SOUTHWEST REGION
EMERGENCY MEDICAL SERVICES
& TRAUMA CARE SYSTEM

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

July 1, 2 0 0 9 - June 30, 2 0 1 2

Submitted by the Southwest Region EMS and Trauma Care Council
August 4, 2009

EXECUTIVE SUMMARY

The Strategic Plan guides the Southwest Region Emergency Medical Services (EMS) & Trauma System. The goals were provided by the State in alignment with the statewide 2007-2012 EMS and Trauma System Strategic Plan. The objectives and strategies were developed by the Southwest Region EMS and Trauma Care Council and system stakeholders. The Regional Plan directs necessary work to be conducted during the planning cycle by system stakeholders. All of the tasks outlined within the objectives and strategies are in support of obtaining the Regional system goals. The key to the Plan's success is the collaboration and work each Regional Stakeholder will do over the next three years.

System Leadership

The Southwest Region EMS and Trauma Care Council provide EMS and Trauma System coordination in the Southwest Region of Washington State. The Region Council board consists of stakeholders from multidisciplinary private and public health care providers across the EMS and Trauma Care System. Local County Councils provide coordination at the county level. In order to address goals # 1-3 the following work is needed;

- Verify Region and Local Council structure is compliant with WAC.
- Conduct a strategic review of the Region and Local Council organization's functional documents and make needed changes to ensure up to date standards.
- Develop a targeted recruitment and retention plan to fill membership gaps.
- Identify and implement leadership training to ensure sustainability of Region and Local Council continuity.
- Establish outreach opportunities to exchange timely information.

System Development

The Region Council and stakeholders work to continually improve the system as a whole and address emerging issues as they arise. The Regional EMS and Trauma Care System planning process uses an inclusive multidisciplinary planning approach. The Regional Plan is a guiding document for the Southwest Region EMS and Trauma Care System. In order to address goals # 4 - 8 the following work is needed;

- Monitor implementation of the strategic plan with regular progress checkpoints.
- Review the work of the Regional plan and the State Strategic plan.
- Identify distribution channels for exchange timely information.
- Analyze all hazard preparedness planning methods and then notify DOH of the current planning status.
- Conduct interoperable communications status assessment and the development of strategies to identify gaps.

System Public Information and Education

EMS and Trauma System Stakeholders recognize the fact that the general public, political leaders and EMS and Trauma Care System stakeholders from different roles do not always have an accurate clear understanding of the whole EMS and Trauma Care

Acute Hospital Care
The Southwest Region has five (5) designated trauma services within the regional boundaries providing quality emergency medical and trauma patient care. The minimum/maximum numbers allow for distribution of trauma services throughout the region. All of the Region's hospitals participate in the initial and ongoing training of prehospital EMS providers. In order to address goal # 14 the following work is needed;

- The hospitals will evaluate routine surge capacity and educate prehospital services.
- Each hospital will review and provide a recommendation on minimum/maximum numbers of designated trauma services.

Pediatric Care
The regional hospital receiving facilities are equipped, trained and dedicated to providing pediatric patient care. EMS providers are trained to care for pediatric patients and in the use of pediatric specialty equipment. Pediatric patients make up a minority of the EMS and trauma patient volume within the Southwest Region. Due to the infrequency of prehospital pediatric emergency calls, added emphasis is given to the ongoing training of prehospital providers in pediatric emergency care. In order to address goal # 15 the following work is needed;

- The regional system will contribute to providing pediatric education.

Trauma Rehabilitation
Trauma rehabilitation care is provided through hospital and private local rehabilitation services. Southwest Washington Medical Center is currently the only Washington State Designated Trauma Rehabilitation Service in the Southwest Region. The minimum/maximum numbers allow for distribution of trauma rehabilitation services throughout the region. In order to address goal # 16 the following work is needed;

- Offer a summary presentation of available rehabilitation services is needed.
- Review and provide a recommendation on minimum/maximum numbers of rehabilitation services.

System Evaluation
A number of prehospital agencies have begun to submit data to Washington EMS Information System (WEMSIS). Prehospital EMS providers and the region's designated trauma facilities are active members of the Southwest Region Quality Assurance & Improvement (QA&I) Committee. Through that body, system efficiencies and issues are identified and action plans are recommended to trauma care providers. In order to address goals # 17 -18 the following work is needed;

- Evaluate WEMSIS use by agencies.
- Analyze evaluation and determine strategies to assist any agencies not using WEMSIS.
- The Regional QA&I committee will develop a mechanism for providing a written summary report on system level issues and findings.
- Selected data reports will be used to develop system recommendations for planning and system development.

- Clark County EMS & Trauma Care Council
- Cowlitz County EMS & Trauma Care Council
- Klickitat County EMS & Trauma Care Council
- Skamania County EMS & Trauma Care Council
- South Pacific County EMS & Trauma Care Council
- Wahkiakum County EMS & Trauma Care Council

The Region Council acknowledges the broad knowledge, experience, and dedication of the Region and Local Council members. Their commitment and hard work is needed to provide the infrastructure for system coordination.

In order to address goals # 1-3 the following work is needed;

- Verify Region and Local Council structure is compliant with WAC.
- Conduct a strategic review of the Region and Local Council organization's functional documents and make needed changes to ensure up to date standards.
- Develop a targeted recruitment and retention plan to fill membership gaps.
- Identify and implement leadership training to ensure sustainability of Region and Local Council continuity.
- Establish outreach opportunities to exchange timely information.

SYSTEM LEADERSHIP

- Goal #2 - Multi-disciplinary coalitions of private/public health care providers are fully engaged in regional and local EMS and trauma systems.	
Objective 1: By September 2010, the Region and Local Councils will collaboratively develop and implement a Council membership recruitment and retention plan including identified applicable parts of the state membership tool to increase membership engagement.	**Strategy 1:** By April 2010 Region and Local Councils will utilize the information from the strategic review of the Council organizational components to formalize a direction for the membership project.
	Strategy 2: By April 2010 the Region Council will review and adopt the state provided membership tool for both Region and Local Councils to use in recruiting and engaging membership.
	Strategy 3: By April 2010 the Region and Local Councils will determine whether to write a recruitment plan as a council body or appoint a sub-committee/work group.
	Strategy 4: By September 2010 the Region and Local Councils will write a recruitment plan including identified applicable parts of the state membership tool to increase membership engagement.
	Strategy 5: By September 2010 the Region and Local Councils will vote to adopt a membership recruitment plan
	Strategy 6: By September 2010 the Region and Local Councils will implement the membership recruitment plan.

SYSTEM DEVELOPMENT

Introduction

The Southwest Region EMS and Trauma Care Council is committed to a regional system that parallels the State of Washington's EMS and Trauma Care System's continuum of care model including;

- Prevention
- Prehospital
- Hospital
- Pediatric
- Trauma
- Rehabilitation
- System Evaluation

The Regional EMS and Trauma Care System Plan addresses administrative and clinical elements of the system and identifies work for the next three years within the region. The plan identifies what is in place, what is needed, and proposes objectives and strategies toward obtaining the regional goals. The Southwest Region EMS and Trauma Care Council as authorized by WAC 246-976-960 as a regional coordinating body to develop and implement the regional system plan. In developing the system plan, the Region Council seeks and considers the recommendation of the Local EMS and Trauma Care Councils. The plan serves as the guiding document for the Southwest Region EMS and Trauma Care system.

Our system planning process uses an inclusive multidisciplinary planning approach to build a system of appropriate and adequate trauma and emergency care that minimizes human suffering and cost associated with preventable mortality and morbidity. The Regional Plan is congruent with the statewide strategic plan in form and addresses the same functional areas. The objectives and strategies are region specific to meet regional needs and provide direction for the future.

Within the EMS and Trauma System there are multiple stakeholder groups such as; the Governor's Steering Committee and the various specialty Technical Advisory Committees (TAC), Regional Advisory TAC, Pediatric TAC, Data TAC, Cardiac and Stroke TAC and others. These and other bodies work to continually improve the system as a whole. In the process of doing so important emerging issues arise. A consistent mechanism of information sharing across the region will bring about broad awareness between system stakeholders as important issues emerge.

Interoperable communications is identified as a critical element of the EMS and Trauma Care System. The ability of hospitals, prehospital EMS agencies, and public service access points (PSAP) dispatch centers to communicate is vital. Assessing the interoperable communications status will establish what is needed so that steps can be taken to assure continued interoperability.

In order to address goals # 4 - 8 the following work is needed;

SYSTEM DEVELOPMENT

- Goal #4 -	
There is 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.	
Objective 1: By April annually the Regional Council will report on the progress of the Regional Stakeholders implementation of the objectives, and strategies within the 2009-2012 Southwest Region EMS and Trauma Care System Plan.	**Strategy 1:** By December 2009 the Region staff will provide copies of the plan and work plan spreadsheet to the Region and Local Council members and other key stakeholder groups.
	Strategy 2: At bimonthly Regional Council meetings held, the Region Council will monitor implementation progress by review of objective and strategy progress.
	Strategy 3: By March annually the Local Council will monitor implementation progress by review of objective and strategy progress at Local Council meetings held. The Local Councils will provide all council meeting minutes to the Region Council office.
	Strategy 4: By April annually the Region Council will report to DOH the maintenance of a link to the DOH posted approved 2009-2012 Southwest Region EMS and Trauma Care System Plan on the regional website.
	Strategy 5: By April annually the Regional Council will report on progress of the Regional Stakeholders implementation of the objectives and strategies within the 2009-2012 Southwest Region EMS and Trauma Care System Plan.
	Strategy 6: By October annually needed changes will be brought forward for action to the Region Plan sub-committee.

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 March 2011 Region and Local Councils will identify existing distribution channels for use in timely distribution of Steering Committee and TAC information to regional stakeholders on emerging issues and will develop and implement an information distribution process.	**Strategy 1.** By September 2010 Region and Local Council representatives will identify *or* form a group representing all counties within the region to determine existing information distribution channels.
	Strategy 2. By January 2011 the identified group will develop a process for timely distribution of information on emerging issues.
	Strategy 3. By March 2011 the emerging issues information dissemination process will be implemented within the regional system.

System Development

- Goal #8 - Region-wide interoperable communications are in place for emergency responders and hospitals.	
Objective 1: By May 2011 medical receiving hospitals, agencies, and Public Service Access Points (PSAP) in the region will assess interoperable communication capabilities with all licensed prehospital EMS agencies and hospitals in the region, identify gaps and develop regional plan strategies to help attain interoperability.	**Strategy 1:** By October 2010 the Region Council will work with DOH in the development of a survey which will evaluate the interoperable communication capabilities.
	Strategy 2: By December 2010 the Region Council will obtain the most current DOH statewide EMS Preparedness survey results and/or conduct an interoperable communication evaluation survey of medical receiving hospitals, EMS agencies, and Public Service Access Points.
	Strategy 3: By March 2011 the Region Council in conjunction with DOH will analyze the survey results, write a summary report and provide the report to the Region and Local Councils and all stakeholders involved in the survey.
	Strategy 4: By May 2011 the Region Council will utilize the survey results and summary report in the development of interoperability objectives and strategies for the 2012-17 Southwest Region EMS and Trauma Care System Plan.

System Public Information & Education

<table>
<tr><td colspan="2">- 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.</td></tr>
<tr><td rowspan="4">Objective 1:
By March 2011 the Region Council will develop a Southwest Region Public Information and Education Plan.</td><td>Strategy 1:
By July 2010 the Region Council will receive the State Public Information Plan.</td></tr>
<tr><td>Strategy 2:
By November 2010 the Region Council will evaluate how the State Public Information Plan can be adapted for regional system information and education uses.</td></tr>
<tr><td>Strategy 3:
By December 2010 the Region Council will write a work plan outlining how the Public Information Plan will be implemented in the Southwest Region.</td></tr>
<tr><td>Strategy 4:
By March 2011 the Region Council will incorporate applicable portions of the State Public Information Plan and other available Public Information and Education products as the Regional Public Information and Education Plan and implement it.</td></tr>
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SYSTEM FINANCE

- Goal #11 - There is consistent and sustainable funding to ensure a financially viable regional EMS and Trauma Care System.	
Objective 1: By May 2012 Region and Local Councils will utilize the State funding opportunity action plan, as referenced in the 2007-2012 State Plan Goal # 11, to identify funding opportunities for stakeholder groups to pursue and identify strategies for them to use in seeking funding.	**Strategy 1:** By Jan 2012, the Region Council will receive and review the State funding opportunity report.
	Strategy 2: By March 2012, the Region Council will disseminate the State funding opportunity action plan, as referenced in the 2007-2012 State Plan Goal # 11, to the Region and Local Councils and licensed EMS agencies for their use in identifying funding resources.
	Strategy 3: By May 2012 the Region Council will provide recommendations on funding opportunities through additional funding resources to stakeholder groups including Region and Local Councils and licensed EMS agencies and identify strategies for success in seeking funding from available sources.

INJURY PREVENTION & CONTROL

- Goal #12 - Preventable/premature death and disability due to injury is reduced through targeted injury prevention activities and programs.	
Objective 1: By September annually the Region Council will utilize the regional process to identify Injury Prevention and Public Education (IPPE) needs and allocate available funding to support evidence based and/or best practice activities in the counties.	**Strategy 1:** By May annually the Regional IPPE Committee will conduct a regional IPPE needs assessment of the Local County Councils for the following fiscal year.
	Strategy 2: By September annually, the Region Council will review the distribution of funding from the prior fiscal year and determine a direction for the fiscal year.
	Strategy 3: By September annually, the Region Council will approve a budget for IPPE activity support.

20D12	Klickitat County FPD #12	BLS Verified Aid Vehicle
20D13	Klickitat County FPD #13	BLS Verified Aid Vehicle
20D14	Klickitat County FPD #14	BLS Verified Aid Vehicle
20D15	Klickitat County FPD #15	BLS Verified Aid Vehicle
20X01	Klickitat Valley Ambulance	ALS Verified Ambulance
20X02	Klickitat PHD #2/Skyline Ambulance	ALS Verified Ambulance
Skamania County		
30D01	Skamania County FPD #1	BLS Licensed Aid Vehicle
30D04	Skamania County FPD #4	BLS Verified Aid Vehicle
30D06	Skamania County FPD #6	BLS Verified Aid Vehicle
30X01	Skamania County EMS	ALS Verified Ambulance
South Pacific County		
25D01	Pacific County FPD #1	ALS Verified Ambulance
25D02	Pacific County FPD #2	BLS Licensed Aid Vehicle
25M01	Ilwaco Fire Department	BLS Licensed Ambulance
25X01	Naselle Volunteer FD, Inc.	BLS Licensed Ambulance
25X03	Medix Ambulance Service	ALS Verified Ambulance
Wahkiakum County		
35D02	Wahkiakum County FPD #2	N/A Licensed Aid Vehicle
35D03	Wahkiakum County FPD #3	BLS Verified Ambulance
35M01	Cathlamet Fire Department	BLS Verified Ambulance

Air ambulance service is currently provided within the Southwest Region. The State of Washington's Air Medical Plan has allocated a minimum of one and maximum of one air medical service for the region. Due to the immense geography of the region and the current siting of available air medical services the Region Council will request an increase of minimum/maximum allocation to one (1) minimum and three (3) maximum.

Recruitment and retention of qualified personnel is an ongoing need and challenge in rural areas. This is due in part to the evolution of the EMS profession in which the personnel base is evolving from a volunteer pool to full time professional EMS providers. This challenges rural areas because fewer resources are available in rural areas to meet the increasing demand on volunteers to maintain EMS certification and skill levels. The retention of rural personnel can be augmented by offering training opportunities. The cost for initial training and all ongoing continuing medical education of personnel is borne by individual agencies and supplemented by Southwest Regional Council Training Grants. Because funding is an ongoing issue agencies are encouraged to seek funds through the DOH Needs Grants and other outside sources to help fund training courses and training equipment.

All Southwest Region Local County Councils report that Ongoing Training and Evaluation Program (OTEP) programs are being utilized. However the travel distance between county centralized training sites or partnering agency training sites is a challenge for volunteer providers to maintain didactic and skills proficiency. The use of online training has increased to help meet this challenge. Rural agencies and Local County Councils have asked for more instructors and EMS evaluators for both ongoing and initial training needs.

PREHOSPITAL

- 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: By January 2011, the Region Council will review and update Regional Patient Care Procedures (PCP).	**Strategy 1:** By May 2010 the Region Council will appoint a sub-committee/workgroup, led by the Regional MPDs, including at least one representative from each County Council to review and update the Regional Patient Care Procedures (PCP).
	Strategy 2: By May 2010 the Regional Patient Care Procedures (PCP) sub-committee/workgroup will draft a meeting schedule and work plan to complete the PCP review/update project.
	Strategy 3: By August 2010, the Regional PCP sub-committee/workgroup will receive available data from WEMSIS to utilize in updating Regional Patient Care Procedures.
	Strategy 4: By November 2010 the Regional PCP sub-committee/workgroup will review the Regional Patient Care Procedures, develop and submit recommended revisions to the Region Council for approval.
	Strategy 5: By January 2011, the Region Council will adopt the revised Regional Patient Care Procedures for inclusion in the 2012-17 Southwest Region EMS and Trauma Care System Plan.

PREHOSPITAL

Objective	Strategy
Objective 4: By May 2011, the Local County Councils will use standardized methods to provide a recommendation on minimum/maximum numbers of trauma verified services to the Region Council.	**Strategy 1:** By September 2010 the Region Council will receive the methodologies from DOH which identify regional needs, minimum/maximum numbers for levels of distribution of designated services and verified prehospital services and will provide a copy to the Local County Councils.
	Strategy 2: By September 2010 the region will notify each of the Local Councils requesting they review and update their minimum/maximum numbers for prehospital verified trauma services using standardized methods.
	Strategy 3: By September 2010 the Region Council will make trauma response area maps available to each county for their use in determining distribution of services.
	Strategy 4: By January 2011, the Local County Council will review, update, and submit a written recommendation for minimum/maximum number of prehospital verified trauma services to the Region Council.
	Strategy 5: By May 2011, the Region Council will utilize the Local Council recommended minimum/maximum number of prehospital verified trauma services in developing the 2012-17 Southwest Region EMS and Trauma Care System Plan.
Objective 5: By September annually the Region Council will utilize the regional process to identify needs and allocate available funding to support prehospital training.	**Strategy 1:** By May annually the Region Council will conduct a regional training needs assessment for the following fiscal year.
	Strategy 2: By September annually the Region Council will review the distribution of funding from the prior year and determine a direction for the following fiscal year.
	Strategy 3: By September annually, the Region Council will establish a budget for prehospital training support.

ACUTE HOSPITAL

- 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: By March 2012, the Southwest Region hospital representatives will analyze diversion and routine surge capacity to educate the Prehospital services and further a working understanding of hospital capabilities for system improvement planning.	**Strategy 1:** By October 2011 hospital representatives will analyze assembled data needed to look at diversion, surge capacity, and interfacility transfer impact across the region.
	Strategy 2: By March 2012 the hospital representatives will present their findings and submit a summary report to the Region Council and the Regional QA&I Committee for prehospital education and system improvement planning.
Objective 2: By May 2011 Southwest Region hospitals will use standardized methods to recommend minimum/maximum numbers of trauma designated services to the Region Council for system planning.	**Strategy 1:** By September 2010, the Region Council will request hospitals review current minimum/maximum numbers.
	Strategy 2: By January 2011, the hospitals will conduct a review of current minimum/maximum numbers using standardized methods provided by DOH and make recommendations to the Region Council.
	Strategy 3: By May 2011, the Region Council will review recommendations and incorporate any changes into the 2012-17 Southwest Region EMS and Trauma Care System Plan.

PEDIATRIC

- 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).	
Objective 1: By November 2011 the Region Council will survey prehospital providers to determine pediatric specific training needs within the region for integration into the Regional Pediatric Seminar/Conference program.	**Strategy 1:** By August 2011 the Regional Training Committee will develop a survey to determine pediatric specific prehospital training needs.
	Strategy 2: By September 2011 the Region Council will distribute the survey to EMS agencies in order to obtain information from their prehospital EMS providers.
	Strategy 3: By November 2011 the Region Council will analyze the survey results, develop program topics and identify possible speakers to address identified training needs at the Regional Pediatric Seminar/Conference.
Objective 2: By May 2012, based on available funding, the Region Council/other sponsors will conduct a Pediatric Seminar/Conference within the region to meet the pediatric education and training needs of prehospital EMS providers and clinical stakeholders.	**Strategy 1:** By September 2011 the Regional Training Committee will determine funding availability and secure funding as available.
	Strategy 2: By November 2011 the Regional Training Committee will coordinate the pediatric seminar/conference planning.
	Strategy 3: By May 2012 the Region Council/other sponsors will hold a seminar/conference and evaluate it through participant evaluations for meeting the determined pediatric training needs.

TRAUMA REHABILITATION

- 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	Strategy
Objective 1: By May 2011, in order to have an improved understanding of how trauma rehabilitation is an essential part of the continuum of trauma care, the Southwest Region Designated Trauma Rehabilitation Service will conduct a presentation of available rehabilitation services within the Southwest Region at a Regional QA&I committee meeting.	**Strategy 1:** By September 2010 the Southwest Region Designated Trauma Rehabilitation Service will be invited to conduct a presentation of available rehabilitation services and the role rehabilitation has within the Southwest Region EMS & Trauma Care System.
	Strategy 2: By May 2011 a presentation of rehabilitation care will be included in a scheduled Regional QA&I committee meeting to raise awareness of the role of rehabilitation services in the Southwest Region EMS & Trauma Care system.
	Strategy 3: By May 2011 the Region Council will incorporate information gained from the presentation in the development of the 2012-17 Regional System Plan.
Objective 2: By May 2011 rehabilitation facilities in the regional system will recommend minimum/maximum numbers of rehabilitation services to the Region Council for system planning.	**Strategy 1:** By September 2010 the Region Council will request rehabilitation facilities review current minimum/maximum numbers.
	Strategy 2: By January 2011 the rehabilitation facilities will conduct a review of need and provide recommendations to the Region Council.
	Strategy 3: By May 2011 the Region Council will review the recommendations and incorporate changes into the 2012-17 Southwest Region EMS and Trauma Care System Plan.

System Evaluation

- Goal #17 - The Regional EMS and Trauma Care System has data management capabilities to support evaluation and improvement.	
Objective 1: By March 2012 the Region Council will conduct a survey of the Southwest Region licensed prehospital EMS agencies to evaluate the use of WEMSIS and identify barriers to participate in WEMSIS.	**Strategy 1:** By November 2011 the Region Council will work with DOH in the development of a survey which will evaluate the use of WEMSIS and identify barriers to participate in WEMSIS.
	Strategy 2: By January 2012 the Region Council will conduct a WEMSIS evaluation survey of the licensed prehospital EMS agencies.
	Strategy 3: By March 2012 the Region Council, with DOH assistance, will analyze the WEMSIS evaluation survey results, write a summary report and provide findings to the Region, Local Councils, and DOH.
Objective 2: By June 2012, the Region Council will promote 100% of licensed prehospital EMS agencies in the region will have access to WEMSIS and will be capable of collecting and submitting EMS run data and using WEMSIS reports.	**Strategy 1:** By March 2012 the Region Council will utilize WEMSIS survey data and barrier analysis to determine strategies for assisting any prehospital EMS agencies not using WEMSIS to be able to do so.
	Strategy 2: By June 2012 The Region Council will partner with DOH to assist non participating agencies in collecting EMS run data and the use of WEMSIS reporting capabilities.

APPENDICES

Appendix 1.

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

County (Name)	Verified Service Type	State Approved - *Minimum number*	State Approved - *Maximum number*	Current Status (# Verified for each Service Type)
Clark	Aid – BLS	1	12	4
	Aid –ILS	0	0	0
	Aid – ALS	1	12	3
	Amb –BLS	1	4	0
	Amb – ILS	0	0	0
	Amb – ALS	1	4	3
Cowlitz	Aid – BLS	1	5	4
	Aid –ILS	0	0	0
	Aid – ALS	1	5	0
	Amb –BLS	1	5	2
	Amb – ILS	0	0	0
	Amb – ALS	1	5	5
Klickitat	Aid – BLS	1	11	10
	Aid –ILS	0	0	0
	Aid – ALS	1	4	0
	Amb –BLS	1	4	2
	Amb – ILS	0	0	0
	Amb – ALS	1	2	2
Skamania	Aid – BLS	1	6	2
	Aid –ILS	0	0	0
	Aid – ALS	1	1	0
	Amb –BLS	1	1	0
	Amb – ILS	0	0	0
	Amb – ALS	1	1	1
South Pacific	Aid – BLS	1	2	1
	Aid –ILS	0	0	0
	Aid – ALS	1	2	0
	Amb –BLS	1	2	0
	Amb – ILS	0	0	0
	Amb – ALS	1	3	2
Wahkiakum	Aid – BLS	1	1	0
	Aid –ILS	0	0	0
	Aid – ALS	1	1	0
	Amb –BLS	1	3	2
	Amb – ILS	0	0	0
	Amb – ALS	1	2	0

Trauma Response Areas by County (continued)

Cowlitz 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 to describe as available	**Type and # of Verified Services available in each Response Areas** (*use key below – **see explanation)
	# 1	Within the boundaries of Cowlitz FPD # 1 and the city limits of Woodland	D-2, F-1
	# 2	Within the boundaries of Cowlitz FPD # 2 and the city limits of Kelso	F-1
	# 3	Within the boundaries of Cowlitz FPD # 3	A-1, F-1
	# 4	Within the boundaries of Cowlitz FPD # 4	A-1
	# 5	Within the boundaries of Cowlitz FPD # 5	F-1
	# 6	Within the boundaries of Cowlitz FPD # 6 and the city limits of Castle Rock	F-1
	# 7	Within the boundaries of Cowlitz-Skamania FPD # 7	A-1, F-1
	# 8	Within the city limits of Long View and land area to the southern county line	A-1, F-1
	# 100	All land area between Trauma Response Area # 2, # 4, # 6, and the northern and western county line	None
	# 101	All land area between the eastern and northern county line and the boundaries of Trauma Response Area # 1, # 2, # 3, # 5, # 6, and # 7	None

***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.

Trauma Response Areas by County (continued)

Skamania 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 to describe as available	**Type and # of Verified Services available in each Response Areas** (*use key below – **see explanation)
	# 1	Within the boundaries of Skamania FPD # 1	F-1
	# 2	Within the boundaries of Skamania FPD # 2	F-1
	# 3	Within the boundaries of Skamania FPD # 3	F-1
	# 4	Within the boundaries of Skamania FPD # 4	A-1, F-1
	# 5	Within the boundaries of Skamania FPD # 5	F-1
	# 6	Within the boundaries of Skamania FPD # 6	A-1, F-1
	# 7	Within the boundaries of Cowlitz-Skamania FPD # 7	F-1
	# 100	All land area outside Trauma Response Areas # 1, 2, 3, 4, 5, 6, 7, to the northern, southern, western, and eastern county lines	None

***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.

Trauma Response Areas by County (continued)

Wahkiakum 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 to describe as available	**Type and # of Verified Services available in each Response Areas** (*use key below – **see explanation)
	# 1	Within the boundaries of Wahkiakum FPD # 1 and # 4, and the city limits of Cathlamet	D-1
	# 2	Within the boundaries of Wahkiakum FPD # 2	D-1
	# 3	Within the boundaries of Wahkiakum FPD # 3	D-1
	# 100	All land area outside Trauma Response Area # 3 west of mile post 22 on State Route 4, to the western, northern, and southern county lines	None
	# 101	All land area outside Trauma Response Areas # 1 and # 2 east of mile post 22 on State Route 4, to the eastern, northern, and southern county lines	None

***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 4.
Patient Care Procedures (PCPs)

2002-2003

Regional Patient Care Procedures (PCPs)

Adopted November 6, 2002

Southwest Region EMS and Trauma
Care Council

SW Region Prehospital Trauma System Activation & Destination Procedures

DEFINITIONS

"Aid Vehicle" Means a first response, non-transport vehicle that meets the Washington Administrative Code (WAC 246-976) and in the Southwest Region, one that provides first response emergency medical services on a 24 hour per day, seven day per week period and is recognized as a resource in the Regional EMS and Trauma Plan.

"Ambulance" Means a transport vehicle that meets the Washington Administrative Code (WACs 246-976) for ill and injured patients, and in the Southwest Region, one that provides emergency medical services on a 24 hour per day, seven day per week period, and is recognized as a resource in the Regional EMS and Trauma Plan.

"EMD" Means provision of special procedures and trained personnel to ensure the efficient handling of medical emergencies and dispatch of aid. It includes pre arrival instructions for CPR and other verbal aid to callers. (from WAC)

"Global Positioning System (GPS)" means a satellite based location system for accurately determining the exact latitude and longitude of a particular point on the Earth's surface.

"Major Trauma Patient" Means a patient who meets the Washington State Prehospital Trauma Triage Tool's Step 1 or 2 (physiologic or anatomic) criteria for potentially life threatening injuries.

"Medical control" means the on-line and/or off-line direction (protocols) of prehospital EMS providers provided by MPD'S and/or MPD approved physician delegates.

"Patient Care Procedures Standard" Means the expectation set on a regional or statewide basis by which the system will be evaluated.

Patient Care Procedures Purpose" Defines why a procedure covering an area of the EMS and Trauma Care System is necessary.

"Patient Care Procedure means written operating guidelines adopted by the regional emergency medical services and trauma care council in accordance with state-wide minimum standards. The patient care procedures shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary, and includes a description of the activation of the trauma system.

"Patient Care Protocols" Mean standard medical orders developed and adopted by a county Medical Program Director that indicate the type of care to be provided to medical and trauma patients.

Center as quickly as the patient is stabilized or is ordered transferred by the lower level designated Trauma Center's medical staff).

In The Southwest Region, the following level I, III and IV hospitals in Oregon and Washington are recognized as trauma resource hospitals for the Region.

- Providence Hospital	Yakima	Level IV
- Yakima Memorial	Yakima	Level III
- Legacy Emanuel Hospital and Health Center	Portland	Level I
- Oregon Health Sciences University	Portland	Level I
- Columbia Memorial Hospital	Astoria	Level III
- Hood River Memorial Hospital	Hood River	Level III
- Mid-Columbia Medical Center	The Dalles	Level III

PREHOSPITAL PROCEDURES

When a prehospital trauma verified service has identified a patient as a "major" trauma patient, the prehospital service should ensure the following:

1. Contact with Medical Resource Hospital (University Hospital, Portland, OR) for Level I access or the Level II Trauma Designated Trauma Center (Southwest Washington Medical Center), where available; or

2. The highest level of designated facility within the agency's immediate response jurisdiction if a Level I or Level II Trauma

   Center is not within a 30 minute response time. Contact by radio, cellular phone, telephone, or other means as conditions dictate.

When a non trauma verified prehospital service has contact with a major trauma patient prior to the arrival or dispatch of trauma verified service(s) they shall ensure that:

- ♦ The appropriate 9-1-1 dispatch center is immediately notified so that trauma verified services can be activated as per the dispatch system for that location.

have Global Positioning System coordinates of your location, give these to your 9-1-1 Center and/or Dispatch Services so that they may relay them to the Air Ambulance Service. If you begin ground transport of the patient for rendezvous with an air ambulance service, notify the service of your intent to meet them at a location. Again, if the GPS of the rendezvous is known, give that location to the 9-1-1 center or dispatch service for relay to the air ambulance service.

It is highly recommended that all EMS services have predesignated rendezvous sights within their county and GPS coordinates for each sight should be identified in advance. These GPS coordinates should be placed on a map inside each trauma verified vehicle that will respond to a major trauma patient. These maps should be readily available to each first responder, EMT, or paramedic using the vehicle.

PROLONGED TRANSPORT

When the transport of an major trauma will be greater than 30 minutes to a Level I or II Trauma Center but within 30 minutes of an lesser level facility, the highest level EMS provider on the scene should immediately contact on line medical control and request instructions as to whether the patient should be transported to a Level V, IV, or III center for stabilization or whether they should be transported directly to a Level I or Level II Trauma Center.

All information on "major" trauma patients shall be documented according to WAC and County Medical Program Director guidelines.

While enroute to the receiving facility, the transporting agency should provide a complete report to the receiving trauma center regarding the patient's status, and provide them with any further information that may be needed, including estimated time of arrival to their facility.

PEDIATRIC MAJOR TRAUMA PATIENTS

For a pediatric major trauma patient consideration should be given to transport the patient directly from the field (either by air ambulance or ground ambulance -- see above, Air Ambulance for guidance) to the most appropriate (Level I, II, III) trauma facility within the Region. In most cases, a pediatric major trauma patient will be transported to a Level I Trauma Center. However, Level II and /or Level III Centers, may offer initial stabilization of the pediatric patient. All level Trauma

MPDs should develop diversion protocols for their respective counties.

MEDICAL PATIENTS

> All EMS Agencies should follow their Medical Program Director's patient care protocols and/or guidelines for the care and transport of medical and non-major trauma patients. If it is unclear as to where a medical or non-major trauma patient should be transported, contact medical control at your nearest resource hospital for directions; otherwise follow off-line medical control of patients as outlined in your standing orders, patient care protocols, and/or guidelines provided by your Medical Program Director.

MPDs, in the development of their patient care protocols and/or guidelines for the care and transport of the medical and non-major trauma patient, shall consider:

A. Patient's desire or choice of medical facility as to where they want to be transported and/or treated. Or, in the case of an unconscious patient, the wishes of the patient's family or personal physician.

B. The type of treatment and the ability of a receiving hospital to treat such medical or non-major trauma (i.e., high risk OB patients, potential ICU/CCU patients, unstable co-morbid medical patients, etc.).

C. Pre-existing financial or organizational agreements with receiving facilities (i.e., HMO members, capitated arrangements, or referral patterns previously established).

D. Level, severity, and type of injuries.

E. Ability of the receiving hospital to adequately treat the medical or non-major trauma patient.

In all cases, unless proper medical care dictates otherwise, the choice of the patient is paramount in the development of standing orders, patient care protocols, and/or guidelines for EMS transport agencies.

QUALITY ASSESSMENT AND IMPROVEMENT (QA&I)

Quality Assessment & Improvement (QA&I) is an integral component of the Southwest Region's Trauma System. For all patients, EMS and health care providers will follow their agency's specific QA&I plan. If an agency does not have a QA&I Plan, one should be developed and adopted. Issues that are deemed by the QA& I committee board for their review and recommendations should be submitted directly to the regional QA&I

DISPATCH OF NEAREST TRAUMA VERIFIED SERVICE

Response Systems

County 9-1-1 Centers should develop response systems to determine which nearest trauma /trauma verified first response and transport service should be dispatched to the scene of a major trauma incident or patient.

For all "major" trauma patients or 'suspected' major trauma patients, emergency dispatch agencies or 9-1-1 Centers shall dispatch trauma verified service(s) to the scene of the trauma incident in accordance with the dispatch system and compatibility of service providers.

In the instance where no trauma verified service is available, the 9-1-1 Center should dispatch the nearest available first response and/or ambulance service to the scene of the trauma incident with the highest level of care available.

If in doubt as to whether the incident being reported to the 9-1-1 Center involves a "major trauma patient" until notified otherwise by a paramedic or the highest level EMS provider on the scene, ASSUME THE INCIDENT INVOLVES A MAJOR TRAUMA PATIENT and dispatch according to this section of the Region's Patient Care Procedures. Remember that time is of the essence for major trauma patients.

RESPONSE MODE

If a major trauma patient is known or suspected, 9-1-1 Centers should advise all responding trauma services of any and all additional information that becomes available to the 9-1-1 center.

RESPONSE TIMES

To ensure timeliness in the dispatch of a trauma verified service, the following guidelines have been adopted by the Region Council for response times (measured from the time the call is received by the responding agency until the time the agency arrives on the scene of the trauma incident):

First Response Trauma Verified Services (response times, 80 percent target)

Urban Areas: 4 minutes

must contact the receiving physician who must accept the transfer of the patient prior to the patient leaving the sending facility.

The transferring physician and facility will ensure the appropriate level of care during transport of the major trauma patient to the receiving Trauma Center.

The receiving facility must accept or be available to accept the major trauma patient prior the patient leaving the sending facility.

The receiving facility will be given the following information on the patient by fax, phone, or other appropriate means:

a. Brief History
b. Pertinent physical findings
c. Summary of any treatment done prior to the transfer
d. Response to therapy and current condition

All appropriate documentation must be available at the receiving facility upon arrival of the patient to the receiving facility (it may be sent with the patient, faxed to the hospital, or relayed by other appropriate means).

The transferring physician's orders shall be followed during transport. Should the patient's condition change during transport, the pre-determined on-line or off-line medical control for the transporting agency shall be utilized.

Further orders may be given by the receiving physician.

MPD approved, or County protocols should be followed during transport, unless direct medical orders by the sending or receiving physician are given to the contrary.

All ground Interfacility transports must be conducted by a trauma-verified service for trauma system patients.

APPENDIX A - INTERFACILITY TRANSFER CRITERIA

All designated health care facilities shall have transfer agreements for the identification and transfer of trauma patients as medically necessary.

General Trauma Transfer Criteria

Patients from the following categories are at high risk for death or disability and shall be considered for transfer to a facility designated to provide Level I or Level II Trauma Care Services.

1. Hemodynamically stable children with documented visceral injury being considered for "observational" management. Although the efficacy of this approach in selected cases has been well documented, two significant caveats always apply:

   a) Hemodynamic instability mandates immediate operative intervention, and;
   b) Non-operative care is safe only in an environment that provides both close clinical observation by a surgeon experienced in the management of childhood trauma and immediately available operative care.

2. Children with abnormal mental status. In all but the infant, outcome from closed head injury has been shown to be significantly better for the child than for the adult. Although the quality and timeliness of initial resuscitation are the most important determinants of outcome from brain injury, continued comprehensive management in specialized units with multi-disciplinary pediatric critical care teams may provide a more rapid and complete recovery.

3. Infants and small children. Severely injured infants and small children are the most vulnerable and, frequently, the least stable trauma victims. Because they require the special resources and environment of a regional pediatric Trauma Center, transfer should occur as soon as safely feasible.

4. Children with injuries requiring complex or extensive reconstruction. These services are traditionally most available in hospitals capable of functioning as a regional pediatric trauma center. It is especially important that children with impairments requiring long-term follow-up and supportive care have this provided or at least coordinated by the regional pediatric Trauma Center. Longitudinal follow-up of injury-related disability is an essential requirement of the regional pediatric Trauma Center's trauma registry.

5. Children with polysystem trauma requiring organ system support. This is especially important for those patients requiring ventilatory, cardiovascular, renal, or nutritional support. Because these problems usually occur synchronously and require precise interdisciplinary coordination, they are best managed in comprehensive facilities such as regional pediatric Trauma Centers.

Southwest Regional EMS & Trauma Care Council
REGIONAL PATIENT CARE PROCEDURE
ALL HAZARDS – MCI – SEVERE BURNS

Approved May 3, 2006

I. STANDARD: During a mass casualty incident (MCI) with severely burned adult and pediatric patients,

1. All verified ambulance and verified aid services shall respond to an MCI per the local MCI plans.

2. When activated by dispatch in support of the local MCI Plan and/or in support of verified EMS services, all licensed ambulance and licensed aids services shall assist during an MCI per local MCI plans.

3. When activated by dispatch in support of the local MCI Plan and/or in support of verified EMS services, all EMS certified individuals shall assist during an MCI per local MCI plans.

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 Incident Command System as identified in local protocol and MCI plan.

II. PURPOSE:

1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.

2. To implement local MCI plans during an MCI.

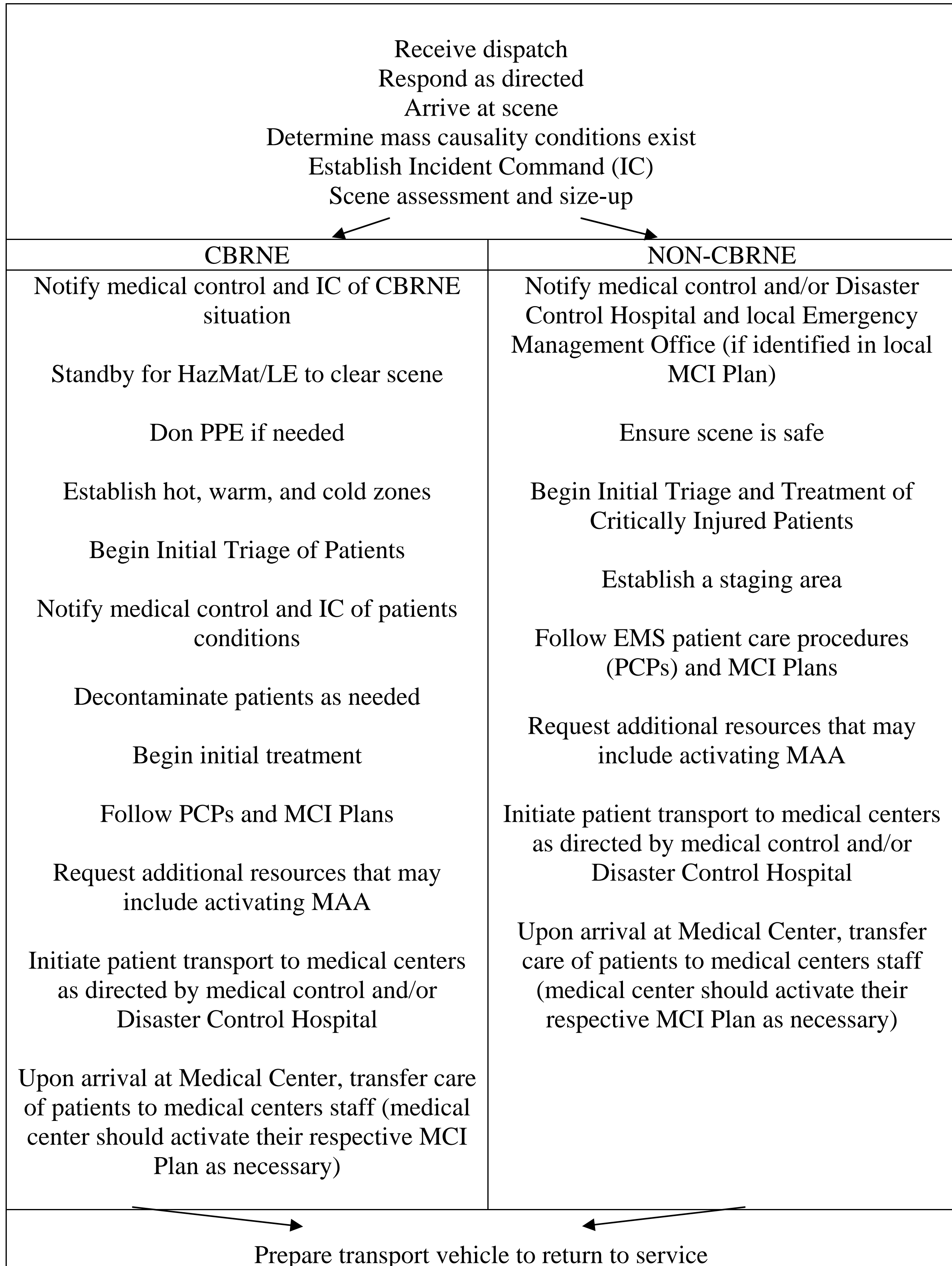
3. To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.

4. To provide safe mass transportation with pre-identified medical staff, equipment, and supplies per mass transport vehicle.

III. PROCEDURES:

1. Certified EMS personnel should, following local MCI Plans, inform medical control and the disaster medical control hospital when an MCI condition exists.

Prehospital Mass Causality Incident (MCI) General Algorithm



Receive dispatch
Respond as directed
Arrive at scene
Determine mass causality conditions exist
Establish Incident Command (IC)
Scene assessment and size-up

CBRNE	NON-CBRNE
Notify medical control and IC of CBRNE situation	Notify medical control and/or Disaster Control Hospital and local Emergency Management Office (if identified in local MCI Plan)
Standby for HazMat/LE to clear scene	Ensure scene is safe
Don PPE if needed	Begin Initial Triage and Treatment of Critically Injured Patients
Establish hot, warm, and cold zones	Establish a staging area
Begin Initial Triage of Patients	Follow EMS patient care procedures (PCPs) and MCI Plans
Notify medical control and IC of patients conditions	Request additional resources that may include activating MAA
Decontaminate patients as needed	Initiate patient transport to medical centers as directed by medical control and/or Disaster Control Hospital
Begin initial treatment	Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)
Follow PCPs and MCI Plans	
Request additional resources that may include activating MAA	
Initiate patient transport to medical centers as directed by medical control and/or Disaster Control Hospital	
Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary)	

Prepare transport vehicle to return to service

Canceling Response; Slowing Response; Diverting to Another Call

See "Cancellation/Slowdown"

CLARK COUNTY MEDICAL PRIORITY DISPATCH SYSTEM EMS RESPONSE MODES

TYPE I
- County-Wide Fire/EMS Areas, Excluding NCEMS and DNR -

Response Determinant	Response Mode	
	First Response	Ambulance
A (Alpha)	Cold	Cold
B (Bravo)	Hot	Cold
C (Charlie)	Hot	Hot
D (Delta)	Hot	Hot
E (Echo)	Hot	Hot

TYPE II
- NCEMS and DNR Fire/EMS Areas -

Response Determinant	Response Mode	
	First Response (If Available)	Ambulance
A (Alpha)	Cold	Cold
B (Bravo)	Hot	Hot
C (Charlie)	Hot	Hot
D (Delta)	Hot	Hot
E (Echo)	Hot	Hot

EXCEPTIONS:

A. 26-A-27 (Sick person, with non-priority symptoms, needing transportation only.) CRESA shall only notify the call location's assigned ambulance on calls triaged as a sick person, with non-priority symptoms, needing transportation only.

Hospital Notification Report Format (H.E.A.R. – Landline – 800 MHz)

A. ALS/Emergency Report Format:
1. Unit identification
2. Age and sex of patient
3. Transport code (1 or 3)
4. Chief complaint or reason for transport
5. Very brief pertinent medical history (one sentence if possible)
6. Vital signs
7. Pertinent treatment rendered
8. Request for additional information or treatment
9. Estimated time of arrival (ETA)

-Note- The pre-hospital report should be provided to the receiving facility as soon as practical once transport has begun. All reports should be given in this order and should have a maximum of sixty seconds. The pre-hospital report is not meant to be a full patient report and should relay only pertinent patient care information. (Patient identification information is inappropriate to be given on the H.E.A.R. frequency.) Format for trauma system patients will follow specific reporting format as indicated in Trauma Protocols.

B. BLS/Non-Emergency Report Format:
1. Unit identification
2. Age and sex of the patient
3. Reason for transport
4. Estimated time of arrival (ETA)

-Note- The pre-hospital report should be provided as soon as practical once transport has begun. All reports should be given in this order and should have a maximum of thirty seconds. (Patient identification information is inappropriate to be given on the H.E.A.R. frequency.) If possible, use landline for hospital contact on transfers.

C. Advise Medical Control or receiving emergency department of changes in patient's condition en route and request for further treatment.

Verbal Report to Emergency Department Physician And/Or Triage Nurse

A. This should contain more detail than the radio report. The EMT now has the time to present thorough details of the scene, complete assessment of the patient, and complete report on patient care and the result of your efforts.
1. Name, age, sex and patient's physician
2. Chief complaint or injuries
3. If trauma, describe the trauma scene
4. Pertinent medical history
5. Physical examination findings
6. Explain patient treatments and results of such

Written Reports/Documentation

A. A State of Washington approved EMS Medical Incident Report (MIR) form (or other approved electronic report format) must be appropriately documented and filed for any call for EMS assistance resulting in patient contact within Clark County regardless of patient transport. This will apply to both basic and advanced life support units and includes public assist calls.

B. Documentation format
1. S.O.A.P. charting is the most acceptable method of report writing. This is a LEGAL record and may be called upon as evidence in any court of law. (IF IT IS NOT WRITTEN, IT WAS NOT SEEN OR DONE.)

C. Trauma - 10 minutes or less once extrication has been accomplished and the patient can be removed from the site.
D. Code 99 - 30 minutes or less after initial encounter.

-Note- Document extenuating circumstances.

LEVEL OF CARE DURING TRANSPORT

EMT-P AND EMT ON CAR

Attendance of the patient during transport will be appropriate to the degree of illness as determined by the judgment of the paramedic. All ALS transports will be attended by an emergency medical technician qualified and certified by Washington State Department of Health to provide the appropriate ALS procedures. The only exception may occur during mass casualty incidents.**-Note-**
Inappropriate assignment of medical attendants will be grounds for suspension of standing orders for EMT-P and EMT.

RECEIVING HOSPITAL

Triage Criteria:

A. Non-Life Threatening Injuries or Illness - Hospital destination at the discretion of patient, family, or the patient's physician.

B. Life Threatening Injuries or Illness - All patients will be delivered to the closest appropriate facility unless diversion criteria in effect.

C. Patients meeting the following criteria will be transported to SWMC:
  1. STEMI
  2. CVA/Stroke protocol
  3. Trauma Activation (unless the following diversion criteria apply)

Diversion Criteria:

A. Medical Diversion - Diversion by SWMC Medical Control to area hospitals may occur due to availability of resources, equipment, and/or facilities at SWMC. Destination hospital will generally be determined by closest facility.

B. Trauma Diversion - The final decision for diversion to Emanuel or OHSU rests with Medical Control at SWMC. Contact Medical Control as soon as possible with patient information; if directed to divert, contact Trauma Communications Center (TCC) at OHSU for further instructions.
  1. Criteria for diversion may include:
    a) Penetrating or severe injuries to the mid thorax and in shock.
    b) Major burns (patients requiring burn center intervention).
    c) Pregnancy with multi-system trauma in shock, unresponsive to aggressive resuscitation or immediate surgery anticipated.
    d) Pediatric trauma patient with shock/respiratory distress
    e) SWMC Medical Control advised diversion.

C. Hyperbaric Diversion - Hyperbaric chamber is located at Providence Hospital in Portland. Contact Medical Control as soon as possible with patient information; if directed to divert, contact Providence via H.E.A.R.
  1. Criteria for hyperbaric treatment include:
    a) Carbon Monoxide poisoning.

Other Considerations

A. If a BLS transport is requested and it is the judgment of the BLS crew that the patient needs to be transported by an ALS ambulance, it is mandated that dispatch be contacted and an ALS crew dispatched. Under no circumstances should a BLS crew transport a patient, if in their judgment, this is an ALS call. (Exception: mass casualty incidents.)

B. Emergencies en route:
   1. Pre-hospital protocols and guidelines will immediately apply.
   2. Medical Control should be contacted for concurrence of any orders as appropriate; the receiving facility should be contacted as soon as possible to inform them of changes in the patient's condition.

-Note- Any deviation from this guideline or from the transport protocols should be reported to the MPD on an incident report within 24 hours of occurrence.

NON-TRANSPORT OF PATIENTS

The EMT may be of the judgment that the patient need not be transported by ambulance, but unless the patient and/or custodian agrees with this judgment transport will be done. In general, the only reasons for a non-transport are Signed "Refusal for Transport", completed by patient, family or custodian or No patient (DOA, termination of Code 99 effort, etc.).

Patients Refusing Care and/or Transport (classified as follows):

A. No medical need exists.

B. A person with normal decision making capacity who, after having been informed of risks and benefits of treatment/transport, voluntarily declines further services.

C. Any other person is assumed to require a medical screening evaluation and EMS personnel will use all resources available to have that person treated and transported.

Impaired Decision Making Capacity Defined

A. Inability to understand the nature of his/her illness/injury.

B. Inability to understand risks or consequences of refusing care/transport.

C. Individuals impaired by:
   1. Alcohol/drugs
   2. Psychiatric conditions
   3. Injuries (head injury, shock, etc.)
   4. OBS (Alzheimer's, mental retardation, etc.)
   5. Minors (<18 years old)
   6. Language/communication barrier (incl. deafness)

Criteria for Informed Refusal/Consent

A. Person is given accurate information about possible medical problems and the risk/benefits of treatment or refusal.

B. Person is able to understand and verbalize these risks and benefits.

C. Person is able to make a decision consistent with his/her beliefs and life goals.

B. Three tubes (one red top tube, one 3cc lavender tube, one 3cc blue tube, 10-12 cc total) will be obtained for blood draw, appropriately labeled, and given to emergency department or laboratory personnel.

C. Appropriate laboratory tubes and Fenwall I.D. Bands will be provided by SWMC laboratory. Inservice education will be provided by laboratory personnel on an ongoing basis.

Special Considerations

A. Blood for legal alcohol determination may be drawn at request of law enforcement as provided by RCW 46.61.520, RCW 46.61.502, and/or RCW 46.61.522, if the patient is: (1) unconscious or (2) is under arrest for the crime of vehicular homicide or vehicular assault or is under arrest for the crime of driving while under the influence of intoxicating liquor or drugs, which arrest results from an accident in which another person is injured and there is a reasonable likelihood that such other person may die as a result of injuries sustained in the accident. Document law enforcement request on attached form.

DIRECTION TO TAKE BLOOD TEST

The undersigned states that________________________________
is either (1) unconscious or (2) is under arrest for the crime of vehicular homicide as provided in RCW 46.61.520 or vehicular assault as provided in RCW 46.61.522, or that such person is under arrest for the crime of driving while under the influence of intoxicating liquor or drugs as provided in RCW 46.61.502, which arrest results from an accident in which another person has been injured and there is a reasonable likelihood that such other person may die as a result of injuries sustained in the accident. The undersigned directs Clark County EMS to administer a blood test without the consent of the individual so unconscious or so arrested.

DATE____________ OFFICER______________________________________

MEDICATION ADMINISTRATION GUIDELINES

Controlled Medications

A. Controlled (legend) medications will be maintained at each agency utilizing approved protocols and security, to include lot number and vial number. When a controlled substance is given, the Clark County Controlled Drug Proof of Use form will be completed by the paramedic administering the medication and the agency officer authorized to replace the medication. Each agency will maintain the Controlled Drug Proof of Use form as a permanent record.

* B. Paramedics only are authorized to administer controlled drugs.
   1. Morphine - Up to 20 mg of Morphine may be given per protocols without need to contact Medical Control (e.g., cardiac pain, congestive failure, severe musculo-skeletal pain). Additional Morphine may be given only with Medical Control concurrence.
   2. Versed - Up to 10 mg of Versed (Midazolam) may be given per protocol for sedation (with Succinylcholine intubation or for synchronized cardioversion) without need to contact Medical Control. Additional Versed may be given only with Medical Control concurrence.

Allergies to Medications

A. All medications in these guidelines are to be administered only after ascertaining that the patient is not allergic to them. In critical situations when the patient is obtunded, personnel are reminded to question family, friends, and to look for Medic-Alert identification and/or "Vial of Life" canisters.

CHEST PAIN POSSIBLY CARDIAC ORIGIN

If MI Suspected; Acute MI in Clark County – Early Response Protocol

A. Patient Selection
   1. Active chest pain <12 hours
   2. 12 lead EKG w/ ST elevation in @ least 2 contiguous leads – ST Elevation MI (STEMI)
   3. No LBBB or paced rhythm
   4. No active bleeding, severe liver failure, severe systemic disease

B. Treatment
   1. Notify ED of Acute MI ASAP, transmit EKG using LP 12 internal data transmission function to LifeNet receiving station at SWMC
   2. Provide above care prn including ASA, NTG, analgesia as appropriate
   3. Draw blood and label as appropriate. Recommended order:
      a) Red, blue, green then lavender top
   4. Transport Emergently to SWMC

CVA

Transport Emergently if the patient meets the following criteria:

A. Patient >18 years of age not pregnant exhibiting acute signs of ischemic CVA.

B. Signs and symptoms must have been recognized within 5 hours

C. Notify SWMC to activate the stroke team.

ABANDONED NEWBORNS

Introduction;

A. Senate Bill 5236 allows for the relinquishment of newborn children at hospitals or fire stations. The key provisions of this law include:
   1. Protecting the parents anonymity
   2. Gathering the medical history of the parents and child
   3. Providing referral information to the parent about adoption options, counseling, medical and emotional aftercare services, domestic violence, and the legal rights of the transferring parent
   4. Notifying and releasing the newborn to child protective services (CPS).
      a. SB 5236 defines newborn as less than 6 days old.

Procedure;

A. If delivery has not occurred and appears imminent follow Emergency Delivery protocol. Provide appropriate care to mother per protocol.

B. If EMS is presented with a newborn and child in extremis:
   1. Follow Newborn Resuscitation or Management of the Severely Ill or Injured Child protocol.

C. Patient not in immediate need for medical care:
   1. Ascertain child's medical history as appropriate
      a. History of birth including complications, date, time, etc.
      b. Known congenital anomalies
   2. Paternal/Maternal medical history
      a. Prenatal care

2. Isolated head injury with no other findings
3. Spinal cord injury with paralysis
4. Flail chest
5. Two or more obvious proximal long bone fractures
6. Combination of burns 20% or greater or involving face, airway, hands, feet, genitalia
7. Amputation above wrist or ankle
8. Biomechanics
   a) Penetrating head injury
   b) Death of same car occupant
   c) Ejection of patient from vehicle
   d) Falls 20 feet or greater
   e) Pedestrian hit at 20 mph or greater OR thrown 15 feet or greater
9. Consider
   a) Paramedic gut feeling of injury severity
   b) Extremes of age (<12,>60) or environment
   c) Underlying medical illness
   d) Presence of intoxicants
   e) Second or third trimester of pregnancy
   f) Rollover
   g) Motorcycle, ATV or bicycle accident.
   h) Extrication longer than 20 minutes
   i) Significant intrusion

LIFE FLIGHT/AIR AMBULANCE TRANSPORT

General Considerations

A. Air Ambulance is appropriate for the critical trauma patient if transport time can be reduced by at least 10 minutes versus ground. Consider the following when deciding on Air transport:
   1. Transport time to a level I or II trauma center can be reduced by 10 minutes versus ground transport. Factors affecting the 10 minute reduction include:
      a. Transfer of patient care to Life Flight personnel
      b. Establishing and transporting to the landing zone
   2. In general, incidents occurring within 20 miles of the trauma center do not necessitate helicopter transport.

Standby

A. LIFE FLIGHT may be placed on standby by:
   1. 1st Responder
   2. EMT
   3. Paramedic
   4. Any Physician
   5. Any Police Officer

   -Note- When LIFE FLIGHT is put on standby status; the helicopter is readied but remains available for any other requests on a priority basis. If another agency requests activation and you have LIFE FLIGHT on standby, LIFE FLIGHT will check with you for activation or stand-down.

B. LIFE FLIGHT should be placed on standby by trained personnel on scene after patient assessment has been done. It would be appropriate to place LIFE FLIGHT on standby prior to personnel arrival based on the following guidelines:
   1. If first response unit arrival at the scene will be greater than 10 minutes and the information dispatched purports to be the type of patient who will benefit from LIFE FLIGHT. Examples of situations:
      a) gunshot or penetrating trauma
      b) MVA; person trapped or multiple patients

Cowlitz County Operating Procedures (COPS)

2008

Draft from COP Committee
12/18/2007
4/1/08 Update

Cowlitz County EMS Council

A. It is appropriate to place Air Medical Transport on standby prior to EMS personnel arrival on the scene if first response time to the scene will be greater than 10 minutes and the information dispatched purports to be the type of patient who will benefit from Air Medical Transport.

B. Air Medical Transport may be placed on "Standby" by contacting the Cowlitz County 911 Communications Center.

   1. Any certified EMS personnel can request Standby status for Air Medical Transport.
   2. NOTE: LIFE FLIGHT also will accept requests from non-EMS personnel such as, logging crew bosses, law enforcement, etc.

V. Activation of Air Medical Transport

A. The decision to activate Air Medical Transport rests with a responding paramedic, first response incident commander, or a physician on scene:

   1. As paramedic arrives on scene and evaluates patient OR;
   2. Based upon information relayed to paramedic by people on scene.

B. In some cases Air Medical Transport can be immediately dispatched (activated) to the scene prior to the arrival of a first-in unit or paramedic, when:

   1. Travel time for that first-in unit will be over 20 minutes and the situation as known suggests to be the type of patient who will benefit from Air Medical Transport.
   2. Where it is known that difficult terrain will be encountered rendering ground assess difficult but where the helicopter can get near the patient easily.
   3. Where the reporting party relates some other special circumstance indicating the need for immediate activation of Air Medical Transport.
   4. On scene EMS responders relate to the paramedic the need for activation of Air Medical Transport prior to the paramedic's arrival

C. In all situations of activation, it shall be done with concurrence of responding paramedic(s).

VI. Cancellation Of Air Medical Transport

A. Only a responding paramedic can cancel Air Medical Transport once it has been activated.

B. The responding paramedic can cancel Air Medical Transport based on the information provided from on-scene EMS personnel but is still ultimately

3. The first ambulance is decidedly closer to the second call and the response would be vital to the patient's survival.

II. Level of Care

A. The EMS personnel with highest level of certification level shall be in charge of patient care.

1. Paramedics may delegate non-ALS patients to an EMT but the paramedic is ultimately responsible for the care delivered and the documentation while the Paramedic is on-scene or enroute to the hospital with that patient.

a. First Responders (medical certification) cannot be designated to provide patient care during transports.
b. Inappropriate designation of EMS personnel to provide patient care may be grounds for removal of protocol privileges pending formal determination and/or investigation from the Department of Health.

2. When more than one patient is in need of care, the most critical patients shall receive care from the EMS personnel with the highest certification, the most training and experience as appropriate.
3. All ALS patients shall receive care from paramedics whenever possible.

a. Dispatch criteria for ALS / paramedic response include:

1. Patient's requiring or possibly requiring ALS procedures.
2. Patient's requiring or possibly requiring any medication.
3. Abdominal pain,
4. Allergic reaction,
5. Breathing problems, shortness of breath, respiratory arrest,
6. Any symptom of cardiac origin, chest pain, cardiac arrest,
7. Convulsions / seizures,
8. Drowning / near drowning
9. Diabetic problems,
10. Multiple traumas,
11. Overdose / poisoning,
12. Patient in shock (or possibly will develop shock),
13. Person down – Unknown

1. If at any time EMS personnel have been or predict they will be on the scene for more than 20-30 minutes after the initial encounter, he/she will contact Medical Control for advice on whether the patient should be transported immediately or have further care rendered on the scene.

C. Trauma Scene

1. The trauma patient should be transported immediately. Only airway management, extrication, and spine immobilization should delay transport. Other treatments, including I.V. attempts, should not delay transport.

D. Cardiac Arrest Scene

1. Maximum scene time is 30 minutes.

E. Extenuating Circumstances

1. There may be times that scene times exceed maximum times. In those cases, the rational for extended scene times must be documented.
2. In cases of two or more patients, each with varying extrication times, additional transport vehicles should be requested to affect the earliest transport of patients as they are extricated.

IV. Transfer of Patient Care Between EMS Personnel.

A. Attention to quality patient care is of utmost concern. Should any issues or problems occur remember patient care comes first. All issues or problems that may affect patient care must be reported to the Medical Control immediately.
B. Both parties must acknowledge the transfer of care and record it in their respective documentation.
C. The transfer of patient care must be orderly, efficient and expedient.
D. A verbal or written report must be exchanged and the content of the report documented attached to the Medical Incident Report for the MPD.

NOTE: For more information refer to the Cowlitz County Mass Casualty Plan Appendix "A" on which this section is based.

WHAT CONSTITUTES A MULTIPLE PATIENT SCENE (MPS) and a MASS CASUALTY INCIDENT (MCI)

If, at any time, the scene escalates to the point that it meets the criteria established for a Mass Casualty Incident (MCI), the MCI plan will be implemented and the MCI protocol will be followed, and Cowlitz County Communications (9-1-1) shall be notified of the change in status.

NOTE: *It is assumed that all responders on either the ambulance or rescue vehicles will be trained to at least the First Responder level.*

TRIAGE TAGGING

Since first responders will be doing the bulk of field triage in extensive emergency operations, it is important that they understand the use of triage tags and/or triage tape.

Identification and priority tags are essential for smooth triage at a disaster site. Color–coded tags or tape help to inform the Transportation Team Leader as to which patients to evacuate next.

The tags are 4 ½" x 8 ½" and are relatively durable. These tags should be affixed to each casualty during the initial triage. Triage tape may be used in place of triage tags. If tape is used, it should be tied to the patient's upper arm.

At plane crashes, it is required that the upper left corner on the injury diagram side of the tag be removed and left where the victim was found.

Below is the tag used in field triage. Front and back sides have space for recording patient identification and treatment. Urgency-rating strips at the bottom are color-coded green (III), yellow (II), red (I), and black (O).

Transport and intervention may be delayed for a time without endangering life.

Priority 3: (Green)

The "walking wounded;" minor wounds, minor fractures, small foreign bodies, and minor emotional problems.

Priority 4: DEAD OR CANNOT BE SAVED (Black or black and white striped)

Cannot be saved under the circumstances, Dead or almost dead, i.e., decapitation, massive chest wounds, total body burns with inhalation injury, etc. Included are patients in cardiac arrest following trauma; if there are limited resources or personnel available, transportation can be delayed.

MASS CASUALTY INCIDENT (MCI) TRIAGE SPECIAL CONSIDERATIONS

A. Simple Triage and Rapid Transport (START) Triage is the county standard.
B. Wear protective clothing in the Immediate Danger Zone.
C. If there is any over-riding danger of fire or explosion, get the victims out of the danger zone immediately, if possible.
D. Remove victims to triage area.
E. Move the dead only if it is necessary for fire fighting or rescue effort.
F. Only immediate life saving treatment is to be done in the danger zone. Examples: Opening the airway.
G. Victims brought to the staging area should be placed with their heads toward the center of the tarp so the EMTs can better monitor them. NOTE: Tarps should not be placed too close together.
H. If the personnel are too busy in the Staging Area they should contact the Triage Officer. The Triage Officer will contact the Command Post to get more manpower.
I. A manpower pool may need to be established. The Command Post should be organized to perform additional sweeps over the area.
J. Field assessment can be handled by fire fighters. A search should be organized to perform additional sweeps over the area.
K. Crews should stay together as much as possible.
L. No victim should be left unattended in the Staging Area without checking with both the Triage Officer and the Transportation Officer. All victims should be funneled past the Triage Officer for screening. In this way, all victims are accounted for.

It will also be necessary to request ambulances for coverage of other incidents that will happen during these events.

MPS and MCI incidents require a focus on the provision of BLS care as primary, with ALS care as secondary and only after BLS care needs have been addressed. The care of the many will prioritize over the critical care needs of a select few.

When necessary BLS transport-capable units that are only licensed as aid vehicles will be used for transporting patients to medical facilities to assist in filling the shortage of ambulances.

Some MPS and all MCI incidents will find it necessary for each ambulance to carry as many patients to the hospitals as they are equipped to handle. The ability to care for patients while being transported will be restricted, however the need to move patients to the medical receiving facilities will be the greater priority. Because of the prioritization on BLS-level care, patient care contact will be minimized.

Cowlitz County has one (1) 100 patient MCI trailer, housed in Woodland. MCI9-2 is equipped with the supplies and equipment to immobilize 100 patients, provide for basic wound care and splinting needs, oxygen therapy, and also carries IV therapy supplies. When requested, MCI9-2 response with a crew of two (2) who function as resource asset managers. The trailer provides supplies and equipment for at scene caregivers.

Appendix 5.

July 2009- June 2012 Regional Plan Gantt Chart