

**SOUTHWEST REGION
EMERGENCY MEDICAL SERVICES
& TRAUMA CARE SYSTEM**

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

July 1, 2009 - June 30, 2012

Submitted by the Southwest Region EMS and Trauma Care
Council
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EXECUTIVE SUMMARY

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

System Leadership

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

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

System Development

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

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

System Public Information and Education

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

System at the State, Region or Local level. Therefore, the Regional plan includes educating and informing individuals and groups about the EMS and Trauma Care System. In order to address goal # 9 the following work is needed;

- Develop and implement a Regional Public Information Plan or adopt one that works in the region.
- Share the Regional Public Information Plan with Region and Local Councils and other system stakeholders.

System Finance

Consistent sustainable funding has been and continues to be a challenge for all providers involved across the continuum of patient care within the Regional System. Southwest Region agencies and facility stakeholders routinely confront this issue individually rather than as a system. Inconsistent or inadequate funding threatens the stability of the system as a whole. All parts of the system must remain in place for the system to function as planned. In order to address goal # 11 the following work is needed;

- Provide the State funding opportunity action plan as referenced in the State 2001-2012 Plan Goal #11 for stakeholders groups to pursue.
- Analyze the council budgetary needs and financial opportunities to ensure appropriate funding is available to continue its critical work.

Injury Prevention and Control

The highest rate injury categories within the region are; falls, motor vehicle related injuries and deaths, poisonings, violence against women, and drowning. Injury Prevention and Public Education (IPPE) is provided through a variety programs and activities by partner organizations. In order to address goal # 12 the following work is needed;

- Ensure Regional Council grant funded IPPE activities are evidence based and/or best practice.
- Coordinate the IPPE stakeholders meeting of the Regional IPPE Committee.

Pre-Hospital Care

The prehospital care system consists of dispatch centers, licensed and/or trauma verified prehospital EMS agencies, air medical service, and hospital receiving facilities. The minimum/maximum numbers allow for distribution of trauma services throughout the region. The patient care procedures provide operational coordination. In order to address goal # 13 the following work is needed;

- Review and update the Regional Patient Care Procedures.
- Review and update existing County Operating Procedures.
- Assess the need for Counties without formal County Operating Procedures to adopt County Operating Procedures.
- Conduct a comparative analysis of PSAP Dispatch Center Emergency Medical Procedures, Patient Care Procedures, County Operating Procedures, and County Prehospital EMS Protocols by each Local County Council.
- Each Local County Council will review and provide a recommendation on minimum/maximum numbers of prehospital trauma verified services.
- Identify prehospital EMS provider training needs and financial support.

Acute Hospital Care

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

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

Pediatric Care

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

- The regional system will contribute to providing pediatric education.

Trauma Rehabilitation

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

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

System Evaluation

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

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

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

ADMINISTRATIVE COMPONENTS

SYSTEM LEADERSHIP

Introduction

The Southwest Region Emergency Medical Services (EMS) and Trauma Care Council (referred to as “Region Council”) provide EMS and Trauma System coordination in the Southwest Region of Washington State in accordance with RCW 70.168.100 – RCW 70.168.130 and WAC 246-976-960. The region is comprised of the following Counties:

- Clark
- Cowlitz
- Klickitat
- Skamania
- South Pacific
- Wahkiakum

The Region Council board consists of stakeholders from multidisciplinary private and public health care providers across the EMS and Trauma Care System.

The Council members represent:

- Prehospital
- Hospitals
- Medical Program Directors
- Injury Prevention
- 911 Centers
- Law Enforcement
- Government Representatives
- Elected Officials
- Consumer Representatives

Local County Emergency Medical Services and Trauma Care Councils (referred to as “Local Council”) provide coordination at the county level. Local Councils are charged under RCW 70.168.120 and WAC 246-976-970 to review and provide recommendations for the Region Council on the EMS and Trauma System Plan as well as communicate with the Region Council on emerging issues. Local Councils also make recommendations on minimum/maximum numbers of prehospital verified trauma services and Regional Council member appointments.

The Local County Councils are as follows:

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

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

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

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

SYSTEM LEADERSHIP

- Goal #1 -

There are viable, active local and regional EMS and trauma care councils comprised of multi-disciplinary, EMS and trauma system representation.

<p>Objective 1: By March 2010, the Region and Local Councils will bring their organizational structure into alignment with WAC.</p>	<p>Strategy 1: By August 2009 the Region staff will provide copies of current WAC to the Region and Local Council membership.</p>
	<p>Strategy 2: By March 2010 Region and Local Council's will determine gaps in current membership categories and identify membership positions that need to be added to their bylaws to meet WAC and other representation needs.</p>
	<p>Strategy 3: By March 2010 Region and Local Councils will vote on changes to membership categories and provide the Region Council a copy of the new membership scheme.</p>
<p>Objective 2: By March 2010 the Region and Local Councils will conduct a strategic review of the Council organization, mission statements, bylaws, membership roles and responsibilities and make changes that enhance Council viability for the future.</p>	<p>Strategy 1: By September 2009 the Region and Local Councils will gather documents (bylaws, articles of incorporation, mission statements, member roles and responsibilities and expectations etc.) related to the organizational structure and function of each council or determine the lack of organizational documents. The Local Councils will submit copies of those documents to the Regional Council office.</p>
	<p>Strategy 2: By January 2010 the Region and Local Councils will determine whether to conduct the strategic review as a council body or appoint a sub-committee/workgroup.</p>
	<p>Strategy 3: By March 2010 the Region and Local Councils with region staff assistance will conduct a strategic review of their council and make recommendations for any council organizational changes for council adoption.</p>
	<p>Strategy 4: By March 2010 the Region and Local Councils will vote on the recommended organizational changes.</p>
	<p>Strategy 5: By March 2010 the Region and Local Councils will submit copies of the updated organizational structure documents of their council to the region office.</p>

SYSTEM LEADERSHIP

- Goal #2 -

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

Objective 1:

By September 2010, the Region and Local Councils will collaboratively develop and implement a Council membership recruitment and retention plan including identified applicable parts of the state membership tool to increase membership engagement.

Strategy 1:

By April 2010 Region and Local Councils will utilize the information from the strategic review of the Council organizational components to formalize a direction for the membership project.

Strategy 2:

By April 2010 the Region Council will review and adopt the state provided membership tool for both Region and Local Councils to use in recruiting and engaging membership.

Strategy 3:

By April 2010 the Region and Local Councils will determine whether to write a recruitment plan as a council body or appoint a sub-committee/work group.

Strategy 4:

By September 2010 the Region and Local Councils will write a recruitment plan including identified applicable parts of the state membership tool to increase membership engagement.

Strategy 5:

By September 2010 the Region and Local Councils will vote to adopt a membership recruitment plan

Strategy 6:

By September 2010 the Region and Local Councils will implement the membership recruitment plan.

SYSTEM LEADERSHIP

- Goal #3 -

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

<p>Objective 1: By October 2009 the Region Council will disseminate available State resource and leadership training program information and recommendations for implementation to Region and Local Councils.</p>	<p>Strategy 1: By September 2009 the Region Council will receive and review the DOH identified leadership resources or training programs that include processes specific to EMS and Trauma Systems.</p>
	<p>Strategy 2: By September 2009 the Region Council will identify and review other related leadership training resources or programs for possible use in the region.</p>
	<p>Strategy 3: By October 2009 the Region Council will compile a report on findings pertaining to EMS System Leadership training.</p>
	<p>Strategy 4: By October 2009 the Region Council will disseminate State resource and leadership training program information to Region and Local Council membership.</p>
<p>Objective 2: By May 2010 where financially feasible the Region Council will host leadership and board development training for Region and Local Council representatives.</p>	<p>Strategy 1: By August 2009 the Region Council will develop a plan to coordinate and provide leadership and board development training based on information from Region and Local Council work on organizational needs, council membership needs, and other identified needs for training.</p>
	<p>Strategy 2: By January 2010 Region and Local Council representatives will be invited and expected to participate in coordinated leadership training.</p>
	<p>Strategy 3: By March 2010 the Region Council will coordinate and provide the identified leadership and board development training.</p>
	<p>Strategy 4: By May 2010 the Region Council will provide a summary report to the DOH describing the training provided.</p>

SYSTEM DEVELOPMENT

Introduction

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

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

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

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

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

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

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

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

SYSTEM DEVELOPMENT

- Goal #4 -

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

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

SYSTEM DEVELOPMENT

- Goal #5 -

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

<p>Objective 1: By March 2010 the 2009-12 Southwest Region EMS and Trauma Care System Plan will be reviewed annually by the Region Council for ongoing alignment with the 2007-12 State Strategic Plan and make any necessary changes identified using the Regional Plan change process.</p>	<p>Strategy 1: By November 2009 the Region Council will appoint a Regional Plan sub-committee to review the plan annually.</p>
	<p>Strategy 2: By January 2010 the Regional Plan sub-committee will establish a process for the annual review.</p>
	<p>Strategy 3: By March 2010 the Region Council will begin the annual review and implement the DOH plan change process as needed for changing the plan contents.</p>
<p>Objective 2: By September 2011 or DOH timeline, a 2012-17 Southwest Region EMS and Trauma Care System Plan will be developed by the Region Council that is aligned with the direction of the State EMS and Trauma System Strategic Plan and includes the input of Local Councils, MPDs, and other stakeholder groups in the regional system.</p>	<p>Strategy 1: By January 2011 the Region Council will draft a work plan to write the 2012 -17 Southwest Region EMS and Trauma Care System Plan.</p>
	<p>Strategy 2: September 2011 the Region Council will implement a process of review and development of the 2012-17 Southwest Region EMS and Trauma Care System Plan, consistent with the DOH guidelines, through the coordination and hosting of planning meetings and other related work.</p>
	<p>Strategy 3: By September 2011 in accordance with the DOH timeline and guidelines, the Region Council will approve the final draft of the plan for timely submission to DOH.</p>

SYSTEM DEVELOPMENT

- Goal #6 -

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

Objective 1.

By March 2011 Region and Local Councils will identify existing distribution channels for use in timely distribution of Steering Committee and TAC information to regional stakeholders on emerging issues and will develop and implement an information distribution process.

Strategy 1.

By September 2010 Region and Local Council representatives will identify *or* form a group representing all counties within the region to determine existing information distribution channels.

Strategy 2.

By January 2011 the identified group will develop a process for timely distribution of information on emerging issues.

Strategy 3.

By March 2011 the emerging issues information dissemination process will be implemented within the regional system.

SYSTEM DEVELOPMENT

- Goal #7 -

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

<p>Objective 1: By January 2010, leadership involved in Regional Emergency preparedness planning and EMS and trauma system planning will meet to determine how to coordinate similar work and implement workable processes.</p>	<p>Strategy 1: By November 2009 the leadership representatives of emergency managers and local public health will be identified by the Region Council.</p>
	<p>Strategy 2: By January 2010, the Region Council will host a meeting of the identified leadership representatives to discuss how to effectively coordinate Emergency Preparedness planning between groups and will implement workable processes.</p>
<p>Objective 2: By March 2010, leadership involved in Regional Emergency preparedness planning and EMS and trauma system planning will develop a recommendation to the State DOH regarding coordination of Public Health, Emergency Management, Homeland Security, Health Care Coalitions and EMS system geographical planning boundaries.</p>	<p>Strategy 1: By January 2010 the leadership involved in Regional Emergency preparedness planning will identify the challenges and discrepancies within the planning boundaries and develop recommendations to overcome the planning and coordination obstacles generated by the current geographical planning boundaries of the public health regions and EMS and Trauma Regions.</p>
	<p>Strategy 2: By March 2010 the leadership involved in Regional Emergency preparedness planning and EMS and trauma system planning will draft a position statement outlining the challenges and opportunities, and propose recommendations to overcome the current discrepancies of the Regional EMS and public health geographical boundaries in order to improve unified preparedness system planning.</p>

SYSTEM DEVELOPMENT

- Goal #8 -

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

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

SYSTEM PUBLIC INFORMATION & EDUCATION

Introduction

EMS and Trauma System Stakeholders recognize the fact that the general public, political leaders and EMS and Trauma Care System stakeholders from different roles do not always have an accurate clear understanding of the whole EMS and Trauma Care System at the state, region or local level. Therefore, the regional plan includes educating and informing individuals and groups about the EMS and Trauma Care System. This includes general public, decision makers and the health care community.

In order to address goal # 9 the following work is needed;

- Develop and implement a Regional Public Information Plan or adopt one that works in the region.
- Share the Regional Public Information Plan with Region and Local Councils and other system stakeholders.

SYSTEM PUBLIC INFORMATION & EDUCATION

- Goal #9 -

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

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

There is no Regional Plan goal #10

SYSTEM FINANCE

Introduction

Consistent sustainable funding has been and continues to be a challenge for all providers involved across the continuum of patient care within the Regional EMS and Trauma Care System. Southwest Region agencies and facility stakeholders routinely confront this issue individually rather than as a system. Funding for prevention partners, dispatch centers, prehospital agencies, hospital receiving facilities, rehabilitation centers and other related providers is obtained from multiple sources but may not always meet operation needs. Levies and grants are inherently temporary funding sources and are in ongoing jeopardy. Inconsistent or inadequate funding threatens the stability of the system as a whole. All parts of the system must remain in place for the system to function as planned.

The Southwest Region EMS and Trauma Care Council receive grant funding through contracts with Washington State Department of Health for operational funding. The Region Council applies for and has been granted funding for special projects from various sources. The Region Council uses funds to maintain Council operations and to provide funding for Local EMS County Council support, prehospital provider training, and injury prevention and public education (IPPE).

In order to address goal # 11 the following work is needed;

- Provide the State funding opportunity action plan, as referenced in the State 2007-2012 Plan Goal # 11, for stakeholders groups to pursue.
- Analyze the council budgetary needs and financial opportunities to ensure appropriate funding is available to continue its critical work.

SYSTEM FINANCE

- Goal #11 -

There is consistent and sustainable funding to ensure a financially viable regional EMS and Trauma Care System.

<p>Objective 1: By May 2012 Region and Local Councils will utilize the State funding opportunity action plan, as referenced in the 2007-2012 State Plan Goal # 11, to identify funding opportunities for stakeholder groups to pursue and identify strategies for them to use in seeking funding.</p>	<p>Strategy 1: By Jan 2012, the Region Council will receive and review the State funding opportunity report.</p>
	<p>Strategy 2: By March 2012, the Region Council will disseminate the State funding opportunity action plan, as referenced in the 2007-2012 State Plan Goal # 11, to the Region and Local Councils and licensed EMS agencies for their use in identifying funding resources.</p>
	<p>Strategy 3: By May 2012 the Region Council will provide recommendations on funding opportunities through additional funding resources to stakeholder groups including Region and Local Councils and licensed EMS agencies and identify strategies for success in seeking funding from available sources.</p>

CLINICAL COMPONENTS

INJURY PREVENTION & CONTROL

Introduction

When injury is prevented the savings to the individual and the health care system within the region can be enormous. Therefore; preventable premature death and disability due to injury reduction through targeted injury prevention activities and programs is a goal of the Southwest Region EMS and Trauma Care System. Injury Prevention and Public Education (IPPE) is provided through a variety of programs and activities by partner organizations. The following are some of the organizations within Southwest Washington involved in injury prevention awareness projects and programs:

- All of the Southwest Region Local County EMS and Trauma Care Councils
- Southwest Washington Medical Center
- Legacy Salmon Creek Hospital
- Clark County Public Safety Educators
- Clark County SAFE KIDS Coalition
- Southwest Advocates for Youth
- Lower Columbia SAFE KIDS Coalition Cowlitz
- St. John Peace Health Medical Center
- Klickitat Valley Medical Center
- Skyline Hospital
- Ocean Beach Hospital
- Pacific County Injury Prevention Traffic Safety Task Force
- Washington Traffic Safety Commission
- Washington State Patrol

The Southwest Region EMS and Trauma Care Council provides funding support and guidance to each of the Local County EMS and Trauma Care Council's injury prevention and public education activities and programs. A regional funding process requires local Councils to utilize regional funding to support injury prevention activities and programs in top injury categories within the region; falls, motor vehicle related injuries and deaths, poisonings, violence against women, and drowning. The Region Council is particularly interested in funding evidence-based injury prevention efforts.

In order to address goal # 12 the following work is needed;

- Ensure Regional Council grant funded IPPE activities are evidence based and/or best practice.
- Coordinate the IPPE stakeholders meeting of the Regional IPPE Committee.

INJURY PREVENTION & CONTROL

- Goal #12 -

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

<p>Objective 1: By September annually the Region Council will utilize the regional process to identify Injury Prevention and Public Education (IPPE) needs and allocate available funding to support evidence based and/or best practice activities in the counties.</p>	<p>Strategy 1: By May annually the Regional IPPE Committee will conduct a regional IPPE needs assessment of the Local County Councils for the following fiscal year.</p>
	<p>Strategy 2: By September annually, the Region Council will review the distribution of funding from the prior fiscal year and determine a direction for the fiscal year.</p>
	<p>Strategy 3: By September annually, the Region Council will approve a budget for IPPE activity support.</p>

PREHOSPITAL

Introduction

The Washington Emergency Medical Services Act of 1990 declared that a trauma care system, one which delivers the “right” patient to the “right” facility in the “right” amount of time, would be cost effective, assure appropriate and adequate care, prevent human suffering and reduce the personal and societal burden that results from trauma. The Act requires that the full continuum of care from prevention through prehospital, hospital and rehabilitation be implemented within Washington State. The minimum/maximum numbers allow for distribution of prehospital trauma services throughout the region. The following are the current ground licensed and verified EMS agencies serving the region:

Clark County		
06D01	East County Fire & Rescue	BLS Verified Aid Vehicle
06D03	Clark County FPD #3	BLS Verified Aid Vehicle
06D06	Clark County FPD #6	ALS Verified Aid Vehicle
06D10	Clark County FPD #10	BLS Verified Aid Vehicle
06D15	Clark County Fire & Rescue	ALS Verified Aid Vehicle
06M02	Camas Fire Department	ALS Verified Ambulance
06M05	Vancouver Fire Department	ALS Verified Aid Vehicle
06M06	Washougal Fire & Rescue	BLS Verified Aid Vehicle
06X03	North Country EMS	ALS Verified Ambulance
06X04	American Medical Response	ALS Verified Ambulance
Cowlitz County		
08D01	Cowlitz County FPD #1	BLS Verified Ambulance
08D02	Cowlitz #2 Fire & Rescue	ALS Verified Ambulance
08D03	Cowlitz County FPD #3	BLS Verified Aid Vehicle
08D04	Cowlitz County FPD #4	BLS Verified Aid Vehicle
08D05	Cowlitz County FPD #5	ALS Verified Ambulance
08D06	Cowlitz County FPD #6	ALS Verified Ambulance
08D07	Cowlitz-Skamania County FPD #7	BLS Verified Aid Vehicle
08M04	Longview Fire Department	BLS Verified Aid Vehicle
08M05	Woodland Fire Department	BLS Verified Ambulance
08X01	American Medical Response	ALS Verified Ambulance
06X05	Life Flight Network	ALS Verified Ambulance
Klickitat County		
20D01	Klickitat County FPD #1	BLS Verified Aid Vehicle
20D02	Klickitat County FPD #2	BLS Verified Ambulance
20D03	Klickitat County FPD #3	BLS Verified Aid Vehicle
20D04	Klickitat County FPD #4	BLS Verified Aid Vehicle
20D06	Klickitat County FPD #6	N/A Licensed Aid Vehicle
20D07	Klickitat County FPD #7	BLS Verified Aid Vehicle
20D08	Klickitat County FPD #8	BLS Verified Ambulance
20D09	Klickitat County FPD #9	BLS Verified Aid Vehicle
20D10	Klickitat County FPD #10	BLS Verified Aid Vehicle
20D11	Klickitat County FPD #11	BLS Licensed Aid Vehicle

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

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

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

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

Regional Council support of prehospital EMS personnel training will provide tools of excellence which will enhance patient care throughout the region. The Southwest Region EMS and Trauma Care Council offers training grants to the Local County Councils, available to all prehospital EMS providers in the Region. The Region Council office maintains instructor resources such as; instructor materials, a library of videos, text books, and training aid equipment, available on loan to Southwest Region EMS instructors and agencies.

The organization of Regional EMS and Trauma System operations is based on Regional Patient Care Procedures, County Operating Procedures, and Public Safety Access Point (PSAP) Emergency Medical Dispatch Procedures. As defined in RCW 18.73.030 “Patient Care Procedures” (PCP) means; written operating guidelines adopted by Region EMS and Trauma Care Council, in consultation with the Local EMS and Trauma Care Councils, emergency communication centers, and EMS Medical Program Director (MPD), in accordance with statewide minimum standards. The patient care procedures 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, the name and location of other trauma facilities to receive the patient should an interfacility transfer be necessary. County Operating Procedures (COPs) have been developed at the county level to address county specific issues related to patient care procedure. Periodic review and update of the Regional Patient Care Procedures and County Operating Procedures will maintain system stability over time. Public Safety Access Point (PSAP) Emergency Medical Dispatch Procedures dictate the activation and dispatch of the EMS and Trauma prehospital system agencies. It is important that the dispatch procedures, the Regional Patient Care Procedures, and County Operating Procedures are in alignment. A comparative analysis of these documents will identify procedural conflicts and will foster a better understanding of the system fundamentals.

In order to address goal # 13 the following work is needed;

- Review and update the Regional Patient Care Procedures.
- Review and update existing County Operating Procedures.
- Assess the need for Counties without formal County Operating Procedures to adopt County Operating Procedures.
- Conduct a comparative analysis of PSAP Dispatch Center Emergency Medical Procedures, Patient Care Procedures, County Operating Procedures, and County Prehospital EMS Protocols by each Local County Council.
- Each Local County Council will review and provide a recommendation on minimum/maximum numbers of prehospital trauma verified services.
- Identify prehospital EMS provider training needs and financial support.

PREHOSPITAL

- Goal #13 -

There is a sustainable region-wide prehospital EMS system utilizing standardized, evidence-based procedures and performance measures that address both trauma and medical emergencies

Objective 1:

By January 2011, the Region Council will review and update Regional Patient Care Procedures (PCP).

Strategy 1:

By May 2010 the Region Council will appoint a sub-committee/workgroup, led by the Regional MPDs, including at least one representative from each County Council to review and update the Regional Patient Care Procedures (PCP).

Strategy 2:

By May 2010 the Regional Patient Care Procedures (PCP) sub-committee/workgroup will draft a meeting schedule and work plan to complete the PCP review/update project.

Strategy 3:

By August 2010, the Regional PCP sub-committee/workgroup will receive available data from WEMSIS to utilize in updating Regional Patient Care Procedures.

Strategy 4:

By November 2010 the Regional PCP sub-committee/workgroup will review the Regional Patient Care Procedures, develop and submit recommended revisions to the Region Council for approval.

Strategy 5:

By January 2011, the Region Council will adopt the revised Regional Patient Care Procedures for inclusion in the 2012-17 Southwest Region EMS and Trauma Care System Plan.

PREHOSPITAL

<p>Objective 2: By March 2011, Counties with existing County Operating Procedures (COPs) will review and update them and counties without COPs will assess the need for developing COPs.</p>	<p>Strategy 1: By October 2010, each Local Council will appoint a sub-committee/workgroup, to include the county MPD and local county Council representatives to review and update or develop COPs.</p>
	<p>Strategy 2: By October 2010 the COPs sub-committee/workgroup will draft a meeting schedule and work plan to complete the COPs review and update project.</p>
	<p>Strategy 3: By October 2010 the Region Council will assist the Local Councils by creating a template including a list of elements for use as a guide in the development of COPs and/or updating COPs.</p>
	<p>Strategy 4: By February 2011, the COPs sub-committee/workgroup will review the COPs, develop and submit recommendations to the Local Council for approval.</p>
	<p>Strategy 5: By March 2011, the Local Council will submit updated COPs to the Region Council.</p>
	<p>Strategy 6: By March 2011, the Region Council will include the COPs in the 2012-17 Southwest Region EMS and Trauma Care System Plan.</p>
<p>Objective 3: By May 2011, each Local County Council and County Public Safety Access Point (PSAP) Emergency Medical Dispatch Center will conduct a comparative analysis to establish alignment of the Dispatch Procedures, Regional Patient Care Procedures, County Operating Procedures, and County Prehospital EMS Protocols for use in future planning.</p>	<p>Strategy 1: By October 2010 each Local County Council will appoint a Communications sub-committee/workgroup comprised of at minimum the County Council chair, County Council appointed members, County MPD, key representatives from the County PSAP Dispatch Center and a Region Council representative.</p>
	<p>Strategy 2: By October 2010 the County Council Communications sub-committee/workgroup will draft a meeting schedule and workplan to complete the analysis.</p>
	<p>Strategy 3: By May 2011 the Local County Council will conduct the analysis and submit findings and recommendations of workgroup sessions to the Regional Council for system planning.</p>

PREHOSPITAL

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

ACUTE HOSPITAL

Introduction

The Southwest Region has five designated trauma services within the regional boundaries providing quality emergency medical and trauma patient care.

Designated Trauma Services in the Southwest Region

Southwest Washington Medical Center	Level II
St. John Peace Health Medical Center	Level III
Skyline Hospital	Level IV
Klickitat Valley Medical Center	Level IV
Ocean Beach Hospital	Level IV

Legacy Salmon Creek Hospital is a medical receiving facility. It is not currently seeking trauma designation. At this time the minimum/maximum numbers of designated trauma services have been met and patient care needs are being fulfilled. As a result, there are no recommended changes to the identified minimum/maximum numbers of trauma designated services in the Regional Plan.

All of the region's hospitals participate in the initial and ongoing training of prehospital EMS providers. Skills training opportunities are provided through scheduled time in the emergency departments and operating rooms. This training allows the providers especially the rural providers to maintain their patient care skills proficiency. The hospitals also open enrollment to prehospital providers for education seminars and training events.

Emergency Department regular operations are impacted by routine patient surge demands. As a result, hospitals have an emergency department diversion mechanism in place. The prehospital EMS agencies need to be informed and educated to further a working understanding of emergency department diversion.

In order to address goal # 14 the following work is needed;

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

ACUTE HOSPITAL

- Goal #14 -

There is a sustainable region-wide system of designated trauma services that provides appropriate capacity and distribution of resources to support high-quality trauma patient care

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

PEDIATRIC

Introduction

The Southwest Region provides pediatric care through a sustainable region-wide EMS and Trauma Care System that integrates pediatric care into the system continuum. The regional licensed and trauma verified prehospital EMS agencies maintain pediatric patient care equipment on responding units. EMS providers are trained to care for pediatric patients and in the use of pediatric specialty equipment. The regional hospital receiving facilities are equipped, trained and dedicated to providing pediatric patient care.

Pediatric patients make up a minority of the EMS and trauma patient volume within the Southwest Region. Due to the infrequency of prehospital pediatric emergency calls, added emphasis is given to the ongoing training of prehospital providers in pediatric emergency care. This training is provided through initial certification, Ongoing Training and Evaluation Programs (OTEP), specialty courses, and the Southwest Region Pediatric EMS Conference.

In order to address goal # 15 the following work is needed;

- The regional system will contribute to providing pediatric education.

PEDIATRIC

- Goal #15 -

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

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

TRAUMA REHABILITATION

Introduction

Trauma rehabilitation care is provided through hospital and private local rehabilitation services. Southwest Washington Medical Center is currently the only Washington State Designated Trauma Rehabilitation Service in the Southwest Region.

Trauma Rehabilitation is the final step in patient care and consequently is at times a forgotten element of the continuum of patient care. However the importance of rehabilitation can not be understated in the role of giving patients the means to return to an optimal quality of life. Because rehabilitation occurs after initial hospitalization, prehospital providers may not be knowledgeable about the role of rehabilitation or how what they do in the field care impacts the rehabilitation of injured patients.

In order to address goal # 16 the following work is needed;

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

TRAUMA REHABILITATION

- Goal #16 -

There is a sustainable region-wide system of designated trauma rehabilitation services that provides adequate capacity and distribution of resources to support high-quality trauma rehabilitation care.

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

SYSTEM EVALUATION

Introduction

EMS and trauma data and system information are important elements of the Southwest Region EMS and Trauma Care System. System participants are strong supporters of the data availability to direct system planning. The Region Council has individuals involved in the Washington State EMS Information System (WEMSIS) project. Hospital and Prehospital services are at various levels of data collection in the regional system. A number of prehospital agencies have begun to submit data to WEMSIS. Various prehospital agencies currently use electronic data collection systems. Other agencies use paper systems. Throughout the region, MPDs require patient care reporting and utilize run review information to evaluate prehospital care. The current capabilities of prehospital services to submit data through WEMSIS and their current level of data submission are not fully known. The designated trauma services within the Southwest Region participate in the State Trauma Registry and have been collecting and submitting trauma patient data since the 1990s.

Prehospital EMS providers and the Designated Trauma facilities are active members represented at the Southwest Region Quality Assurance and Improvement (QA&I) Committee. The Region QA&I Committee functions under separate legislation, RCW 70.168.090, to look at the care of trauma patients in the region. Through that body, system efficiencies and issues are identified and action plans are recommended to trauma care providers. Leadership at the prehospital level is provided by the MPDs, several of which are actively involved in the Regional QA&I Committee. MPDs provide direction for system improvement at the prehospital level. Trauma Coordinators and physicians are members of the Region QA&I Committee and provide leadership of overall regional trauma quality assurance. There is limited reporting from the Regional QA&I committee to the Region Council for use in system planning.

In order to address goals # 17 -18 the following work is needed;

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

SYSTEM EVALUATION

- Goal #17 -

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

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

SYSTEM EVALUATION

- Goal #18 -

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

<p>Objective 1: By May 2011 the Regional QA&I committee will utilize aggregated data during the QA&I committee meetings to evaluate patient care and other areas of system performance and will provide summary reports to the Region Council.</p>	<p>Strategy 1: By May 2011 the Regional QA&I committee will identify system data reports available from DOH for use in regular Regional QA&I committee meetings.</p>
	<p>Strategy 2: By May 2011 the Regional QA&I committee will provide a summary report at a Region Council meeting on system level issues and findings. .</p>
<p>Objective 2: By September 2011 Region and Local Councils will use system data and recommendations of the Regional QA&I Committee in the development of the 2012-17 Regional EMS & Trauma Care System Plan.</p>	<p>Strategy 1: By September 2011 Regional Council will use selected data reports to develop system recommendations for the 2012-17 Regional EMS & Trauma Care System Plan.</p>
	<p>Strategy 2: By September 2011 the Regional Council will use Regional QA&I Committee reports to develop system recommendations for the 2012-17 Regional EMS & Trauma Care System Plan.</p>

APPENDICES

Appendix 1.

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

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

Appendix 2.

Trauma Response Areas by County

Clark County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	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

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

Aid-BLS = A Ambulance-BLS = D

Aid-ILS = B Ambulance-ILS = E

Aid-ALS = C Ambulance-ALS = F

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

Trauma Response Areas by County (continued)

Cowlitz County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	# 1	Within the boundaries of Cowlitz FPD # 1 and the city limits of Woodland	D-2, F-1
	# 2	Within the boundaries of Cowlitz FPD # 2 and the city limits of Kelso	F-1
	# 3	Within the boundaries of Cowlitz FPD # 3	A-1, F-1
	# 4	Within the boundaries of Cowlitz FPD # 4	A-1
	# 5	Within the boundaries of Cowlitz FPD # 5	F-1
	# 6	Within the boundaries of Cowlitz FPD # 6 and the city limits of Castle Rock	F-1
	# 7	Within the boundaries of Cowlitz-Skamania FPD # 7	A-1, F-1
	# 8	Within the city limits of Long View and land area to the southern county line	A-1, F-1
	# 100	All land area between Trauma Response Area # 2, # 4, # 6, and the northern and western county line	None
	# 101	All land area between the eastern and northern county line and the boundaries of Trauma Response Area # 1, # 2, # 3, # 5, # 6, and # 7	None

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

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

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

Trauma Response Areas by County (continued)

Klickitat County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	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

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

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

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

Trauma Response Areas by County (continued)

Skamania County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	# 1	Within the boundaries of Skamania FPD # 1	F-1
	# 2	Within the boundaries of Skamania FPD # 2	F-1
	# 3	Within the boundaries of Skamania FPD # 3	F-1
	# 4	Within the boundaries of Skamania FPD # 4	A-1, F-1
	# 5	Within the boundaries of Skamania FPD # 5	F-1
	# 6	Within the boundaries of Skamania FPD # 6	A-1, F-1
	# 7	Within the boundaries of Cowlitz-Skamania FPD # 7	F-1
	# 100	All land area outside Trauma Response Areas # 1, 2, 3, 4, 5, 6, 7, to the northern, southern, western, and eastern county lines	None

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

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

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

Trauma Response Areas by County (continued)

South Pacific County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	# 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

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

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

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

Trauma Response Areas by County (continued)

Wahkiakum County	Trauma Response Area Number	Description of Trauma Response Area's Geographic Boundaries (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	Type and # of Verified Services available in each Response Areas (*use key below – **see explanation)
	# 1	Within the boundaries of Wahkiakum FPD # 1 and # 4, and the city limits of Cathlamet	D-1
	# 2	Within the boundaries of Wahkiakum FPD # 2	D-1
	# 3	Within the boundaries of Wahkiakum FPD # 3	D-1
	# 100	All land area outside Trauma Response Area # 3 west of mile post 22 on State Route 4, to the western, northern, and southern county lines	None
	# 101	All land area outside Trauma Response Areas # 1 and # 2 east of mile post 22 on State Route 4, to the eastern, northern, and southern county lines	None

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

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

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

Appendix 3.

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

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

Appendix 4.
Patient Care Procedures (PCPs)

2002-2003

Regional Patient Care Procedures (PCPs)

Adopted November 6, 2002

**Southwest Region EMS and Trauma
Care Council**

SW Region Prehospital Trauma System Activation & Destination Procedures

These procedures are based on the triage/assessment of the trauma patient using the State of Washington Prehospital Trauma Triage Destination Procedures (see p. 19).

Airway is of primary concern! If the patient's airway cannot be effectively managed consider rendezvous with ALS or immediate diversion to closest facility able to provide definitive airway management.

Step I **Assess Vital Signs and Level of Consciousness:**

If any criteria met:

- Immediately notify the highest level trauma center within 30 minute transport time that your patient meets *Trauma Team* criteria and begin transport.
- If facility cannot accept your patient (i.e. on divert) immediately divert to the next closest, highest level trauma center. Notify receiving facility that your patient meets *Trauma Team* criteria.

Step II **Assess Anatomy of Injury:**

If any criteria met:

- Immediately notify the highest level trauma center within 30 minute transport time that your patient meets *Trauma Team* criteria and begin transport.
- If facility cannot accept your patient (i.e. on divert) immediately divert to the next closest, highest level trauma center. Notify receiving facility that your patient meets *Trauma Team* criteria.

Step III **Assess Biomechanics of Injury and Other Risk Factors:**

If any criteria met:

- Immediately notify the closest trauma center that your patient meets *Trauma Alert* criteria and begin transport.
- If facility cannot accept your patient (i.e. on divert) immediately divert to the next closest, highest level trauma center. Notify receiving facility that your patient meets *Trauma Alert* criteria.
- Special considerations:
 - If, during the course of your treatment and evaluation, the patient meets Vital Signs and LOC or Anatomy criteria, upgrade patient to *Trauma Team* status and proceed per Step I or II as above.
 - Always err on the side of patient care. If in doubt, assume injuries are of a critical nature and transport the patient to the highest level trauma center.

For all Trauma Team and Trauma Alert Patients:

- Affix the State of Washington Trauma ID Band to the patient, document the number and submit data (after the incident) to the State.
- Consider activation of an Air Ambulance if it will decrease total out of hospital time to the trauma center by 10 minutes or more.
- If in doubt regarding destination decision, follow local on or off line Medical Control.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

“Pediatric Major Trauma Patient” Means a patient who is a major trauma patient estimated to be under the age of 15 years.

“Quality Improvement” Means the process or methodology used to evaluate the effectiveness of the procedure on the system and recommend changes in the implementation process of the Regional Plan and in this procedure as may be indicated.

Trauma Alert criteria: used for activating the SW Region Trauma System that indicates patient severity. Generally denotes patient meeting Biomechanics of Injury and other Risk Factors (Step III) criteria in the SW Region Prehospital Trauma System Activation and Destination Procedures.

Trauma Team criteria: used for activating the SW Region Trauma System that indicates patient severity. Generally denotes patient meeting Vital Signs/Level of Consciousness (Step I) and/or Anatomy of Injury (Step II) criteria in the SW Region Prehospital Trauma System Activation Destination Procedures.

“Trauma Verified Service: means a DOH approved, and regionally recommended, first response or ambulance service that provides twenty-four hour per day emergency medical responses, seven days per week, with response ambulances and/or first response vehicles with personnel trained in emergency care of the traumatically injured patient.

DESIGNATED TRAUMA CENTERS - Southwest Region

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

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

(Level I is the highest level of designated Trauma Center in the Regional Trauma System, with in-house trauma care available, 24 hours per day. Southwest Washington recognizes Levels I, II, III, IV, and V. A Level V trauma center can provide the least technical care and should be considered as stabilization center only, with the intent of getting a major trauma patient from a Level III, IV or V trauma Center to a Level I or Level II Trauma

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

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

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

PREHOSPITAL PROCEDURES

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

1. Contact with Medical Resource Hospital (University Hospital, Portland, OR) for Level I access or the Level II Trauma Designated Trauma Center (Southwest Washington Medical Center), where available; or
2. The highest level of designated facility within the agency's immediate response jurisdiction if a Level I or Level II Trauma

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

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

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

ACTIVATING THE TRAUMA SYSTEM

Contact

To activate the Trauma System in the Southwest Region, contact with the appropriate designated Trauma Center shall be preceded with the phrase: "THIS IS A TRAUMA SYSTEM ENTRY." this alerts the trauma center that you have a potential 'major' trauma patient.

It is important for the EMS agency to provide the designated Trauma Center with the following information:

- A. Identification of the EMS agency or Trauma Verified Service
- B. Patient's chief complaint(s) or problem: identification of biomechanics and anatomy of injury.
- C. Approximate age of the patient
- D. Basic vital signs (palpable pulse rate, where pulse was palpated, and rate of respiration).
- E. Level of consciousness (Glasgow Coma Score)**
- F. Other factors that require consultation with the base station.
- G. Number of patients (if known)
- H. Estimated Time of Arrival
- I. Whether an air ambulance has been activated for scene, field, or hospital rendezvous.

MAJOR TRAUMA PATIENTS

When it has been determined that a patient meets the trauma inclusion criteria an orange Washington State Trauma Registry band should be attached to the patient's wrist or ankle as soon as possible. The number on the Trauma Registry Band shall be recorded on the medical incident report (by all prehospital agencies -- both first response and transport agencies) and in the hospital trauma registry database (by the Trauma Registrar at the hospital).

AIR AMBULANCE

Air ambulance shall be considered for use by prehospital agencies in the Southwest Region for major trauma patients when transport by air will reduce the overall out of hospital time to the most appropriate designated trauma center by 10 minutes or more. If the air ambulance is required, request 9-1 -1 or your dispatch services to "ACTIVATE AIR AMBULANCE FOR A TRAUMA SYSTEM ENTRY." If you

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

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

PROLONGED TRANSPORT

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

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

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

PEDIATRIC MAJOR TRAUMA PATIENTS

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

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 Trauma Center that they have a major pediatric trauma patient, the Level II, III, IV, or V center should immediately notify the trauma designated EMS agencies of the diversion policy.

DIVERSION – TRAUMA CENTER(s) NOT ACCEPTING PATIENTS

Designated Trauma Centers in the Region will go on diversion for receiving major trauma patients based on the facilities' inability 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 inability of the facility to manage specific types of major trauma or all major trauma at the time.

Trauma Centers shall consider diversion of major trauma patients when:

1. A Surgeon is unavailable
2. The OR is unavailable
3. The CT scanner is down (if Level II)
4. Neurosurgeon is unavailable if (Level II)
5. Emergency Department is unable to manage more major trauma; and/or
6. Other specific resources needed for care of a trauma patient are unavailable

Each designated Trauma Center will have a hospital-approved policy to divert patients to other designated facilities based on its ability to manage each patient at a particular time. A diversion log will be kept, indicating the time of diversion and the reason for partial or total diversion.

EMS agencies in the Southwest Region will be notified if and when a Trauma Center is on diversion status. Trauma verified services will follow their medical program director's guidelines on where trauma patients should be taken, in the event the closest or most appropriate trauma center is not accepting patients.

MPDs should develop diversion protocols for their respective counties.

MEDICAL PATIENTS

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

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

- A. Patient's desire or choice of medical facility as to where they want to be transported and/or treated. Or, in the case of an unconscious patient, the wishes of the patient's family or personal physician.
- B. The type of treatment and the ability of a receiving hospital to treat such medical or non-major trauma (i.e., high risk OB patients, potential ICU/CCU patients, unstable co-morbid medical patients, etc.).
- C. Pre-existing financial or organizational agreements with receiving facilities (i.e., HMO members, capitated arrangements, or referral patterns previously established).
- D. Level, severity, and type of injuries.
- E. Ability of the receiving hospital to adequately treat the medical or non-major trauma patient.

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

QUALITY ASSESSMENT AND IMPROVEMENT (QA&I)

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

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, available from the State EMS Office. Any system issues that affect patient care are encouraged to be submitted. Refer to SW Region QA&I plan for more information regarding QA&I for the region.

PATIENT CARE PROCEDURES - DISPATCH AND RESPONSE TIMES

STANDARD: DISPATCH

Dispatchers who operate a 9-1-1 Center in the Southwest Region should use a regionally approved medical priority dispatch program available from the Southwest Region EMS & Trauma Care Council. All dispatchers should be trained in a regionally adopted and medical program director approved emergency medical dispatch program (EMD) and be regionally certified as EMDs. Such persons who are not certified should be in a sixteen-hour in-house training program that provides them with the principles of EMD dispatch. EMDs should follow priority dispatch for major trauma patients.

EMDs should use the priority dispatch guidelines when dealing with a major trauma patient.

LEVEL OF SERVICE TO BE DISPATCHED

When a 9-1-1 Center receives a call that suggests to the emergency medical dispatcher (EMD) that a "major" trauma patient is involved, the EMD should dispatch the highest level of care that is generally available in the response area. First response trauma verified services, where available, should also be dispatched. In all counties in the Southwest Region, paramedics or the highest level of provider, specifically trained in prehospital trauma life support should be dispatched to the scene of a major trauma incident, when available.

The 9-1-1 Center should immediately notify both the first response service and the transport service that this is "a potential 'major' trauma patient response." It is the responsibility of the responding agency to have the appropriate trained prehospital trauma life support medical technicians respond to the scene. If prehospital agencies do not have resources available who are trained in prehospital trauma life support, the agency should immediately notify the 9-1-1 Center to dispatch a trauma verified service to the scene of the call to assist with the patient or patient(s). In all suspected "major" trauma patients, the nearest and highest level of EMS provider should be dispatched as part of the initial EMS response to any trauma patient. Ideally, this would be a paramedic service with trauma trained individuals on board.

DISPATCH OF NEAREST TRAUMA VERIFIED SERVICE

Response Systems

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

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

In the instance where no trauma verified service is available, the 9-1-1 Center should

dispatch the nearest available first response and/or ambulance service to the scene

of the trauma incident with the highest level of care available.

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

RESPONSE MODE

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

RESPONSE TIMES

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

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

Urban Areas: 4 minutes

Suburban Areas: 5 minutes
Rural: 12 minutes
Wilderness: within 60 minutes, but as soon as possible.

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

Urban Areas 8 minutes
Suburban Areas 15 minutes
Rural 35 minutes
Wilderness: within 60 minutes, but as soon as possible.

These response times apply to all trauma verified services in the Southwest Region, and apply to all major trauma patients.

INTERFACILITY TRANSFER/TRANSFER AGREEMENTS

All Level II (Southwest Washington Medical Center, Medical Center Campus, Vancouver), Level III (St. John Medical Center, Longview), IV (Ocean Beach Hospital, Ilwaco, WA; Skyline Hospital, White Salmon; and Klickitat Valley Hospital, Goldendale, WA), and Level V (none at present) designated trauma facilities shall have transfer agreements with Level I Trauma Centers (Emanuel Hospital and/or University Hospital) for the transfer of emergency medical and trauma patients, as necessary. Identification of patients who meet trauma transfer criteria shall be according to the Washington State recommended guidelines for Adult & Pediatric Trauma Transfer Criteria (See Appendix A)

All Interfacility transfers shall be in compliance with current EMTLA regulations and must be consistent with the Revised Codes of Washington (70.170.060(2)).

All Interfacility transfers of major trauma patients shall consider an air ambulance service where out of hospital times can be reduced by 10 minutes or more, or an appropriate level of trauma verified transport service (where transport can be appropriately handled by such a ground service (i.e., Southwest Washington Medical Center to University Hospital, for example), in all other cases.

PROCEDURES

Designated Trauma Centers shall have published adult and pediatric trauma transfer criteria available for use by the emergency department personnel (Appendix A).

INTERFACILITY TRANSFER OF A MAJOR TRAUMA PATIENT

When a major trauma patient must be transferred from a lower level Trauma Center to a higher level center (Level IV to Level I, for example), the transferring physician

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

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

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

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

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

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

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

Further orders may be given by the receiving physician.

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

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

APPENDIX A - INTERFACILITY TRANSFER CRITERIA

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

General Trauma Transfer Criteria

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

A. Central Nervous System

1. Head injury with (any 1 of the following):
 - (a) Open, penetrating, or depressed skull fracture
 - (b) CSF leak
 - (c) Severe coma (9GCS < 10)
 - (d) Deterioration in GCS of 2 or more
 - (e) Lateralizing signs
2. Unstable spine
3. Spinal cord injury (any level)

B. Chest

1. Suspected great vessel or cardiac injuries
2. Major chest wall injury
3. Patients who may require protracted ventilation

C. Pelvis

1. Pelvic ring disruption requiring transfusions
2. Evidence of continued hemorrhage
3. Compound/open pelvic injury or pelvic visceral injury

D. Multiple system injury

1. Severe facial injury with head injury
2. Chest injury with head injury
3. Abdominal injury with head injury
4. Bums with head injury

E. Specialized Problems

1. Critical burns >20% of body surface areas or involving airway;

F. Secondary Deterioration (late sequelae)

1. Patient requires mechanical ventilation
2. Sepsis
3. Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation systems)
4. Osteomyelitis

Pediatric Trauma Transfer Guidelines

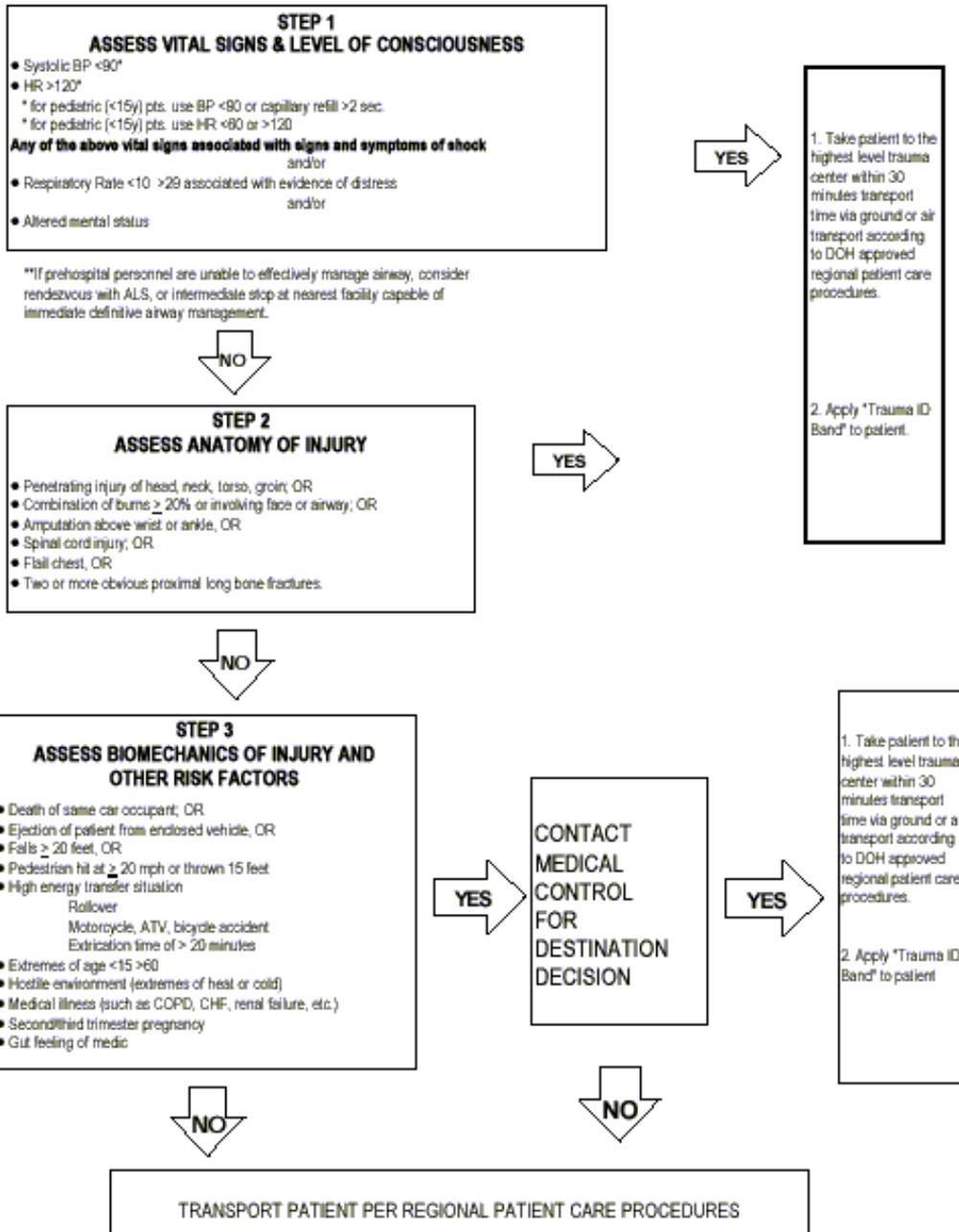
(Adopted by the Governor's EMS & Trauma Care Steering Committee on July 19, 1995)

Consideration shall be given to early transfer of a child to the regional pediatric trauma center when required surgical or medical subspecialty care or resources are unavailable. These include, but are not limited to the following:

1. Hemodynamically stable children with documented visceral injury being considered for "observational" management. Although the efficacy of this approach in selected cases has been well documented, two significant caveats always apply:
 - a) Hemodynamic instability mandates immediate operative intervention, and;
 - b) Non-operative care is safe only in an environment that provides both close clinical observation by a surgeon experienced in the management of childhood trauma and immediately available operative care.
2. Children with abnormal mental status. In all but the infant, outcome from closed head injury has been shown to be significantly better for the child than for the adult. Although the quality and timeliness of initial resuscitation are the most important determinants of outcome from brain injury, continued comprehensive management in specialized units with multi-disciplinary pediatric critical care teams may provide a more rapid and complete recovery.
3. Infants and small children. Severely injured infants and small children are the most vulnerable and, frequently, the least stable trauma victims. Because they require the special resources and environment of a regional pediatric Trauma Center, transfer should occur as soon as safely feasible.
4. Children with injuries requiring complex or extensive reconstruction. These services are traditionally most available in hospitals capable of functioning as a regional pediatric trauma center. It is especially important that children with impairments requiring long-term follow-up and supportive care have this provided or at least coordinated by the regional pediatric Trauma Center. Longitudinal follow-up of injury-related disability is an essential requirement of the regional pediatric Trauma Center's trauma registry.
5. Children with polysystem trauma requiring organ system support. This is especially important for those patients requiring ventilatory, cardiovascular, renal, or nutritional support. Because these problems usually occur synchronously and require precise interdisciplinary coordination, they are best managed in comprehensive facilities such as regional pediatric Trauma Centers.

**STATE OF WASHINGTON
PREHOSPITAL TRAUMA TRIAGE (DESTINATION) PROCEDURES
EFFECTIVE DATE 1/95**

- Prehospital triage is based on the following 3 steps. **Steps 1 and 2 require prehospital EMS personnel to notify medical control and activate the Trauma System. Activation of the Trauma System in Step 3 is determined by medical control****



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

Approved May 3, 2006

- I. **STANDARD:** During a mass casualty incident (MCI) with severely burned adult and pediatric patients,
1. All verified ambulance and verified aid services shall respond to an MCI per the local MCI plans.
 2. When activated by dispatch in support of the local MCI Plan and/or in support of verified EMS services, all licensed ambulance and licensed aids services shall assist during an MCI per local MCI plans.
 3. When activated by dispatch in support of the local MCI Plan and/or in support of verified EMS services, all EMS certified individuals shall assist during an MCI per local MCI plans.
 4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
 5. All EMS agencies working during an MCI event shall operate within the Incident Command System as identified in local protocol and MCI plan.
- II. **PURPOSE:**
1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.
 2. To implement local MCI plans during an MCI.
 3. To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.
 4. To provide safe mass transportation with pre-identified medical staff, equipment, and supplies per mass transport vehicle.
- III. **PROCEDURES:**

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

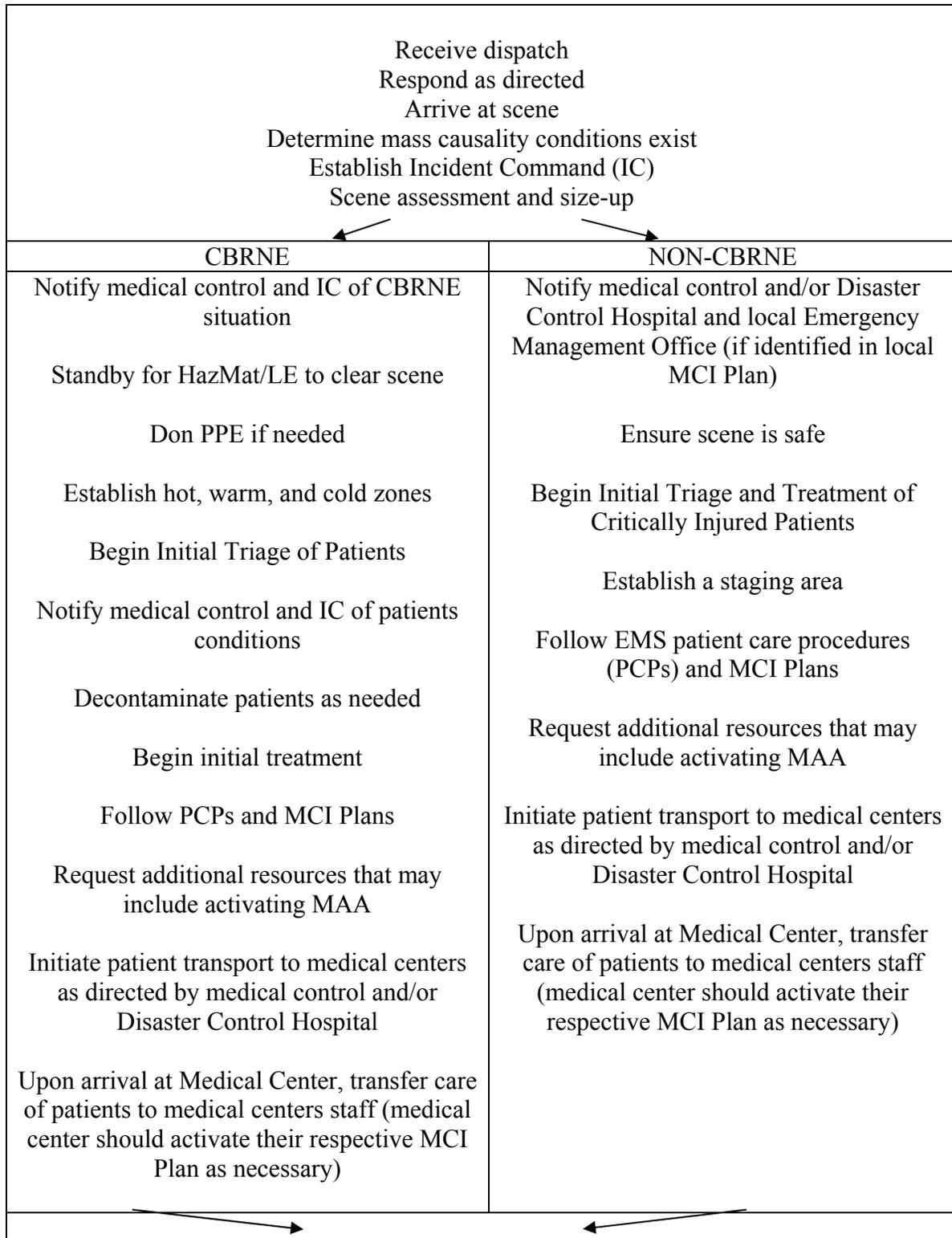
Include copies of MCI/All Hazards protocols for each County in the SW Region. If no county protocol exists then the State protocol will be followed <http://www.doh.wa.gov/hsqa/emstrauma/download/allhazprot>.

2. EMS personnel will follow DOH and MPD approved patient care protocols while providing patient care during an MCI.
3. EMS personnel may use the “Prehospital Mass Casualty Incident (MCI) general Algorithm during the MCI incident.

IV. QUALITY IMPROVEMENT:

The Regional Council Planning Committee will review this PCP upon receipt of suggested modifications from a local provider, the Southwest Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Prehospital Mass Causality Incident (MCI) General Algorithm



Clark County Operating Procedures (COPS)

MEDICAL CONTROL

Southwest Washington Medical Center is Medical Control Base Station for clarification of orders or patient disposition, in cases of disparity between the pre-hospital care guidelines and private physician wishes, and for general medical information and for controlled substances or treatment (***)

If a patient is being transported to a facility outside of Clark County, Medical Control must be utilized for treatment concurrence while the EMS unit is within Clark County. When the transport unit is operating in Multnomah County, Medical Control is at Medical Resource Hospital, OHSU.

In cases where life-threatening conditions exist or when communication is impossible, controlled medical treatment(s) (***) can be given without base station physician concurrence, or with the concurrence of the patient's private physician.

Medical Control will be contacted on all trauma patients if diversion to Level I facility is anticipated. Occasionally, contact with Medical Control may be impossible prior to diversion/transport by Life Flight. In this instance, Medical Control will be contacted as soon as possible before leaving the scene by the paramedic with patient/scene information

EMS RESPONSE MODES

All Fire and Medic units responding on 911 calls will follow the Clark County Medical Priority Dispatch System (MPDS) EMS Response Modes. At times deviation from these modes may be appropriate. Any deviation by responding units shall be documented in writing and submitted to the unit's agency and Medical Program Director for review.

Transportation Only (26-A-27 response determinant)

- A. CRESA shall only notify the assigned ambulance on calls triaged as a sick person, with non-priority symptoms, needing transportation only.

First Response Unit Delayed

Delayed response is defined as any response time (time of dispatch to time of arrival) exceeding an EMS agency's response time standard for the incident location. When a first response unit realizes it will have a delayed response:

- A. The first response unit shall advise CRESA to notify the responding ambulance of the delay;
 - 1. CRESA shall advise the responding ambulance of the delayed response;
 - 2. The responding ambulance shall upgrade to the First Response EMS Response Mode.

Ambulance Closer to a Call

When a responding ambulance unit realizes it is closer to a call:

- A. The ambulance shall advise the first responder of their location and respond according to the First Response EMS Response Mode;
- B. The first responder shall decide if it will respond according to First Response or Ambulance Response Mode.

Canceling Response; Slowing Response; Diverting to Another Call

See "Cancellation/Slowdown"

CLARK COUNTY MEDICAL PRIORITY DISPATCH SYSTEM EMS RESPONSE MODES

TYPE I

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

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

TYPE II

- NCEMS and DNR Fire/EMS Areas -

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

EXCEPTIONS:

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

CANCELLATION/SLOWDOWN

Once a call is received by an ALS transport unit from CRESA or other means, the ALS transport unit will respond as rapidly as possible and make contact with the requesting party or victim and determine the level of care or treatment required and administer emergency medical care as needed.

Canceling of Response

- A. CRESA reports back that the original caller has canceled the request for service. Upon such request, the paramedic will make the decision to cancel or continue the call based on information from CRESA.
- 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 ALS transport unit that the patient does not want or need contact by ALS transport unit.
 - 1. This denial can be due to no need for medical treatment or that only minor care is needed and can be administered by the first-in units.
 - 2. If the request for cancellation is based on a desire by the patient for POV transport, this should be conveyed to transport unit. If the first-in unit feels that the ALS transport paramedic should continue in for evaluation, this should be conveyed to responding medic unit.
 - 3. In these cases #1 and #2 above, it shall be the discretion of the paramedic on the responding medic unit whether to continue to the scene.
 - 4. In the event the ALS transport unit does not respond based on #1 and #2 above, the first-in unit canceling the paramedic shall obtain a waiver form signed by the patient or other responsible person stating that based on his/her own initiative or advice from first-in unit they do not desire transport.

Slowdown

- A. Transport units may be slowed to a lesser response code by first-in units when that EMS unit, staffed by a paramedic or EMT, has evaluated the patient and has made the determination that a slower response is appropriate.
- B. Rather than slow the responding medic unit, it would be more appropriate for the first-in unit to convey the patient assessment information to the medic unit and let that responding paramedic decide if a slower response is appropriate.

Diversion

- A. An ALS transport unit may be diverted to another call when:
 - 1. It is obvious the second call is a life-threatening emergency and first-in units known to ALS transport unit as EMTs and/or paramedics report that first call can await a second ambulance.
 - 2. A second ambulance is dispatched to first call.
 - 3. The first ambulance is decidedly closer to the second call and the response by it to the second call might conceivably be vital to the patient's outcome.

PREHOSPITAL COMMUNICATIONS

Trauma Status of SWMC

Responding units (including dispatch) shall not contact Medical Control to inquire the trauma status of SWMC when en-route to the scene; hospital trauma status will be given to the paramedic requesting trauma system entry after evaluation of the patient.

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

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

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

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

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

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

Verbal Report to Emergency Department Physician And/Or Triage Nurse

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

Written Reports/Documentation

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

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

[S]-SUBJECTIVE and SCENE information. That information which the patient, family, bystanders or other witnesses tell you.

Age of the patient, gender, race, estimated weight in Kg, chief complaint, scene description, history of the event, pertinent medical history of the patient, patient physician, medications, allergies, other extenuating circumstances, history of smoking if known.

[O]-OBJECTIVE information. This information you find on your complete head-to-toe physical exam.

Level of consciousness/psychiatric status, skin vitals, vital signs (baseline, B/P, pulse, respirations), HEENT, neck, spine, thoracic, abdominal, pelvic, lower extremities, upper extremities, neurological including motor and sensation, note placement of medical alert tags.

[A]-ASSESSMENT. The patient diagnosis. May include more than one.

[P]-PLAN/EVALUATION. PLAN of treatment. Record of your patient care and its results. Record whether patient's condition improved, continued to decline, stabilized, etc.

C. Documentation of Response Determinant

1. All calls to 911 will be triaged and dispatched, based on the medical Priority Dispatch System and its inherent response determinants (ALPHA, BRAVO, CHARLIE, DELTA). Complete documentation of patient care will include the determinant assigned at initial dispatch and any upgrades received while en-route.

TRANSFER OF CARE/TIME ON THE SCENE

Transfer of Care

- A. In many situations, two or more ALS units (e.g. first responding fire ALS and ALS transport) will respond. When more than one paramedic is on scene they will work cooperatively in making patient care decisions. If a disagreement exists on the correct course of action, Medical Control will be contacted for direction. An orderly and efficient transfer of patient care responsibilities from first-responding ALS personnel to the transport team must occur, including:
 1. Transfer of patient care responsibility that does not interfere with or lengthen scene times.
 2. Written and/or verbal report that includes: Documentation of vitals, findings, and all treatment(s) rendered.
 3. In cases of multiple patient incidents, protocol is established.

-Note- Many times patient condition may warrant attendance during transport by both the first responding Paramedic and the transport Paramedic. In these situations, working cooperation when making patient care decisions is paramount and should not be influenced by agency affiliation. Resources should be utilized to the fullest for the benefit of patient care. The transport Paramedic has patient care responsibility/authority when the patient is in the ambulance, but may delegate this to the attending first responding Paramedic if indicated for patient care continuity.

Time on Scene

- A. Any time an EMT cannot provide a patent airway to a patient within 2 minutes after initial encounter and initiating emergency medical care, he/she is required to transport the patient immediately, unless there are extenuating circumstances.
- B. Medical – 30 minutes or less after initial encounter.
- C. Trauma - 10 minutes or less once extrication has been accomplished and the patient can be removed from the site.
- D. Code 99 - 30 minutes or less after initial encounter.

-Note- Document extenuating circumstances.

LEVEL OF CARE DURING TRANSPORT

EMT-P AND EMT ON CAR

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

RECEIVING HOSPITAL

Triage Criteria:

- A. Non-Life Threatening Injuries or Illness - Hospital destination at the discretion of patient, family, or the patient's physician.
- B. Life Threatening Injuries or Illness - All patients will be delivered to the closest appropriate facility unless diversion criteria in effect.
- C. Patients meeting the following criteria will be transported to SWMC:
 - 1. STEMI
 - 2. CVA/Stroke protocol
 - 3. Trauma Activation (unless the following diversion criteria apply)

Diversion Criteria:

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

- C. Hyperbaric Diversion - Hyperbaric chamber is located at Providence Hospital in Portland. Contact Medical Control as soon as possible with patient information; if directed to divert, contact Providence via H.E.A.R.
 - 1. Criteria for hyperbaric treatment include:
 - a) Carbon Monoxide poisoning.
 - b) Barotrauma
- D. Diversion Based on Patient Request, Private Physician, and/or Primary Care/Health Plan:
 - 1. If patient condition critical (emergent transport) divert to SWMC.
 - 2. Potential for further diversions, i.e. receiving hospital on divert to another hospital. If intended hospital on divert, Paramedic may divert to SWMC.
 - 3. Other Considerations:
 - a) weather
 - b) traffic patterns, time of day, etc.
 - c) ambulance levels in the county (all agencies)

*If, in the Paramedics best judgment, diverting to a Portland hospital will result in a prolonged out-of-service time, that Paramedic should divert to the closest facility (SWMC). The receiving ED physician will be informed of the criteria and reason for the diversion to SWMC; these shall also be documented in the MIR and be included in the criteria for MPD review. Concurrence by Medical Control at SWMC is mandatory on all diversions to Portland unless contact impossible. Document concurrence/variance on MIR.

INTER-FACILITY TRANSPORT

General Responsibility and Instructions

- A. It is the responsibility of the transferring facility to insure that the medical necessities for safe patient transfer are met including stabilization.
- B. Medical instructions of the attending physician and registered nurses will be followed unless contrary to standing orders.
- C. Attendance of the patient during transport.
 - 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 paramedic.

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.
- B. Stabilization of patients prior to transfer to include the following:
 - 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.
- C. ALS patient and Above Criteria Not Met:

1. You may initiate pre-hospital protocols and guidelines including the establishment of intravenous lines, airway control, etc.
- *** 2. You may refuse to transfer the patient until the facility has complied with the above evaluation and/or treatment. Should you decide this is necessary, 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. (Exception: mass casualty incidents.)
- B. Emergencies en route:
 1. Pre-hospital protocols and guidelines will immediately apply.
 2. Medical Control should be contacted for concurrence of any orders as appropriate; the receiving facility should be contacted as soon as possible to inform them of changes in the patient's condition.

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

NON-TRANSPORT OF PATIENTS

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

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

- A. No medical need exists.
- B. A person with normal decision making capacity who, after having been informed of risks and benefits of treatment/transport, voluntarily declines further services.
- C. Any other person is assumed to require a medical screening evaluation and EMS personnel will use all resources available to have that person treated and transported.

Impaired Decision Making Capacity Defined

- A. Inability to understand the nature of his/her illness/injury.
- B. Inability to understand risks or consequences of refusing care/transport.
- C. Individuals impaired by:
 1. Alcohol/drugs
 2. Psychiatric conditions
 3. Injuries (head injury, shock, etc.)
 4. OBS (Alzheimer's, mental retardation, etc.)
 5. Minors (<18 years old)
 6. Language/communication barrier (incl. deafness)

Criteria for Informed Refusal/Consent

- A. Person is given accurate information about possible medical problems and the risk/benefits of treatment or refusal.
- B. Person is able to understand and verbalize these risks and benefits.
- C. Person is able to make a decision consistent with his/her beliefs and life goals.

PRIVATE PHYSICIAN AND/OR MEDICAL PROFESSIONALS AT THE SCENE

When the patient's private physician is in attendance and has identified himself/herself upon the arrival of the ALS team, the ALS team will comply with the private physician's instructions for the patient. Base hospital will be contacted for reporting and estimated time of arrival. 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 the ALS Team with another pair of eyes, hands, or suggestions, leaving the ALS team under Medical Control;
- C. Take total responsibility for the patient with the concurrence of the Medical Control Physician.

Transport

- A. 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.

Medical Professionals at the Scene

- A. Medical professionals at the scene of an emergency may provide assistance to paramedics and should be treated with professional courtesy. Medical professionals who offer their assistance should identify themselves. Physicians should provide proof of their identity, if they wish to assume or retain responsibility for the care given the patient after the arrival of the paramedic unit.

BLOOD DRAWS

Blood draws will be limited to:

- A. Medical cases requiring laboratory documentation.
 - 1. Suspected drug overdose.
 - 2. Unconscious patient, unknown cause.
 - 3. Trauma team patients.
 - 4. Thrombolytic candidates (AMI, CVA <2hrs)
 - 5. Blood for legal alcohol as documented below.

Procedure

- A. All blood draws to occur at the time of I.V. start only, with aseptic technique (providine-iodine and no alcohol swabs).
- B. Three tubes (one red top tube, one 3cc lavender tube, one 3cc blue tube, 10-12 cc total) will be obtained for blood draw, appropriately labeled, and given to emergency department or laboratory personnel.
- C. Appropriate laboratory tubes and Fenwall I.D. Bands will be provided by SWMC laboratory. Inservice education will be provided by laboratory personnel on an ongoing basis.

Special Considerations

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

DIRECTION TO TAKE BLOOD TEST

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

DATE _____ OFFICER _____

MEDICATION ADMINISTRATION GUIDELINES

Controlled Medications

- A. Controlled (legend) medications will be maintained at each agency utilizing approved protocols and security, to include lot number and vial number. When a controlled substance is given, the Clark County Controlled Drug Proof of Use form will be completed by the paramedic administering the medication and the agency officer authorized to replace the medication. Each agency will maintain the Controlled Drug Proof of Use form as a permanent record.
- * B. Paramedics only are authorized to administer controlled drugs.
 - 1. Morphine - Up to 20 mg of Morphine may be given per protocols without need to contact Medical Control (e.g., cardiac pain, congestive failure, severe musculo-skeletal pain). Additional Morphine may be given only with Medical Control concurrence.
 - 2. Versed - Up to 10 mg of Versed (Midazolam) may be given per protocol for sedation (with Succinylcholine intubation or for synchronized cardioversion) without need to contact Medical Control. Additional Versed may be given only with Medical Control concurrence.

Allergies to Medications

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

I.V. Fluids

- A. Intravenous access is to be established on all ALS patients unless unable.
- B. The purposes of I.V. access are:
 - 1. Fluid resuscitation.
 - 2. Administration of I.V. medications per protocol.
 - 3. The anticipation of need for the above.
- C. I.V. fluid of choice is a balanced salt solution. If fluid is not needed for resuscitation, this will be TKO or a saline lock.

Adult Intraosseous (IO) Access

- A. Attempts at peripheral sites unsuccessful, patient obtunded and requiring vascular access, i.e. trauma resuscitation, code 99.
- B. Documentation of training for use with specific device (i.e., Fast 1 sternal IO, Bone Injection Gun, etc.) must be provided to MPD prior to authorization for use.
- C. IO devices must be pre-approved by the MPD prior to use.

PREHOSPITAL EXPOSURE

Known or Suspected Exposure

- A. If exposure occurs, follow agency SOP for notification of appropriate agency administrators.
- B. Upon hospital arrival, notify SWMC ED charge nurse of potential exposure to communicable disease. In addition, you should inform the charge nurse of all other prehospital personnel who made patient contact (includes fire, police, etc.). The charge nurse will document this information in the "Prehospital Exposure Log". If you work for a non-transporting agency, contact the SWMC ED charge nurse via telephone to report the exposure.
 - 1. If communicable disease suspected, all personnel in contact with the patient will be documented on the prehospital exposure log and be contacted (or their agency contact person) upon confirmation of communicable disease.
 - 2. If communicable disease confirmed via laboratory analysis, all personnel documented on the prehospital exposure log (or their agency contact person) will be contacted by the charge RN or his/her designate.
- C. Treatment/prophylaxis will be provided as per "Guidelines for Prophylaxis of Occupational Exposure to Common Infectious Diseases".
 - 1. If indicated, prehospital personnel will be required to sign in to Fas Track and complete workers compensation form.

Unknown Exposure

- A. Prehospital personnel (or their designated agency representative) will be contacted by the charge nurse upon confirmation of communicable disease.
- B. All prehospital personnel will be documented on the "Prehospital Exposure Log".

- C. Treatment/prophylaxis will be provided as per “Guidelines for Prophylaxis of Occupational Exposure to Common Infectious Diseases”.
 - 1. If indicated, prehospital personnel will be required to sign in to Fas Track and complete workers compensation form.

CHEST PAIN POSSIBLY CARDIAC ORIGIN

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

- A. Patient Selection
 - 1. Active chest pain <12 hours
 - 2. 12 lead EKG w/ ST elevation in @ least 2 contiguous leads – ST Elevation MI (STEMI)
 - 3. No LBBB or paced rhythm
 - 4. No active bleeding, severe liver failure, severe systemic disease
- B. Treatment
 - 1. Notify ED of Acute MI ASAP, transmit EKG using LP 12 internal data transmission function to LifeNet receiving station at SWMC
 - 2. Provide above care prn including ASA, NTG, analgesia as appropriate
 - 3. Draw blood and label as appropriate. Recommended order:
 - a) Red, blue, green then lavender top
 - 4. Transport Emergently to SWMC

CVA

Transport Emergently if the patient meets the following criteria:

- A. Patient >18 years of age not pregnant exhibiting acute signs of ischemic CVA.
- B. Signs and symptoms must have been recognized within 5 hours
- C. Notify SWMC to activate the stroke team.

ABANDONED NEWBORNS

Introduction;

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

Procedure;

- A. If delivery has not occurred and appears imminent follow Emergency Delivery protocol. Provide appropriate care to mother per protocol.
- B. If EMS is presented with a newborn and child in extremis:
 - 1. Follow Newborn Resuscitation or Management of the Severely Ill or Injured Child protocol.
- C. Patient not in immediate need for medical care:

1. Ascertain child's medical history as appropriate
 - a. History of birth including complications, date, time, etc.
 - b. Known congenital anomalies
 2. Paternal/Maternal medical history
 - a. Prenatal care
 - b. Drug use during pregnancy
 - c. Other factors influencing child's health
- D. Transport to SWMC.
1. Notify staff en route of need for CPS referral

Circumstance:

- A. Maintaining parent confidentiality is paramount. Ascertain as much history as appropriate while providing a non-judgmental environment.
- B. Provide the following referral information to the parent(s) as time allows (Patient care is the priority).
 1. Medical and emotional aftercare (i.e. TIP, Chaplaincy, etc.)
 2. CPS

TRAUMA PROTOCOLS

General Considerations

- A. Ten minutes on-scene time, unless there are extenuating extrication problems.
 -Note- It cannot be overemphasized that adequate management of the severely traumatized patient can occur only in the operating room, and that field care is appropriate to stabilize the patient's vital functions and to ensure safe transport without further injury. In other words, a modified scoop and run approach is the standard of care.
- B. Upon evaluation of the patient(s) and determining the need for a trauma system entry, the paramedic will contact Medical Control to discuss patient transport and destination. Use Trauma H.E.A.R. Report form for accurate relay of information. If diversion to Portland is advised:
 1. Contact Trauma Communications Center (TCC) at OHSU as soon as possible.
 2. Enter Oregon's Trauma System.
 3. Emanuel Hospital will be destination hospital under usual circumstances, except as indicated by TCC.

TRAUMA TEAM/TRAUMA ALERT

Initial evaluation of patient(s) and scene should be made rapidly to determine need for trauma center care or rapid transport. Establish DIRECT communication with Medical Control and request Trauma Team or Trauma Alert, if any of the following criteria are met:

Trauma Team

- A. Criteria for Activation
 1. Shock adult BP 90 or less
 2. Respiration 10 or less OR 29 or greater
 3. Pediatric BP 80 or less OR Pulse 120 or greater
 4. Penetrating thoracic injury
 5. Truncal GSW (neck, chest, abdomen, or groin)

Trauma Alert

B. Criteria for Activation

1. GCS 13 or less
2. Isolated head injury with no other findings
3. Spinal cord injury with paralysis
4. Flail chest
5. Two or more obvious proximal long bone fractures
6. Combination of burns 20% or greater or involving face, airway, hands, feet, genitalia
7. Amputation above wrist or ankle
8. Biomechanics
 - a) Penetrating head injury
 - b) Death of same car occupant
 - c) Ejection of patient from vehicle
 - d) Falls 20 feet or greater
 - e) Pedestrian hit at 20 mph or greater OR thrown 15 feet or greater
9. Consider
 - a) Paramedic gut feeling of injury severity
 - b) Extremes of age (<12,>60) or environment
 - c) Underlying medical illness
 - d) Presence of intoxicants
 - e) Second or third trimester of pregnancy
 - f) Rollover
 - g) Motorcycle, ATV or bicycle accident.
 - h) Extrication longer than 20 minutes
 - i) Significant intrusion

LIFE FLIGHT/AIR AMBULANCE TRANSPORT

General Considerations

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

Standby

- A. LIFE FLIGHT may be placed on standby by:

1. 1st Responder
2. EMT
3. Paramedic
4. Any Physician
5. Any Police Officer

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

- B. LIFE FLIGHT should be placed on standby by trained personnel on scene after patient assessment has been done. It would be appropriate to place LIFE FLIGHT on standby prior to personnel arrival based on the following guidelines:

1. If first response unit arrival at the scene will be greater than 10 minutes and the information dispatched purports to be the type of patient who will benefit from LIFE FLIGHT. Examples of situations:
 - a) gunshot or penetrating trauma
 - b) MVA; person trapped or multiple patients
 - c) auto-pedestrian
 - d) severe burns
 - e) major amputation
 - f) entrapment, i.e., cave-in, machine on person, etc.
 - g) any call the paramedic deems is necessary

Activation

- A. The decision to activate LIFE FLIGHT rests with a responding paramedic (or a physician on scene):
 1. As paramedic arrives on scene and evaluates patient.
 2. Based upon information relayed to paramedic by people on scene.

- B. In some cases, LIFE FLIGHT can be immediately dispatched (activated) to the scene prior to the arrival of a first-in unit or paramedic, when:
 1. Travel time for that first-in unit will be over 20 minutes and the situation as known purports to be the type of patient who will benefit from LIFE FLIGHT.
 2. Where it is known that difficult terrain will be encountered rendering ground access difficult but where the helicopter can get near the patient easily.
 3. Where the reporting party relates some other special circumstance indicating the need for its immediate activation.
 4. On scene EMS responders relate to the paramedic the need for activation of LIFE FLIGHT prior to that paramedic's arrival.

-Note- In those situations (A or B above), activation shall be done through CRESA with concurrence of responding paramedic.

- C. Criteria for Activation
 1. Patient(s) meet criteria for trauma team/trauma alert (see p. D-2 for TSE/TA criteria) and extrication and/or ground transport will be prolonged (□ 10 minutes).
 2. Type of injury may dictate immediate transport to level I (Emanuel Hospital, OHSU).
*** Medical Control at Southwest Washington Medical Center to be contacted as soon as possible for instruction and/or concurrence for diversion to Portland. Situations that may result in diversion include but are not limited to:
 - a) Penetrating or severe injuries involving mid thorax and in shock
 - b) Burns (major).
 - c) Pregnancy with multi-system trauma in shock, unresponsive to aggressive resuscitation, or where surgery is anticipated immediately.
 - d) Pediatric patient with shock/respiratory distress.
 3. Multiple victims meeting trauma team criteria.
 4. Diversion to Portland by Medical Control due to hospital resources (Southwest Washington Medical Center down for trauma).
 5. LIFE FLIGHT should not be used for obvious DOAs, trauma codes and other situations where the outcome is an obvious fatality. (Refer to DEATH IN THE FIELD protocol.)

- D. Destination Hospital
 - *** 1. Unless diversion criteria in #2 above applies, the destination hospital shall be indicated to LIFE FLIGHT by the paramedic in charge (PIC). The PIC will consult with Medical Control and TCC to determine destination

Cancellation

- A. LIFE FLIGHT may be canceled by the paramedic responsible for the patient upon examination of the patient and it is apparent that air transport is not necessary. (See Criteria for Activation.)

Case Reviews

- A. LIFE FLIGHT calls will be reviewed by Clark County QA Committee and reported to the Medical Program Director.

Cowlitz County Operating Procedures (COPS)

2008

Draft from COP Committee

12/18/2007

4/1/08 Update

Cowlitz County EMS Council

Air Medical Transport STAND-BY AND ACTIVATION PROTOCOL

- I. The use of Air Medical Transport should be considered when a patient is a high priority for immediate transport and the use of Air Medical Transport will save 10 minutes of patient's total out-of-hospital time.
- II. Other Situations That May Warrant The Use Of Air Medical Transport:
 - A. Multiple patient scenes or Mass Casualty Incidents;
 - B. Extended extrication, resulting in extended scene times;
 - C. Traffic impediments such as snowy or icy roads, heavy traffic congestion, obstructed scene;
 - D. High EMS system demands;
 - E. Difficulty for ground ambulance to access scene;
 - F. Normal ground routes to a receiving facility inaccessible.
 - G. Paramedic's discretion based on the following considerations:
 - 1) Major Trauma patients with severe head injury GCS <10 or spinal cord injury with paralysis.
 - 2) Major Burns requiring burn center intervention.
 - 3) Pediatric multisystem trauma patient with shock and/or potential PICU admission.
 - H. If in doubt, the Paramedic is encouraged to contact Medical Control for guidance.
- III. Considerations For Air Medical Transport Requests:
 - A. Inclement weather may prevent flight;
 - B. Helicopter availability;
 - C. Landing zone proximity to the scene and the role of an intermediate rendezvous point between the scene and the hospital;
 - D. On main arterial roads, consider the possibility that Air Medical Transport may not save time;
 - E. Air Medical Transport may have multiple, simultaneous requests and may have to triage the requests.
 - F. It may be appropriate to activate Air Medical Transport and then cancel it if the situation changes and ground transport would be more prudent.
- IV. Standby:

An Air Medical Transport can be placed on “Standby” status where the helicopter and flight crew are readied for service but do not respond until activated. *Keep in mind that this may prohibit the service from responding to another call until cleared by the initial requesting agency.*

- A. It is appropriate to place Air Medical Transport on standby prior to EMS personnel arrival on the scene if first response time to the scene will be greater than 10 minutes and the information dispatched purports to be the type of patient who will benefit from Air Medical Transport.
- B. Air Medical Transport may be placed on “Standby” by contacting the Cowlitz County 911 Communications Center.
 - 1. Any certified EMS personnel can request Standby status for Air Medical Transport.
 - 2. NOTE: LIFE FLIGHT also will accept requests from non-EMS personnel such as, logging crew bosses, law enforcement, etc.

V. Activation of Air Medical Transport

- A. The decision to activate Air Medical Transport rests with a responding paramedic, first response incident commander, or a physician on scene:
 - 1. As paramedic arrives on scene and evaluates patient OR;
 - 2. Based upon information relayed to paramedic by people on scene.
- B. In some cases Air Medical Transport can be immediately dispatched (activated) to the scene prior to the arrival of a first-in unit or paramedic, when:
 - 1. Travel time for that first-in unit will be over 20 minutes and the situation as known suggests to be the type of patient who will benefit from Air Medical Transport.
 - 2. Where it is known that difficult terrain will be encountered rendering ground assess difficult but where the helicopter can get near the patient easily.
 - 3. Where the reporting party relates some other special circumstance indicating the need for immediate activation of Air Medical Transport.
 - 4. On scene EMS responders relate to the paramedic the need for activation of Air Medical Transport prior to the paramedic’s arrival
- C. In all situations of activation, it shall be done with concurrence of responding paramedic(s).

VI. Cancellation Of Air Medical Transport

- A. Only a responding paramedic can cancel Air Medical Transport once it has been activated.
- B. The responding paramedic can cancel Air Medical Transport based on the information provided from on-scene EMS personnel but is still ultimately responsible for the decision. It shall not be the decision of a First Responder or an EMT at the scene to cancel Air Medical Transport.
- C. Air Medical Transport may be canceled by the paramedic responsible for the patient upon examination of the patient and it is apparent that air transport is not necessary.
- D. Air Medical Transport should not be used for obvious DOAs, trauma codes and other situations where the outcome is an obvious fatality. (Refer to Death in the Field protocol).

VII. Quality Assurance Review

- A. All use of Air Medical Transport, including standby, will be reviewed by the Medical Program Director in 100% QA&I review.

General Patient Care Related Guidelines

I. Level of EMS Response

- A. It is recognized that it is in the best interest of patient care and public safety to slow down or cancel EMS units responding Code 3 to emergency calls when it is determined by certified EMS personnel that the patient does not require an additional emergency response. It is also recognized that situations may arise that immediate emergent transport will improve patient care.
 - 1. “Slow down”
 - a. The first arriving EMS unit should slow down other responding EMS units to an appropriate lower response level when it is determined by EMS personnel that an immediate emergency does not exist.
 - 2. “Cancellation”
 - a. The first arriving EMS unit may “cancel” other responding EMS units if no patient can be found or if no additional resources are needed.
- B. An ALS transport unit may be diverted to another call when all the following conditions are met:

1. It is obvious the second call is a life threatening emergency and it is determined by certified EMTs or Paramedics that the first call can await a second ambulance.
2. A second ambulance is dispatched to the first call.
3. The first ambulance is decidedly closer to the second call and the response would be vital to the patient's survival.

II. Level of Care

- A. The EMS personnel with highest level of certification level shall be in charge of patient care.
 1. Paramedics may delegate non-ALS patients to an EMT but the paramedic is ultimately responsible for the care delivered and the documentation while the Paramedic is on-scene or enroute to the hospital with that patient.
 - a. First Responders (medical certification) cannot be designated to provide patient care during transports.
 - b. Inappropriate designation of EMS personnel to provide patient care may be grounds for removal of protocol privileges pending formal determination and/or investigation from the Department of Health.
 2. When more than one patient is in need of care, the most critical patients shall receive care from the EMS personnel with the highest certification, the most training and experience as appropriate.
 3. All ALS patients shall receive care from paramedics whenever possible.
 - a. Dispatch criteria for ALS / paramedic response include:
 1. Patient's requiring or possibly requiring ALS procedures.
 2. Patient's requiring or possibly requiring any medication.
 3. Abdominal pain,
 4. Allergic reaction,
 5. Breathing problems, shortness of breath, respiratory arrest,
 6. Any symptom of cardiac origin, chest pain, cardiac arrest,
 7. Convulsions / seizures,
 8. Drowning / near drowning
 9. Diabetic problems,

10. Multiple traumas,
11. Overdose / poisoning,
12. Patient in shock (or possibly will develop shock),
13. Person down – Unknown
14. Possible DOA,
15. Pregnancy / Childbirth,
16. Stroke / CVA,
17. Unconsciousness for any reason or any altered mental status.

4. Rapid transport by BLS should not be delayed awaiting an ALS unit in cases with critically ill or injured patients. Arrangements for a rendezvous should be coordinated to take place enroute.
5. After an ALS evaluation by a county certified paramedic, if the patient is deemed medically appropriate for BLS transport, that patient can be transported by a BLS ambulance. If there is any question as to the appropriateness of the BLS downgrade, transport ALS or contact Medical Control for further direction or clarification.
6. When a BLS patient who is being transported BLS has a change in his or her condition that makes him/her potentially ALS, the BLS unit will rendezvous with an ALS unit or go Code 3 to the hospital, whichever is quicker.

B. Cancellation of ALS / Paramedic Response

1. An ALS unit may be cancelled by First Response Unit EMS personnel if their evaluation **CLEARLY DETERMINES A LACK OF POTENTIAL NEED** and responding paramedics or Medical Control agree.

C. Cancellation of Air Medical Transport

1. Once Air Medical Transport have been activated or placed on stand-by, it may only be canceled by responding paramedics. This may occur after direct communication with First Response Unit EMS personnel already at the scene.
2. Air Medical Transport (See Air Medical Protocol).

III. Time On Scene

A. Airway Management

1. Any time an adequate airway cannot be established by BLS personnel **within 2 minutes** after initial encounter, transport the patient immediately, unless there are extenuating circumstances

such as imminent arrival of ALS or inability to extricate. In such cases, it is essential to verify that ALS is enroute.

B. Medical Scene

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

C. Trauma Scene

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

D. Cardiac Arrest Scene

1. Maximum scene time is 30 minutes.

E. Extenuating Circumstances

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

IV. Transfer of Patient Care Between EMS Personnel.

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

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

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

NOTE: A Multiple Patient Scene (MPS) is an emergency scene with **less than 5 CRITICAL PATIENTS** or **less than 10 TOTAL PATIENTS**. These numbers are intended as a guide only and may be adjusted to meet the needs of the incident. A Multiple Patient Scene does not trigger the activation of the Cowlitz County Emergency Operations Center unless other factors are involved.

NOTE: A mass Casualty Incident (MCI) is an emergency scene with **5 or more CRITICAL PATIENTS** or **10 or more TOTAL PATIENTS**. These numbers are intended as a guide only and may be adjusted to meet the needs of the incident.

- A. Protocols require either the Incident Commander or Medical Group Supervisor to contact St. John Medical Center for trauma patients of a disaster. (St. John Medical Center will be used exclusively for all initial medical contact and will be accessed on the existing radio system at HEAR [VHF 155.34.]
- B. LIMIT radio traffic to essential information only.
- C. MPS and MCI's will use NIMS ICS.

PROTOCOL:

The EMT directing overall patient care is generally the first arriving medical unit. Terminology, responsibilities and duties will be much the same as a Mass Casualty Incident (MCI). All units will utilize the Incident Command System (ICS).

- A. Upon arrival at the scene with multiple patients, the first arriving unit will advise Cowlitz County Communications (9-1-1) of:
 - a. approximate number of patients,
 - b. number, type and code of additional units needed,
 - c. best access to the scene, if appropriate,
 - d. any obvious or possible hazardous conditions.
- B. Upon arrival at the scene with multiple patients, the first arriving medical unit * will:
 - a. coordinate patient care,
 - b. assure rapid triage of victims,
 - c. have incoming EMS units report for patient assignments,
 - d. if necessary, communicate with St. John Medical Center Emergency Department for patient destination instructions,
 - e. monitor scene time.

- (This position should eventually be filled by a paramedic unless the determination by mutual agreement is made that a senior experienced EMT can better fill the needs of the position.)

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

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

TRIAGE TAGGING

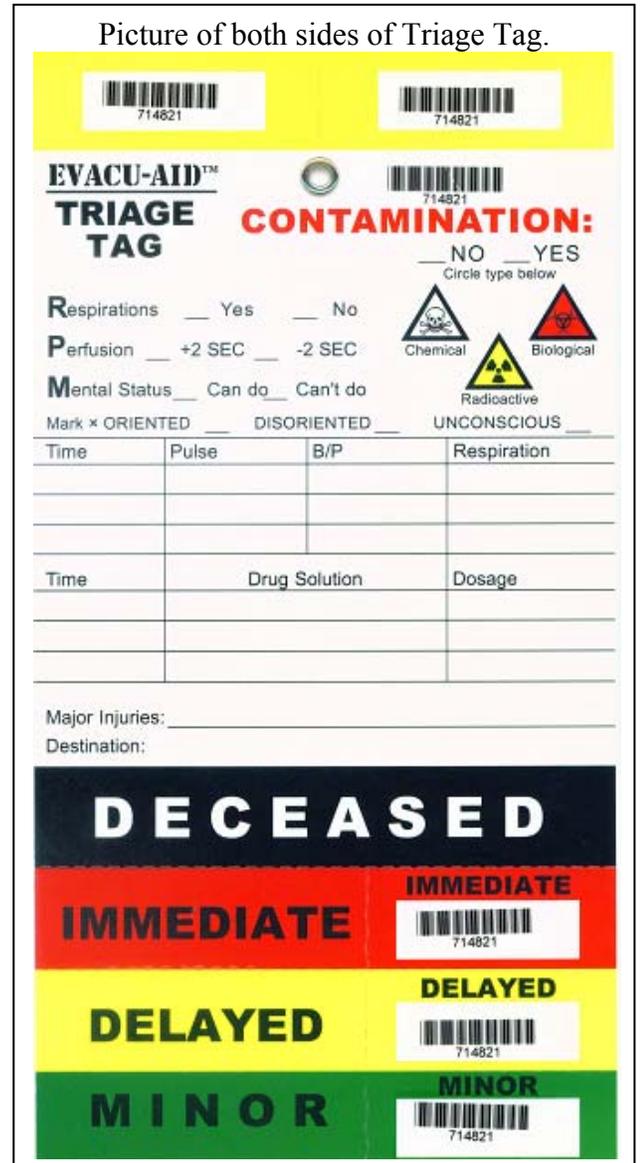
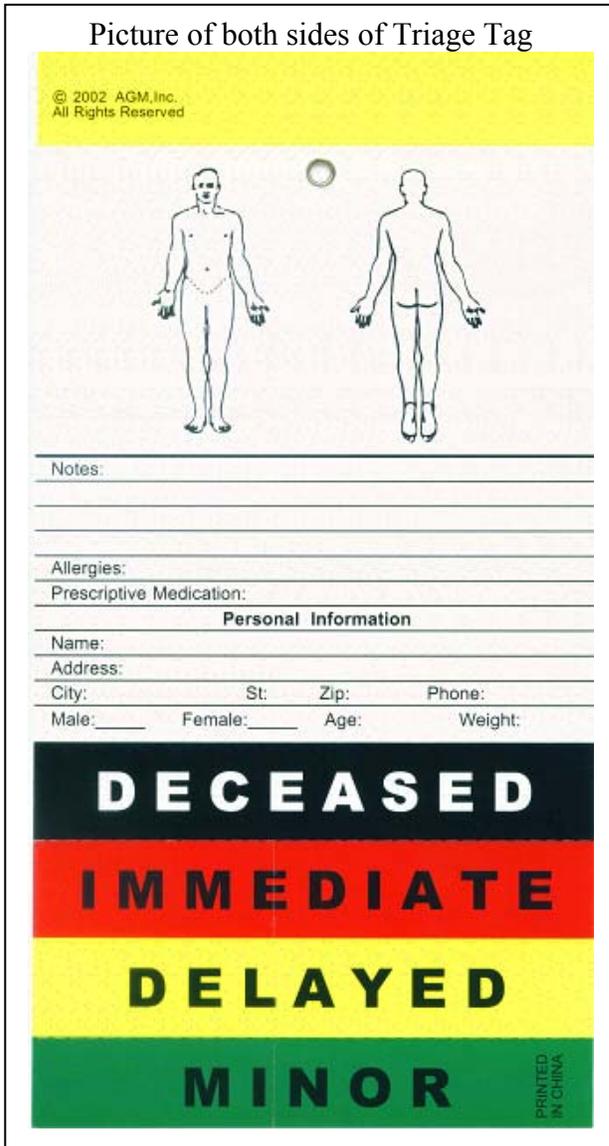
Since first responders will be doing the bulk of field triage in extensive emergency operations, it is important that they understand the use of triage tags and/or triage tape.

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

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

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

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



The treatment and transportation area must be designed to handle the following priorities:

Priority 1: IMMEDIATE (Red)

Immediate life-threatening situation, which can be, more or less, promptly and easily corrected, i.e., coma with airway obstruction, massive external bleeding, tension pneumothorax, etc. Prompt transport.

Priority 2: DELAYED (Yellow)

Immediate treatment can be given; life is not immediately threatened, i.e., active moderate hemorrhage, major fractures, severe pain, and hysteria.

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

Priority 3: (Green)

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

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

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

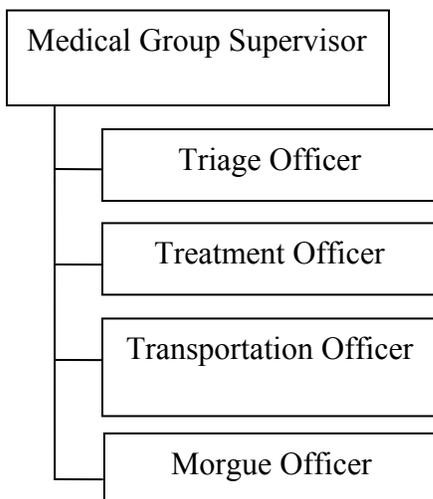
MASS CASUALTY INCIDENT (MCI) TRIAGE SPECIAL CONSIDERATIONS

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

- M. A school bus may prove handy for collecting the ambulatory victims and transporting them to a receiving facility. A church or school gym may be nearby and available to receive these people.
- N. All victims, ambulatory or otherwise will be tagged. All tagged victims will be transported by a designated transport vehicle authorized by the Transportation Officer.
- O. Other special considerations may be:
 - a. An accurate size-up by the first arriving company.
 - b. Is additional equipment needed?
 - c. How many ambulances needed?
 - d. Are police needed for crowd or traffic control?
 - e. Should the Immediate Danger Zone be roped or sealed off?

Resources and Resource Management

MPS and MCI situations will be managed using NIMS-complaint positions and terminology. The ICS positions for the medical area on these incidents are as herein. The Medical Group Supervisor reports to a Branch Director, Operations Section Chief or the Incident Commander, depending on the incident.



Each fire agency needs to develop their MCI run card assignment based on their anticipated needs for these incidents. These run cards are not all inclusive of every resource and asset needed for these situations, but are an initial set of resources to be sent when these incidents occur. Incident Commanders will need to request additional resources specifically based on the needs of the incident.

Cowlitz County has a limited number of ambulance resources everyday, and these incidents will overtax them well beyond their limits. The request for ambulance assets from outside the county will need to be made very early on in the incident to be effective.

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

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

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

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

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

Wahkiakum County Operating Procedures (COPS)

Wahkiakum County EMS & Trauma Care Council

No. 1

Subject: Automatic Dispatch of Adjacent Service

If within (5) minutes of initial dispatch, there is no response from the agency with primary jurisdiction, then dispatch shall re-tone the primary jurisdiction and shall also automatically dispatch the next closest licensed EMS agency in Wahkiakum County. "Response" means verification that a full crew is en route to the station or the EMS vehicle is en route from the station with appropriate crew en route to the scene.

No. 2

Subject: Verification of paramedic response

For the following types of calls, dispatch shall verify a paramedic response:

Motor Vehicle Collision involving more than one vehicle

Vehicle/pedestrian or vehicle/bicycle collision

Any call where the patient is unconscious and/or not breathing.

Any call where the patient is known to be experiencing anaphylaxis or hypoglycemia.

Any call where the patient is 45 years of age or older and is experiencing chest pain.

Any call where the patient is experiencing respiratory distress and is exhibiting an altered level of consciousness.

Any gunshot wound.

If the primary jurisdiction does not have a paramedic available, dispatch shall automatically dispatch a paramedic from the nearest available agency.

Appendix 5.
July 2009- June 2012 Regional Plan Gantt Chart