

SOUTH CENTRAL REGION EMERGENCY MEDICAL SERVICES & TRAUMA SYSTEM

STRATEGIC PLAN

July 2009 - June 2012



Submitted by the
South Central Region EMS and Trauma Care Council
September 15, 2008/Revised August 2009/Revised September 2009

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EXECUTIVE SUMMARY

The South Central Region is located in the south eastern part of Washington State. The Region is comprised of six counties: Benton, Columbia, Franklin, Kittitas, Walla Walla and Yakima Counties. The Region is primarily rural in nature with five urban suburban areas where the ALS Ambulance services and trauma services are located.

There are fifty-nine EMS trauma verified aid and ambulance services within the South Central Region.

County	ALS Ambulance	ILS Ambulance	BLS Ambulance	BLS Aid
Benton	5	2		3
Columbia		1		1
Franklin	1		2	1
Kittitas	2		3	6
Walla Walla	1		3	6
Yakima	3	1		18

Ten trauma services are designated within the South Central Region:

Adult Level III	Adult Level IV	Adult Level V	Pediatric Level III	Rehabilitation Level II
5	4	1	2	3

The South Central Region Council (Regional Council) is authorized by RCW and Washington Administrative Code (WAC) and the Emergency Medical Service (EMS) & Trauma System legislation. Regional Council membership is comprised of the following mandatory membership positions: Local Government, Prehospital, and Hospital Agencies. Additional positions can be from the following positions: County EMS Coordinators, Law Enforcement, Paramedics, Consumer, and Education providers, Physician and Medical Program Director (MPD).

The Regional Council is tasked with leading the development and implementation of an EMS & Trauma Care System Plan. The Plan addresses the continuum of EMS and trauma care that addresses all the components of the system from prevention of injury, the 9-1-1 emergency dispatch system, EMS response and care system, trauma designated trauma service system, trauma designated rehabilitation service system, trauma system evaluation with the regional Continuous Quality Improvement (CQI) process, and all hazards preparedness.

RCW and WAC authorizes that counties may have local EMS & Trauma Care Councils to provide EMS & Trauma System leadership in their counties and give input and recommendations to the Regional Council. SCR has five (5) Local Councils with membership that parallels the Regional Council membership. The South Central Region's Local Councils include: Mid Columbia EMS & Trauma Care Council (for Benton and Franklin Counties), Columbia County EMS & Trauma Care Council, Kittitas County EMS & Trauma Care Council, Walla Walla County EMS & Trauma Care Council, and Yakima County EMS & Trauma Care Council.

The Region's Strategic EMS & Trauma Care System Plan is made up of administrative and clinical components. The goals are adapted from the State Strategic EMS & Trauma Care System Plan. The objectives and strategies are developed by the Regional Council and its stakeholders to meet the goals of the Region.

The Regional Council has adopted the following new mission and vision statement that will be incorporated into the planning process and formal Regional communication methods:

Mission: To Advance the Emergency Medical Service and Trauma Care System.

Vision: Be the best Emergency Medical Service and Trauma Care system we can be through: providing a continuum of care from prevention to return to the community with the highest quality of life possible; collaborative coordination of all stakeholders; producing the highest level of efficiency and effectiveness; and being a model EMS & Trauma System in Washington State.

System Leadership

RCW and WAC identify and define the roles and responsibilities of the Regional and Local EMS & Trauma Care Councils. The Regional Council, as the lead organization, works closely with the Local EMS & Trauma Care Councils, MPDs, EMS providers, trauma services, public health, emergency management, emergency dispatch agencies and other EMS and trauma stakeholders to assure a multi-disciplinary approach to EMS and trauma care system development. A leadership training program is recognized as a **need** and will be implemented for Regional and Local Council members and other leaders in the EMS, trauma, and stakeholder communities.

System Development

The Regional Council is striving to be congruent with the State Strategic EMS & Trauma Care System Plan and will utilize the methods developed by the Department of Health (DOH) to standardize identifying resource needs. The Regional Council has a new mission and vision statement that is dynamic and action oriented. The philosophy of advancing the EMS & Trauma Care System by being the best we can be through a continuum of care from prevention through return to the community with the highest quality of life possible **needs** to be embedded in all aspects of the Regional Council work during the plan period.

The Regional Council works in collaboration with Public Health Region 8 in all hazards and emergency preparedness planning. A Region 8 Regional Hospital Preparedness Plan has been developed and equipment and medical supplies obtained. The division of counties for Public Health Region 8 and the South Central Region is not identical, and causes a challenge for planning and implementation of both systems. There is a **need** for stakeholder in the region to continue to participate in preparedness even if state and federal support ends.

System Public Information and Education

The role of public information and public education has not received emphasis in the past in the South Central Region and is a regional system **need**. It will be imperative to inform the general public, political leaders, as well as the EMS and Trauma Care Stakeholders of the multifaceted components of the EMS and Trauma Care System.

System Finance

Obtaining consistent and sustainable funding to ensure financially viable Regional EMS & Trauma Care System is a great **need**. EMS agencies are funded in multiple ways from private “for profit” agencies to tax based agencies relying on billing or levies. At least sixty percent of our agencies are volunteer agencies as well. Most trauma services are non profit facilities and depend on third party payers. The Regional Council itself is fully funded by State contracts through the general fund. A robust training and education program in collaboration with the local EMS & Trauma Care Councils is facilitated with these funds. Injury Prevention programs are also funded through contracts with the four SAFE KIDS Coalitions. A major Regional Council goal and system **need** is to be a good steward of the contract funds provided through the State.

Injury Prevention and Control

The Regional Council focuses on three injury prevention goals: reduction of motor vehicle crashes, reduction in falls especially in the elderly and drowning prevention. Regional data shows that motor vehicle crashes are the primary cause of unintentional death in the South Central Region. The Regional Council has identified the **need** to continue to provide funding for injury prevention activities to further its three prevention goals through agreements and contracts with four SAFE KIDS Coalitions within the Region to address the injury prevention goals.

Pre-Hospital Care

All aid and ambulance services in the South Central Region are trauma verified and participate in the established three tiered EMS & Trauma Care System that transports the right patient to the right place in the right amount of time. An ongoing **need** in the system is to continue to facilitate the Local Council's EMS training and education. In addition, the Regional Training & Education Committee will develop a matrix for allocating funding and reporting Prehospital training and education to the Regional Council and to DOH.

The Regional Council **needs** to continue to recommend the minimum and maximum numbers and levels of EMS verified trauma services. Recommendations from the Local Councils will be utilized as well as the methods being developed by the DOH to standardize identifying Prehospital system resource needs. The Local Councils also assist in identifying trauma response areas in each County and developing trauma response area maps need to increase their involvement.

Regional Patient Care Procedures (PCPs) have been developed to provide specific directions for how the trauma system should function within the South Central Region; Local Councils have developed County Operating Procedures (COPs) with their MPDs that provide details on how local EMS agency will carry out the Regional PCPs. The Regional PCP Committee reviews the COPS to assure they are congruent with the Regional PCPs and in line with the standardized methods from DOH to determine optimal Prehospital system recommendations. PCP review will be **needed** during the plan cycle.

Acute Hospital Care

There are ten designated trauma services that range from modern hospital medical center in the urban/suburban cities, to small rural hospitals. There are two joint designations. Many trauma services have designation at levels below the original recommendations of the Regional Council. The Regional Council identifies a strategic plan **need** to continue to encourage under-designated trauma services to work toward increasing designation levels as identified. South Central Region will utilize the standardized method from DOH to determine the **need** for minimum and maximum numbers and levels of designated trauma services for system development.

Pediatric Care

Pediatric care has been incorporated into all training and education EMS & Trauma Care programs in the South Central Region. EMS and hospitals have specialized equipment for pediatric patients. Pediatric patients make up a very small part of EMS and trauma and medical care in the Region. The Regional Council has identified a **need** to evaluate the pediatric service demands within the Region. Two Trauma Services are designated as level III pediatric trauma services.

Trauma Rehabilitation

There are three level II Trauma Rehabilitation Services in the South Central Region. The Regional Council will review the trauma rehabilitation service **needs** and the current capacity of the three services to meet EMS & trauma system needs.

System Evaluation

Designated trauma services collect and submit data to the State Trauma Registry. The Regional Council will work with the Washington EMS Information System (WEMSIS) program for EMS data collection to address the **need** for 100% participation by EMS agencies. The Regional Council has identified a **need** for a standardized quality improvement programs. The South Central Region has a strong Trauma CQI Committee. In collaboration with the regional Trauma CQI Committee, the Regional Council will evaluate the programs currently being used by county MPDs and the States program for common components.

REGIONAL SYSTEM

GOALS – OBJECTIVES – STRATEGIES JUNE 2009 – JULY 2012

ADMINISTRATIVE COMPONENTS

SYSTEM LEADERSHIP

Introduction

The Regional Council is given the authority to develop and coordinate the EMS & Trauma System in the South Central Region (SCR) by RCW 70.168.100 through RCW70.681.130 and WAC 246-976-960. WAC and RCW outline the membership composition of both the Regional and Local Councils to assure a multi-disciplinary approach to EMS & Trauma System development. Included are three mandatory membership categories: EMS provider, hospital representative, and local government official. Additional membership categories including County EMS director, County Medical Program Directors (MPDs), EMS educator, physician and others involved in trauma system development and implementation.

Local EMS & Trauma Care Councils provide the membership to the Regional Council. In the South Central Region, each local council has five representatives. The five local EMS & Trauma Care Councils in the South Central Region are as follows: Mid Columbia EMS & Trauma Care Council (Benton and Franklin Counties), Columbia County EMS & Trauma Care Council, Kittitas County EMS & Trauma Care Council, Walla Walla County EMS & Trauma Care Council, and Yakima County EMS & Trauma Care Council. The Regional Council seeks input from the local EMS & Trauma Councils, MPDs, and other agencies and organizations involved in EMS & Trauma Care to develop the multi-system approach to the EMS & Trauma System including recommendations for minimum and maximum numbers of Prehospital verified trauma services and minimum and maximum numbers of designated trauma services in each respective county.

Needs in the Strategic Plan:

- Determine that both Regional and Local Councils have multi-disciplinary representation. The Regional Council will review its membership and the Local Council membership for compliance with statute and rule. The Regional Council will implement both a board orientation process and leadership board training/seminar opportunities for the Regional and Local Council members and other leaders from the EMS and trauma system stakeholders.
- Develop a method for communicating the Strategic EMS and Trauma Care Plan to the private and public health care providers who participate in the EMS & Trauma Care System.

Goal 1	
There are viable, active local and regional EMS and trauma care councils comprised of multi-disciplinary, EMS and trauma system representation.	
Objective 1: By March 2010, The Regional Council Administrative Committee will present the Strategic Plan throughout the Regional EMS community.	Strategy 1. By September 2009, The Regional Council will identify the stakeholders to receive the presentation.
	Strategy 2. By October 2009, The Regional Council will determine a delivery format and complete presentation.
	Strategy 3. By March 2010, Members of the Administrative Committee will present the plan to stakeholders
Objective 2: By January 2010, The Regional Council will review council membership for compliance with RCW and WAC and members needed to advance the system and fill newly created membership positions.	Strategy 1. By September 2009, The Regional Council will identify open Local Council positions on the Regional Council and ask Local Councils to fill vacant positions from their councils to the Regional Council.
	Strategy 2. By September 2009, The Regional Council will review its membership structure for possible other positions needed to advance the system
	Strategy 3. By January 2010, The Regional Council will have a full complement of members needed to advance the system.
Objective 3: By March 2010, The local Councils will review their membership and make changes to align with statute and rule.	Strategy 1. By September 2009, The Regional Council will request that the local councils review their membership organization structure for compliance with RCW and WAC and submit a list of current membership positions to the Regional Council.
	Strategy 2. By January 2010, The local councils will fill vacant positions to the Regional Council.
	Strategy 3. By March 2010, The Planning & Standards Committee will review the local council structure and make recommendations to the Regional Council for any additional positions on the Local Councils needed to advance the system
Objective 4: By May 2010, The Regional Council will develop and implement a board membership orientation program.	Strategy 1. By January 2010, The Administrative Committee will identify specific information to be included in an orientation program.
	Strategy 2. By March 2010, The Executive Committee will review leadership materials provided by DOH and

	determine their use in the orientation program.
	Strategy 3. By May 2010, The Administrative Committee will provide Regional Council information to all current Regional Council board members and new members as they are appointed using the board membership orientation program.

SYSTEM LEADERSHIP

Goal 2

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

SYSTEM LEADERSHIP

Goal 3

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

Objective 1. By June 2011, The Regional and Local Councils will explore and conduct Board development opportunities

Strategy 1. By December 2010, the Regional and Local councils will identify a representative group to determine Board development needs.

Strategy 2. By March 2011, the Regional and Local Councils will identify viable options for Board development training/seminars and present options to the Councils.

Strategy 3. By June 2011, Regional and Local council members will participate in Board training/seminars.

SYSTEM DEVELOPMENT

Introduction

The Regional Council functions as a coordinating body for EMS and Trauma System development and implementation in the South Central Region. The Regional Council coordinates and develops the Regional EMS and Trauma Care System Plan with input from Local Councils, MPDs and other system stakeholder groups. Regional Council committees have membership from the counties and stakeholder agencies within the system. The work from the committees, result in recommendations to the Regional Council for a region-wide coordinated focus on system issues including injury prevention, Prehospital training and education, patient care standards and all hazards preparedness. Verification and designation recommendations to DOH are developed by the Regional Council with input from Local Councils. Recommendations focus on maintaining a system of care without duplication of services or inadequate care.

The Regional Council will strive to maintain congruency with the State-wide Strategic EMS and Trauma Care System Plan and plans to utilize the standardized methods developed by the Department of Health to identify resources for system planning.

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

The Regional Council will continue to work in coalition with Region 8 Public Health and Region 8 Emergency Management to develop a region-wide system for disaster preparedness and All Hazards Planning.

The Regional Council will identify the current Regional status and gaps in communication capabilities, develop and distribute a matrix of regional communications.

Needs addressed in the Strategic Plan:

- A quality philosophy for the regional system.
- Funding for Prehospital EMS education.
- Standardized methods for identifying and reporting needs.
- Keeping the regional plan congruent with the state plan
- Survey status and gaps between EMS and hospitals and develop a matrix of communications.
- Distribution process to forward information
- Involvement in preparedness
- Communications across the system

Goal 4

There is strong, efficient, well-coordinated region-wide EMS & 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 December 2011, The Regional Council will identify and adopt a system wide quality philosophy that is incorporated in all aspects of system programs and projects.</p>	<p>Strategy 1. By January 2010, The Regional Council will embed the quality philosophy by incorporating the mission and vision in all formal communication mediums.</p>
	<p>Strategy 2. By December 2011, The Regional Council will develop and implement processes to include the quality philosophy regarding continuum of care in all projects and programs.</p>
<p>Objective 2: By August, annually, the Regional Council will provide funding assistance to local council EMS education and training programs and allocate funds as available.</p>	<p>Strategy 1. By April annually, The Local Councils will survey local EMS agencies for training and education needs and submit training and education needs assessment and projection in the required report format to the Regional Council</p>
	<p>Strategy 2. By May annually, The Regional Council will submit required report form to DOH.</p>
	<p>Strategy 3. By August annually, The Regional Council will establish contracts with each local council for EMS training and education and funds allocated.</p>
<p>Objective 3: By December, annually Local Council EMS Training workplans will be approved by the Regional Council.</p>	<p>Strategy 1. By September, annually, The Local Councils will submit annual EMS training and education work plans to the Education and Training Sub-Committee for review.</p>
	<p>Strategy 2. By December, Annually, The Regional Training and Education Sub-Committee will review Local Council work plans and make recommendations for approval to the Regional Council.</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 January 2011, The Regional Council will utilize standardized methods as identified by DOH for identifying and reporting system resource needs and developing the 2012-17 plan.</p>	<p>Strategy 1. By September 2010, The Regional Planning & Standards Committee will review data to identify resource needs with the Region</p>
	<p>Strategy 2. By December 2010, the Regional Planning & Standards Committee will provide recommendations to the Regional Council, based on data to identify EMS & Trauma system resource needs.</p>
	<p>Strategy 3: By January 2011, the Regional Council will develop the 2012-2017 plan utilizing provided data and standardized methods.</p>
<p>Objective 2: Starting July 2010 and then annually, the Regional and Local Councils will review the Regional plan and identify changes to meet Regional System needs and be congruent with the statewide system plan</p>	<p>Strategy 1. Starting April 2010 and then annually, Local Council members will review the Regional EMS & Trauma Care System Plan and recommend changes to meet Regional system needs and make suggestions for updating the next Regional Plan,</p>
	<p>Strategy 2. Starting July 2010 and then annually, the Regional Council Planning and Standards Committee will review the plan and input from Local Councils and make recommendations to the Regional Council for EMS & Trauma System Plan changes</p>

SYSTEM DEVELOPMENT

Goal 6

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

Objective 1: By April, 2010, Regional and Local Councils will identify existing distribution channels for use in timely distribution of Steering Committee & TAC information to regional stakeholders on emerging issues and will develop and implement an information distribution process.

Strategy 1. By December 2009, Regional 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 March 2010, The identified group will develop a process for timely distribution of information on emerging issues, Including report local and Regional Councils to DOH by direct contact or through regular written reports.

Strategy 3. By April 2010, 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: During the 2009-2012 Plan cycle, Based on DOH Emergency Preparedness contract timelines and funding availability, the Regional Council staff will provide coordination support to Public Health Emergency Preparedness Region 8 and provide a report at Regional Council meetings.</p>	<p>Strategy 1. Monthly Regional Council staff and or representative will attend monthly Region 8 Hospital Planning meetings and quarterly Health Care Coalition meetings to provide a liaison representation between Emergency Preparedness planning and EMS & Trauma Care System planning.</p>
	<p>Strategy 2. By July 2009, Regional Council staff will assist Emergency Preparedness Region 8 in the coordination of training of hospital staff in use of the new Hospital Capacity Website by assisting with arrangements for training secessions.</p>
	<p>Strategy 3. At bimonthly Regional Council meetings, Public Health Region 8 or Regional Council Staff will provide a report on the Emergency Preparedness involvement to the Regional Council.</p>
<p>Objective 2: During the 2009-2012 Plan cycle, The Designated Trauma Services will continue to actively support the Region 8 Heath Care Coalition All Hazards planning through participation and representation at regularly scheduled Healthcare Coalition activities.</p>	<p>Strategy 1: During the Plan cycle, The Designated Trauma Services in the South Central Region will participate in the Region 8 Health Care Coalition by regularly attending scheduled meetings and planning activities.</p>
	<p>Strategy 2. During the Plan cycle, The Designated Trauma Services in Public Health Region 8 and the South Central Region will participate in scheduled drills and drill planning activities.</p>

SYSTEM DEVELOPMENT

Goal 8	
Region-wide interoperable communications are in place for emergency responders and hospitals.	
Objective 1: By June 2011, The Regional Council Communications Committee and dispatch centers will identify the current Regional status and gaps in communication capabilities and recommend interoperability improvements and enhancements for system planning.	Strategy 1. By January 2010, The Regional Council Communication Committee and the County Emergency Dispatch Centers will gather communication plans in use by each county.
	Strategy 2. By July 2010, The Regional Council Communications Committee will review communication plans for commonalities and disparities.
	Strategy 3. By January 2011, The Regional Council Communications Committee will create a report including gaps and recommendations to the Regional Council for system planning.

SYSTEM PUBLIC INFORMATION & EDUCATION

Introduction

In the past there has not been an emphasis on public information and education about the system in the South Central Region. The SAFE KIDS Coalitions list the South Central Regional Council as a sponsor on their written information, but anyone not involved in the EMS and Trauma System would not know who was involved in the EMS and trauma system or what the system does. The Regional Council developed a brochure that can be distributed with system information but it has been met with limited success. DOH developing a plan for Trauma System Public Information and Education that is to inform the general public, decision makers, and the health care community about the EMS & Trauma Care System in the regions and state-wide. The Regional Council will utilize the state plan and other public information and education plans to develop a Regional Public Education and Education Plan that will disseminate information on the multifaceted components of the EMS & Trauma System throughout the South Central Region. The Regional plan is to utilize individuals already involved in public education to assist in development of this process and program.

Need addressed in the strategic plan:

Statewide and Region-wide plan to inform the general public, decision makers, and the health care community about the EMS and Trauma Care System.

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.	

There is no Regional Plan goal #10

SYSTEM FINANCE

Introduction

The EMS and Trauma System is consistently challenged with sustainable funding issues. EMS agencies are funded in multiple ways from private “for profit” agencies to tax based agencies relying on taxes, levies, state and federal funding and third party payers. Agencies relying on tax levies have experienced problems passing their levies in the last few years. Over sixty percent of the EMS agencies in the South Central Region are volunteer agencies. These volunteer agencies often have small budgets and inadequate funding.

Trauma services are primarily nonprofit hospitals some with religious sponsors, however all hospitals depend on state funding and third party payers. The Regional Council is fully funded by State contracts through the trauma fund and federal emergency preparedness. With these funds the Regional Council strives to coordinate many activities with the South Central Region EMS & Trauma System. It facilitates a robust EMS training and education program in collaboration with the local EMS & Trauma Care Councils. Injury Prevention programs are funded through contracts with the four SAFE KIDS Coalitions within the Region. The Regional Council strives to be a good steward of the contract funds provided through DOH. An annual budget is developed that prioritizes spending and asset allocation based on critical work of the Regional Council.

Needs addressed in the Strategic Plan:

- Regional Council funding for critical work of the Regional Council.
- Regional website to provide information on financial resources and grant opportunities.

Goal 11	
There is consistent and sustainable funding to ensure a financially viable regional EMS and Trauma Care System.	
Objective 1: During the 2009-2012 Plan cycle, The Regional Council will be fiscally responsible with available funding by prioritizing spending and asset allocation and setting and implementing the budget to address critical work.	Strategy 1. By July annually, The Regional Council will develop an itemized budget and allocate State contract funding based on prioritization of critical work for the funding year.
	Strategy 2. Bi-Monthly, Regional Administration will provide financial reports to the Regional Council at each regional council meeting.
	Strategy 3. Three times Annually, The Regional Prevention Committee will provide reports to the Regional Council regarding their grant acquisition and other funding resources.
Objective 2: By October 2010, Regional Council will create a financial resource information page on the Regional Website where agencies can share grant submission and success	Strategy 1. By July 2010, Regional Council will identify a webmaster to maintain and improve the Regional website to be able to serve as a grant resource.
	Strategy 2. By October 2010, The Regional webmaster will develop information

information.	exchange forum for grant related information including grant writing classes and courses.
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CLINICAL COMPONENTS

INJURY PREVENTION & CONTROL

Introduction

The overarching Injury Prevention & Control goal for the South Central Region is that preventable death and disability due to injury is reduced through targeted injury prevention activities and programs. Three main areas for injury prevention activities have been targeted in the Region are as follows:

- Decrease in motor vehicle related deaths and injury,
- Prevention of falls especially in the elderly, and
- Drowning prevention.

Data from Washington State Vital Statistics identifies motor vehicle crashes (MVC) as the leading cause of injury deaths in all of the six counties in the South Central Region. Falls especially in the elderly are the leading cause of hospitalizations due to injury within the Region. And although drowning is not a leading cause of death in the South Central Region, the Regional Council has helped to sponsor a robust and growing life jacket loaner board and drowning prevention program. The program is highly visible within our communities and has been well received. The Regional Council voted to continue to support this important prevention program.

To facilitate the Regional injury prevention activities, the Regional Council provides funding through contracts with the four SAFE KIDS Coalitions located in Kittitas, Yakima, Walla Walla/Columbia and Benton/Franklin Counties. The membership of each coalition varies from county to county; however, all coalitions have representation from hospitals, law enforcement, EMS, public health, schools, city parks and recreation, Corps of Engineers, dive rescue and many others. The Regional Council encourages each Coalition to utilize evidence based injury prevention programs whenever possible.

The Regional Council Prevention Committee meets with the SAFE KIDS Coalitions every other month to review prevention activities, share ideas, provide information from the State Injury Prevention TAC and Regional EMS & Trauma Care System information and provide guidance if needed.

Each SAFE KIDS Coalition has well developed and implemented injury prevention and safety programs to reduce MVC deaths and injury such as:

- Seat belt use
- Child safety seat programs including at least monthly child safety seat check stations
- Bicycle safety and bike helmet fit and use programs
- Pedestrian safety programs
- Impaired driving prevention programs

The Regional Prevention Committee and the SAFE KIDS Coalitions are partnering with the Retired Senior Volunteer Programs (RSVP) in several of the counties who are developing and implementing falls prevention programs as well as working with other agencies utilizing falls prevention programs.

Each SAFE KIDS Coalition has well established life jacket loaner boards and drowning prevention programs. Since the Regional Council helped to establish this program, it will continue to support the drowning prevention activities with the SAFE KIDS Coalitions.

Need addressed in the Strategic Plan:

- Continue funding for evidenced injury prevention programs that address the top Regional injury prevention goals

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 Regional Prevention Committee will recommend evidenced based injury prevention programs/projects to the Regional Council for use in planning Injury Prevention budget allocations.</p>	<p>Strategy 1. By July annually, The Regional Prevention Committee will obtain and review data from DOH and other relevant and available injury data and information on the areas of highest mortality and morbidity in the South Central Region.</p>
	<p>Strategy 2. By September annually, The Regional Prevention Committee will identify and recommend to the Regional Council evidence based injury prevention programs and projects using data and the State Injury Prevention Guide.</p>
<p>Objective 2: By October annually, The Regional Council will allocate State contract funding as available for evidence-based injury prevention programs/projects.</p>	<p>Strategy 1. By October annually, the Regional Council will utilize the information and recommendations from the Regional Prevention Committee to direct the focus of the injury prevention activities and allocation of funds for the year.</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 also 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.

In the South Central Region system Prehospital agencies provide an organized approach to care for EMS and Trauma patients by responding in a tiered response: Basic Life Support (BLS) aid with BLS ambulance with Intermediate Life Support (ILS) or Advanced Life Support (ALS). Rendezvous agreements have been established and Regional PCPs are developed to provide guidance.

There are sixty-one EMS trauma verified aid and ambulance services within the SCR:

County	ALS Services	ILS Services	BLS Services	BLS Aid Services
Benton	5	2		3
	Kennewick FD	Benton Co. FD #2		Benton Co. FD #1
	Richland FD	Benton Co. FD #6		Benton Co. FD #4
	Hanford FD			Prosser FD
	Prosser Ambulance			
	American Medical Response			
Columbia			1	1
			Columbia Co. FD #3	Columbia Co. FD #1
Franklin	1		2	1
	Pasco FD		Franklin Co. PHD #1	Franklin Co FD #3
			Franklin Co. FD #2	
Kittitas	2		3	6
	Kittitas Valley Fire & Rescue		Kittitas FD	Kittitas FD #1
	Kittitas Co. PHD #2		Cle Elum FD	Kittitas FD #3
			Kittitas FD #5/ King Co FD 51 (Verified in King Co)	Kittitas FD #4
			Kittitas FD #7	Kittitas FD #8

				So. Cle Elum FD
Walla Walla	1		3	7
	Walla Walla FD		Walla Walla FD #4	Walla Walla FD #1
			Walla Walla FD #5	Walla Walla FD #2
			Waitsburg Ambulance	Walla Walla FD #3
				Walla Walla FD #6
				Walla Walla FD #7
				Walla Walla FD #8
				College Place FD
Yakima	3	1		18
	ALS Ambulance	White Swan Ambulance		Yakima FD #1
	AMR Ambulance			Yakima FD #2
	Sunnyside FD			Yakima FD #3
				Yakima FD #4
				Yakima FD #5
				Yakima FD #6
				Yakima FD #9
				Yakima FD #12
				Yakima FD #14
				Grandview FD
				Granger FD
				Mabton FD
				Tieton FD
				Toppenish FD
				Union Gap FD
				Wapato FD
				Yakima FD
				Zillah FD

Over the years, several new EMS agencies have been established and several agencies have increased their service levels from BLS to ILS or ALS. An air ambulance service is now available within the Region to enhance EMS response and transport.

A primary focus of the Regional Council continues to be providing funding to assist with EMS training including On Going Training Programs (OTEP) and Continuing Medical Education (CME). The Regional Council has well established training and education programs through contracts with the local EMS & Trauma Care Councils to provide EMS training.

The Regional Council recommends the minimum and maximum numbers and levels of EMS verified trauma services with input from the Local EMS & Trauma Councils and MPDs. The

Local Councils also assist in identifying trauma response areas in each County and developing trauma response area maps.

Regional Patient Care Procedures (PCPs) have been developed to provide specific directions for how the EMS and Trauma Care System should function within the South Central Region. Local Councils have developed County Operating Procedures (COPS) with their MPDs that provide details on how local EMS agency should carry out the Regional PCPs within the counties.

Need addressed in the Strategic Plan:

- Funding for Prehospital training.
- Standardized methods for identifying Prehospital system resource needs.
- Review and update Regional PCPs
- Review the local Council COPS to assure they are congruent with the Regional PCPs.

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.	
<p>Objective 1: By July 2011, The Regional Council will use the recommendations of the Patient Care Procedure (PCP) Committee to make updates and changes that are evidenced based that can be included in the EMS & Trauma System Plan.</p>	<p>Strategy 1. September annually starting in 2010, The Regional PCP Committee will solicit input from local council and MPD’s for evidenced based updates and/or changes to Regional PCPs.</p>
	<p>Strategy 2. March annually starting in 2010, The Regional PCP Committee will verify that the Regional PCPs are aligned with the evidence based documents such as EMS Agenda for the Future and National Scope of Practice, and recommend an updated draft as needed to the Regional Council</p>
	<p>Strategy 3. By July 2011, The Regional Council will incorporate PCP changes that can be submitted with the updated plan to DOH.</p>
<p>Objective 2: By January 2011, The Regional Council will make recommendations for the minimum and maximum numbers and levels of trauma verified agencies from each county utilizing the standardized methods provided by DOH to determine system recommendations for the next plan.</p>	<p>Strategy 1. By April 2010, The Regional Council Planning & Standards Committee will solicit input from local councils regarding regional EMS agency needs and recommendations for minimum and maximum numbers and levels of EMS agencies based on the standardized methods from DOH for determining optimal Prehospital system recommendations.</p>
	<p>Strategy 2. By September 2010, The Regional Planning & Standards Committee will review recommendations from the local councils and use standardized methods provided by DOH to determine optimal Prehospital system recommendations to the Regional Council for approval.</p>
	<p>Strategy 3. By January 2011, the Regional Council will make recommendations for the minimum and maximum numbers and levels of trauma verified agencies from each county utilizing the standardized methods provided by /DOH and incorporate them into</p>

	the revised and updated EMS & Trauma System plan,
Objective 3: By July 2011, The Regional PCP Committee will review local council County Operating Procedure (COPS) for congruency and alignment with the Regional PCPs and make recommendations to the Regional Council.	Strategy 1. By January 2011, The Regional PCP Committee will request the current COPS from the local Councils,
	Strategy 2. By July 2011, The Regional PCP Committee will make recommendations to the Regional Council for inclusion of COPs with Regional PCPs in the System Plan.
Objective 4: By July 2010, The Regional Council will adopt and implement guidelines for use in Regional Funding for Prehospital training and education and reporting to DOH.	Strategy 1. By January 2010, The Regional Training & Education Committee will review existing models available.
	Strategy 2. By April 2010, the Regional Training & Education Committee will solicit input from Local Councils regarding EMS agency needs for training and education.
	Strategy 3. By July 2010, The Regional Training & Education Committee will develop and recommend to the Regional Council a matrix to allocate funding and to report Prehospital training and education including standardized reporting to DOH.

ACUTE HOSPITAL

Introduction

All hospitals in the South Central Region are participating in the Trauma System and are designated as trauma services. Regional analysis shows there is a broad spectrum of trauma care and medical staff capabilities, ranging from small rural hospitals with limited medical resources, to large medical centers with sophisticated trauma care equipment and medical specialties. None of the trauma services in the South Central Region have the resources to be a Level I or II designated trauma service. Trauma patients requiring Level I or II trauma care are transported to Harborview Medical Center, Level I Trauma Service in Seattle or the Level II designated trauma services in Spokane. Each Regional trauma Service has written transfer agreements with the Level I and II Trauma Services. Due to the distances to the Level I and II Trauma Services, air ambulance is most often utilized for transport.

The ten designated Regional trauma services are as follow:

Adult Level III	Adult Level IV	Adult Level V	Pediatric Level III	Rehabilitation Level II
5	4	1	2	3
Yakima Trauma Service	Kittitas Valley Community Hospital	Dayton General Hospital	Yakima Trauma Service	Yakima Joint Designation
Kadlec Medical Center	Toppenish Community Hospital		St. Mary Medical Service	Tri City Trauma Service/Kadlec Medical Center
Tri City Trauma Service	Sunnyside Community Hospital			St. Mary Medical Center
St. Mary Medical Center	Prosser Memorial Hospital			
Walla Walla General Hospital				

There are two joint level III Adult Trauma Designations, Yakima Trauma Service and Tri City Trauma Service.

The Regional Council recommends to DOH the minimum and maximum numbers and levels of designated trauma services bases on EMS & Trauma System current needs and resources. The Regional Council works in collaboration with the Local EMS & Trauma Care Councils, MPDs and the regional Continuous Quality Improvement (CQI) Committee. The Regional Council and the regional CQI Committee will work toward using the standardized methods provided by DOH for determining resources. Most trauma services are currently under designated from the recommendations of the Regional Council.

State Trauma Steering Committee with its Hospital TAC, Trauma Medical Directors, and DOH are in the process of evaluating the entire trauma service designation process and will provide the EMS & Trauma Care Councils with further directions.

Needs addressed in the Strategic Plan:

- Utilize standardized methods for recommending minimum and maximum numbers and levels of Adult Designated Trauma Services using the standardized method for
- Designated Trauma Services participate in the CQI Committee and its activities by attending meetings.

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 2011, The Regional Council will review the min/max numbers and levels for designated adult trauma services and make recommendations to DOH for the 2012-2017 Strategic EMS & Trauma Care Plan.</p>	<p>Strategy 1. By October 2010, The Regional CQI Committee will solicit input from stakeholders regarding Regional Designated Adult Trauma Services needs.</p>
	<p>Strategy 2. By January 2011, The Regional CQI Committee will compare compiled input to current Adult Trauma Service designations.</p>
	<p>Strategy 3. By February 2011, The Regional CQI Committee will make recommendations regarding Adult Trauma Service Designation to the Regional Council</p>
	<p>Strategy 4. By March 2011, The Regional Council will make recommendations regarding designated Adult Trauma Services to DOH</p>
<p>Objective 2: By December 2010, All Designated Trauma Services will actively participate in regional CQI programs and reporting processes by attending meetings.</p>	<p>Strategy 1. By October 2010, The CQI Committee will develop a methodology for involving designated Trauma Services not currently attending CQI meetings and monitor.</p>
	<p>Strategy 2. Quarterly, The Designated Trauma Services will attend regularly scheduled Regional CQI meetings.</p>

PEDIATRIC

Introduction

The Care of pediatric patients is intergraded into the all parts of EMS and trauma care. Regional injury prevention activities are specifically focused toward the pediatric community through the work of the SAFE KIDS Coalitions. All trauma verified aid and ambulance services receive ongoing training on the care of pediatric patients. All ambulances carry specialized equipment especially for the care of pediatric patients.

Trauma service staff receives specific training on caring for pediatric patients and have specialized equipment for this care. If care is beyond the capabilities of a trauma service, transfer agreements with higher level pediatric care facilities are in place and utilized.

Pediatric care is a small part of EMS, trauma and medical care, however, cause the most stress and anxiety in both the EMS and medical community. There are two Level III designated pediatric trauma services within the South Central Region, Yakima Trauma Service and St. Mary Medical Center.

Needs addressed in the Strategic Plan:

- Pediatric care data for the Region.
- Recommendations for minimum and maximum numbers and levels of designated Trauma Pediatric services
- Pediatric training/education needs from data

Goal 15	
There is a sustainable region-wide EMS and Trauma Care System that integrates pediatric care into the system continuum (prevention, Prehospital, hospital, rehabilitation and system evaluation.)	
Objective 1: By May 2011, The Regional CQI Committee will evaluate and identify the Region’s EMS & Trauma Care System’s ability to meet the pediatric Care needs and make recommendations to the Regional Council for further system development.	Strategy 1. By December 2010, The Regional CQI Committee will request annual pediatric data including ages, types of injury, location, transfers, and outcomes from the DOH trauma registry, WEMESIS data and other data as available.
	Strategy 2. By March 2011, The Regional CQI Committee will evaluate initial compiled data and analyze pediatric care needs as determined by the data.
	Strategy 3. By May of 2011, The Regional CQI Committee will utilize regional data and state pediatric guidelines to develop recommendations to the Regional Council for meeting the pediatric care needs for further EMS & Trauma System planning.
Objective 2: By May 2011, The Regional Council will utilize the information from Objective 1 to identify pediatric	Strategy 1. By September 2010 The Regional Council will work with the MPDs and Trauma Services to identify the pediatric education topics needed

training/education needs for EMS and hospital providers for incorporation into the 2012-2017 Regional System Plan,	within the Region.
	Strategy 2. October 2010, The Regional Council will identify where pediatric training classes are available and post on the Regional web site.
	Strategy 3. By May 2011. The Regional Council will receive and review the recommendations from Objective 1 and incorporate the needs into the 2012-2017 Regional EMS & Trauma System Plan for pediatric training/education needs.
Objective 3: By June 2011, The Regional Council will review the min/max numbers and levels for designated Pediatric Trauma Services and make recommendations to DOH for the 2012-2017 Strategic EMS & Trauma Care Plan.	Strategy 1. By December 2010, The Regional CQI Committee will solicit input from stakeholders regarding regional Pediatric Trauma Designation needs.
	Strategy 2. By March 2011, The Regional CQI Committee will compare compiled input to current designated Pediatric Trauma Services designations and make recommendations regarding facility Pediatric Trauma Service designation to the Regional Council.
	Strategy 3. By June 2011, The Regional Council will review recommendations from the regional CQI Committee regarding Pediatric Trauma Service designation and include recommendations in the EMS & Trauma System Plan to be submitted to DOH.

TRAUMA REHABILITATION

Introduction

Rehabilitation care is imbedded in the care provided by the associated trauma services in the South Central Region. Trauma rehabilitation care in the South Central Region is provided by three Level II designated Trauma Rehabilitation Services as follows:

Rehabilitation Level II	Yakima Trauma Service	Tri Cities Trauma Service/Kadlec Medical Center	St. Mary Medical Center
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Although the Regional Council created a position on the Regional Council board, the position has been vacant for a number of years.

Needs addressed in the Strategic Plan:

- Trauma Rehabilitation representative on the Regional Council.
- Recommendations for minimum and maximum numbers and levels of Trauma Rehabilitation services

Goal 16	
There is a sustainable region-wide system of designated trauma rehabilitation services that provides adequate capacity and distribution of resources to support high-quality trauma rehabilitation care.	
Objective 1: By May 2011, The Regional CQI Committee will evaluate and identify the Region’s EMS & Trauma Care System’s ability to meet the Trauma Rehabilitation needs and make recommendations to the Regional Council for system planning.	Strategy 1. By December 2010, The Regional CQI Committee will annually request trauma rehabilitation data from the Regional designated trauma rehabilitation services, Regional designated trauma services and other available rehabilitation data sources.
	Strategy 2. By March 2011, The Regional CQI Committee will evaluate compiled data and assess trauma rehabilitation needs as determined by the data.
	Strategy 3. By May 2011, The Regional CQI Committee will submit recommendations for meeting the trauma rehabilitation service needs to the Regional Council to be used in system planning.
Objective 2: By June 2011 The Regional Council will review the minimum and maximum numbers and levels of trauma rehabilitation services for recommendations to DOH for the 2012-2017 Strategic EMS & Trauma Care Plan.	Strategy 1. By December 2010, The Regional CQI Committee will solicit input from stakeholders regarding regional designated trauma rehabilitation needs.
	Strategy 2. By May 2011, The Regional CQI Committee will compare compiled input

	to current trauma rehabilitation services designations and make recommendations regarding trauma rehabilitation services designation to the Regional Council.
	Strategy 3. By June 2011, The Regional Council will make recommendations regarding designated trauma rehabilitation services to be included in the EMS & Trauma System Plan to be submitted to DOH.
Objective 3: By January 2010, the Regional CQI Committee will have Trauma Rehabilitation representation.	Strategy 1. By November 2009, The Regional CQI Committee will work with the designated trauma rehabilitation services and designated trauma services where trauma rehabilitation is provided to identify a Trauma Rehabilitation representative for the Regional CQI Committee.
	Strategy 2. By January 2010, The Regional CQI Committee will have a Trauma Rehabilitation Representative.

SYSTEM EVALUATION

Introduction

WAC 246-976-430 directs *designated* trauma services to collect trauma data for the State Trauma Registry and to develop a regional EMS and Trauma System Continuous Quality Improvement (CQI) and evaluation process. The regional CQI Committee is the lead group within the Region to develop a plan and a process for trauma system evaluation. The membership of the regional CQI Committee is multifaceted and includes representation from the following:

- Trauma Coordinators from each trauma service
- Trauma Medical Directors from each trauma service
- Prehospital providers
- County MPDs
- County EMS Coordinators
- Emergency Medical Dispatch
- Regional Council representative

This combination has worked well to address trauma care issues that have come before the CQI Committee. Due to confidentiality concerns, reporting to the Regional Council from the Regional CQI Committee has been limited to generalities. The Regional Council as well as the Regional CQI Committee recognize this as a barrier to loop closure and are committed to improving the reporting mechanisms.

The Regional Council has long recognized that timely collection and submission of complete and accurate EMS and trauma system data is vital to trauma system evaluation. Over the years, the Regional Council has provided Collector training for the trauma services. WEMSIS training and assistance for EMS Agencies has just been provided. Designated trauma services have been collecting and submitting Trauma Registry data for many years. The larger EMS agencies in the South Central Region are collecting data electronically and submission to the WEMSIS system should not be difficult, once the appropriate links are established. Smaller rural EMS agencies however, often are using paper collection of data. Since the WEMSIS program has not been in place for long, the Regional Council will evaluate gaps identified within the Region and develop a plan with DOH to assist EMS agencies where needed.

Needs addressed in the Strategic Plan:

- All EMS agencies participation in WEMSIS program
- Reporting process of loop closure from the CQI Committee to the Regional Council and to the county MPDs.
- Utilize DOH aggregate data in CQI meetings.

Goal 17	
The Regional EMS and Trauma Care System has data management capabilities to support evaluation and improvement.	
Objective 1: By March 2010, The Regional Council will implement a process/plan with DOH to meet the EMS data management needs of the	Strategy 1. By December 2009, the Regional Council will review information and recommendations from the Planning & Standards Committee to assist Prehospital agencies in data collection and submission through WEMSIS.

Region.	
Objective 2: By May 2012, the Regional Council will utilize data available to identify Regional prehospital benchmarks for care.	Strategy 1. By January 2012, the Regional Planning & Standards Committee will review and evaluate prehospital data for development of patient care benchmarks,
	Strategy 2. By March 2012, the Planning & Standards Committee will recommend prehospital patient care benchmarks to the Regional Council to evaluate system care within the Region.

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 July 2010, The Regional Council will utilize the Regional CQI Committee report to educate stakeholders of DOH performance measures and common CQI Components for further system planning,</p>	<p>Strategy 1. By March 2010, The Regional CQI Committee will obtain the standard performance measures developed by DOH for trauma services and EMS agencies, the CQI components from each of the county MPDs plans, components from the CQI plans from the designated trauma services and the regional CQI Plan to review for commonalities.</p>
	<p>Strategy 2. By July 2010, The Regional CQI Committee will review DOH performance measures and CQI program commonalities and develop a report to the Regional Council to be used for further system planning.</p>
	<p>Strategy 3. By October 2010, the Regional CQI Committee will develop a report on the commonalities and how they compare with the DOH performance measures and provide to the Regional Council, Trauma Services and MPDs for evaluation and distribution to EMS agencies.</p>
<p>Objective 2: From July 2009 to June 2012, the Regional CQI Committee will utilize aggregate evidenced based data provided by DOH for trauma system evaluation at their meetings.</p>	<p>Strategy 1. Prior to each Regional CQI Committee meeting, aggregate data will be requested from DOH on the topic for the meeting.</p>
	<p>Strategy 2. At each Regional CQI Committee meeting, data from DOH will be utilized for system evaluation</p>
<p>Objective 3: By December 2010, The Regional CQI Committee will develop a method and format to provide loop closure for Regional Council and MPDs and implement it.</p>	<p>Strategy 1. By August 2010, The Regional CQI Committee will develop a method and format to use in reporting at various levels within the system.</p>
	<p>Strategy 2. By October 2010, The Regional CQI committee will provide system level reports for loop closure at Regional Council meeting.</p>
	<p>Strategy 3. By December 2010, The Regional CQI Committee will formulate and implement a loop-closure report to county MPDs.</p>
<p>Objective 4: By December 2010, The Regional Council will develop, implement and begin monitoring system performance measures in conjunction with the state performance measures.</p>	<p>Strategy 1. By June 2010, The Regional CQI Committee will develop an initial set of system performance measures.</p>
	<p>Strategy 2. By December 2010,</p>

	The Regional CQI Committee will implement the performance measures.
	Strategy 3. By December 2010, The Regional CQI Committee will share the performance measure monitoring process with the Regional Council.

South Central Region
Appendix 1.

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

Benton County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (# Verified for each Service Type)
	Aid – BLS	4	4	3
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	0	1	0
	Amb – ILS	0	2	2
	Amb - ALS	4	5	5

Columbia County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (# Verified for each Service Type)
	Aid – BLS	2	3	1
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	1	1	1
	Amb – ILS	0	1	0
	Amb - ALS	0	0	0

Franklin County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (# Verified for each Service Type)
	Aid – BLS	1	3	1
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	2	2	2
	Amb – ILS	0	1	0
	Amb - ALS	1	1	1

Kittitas County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (# Verified for each Service Type)
	Aid – BLS	5	8	5
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	1	3	3
	Amb – ILS	0	0	0

	Amb - ALS	2	2	2
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Walla Walla County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (# Verified for each Service Type)
	Aid - BLS	8	8	6
	Aid - ILS	0	0	0
	Aid - ALS	0	0	0
	Amb - BLS	1	3	3
	Amb - ILS	0	1	0
	Amb - ALS	1	1	1

Yakima County	Verified Service Type	State Approved - Minimum number	State Approved - Maximum number	Current Status (# Verified for each Service Type)
	Aid - BLS	18	20	18
	Aid - ILS	0	1	0
	Aid - ALS	0	0	0
	Amb - BLS	2	9	0
	Amb - ILS	0	1	1
	Amb - ALS	3	3	3

South Central Region

Appendix 2. TRAUMA RESPONSE AREAS BY COUNTY

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

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

Columbia County	EMS & Trauma Response Area #	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas
	#1	Within the boundaries of Columbia County	A-1 E-1

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

Franklin County	EMS & Trauma Response Area #	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas
	#1	Within the current City limits of Pasco, Franklin County FD #3 boundaries, and north to Sagemore Road.	A-1 F-1
	#2	Within the boundaries of Franklin County Hospital District #1 that includes the communities of Connell, Mesa, Basin City and Merrill's Corner, west to the Columbia River and south to Sagemore Road.	D-1
	#3	Within the current city limits of Kahlotus and the boundaries of Franklin County Fire District #2	D-1

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

Kittitas County	EMS & Trauma Response Area #	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas
	#1	From the southern county boundary to the east and west county boundaries encompassing the boundaries of Kittitas County Public Hospital District #1 to Exit 93 (Elk Heights and including Sunlight Waters to the development, <i>south</i> on 182 to milepost 18.5 (N. Umptanum turnaround), <i>south</i> on SR 821 to mile post 14 (Weimer Cut), <i>west</i> on State Route 10 to mile post 93 (east end of Bristol Flats), <i>west</i> of Lauderdale on State Route 97, <i>north</i> to	A-2 D-1 F-1

		mile post 163.7 (Blewett Pass Summit). This trauma area also includes the cities of Ellensburg and Kittitas, the rural communities of Vantage and Thorp, and boundaries of FD#1, FD#2, and FD#4 and surrounding rural and wilderness areas.	
	#2	From the northern county boarder and within the current boundaries of Kittitas County Public Hospital District #2, 190 east to MP 93.5 (Elk Heights OP, Exit 93). 109 west to MP 54.5 (exit 53/E. Summit), SR 10 to MP 93 (E. end of Bristol Flats-HD #1), SR 970 north to MP 149.5 (Lauderdale Junction/SR 97, MP 10.3, West of Lauderdale Junction on SR 97 (including area around junction and residences accessed from SR 97, SR 970 from Teanaway Junction (MP 2.6) east to Lauderdale Junction (end of SR 970, MP 10.3), the Cities of Cle Elum and Roslyn, Town of S. Cle Elum, the rural community of Ronald, Easton, and Snoqualmie Pass, to the eastern and western county boundaries encompassing the surrounding rural and wilderness areas within HD #2.	A-3 D-2 F-1

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

Walla Walla County	EMS & Trauma Response Area #	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in Each Response Area
	#1	Within the current boundaries of Walla Walla County	A-6 D-3 F-1

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

Yakima County	EMS & Trauma Response Area #	Description of Trauma Response Area's Geographic Boundaries	Type and # of Verified Services in each Response Areas
	#1	North county line to west county line; south to south county line; east to Boundary Road; along Boundary Road to Newland Road and north on Newland Road to Yakima River; north along the Yakima River to Beam Road; north on Beam Road to end of the road and directly east to County line.	A-16 E-1 F-2
	#2	North Beam Road east to county line; county line south to Alexander Extension; southwest on Alexander Extension to Yakima River; and Yakima River north to Beam Road.	A-1 F-1
	#3	Alexander Extension south west to Yakima River; north from Yakima River on Newland Road; south to county line, east on county line; and north to Alexander Extension,	A-3 F-1

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

South Central Region

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	3	3	0
III	3	4	5
IV	2	2	4
V	1	2	1
II P	0	1	0
III P	3	3	2

Rehabilitation Trauma Care Services

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

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

**APPENDIX 4
SOUTH CENTRAL REGION EMS & TRAUMA CARE COUNCIL**

PATIENT CARE PROCEDURES

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South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURES #1	Effective Date: 07/24/96	Page: 1 of 2
Subject: DISPATCH		

I. STANDARD

1. Licensed aid and/or ambulance services shall be dispatched to all emergency medical incidents per the response maps developed by local EMS & Trauma Care Councils and the South Central Region. Detailed maps of service areas are available through Department of Health EMS & Trauma web site (www.doh.wa.gov).
2. Trauma verified aid and/or ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents requiring an emergency response per the response maps developed by local EMS & Trauma Care Councils and the South Central Region. Detailed maps of service areas are available through Department of Health EMS & Trauma web site (www.doh.wa.gov).

II. PURPOSE

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

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council (RC) with a copy of their COPs for review, adoption, and inclusion with the Regional Patient Care Procedures. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. The nearest “appropriate” aid and/or ambulance service shall be dispatched per the above standards.
3. Trauma verified and licensed EMS services should proceed in an emergency response mode until they have been advised of non-emergent status.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #1	Effective Date: 07/24/96	Page: 2 of 2
Subject: DISPATCH		

IV. DEFINITIONS

1. **Appropriate** – Defined as the trauma verified or licensed EMS service that responds within an identified service area.
2. **Emergency Response** – Defined as a response using warning devices such as lights, sirens, and use of Opticom devices where available.
3. **Dispatch Interval** – Defined as the time the call is received by the dispatcher to the time the first unit is dispatched.

V. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #2	Effective Date: 07/24/96	Page: 1 of 3
Subject: RESPONSE TIMES		

I. STANDARD

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

II. PURPOSE

1. To provide “timely” emergency medical services to patients who have medical and/or injury incidents requiring emergency care response.
2. To collect data required by the state Trauma Registry and by the Regional Continuous Quality Improvement (CQI) Plan.

III. PROCEDURES

1. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** of the South Central Region identified above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional Patient Care Procedures. The Regional Council will make a recommendation to Department of Health that the COPs be approved.
2. Detailed maps of service areas are available through the Department of Health EMS & Trauma web site (www.dohems.wa.gov).
3. Trauma verified aid and/or ambulance services are responsible for documenting the Washington Emergency Medical Service Information System (WEMSIS) data elements.
4. Included in the WEMSIS information will be unit response time. Verified aid and/or ambulance services shall meet the minimum agency responses to response area as defined in WAC 246-976-390 (10).

South Central Region EMS & Trauma Care Council		
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Subject: RESPONSE TIMES		

Trauma Verified AID Service

Urban	8 Minutes-80% of the time
Suburban	15 Minutes-80% of the time
Rural	45 Minutes-80% of the time
Wilderness	as soon as possible

Trauma Verified AMBULANCE Service

Urban	10 Minutes-80% of the time
Suburban	20 Minutes-80% of the time
Rural	45 Minutes-80% of the time
Wilderness	as soon as possible

IV. DEFINITIONS

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #2	Effective Date: 07/24/96	Page: 3 of 3
Subject: RESPONSE TIMES		

6. **EMS Personnel** – First Responder skill level or higher.
7. **WEMSIS** – Washington EMS Information System

V. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #3	Effective Date: 07/24/96	Page: 1 of 4
Subject: TRIAGE AND TRANSPORT		

I. STANDARD

All licensed and trauma verified aid and/or ambulance services shall comply with the State of Washington Prehospital Trauma Triage Destination Tool as defined in Washington Administrative Code (WAC). Medical and injured patients who do not meet prehospital triage criteria will be transported to local facilities according to Regional Patient Care Procedures (PCPs), Medical Program Director (MPD) protocols, and County Operating Procedures (COPs).

II. PURPOSE

1. To ensure that all trauma patients are transported to the most appropriate trauma designated facility in accordance with the Trauma Triage Destination Procedures.
2. To ensure that all patients that do not meet Washington State Prehospital Trauma Triage Destination Procedures criteria are transported according to PCPs, MPD Protocols, and COPs.
3. To allow the receiving facility or trauma designated service adequate time to activate their emergency medical and/or trauma response team.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend COPs that meet or exceed the **STANDARD** and **PURPOSE** of the South Central Region identified above. The local Council will provide the Regional Council (RC) with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The RC will make a recommendation to Department of Health (DOH) that the COPs be approved.
2. Trauma Triage
 - a. The first certified Emergency Medical Service (EMS) provider to determine that a patient meets the Trauma Triage Destination Tool, shall contact their base station, medical control, or the receiving trauma service via their local communication system, as soon as possible.
 - b. Patients meeting Washington State Trauma Triage Destination criteria are major trauma patients who may or may not have the ability to make an informed decision. They shall be transported to a designated trauma

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #3	Effective Date: 07/24/96	Page: 2 of 4
Subject: TRIAGE AND TRANSPORT		

service in accordance with the State of Washington Prehospital Trauma Triage Destination Procedures, Regional PCPs, and COPs.

- c. The Medical Control and/or receiving facility should be provided with the following information, as outlined in the Washington State Prehospital Trauma Triage Destination Procedures:
 - 1. Vital signs
 - 2. Level of Consciousness
 - 3. Anatomy of Injury
 - 4. Biomechanics of Injury
 - 5. Co-morbid Factors
- 3. Major trauma patient will be identified as the following:
 - a. Patients meeting the first two steps of the current State of Washington Prehospital Trauma Triage Destination Procedures or any other DOH approved triage destination procedures.
 - b. Patients activating the Region’s Trauma Services and hospitals modified and full trauma team activation.
 - c. Patients included by the Region’s Prehospital services, designated trauma services, and hospitals in the State Trauma Registry using the Trauma Registry inclusion criteria as outlined in WAC.
 - d. If a patient meets the State of Washington Trauma Triage Destination procedures, a Washington State Trauma Registry Band should be attached to the patient’s wrist/ankle.
 - e. If Prehospital personnel are unable to effectively manage a trauma patient’s airway, an Advanced Life Support (ALS) rendezvous or an immediate stop at the nearest facility capable of immediate definitive airway management should be considered.
 - f. South Central Region Designated Trauma services and maps of their locations are available from the DOH web site (www.doh.wa.gov).
 - g. Designated trauma services shall have written procedure and protocol for diversion of trauma patients when the facility is temporarily unable to care for trauma patients. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be life saving.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #3	Effective Date: 07/24/96	Page: 3 of 4
Subject: TRIAGE AND TRANSPORT		

Note: Exceptions to diversion:

- a. **Airway compromise**
 - b. **Traumatic arrest**
 - c. **Active seizing**
 - d. **Persistent shock**
 - e. **Uncontrolled hemorrhage**
 - f. **Urgent need for IV access, chest tube, etc**
 - g. **Disaster**
4. Non-Trauma/Medical
- a. Prehospital personnel may request response or rendezvous with ALS/Intermediate Life Support providers and all EMS providers may request emergency aero-medical evacuation if they are unable to effectively manage a patient.
 - b. Medical and injured patients who do not meet Prehospital triage criteria for trauma system activation will be transported to local facilities according to local MPD protocols, COPs, and Regional PCPs.
 - c. While in route and prior to arrival at the receiving facility, the transporting agency should provide a complete report to the receiving hospital regarding the patient's status via radio or other approved communication system according to local MPD protocols, COPs, and Regional PCPs.
 - d. Before leaving the receiving facility, the transporting agency will leave a completed MPD approved medical incident report form or provide the information that entered the patient into the trauma system in the "receiving facility" approved method. The additional information from the MIR shall be made available to the receiving facility as soon as possible in accordance with WAC.

IV. DEFINITION

- 1. Designated Trauma Service – A health care facility or facilities in a joint venture, whom have been formally determined capable of delivering a specific level of trauma care by the DOH.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #3	Effective Date: 07/24/96	Page: 4 of 4
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2. Other DOH approved Prehospital Trauma Triage Destination Procedures.

V. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #4	Effective Date: 07/24/96	Page: 1 of 2
Subject: INTERFACILITY TRANSFER		

I. STANDARD

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

II. PURPOSE

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

III. PROCEDURES

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #4	Effective Date: 07/24/96	Page: 2 of 2
Subject: INTERFACILITY TRANSFER		

IV. DEFINITIONS

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

V. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #5	Effective Date: 07/24/96	Page: 1 of 1
Subject: MEDICAL COMMAND AT SCENE		

I. STANDARD

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

II. PURPOSE

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

III. PROCEDURE

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

IV. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #6	Effective Date: 07/24/96	Page: 1 of 2
Subject: EMS/MEDICAL CONTROL COMMUNICATIONS		

I. STANDARD

Communications between Prehospital personnel, trauma services, and health care facilities will utilize the most effective communication means to expedite patient information exchange.

II. PURPOSE

To define methods of expedient communications between Prehospital personnel and trauma services, other health care facilities, and medical control.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional Patient Care Procedures. The Regional Council will make a recommendation to Department of Health that the COPs be approved.
2. Communication between EMS providers, trauma services, and health care facilities can be “direct” to trauma services or health care facilities or communications can be “indirect” from dispatching agency to trauma services or health care facilities.
3. County Medical Program Director will be responsible for establishing communication procedures between the EMS provider(s) and the trauma service(s) or health care facilities in accordance with WAC 246-976-920.
4. EMS agencies will maintain communication equipment and training needed to communicate in accordance with WAC.
 - a. Ground ambulance and aid services shall provide each licensed vehicle with communication equipment which:
 1. Is in good working order.
 2. Allows direct two-way communication between the vehicle and its system control point.
 3. If cellular phones are used, there must also be a method for radio contact with dispatch and medical control.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #6	Effective Date: 07/24/96	Page: 2 of 2
Subject: EMS/MEDICAL CONTROL COMMUNICATIONS		

- b. In addition, Prehospital services shall provide each licensed ambulance with communication equipment which:
 - 1. Allows direct two-way communication, from both the driver's and patient's compartments, with all hospitals in the service area of the vehicle.
 - 2. Incorporates appropriate encoding and selective signaling devices if appropriate.
 - 3. When transporting patients out of normal service area, allows for communications with receiving facilities.

IV. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #7	Effective Date: 07/24/96	Page: 1 of 3
Subject: HELICOPTER ALERT, RESPONSE AND TRANSPORT		

I. STANDARD

A system of Air Medical response to provide safe and expeditious transport of critically ill or injured patients to the appropriate hospital, including designated trauma services for the critically injured

II. PURPOSE

To define the criteria for alerting, requesting and transporting patients by on-scene emergency medical helicopter.

To provide guidelines for those initiating the request for emergency medical helicopter to the scene.

III. PROCEDURE

A. Alert

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

B. Response

1. Request for on-scene emergency medical helicopter should be initiated through the appropriate emergency dispatch agency for the area.
2. The dispatching agency will provide the helicopter with the correct radio frequency to use for contacting EMS ground units
3. At launch time the emergency medical helicopter communication center will inform the flight crew as to the nearest level III designated trauma facility by air from the scene, (e.g. Benton/Franklin Counties- Lourdes Medical Center/Kadlec Medical Center/Kennewick General Hospital; Walla Walla County - St. Mary's/Walla Walla General Hospital; Yakima County – Regional Medical Center/Yakima Valley Memorial Hospital as well as the designated Medical Control facility for the location of the scene.
4. While in route, the flight crew will make contact with the designated Medical Control facility for the area, with preliminary patient information and ETA to the scene.

South Central Region EMS & Trauma Care Council		
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Subject: HELICOPTER ALERT, RESPONSE AND TRANSPORT		

C. Transport

1. The flight crew will transport the trauma patient per the State of Washington Trauma Triage Tool by identifying the most appropriate facility for trauma patients as follows:
 - a. Step 1 Patients: Transport patient to the highest appropriate level trauma center within 30 minutes of the scene.
 - b. Step 2 Patients: Transport patient to the highest appropriate level trauma center within 30 minutes.
 - c. Step 3 Patients: The Medical Control Physician within the jurisdiction (county, city, etc.) of the scene will be contacted for destination decision.
 - d. The transport of the patient to the most appropriate facility may be changed due to the following:
 1. Diversion by facility to another receiving facility based on patient condition report from the flight crew and the facility's availability of appropriate resources or
 2. Patient preference, if appropriate to clinical condition, or
 3. Weather precludes flying to the designated facility
2. The helicopter will make radio contact with the receiving trauma service as soon as possible.
3. Documentation standards shall include the name of the EMS personnel on-scene whenever possible and, if needed, the rationale for transporting the patient to other than the designated Medical Control facility

IV. DEFINITIONS

Designated Level III Trauma Service – A health care facility or facilities in a joint venture, who have been formally determined capable of delivering a specific level of trauma care by the DOH as defined in RCW 70.168.015.

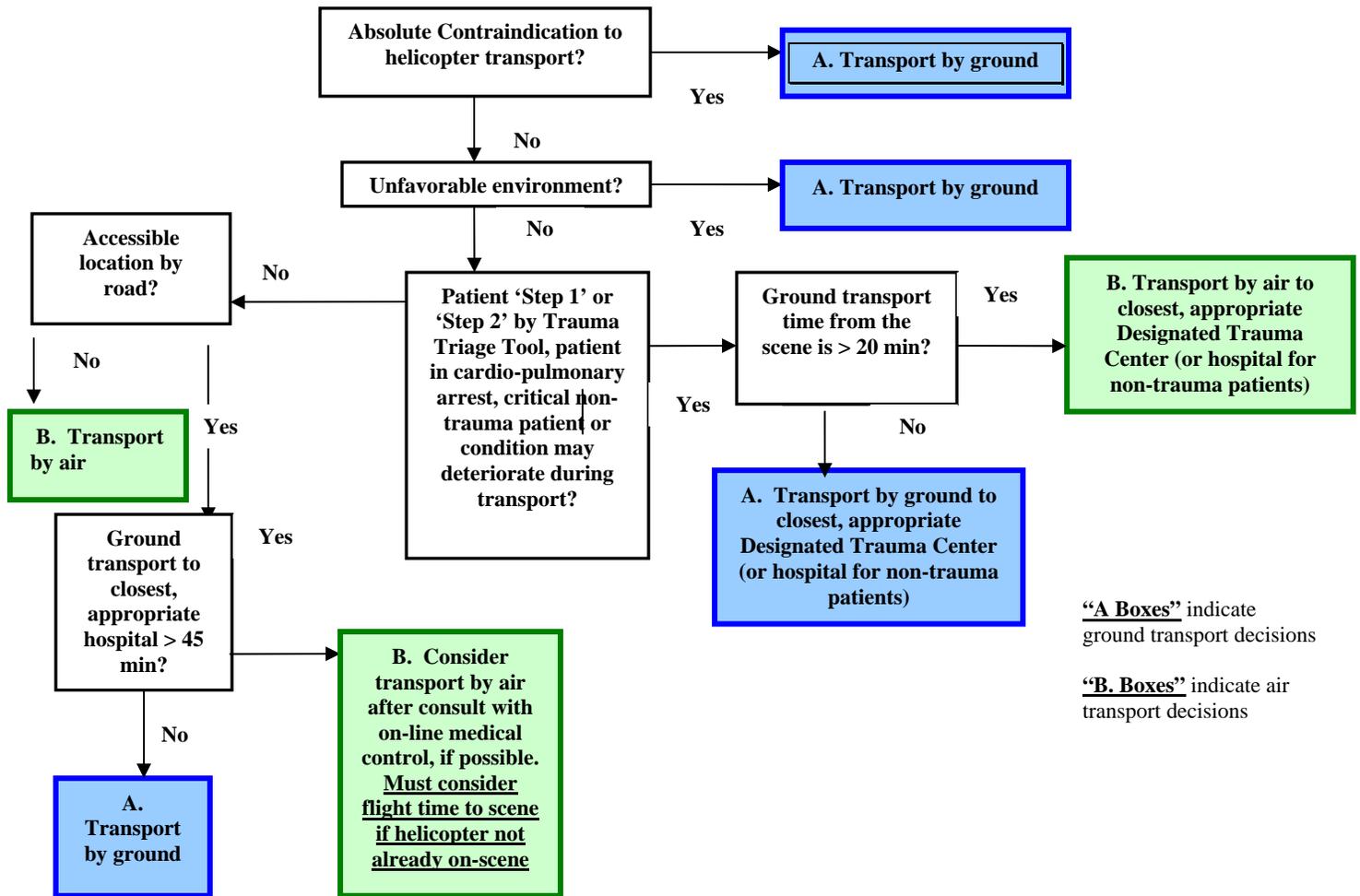
Medical Control Facility - A designated Trauma Service used by EMS personnel for the location of the scene

South Central Region EMS & Trauma Care Council		
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V. QUALITY ASSURANCE

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

ADDENDUM 'A'- "STATE OF WASHINGTON PRE-HOSPITAL HELICOPTER TRANSPORT DECISION ALGORITHM"



“A Boxes” indicate ground transport decisions
 “B. Boxes” indicate air transport decisions

Definitions

Absolute Contraindications to Helicopter Transport: Weather, Unsafe Landing Zone, Patient weight exceeds aircraft capabilities; patient condition is non life-threatening;

Unfavorable Environment: Weather conditions as determined by aircraft pilot; aggressive or uncooperative patients that may pose a danger in-flight; patients contaminated by chemical agents that may adversely affect aircraft pilot and crew; scene on ground is not secure (e.g., presence of gunfire, potential for explosive detonation, etc.)

Critical Non-Trauma Patient: Patients with compromised airway; respiratory failure/severe distress; Unstable cardiac dysrhythmias, **abnormal:** respiratory rate, pulse rate, blood pressure or neurologic status- either alone or in combination;

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #8	Effective Date: 07/24/96	Page: 1 of 2
Subject: DIVERSION		

I. STANDARD

All designated trauma services within the Region will have hospital approved policies to divert trauma patients to other designated trauma facilities.

II. PURPOSE

1. To divert trauma patients to other designated trauma facilities based on the facilities inability to provide initial resuscitation, diagnostic procedures, and operative intervention (WAC).
2. To identify communication procedures for diversion of trauma patients to another accepting facility.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional PCPs. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. Each trauma service will have written policies and procedures that outline reasons to divert trauma from their service (WAC).
3. Trauma Services must consider diversion when essential services including but not limited to the following are not available:
 - a. Surgeon
 - b. Operating Room
 - c. For a Level II – CT
 - d. For a Level II – Neuro Surgeon
 - e. ER is unable to manage additional patients
4. When the trauma service is unable to manage major trauma, they will have an established procedure to notify the EMS transport agencies and other trauma services in their area that they are on trauma divert. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be life saving.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #8	Effective Date: 07/24/96	Page: 2 of 2
Subject: DIVERSION		

Note: Exceptions to diversion:

- a. Airway compromise**
 - b. Traumatic arrest**
 - c. Active seizing**
 - d. Persistent shock**
 - e. Uncontrolled hemorrhage**
 - f. Urgent need for IV access, chest tube, etc**
 - g. Disaster**
5. Each designated trauma service will maintain a diversion log providing time, date and reason for diversion. This log will be made available to the Regional Continuous Quality Improvement Committee (CQI) for review, if required.

IV. QUALITY ASSURANCE

The South Central Region CQI, consisting of at least one member of each designated facilities medical staff, an EMS provider, and a member of the South Central Region EMS & Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The regional CQI Committee will analyze data for patterns and trends and compliance with Regional standards of trauma care.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #9	Effective Date: 05/22/97	Page: 1 of 2
Subject: BASIC LIFE SUPPORT/INTERMEDIATE LIFE SUPPORT AMBULANCE RENDEZVOUS WITH ADVANCED LIFE SUPPORT AMBULANCE		

I. STANDARD

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

II. PURPOSE

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

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional Patient Care Procedures. The Regional Council will make a recommendation to Department of Health that the COPs be approved.
2. Local EMS & Trauma Care Councils and MPDs that choose not to adopt their own protocol or policy shall adhere to the following procedures:
 - a. Emergency Medical Dispatch Guidelines will be used to identify critically ill or injured patients.
 - b. When an ALS response is deemed necessary or requested, the ALS service shall be dispatched with the BLS/ILS ambulance or as soon as possible.
3. The BLS/ILS ambulance may request ALS ambulance rendezvous at anytime.
4. Based on updated information, BLS/ILS personnel either while in route or on scene may determine that ALS intervention is not needed. The responding ALS ambulance may be notified and given the option to cancel.
5. Upon rendezvous, the method of transport, i.e., BLS vehicle or ALS vehicle shall be in the best interest of the patient’s care in accordance with RCW 18.71.210.

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #9	Effective Date: 05/22/97	Page: 2 of 2
Subject: BLS/ILS AMBULANCE RENDEZVOUS WITH ALS AMBULANCE		

IV. DEFINITION

1. **ALS** – Advanced Life Support as defined in WAC 246-976.010.
2. **Attempted** – After identification of the need for ALS intervention, every effort will be made to arrange a BLS/ILS ambulance with ALS ambulance rendezvous.
3. **BLS** – Basic Life Support as defined in WAC 246-976-010.
4. **Emergency Medical Dispatch Guidelines** – Established and accepted emergency medical dispatching guidelines that utilize specific questions and responses to determine EMS levels to be dispatched.
5. **ILS** – Intermediate Life Support as defined in WAC 246-976-010.
6. **Rendezvous** – A pre-arranged agreed upon meeting either on scene, in route from or another specified location.

V. QUALITY IMPROVEMENT

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #10	Effective Date: 05/22/97	Page: 1 of 1
Subject: TRAUMA SYSTEM DATA COLLECTION		

I. STANDARD

Trauma verified Emergency Medical Service (EMS) agencies and designated trauma services shall collect the required Trauma Registry data. Trauma Services will submit Trauma Registry Data to the Department of Health (DOH) per WAC.

II. PURPOSE

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

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional Patient Care Procedures. The Regional Council will make a recommendation to DOH that the COPs be approved.
2. EMS agencies will identify trauma patients using the parameters set by the Washington State Trauma Triage Destination Procedure or other DOH approved triage tool.
3. Designated trauma services will identify trauma patients using the Trauma Registry inclusion criteria.

IV. QUALITY IMPROVEMENT

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #11	Effective Date: 09/15/99	Page: 1 of 2
Subject: ROUTINE EMS RESPONSE OUTSIDE OF RECOGNIZED SERVICE COVERAGE ZONE		

I. STANDARD

Establish a continuum of patient care per the South Central Region EMS & Trauma Care Council’s Trauma Plan.

II. PURPOSE

1. Provide an avenue for reliable EMS agency relationships and coordination of optimal trauma/medical patient care as described in the Regional Trauma Plan.
2. Provide for the safety of crews, patients, the public and other emergency responders.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional Patient Care Procedures. The Regional Council will make a recommendation to Department of Health that the COPs be approved.
2. Local EMS & Trauma Care Councils will identify EMS agencies within the South Central Region and from other regions who routinely respond into areas beyond their recognized service coverage zone to provide ambulance service.
3. Local EMS & Trauma Care Councils will identify and encourage specific EMS Mutual Aid Agreements among EMS agencies that routinely respond into other service coverage zones that address the following:
 - a. Dispatch Criteria
 - b. Highest level of appropriate trauma verified EMS care utilized
 - c. Transport to the appropriate designated trauma service or medical facility

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #11	Effective Date: 09/15/99	Page: 2 of 2
Subject: ROUTINE EMS RESPONSE OUTSIDE OF RECOGNIZED SERVICE COVERAGE ZONE		

4. Establish emergency response routes and notification standards.
 - a. When in route to a facility outside routine response area for the purpose of patient transfer, and when the response requires emergency response that crosses jurisdictional boundaries of counties, the base dispatch center may contact dispatch centers in those jurisdictions giving the route of travel, time of estimated arrival and destination.
 - b. If transporting agency will be leaving the area in an emergency response mode, the procedure above may be followed.

IV. DEFINITION

1. **Routine** – Usual or established “response zone”.
2. **Response Area** – A service coverage zone identified in an approved regional trauma plan.
3. **Emergency Response** – Defined as a response using warning devices such as lights and sirens and use of Opticom devices where available.

V. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURE #12	Effective Date: 09/15/99	Page: 1 of 2
Subject: EMERGENCY PREPAREDNESS/SPECIAL RESPONDERS		

I. STANDARD

Each county Emergency Management Administration within the South Central Region shall have a written Emergency Preparedness plan that includes EMS and health care facilities per Revised Code of Washington (RCW) and Washington Administrative Code (WAC).

II. PURPOSE

To assure that the county Emergency Preparedness written plan addresses EMS and designated trauma services roles and responsibilities in multi-casualty and disaster incidents.

III. PROCEDURE

1. Each local EMS & Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** described above. The local Council will provide the Regional Council with a copy of their COPs for review, adoption and inclusion with the Regional Patient Care Procedures. The Regional Council will make a recommendation to Department of Health that the COPs be approved.
2. Local EMS & Trauma Care Councils will verify that EMS agencies and designated trauma services roles and responsibilities in county emergency preparedness plans are included and accurate.

V. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURES # 13	Effective Date: 12/2005	Page: 1 of 2
Subject: ALL HAZARDS-MCI-SEVERE BURNS		

I. STANDARD

During an all hazards mass casualty incident (MCI) that can include severely burned adult and pediatric patients;

1. All verified ambulance and verified aid services shall respond as requested to an MCI per local MCI plans, County Operating Procedures and Regional Patient Care Procedures.
2. When activated by dispatch in support of the local MCI Plan and/or in support of verified EMS services, all licensed ambulance and licensed aid services may respond to assist during an MCI.
3. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
4. All EMS agencies working during an MCI event shall operate within the National Incident Management System (NIMS).

II. PURPOSE

1. To develop and communicate the information of the South Central Region EMS & Trauma System Plan, Section VII prior to an MCI.
2. To implement local MCI plans during an MCI.
3. To provide trauma care including burn for at least 50 severely injured adult and pediatric patients within the South Central Region.
4. To provide safe mass transportation with pre-identified personnel, equipment and supplies per the approved local MCI plan.

III. PROCEDURE

1. Incident Commanders shall follow the local MCI Plan to inform medical control when an MCI condition either CBRNE or NON-CBRNE exists.
2. Medical Program Directors have agreed that local protocols will be used by the responding agencies throughout the transport of patients, whether it is in another county, region or state. This will ensure consistent patient care in the field by personnel trained to use specific medications, equipment, procedures, and/or protocols until the patient is delivered to a receiving facility.
3. EMS personnel may use the "Region 8 Hospital Multi Casualty Incident (MCI) Response Algorithm during the MCI incident.

South Central Region EMS & Trauma Care Council		
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IV. DEFINITION

CBRNE – Chemical, Biological, Radiological, Nuclear, Explosive

V. QUALITY ASSURANCE

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

South Central Region EMS & Trauma Care Council		
PATIENT CARE PROCEDURES #14	Effective Date: 12/2006	Page: 1 of 1
Subject: EMERGENCY MEDICAL SERVICES PROVIDERS IN THE SOUTH CENTRAL REGION IDENTIFY TRENDS OF ILLNESS OR POTENTIAL TERRORISM EVENTS		

I. STANDARD

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

II. PURPOSE

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

III. PROCEDURE

1. Any EMS Provider who recognizes a trend/cluster of chief complaints or signs and symptoms such as but not limited to flu-like symptoms, respiratory symptoms, rash or unusual burns, will inform their county Public Health officials.
- 2.

Health Dept	Main Telephone
Benton/Franklin Health District	509-943-2614
Columbia Co. Health District	509-382-2181
Kittitas Co. Health District	509-962-7615
Klickitat Co. Health Dept.	509-733-4565
Walla Walla Co. Health Dept.	509-542-2650
Yakima Health District	509-575-4040

IV. QUALITY ASSURANCE

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

South Central Region Appendices A

EMS Trauma Verified Needs by County Trauma Response Areas

Benton County needs for EMS Trauma Verified Services

1. A BLS Trauma Verified Ambulance Service in Benton County Trauma Response Area # 2.b.
2. A Trauma Verified BLS Aid Service in the rural western portion of Benton County in Trauma Response Areas #5 and #6.

Columbia County need for EMS Trauma Verified Services

1. An ILS/ALS Trauma Verified Ambulance Service in Columbia County Trauma Response Area #1.a.
2. A BLS Trauma Verified Aid Service in Columbia County Trauma Response Area #1, in the combined department boundaries of Columbia County Fire District #2 and Walla Walla County Fire District #2.
3. A BLS Trauma Verified Aid Service in Columbia County Trauma Response Area #1.a, in the Tucannon Recreational Area, located in the eastern portion of Columbia County. Increased EMS responses and acuity of EMS responses justify this need.

Franklin County needs for EMS Trauma Verified Services

1. A Trauma Verified ILS/ALS Ambulance in Franklin County Trauma Response Area #2.
2. A Trauma Verified ILS Ambulance in Franklin County Trauma Response #3.
3. BLS Trauma Verified BLS Aid Services to do a tiered response with the BLS Trauma Verified Ambulance service in Franklin County Trauma Response Areas #2 and #3.
4. An ILS or BLS response to Franklin County Trauma Response Area #3 may be better served if response came from the BLS Aid Service in Franklin County Trauma Response Area 1.b.

Kittitas County need for EMS Trauma Verified Services

1. A BLS Trauma Verified Aid Service in Kittitas County Trauma Response Area #2, f, in the area of Blewitt Pass.

Walla Walla County need for EMS Trauma Verified Services

1. A BLS Trauma Verified Aid Service in Walla Walla County Trauma Response Area #g.
2. An ILS Trauma Verified Ambulance Service in Walla Walla County Trauma Response Area #1.j.

Yakima County needs for EMS Trauma Verified Services

1. Verified 1. Ambulance Services in Yakima County Trauma Response Areas #1.h, #1.i, #1.f, #1.k and #2.
2. A BLS Trauma Verified Aid Service in Yakima County Trauma Response Area #4, between the towns of Mabton and Bickleton as defined by the boundaries of Yakima County Fire District #7.