1
	#10	The current boundaries of Okanogan County Fire District #10 proper	A1, D1, E1, F1
	#11	The current boundaries of Okanogan County Fire District #11 proper	D1
	#12	The current boundaries of Okanogan County Fire District #12 proper	D2
	#13	The current boundaries of the Colville Tribal Reservation within Okanogan County	D2
	U-1	East Boundary: West boundary of trauma response area #7, North Boundary: Encompasses Chewiliken Road, east to NF125, Southeast through NF200 and NF30. South Boundary is a portion of the North border of trauma response are #13.	A1, F1

Okanogan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that can be mapped and encompass the entire trauma response area – may use GIS as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	U-2	West border of trauma response area #4, Encompassing areas to the North, Longaneker road. North Western Boundary includes Talkire Lake Road, heading southwest, along vehicle road. Southern Boundary along Northern boundary of trauma response area U-1,	A1, D1, E1, F1
	U-3	Aeneas Valley	D1
	U-4	Western boundary includes NF3820 along Cecile Creek Road, heading north to Chopaka Lake, north to Canadian Border. Northwest border encompasses Chopaka Road heading south to Palmer Lake, Southwest to Palmer Mt. Road, Southwest to Wannacut Lake Road, heading west to trauma response area #1 western border. Continuing south to trauma response area #4 westerly border. South boundary encompasses Silver Star Mine Road, Horse Springs Coulee Road and the Northern Border of trauma response area U-6	A1, D1, E1, F1
	U-5	West border meets the western border of trauma response area U-4. Northern border encompasses Loomis/Oroville Road and North to the Canandian Border. Eastern border is the western border of trauma response area #1. Southern border includes trauma response area U-4's Northern border.	D1

Okanogan County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that can be mapped and encompass the entire trauma response area – may use GIS as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	U-6	Western border includes NF3820 and reaches to trauma response area U-7's eastern border. Northern border encompasses trauma response area U-4's southern border including Sinlahekin Road. Eastern trauma response area U-6 border meets trauma response area #4's western border, trauma response area #7, trauma response area #9 and trauma response area #3 eastern borders. Southwestern border includes Old 97 Highway, Monse South Road, and follows the Columbia River south to trauma response area #5 Northern Border. Follows Okanogan County Line to the west encompassing NF4330 to FS Trail 408-North to the southern border of trauma response area #6.	A2, D1
	U-7	Western border meets trauma response area #6 eastern border, North Border is the Canadian Border, Western Border encompasses eastern border of trauma response area U-4, including NF3820, eastern border of trauma response area U-6 and eastern border of trauma response area #9, including Medicine Lake, county road 2017, Buzzard Lake Road, Southwest border encompasses trauma response area #3 border including B&O west road, south border includes Davis Canyon Road, NF115 over to NF325.	A3, F2
	U-8	Responded to out of Ferry County. Unsure the defined boundaries by State Mapping	D1
	U-9	City Limits of Twisp	A1, F1

*Key: For each level the type and number should be indicated

Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F

Explanation: The *type and number* column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the **total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a county; it may be a larger number in Trauma Response Area table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

Appendix 3. Min/Max of Designated Trauma Facilities

Approved Min/Max numbers of Verified Designated Trauma Care Services in the Region (General Acute Trauma Services) by level

A: Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services (General Acute Trauma Services)

Level	State Approved		Current Status
	Min	Max	
II	1	1	0
III	2	2	1
IV	4	7	6
V	3	3	3
II P	1	0	0
III P	1	1	1

B: Approved Minimum/Maximum (Min/Max) numbers of Rehabilitation Care Services

Level	State Approved		Current Status
	Min	Max	
II	1	1	1
III*			0

*There are no restrictions on the number of Level III Rehab Services

Appendix 4. Patient Care Procedures

Dispatch of Agencies

North Central Region Patient Care Procedure

Adopted by Regional Council: 04/04/2001

Approved by DOH: 02/13/2002

Revised: May 2008

I) Purpose:

- 1) To provide timely & appropriate care to all emergency medical & trauma patients as identified in WAC 246-976-390
- 2) To minimize “response time” in order to get appropriately trained EMS personnel to the scene as quickly as possible.
- 3) To establish uniform & appropriate dispatch of response agencies
- 4) To utilize Criteria Based EMD trained dispatchers to identify potential Major Trauma incidents & activate the Trauma System by dispatching the appropriate services.

II) Standards

- 1) Licensed aid and/or licensed ambulance services shall be dispatched by trained dispatchers to all emergency medical incidents.
- 2) Verified aid and/or verified ambulance services shall be dispatched by trained dispatchers to all known injury incidents, which meet Trauma Registry Inclusion Criteria.
- 3) All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.

III) Procedure

- 1) The nearest appropriate aid and/or ambulance service shall be dispatched per the above standards as identified in the North Central Region EMS/Trauma Care response area maps, or s defined in local and/or county operating procedures.

IV) Definition:

- 1) Per WAC 246-976-010, “response time” is defined as “the time from agency notification until the time of first EMS personnel arrive at the scene.”
- 2) “Appropriate” is defined as “the verified or licensed service that normally responds within an identified service area.”

V) Quality Improvement

- 1) The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Response Times

North Central Region Patient Care Procedure

Adopted by Regional Council: 04/04/2001

Approved by DOH: 02/13/2002

Revised: May 2008

I) Purpose:

- 1) To define prehospital response times for emergency medical & trauma incidents to urban, suburban, rural and wilderness areas in the North Central Region.
- 2) To define urban, suburban, rural and wilderness response areas.
- 3) To provide trauma patients with appropriate & timely care.

II) Standards:

- 1) All verified ambulance & aid services shall respond to emergency medical & trauma incidents in a timely manner in accordance with WAC 246-976-390
- 2) All licensed ambulance & aid services shall respond to emergency medical incidents in a timely manner.

III) Procedure:

- 1) The Regional Council, with input from prehospital providers and Local Councils, shall identify response areas & times as urban, suburban, rural and wilderness.
- 2) Verified/licensed ambulance & verified/licensed aid services shall collect & submit documentation to ensure they following response times are met or exceeded as established by PCP, COP or WAC 246-976-430.

	Aid Vehicle	Ambulance
Urban	8 minutes	10 minutes
Suburban	15 minutes	20 minutes
Rural	45 minutes	45 minutes
Wilderness	ASAP	ASAP

- 3) Verified aid & ambulance services shall provide documentation on major trauma cases to show the above response times are met 80% of the time.
- 4) County Operating Procedures must meet or exceed the above standards.
- 5) Verified/licensed ambulance & verified/licensed aid are encouraged to set the "Golden Hour" as a goal for wilderness response times.

IV) Definition:

- 1) An agency response area or portion thereof:
 - a) **Urban:** an incorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 & a population density over 2,000 per square mile.
 - b) **Suburban:** an incorporated or unincorporated area with a population of 10,000 to 29,999 or any area with a population density of 1,000 to 2,, per square mile.
 - c) **Rural:** an incorporated or unincorporated area with a total population less than 10,000 or with a population density of less than 1,000 per square mile.
 - d) **Wilderness:** any rural area not readily accessible by public or private road.
 - e) **Agency response time:** is defined as the time from agency notification until the time of first EMS personnel arrive at the scene. (This is defined in WAC and constitutes "activation time" plus "enroute time.")

V) Quality Improvement:

- 1) The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Timely & Appropriate EMS Response

North Central Region Patient Care Procedure

Adopted by Regional Council: 04/04/2001

Approved by DOH: 04/01/2002

Revised: May 2008

I) Purpose:

- 1) To ensure that emergency medical and trauma patients who live in an area that is serviced by two or more ambulance providers, which have the same level of licensure, receive the timeliest & highest level of care that is available.

II) Standards:

- 1) If available, the highest-level “appropriately staffed” ambulance within the designated area shall be dispatched to emergency medical & trauma incidents.

III) Procedure:

- 1) Except when “extraordinary circumstances” exist, the highest level “appropriately staffed” licensed ambulance shall respond to all emergency medical & trauma incidents.
- 2) When a licensed ambulance provider is unable to immediately respond an “appropriately staffed” ambulance to an emergency medical or trauma incident, and there exists another ambulance which is “appropriately staffed” and capable of responding to the incident in a timely manner, then the service that was originally dispatched shall transfer the call to the second ambulance for response.
- 3) This procedure shall only apply to emergency calls received through the county 911-dispatch center.

IV) Definition:

- 1) Extraordinary Circumstances: shall be defined as situations out of the usual when all available ambulances from local licensed ambulance providers are committed to calls for service.
- 2) Appropriately staffed: shall be defined as an ambulance which immediately initiates it’s response to an emergency medical or trauma incident staffed with at least tow crew members which are certified to a level that is commensurate with the standard of care that has been set in the local area (i.e., Paramedic/EMT, ILS-EMT/EMT, EMT.EMT or EMT/1st Responder)
- 3) Highest Level: shall be defined as the service within the response area that has the highest level of certified personnel available, at the time of the call.

V) Quality Improvement:

- 1) The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Helicopter Response

North Central Region Patient Care Procedure

Adopted by Regional Council: 04/04/2001

Approved by DOH: 02/13/2002

Revised: May 2008

I) Purpose:

- 1) To define who may initiate the request for on-scene emergency air medical services and under what circumstances non-medical personnel may request on-scene air medical services.
- 2) To institute a program of continuous evaluation to determine the best utilization of air medical services in our region.

II) Standards:

- 1) Early activation of air ambulance services should be initiated as soon as the medical condition of the patient and scene location/conditions would favor, by at least 15 minutes, air transport of the major trauma or critical medical patient.

III) Procedure:

- 1) Air ambulance services should be used when it will reduce total out of hospital time for a major trauma patient by 15 minutes or more.
- 2) Air ambulance services may be used for medical and non-major trauma patient under special circumstances and only with clearance by medical control.
- 3) Prehospital personnel en route to the scene should make the request to place an air ambulance service on standby, or initiate a request for an on-scene response.
- 4) The call must be initiated through the appropriate medical emergency dispatching agency.
- 5) The helicopter communications staff will always give an approximate launch time, flight time and advise when lifted to the dispatchers requesting services.
- 6) The responding helicopter will make radio contact with the receiving hospital at, or shortly after liftoff from the scene.
- 7) An air ambulance that has been launched or placed on standby can only be cancelled by the highest level of transporting prehospital personnel dispatched to the scene.

IV) Definition:

- 1) Standby: Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from the standby.
- 2) Launch Time: Launch time is the time the skids lift the helipad en route to the scene location.

V) Quality Improvement:

- 1) A regional helicopter response report form for each flight or standby request, including cancelled flights, must be submitted to the QI Committee at the end of each calendar quarter. These will be reviewed, with local input to develop a definition of the most appropriate circumstances for helicopter requests.

Identification of Major Trauma & Emergency Medical Patients

North Central Region Patient Care Procedure

Adopted by Regional Council: 10/23/1998

Approved by DOH: 10/23/1998

Revised: May 2008

I) Purpose:

- 1) To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedures.
- 2) To ensure that all emergency medical patients are transported to the closest most appropriate facility in the shortest time possible.
- 3) To ensure that all major trauma patients are transported to the most appropriate facility capable of meeting the patient's need in accordance with WAC 246-976-370
- 4) To allow the designated facility sufficient time to activate their emergency medical and/or trauma resuscitation team. (See WA 246-976-550 (d).

II) Standards:

- 1) Major trauma patients will be identified in the initial EMS field assessment using the most current State of Washington Prehospital trauma Triage (Destination) Procedures as published by the Department of Health.
- 2) Major trauma patients will be identified by the region's prehospital services and hospitals for the purposes of state trauma registry inclusion using the trauma registry inclusion criteria as outlined in WAC 246-976-430.
- 3) Major trauma patients will be identified for the purposes of regional quality improvement as patients who meet the Trauma System Activation criteria of the most current version of the State of Washington Prehospital Triage Procedures, and the patients who activate hospital resource teams and those who meet the hospital trauma patient registry criteria.
- 4) Patients not meeting the criteria to activate the trauma system will be transported to the closest most appropriate local facility as outlined in local procedures.

III) Procedure:

- 1) The first certified EMS/TC provider to determine that a patient:
 - a) Meets the trauma triage criteria and/or
 - b) Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)
 - c) Needs definitive medical care should contact the nearest appropriate highest designated facility via the H.E.A.R. frequency (or other means as conditions dictate).
- 2) Radio contact with the receiving facility should be preceded with the phrase: "This is a major trauma or major heart alert."
- 3) The receiving facility shall be provided with the following information, as outlined in the Prehospital Destination Tool:
 - a) Identification of EMS agency.
 - b) Patient's age
 - c) Patient's chief complaint or problem.
 - d) If injury, identification of the biomechanics of anatomy of the injury.
 - e) Vital signs
 - f) Level of consciousness
 - g) Other factors that require consultation with medical control
 - h) Number of patients (if more than one)

- i) Amount of time it would take to transport the patient from scene to the nearest appropriate hospital (transport time)
- 4) When determined that a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist or ankle as soon as appropriate.
- 5) Whenever possible, ILS or ALS service should be dispatched to the scene by ground or air as appropriate. If unavailable, rendezvous will be arranged with the highest possible level of care.
- 6) While enroute to the receiving facility the transporting agency shall provide complete report to the receiving hospital regarding the patients status
- 7) All information shall be documented on an appropriate medical incident report (MIR) form approved by the county medical program director.

IV) Quality Improvement:

- 1) The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Interfacility Transfer

North Central Region Patient Care Procedure

Adopted by Regional Council: 10/23/1998

Approved by DOH: 10/23/1998

Revised: May 2008

Revised: February 3, 2010

I) Purpose:

- 1) To ensure that trauma patients receive treatment in facilities that have made a commitment to the provision of designated trauma service.
- 2) To define the referral resources for inter-facility transfers of patients requiring a higher level of care or transfer due to situational inability to provide care.
- 3) To recommend criteria for inter-facility transfer of major trauma patients from receiving facility to a higher level of care.

II) Standards:

- 1) Written transfer agreements will be in place among all facilities in the region and tertiary care facilities commonly referred to which are out of the region.
- 2) All interfacility transfers shall be in compliance with current OBRA/COBRA regulations and consistent with RCW 70.170.060(02).
- 3) Level IV and V facilities will transfer the following adult and pediatric patients to a level III or higher facility for post resuscitation care:
 - a) Central Nervous System Injury Dx
 - b) Head injury with any one of the following:
 - (1) Open, penetrating, or depressed skull fracture
 - (2) Severe coma (Glasgow Coma Score <10)
 - (3) Deterioration in Coma Score of 2 or more points
 - (4) Lateralizing signs
 - c) Unstable spine
 - d) Spinal cord injury (any level)
 - e) Chest Injury Dx
 - f) Suspected great vessel or cardiac injuries
 - g) Major chest wall injury
 - h) Patients who may require protracted ventilation
 - i) Pelvis Injury Dx
 - j) Pelvic ring disruption with shock requirement more than 5 units of blood transfusion
 - k) Evidence of continued hemorrhage
 - l) Compounded/open pelvic fracture or pelvic visceral injury
 - m) Multiple System Injury Dx
 - n) Severe facial injury with head injury
 - o) Chest injury with head injury
 - p) Abdominal or pelvic injury with head injury
 - q) Burns with head injury
 - r) Specialized Problems
 - (1) Burns > 20% BSA or involving airway
 - (2) Carbon Monoxide poisoning
 - (3) Barotrauma
 - s) Secondary Deterioration (Late Sequelae)
 - (1) Patient's requiring mechanical ventilation

- (2) Sepsis
- t) Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal or coagulation systems)
- 4) All pediatric patients less than 15 years who are triage under Step I or II of the Prehospital triage tool, or are unstable after ED resuscitation or emergent observation intervention at hospital with general designations should be considered for immediate transfer to a higher level designated pediatric trauma center.
- 5) For inter-facility transfer of critical major trauma patients, air or ground ALS transport is the standard. Trauma verified services shall be used for all inter-facility transfers of major trauma patients.
- 6) Transport of patients out of region shall be consistent with these standards.

III) Procedure:

- 1) The General and Pediatric Trauma Transfer Criteria established by the Department of Health should be followed. Each designated trauma facility is required to develop procedures, protocols, and criteria defining which patients they keep or transfer.
- 2) The transferring facility must make arrangements for the appropriate level of care during transport.
- 3) The receiving facility must accept the transfer prior to the patient leaving the sending facility.
- 4) All appropriate documentation must accompany the patient to the receiving facility.
- 5) The transferring physician's order shall be followed during transport as allowed by MPD protocols. Should the patient's condition change during the transport, the transferring/sending physician, if readily available, should be contacted for further orders.
- 6) The receiving facility will be given the following information:
 - a) Brief history
 - b) Pertinent physical findings
 - c) Summary of treatment
 - d) Response to therapy and current condition.
- 7) MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.
- 8) Level IV and V trauma facilities should consider having trauma patients transferred by either ground or air according to the facilities interfacility transport plan.
- 9) Air transport should be considered for interfacility transfer in the North Central Region based on patient acuity and consideration of total out of hospital time, in consultation with the receiving physician. .

IV) Quality Improvement:

- 1) The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Designated Trauma Center Diversion

North Central Region Patient Care Procedure

Adopted by Regional Council: 10/23/1998

Approved by DOH: 10/23/1998

Revised: May 2008

I) Purpose:

- 1) To define implications for initiation of trauma center diversion (bypass) status in the Region.
- 2) To define the methods for notification of initiation of trauma center diversion.
- 3) To identify situations when a facility must consider diverting major trauma patients to another designated trauma center.

II) Standards:

- 1) Designated trauma centers in the North Central Region will go on diversion for receiving major trauma patients based on the facilities' ability to provide initial resuscitation, diagnostic procedures, and operative intervention at the designated level of care.
- 2) Diversion will be categorized as partial or total based on the inability of the facility to manage specific types of major trauma or all major traumas at the time. Hospitals must consider diversion when:
 - a) Surgeon is unavailable
 - b) OR is unavailable
 - c) CT is down if Level II
 - d) ER unable to manage more major trauma
 - e) Beds are unavailable
 - f) Shortage of needed staff
- 3) Each designated trauma center will have a hospital approved policy to divert patient to other designated facilities on the ability to manage each patient at a particular time. A diversion log will be kept indicating the time of diversion and the reason for partial or total diversion.
- 4) All facilities initiating diversion must provide notification to other designated trauma centers in Region.

III) Procedure:

- 1) Trauma centers will consider diverting major trauma patients based on the above standards.
- 2) A designated trauma center on partial or total diversion shall notify other designated trauma centers in the Region.

IV) Quality Improvement:

- 1) The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Mass Casualty Incident (MCI)

North Central Region Patient Care Procedure

Adopted by Regional Council: 12/06/2006

Approved by DOH: December 2006

Revised: Reviewed May 2008

I) Purpose:

- 1) To develop and communicate information for response prior to an MCI
- 2) To implement county MCI plans during an MCI
- 3) Severe Burns: To provide trauma and burn care to severely injured adults and pediatric patients per region.
- 4) To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Disaster Plan and/or the Hazardous Mitigation Plan.

II) Standards:

- 1) EMS personnel, licensed ambulance and licensed aid services shall respond to a Mass Casualty Incident (MCI) as identified in this document.
- 2) All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans
- 3) Licensed ambulance and licensed aid services shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.
- 4) Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
- 5) All EMS agencies working during an MCI event shall operate within the National Incident Management System (NIMS) or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.

III) Procedure:

- 1) Incident Commander (IC) shall follow the county MCI Plan to inform medical control and possible appropriate medical facilities when an MCI condition exists. (Refer to county specific Department of Emergency Management Disaster Plan).
- 2) Medical Program directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it is in another county, region or state. This ensures consistent patient care will be provided by personnel trained to use specific medicines, equipment, procedure, and/or protocols until delivery at the receiving facility has been completed.
- 3) EMS personnel may use the Prehospital Mass Casualty Incident General Algorithm (attached) during the MCI incident.

IV) Definitions:

- 1) CBRNE: Chemical, Biological, Radiological, Nuclear, Explosive
- 2) County Disaster Plan: County Emergency Management Plan (CEMP)
- 3) Medical Control: MPD authority to direct medical care provided by certified EMS personnel in the prehospital system.

V) Quality Improvement:

- 1) The North Central Region Training & Education Committee will review this PCP upon receipt of suggested modifications from a regional provider, the North Region Quality Improvement (QI) Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

NORTH CENTRAL REGION EMS/TC COUNCIL
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE

Mass Casualty Incident (MCI)
Prehospital Mass Casualty Incident (IC) General Algorithm

Receive Dispatch

Respond as directed

Arrive at scene and Establish Incident Command (IC)

Scene assessment and size-up

Determine if mass casualty conditions exist

Implement county MCI plan

Request additional resources as needed

The dispatch center shall coordinate notification and dispatch of required agencies and resources including notification of the County Department of Emergency management (DEM) and possible Receiving Facilities. The Local Health Jurisdiction (LHJ) shall be notified in events where a public health threat exists.

Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries. Consider possibility of terrorist attack (WMD, secondary device)

Initiate START

Reaffirm additional resources

Initiate ICS 201 or similar tactical worksheet

Upon arrival at Hospital/Medical Center, transfer care of patients to facility's staff (hospital/medical center should activate their respective MCI Plan as necessary)

Prepare transport vehicle and return to service

EMS Provider Described Trends

North Central Region Patient Care Procedure

Adopted by Regional Council: 12/06/2006

Approved by DOH: December 2007

Revised: Reviewed May 2008

I) Purpose:

- 1) To provide EMS with a mechanism to report trends/clusters or suspicions to the ED staff of infectious disease symptoms or possible trends that could be related to acts of terrorism.
- 2) To alert ED staff of suspicious symptoms or trends/clusters identified by EMS in the field
- 3) ED staff will follow established hospital procedures to notification Public Health of symptoms or trends as warranted.

II) Standards:

- 1) Emergency Medical Services (EMS) Providers, who recognize/identity trends/clusters in possible highly infectious disease or symptoms that could be related to Terrorism or any unusual biological activity or event, will convey suspicions to Emergency Department (ED) staff.

III) Procedure:

- 1) Any EMS Provider who recognized a trend or clusters of patient symptoms such as but not limited to flu-like symptoms, respiratory symptoms, rash or unusual burns, will inform the ED staff.
- 2) ED staff will evaluate the EMS Provider's suspicions and follow established hospital procedures for reporting to Public Health as warranted.

IV) Definitions:

- 1) ED Staff: Emergency Department physician or nurse.

V) Quality Improvement:

- 1) The North Central Region Training & Education Committee will review this PCP upon receipt of suggested modifications from a regional provider, the North Region Quality Improvement (QI) Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Appendix 5. Gantt Chart

July 2009-2012 Regional Plan Gantt Chart

APPENDICIES ADDITIONAL

Appendix A.

Greater Wenatchee County Operating Procedures

ALS Response on U.S. 97 Douglas County

Greater Wenatchee County Operating Procedure

Adopted by Greater Wenatchee Council: 05/15/1996

Adopted by Regional Council: 1996

Approved by DOH: 1996

Revised: May 2008

I) Purpose:

- 1) To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents on U.S. 97 in Douglas County in the area between Sun Cove Estates and Twin W Orchards (milepost 224 to milepost 227).
- 2) To provide timely and appropriate care to all emergency medical and trauma patients.
- 3) To minimize “response time” in order to get appropriately trained EMS personnel to the scene as quickly as possible.
- 4) To establish uniformity and appropriate dispatch of ALS response agencies.

II) Standard:

- 1) An ALS agency from Chelan shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned stretch of U.S. 97 in Douglas County.
- 2) All major trauma patients on this stretch of U.S. 97 shall be automatically transported to highest – level designated trauma center.
- 3) Emergency medical patients shall be transported to the facility of the patient’s choice, if medically appropriate.

III) Procedure:

- 1) Waterville Ambulance shall be dispatched to all major trauma incidents on U.S. 97 to milepost 227. If ALS (paramedic) certified personnel are a part of the response team, the dispatch center shall be so notified.
- 2) When the location of the emergency medical or major trauma incident is south of milepost 224 (entrance to Sun Cove Estates), an ALS agency out of Wenatchee shall be automatically dispatched to the scene.
- 3) When the location of the emergency medical or major trauma incident is north of milepost 224, the ALS agency out of Chelan shall be automatically dispatched to the scene.
- 4) All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
- 5) Emergency medical patients shall be transported to the facility of the patient’s choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

IV) Quality Improvement:

- 1) The Regional Quality Improvement Committee shall develop written plan for implementation to address issues of compliance with the above standards and procedures.

ALS Response in Douglas County Fire District #4

Greater Wenatchee County Operating Procedure

Adopted by Greater Wenatchee Council: 05/15/1996

Adopted by Regional Council: 1996

Approved by DOH: 1996

Revised: May 2008

V) Purpose:

- 1) To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents in the Douglas County Fire District #4 service area currently served by Waterville Ambulance (milepost 138 to milepost 142.5 on U.S. 2.1 and milepost 213 north to milepost 224 on U.S. 97.
- 2) To provide timely and appropriate care to all emergency medical and trauma patients.
- 3) To minimize “response time” in order to get appropriately trained EMS personnel to the scene as quickly as possible.
- 4) To establish uniformity and appropriate dispatch of ALS response agencies.

VI) Standard:

- 1) An ALS agency from Wenatchee shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned areas in Douglas County.
- 2) All major trauma patients in the above mentioned areas of Douglas County shall be automatically transported to highest – level designated trauma center.
- 3) Emergency medical patients shall be transported to the facility of the patient’s choice, if medically appropriate.

VII) Procedure:

- 1) Waterville Ambulance shall be dispatched to all major trauma incidents in the above-mentioned area. If ALS (paramedic) certified personnel are a part of the response team, the dispatch center shall be so notified.
- 2) An ALS agency out of Wenatchee shall automatically be dispatched to all emergency medical and major trauma incidents in the above-mentioned area.
- 3) All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
- 4) Emergency medical patients shall be transported to the facility of the patient’s choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

VIII) Quality Improvement:

The Regional Quality Improvement Committee shall develop written plan for implementation to address issues of compliance with the above standards and procedures

Appendix B. Grant County Operating Procedures

Tiered Rendezvous

Grant County Operating Procedure

Adopted by Grant County Council:

Adopted by Regional Council: 04/04/2001

Approved by DOH: 02/13/2002

Revised: May 2008

IX) Purpose:

- 1) The Grant County Local Council encourages tiered response within the county. A tiered response system shall be used to provide an appropriate higher level of care anywhere in Grant County such care is readily available. Recognizing that there are areas where a tiered response is not appropriate because of time and distance, a rendezvous with an appropriate higher level of care will be requested, per Grant County EMS Protocols, anywhere in Grant County such a rendezvous is readily available.

X) Procedure for Tiered Response:

- 1) The nearest appropriately trained personnel and/or agency shall be dispatched as the primary ambulance.
- 2) If the severity of the incident is known and indicates the necessity of higher level of care, the dispatchers should also dispatch the next level of care immediately in those areas where the Grant County Local Council has identified a tiered response.
- 3) If the severity of the incident is unknown, the primary ambulance shall advise dispatchers to dispatch the next level of care as outlined in the Grant County Protocols. The primary ambulance will not delay transport to wait for higher level of care, but will rendezvous instead.
- 4) When both agencies are on scene, the higher level personnel will assume care of the patient, and determine which ambulance transports.

XI) Procedure for Rendezvous:

- 1) In areas where no tiered response has been identified, agencies should request a rendezvous with a higher level of care as outlined in the Grant County Protocols, if such care is readily available.
- 2) No agency, including ILS and ALS agencies, should delay transport of any patient to perform advanced skills that can be performed en route to the hospital.
- 3) When two agencies rendezvous, the higher level of care shall board the primary ambulance and assume responsibility for the care of the patient.

XII) Quality Improvement:

- 1) The Grant County Quality Assurance Committee will analyze and make necessary changes in the procedure as may be indicated.