

**SOUTH CENTRAL REGION
EMERGENCY MEDICAL SERVICES
& TRAUMA SYSTEM
STRATEGIC PLAN
July 1, 2015 – June 30, 2017**



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INTRODUCTION

The Washington State EMS & Trauma Care System was established as a grassroots, locally-driven system. The system includes a Steering Committee, Region Councils, and County Councils which are in turn comprised of local representatives from EMS agencies, hospitals, MPDs, dispatch, law enforcement, and community members. Region and County Councils are intricately involved in the ongoing development of the EMS & Trauma System. The Region and County Councils are tasked by RCW and WAC with system planning, evaluation, and making quality improvement recommendations to the EMS and Trauma Steering Committee and Department of Health (DOH). The Region and County Councils also provide coordination, support, and resources to local EMS agencies and system partners.

The South Central Region EMS & Trauma Care Council proudly represents and serves Benton, Columbia, Franklin, Kittitas, Walla Walla, and Yakima Counties. Within the region there are currently 58 prehospital Trauma Verified Services, 19 Trauma Designated Facilities, and 23 Cardiac and Stroke Categorized Facilities. The South Central Region residents are industrious, hardworking, and active. Two of the state’s largest rivers, the Snake and the Columbia, flow through the South Central Region. Tourists are drawn to this dynamic region. In addition to farming being one of the region’s major economic activities, the region is also home to the second largest Indian Reservation in the state as well as a 327,000 acre military training center. The Hanford Nuclear Site is located near the center of the Region. These unique features create geographic and sometimes logistic barriers to providing EMS services due to the “off limits” nature of many of these restricted properties. Interagency coordination through the County and Region Councils has created a forum to overcome barriers as outlined in Regional Patient Care Procedures (PCPs), County Operating Procedures (COPs), and other means appropriate to system needs.

Prehospital Verified Services*

COUNTY	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS
Benton	3			1	2	6
Columbia	1			1		
Franklin				2		1
Kittitas	7			2		2
Walla Walla	6			3		1
Yakima	16				1	3

*Numbers are current as of the date submitted

Trauma Designated Facilities*

Adult Level II	Adult Level III	Adult Level IV	Adult Level V	Pediatric Level II	Pediatric Level III	Rehab Level II	Rehab Level III
	6	5	1	0	3	4	

*Numbers are current as of the date submitted:

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/530101.pdf>

Cardiac and Stroke Categorized Facilities*

Cardiac Level I	Cardiac Level II	Cardiac Uncategorized	Stroke Level I	Stroke Level II	Stroke Level III	Stroke Uncategorized
3	8			8	4	

*Numbers are current as of the date submitted:

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf>

The chart below demonstrates that, much like the other EMS regions in Washington State, our Region has a handful of moderate sized cities yet is mostly made up of small rural townships and communities. Parts of each county may be urban or suburban while other areas within the same county are identified as rural or wilderness.

SC Region	Population	Square Miles	Persons/sq. mile
Benton	184,486 pop	1,760	104.8/sq. mile
Columbia	4,032	874	5/sq. mile
Franklin	86,638	1,265	68.4/sq. mile
Kittitas	41,765	2,333	18/sq. mile
Walla Walla	59,530	1,299	46/sq. mile
Yakima	247,044	4,311	56/sq. mile
Total	623,495	11,842	53/sq. mile

The majority of EMS agencies in the region’s rural areas rely solely on volunteers to provide prehospital EMS patient care while the more urban/suburban areas have the ability to maintain full time paid or a mixed paid/volunteer staff. The geographic characteristics of the region exacerbate the disparity of resources and increase the difficulty for agencies to adequately respond in a timely manner between urban and rural areas. Many prehospital agencies have grown from basic aid service to advanced life support service. Other agencies have merged with neighboring agencies in order to survive financially or have disbanded their EMS service entirely due to lack of funding for resources and personnel and/or lack of volunteers to staff the agencies. Rural critical access hospital patient care is impacted by air and ground delays in patient transfers to advanced facilities (for example, inclement weather can delay transport, some agencies may lack the availability of volunteer or paid EMS providers to accompany the patient

during transport, and taking a primary response unit out of service for an extended transfer can adversely affect any additional responses). Across the continuum of care, recruitment, training, and retention of EMS personnel is a challenge in the current “do more with less” culture.

The EMS & Trauma System is also challenged by a great deal of change on a number of fronts such as: the emergence of technology in patient care and electronic records, sustainable funding sources, reimbursement, changing staffing models at DOH (i.e. the old licensing & certification section vs. credentialing), and a large turnover/retirement of individuals who were present at the beginning of the EMS & Trauma System. The original system founders and early leaders understood the whys and wherefores of the system origins and development. This historical knowledge needs to be captured to be passed on to the current and upcoming generation of EMS leadership to understand how we got to where we are now and avoid foreseeable future missteps. To face the challenge during this plan period, the Council will take proactive steps to complete an analysis of the EMS system components to assess the current effectiveness, and efficiencies for system quality improvement. Through the process of system component analysis the what, how, and whys will be captured. The results of the analysis will be used to complete objectives and strategies throughout this plan as well as guide future planning.

The Region EMS & Trauma Care System Strategic Plan is made up of goals aligned with the State Strategic EMS & Trauma Care System Plan. The objectives and strategies created are designed to improve the EMS system through ongoing statutory work and ongoing system quality improvement by addressing emerging issues. Although the beginning dates of each objective and strategy are not shown it is noted here some work is time limited with internal beginning and completion dates while other work will be ongoing throughout the plan period. For example Goal 1 Objective 1 is ongoing work, which will begin immediately and will continue through June 2017 and into the future. Internally, the Region maintains a detailed work plan schedule to meet the projected completion dates. In conclusion, the Council will do its utmost to achieve the plan goals through the work of the objectives and strategies, and with the collaboration of system partners at all levels the EMS system will advance the EMS & Trauma system in the South Central region.

GOAL 1

Work toward a sustainable regional emergency care system that provides high-quality emergency medical, trauma, cardiac and stroke patient care through workforce development, appropriate capacity, and distribution of resources.

The Region and County Councils are, as directed by RCW and WAC, tasked to provide objective system level analysis and make recommendations for system quality improvements where indicated. To advance the system during this plan period, the Council will take proactive steps to complete an analysis of the EMS system components to assess the current effectiveness, and efficiencies for system quality improvement.

For example:

- The Council will select the components and define aspects of those components for analysis. For example: *System Component – “Region PCPs” Aspects to be analyzed - “how PCP content is adapted within COPs and/or distributed separately to providers” or System Component – “Dispatch” Aspects to be analyzed - “dispatch interaction with prehospital providers regarding initial units responding to a scene and requesting additional resources”*
- Solicit input from system partners and use established system documents (RCW, WAC, PCPs, COPs, etc.) to aid in the process.
- Conduct the analysis at the County and Region Council levels.
- Organize results for consideration by the County Councils, Region Council, Steering Committee, and DOH.
- Initiate/implement the system recommendations as practical and appropriate.

The success of this work will be assured by giving each County Council, local agency, hospital, and dispatch center the ability to report what is working, what’s not, and to suggest practical solutions. This activity has the potential to increase EMS agency involvement with the County Councils in order to provide local expertise, to collaborate on solutions to system challenges, and most importantly give them a voice in the future direction of the system. The information drawn from an analysis of the system components will improve operations throughout the Region and Counties by creating a better understanding of why standing practices are in place, adjusting these practices if necessary and/or implementing the practical solutions to fine-tune the system where appropriate.

Minimum/Maximum (min/max) numbers are in place to reduce inefficient duplication of resources and provide service to underserved and unserved areas. Min/Max numbers outline the levels of designated trauma, pediatric, rehabilitation services, and prehospital trauma verified services. Although not included in the min/max process for designated trauma services, self-categorized cardiac/stroke system facilities within the region have been identified. Identifying the current min/max number of “services” does not necessarily demonstrate an organization’s future due to diminishing volunteer personnel and/or resources to staff an agency. An analysis of personnel and resources within the existing entities is needed to effectively identify underserved and unserved areas. Underserved and unserved areas within the region have not previously been clearly identified. Generalized statement such as ‘Columbia County does not have any ALS ground service within the county and rely on volunteer providers for BLS response’ does not identify successes of the rural agencies or ongoing critical shortages. There are also areas within the counties with no local EMS agencies which cause the burden of response to fall on

<p>neighboring agencies to on a "mutual" aid basis. This strains the neighboring EMS agencies in fulfilling their primary responsibilities by being out of district and extending response times. This practice also puts agencies at risk for providing tax funded services outside of the taxing jurisdiction because it's not "mutual" if there is no primary local EMS agency. The domino effect has all agencies doing the best they can to meet an ever increasing need. The goal of an in depth analysis of the distribution of services will identify unserved and underserved areas and specific unmet system needs related to designation and verification. The information gained will be used in future system planning.</p>	
<p>Objective 1: By June 2016 and periodically thereafter, the Region Council will analyze EMS & Trauma System components for current effectiveness and system improvement to maintain and advance the system. (RCW 70.168.120) (WAC 246-976-960)</p>	<p>Strategy 1: By September 2015, the Region Council will request Region and County Council members, EMS agencies, hospitals, and QA&I committees submit suggestions that identify which EMS system components should be considered for analysis.</p>
	<p>Strategy 2: By December 2015, the Region Council will identify and prioritize which EMS system components will be analyzed.</p>
	<p>Strategy 3: By January 2016, the Region Council will determine a schedule and method to conduct the analysis.</p>
	<p>Strategy 4: Beginning January 2016, the Region and County Councils will conduct the analysis of system components.</p>
	<p>Strategy 5: Beginning March 2016, the Region and County Councils will compile system benchmarks and recommendations derived from the analysis of system components.</p>
	<p>Strategy 6: Beginning May 2016 and as developed, the Region and County Councils will share the outcomes of system recommendations with DOH and the Steering Committee to assist in developing appropriate implementation methods.</p>
	<p>Strategy 7: By June 2016 and as developed, the Region will initiate/implement the system recommendations as practical and appropriate.</p>
	<p>Strategy 8: By June 2016 and periodically thereafter, the Region Council will assess the impact of the system changes to make corrections as needed at the one year mark following implementation of system change.</p>
<p>Objective 2: By June 2017 the Region Council will analyze min/max numbers and levels of Designated Trauma Adult, Pediatric, and Rehabilitation Services and resources in preparation for the SC Region hospital designation cycle beginning January 2018. (RCW 70.168.100) (WAC 246-976-960)</p>	<p>Strategy 1: By March 2016, the Region Council will conduct a survey of Designated Trauma Adult, Pediatric, and Rehabilitation Services regarding anticipated designation changes, personnel, and resources.</p>
	<p>Strategy 2: By April 2017, the Region and County Councils will use survey results and DOH established guidelines with specific criteria to conduct an analysis of resources min/max numbers.</p>
	<p>Strategy 3: By May 2017, the Designated Services and County Councils will work together to prepare any proposed changes of min/max numbers and levels of Designated Trauma Services to DOH.</p>
	<p>Strategy 4: By June 2017, the Region Council will review County Council recommended changes of min/max numbers and levels of Designated Trauma Services for submission to DOH.</p>

<p>Objective 3: By May 2016, the Region Council will analyze the Prehospital Trauma Verified Service minimum and maximum numbers and levels resources to maintain and advance the system. (RCW 70.168.100) (WAC 246-976-960)</p>	<p>Strategy 1: As needed, the Region Council will, upon receipt from DOH, review any applications for new trauma verification services within the 45 day timeframe as required by WAC.</p>
	<p>Strategy 2: By October 2015, the Region Council will conduct a survey regarding the resources of Prehospital Trauma Verified Services.</p>
	<p>Strategy 3: By January 2016, the Region and the County Councils will use survey results and DOH established guidelines with specific criteria, to conduct an analysis of Prehospital Trauma Verified Services resources and min/max numbers.</p>
	<p>Strategy 4: By April 2016, the County Councils will work together to prepare any proposed changes to min/max numbers and levels of Prehospital Trauma Verified Services.</p>
	<p>Strategy 5: By May 2016, the Region Council will review County Council recommended changes of Prehospital Trauma Verified Services min/max numbers for submission to DOH.</p>
<p>Objective 4: By June 2017, the Region Council will analyze Emergency Cardiac and Stroke Categorized participation and resources to maintain and advance the system, in preparation for the SC re-categorization beginning July 2017. (RCW 70.168.150) (WAC 246-976-960)</p>	<p>Strategy 1: By January 2017, the Region Council will conduct a survey regarding the Emergency Cardiac and Stroke Categorized participation and resources.</p>
	<p>Strategy 2: By January 2017, the Region and County Councils will work together to review survey results and develop recommendations where practical to maintain and advance the cardiac and stroke system.</p>
	<p>Strategy 3: By May 2017, the Region and County Councils will revise the PCPs or COPs as needed, to direct the operations of the Emergency Cardiac and Stroke Categorized participating hospital system where applicable.</p>
	<p>Strategy 4: By June 2017, the Region Council will include the list of Emergency Cardiac and Stroke Categorized participating hospitals in the system plan.</p>

GOAL 2

Prepare for, respond to, and recover from public health threats through collaboration within the Region and County Councils comprised of multi-disciplinary health care providers and partners who are fully engaged in emergency care service system to increase access to quality, affordable, and integrated emergency care.

The Region Council provides system planning and coordination, a forum to address emerging issues for example; implementation of the Cardiac / Stroke System, revise PCPs to accommodate WAC changes, and prehospital emergency preparedness planning. The Region Council Members are a conduit for system information among our partners including the County Councils, MPDs, prehospital EMS agencies, hospitals, public health, emergency management, emergency dispatch centers, and other EMS and trauma system stakeholders. Region Council Members serve on a variety of Steering Committee TACs, local County EMS & Trauma Care Councils, Public Health Preparedness Committees, as well as interagency workgroups. To facilitate ongoing system communication, agency contact and agency verification status information is periodically updated and reconciled with DOH records. Organizational and leadership training is a necessity to help sustain and advance this level of multidisciplinary collaboration.

The Council Members remain dedicated to accomplishing system work in a cost effective and efficient manner, through direct engagement in the business management process. In an effort to improve Region Council sustainability and maximize diminishing funds, the Southwest and South Central Regions contracted with each other to consolidate business administration in 2012. By contract, the Southwest Region Council provides administrative services for the South Central Region Council. Each Region will remain a separate business entity. Both Regions maintain their respective council structures, bylaws, and operations. The Region Councils individually contract with DOH to implement the regional system plan work and maintain system functionality through localized planning, system component evaluation, and providing system recommendations where needed. To efficiently accomplish the objectives and strategies the Southwest Region and South Central Region plan work mirror each other.

<p>Objective 1: By August 2015 and ongoing, the Region Council will maintain EMS System information and resources on the Region Council website.</p>	<p>Strategy 1: By July 2015 and ongoing, or when the Plan is approved by DOH, the Region Council will distribute and post the new Region EMS and Trauma Care System Plan on the Region website.</p>
	<p>Strategy 2: By August 2015 and ongoing, the Region Council will provide Council Member resources on the website (such as the council member handbook, bylaws, etc.)</p>
	<p>Strategy 3: By August 2015 and ongoing, the Region will maintain EMS and Trauma Care System information and resources links on the Region Council website.</p>
<p>Objective 2: By June 2017, the Region Council will continue to conduct business in an effective and efficient manner. (RCW 70.168.130) (WAC 246-976-960)</p>	<p>Strategy 1: By August annually, the Region Council will provide DOH with an annual budget.</p>
	<p>Strategy 2: By November annually, the Region Council will submit the annual BARS report to the SAO.</p>
	<p>Strategy 3: By January 2017, the Region Council will review council bylaws and revise as needed.</p>
	<p>Strategy 4: By June 2017, the Region Council will review</p>

	council policies and revise as needed.
<p>Objective 3: By June 2017, the Region Council will collaborate with the other Regions in the state to maintain and advance the emergency care system. (RCW 70.168.120) (WAC 246-976-960)</p>	<p>Strategy 1: By July 2015, by contractual agreement the Southwest Region Council will provide business office and administrative services, for the South Central Region Council.</p>
	<p>Strategy 2: By September 2015 and periodically during the plan period, the Region Council will review the Steering Committee and associated TAC strategic plans to identify areas of strategic synergy in implementing the plan work.</p>
	<p>Strategy 3: By June 2017, the Region Council will collaborate with the RAC to accomplish the work of the State EMS & Trauma System Plan to maintain and advance the system.</p>
	<p>Strategy 4: By June 2017, the Region Council will work with other Regions to compare business processes and operations in order to adapt and integrate efficiencies.</p>
<p>Objective 4: By June 2017, the Region Council will seek out, apply for, and administer EMS & Trauma related grant funding sources. (RCW 70.168.100) (WAC 246-976-960)</p>	<p>Strategy 1: By December 2015, the fundraising subcommittee will prioritize fundraising strategies and goals.</p>
	<p>Strategy 2: By March 2016, the Region Council will apply for grants.</p>
	<p>Strategy 3: By September 2016, the fundraising subcommittee will review grants or donations received.</p>
	<p>Strategy 4: By June 2017, the Region Council will administer grants and donations received.</p>
<p>Objective 5: By May annually, the Region Council will reconcile prehospital agency contact information, personnel resources, and level of service. (RCW 70.168.100) (WAC 246-976-960)</p>	<p>Strategy 1: By February annually, the Region Council will obtain from the DOH a detailed list of all prehospital agency information.</p>
	<p>Strategy 2: By February annually, the Region and County Councils will request updated detailed contact information from all agencies in the region.</p>
	<p>Strategy 3: By April annually, the Region will reconcile the information to ensure it is correct and up to date.</p>
	<p>Strategy 4: By May annually, the Region Council will provide updated agency information to DOH.</p>
<p>Objective 6: By June 2017, The Region Council will facilitate organizational and leadership training for the Region and County Council’s members and EMS agencies as becomes reasonably available and practical.</p>	<p>Strategy 1: By January 2017, the Region Council will provide a Council Member orientation as new members are appointed.</p>
	<p>Strategy 2: By January 2017, The Region Council will share outside training information and best practices with County Councils, EMS agencies, and system partners.</p>
	<p>Strategy 3: By June 2017, the Region Council will participate in DOH business and system trainings as they become reasonably available.</p>
	<p>Strategy 4: By June 2017, the Region Council will facilitate organizational and leadership training as becomes reasonably available and practical.</p>
<p>Objective 7: By May 2017 or DOH timeline, the Region Council will develop</p>	<p>Strategy 1: By September 2016, the Region Council will determine a process to develop the next Region EMS & Trauma System Plan.</p>

<p>the next Region EMS & Trauma System Plan in accordance with DOH guidelines. (RCW 70.168.100) (WAC 246-976-960) (WAC 246-976-970)</p>	<p>Strategy 2: By December 2016, the Region Council will request that County Councils assist in the development of the plan and submit recommendations for the next Region EMS & Trauma System Plan.</p>
	<p>Strategy 3: By March 2017, the Region Council will review progress of the plan development at regular council meetings.</p>
	<p>Strategy 4: By May 2017 or DOH timeline, the Region Council and County Councils will develop the next Region EMS & Trauma System Plan in accordance with DOH guidelines.</p>
	<p>Strategy 5: By May 2017, the Region Council will review and take formal action to adopt the next Region EMS & Trauma System Plan for final submission to DOH.</p>
	<p>Strategy 6: By May 2017 or DOH timeline, the Region Council will submit the next Region EMS & Trauma System Plan to the DOH for approval.</p>
<p>Objective 8: By January 2016, the Region Council will collaborate with system partners on pre-hospital emergency preparedness planning.</p>	<p>Strategy 1: By September 2015, the Region Council will distribute and post prehospital Emergency Preparedness information on the Region website and update as needed.</p>
	<p>Strategy 2: By January 2016, the Region Council members will participate in various TACs conducting Emergency Preparedness planning for pre-hospital providers.</p>

<i>GOAL 3</i>	
Promote and enhance the sustainability of the emergency care system by educating providers, utilizing standardized evidence-based procedures and performance measures, and continuous quality improvement.	
<p>Regional Patient Care Procedures (PCPs) as well as County Operating Procedures (COPs) are in place to get the right patient, to the right care destination, in the right amount of time thus improving the patient outcome by reducing morbidity and mortality. Region PCPs have been developed to provide operational guidelines throughout the Region while some of the County Councils have also developed COPs with their MPDs to provide county specific operational guidelines. The Region Council reviews the COPS to assure that they are congruent with the PCPs and in line with prehospital system operations.</p> <p>EMS agencies continually strive to meet increasing operational requirements. Providing EMS comes at a cost of time, effort, and money for essentials such as; initial and ongoing training for EMS providers, ambulance supplies, gear for employee and volunteer use, and keeping up with the continual evolution of technology used in the field to provide ever advancing emergency medical care to the citizens of our region. All facets are dependent on diminishing resources. To bridge the gap of training resources, the Region Council provides training grant funding to each County Council to supplement the unique needs of each County. The Region emphasizes support to encourage volunteers directly by offsetting training costs. Volunteers remain the backbone of the rural EMS & Trauma System. The distribution of training grant funds is accomplished through a Region Council established sub-recipient grant process.</p>	
<p>Objective 1: Each June, the Region Council will utilize a process to identify needs and allocate available funding to support Prehospital training. (RCW 70.168.130) (WAC 246-976-960)</p>	<p>Strategy 1: Each March, the Region Council will initiate the sub recipient grant process to support prehospital training for the next fiscal year by conducting a training needs assessment.</p>
	<p>Strategy 2: Each July, the Region Council will allocate available funding to support prehospital training (funds will be distributed throughout the year as training occurs and complete documentation is submitted to the Region).</p>
	<p>Strategy 3: Each September, the Region Council will establish grant contracts with each recipient.</p>
	<p>Strategy 4: Each June, the Region Council grants contract administration will be completed.</p>
	<p>Strategy 5: Each June, the Region Council will report the outcome of grant sponsored training for EMS providers. (on the DOH “Exhibit C” report)</p>
<p>Objective 2: By January 2017, the Region Council will review the Region Patient Care Procedures (PCP) and make updates as needed. (RCW 70.168.100) (WAC 246-976-960) (WAC 246-976-970)</p>	<p>Strategy 1: By September 2016, the Region Council will revise the PCPs where indicated based on the outcome of the system component analysis.</p>
	<p>Strategy 2: By October 2016, the Region Council will request input from the County Councils and MPDs for recommendations of updates and/or changes to the Region PCPs.</p>
	<p>Strategy 3: By November 2016, the Region Council will review and use input to draft revisions.</p>
	<p>Strategy 4: By January 2017, the Region Council will submit PCPs to the DOH for approval.</p>

	<p>Strategy 5: By January 2017, or when the PCPs are approved by DOH, the Region Council will revise the Region Plan and distribute the plan to Region members, County Councils, MPDs, and agencies for implementation.</p>
<p>Objective 3: By May 2017, the Region Council will review as needed, County Council COPS for congruency and alignment with the Region PCPs. (RCW 70.168.100) (WAC 246-976-960) (WAC 246-976-970)</p>	<p>Strategy 1: By November 2016, the County Councils will consider revision of their COPs based on the outcome of the system component analysis where indicated.</p>
	<p>Strategy 2: By February 2017, the County Councils will take formal action on proposed revisions of the COPs.</p>
	<p>Strategy 3: By March 2017, the Region Council will review any submitted COPs for consistency with the Region PCPs and notify the County Councils of the result.</p>
	<p>Strategy 4: By April 2017, the County Council will submit COPs to the DOH for approval.</p>
	<p>Strategy 5: By May 2017, or when the COPs are approved by DOH, the County Council will notify the Region Council of the approval, and will include any revised COPs in the Region Plan.</p>
<p>Objective 4: By May 2016, the Region Council will collaborate with DOH, RAC, and partners to develop useful WEMISIS data report templates for routine (monthly, quarterly, or semiannually) distribution to the agencies, County Councils, MPDs, and QA&I committees.</p>	<p>Strategy 1: By September 2015, the Region Council will request access to region wide WEMISIS data and any current DOH/OCHS developed report templates.</p>
	<p>Strategy 2: By November 2015, the Region Council will ask County Councils and prehospital agencies to identify additional types of data reports that would be helpful to their agency or county.</p>
	<p>Strategy 3: By January 2016, the Region Council will collaborate with DOH to develop new system data report templates.</p>
	<p>Strategy 4: By March 2016, the Region Councils will distribute template WEMISIS data reports to County Councils, Prehospital Agencies, MPDs, and Hospitals.</p>
	<p>Strategy 5: By May annually, the Region and County Councils will request feedback on the usefulness of the data reports.</p>

<i>GOAL 4</i>	
Promote programs and policies to reduce the incidence and impact of injuries, violence, and illness.	
<p>The first point on the continuum of care is prevention. The Region Council provides prevention resource information and links to injury prevention activities and organizations on the region website. Area hospitals and EMS agencies also host a multitude of prevention activities that specifically address local issues as well as universal initiatives. Solid evidenced-based injury prevention projects on the small scale that the Region is equipped to support are rare because in spite of extensive cost cutting measure already taken by the Region Council to date, has not allocated funding to provide injury prevention sub-recipient grants. The Region Council will continue supporting injury prevention efforts by maintaining prevention resource links on the region website.</p>	
<p>Objective 1: By July 2015 and ongoing, the Region Council will support injury and violence prevention (IVP) awareness through communicating resources and opportunities with system partner projects and programs. (RCW 70.168.130) (WAC 246-976-960)</p>	<p>Strategy 1: By July 2015 and ongoing, the Region Council will provide prevention resource information and links of activities and organizations on the region website (updating as needed) and within the content of the SC/SW Region e-newsletter.</p>
	<p>Strategy 2: Each January, the Region Council will obtain SC Region and WA State injury data tables (Fatal and nonfatal injuries by county) from DOH and provide this information to local agencies and County Councils.</p>
	<p>Strategy 3: By August 2015 and ongoing, the Region Council will forward IVP information from DOH to system partners.</p>
	<p>Strategy 4: By July 2015 and ongoing, the Region Council will provide representation on the IVP TAC to collaborate with the State IVP TAC to support statewide prevention emphasis initiative and/or IVP programs.</p>

Appendix 1

Approved Min/Max numbers of Verified Trauma Services

County	Verified Service Type	State Approved - <i>Minimum number</i>	State Approved <i>Maximum number</i>	Current Status (# Verified for each Service Type)
Benton County	Aid – BLS	4	4	3
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	0	1	1
	Amb – ILS	0	2	2
	Amb - ALS	4	6	6
Columbia County	Aid – BLS	2	3	1
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	1	1	1
	Amb – ILS	0	0	0
	Amb - ALS	0	0	0
Franklin County	Aid – BLS	1	3	0
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	2	2	2
	Amb – ILS	0	1	0
	Amb - ALS	1	1	1
Kittitas County	Aid – BLS	5	8	7
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	1	3	2
	Amb – ILS	0	0	0
	Amb - ALS	2	2	2
Walla Walla County	Aid – BLS	8	8	6
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	1	3	3
	Amb – ILS	0	1	0
	Amb - ALS	1	1	1
Yakima County	Aid – BLS	18	20	16
	Aid –ILS	0	1	0
	Aid – ALS	0	1	0
	Amb –BLS	2	9	0
	Amb – ILS	0	1	1
	Amb - ALS	3	3	3

SC 15-17 Plan

South Central Region Prehospital Trauma Verified Service List							
	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Benton County							
Benton County Fire District #1 (Kennewick)	X						
Prosser Fire District #3 (Prosser)	X						
Benton County Fire District #2 (Benton City)					X		
Benton County Fire District #4 (W Richland)				X			
Benton County Fire District #5 (Prosser)	X						
Benton County Fire District #6 (Paterson)					X		
Kennewick Fire Department (Kennewick)						X	
Richland Fire & EMS (Richland)						X	
Hanford Fire Department (Hanford)						X	
American Medical Response (Pasco)						X	
Prosser Memorial Hospital EMS (Prosser)						X	
NW Med Star (Richland)						X	
Benton County Total	3	0	0	1	2	6	
Columbia County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Columbia County Fire District #1 (Starbuck)	X						
Columbia County Rural #3 (Dayton)				X			
Columbia County Total	1	0	0	1	0	0	
Franklin County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Franklin County Fire District #3 (Pasco)				X			
Pasco Fire Department (Pasco)						X	
Franklin County PHD #1 (Eltopia)				X			
Franklin County Total	0	0	0	2	0	1	
Kittitas County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Kittitas County Fire District #1 (Thorp)	X						
Kittitas County Fire District # 3 (Easton)	X						
Kittitas County Fire District #4 (Vantage)	X						
Kittitas County Fire District #8 (Easton)	X						
South Cle Elum Fire (South Cle Elum)	X						
City of Kittitas Fire Department (Kittitas)	X						
Kittitas County Fire District #6 (Ronald)	X						
Kittitas Valley Fire and Rescue (Ellensburg)						X	
Kittitas County Fire & Rescue (Kittitas)				X			
Cle Elum Fire Department (Cle Elum)				X			
Upper Kittitas County Medic One (Cle Elum)						X	
Roslyn Fire Department (Roslyn)							X

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Kittitas County Total	7	0	0	2	0	2	1
Walla Walla County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Walla Walla Fire District #1 (Walla Walla)	X						
Eureka Fire Protection District # 3 (Prescott)	X						
Walla Walla FPD #6 (Touchet)	X						
Walla Walla Fire District #7 (Prescott)	X						
Walla Walla County Fire District #8 (Dixie)	X						
College Place Fire Depart. (College Place)	X						
Walla Walla Fire District #4 (Walla Walla)				X			
Walla Walla Fire District #5 (Burbank)				X			
Walla Walla Fire Department (Walla Walla)						X	
Waitsburg Ambulance Service (Waitsburg)				X			
Walla Walla County Total	6	0	0	3	0	1	
Yakima County Total	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Highland Fire Department (Coviche)	X						
Selah Fire Department (Selah)	X						
Naches Fire Department (Naches)	X						
East Valley Fire Department (Yakima)	X						
Yakima County Fire District #5 (Zillah)	X						
Gleed Fire (Yakima)	X						
Naches Heights Fire Department (Coviche)	X						
West Valley Fire Department (Yakima)	X						
Nile-Cliffdell Fire Department (Naches)	X						
Grandview Fire Department (Grandview)	X						
Granger City Fire Department (Granger)	X						
Mabton Fire Department (Mabton)	X						
Toppenish Fire Department (Toppenish)	X						
Wapato Fire Department (Wapato)	X						
Yakima Fire Department (Yakima)	X						
Zillah Fire Department (Zillah)	X						
Sunnyside Fire Department (Sunnyside)						X	
White Swan Ambulance (White Swan)					X		
American Medical Response (Yakima)						X	
Advanced Life Systems (Yakima)						X	
Yakima County Total	16	0	0	0	1	3	
	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
South Central Region Total	33	0	0	9	3	13	1

Appendix 2

A. Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services in the Region (General Acute Trauma Services) by level

<https://fortress.wa.gov/doh/eh/maps/EMS/index.html> (hospital map)

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf> (hospital list)

Level	Region Recommendations		Current Status
	Min	Max	
II	1	2	0
III	5	6	6
IV	4	5	5
V	1	2	1
II P	0	1	0
III P	3	3	3

	Designated Trauma Centers	Trauma	Peds	Rehab
Benton	Kadlec Regional Medical Center (Richland)	III		II R
Benton	Trios Hospital (Kennewick)	III	II P	
Walla Walla	Providence St Mary Medical Center (Walla Walla)	III	II P	II R
Walla Walla	Walla Walla General Hospital (Walla Walla)	III		
Yakima	Yakima Regional Medical & Cardiac Center (Yakima)	III		II R
Yakima	Yakima Valley Memorial Hospital (Yakima)	III	II P	
Kittitas	Kittitas Valley Healthcare (Ellensburg)	IV		
Franklin	Lourdes Medical Center (Pasco)	IV		II R
Benton	Prosser Memorial Hospital (Prosser)	IV		
Yakima	Sunnyside Community Hospital (Sunnyside)	IV		
Yakima	Toppenish Community Hospital (Toppenish)	IV		
Columbia	Dayton General Hospital (Dayton)	V		

B. Approved Minimum/Maximum (min/max) numbers of Designated Rehabilitation Trauma Care Services in the Region by level

Level	State Approved		Current Status
	Min	Max	
II	3	4	4
III*	0	0	0

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

C. Categorized Cardiac and Stroke Facilities

<http://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf>

Cardiac Level I	Cardiac Level II	Cardiac Uncategorized	Stroke Level I	Stroke Level II	Stroke Level III	Stroke Uncategorized
3	8			8	4	

Appendix 3

Trauma Response Areas

DOH Map Link to Trauma Response Areas

<http://ww4.doh.wa.gov/gis/EMS.htm>

***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.

Benton County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas
	#1	Within the current city limits of Kennewick and boundaries of Kennewick Fire Department and Benton County Fire District #1	A-1 F-1
	#2	Within the current city limits of Richland and West Richland and boundaries of the Richland Fire Department and Benton County Fire District #4.	A-1 D-1
	#3	Within the current boundaries of the Hanford Nuclear Reservation, with north boundaries the Columbia River, east and west boundaries the county lines and south boundaries with trauma service areas #2, #4 and #5.	F-1
	#4	In the current city limits of Benton City and the boundaries of Benton County Fire District #2	E-1
	#5	Within the current boundaries of Prosser Hospital District, Benton County FD #3, south on Highway 22 to south of Horrigan Road, west boundary the county line, north boundary with trauma service area #3, east boundary with trauma service areas #4 and #6.	A-1 F-1

	#6	Within the current city limits of Paterson, the boundaries of Benton County FD #6, north to Sellards Road, east to Plymouth Road, west to county line, south to the Columbia River, east to boundary with trauma service area #1.	E-1
Columbia County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas
	#1	Within the boundaries of Columbia County	A-1 E-1
Franklin County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas
	#1	Within the current City limits of Pasco, Franklin County FD #3 boundaries, and north to Sagemore Road.	A-1 F-1
	#2	Within the boundaries of Franklin County Hospital District #1 that includes the communities of Connell, Mesa, Basin City and Merrill's Corner, west to the Columbia River and south to Sagemore Road.	D-1
	#3	Within the current city limits of Kahlotus and the boundaries of Franklin County Fire District #2	Mutual aid responses
Kittitas County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas
	#1	From the southern county boundary to the east and west county boundaries encompassing the boundaries of Kittitas County Public Hospital District #1 to Exit 93 (Elk Heights and including Sunlight Waters to the development, <i>south</i> on 182 to milepost 18.5 (N. Umptanum turnaround), <i>south</i> on SR 821 to mile post 14 (Weimer Cut), <i>west</i> on State Route 10 to mile post 93 (east end of Bristol Flats), <i>west</i> of Lauderdale on State Route 97, <i>north</i> to mile post 163.7 (Blewett Pass Summit). This trauma area also includes	A-3 F-1

		the cities of Ellensburg and Kittitas, the rural communities of Vantage and Thorp, and boundaries of FD#1, FD#2, and FD#4 and surrounding rural and wilderness areas.	
	#2	From the northern county boarder and within the current boundaries of Kittitas County Public Hospital District #2, 190 east to MP 93.5 (Elk Heights OP, Exit 93). 109 west to MP 54.5 (exit 53/E. Summit), SR 10 to MP 93 (E. end of Bristol Flats-HD #1), SR 970 north to MP 149.5 (Lauderdale Junction/SR 97, MP 10.3, West of Lauderdale Junction on SR 97 (including area around junction and residences accessed from SR 97, SR 970 from Teanaway Junction (MP 2.6) east to Lauderdale Junction (end of SR 970, MP 10.3), the Cities of Cle Elum and Roslyn, Town of S. Cle Elum, the rural community of Ronald, Easton, and Snoqualmie Pass, to the eastern and western county boundaries encompassing the surrounding rural and wilderness areas within HD #2.	A-4 D-2 F-1
Walla Walla County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas
	#1	Within the current boundaries of Walla Walla County	A-6 D-3 F-1
Yakima County	EMS & Trauma Response Area #	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas
	#1	North county line to west county line; south to south county line; east to Boundary Road; along Boundary Road to Newland Road and north on Newland Road to Yakima River; north along the Yakima River to Beam Road; north on Beam Road to end of the road and directly east to County line.	A-16 E-1 F-2
	#2	North Beam Road east to county line;	A-1

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		county line south to Alexander Extension; southwest on Alexander Extension to Yakima River; and Yakima River north to Beam Road.	F-1
	#3	Alexander Extension south west to Yakima River; north from Yakima River on Newland Road; south to county line, east on county line; and north to Alexander Extension,	A-3 F-1

Appendix 4

Fatal and Non-Fatal Injury Data

Nonfatal Injury Hospitalizations SouthCentral										Cause by Year 2004-2013	
Counts	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
Unintentional											
Bites/Stings	46	38	59	52	71	75	86	66	82	60	635
Drowning	3	8	3	2	3	4	8	6	3	2	42
Falls	1,313	1,462	1,484	1,674	1,857	1,782	1,953	1,975	2,019	1,968	17,487
Fire/Flame/Hot Object/Substance	52	60	66	76	71	52	61	111	75	40	664
Firearm	11	7	10	14	10	12	11	19	14	21	129
MVT-(occupant)	197	248	224	242	223	260	227	211	196	176	2,204
MVT-(motorcyclist)	46	40	61	69	68	50	52	68	51	46	551
MVT-(pedal cyclist)	7	6	6	8	10	13	5	7	10	4	76
MVT-(pedestrian)	36	28	29	23	34	36	33	42	42	25	328
Pedal-cyclist(Other)	32	25	28	38	28	19	28	25	33	29	285
Pedestrian(Other)	12	12	6	9	8	7	7	6	6	1	74
Poisoning	162	192	181	203	227	277	292	279	280	275	2,368
Struck by or against	75	98	90	88	97	113	116	104	80	73	934
Suffocation & obstructing	39	27	20	31	27	20	23	32	26	33	278
Total (including other unintentional)	2,697	2,939	3,019	3,303	3,618	3,605	3,801	3,904	3,797	3,662	34,345
Self Inflicted											
Cut/Pierce	35	28	35	46	39	16	29	30	37	27	322
Firearm	4	4	3	1	6	3	-	4	5	6	36
Poisoning	255	278	264	218	271	278	296	281	259	213	2,613
Suffocation & obstructing	11	5	2	5	3	2	4	5	6	8	51
Total (including other suicides)	322	321	321	277	331	312	343	327	324	272	3,150
Assault											
Cut/Pierce	32	24	18	27	31	36	23	26	23	23	263
Firearm	16	17	12	15	33	48	32	41	50	33	297
Struck by or against	38	53	67	67	90	56	59	58	52	43	583
Total (including other homicides)	129	141	155	134	192	197	187	202	171	144	1,632
Undetermined, Legal, War, Other intents	191	166	248	230	189	183	276	262	224	187	2,156
All Nonfatal Injury Hospitalizations	3,339	3,567	3,743	3,944	4,330	4,297	4,587	4,695	4,516	4,265	41,283
Rate* per 100,000 Resident Population											
Unintentional											
Bites/Stings	8.5	6.9	10.5	9.1	12.2	12.7	14.3	10.9	13.4	9.7	10.9
Drowning	-	1.4	-	-	-	-	1.3	1.0	-	-	0.7
Falls	242.5	264.6	263.8	292.4	319.3	301.2	325.3	325.2	329.3	316.9	299.2
Fire/Flame/Hot Object/Substance	9.6	10.9	11.7	13.3	12.2	8.8	10.2	18.3	12.2	6.4	11.4
Firearm	2.0	1.3	1.8	2.4	1.7	2.0	1.8	3.1	2.3	3.4	2.2
MVT-(occupant)	36.4	44.9	39.8	42.3	38.3	43.9	37.8	34.7	32.0	28.3	37.7
MVT-(motorcyclist)	8.5	7.2	10.8	12.1	11.7	8.5	8.7	11.2	8.3	7.4	9.4
MVT-(pedal cyclist)	1.3	1.1	1.1	1.4	1.7	2.2	0.8	1.2	1.6	-	1.3
MVT-(pedestrian)	6.6	5.1	5.2	4.0	5.8	6.1	5.5	6.9	6.8	4.0	5.6
Pedal-cyclist(Other)	5.9	4.5	5.0	6.6	4.8	3.2	4.7	4.1	5.4	4.7	4.9
Pedestrian(Other)	2.2	2.2	1.1	1.6	1.4	1.2	1.2	1.0	1.0	-	1.3
Poisoning	29.9	34.7	32.2	35.5	39.0	46.8	48.6	45.9	45.7	44.3	40.5
Struck by or against	13.9	17.7	16.0	15.4	16.7	19.1	19.3	17.1	13.0	11.8	16.0
Suffocation & obstructing	7.2	4.9	3.6	5.4	4.6	3.4	3.8	5.3	4.2	5.3	4.8
Total (including other unintentional)	498.0	531.9	536.7	576.9	622.0	609.4	633.1	642.8	619.2	589.7	587.7
Self Inflicted											
Cut/Pierce	6.5	5.1	6.2	8.0	6.7	2.7	4.8	4.9	6.0	4.3	5.5
Firearm	-	-	-	-	1.0	-	-	-	0.8	1.0	0.6
Poisoning	47.1	50.3	46.9	38.1	46.6	47.0	49.3	46.3	42.2	34.3	44.7
Suffocation & obstructing	2.0	0.9	-	0.9	-	-	-	0.8	1.0	1.3	0.9
Total (including other suicides)	59.5	58.1	57.1	48.4	56.9	52.7	57.1	53.8	52.8	43.8	53.9
Assault											
Cut/Pierce	5.9	4.3	3.2	4.7	5.3	6.1	3.8	4.3	3.8	3.7	4.5
Firearm	3.0	3.1	2.1	2.6	5.7	8.1	5.3	6.8	8.2	5.3	5.1
Struck by or against	7.0	9.6	11.9	11.7	15.5	9.5	9.8	9.6	8.5	6.9	10.0
Total (including other homicides)	23.8	25.5	27.6	23.4	33.0	33.3	27.8	33.3	27.9	23.2	27.9
Undetermined, Legal, War, Other intents	35.3	30.0	44.1	40.2	32.5	30.9	46.0	43.1	36.5	30.1	36.9
All Nonfatal Injury Hospitalizations	616.6	645.5	665.4	688.8	744.4	726.3	764.1	764.1	736.5	686.9	706.4

*Rate not calculated for values <5. "-" represents categories for which there are no values.

Note: Injury counts are tabulated by location of residence.

Data source: Washington State Department of Health, Center for Health Statistics, Comprehensive Hospital Abstract Reporting System (CHARS - 2014 release)

Population source: Washington State Office of Financial Management

For questions and/or additional information, email injury.data@doh.wa.gov

Washington State Department of Health: Research, Analysis, & Data

DOH 689-149
3/23/2015

Appendix 5

Patient Care Procedures South Central Region EMS & Trauma Care Council

Table of Contents

- PCP #1 Dispatch
- PCP #2 Response Times
- PCP #3 Triage and Transport
- PCP #4 Inter-Facility Transfer
- PCP #5 Medical Command at Scene
- PCP #6 EMS/Medical Control Communications
- PCP #7 Helicopter Alert, Response, and Transport
- PCP #8 Diversion
- PCP #9 BLS/ILS Ambulance Rendezvous with ALS Ambulance
- PCP #10 EMS and Health Care Services Data Collection
- PCP #11 Routine EMS Response Outside of Recognized Service Coverage Zone
- PCP #12 Emergency Preparedness/Special Responders
- PCP #13 All Hazards/Mass Casualty Incident/Severe Burns
- PCP #14 EMS Providers in SC Region Identify Trends of Illness or Potential Terrorism Events
- PCP #15 Cardiac and Stroke Triage and Transport Procedure

DEFINITIONS WAC (246-976-010)

“Region Patient Care Procedures” or “PCPs” means Department of Health (DOH) approved written operating guidelines adopted by the Region emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communications centers, and the emergency medical services medical program directors, 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 inter-facility transfer be necessary. Patient care procedures do not relate to direct patient care.

“County Operating Procedures” or “COPs” means the written operational procedures adopted by the county Medical Program Director (MPD) and the local EMS council specific to county needs. COPs may not conflict with Region patient care procedures.

“Prehospital Patient Care Protocols” means the Department of Health (DOH) approved, written orders adopted by the Medical Program Director (MPD) which direct the out of hospital care of patients. These protocols are related only to delivery and documentation of direct patient treatment.

PATIENT CARE PROCEDURE #1 DISPATCH

Effective date: 7/24/1996

Standard

- A. Licensed aid and/or ambulance services shall be dispatched to all emergency medical incidents by the primary County Public Safety Answering Point (PSAP) per the response maps developed by local EMS & Trauma Care Councils and the South Central Region. Detailed maps of service areas are available through Department of Health EMS & Trauma web site (www.doh.wa.gov).
- B. Trauma verified aid and/or ambulance services shall be dispatched by the County PSAP to all known injury incidents, as well as unknown injury incidents requiring an emergency response per the response maps developed by local EMS & Trauma Care Councils and the South Central Region. Detailed maps of service areas are available through Department of Health EMS & Trauma web site (<http://ww4.doh.wa.gov/gis/ems.htm>).
- C. Licensed and verified EMS agencies should update DOH and Region Council to service area changes as soon as possible.
- D. Dispatchers should be trained in an Emergency Medical Dispatch (EMD) Program.

Purpose

- A. To minimize “dispatch interval” and provide timely care by certified EMS personnel to all emergency medical and trauma patients.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Region Council (RC) with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to DOH that the COPs be approved.
- B. Local EMS & Trauma Care Council’s should identify primary and secondary PSAPs per county and provide information to the Region Council.
- C. The nearest “appropriate” aid and/or ambulance service shall be dispatched per the above standards.
- D. Trauma verified and licensed EMS services should proceed in an emergency response mode until they have been advised of non-emergent status.

Definitions

- A. **Appropriate** – Defined as the trauma verified or licensed EMS service that responds within an identified service area that can meet the patient care needs. Appropriate agency may be part of a tiered response.
- B. **Emergency Response** – Defined as a response using warning devices such as lights, sirens, and use of Opticom devices where available.
- C. **PSAP** – Public Safety Answering Point – is a call center regulated by the FCC that is responsible for answering calls to an emergency telephone number for police, firefighting, and ambulance services. Trained telephone operators are also usually responsible for dispatching these emergency services.
- D. **Dispatch Interval** – Defined as the time the call is received by the dispatcher to the time the first unit is dispatched.

Quality Assurance

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #2 RESPONSE TIMES

Effective date: 7/24/1996

Standard

- A. All licensed and trauma verified aid and/or ambulance services shall respond to emergency medical and injury incidents in a timely manner in accordance with Washington Administrative Code (WAC 246-976-390 [10]).

Purpose

- A. To provide “timely” emergency medical services to patients who have medical and/or injury incidents requiring emergency care response.
- B. To collect data required by the Washington Emergency Medical Services Information System (WEMISIS) and by the Region Continuous Quality Improvement (CQI) Plan.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** of the South Central

Region identified above. The local Council will provide the Region Council with a copy of their COPs for review, adoption and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.

- B. Detailed maps of service areas are available through the Department of Health EMS & Trauma web site (<http://ww4.doh.wa.gov/gis/ems.htm>).
- C. Trauma verified aid and/or ambulance services are responsible for documenting the WEMSYS data elements.
- D. Included in the WEMSYS information will be unit response times. Verified aid and/or ambulance services shall meet the minimum agency response times to response areas as defined in WAC 246-976-390.

Trauma Verified AID Service

Urban	8 minutes or less, 80% of the time
Suburban	15 minutes or less, 80% of the time
Rural	45 minutes or less, 80% of the time
Wilderness	As soon as possible

Trauma Verified AMBULANCE Service

Urban	10 minutes or less, 80% of the time
Suburban	20 minutes or less, 80% of the time
Rural	45 minutes or less, 80% of the time
Wilderness	As soon as possible

Definitions

- A. **Urban** – Incorporated area over thirty thousand; or an incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square miles WAC 246-976-010.
- B. **Suburban** – Incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of less than 1,000 to 2,000 people per square mile WAC 246-976-010.
- C. **Rural** – Incorporated or unincorporated areas with total population less than 10,000 or with a population density of less than 1,000 per square mile WAC 246-976-010.
- D. **Wilderness** – Any rural area that is not accessible by public or private maintained roadways WAC 246-976-010.
- E. **Response Time** – Interval of time from agency notification to arrival on the scene. It is the combination of activation and in route times defined under response times WAC 246-976-390.

- F. **EMS Personnel** –means an individual certified by the secretary or the University Of Washington School Of Medicine under chapters 18.71 and 18.73 RCW to provide prehospital emergency response, patient care and transportation.
- G. **WEMSIS** – Washington EMS Information System

Quality Assurance

- A. The South Central Region CQI Committee, consisting of at least one member of the designated/categorized health care services staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region Standards of care.

**PATIENT CARE PROCEDURE #3
TRIAGE AND TRANSPORT**

Effective date: 7/24/1996

Standard

- A. All licensed and trauma verified aid and/or ambulance services shall comply with the State of Washington Prehospital Triage Destination Tools Trauma - (<http://www.cdc.gov/FieldTriage>, Cardiac Triage Tool (www.doh.wa.gov/hsqa/hdsp/files/acsq/pdf) and Stroke Triage Tool (www.doh.wa.gov/hdsp/files/strokeq/pdf) as defined in Washington Administrative Code (WAC) and RCW. Medical and injured patients who do not meet prehospital triage criteria will be transported to local health care services according to Region Patient Care Procedures (PCPs), Medical Program Director (MPD) protocols, and County Operating Procedures (COPs).

Purpose

- A. To ensure that all emergent patients are transported to the most appropriate designated or categorized facility in accordance with the most current Washington State Triage Destination Procedures for Trauma, Cardiac and Stroke.
- B. To ensure that all patients that do not meet Washington State Prehospital Triage Destination Procedures criteria are transported according to PCPs, MPD Protocols, and COPs.
- C. To allow the receiving health care service or designated/categorized health care service adequate time to activate their emergency medical and/or trauma response team.

Procedure

- A. Each local EMS & Trauma Care Council may recommend COPs that meet or exceed the **STANDARD** and **PURPOSE** of the South Central Region identified above. The local Council will provide the Region Council (RC) with a copy of their COPs for review and inclusion with the Region PCPs. The RC will make a recommendation to Department of Health (DOH) that the COPs be approved.
- B. Trauma, Cardiac & Stroke Triage
 1. The first certified Emergency Medical Service (EMS) provider to determine that a patient meets one of the Prehospital Triage Destination Tools, shall contact their base station, medical control, or the receiving Health Care Service via their local communication system, as soon as possible.
 2. Patients meeting Washington State Triage Destination criteria who may or may not have the ability to make an informed decision shall be transported to a designated/categorized service in accordance with the State of Washington Prehospital Triage Destination Procedures, Region PCPs, and COPs.
 3. If Prehospital personnel are unable to effectively manage a patient's airway, an Advanced Life Support (ALS) rendezvous or an immediate stop at the nearest health care service capable of immediate definitive airway management should be considered.
 4. South Central Region Designated Trauma services and maps of their locations are available from the DOH web site (<http://ww4.doh.wa.gov/gis/ems.htm>).
- C. Designated trauma services shall have written procedure and protocol for diversion of trauma patients when the facility is temporarily unable to care for trauma patients. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be life saving.
Exceptions to diversion:
 1. **Airway compromise**
 2. **Traumatic arrest**
 3. **Active seizing**
 4. **Persistent shock**
 5. **Uncontrollable hemorrhaging**
 6. **Urgent need for IV access, chest tube, etc.**
 7. **Disaster**
- D. Non Critical Trauma (do not meet trauma, cardiac, or stroke triage tools),
 1. Prehospital personnel may request response or rendezvous with ALS/Intermediate Life Support providers and all EMS providers may request emergency aero-medical evacuation if they are unable to effectively manage a patient.

2. Medical and injured patients who do not meet Prehospital triage criteria for trauma, cardiac, or stroke system activation will be transported to local facilities according to local MPD protocols, COPs, and Region PCPs.
 3. While in route and prior to arrival at the receiving facility, the transporting agency should provide a complete report to the receiving hospital regarding the patient's status via radio or other approved communication system according to local MPD protocols, COPs, and Region PCPs.
- E. Before leaving the receiving facility, the transporting agency will leave a completed approved medical incident report form for all patients. The additional information for the medical incident report (MIR) either written or electronic shall be made available to the receiving facility within twenty-four hours of arrival, in accordance with WAC 246-976-330.

Definitions

- A. **Designated Trauma Service** – A health care facility or facilities in a joint venture, who have been formally determined capable of delivering a specific level of trauma care by DOH.
- B. **Designated/ Categorized Cardiac Hospital** - A health care facility that has been formally determined capable of delivering a specific level of Cardiac care by the DOH.
- C. **Prehospital Triage Destination Tools**
 1. Trauma Triage Tool
 2. Cardiac Triage Tool
 3. Stroke Triage Tool

Quality Assurance

- A. The South Central Region Continuous Quality Information (CQI) Committee, consisting of at least one member of each designated/categorized health care services staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, has developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #4 INTERFACILITY TRANSFER

Effective date: 7/24/1996

Standard

- A. All interfacility trauma, cardiac and stroke patient transfers via ground or air shall be provided by appropriate licensed or verified service with appropriate personnel and equipment to meet the patient needs.
- B. Immediately upon determination that a patient's needs exceed the scope of practice and/or protocols, Emergency Medical Service (EMS) personnel shall advise the facility that they do not have the resources to do the transfer per WAC.

Purpose

- A. Provide a procedure that will achieve the goal of transferring high-risk trauma and medical patients without adverse impact to clinical outcomes.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** of the South Central Region. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.
- B. Medical responsibility during transport should be arranged at the time of the initial contact between receiving and referring physicians, and transfer orders should be written after consultation between them.
- C. When on line medical control is not available, Prehospital Medical Program Director (MPD) protocols shall be followed during an EMS transport in the event that an emergency situation occurs while in route that is not anticipated prior to transport.
- D. While in route, the transporting agency should communicate patient status and estimated time of arrival to the receiving health care service per MPD local protocols and COPs.

Definitions

- A. **Authorized Care** – Patient care within the scope of approved level of EMS certification and /or specialized training as identified in WAC.

Quality Assurance

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

**PATIENT CARE PROCEDURE #5
MEDICAL COMMAND AT SCENE**

Effective date: 7/24/1996

Standard

- A. The Incident Command System (ICS) National Information Management System (NIMS) compliant terminology shall be used.

Purpose

- A. To define who is in medical command at the Emergency Medical Service (EMS) scene and to define the line of command when multiple EMS agencies respond.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to DOH that the COPs be approved.
- B. Medical Command will be assigned by the Incident Commander.
- C. Whenever possible, the Medical Commander/Medical Group Supervisor will be an individual trained in the ICS, familiar with both the local EMS resources and the county Mass Casualty Incident and Disaster Plan, and capable of coordinating the medical component of a multiple patient incident.

Quality Assurance

- A. The South Central Region Continuous Quality Information (CQI) Committee, consisting of at least one member of each designated/categorized health care services staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, has developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

**PATIENT CARE PROCEDURE #6
EMS/MEDICAL CONTROL COMMUNICATIONS**

Effective date: 7/24/1996

Standard

- A. Communications between Prehospital personnel and all receiving health care services (to include designate trauma services and categorized cardiac and stroke health care services) should utilize the most effective communication means to expedite patient information exchange.

Purpose

- A. To define methods of expedient communications between Prehospital personnel and all health care services, including trauma, cardiac, and stroke health care services and medical control.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.
- B. Communication between EMS providers and health care facilities can be “direct” or “indirect” from dispatching agency to health care services.
- C. EMS agencies will maintain communication equipment and training needed to communicate in accordance with WAC.

Quality Assurance

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #7

HELICOPTER ALERT, RESPONSE, AND TRANSPORT

Effective date: 7/24/1996

Standard

- A. A system of Air Medical response to provide safe and expeditious transport of critically ill or injured patients to the appropriate hospital, including designated/categorized health care services.

Purpose

- A. To define the criteria for alerting, requesting and transporting patients by on-scene emergency medical helicopter.
- B. To provide guidelines for those initiating the request for emergency medical helicopter to the scene.

Procedure

A. Alert

1. On-scene emergency medical helicopter may be alerted for possible response by dispatch personnel, the highest level EMS certified ground personnel or fire and law enforcement agencies utilizing, State of Washington Pre-hospital Helicopter Transport Decision Algorithm for decision making.
2. The emergency medical helicopter communication center, at the time of the initial call in addition to on-scene information, will attempt to identify the Medical Control facility for the location of the scene.

B. Response

1. Request for on-scene emergency medical helicopter should be initiated through the appropriate emergency dispatch agency for the area.
2. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units.
3. At launch time the emergency medical helicopter communication center will inform the flight crew as to the nearest appropriate designated/categorized health care service.
4. While in route, the flight crew will make contact with the designated Medical Control facility for the area, with preliminary patient information and ETA to the scene.

C. Transport

1. The flight crew will transport the emergent patient per the State of Washington Trauma, Cardiac, or Stroke Triage Destination Procedures by identifying the most appropriate health care service.
2. The transport of the patient to the most appropriate health care service may be changed due to the following:
 - a. Diversion by facility to another receiving facility based on patient condition report from the flight crew and the facility's availability of appropriate resources or
 - b. Patient preference, if appropriate to clinical condition, or
 - c. Weather precludes flying to the designated/categorized facility
3. The helicopter will make radio contact with the receiving designated/categorized facility as soon as possible.

4. Documentation standards shall include the name of the EMS personnel on-scene whenever possible and, if needed, the rationale for transporting the patient to other than the designated/categorized facility.

Definitions

- A. Medical Control Facility - A hospital facility used by EMS personnel for medical direction for their service area.

Quality Assurance

- A. The South Central Region CQI Committee, consisting of at least one member of the designated/categorized health care services staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region Standards of care.

PATIENT CARE PROCEDURE #8

DIVERSION

Effective date: 7/24/1996

Standard

- A. All designated trauma services, and categorized cardiac and stroke hospitals within the Region will have hospital approved policies to divert patients to other appropriate designated/categorized facilities.

Purpose

- A. To divert trauma, cardiac, or stroke patients to other appropriate facilities based on the facilities inability to provide initial resuscitation, diagnostic procedures, and operative intervention.
- B. To identify communication procedures for diversion of trauma, cardiac and stroke patients to another accepting facility.

Procedure

- A. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region PCPs. The Region Council will make a recommendation to DOH that the COPs be approved.

- B. Each trauma designated service will have written policies and procedures that outline reasons to divert patients from their service.
- C. Designated Trauma Services must consider diversion when essential services including but not limited to the following are **not** available:
 - 1. Surgeon
 - 2. Operating room
 - 3. For a Level II—CT
 - 4. For a Level II—Neurosurgeon
 - 5. ER is unable to manage additional patients
- D. When the designated/categorized service is unable to manage major trauma, cardiac and stroke patients, they will have an established procedure to notify the EMS transport agencies and other designated services in their area that they are on divert. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be lifesaving. **Note: Exceptions to Diversion:**
 - 1. Airway compromise
 - 2. Traumatic arrest
 - 3. Active seizing
 - 4. Persistent shock
 - 5. Uncontrolled hemorrhage
 - 6. Urgent need for IV access, chest tube, etc.
 - 7. Disaster
- E. Each designated service will maintain a diversion log providing time, date and reason for diversion. This log will be made available to the Region Continuous Quality Improvement Committee (CQI) for review, if required.
- F. For Cardiac STEMI patients, there is a "no divert" policy that also identifies a backup plan for situations when the hospital's cardiac care resources are temporarily unavailable.

Quality Assurance

- A. The South Central Region Continuous Quality Information (CQI) Committee, consisting of at least one member of each designated/categorized health care services staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, has developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #9

BLS/ILS AMBULANCE RENDEZVOUS WITH ALS AMBULANCE

Effective date: 5/22/1997

Standard

- A. In service areas with only Basic Life Support (BLS)/Intermediate Life Support (ILS) ambulances, a “rendezvous” with an Advanced Life Support (ALS) response will be “attempted” for all patients who may benefit from ALS intervention.

Purpose

- A. To provide ALS intervention based on patient illness and/or injury, and the proximity of the receiving facility in areas serviced by only BLS/ ILS ambulances.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.
- B. Local EMS & Trauma Care Councils and MPDs that choose not to adopt their own protocol or policy shall adhere to the following procedures:
 - 1. Emergency Medical Dispatch Guidelines will be used to identify critically ill or injured patients.
 - 2. When an ALS response is deemed necessary or requested, the ALS service shall be dispatched with the BLS/ILS ambulance or as soon as possible.
- C. The BLS/ILS ambulance may request ALS ambulance rendezvous at anytime.
- D. Based on updated information, BLS/ILS personnel either while in route or on scene may determine that ALS intervention is not needed. The responding ALS ambulance may be notified and given the option to cancel.
- E. Upon rendezvous, the method of transport, i.e., BLS vehicle or ALS vehicle shall be in the best interest of the patient’s care.

Definitions

- A. Advanced emergency medical technician (AEMT)-means a person who has been examined and certified by the secretary as an intermediate life support technician as defined in RCW 18.71.200 and 18.71.205
- B. ALS – Advanced Life Support as defined in WAC 246-976-010.
- C. Attempted – After identification of the need for ALS intervention, every effort will be made to arrange a BLS/ILS ambulance with ALS ambulance rendezvous.
- D. BLS – Basic Life Support as defined in WAC 246-976-010.

- E. Emergency Medical Dispatch Guidelines – Established and accepted emergency medical dispatching guidelines that utilize specific questions and responses to determine EMS levels to be dispatched.
- F. ILS – Intermediate Life Support as defined in WAC 246-976-390 as having at least one AEMT.
- G.
- H. Rendezvous – A pre-arranged agreed upon meeting either on scene, in route from or another specified location.

Quality Improvement

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #10

EMS AND HEALTH CARE SERVICES DATA COLLECTION

Effective date: 5/22/1997

Standard

- A. Licensed and Trauma verified Emergency Medical Service (EMS) agencies and designated/categorized health Care services shall collect and submit data to the Department of Health (DOH) per WAC.

Purpose

- A. The purpose of Data Collection is to have a means to monitor and evaluate patient care best practices, outcomes and the effectiveness of the EMS and Trauma Care delivery system.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to DOH that the COPs be approved.

- B. EMS agencies will identify trauma, cardiac, and stroke patients using the parameters set by the Washington State Triage Destination Procedures.
- C. Designated services will identify trauma patients using the Trauma Registry inclusion criteria.
- D. Categorized health Care Services should utilize a nationally, state or local recognized cardiac and stroke data collection system.

Quality Improvement

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health Care Services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #11

ROUTINE EMS RESPONSE OUTSIDE OF RECOGNIZED SERVICE AREA

Effective date: 9/15/1999

Standard

- A. Establish a continuum of patient care per the South Central Region's EMS & Trauma System Strategic Plan.

Purpose

- A. Provide an avenue for reliable EMS agency relationships and coordination of optimal patient care as described in the Region EMS & Trauma System Strategic Plan.
- B. Provide for the safety of crews, patients, the public and other emergency responders.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.
- B. Local EMS & Trauma Care Councils will identify EMS agencies within the South Central Region and from other regions who routinely respond into areas beyond their recognized service coverage zone to provide ambulance service.

- C. Local EMS & Trauma Care Councils will identify and encourage specific EMS Mutual Aid Agreements among EMS agencies that routinely respond into other service coverage zones that address the following:
 - 1. Dispatch criteria
 - 2. Highest level of appropriate EMS unit utilized
 - 3. Transport to the closest, appropriate health care services
- D. Establish emergency response routes and notification standards.
 - 1. When in route to a facility outside routine response area for the purpose of patient transfer, and when the response requires emergency response that crosses jurisdictional boundaries of counties, the base dispatch center may contact dispatch centers in those jurisdictions giving the route of travel, time of estimated arrival and destination.
 - 2. If transporting agency will be leaving the area in an emergency response mode, the procedure above may be followed.

Definitions

- A. Routine – Usual or established “response”.
- B. Response Area – A trauma response area identified in an approved Region EMS & Trauma System Strategic Plan.
- C. Emergency Response – Defined as a response using warning devices such as lights and sirens and use of Opticom devices where available.

Quality Assurance

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #12 EMERGENCY PREPAREDNESS/SPECIAL RESPONDERS

Effective date: 9/15/1999

Standard

- A. Public Health Emergency Preparedness Health Care Coalitions in collaboration with Emergency Management will maintain written emergency preparedness plans that include EMS and Health Care Services.

Purpose

- A. To assure that Region Health Care Services and EMS are included in written plans that addresses their roles and responsibilities in multi-casualty and disaster incidents.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region Patient Care Procedures. The Region Council will make recommendation to Department of Health that the COPs be approved.
- B. Healthcare services and EMS agencies are encouraged to participate in the Public Health Preparedness and Emergency Management planning process to ensure that they are included in emergency preparedness plans addressing EMS and Healthcare Services roles and responsibilities.

Quality Assurance

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

**PATIENT CARE PROCEDURE #13
ALL HAZARDS/MCI/SEVERE BURNS**

Effective date: 12/2005

Standard

- A. During an all hazards mass casualty incident (MCI) that can include severely burned adult and pediatric patients;
 - 1. All ambulance and aid services shall respond as requested to an MCI per local MCI plans, County Operating Procedures and Region Patient Care Procedures.
 - 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 aid services may respond to assist during an MCI.
 - 3. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.

4. All EMS agencies working during an MCI event shall operate within the National Incident Management System (NIMS).

Purpose

- A. Communicate the information of the Public Health Emergency Management Preparedness Plans.
- B. Implement local MCI plans during an MCI.
- C. Provide trauma care including burn for at least 50 severely injured adult and pediatric patients.
- D. Provide safe mass transportation with pre-identified personnel, equipment and supplies per the approved local MCI plan.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review, adoption and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.
- B. Incident Commanders shall follow the local MCI Plan to inform medical control when an MCI condition exists.
- C. Medical Program Directors have agreed that local protocols will be used by the responding agencies throughout the transport of patients, whether it is in another county, region or state. This will ensure consistent patient care in the field by personnel trained to use specific medications, equipment, procedures, and/or protocols until the patient is delivered to a receiving facility.
- D. EMS personnel may use the Public Health Emergency Preparedness Plan and (MCI) Response Algorithm during the MCI incident.

Definition

- A. CBRNE – Chemical, Biological, Radiological, Nuclear, Explosive

Quality Assurance

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

**PATIENT CARE PROCEDURE #14
EMS PROVIDERS IN THE SOUTH CENTRAL REGION IDENTIFY TRENDS OF
ILLNESS OR POTENTIAL TERRORISM EVENTS**

Effective date: 12/2006

Standard

- A. Emergency Medical Services (EMS) Providers, who recognize or identify symptoms of infectious disease, illness, or injury that could be related to natural causes or acts of terrorism, will convey suspicions to County Health Districts/Departments.

Purpose

- A. To provide EMS with a mechanism to report trends/clusters (similar symptoms of illness or injury in more than one patient over a brief period of time) that could be from natural causes or from acts of terrorism.

Procedure

- A. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review, adoption and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.
- B. Any EMS Provider who recognizes a trend/cluster of chief complaints or signs and symptoms such as but not limited to flu-like symptoms, respiratory symptoms, rash or unusual burns, will inform their county Public Health officials.

Health Department	Main Telephone
Benton/Franklin Health District	509-460-4550
Columbia Co. Health District	509-382-2181
Kittitas Co. Health District	509-962-7515
Klickitat Co. Health Dept.	509-733-4565
Walla Walla Co. Health Dept.	509-524-2650
Yakima Health District	509-575-4040

Quality Assurance

- A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

**PATIENT CARE PROCEDURE #15
CARDIAC AND STROKE TRIAGE AND TRANSPORT PROCEDURE**

Effective date: 3/2011

Standard

- A. All licensed and trauma verified aid and/or ambulance services shall utilize the most current State of Washington Prehospital Cardiac Triage (Destination) Procedure and Prehospital Stroke Triage (Destination) Procedure to identify and transport patients with signs or symptoms of acute cardiac or stroke.

Purpose

- A. To ensure that all patients presenting with acute cardiac or stroke signs and symptoms are identified and transported to the most appropriate hospital to reduce death and disability.

Procedure

- A. Prehospital providers will utilize the most current Washington State Prehospital Cardiac triage (Destination) Procedure and Prehospital Stroke Triage (Destination) Procedure and local EMS & Trauma Councils COPs and MPD protocols to direct Prehospital providers to take patients to specific State categorized cardiac and stroke hospitals. The triage (destination) procedures will be implemented in accordance with resource readiness and Department of Health approved County Operating Procedures (COPs).

Definitions

- A. Cardiac Patient is identified as meeting the symptoms of the "Applicability for Triage" and "Assess for Immediate Criteria" found in the State of Washington Prehospital Cardiac Triage Destination Procedure. <http://www.doh.wa.gov/hsqa/hdsp/mdems.htm>
- B. Stroke Patient is identified as meeting the symptoms of the "Applicability for Triage" and the "F.A.S.T. Assessment" as found in the State of Washington Prehospital Stroke Triage Destination Procedure. <http://www.doh.wa.gov/hsqa/hdsp/mdems.htm>

Quality Assurance

- A. The South Central Region Continuous Quality Information (CQI) Committee, consisting of at least one member of each designated/categorized health care services staff, EMS provider, and a member of the South Central Region EMS & Trauma Care Council, has developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standard of care.

Note: County Operating Procedures (COPs) can be found on the South Central Region EMS website (www.screms.org) or through the respective County Council.