

**SOUTHWEST 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 the community members. Region and County Councils are intricately involved in the initial and 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 Southwest Region EMS & Trauma Care Council proudly represents and serves Clark, Cowlitz, Klickitat, Skamania, South Pacific, and Wahkiakum Counties. Within the region there are currently 43 Prehospital Trauma Verified Services, 6 Trauma Designated Facilities, and 6 Cardiac and Stroke Categorized Facilities. The Southwest Region is characterized by one major metropolitan area (Vancouver, within Clark County which borders Portland, Oregon) as well as a number of suburban cities and small towns. The region includes an active volcano (Mt St Helens), ocean-front communities, two deep-water shipping ports on the Columbia River, five major inter-state bridges, a number of freshwater lakes, and numerous access points to the Cascade Mountain range. There is a great deal of tourist activity throughout the region, as well as industrial activity ranging from cranberry bogs on the coast to lumber mills to hydroelectric dams. Due to the region’s location on the Oregon border, many patients are transported from the region to Oregon hospitals based on medical need and/or patient request. WA State DOH recognizes Oregon trauma centers level of care capabilities for instance; Legacy Emmanuel is the nearest Level 1 trauma center.

Prehospital Verified Services*

COUNTY	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS
Clark	5		2			4
Cowlitz	2			1		5
Klickitat	9			3		1
Skamania	2					1
South Pacific	2			2		2
Wahkiakum				2		

*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
1	1	3				1	

*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
1	5		1	1	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.

SW Region	Population	Square Miles	Persons/sq. mile
Clark	443,817	656	677/sq. mile
Cowlitz	101,860	1,166	90/sq. mile
Klickitat	20,866	1,904	10/sq. mile
Skamania	11,274	1,683	7/sq. mile
South Pacific	20,498 (all county)	1,223	22/sq. mile
Wahkiakum	4,042	287	15/sq. mile
Total	602,357	6,919	87/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 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 to 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 of the EMS system will advancement the EMS & Trauma system in the Southwest 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 ‘Wahkiakum 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 December 2016 the Region Council will analyze min/max numbers and levels of Designated Trauma Adult, Pediatric, and Rehabilitation Services and resources in preparation for the January 2017 SW Region hospital designation cycle. (RCW 70.168.100) (WAC 246-976-960)</p>	<p>Strategy 1: By September 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 November 2016, the Region and County Councils will use survey results and DOH established guidelines with specific criteria to conduct an analysis of min/max numbers.</p>
	<p>Strategy 3: By December 2016, if needed, the Designated Services and County Councils will work together to prepare any proposed changes of designation levels of trauma services.</p>
	<p>Strategy 4: By December 2016, 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,</p>	<p>Strategy 1: As needed, the Region Council will, upon receipt</p>

<p>the Region Council will analyze the Prehospital Trauma Verified Service minimum and maximum numbers and levels of resources to maintain and advance the system. (RCW 70.168.100) (WAC 246-976-960)</p>	<p>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 of 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 min/max numbers and resources.</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 SW re-categorization beginning January 2018. (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 current 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, 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 Director 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 pre-hospital 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>

GOAL 3

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.

Some of the most important components of the regional EMS system are contained in this goal, namely EMS provider training, ongoing development of PCPs/COPs, and data collection and utilization. In order to address these topics we will use the information collected in Goal 1, Objective 1, System Component Analysis, to review these parts of our trauma system in order to ensure that these aspects of the system continue to evolve to meet the needs of the EMS system providers as well as the citizens in our region.

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.

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>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 report “Exhibit C”).</p>
<p>Objective 2: By January 2017, the Region Council will review the Region</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>Patient Care Procedures (PCP) and make updates as needed. (RCW 70.168.100) (WAC 246-976-960) (WAC 246-976-970)</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 WEMSYS 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 WEMSYS 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 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 WEMSYS 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. In addition, the Region Council provides for grants to local County Councils in the region to support injury prevention projects. Solid evidenced-based injury prevention projects on the small scale that the Region is equipped to support are rare. 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 to injury prevention 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: By January annually, 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 bimonthly, 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>
<p>Objective 2: Each June, the Region Council will utilize a process to identify needs and allocate available funding to support injury prevention projects. (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 injury prevention projects for the next fiscal year by requesting each County Council submit injury prevention grant applications by June, for the following fiscal cycle.</p>
	<p>Strategy 2: Each July, the Region Council will allocate available funding to support injury prevention projects (funds will be distributed throughout the year as injury prevention projects occur 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 grant contracts administration will be completed.</p>

Appendix 1**Approved Min/Max numbers of Verified Trauma Services**

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	5
	Aid – ILS	0	0	0
	Aid – ALS	1	12	2
	Amb – BLS	1	4	0
	Amb – ILS	0	0	0
	Amb – ALS	1	4	4
Cowlitz	Aid – BLS	1	5	2
	Aid – ILS	0	0	0
	Aid – ALS	1	5	0
	Amb – BLS	1	5	1
	Amb – ILS	0	0	0
	Amb – ALS	1	5	5
Klickitat	Aid – BLS	1	11	9
	Aid – ILS	0	0	0
	Aid – ALS	1	4	0
	Amb – BLS	1	4	3
	Amb – ILS	0	0	0
	Amb – ALS	1	2	1
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	2
	Aid – ILS	0	0	0
	Aid – ALS	1	2	0
	Amb – BLS	1	2	2
	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

SW 15-17 Plan

Updated January 2015	Southwest Region Prehospital Trauma Verified Service Listing	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Clark								
06D01	East County Fire & Rescue Camas	X						
06D03	Clark Fire District #3 Brush Prairie	X						
06D06	Clark Fire District #6 Hazel Dell			X				
06D10	Clark Fire District #10 Amboy	X						
06D13	Clark Fire District #13 Yacolt	X						
06M05	Vancouver Fire Department			X				
06M06	Washougal Fire Department	X						
06M02	City of Camas Fire Department						X	
06X03	North Country EMS Yacolt						X	
06X04	American Medical Response						X	
06D15	Clark Fire & Rescue Ridgefield						X	
	Metro West Ambulance							X
	Clark County Current Status	5	0	2	0	0	4	1
	APPROVED MAX #	12	0	12	4	0	4	-
Cowlitz		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
08D02	Cowlitz 2 Fire & Rescue Kelso						X	
08D03	Toutle Fire & Rescue #3 Toutle	X						
08D05	Cowlitz Fire District #5 Kalama						X	
08D06	Cowlitz Fire District #6 Castle Rock						X	
08D07	Cowlitz-Skamania Fire District #7 Ariel	X						
08X01	American Medical Response						X	
08X05	Life Flight Network Longview						X	
08M04	Longview Fire Department				X			
	Cowlitz County Current Status	2	0	0	1	0	5	0
	APPROVED MAX #	5	0	5	5	0	5	-
Klickitat		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
20D01	Klickitat County FPD #1 Trout Lake	X						
20D02	Klickitat County FPD #2 Bickleton				X			
20D03	Klickitat County FPD # 3 Husum				X			
20D04	Klickitat County FPD #4 Lyle	X						
20D06	Klickitat County FPD # 6 Dallesport							X
20D07	Klickitat County Rural 7 Goldendale	X						
20D08	Klickitat County FPD # 8 Glenwood				X			
20D10	Klickitat County FPD # 10 Mabton	X						
20D11	Klickitat County FPD # 11 Wishram							X
20D12	Klickitat County FPD # 12 Klickitat	X						
20D13	Klickitat County FPD #13 Appleton	X						
20D14	Klickitat County FPD #14	X						
20D15	Klickitat County FPD #15	X						
20X01	Klickitat EMS District # 1						X	
20M01	White Salmon Volunteer Fire Dept.	X						
	Klickitat County Current Status	9	0	0	3	0	1	2
	APPROVED MAX #	11	0	4	4	0	2	-

SW 15-17 Plan

		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Skamania								
30X01	Public Hospital District Stevenson						X	
30D01	Skamania FPD #1 Carson							X
30D04	Skamania FPD #4 Washougal	X						
30D05	Skamania FPD #5 North Bonneville							X
30D06	Skamania County FPD #6 Cougar	X						
	Skamania County Current Status	2	0	0	0	0	1	2
	APPROVED MAX #	6	0	1	1	0	1	-
South Pacific		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
25D01	Pacific Fire District #1 Ocean Park						X	
25D02	Pacific Fire District # 2 Chinook	X						
25M01	Ilwaco Fire Department				X			
25X03	Medix Ambulance Ilwaco-Chinook						X	
25X01	Naselle Volunteer Fire Department				X			
25X0	Long Beach Fire Department	X						
	Pacific County Current Status	2	0	0	2	0	2	0
	APPROVED MAX #	2	0	1	2	0	3	-
Wahkiakum		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
35D03	Wahkiakum FD #3 Greys River Rosburg				X			
35D02	Wahkiakum FD # 2 Skamokawa							X
35M01	Cathlamet Fire Department				X			
	Wahkiakum County Current Status	0	0	0	2	0	0	1
	APPROVED MAX #	1	0	1	3	0	2	-
		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
	SW Region 49 Agencies Current Status	20	0	2	8	0	13	6

Appendix 2

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

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

Designated Trauma Care Services in the Region		Designated Trauma
Clark	Peace Health Southwest Medical Center, Vancouver	II
Cowlitz	Peace Health St John Medical Center, Longview	III
Klickitat	Klickitat Valley Hospital, Goldendale	IV
South Pacific	Ocean Beach Hospital, Ilwaco	IV
Klickitat	Skyline Hospital, White Salmon	IV

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	1	1	1
III*	0	0	0

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

Designated Trauma Rehabilitation Care Services in the Region		Designated Rehab
Clark	Peace Health Southwest Medical Center	II

C. Categorized Cardiac and Stroke Facilities

Cardiac Level I	Cardiac Level II	Cardiac Uncategorized	Stroke Level I	Stroke Level II	Stroke Level III	Stroke Uncategorized
1	5		1	1	4	

Appendix 3

Trauma Response Areas by County
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.

Clark County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services available in each Response Areas
	# 2	Within the boundaries of Vancouver Fire Department	C-1, F-1
	# 3	Within the boundaries of Clark FPD # 3	A-1, F-1
	# 5	Within the boundaries of Clark FPD # 5	C-1, F-1
	# 6	Within the boundaries of Clark FPD # 6	C-1, F-1
	# 7	Within the city limits of Camas	F-1
	# 8	Within the city limits of Washougal	A-1, F-1
	# 9	Within the boundaries of Clark FPD #9 and # 1	A-1, F-1
	# 10	Within the boundaries of Clark FPD # 10	A-1, F-1
	# 11	Within the boundaries of Clark FPD # 11 and the city limits of Battleground	C-1, F-1
	# 12	Within the boundaries of Clark FPD # 12	C-1, F-1
	# 13	Within the boundaries of Clark FPD # 13	F-1
	# 20	Within the boundaries of Clark FPD # 2	A-1, F-1
	# 100	Northeast of Trauma Response Area # 13, east of Trauma Response Area # 10 to the northern and eastern county line	None
	# 101	Land Area between Trauma Response Areas # 3, # 5, and # 9	None
	# 102	Parcel between Trauma Response Area # 5 and # 9	None
	# 103	Area bordering the eastern county line between Trauma Response Area # 3, #9, and # 13	None

	# 104	Area between Trauma Response Area # 10 to the northern county line	None
	# 105	Area between Trauma Response Area # 10 to the northern county line	None
	# 106	Area between Trauma Response Area #2, #6, and # 12 to the western county line	None
Cowlitz 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 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
Klickitat 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 Klickitat FPD # 1	A-1, F-1
	# 2	Within the boundaries of Klickitat FPD # 2	D-1, F-1
	# 3	Within the boundaries of Klickitat FPD # 3	A-1, F-1
	# 4	Within the boundaries of Klickitat FPD # 4	A-1, F-1
	# 5	Within the boundaries of Klickitat FPD # 5	F-1
	# 6	Within the boundaries of Klickitat FPD # 6	F-1
	# 7	Within the boundaries of Klickitat FPD # 7	A-1, F-1
	# 8	Within the boundaries of Klickitat FPD # 8	D-1, F-1
	# 9	Within the boundaries of Klickitat FPD # 9	A-1, F-1
	# 10	Within the boundaries of Klickitat FPD # 10	A-1, F-1
	# 11	Within the boundaries of Klickitat FPD # 11	F-1
	# 12	Within the boundaries of Klickitat FPD # 12	A-1, F-1
	# 13	Within the boundaries of Klickitat FPD # 13	A-1, F-1

	# 14	Within the boundaries of Klickitat FPD # 14	A-1, F-1
	# 15	Within the boundaries of Klickitat FPD # 15	A-1, F-1
	# 100	Land Area west of Glenwood Rd. to the western and northern county lines outside Trauma Response Areas # 1, #3, #4, and #13	None
	# 101	Land area east of Glenwood Rd. to Status Loop Rd. to the northern county line outside Trauma Response Areas # 5, #6, #7, #12, #14 and #15	None
	# 102	Land area east of Status Loop Rd. to the northern county line outside Trauma Response Areas # 2, #7, and # 9	None
Skamania 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 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
South Pacific 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 Pacific FPD # 1 and the city limits of Long Beach	F-1
	# 2	Within the boundaries of Pacific FPD # 2	A-1, F-1
	# 3	Within the city limits of Ilwaco	F-1
	# 4	Within the boundaries of Pacific FPD # 4 and the city limits of Naselle, north to the north/south Pacific County division boundary line	F-1
	# 100	All land area outside Trauma Response Areas # 1, 2, and 4, to the north/south Pacific County division line and eastern, southern and western county lines	None

	# 101	Northern tip of peninsula beyond Trauma Response Area # 1 boundary	None
	# 102	Southern tip of peninsula beyond Trauma Response Area # 3 boundary	None
Wahkiakum 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 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

Appendix 4

Non-Fatal and Fatal Injury Data Tables

Nonfatal Injury Hospitalizations Southwest											Cause by Year 2004-2013	
Counts	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total	
Unintentional												
Bites/Stings	51	50	40	51	47	45	48	59	62	73	526	
Drowning	1	1	1	2	2	2	1	5	2	3	20	
Falls	1,166	1,264	1,428	1,398	1,484	1,519	1,749	1,755	1,817	1,743	15,323	
Fire/Flame/Hot Object/Substance	22	12	11	14	9	24	15	19	29	21	176	
Firearm	4	5	8	5	5	6	10	3	6	8	60	
MVT-(occupant)	109	112	157	130	127	131	182	200	141	167	1,456	
MVT-(motorcyclist)	42	47	48	34	59	59	57	59	46	56	507	
MVT-(pedal cyclist)	4	8	4	3	5	7	9	13	10	8	71	
MVT-(pedestrian)	12	6	13	15	16	23	22	32	20	21	180	
Pedal-cyclist(Other)	29	25	31	44	33	32	45	30	47	37	353	
Pedestrian(Other)	8	1	3	3	2	5	1	6	3	3	35	
Poisoning	153	183	207	209	252	279	325	318	300	331	2,557	
Struck by or against	48	61	64	62	63	80	78	80	78	74	688	
Suffocation & obstructing	6	12	12	18	20	9	20	15	23	20	155	
Total (including other unintentional)	2,108	2,294	2,547	2,478	2,666	2,814	3,119	3,195	3,202	3,188	27,611	
Self Inflicted												
Cut/Pierce	75	52	54	52	58	52	40	47	39	55	524	
Firearm	2	2	8	1	4	-	1	1	4	-	23	
Poisoning	287	305	321	297	323	336	349	368	294	281	3,161	
Suffocation & obstructing	5	2	5	5	5	4	10	12	4	3	55	
Total (including other suicides)	376	373	406	365	398	408	415	443	359	356	3,899	
Assault												
Cut/Pierce	9	10	9	9	9	6	16	11	18	16	113	
Firearm	3	2	1	1	2	-	8	7	3	4	31	
Struck by or against	19	32	23	27	29	37	38	46	55	30	336	
Total (including other homicides)	51	61	50	53	52	60	83	85	93	79	667	
Undetermined, Legal, War, Other intents	75	148	366	390	432	265	191	183	270	231	2,551	
All Nonfatal Injury Hospitalizations	2,610	2,876	3,369	3,286	3,548	3,547	3,808	3,906	3,924	3,854	34,728	
Rate* per 100,000 Resident Population												
Unintentional												
Bites/Stings	9.9	9.5	7.4	9.3	8.5	8.0	8.5	10.4	10.9	12.7	9.5	
Drowning	-	-	-	-	-	-	-	0.9	-	-	0.4	
Falls	226.1	240.1	265.2	255.1	267.0	270.7	310.6	309.9	318.7	303.2	277.6	
Fire/Flame/Hot Object/Substance	4.3	2.3	2.0	2.6	1.6	4.3	2.7	3.4	5.1	3.7	3.2	
Firearm	-	0.9	1.5	0.9	0.9	1.1	1.8	-	1.1	1.4	1.1	
MVT-(occupant)	21.1	21.3	29.2	23.7	22.9	23.3	32.3	35.3	24.7	29.1	26.4	
MVT-(motorcyclist)	8.1	8.9	8.9	6.2	10.6	10.5	10.1	10.4	8.1	9.7	9.2	
MVT-(pedal cyclist)	-	1.5	-	-	0.9	1.2	1.6	2.3	1.8	1.4	1.3	
MVT-(pedestrian)	2.3	1.1	2.4	2.7	2.9	4.1	3.9	5.7	3.5	3.7	3.3	
Pedal-cyclist(Other)	5.6	4.7	5.8	8.0	5.9	5.7	8.0	5.3	8.2	6.4	6.4	
Pedestrian(Other)	1.6	-	-	-	-	0.9	-	1.1	-	-	0.6	
Poisoning	29.7	34.8	38.4	38.1	45.3	49.7	57.7	56.1	52.6	57.6	46.3	
Struck by or against	9.3	11.6	11.9	11.3	11.3	14.3	13.9	14.1	13.7	12.9	12.5	
Suffocation & obstructing	1.2	2.3	2.2	3.3	3.6	1.6	3.6	2.6	4.0	3.5	2.8	
Total (including other unintentional)	408.7	435.8	473.0	452.2	479.7	501.4	553.9	564.1	561.6	554.6	500.2	
Self Inflicted												
Cut/Pierce	14.5	9.9	10.0	9.5	10.4	9.3	7.1	8.3	6.8	9.6	9.5	
Firearm	-	-	1.5	-	-	-	-	-	-	-	0.4	
Poisoning	55.6	57.9	59.6	54.2	58.1	59.9	62.0	65.0	51.6	48.9	57.3	
Suffocation & obstructing	1.0	-	0.9	0.9	0.9	-	1.8	2.1	-	-	1.0	
Total (including other suicides)	72.9	70.9	75.4	66.6	71.6	72.7	73.7	78.2	63.0	61.9	70.6	
Assault												
Cut/Pierce	1.7	1.9	1.7	1.6	1.6	1.1	2.8	1.9	3.2	2.8	2.0	
Firearm	-	-	-	-	-	-	1.4	1.2	-	-	0.6	
Struck by or against	3.7	6.1	4.3	4.9	5.2	6.6	6.7	8.1	9.6	5.2	6.1	
Total (including other homicides)	9.9	11.6	9.3	9.7	9.4	10.7	14.7	15.0	16.3	13.7	12.1	
Undetermined, Legal, War, Other intents	14.5	28.1	68.0	71.2	77.7	47.2	33.9	32.3	47.4	40.2	46.2	
All Nonfatal Injury Hospitalizations	506.1	546.3	625.6	599.6	638.4	632.0	676.2	676.2	688.2	670.5	629.1	

*Rate not calculated for values <5.1; - 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 3/17/2015

Appendix 5

Southwest Region Emergency Medical Services and Trauma Care Council

Patient Care Procedures

Revised: February 11, 2011

Adopted: November 6, 2002

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DEFINITIONS

WAC 246-976-010

“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.

“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.

“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.

DISPATCH/RESPONSE TIMES

Dispatch

Agencies that operate a 911 Dispatch Center in the Southwest Region should use a priority dispatch program. All dispatchers should be trained in an emergency medical dispatch (EMD) program.

When a 911 Dispatch Center receives a call that suggests to the emergency medical dispatcher (EMD) that a trauma or major medical incident is involved, the EMD should dispatch the highest level of verified service available. In all counties in the Southwest Region, paramedics or the highest level EMS responder specifically trained in prehospital life support, should be dispatched to the scene of an incident.

It is the responsibility of the responding agency to have trained prehospital medical and trauma life support technicians respond to the scene. If a prehospital agency does not have personnel available who are trained in prehospital trauma life support or cardiac and stroke care, the agency should immediately notify the 911 Dispatch Center to dispatch another service to the scene of the call to assist with the patient(s).

If a major trauma patient is known or suspected, 911 Dispatch Center should advise all responding trauma services of any and all additional information that becomes available to the 911 Dispatch Center.

When a prehospital service that is not Trauma Verified has contact with a major trauma patient prior to the arrival or dispatch of trauma verified service they shall ensure that the 911 Dispatch Center is immediately notified so that trauma verified services can be activated as per the dispatch system for that location.

Response Times

To ensure timeliness in the dispatch of a 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):

Verified Aid Services (response times, 80 percent target)

- Urban Areas: 8 minutes or less
- Suburban Areas: 15 minutes or less
- Rural: 45 minutes or less
- Wilderness: as soon as possible

Verified Ambulance (Transport) Services (response times, 80 percent target)

- Urban Areas 10 minutes or less
- Suburban Areas 20 minutes or less
- Rural 45 minutes or less
- Wilderness: as soon as possible

CANCELLATION/SLOWDOWN/STAGING

Once a call is received by a transport unit, the unit will respond as rapidly as possible and make patient contact to administer emergency medical care as needed.

Cancelling of Response

- A. Dispatch reports the original caller has cancelled the request for service. The highest level EMS provider will make the decision to cancel or continue the call based on information from Dispatch.
- B. A first-in responding unit reports that no patient is present.

- C. A first-in responding unit with an EMT, paramedic, or EMS agency known to the responding unit arrives and reports to the transport unit that the patient does not want or need contact by transport unit. This denial can be due to:
 - 1. No need for treatment or minor care administered by the first-in units.
 - 2. Patient/Guardian desires POV transport (should be conveyed to transport unit). If first-in unit deems transport should continue in for evaluation, this should be conveyed to responding transport unit.
 - 3. It shall be the discretion of the responding transport unit whether to continue to the scene.
 - 4. If the transport unit does not respond, the first-in unit will **obtain a refusal form signed by the patient or other responsible person stating that based on his/her own initiative they do not desire transport.**

Slow Down

- A. Transport units may be slowed by first-in units, staffed by a paramedic or EMT, after evaluating the patient and determining a rapid response is unnecessary.
- B. The first-in unit conveys patient information to the responding transport unit so the responding unit can decide to slow response.

Diversion

- A. An EMS response unit may be diverted to another call when:
 - 1. It is obvious the second call is a life-threatening emergency and first-in EMT's and/or paramedics report that first call can await a second unit.
 - 2. A second ambulance is dispatched to the first call.
 - 3. The first responding unit is closer to the second call and may be vital to the patient's outcome.

Staging

- A. Stage/standby may be done when responding to scenes involving acts of violence or other scene safety issues until the scene is secured by law enforcement or other means. Items to consider:
 - 1. Information from Dispatch indicating violence or potential for violence e.g., assault with weapon, violent individual(s), or hostage situation.
 - 2. Information that raises questions regarding the safety of responders, e.g., hazardous material or other special rescue situation.
- B. Units will advise Dispatch of intent to stage and request Law Enforcement response (if not already done). Dispatch will notify all responding units of intent to stage.
 - 1. When a response unit declares intent to stage all responding agencies will stage until the scene is deemed safe to enter.

2. The responsibility to stage rests with the responding agency. Communication of intent to stage will be shared between multiple responding agencies.
- C. Dispatch should provide ALL pertinent information to the responding units so they can make a determination as to whether to stage. This should be the same complete information provided to law enforcement responding units.

TIME ON THE SCENE

- A. Any time an airway cannot be provided to a patient utilizing MPD approved airway procedures; transport the patient immediately to nearest hospital.
- B. Medical – 30 minutes or less after initial encounter.
- C. STEMI/CVA – 15 minutes or less after initial encounter.
- D. Trauma - 10 minutes or less once extrication has been accomplished and the patient can be removed from the site.

**Note: Document extenuating circumstance.

PRE-HOSPITAL COMMUNICATIONS

Hospital Notification Report Format (H.E.A.R. – Landline – 800 MHz – 900 MHz)

- A. Emergency Report Format:
 1. Unit identification
 2. Age and sex of patient
 3. Transport code (emergent/non-emergent)
 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)
- B. 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 Activating the Trauma System.
- C. Advise Medical Control or receiving emergency department of changes in patient's condition in route and/or request further treatment.

Report to Physician and/or Triage Nurse upon arrival at Emergency Department

- 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 interventions.
 - 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
- B. Transporting units are required to leave at minimum, an abbreviated written report prior to leaving the hospital.

Written Reports/Documentation

- A. An EMS Medical Incident Report (MIR) form (or other electronic report format) must be documented and filed for any call for EMS assistance resulting in patient contact regardless of patient transport. This will apply to all responding agencies, both basic and advanced life support units and includes public assist calls.
 - 1. Patient contact occurs when a provider contacts/sees/hears a patient, even if other providers are on scene. The treatments and evaluations provided, while provider is in contact with the patient, shall be documented.
- B. Documentation Format:
 - 1. If a written format is used, S.O.A.P. charting is the most acceptable method of report writing.
 - 2. If an electronic report format is used then it is necessary to follow the MPD approved documentation guidelines for that particular charting application.
- C. Documentation of Response Determinant
 - 1. Complete documentation of patient care will include the determinant assigned at initial dispatch and any upgrades received while en-route.
- D. The patient care report should reflect the patient care incident as accurately as possible. As such, the report will be completed as soon as feasible after the patient encounter to ensure an accurate accounting of the incident. **ALL REPORTS MUST BE COMPLETED WITHIN 24 HOURS.**
 - 1. Transporting units are required to leave at minimum an abbreviated written report prior to leaving the hospital.
 - 2. Transport units are required to provide the receiving facility a complete written or electronic patient care report within 24 hours of patient arrival.

TRAUMA

All trauma patients must be transported by a trauma verified service and will be managed consistent with the State of Washington approved patient destination procedure; CDC National Trauma Triage (Destination) Procedure.

Activating the Trauma System

- A. 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 a Level I or Level II Designated Trauma Center, where available or;
 - 2. The highest level designated facility within the agency's immediate response jurisdiction if a Level I or Level II Designated Trauma Center is not within a 30 minute transport time.
- B. To activate the Trauma System in the Southwest Region, contact with the Designated Trauma Center shall be preceded with the phrase: "THIS IS A TRAUMA SYSTEM ENTRY."
- C. It is important for the EMS agency to provide the Designated Trauma Center with the following information:
 - 1. Identification of the EMS agency or Trauma Verified Service
 - 2. Patient's chief complaint(s) or problem: identification of biomechanics and anatomy of injury
 - 3. Approximate age of the patient
 - 4. Basic vital signs (palpable pulse rate, where pulse was palpated, and rate of respiration)
 - 5. Level of consciousness (Glasgow Coma Score)
 - 6. Provider impression
 - 7. Other factors that require consultation with the base station
 - 8. Number of patients (if known)
 - 9. Estimated Time of Arrival
 - 10. Whether an air ambulance has been activated for scene, field, or hospital rendezvous

Pediatric Major Trauma Patients

For a pediatric major trauma patient consideration should be given to transport the patient directly from the field 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 Designated Trauma Center. However, Level II and /or Level III Centers, may offer initial stabilization of the pediatric patient. All Designated Trauma Centers in the Southwest Region shall follow their guidelines for diversion of pediatric patients directly from the prehospital setting based on the availability and potential need for surgical or medical subspecialty care or resources specific to the care of the pediatric patient. When a prehospital service notifies a Designated Trauma Center that they have a major pediatric trauma patient, the Level II, III, IV, or V center should immediately notify the EMS agencies of the diversion policy.

DESIGNATED TRAUMA CENTERS

In the Southwest Region, the following hospitals are Washington Designated Trauma Centers:

- Peace Health Southwest Medical Center; Vancouver, WA Level II
- Peace Health St. John Medical Center; Longview, WA Level III
- Skyline Hospital; White Salmon, WA Level IV
- Klickitat Valley Health; Goldendale, WA Level IV
- Ocean Beach Hospital; Ilwaco, WA Level IV

DIVERSION (DESIGNATED TRAUMA CENTER(S) NOT ACCEPTING PATIENTS)

Designated Trauma Centers in the Region may go on diversion for receiving major trauma patients based on the facility's ability to provide initial resuscitation, diagnostic procedures, and/or operative intervention at the designated level of care. Diversion will be categorized as partial or total based on the ability of the facility to manage specific types of major trauma. Each Designated Trauma Center will have a DOH approved policy to divert patients to other designated facilities based on its ability to manage each patient at a particular time.

EMS agencies in the Southwest Region will be notified if and when a Designated Trauma Center is on diversion status. Trauma verified services will follow County Operating Procedures (COPs) on where trauma patients should be taken, in the event a Designated Trauma Center is not accepting patients.

PROLONGED TRANSPORT

When the transport of a major trauma patient will be greater than 30 minutes to a Level I or II Designated Trauma Center but within 30 minutes of a lesser level facility, the highest level EMS provider on scene may contact medical control hospital to determine if the patient should be transported to the highest level Designated Trauma Center within 30 minutes or transported directly to a Level I or Level II Designated Trauma Center.

MEDICAL PATIENTS

All EMS Agencies should follow County Operating Procedures (COPs) for the transport of non-trauma patients.

CARDIAC PATIENTS

Patients presenting with signs and symptoms of acute coronary syndrome, or cardiac arrest with return of spontaneous circulation, shall be identified and transported according to the State of Washington Pre-hospital Cardiac Triage Destination Procedure. County Operating Procedures (COPs) may provide detail on the destination of cardiac patients based on the local community resources and clinical capabilities.

STROKE PATIENTS

Patients presenting with signs and symptoms of a stroke shall be identified and transported according to the State of Washington Pre-hospital Stroke Triage Destination Procedure. County Operating Procedures (COPs) may provide detail on the destination of stroke patients based on the local community resources and clinical capabilities.

AIR AMBULANCE

General considerations

Consider the following when deciding on air transport:

- A. Transport time to a level I or II Designated Trauma Center, or Level I or II Cardiac/Stroke Center, can be reduced by a minimum of 30 minutes versus ground transport. Factors affecting the 30 minute reduction include:
 - 1. Time of air ambulance arrival
 - 2. Transfer of patient to air ambulance personnel
 - 3. Establishing and transporting to the landing zone
 - 4. Road/traffic conditions (time of day)
- B. Patient needs advanced interventions

Standby

****Note:** When Air Ambulance is put on standby status; the helicopter is readied but remains available for any other requests on a priority basis.

- A. Air Ambulance may be placed on standby by:
 - 1. Emergency Medical Responder
 - 2. EMT
 - 3. Paramedic
 - 4. Any physician
 - 5. Any law enforcement
 - 6. 911 Dispatch Center

- B. Air Ambulance may be placed on standby prior to personnel arrival if first response unit arrival at the scene will be greater than 20 minutes or the information dispatched purports to be the type of patient who will benefit from Air Ambulance. Examples of situations:
 - 1. Gunshot or penetrating trauma
 - 2. MVA; person trapped or multiple patients
 - 3. Auto-pedestrian
 - 4. Severe burns
 - 5. Major amputation
 - 6. Entrapment (e.g., cave-in, machine on person, etc.)
 - 7. Critical pediatric patients
 - 8. Acute cardiac or neurological emergencies

Activation

- A. The decision to activate Air Ambulance rests with the highest level EMS provider (or a physician on scene):
 - 1. As EMS provider arrives on scene and evaluates patient.
 - 2. Based upon information relayed by people on scene.
- B. In some cases, Air Ambulance can be immediately activated to the scene prior to the arrival of a first-in unit or highest level EMS responder when:
 - 1. Travel time for that first-in unit will be over 30 minutes and the situation as known purports to be the type of patient who will benefit Air Ambulance.
 - 2. Where it is known ground access will be difficult but where the helicopter can get near the patient.
 - 3. Where the reporting party relates some other special circumstance indicating the need for its immediate activation.

**Note: In those situations (A or B above), activation shall be done through Dispatch with concurrence of responding highest level EMS responder.
- C. Criteria for Activation
 - 1. Patient(s) meet “major trauma” criteria and extrication and/or ground transport will be greater than 30 minutes, or;
 - 2. Patient meets cardiac/stroke triage criteria and ground transport will be greater than 30 minutes.
 - 3. Type of injury or illness may dictate immediate transport to a Designated Trauma Center, Burn Center, or Hyperbaric Center etc.
 - 4. Multiple victims meeting “major trauma” criteria.
- D. Destination Hospital
 - 1. Unless diversion criteria apply, the destination hospital shall be indicated to Air Ambulance by the highest level EMS responder in charge. The highest level EMS responder will consult with Medical Control to determine destination.

Cancellation

Air ambulance may be cancelled by the highest level EMS responder responsible for the patient after examination of the patient and determining that air transport is not necessary.

Quality Assessment and Improvement, Case Reviews

Air ambulance calls will be reported to the County Medical Program Director.

NON-TRANSPORT OF PATIENTS

**Note: Any person with a medical need, EMS personnel will use all resources available to have that person treated and transported.

In general, the only reasons for a non-transport are:

- A. Signed "Refusal for Transport," completed by patient, family or custodian.
- B. No patient (Dead on Arrival (DOA), termination of resuscitation 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.

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 for any reason including but not limited to:
 - 1. Alcohol and/or drugs
 - 2. Psychiatric conditions
 - 3. Injuries (head injury, shock, etc.)
 - 4. Organic Brain Syndrome (Alzheimer's, etc.)
 - 5. Minors (<18 years old)
 - 6. Language/communication barrier (including 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.

Pre-Hospital Guidelines for Patients Refusing Care

Establish if medical need exists. If the patient is refusing or resisting care, determine if patient capable of making informed decision OR patient not capable (in EMT opinion) of making informed decision.

- A. Capable of making informed decision, NO medical need exists (e.g. passersby report traffic accident; all persons deny injury when EMS arrives):
 - 1. A refusal form is not necessary.
 - 2. MIR documentation will include the events necessitating the call to EMS as well as all criteria for no patient/medical need.
- B. Capable of making informed decision, minor medical need exists:
 - 1. A refusal form is necessary. Form and MIR must be completed by highest level EMS provider attending the patient.
 - 2. MIR documentation shall include:
 - a. The patient's chief complaint
 - b. Events prior/reason for call to EMS
 - c. Pertinent medical history
 - d. Description of scene (if relevant to patient's c/c)
 - e. Physical exam including vital signs and clinical impression
 - f. Prehospital interventions
 - g. Consultation with medical control
 - h. Patient's response to medical care and/or transport attempts
 - i. Instructions to patient and/or family including risks/benefits of treatment/transport
- C. Capable of making informed decision, immediate medical care and/or ambulance transport necessary:
 - 1. A refusal form is necessary. Form and MIR must be completed by the highest level EMS provider attending patient.
 - 2. Every effort will be made to convince these patients to accept necessary pre-hospital intervention and transport to definitive care. Options available:
 - a. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport.
 - b. Solicit assistance from law enforcement (police hold), mental health professional (psychiatric hold), and/or clergy as the situation directs.
 - 3. CONSULTATION WITH MEDICAL CONTROL IS MANDATORY.
 - 4. MIR documentation shall include:
 - a. The patient's chief complaint
 - b. Events prior/reason for call to EMS
 - c. Pertinent medical history
 - d. Description of scene (if relevant to patient's c/c)
 - e. Physical exam including vital signs
 - f. Clinical impression

- g. Prehospital interventions
 - h. Consultation with medical control
 - i. Patient's response to medical care and/or transport attempts
 - j. Instructions to patient and/or family including risks/benefits of treatment/transport
5. If the patient still refuses treatment/transport, the highest level EMS provider will be responsible for explaining the REFUSAL FORM. Completion of the form includes:
- a. Explanation of instructions and release of liability to the patient
 - b. Receipt of signature (dated) from patient or legal guardian
 - c. Completion of patient assessment, medical control consult, and patient disposition
- D. Not capable of making informed decision, medical care and/or ambulance transport necessary:
- 1. A refusal form is necessary. Form and MIR must be completed by the highest level EMS provider attending the patient and signed by 2 witnesses.
 - 2. Every effort will be made to convince these patients to accept necessary prehospital intervention and transport to definitive care. Options available include:
 - a. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport
 - b. Solicit assistance from law enforcement (police hold), mental health professional (psychiatric hold), and/or clergy as the situation directs
 - c. Consider physical restraint per Medical Control concurrence based on the patient's condition and current situation
 - d. Chemical restraint per Medical Control concurrence based on the patient's condition and current situation
 - e. Patient restraint can occur only when the highest level EMS provider on scene believes the patient poses a danger to him/herself or others
 - 3. CONSULT WITH MEDICAL CONTROL IS MANDATORY.
 - 4. MIR documentation shall include:
 - a. The patient's chief complaint
 - b. Events prior to/reason for call to EMS
 - c. Pertinent medical history
 - d. Description of scene (if relevant to patient's c/c)
 - e. Physical exam including vital signs
 - f. Clinical impressions
 - g. Prehospital interventions
 - h. Consultation with medical control
 - i. Patient's response to medical care and/or transport attempts
 - j. Instructions to patient and/or family including risks/benefits of treatment/transport
 - 5. If the patient still refuses treatment/transport, the attending highest level EMS provider will be responsible for explaining the EMS REFUSAL INFORMATION FORM. Completion of the form includes:

- a. Explanation of instructions and release of liability to the patient
 - b. Receipt of signature (dated) from patient or legal guardian
 - c. Completion of patient assessment, medical control consult, and patient disposition sections
6. Every reasonable effort should be made to ensure patients receive necessary medical treatment and transport. If the patient seems hesitant regarding their medical care/transportation or any doubt exists, you should provide care/transportation.
 7. Should the above efforts prove fruitless, it may be necessary to leave these patients at the scene. Aforementioned documentation guidelines will be adhered to.
- E. Patient in Custody and/or Incident Involving Law Enforcement:
1. If patient competent, follow protocol outlined above regarding medical need. The patient will require a full medical exam, pertinent to the nature of the chief complaint and mechanism of injury. If the patient refuses care and/or transport a refusal form must be signed by the patient.
 2. If patient refusing transport is under arrest and/or restrained by officers, document refusal in MIR with signature of arresting police officer on refusal form.
 3. All other patients will be transported to the hospital by ambulance

PRIVATE PHYSICIAN AND/OR MEDICAL PROFESSIONALS AT THE SCENE

Physicians and/or medical professionals at the scene of an emergency may provide assistance and should be treated with professional courtesy. Medical professionals who offer their assistance must identify themselves. Physicians must provide proof of their identity, if they wish to assume or retain responsibility for the care given the patient after the arrival of EMS. When the patient's private physician is in attendance and has identified himself/herself upon the arrival of EMS, all EMS responders will comply with the private physician's instructions for the patient. If orders are given which are inconsistent with established protocols, clearance must be obtained through the Medical Control Physician.

The physician at the scene may:

- A. Request to talk directly to the Medical Control Physician to offer advice and assistance;
- B. Offer assistance to EMS with another pair of eyes, hands, or suggestions, leaving the EMS team under Medical Control;
- C. Take total responsibility for the patient with the concurrence of the Medical Control Physician.

Transport

If during transport, the patient's condition should warrant treatment other than that requested by the private physician, Medical Control will be contacted for information and concurrence with any treatment, except in cases of cardiopulmonary arrest.

****Note:** The above "Physician at the Scene" will also apply to cases where a physician may happen upon the scene of a medical emergency and interacts with the ALS team.

DO NOT RESUCITATE ORDERS

Definitions

- A. A DNR (DO NOT RESUSCITATE OR NO CODE) Order is an order issued by a physician directing that in the event the patient suffers a cardiopulmonary arrest, (e.g., clinical death) cardiopulmonary resuscitation will not be administered. DNR orders are only valid when a patient is under the care of skilled nursing personnel.
- B. A Living Will is a legally executed document expressing the patient's wish to not undergo ALS resuscitation.
- C. Physician Orders for Life Sustaining Treatment (POLST) Legal document signed by patient and physician indicating patient preference for life sustaining treatment.
- D. Resuscitation includes attempts to restore failed cardiac and/or ventilatory function by procedures such as endotracheal intubation, mechanical ventilation, closed chest massage, defibrillation, and use of ACLS cardiac medications.

Procedures

- A. When the patient's family, friends, or nursing home personnel state that the patient is not to be resuscitated:
 - 1. BLS protocols will be followed while attempts to determine if a written POLST form, DNR order or a Living Will is present.
 - 2. In the absence of the above, call Medical Control or the attending physician, if known by you and available.
 - 3. The EMS provider must document the POLST form, DNR order, or Living Will in the patient care report.
- B. When Patient is PULSELESS AND NONBREATHING; no BLS or ALS procedures should be performed on a patient who is the subject of a confirmed POLST (no resuscitation) form, DNR order, or has a Living Will.

INTER-FACILITY TRANSFER (HOSPITAL TO HOSPITAL)

General responsibilities and instructions

- A. It is the responsibility of the transferring facility to insure:
 - 1. Medical requirements for safe patient transfer are met including stabilization
 - 2. State of WA Trauma, Cardiac, &/or Stroke patient destination guidelines are adhered to

- B. Medical instructions of the attending physician will be followed unless contrary to standing orders; Medical Control will be contacted for clarification of contrary orders.
- C. Attendance of the patient during transport, by;
 - 1. Physician - he or she will direct all care regardless of standing orders
 - 2. Registered Nurse – he or she will direct the care of the patient via orders from the physician at transfer or the receiving hospital physician. The registered nurse may desire to defer emergency care in some situations to the highest level EMS provider.

Stabilization prior to transfer

- A. Patients will not be transferred to another facility without first being stabilized. Stabilization includes adequate evaluation and initiation of treatment to assure that transfer of a patient will not, within reasonable medical probability, result in material deterioration of the condition, death, or loss or serious impairment of bodily functions, parts, or organs.
 - 1. Establish and assure an adequate airway and adequate ventilation
 - 2. Initiate control of hemorrhage
 - 3. Stabilize and splint the spine or fractures, when indicated
 - 4. Establish and maintain adequate access routes for fluid administration
 - 5. Initiate adequate fluid and/or blood replacement
 - 6. Determine that the patient's vital signs (including blood pressure, pulse, respiration, and urinary output, if indicated) are sufficient to sustain adequate perfusion
- B. Stabilization of patients prior to transfer to include the following:
- C. ALS patient and Above Criteria Not Met:
 - 1. EMTs may, within their certified scope of practice, initiate pre-hospital protocols and guidelines including the establishment of intravenous lines, airway control, etc.
 - 2. EMTs may refuse to transfer the patient until the facility has complied with the above evaluation and/or treatment. Contact Medical Control for concurrence and consultation or contact the MPD directly.

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.
- B. Emergencies en route:
 - 1. Prehospital protocols and guidelines will immediately apply
 - 2. Medical Control should be contacted for concurrence of any orders as needed; 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.

- C. The receiving facility will be given the following information on the patient by fax, phone, or other means:
 - 1. Brief history
 - 2. Pertinent physical findings
 - 3. Summary of any treatment done prior to the transfer
 - 4. Response to therapy and current condition
- D. All required 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 means).
- E. All inter-facility transports must be conducted by a trauma-verified service for trauma system patients.
- F. All designated health care facilities shall have transfer agreements for the identification and transfer of trauma patients as medically necessary.

HAZARDOUS MATERIALS INCIDENT

EMS personnel are urged to be alert for hazardous materials when responding on calls. Hazardous materials may be obvious, but often are not. If a vehicle has a diamond shaped placard or an orange numbered panel on its side or rear, assume the cargo to be hazardous. Not all hazardous materials will be clearly identified. Grocery trucks or delivery vehicles may be carrying hazardous materials without the diamond shaped placard or orange numbered panel to identify such transport. Common sense dictates that each EMT assumes hazardous material is present unless proven otherwise. County Operating Procedures (COPs) may provide detail on Hazardous Materials response procedures, based on the local community resources and clinical capabilities.

MULTI-CASUALTY INCIDENTS AND MEDICAL INCIDENT COMMAND CENTER

It is imperative that a defined organizational structure be followed during incidents where a Multi-Casualty Incident (MCI) is encountered. The Incident Command (IC) system is the accepted standard for organizing the medical operations portion of such incidents. Further education and training is needed for all emergency responders to adequately function at these types of incidents. County Operating Procedures (COPs) may provide detail on MCI & IC response procedures, based on the local community resources and clinical capabilities.

QUALITY ASSESSMENT AND IMPROVEMENT (QA & I)

Quality Assessment & Improvement (QA&I) is an integral component of the Southwest Region's Trauma System, EMS and Cardiac/ Stroke 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 identified by a local QA&I committee for review and recommendations should be submitted directly to the Region QA&I committee for consideration. QA&I prehospital problems, issues, case reviews, areas of improvement, can be "flagged" by checking the "QI" Box on the medical incident reporting form. Any system issues that affect patient care are encouraged to be submitted.

Note: County Operating Procedures (COPs) may be found on the Southwest Region EMS website (www.swems.org) or through the respective County Council.