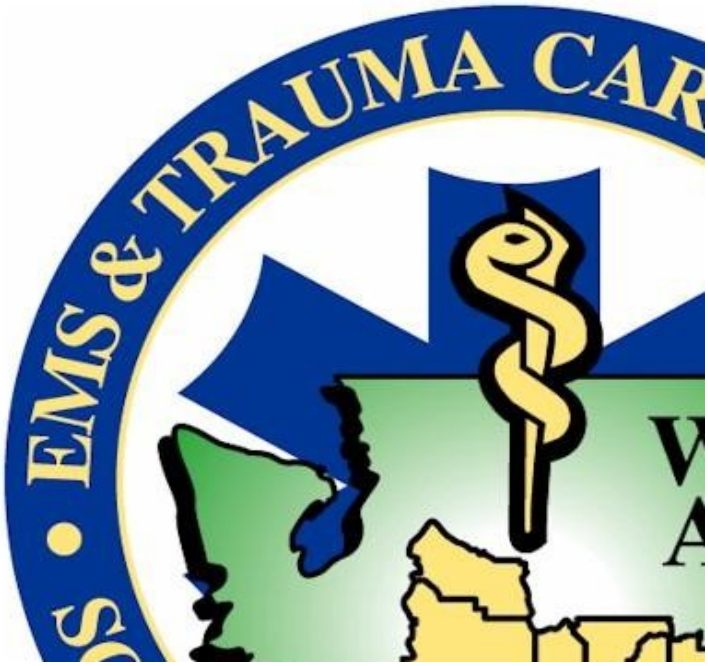
South Central Region
EMS and Trauma Care Council

System Plan

July 1, 2017 – June 30, 2019



Submitted By: South Central Region EMS and Trauma Care Council
Approved by EMS and Trauma Steering Committee on May 17, 2017
Revised January 2018

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The South Central Region Emergency Medical Services (EMS) and Trauma Care Council's (Regional Council) mission is to promote and support a comprehensive emergency medical care system in Columbia, Mid-Columbia (Benton and Franklin), Kittitas, Walla Walla, and Yakima counties in collaboration with the Washington State EMS system. The Regional Council is responsible for the coordination and planning of the EMS and Trauma Care System in the region as well as providing resources including technical assistance and grant funding to County EMS and Trauma Care Councils (County Council), EMS agencies, and system partners. The Regional Council also serves as a liaison between state, county, and EMS agencies. It is comprised of appointed volunteer representatives from EMS agencies, fire districts, hospitals, county Medical Program Directors (MPD), 911 dispatch centers, law enforcement, injury prevention, rehabilitation, air medical, disaster preparedness, and community members. The diverse representation of dedicated decision makers on the Council is extremely beneficial to the EMS system in the region and statewide.

The Regional Council is empowered by legislative authority in the Revised Code of Washington (RCW 70.168.100-70.168.130) and in the Washington Administrative Code (WAC 246.976.960) to plan, develop, and administer the EMS and trauma care system. The RCW and WAC task the Regional and County Councils with system planning, evaluation, and making quality improvement recommendations to the State EMS and Trauma Steering Committee and the Department of Health (DOH). These tasks are in the goals, objectives, and strategies. The Regional Council seeks input from EMS system partners such as MPDs, EMS agencies, County Councils, and state level EMS representatives, so that all have a voice in the development of a practical, system-wide approach to coordination and planning of the EMS system. Each objective in this plan has been designed to build upon previous projects so time and effort is spent as efficiently as possible. The plan objectives and strategies are accomplished either by an ad hoc committee, by the entire council during council meetings, in conjunction with county councils, or with a tiered mix of approaches. In the past the Regional Council maintained a number of standing sub-committees; however, this created an environment where the same small group of people shouldered the majority of the work. Standing sub-committees have been replaced by ad hoc workgroups which are appointed as needed; this change has fostered a more inclusive "all hands" approach.

The Regional Council is a private 501(c)3 nonprofit primarily funded by contracting with the Washington State Department of Health (DOH) to complete the work in the plan. The contract specifies that 50 percent of funding be allocated to administrative work and 50 percent be used for programs. Programs in the region include prehospital EMS training, injury prevention initiatives, and other special projects in support of the system but not specified in the plan. The South Central Regional Council and Southwest Regional Council have successfully consolidated administrative services via contract since July 2012. This consolidation has reduced the duplication of administrative services and, significantly reducing expenses. It also allows both regions to accomplish the work of the DOH contract while maintaining the same level of system support. Additionally, any outside grants the Regional Council receives can be used solely for that specific program

or project.

The Regional Council works closely with County Councils to ensure that local issues are addressed as they arise, important information is relayed from the DOH and system partners to the local agencies and county-level providers, and that information on programs and services which are working in one county can be easily shared with other counties in the region. Representatives from each County Council participate on the Regional Council as well as on various state level EMS workgroups. Regional Council staff participates at County Council meetings. The counties have worked collaboratively in many different areas including sharing MPDs, holding multi-county EMS courses, sharing templates for County Operating Procedures (COPs) and other policies, etc.
The following is a brief description of each county:

- Columbia County is located in the southeast corner of Washington State. This is a small, rural county with a population of 4,100, making it the third least populous county in Washington.
- The Mid Columbia EMS Council encompasses both Benton and Franklin counties. Benton County has a population of 175,000 and includes the Hanford site as well as many wineries and agricultural areas. Franklin County has a population of 78,000 and includes part of the Hanford site. The Columbia River bisects both counties.
- Kittitas County has a population of 41,000 and is home to Central Washington University. The county is mostly rural and spans the Cascade Mountains, from the upper Yakima River Valley to the Columbia River.
- Walla Walla County has a population of 58,000. This county is mostly rural and agricultural in nature, and situated along the Columbia River.
- Yakima County has a population of 243,000 and includes the Yakima Indian Reservation, which is the 15th largest reservation in America. The county includes a major mountain (Mt Adams) recreational destination, vast tracts of farmlands, orchards, and viticulture regions.

Services and Facilities

Pre Hospital Verified Services
Shown in the Prehospital Verified Services chart is the total number of agencies and verification level in each county. The verification demonstrates the level of personnel training and equipment requirements for each trauma verification level.
http://www.doh.wa.gov/Portals/1/Documents/2900/emslic.pdf

COUNTY	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS
Benton	3			1	2	5
Columbia	1			1		
Franklin				2		2

Kittitas	7			2		2
Walla Walla	6			3		1
Yakima	16				1	3

*Numbers are current as of the date submitted

Designated Trauma and Rehabilitation Care Facilities

Shown in the Designated Trauma Care Facilities chart is the total number of hospital receiving facilities in each county. The designation level demonstrates the level of trauma service available.

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

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

Categorized Cardiac and Stroke Facilities

Shown in the Categorized Cardiac and Stroke Facilities chart is the total number of participating categorized hospitals in each county. The categorized level demonstrates the level of Cardiac and /or Stroke services available.

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

Cardiac Level I	Cardiac Level II	Cardiac Uncategorized	Stroke Level I	Stroke Level II	Stroke Level III	Stroke Uncategorized
5	8		0	8	4	

Successes and Challenges

The Regional Council had a number of successes during the 2015-2017 planning period:

- The Regional Council accomplished the work outlined in the 2015-2017 plan including updating min/max numbers, reviewing trauma response area maps, providing training grants to all County Councils.
- The Regional Council extended training grant options by instituting a scholarship program for training new providers, while also continuing direct course reimbursement to County Councils. This has been especially useful in smaller counties, which do not have enough students for a full class. By using scholarships, students may attend initial EMS classes in neighboring counties, thus ensuring that all students have the opportunity to attend EMS classes.
- The Regional Council bolstered system sustainability, as well as council member education, through the system component reviews. An educated membership builds future system leaders for succession planning.

- The Regional Council has had more collaboration in the area of all hazards preparedness. County Councils reported working more closely with their local department of emergency management (DEM) on all hazard training and preparedness, including holding exercises and drills, and have had better County Council participation by local DEM representatives. This is beneficial for future all-hazards planning regional integration.
- The SC and SW Regional Council jointly instituted a council training conference. The training was open to all county and regional council members. The aim of the training is to ensure council members understand the role of the council, member orientation, fiscal best practices, program development, and leadership development. The Regional Council's intent is this will become an annual event.

The Regional Council has also encountered a number of ongoing challenges during the 2015-2017 plan period, which we intend to address during the 2017-2019 plan period:

- The Regional Council has multiple vacant positions. It is a challenge to find volunteers to participate on the council. Since time and travel seem to be two of the main barriers to council meeting attendance, the Regional Council provides remote conferencing services for Regional and County Council meetings to increase participation and engagement. This allows effective use of time and saves travel expenses. To further increase participation, beginning in March 2017, the Regional Council and Regional Quality Improvement (trauma, cardiac and stroke) committees will meet on the same day and location; since many of the members participate in both meetings this will save travel time and expense, and likely increase attendance at both.
- Local rural volunteer EMS agencies continue to struggle with finding enough volunteer EMS providers. This is a critical need for our counties, since the majority of agencies in the region are staffed by volunteers. The Regional Council training grants have assisted with new volunteer education, however, recruitment and retention is an ongoing challenge.
- Adequate sustainable funding remains a challenge for the region. The region applied for several grants in order to increase training and injury prevention funding without success. The effort to increase funding for both general support and to increase funding for training and injury prevention will continue.
- Important EMS and trauma system documents such as PCPs, COPs, and the regional system plan are accessible and, most importantly, useful to the EMS providers in the region, however many providers are not aware of these documents. During the planning period both Regional Council and County Councils will work to determine how best to overcome this challenge.

In conclusion, the work set forth in this plan is designed to meet and exceed the responsibilities found in RCW and WAC, and enhance the EMS and Trauma Care System in the South Central Region.

GOAL 1 **Work toward a sustainable regional emergency care system that provides high-quality emergency medical, trauma, cardiac and stroke patient care through workforce development, appropriate capacity, and distribution of resources.**	
The Regional and County Councils are, as directed by RCW and WAC, are tasked to provide objective system-level analysis and make recommendations for system quality improvements where needed. To advance the system during this plan period, the Council will take proactive steps to complete an analysis of the EMS system components to assess the current effectiveness, and efficiencies for system quality improvement. The success of this work will be assured by giving each County Council, local agency, hospital, and dispatch center the ability to report what is working, what's not, and to suggest practical solutions. This activity has the potential to increase EMS agency involvement with the County Councils in order to provide local expertise, to collaborate on solutions to system challenges, and most importantly give them a voice in the future direction of the system. The information drawn from an analysis of the system components will improve operations throughout the Region and Counties by creating a better understanding of why standing practices are in place, adjusting these practices if necessary, and/or implementing the practical solutions to fine-tune the system as needed. Minimum/Maximum (min/max) numbers are in place to reduce inefficient duplication of resources and provide service to underserved and unserved areas. Min/Max numbers outline the levels of designated trauma, pediatric, rehabilitation services, and prehospital trauma verified services, and self-categorized cardiac/stroke system facilities within the region. There are areas within the counties with no local EMS agencies or agencies which do not transport that cause the burden of response to fall on neighboring agencies on a "mutual" aid basis. This strains the neighboring EMS agencies resources in fulfilling their primary responsibilities by being out of district and extending response times. The domino effect has all agencies doing the best they can to meet an ever increasing need. An in depth analysis of the distribution of services, coordinated by the Regional Council and the CQI Committee, will identify unserved and underserved areas and specific unmet system needs related to designation and verification. The Regional Council and the MPDs will use the information gained for future system planning	
Objective 1 By March 2018, the Regional Council will identify served, underserved and unserved areas within the region.	Strategy 1 By November 2017, Regional Council will analyze the state list of EMS agency's status and contact information to ensure the region's list is congruent with the state's list.
	Strategy 2 By November 2017, the Regional Council will request that each agency which routinely serves an area outside of its primary taxing jurisdiction provide documentation of any formal or informal MOUs.

	Strategy 3 By January 2018, the County Councils will be asked to review and update the trauma response area maps to accurately reflect the current the level of service provided in each area of the county and will provide the results to the Regional Council.
	Strategy 4 By March 2018, the Regional Council and CQI Committee will analyze the information provided and update trauma response area maps as needed and submit changes to DOH.
Objective 2 By November 2018, the Regional Council will review and determine verified prehospital EMS service min/max numbers.	Strategy 1 By March 2018, the County Councils will be asked to review the current verified prehospital EMS service min/max numbers to determine if any changes are needed.
	Strategy 2 By May 2018, the County Councils will vote to recommend any requested changes to the current verified prehospital EMS service min/max numbers.
	Strategy 3 By September 2018, the Regional Council will review the recommendations submitted by each County Council of the verified prehospital EMS service min/max numbers and make a determination.
	Strategy 4 By November 2018, or upon approval of the Steering Committee and DOH, the revised verified prehospital EMS service min/max numbers will be added to the Regional System Plan.
Objective 3 By May 2019, the Regional Council will review and determine designated trauma and rehabilitation service min/max numbers.	Strategy 1 By January 2019, the CQI Committee will be asked to review the current designated trauma and rehabilitation service min/max numbers to determine if any changes are needed.
	Strategy 2 By March 2019, CQI Committee will recommend any requested changes of the current designated trauma and rehabilitation service min/max numbers.
	Strategy 3 By May 2019, Regional Council will review any recommended changes submitted by the CQI Committee of the designated trauma and rehabilitation service min/max numbers and take action.
Objective 4 By March	Strategy 1 By November 2017 Regional Council will

2018, the Regional Council will review and document categorized cardiac and stroke facilities.	analyze the state list of categorized cardiac and stroke facilities and contact information to ensure the region's list is congruent with the state's list.
	Strategy 2 By January 2018 at the Regional Council will ask each categorized cardiac and stroke facilities how quality improvement is being done internally and if the facility is participating in the regional quality improvement program.
	Strategy 3 By March 2018, the updated list of categorized cardiac and stroke facilities will be distributed to MPDs, County and Regional Council Members, and added to the Regional System Plan.

GOAL 2 **Prepare for, respond to, and recover from public health threats through collaboration within the Region and County Councils comprised of multi-disciplinary health care providers and partners who are fully engaged in emergency care service system to increase access to quality, affordable, and integrated emergency care.**	
The Regional Council provides system planning and coordination and a forum to address emerging issues. For example: implementation of the Cardiac / Stroke System, revise PCPs to accommodate WAC changes, and prehospital emergency preparedness planning. The Regional Council Members are a conduit for system information among our partners including the County Councils, MPDs, prehospital EMS agencies, hospitals, public health, emergency management, emergency dispatch centers, and other EMS and trauma system stakeholders. Organizational and leadership training is necessary to help sustain and advance this level of multidisciplinary collaboration. Region Council Members serve on a variety of Steering Committee Technical Advisory Committees (TACs), County EMS and Trauma Care Councils, Public Health Preparedness Committees, as well as interagency workgroups. To facilitate ongoing system communication, agency contact and verification status information is periodically updated and reconciled with DOH records. The Council Members remain dedicated to accomplishing system work in a cost effective and efficient manner, through direct engagement in the business management process. In an effort to improve Regional Council sustainability and maximize diminishing funds, the Southwest and South Central Regions contracted with each other to consolidate business administration in 2012. By contract, the Southwest Regional Council provides administrative services for the South Central Regional Council. Each Region will remain a separate business entity. Both Regions maintain their respective council structures, bylaws, and operations. The regions have instituted monthly fiscal control payment procedures. Vouchers for payment and supporting documentation are prepared by the executive director, and then are reviewed for accuracy and adequate supporting documentation by an outside bookkeeper and check preparer. A list of transactions is sent to the council's executive committee for email approval to process payments. Checks, vouchers, and supporting documentation are sent to the treasurer for signature and mailing. The transaction check stubs and support are returned to the executive director for record maintenance. Continually working with a CPA firm has kept the regions prepared for periodic audits by the Washington State Auditor's Office (SAO). The Regional Councils individually contract with DOH to implement the regional system plan work and maintain system functionality through localized planning, system component evaluation, and providing system recommendations where needed. To efficiently accomplish these objectives and strategies the Southwest Region and South Central Region work plans mirror each other.	
Objective 1 By January	Strategy 1 By September 2017, the Regional Council will

2018, the Regional Council will coordinate and facilitate open communication with system partners to enhance EMS and trauma care within the region.	coordinate and host regular meetings in September, November, January, March, and May. If needed, a July meeting will be held.
	Strategy 2 By November 2017, each County Council will coordinate and host regular County Council meetings as scheduled at the beginning of each year.
	Strategy 3 Ongoing, the Regional Council will maintain an up-to-date website with pertinent Regional and County Council information.
	Strategy 4 By September 2017, the Regional Council will create and distribute a monthly e-newsletter containing council related news and information, training opportunities, injury prevention information, etc. to EMS agencies in the region and system partners.
	Strategy 5 By January 2018, a Regional Council representative will participate in EMS and Trauma related meetings, committees, and workgroups as practical including County Council meetings, State EMS Steering Committee, Regional Advisory Committee (RAC), DOH Office of Community Health meetings, WAC revision, and Regional QI meeting, etc.
Objective 2 By November 2017, the Regional Council will provide continuous financial and business oversight.	Strategy 1 By September 2018, the Regional Council will elect Executive Board Officers per the region's bylaws.
	Strategy 2 By July annually, the Regional Council will renew the contract with DOH for implementation of the System Plan and maintain ongoing contractual compliance oversight.
	Strategy 3 By July annually, the Regional Council will renew the contract with the South Central Regional for administrative services and maintain ongoing contractual compliance oversight.
	Strategy 4 Monthly the Regional Council bills will be paid in accordance with the fiscal control policies.
	Strategy 5 By September 2017, at each Regional Council meeting, financial reports including transaction detail will be provided for review and approval.

	Strategy 6 By June annually, the Regional Council will approve a budget for the new fiscal year.
	Strategy 7 By August annually, the approved budget for the new fiscal year will be submitted to the DOH.
	Strategy 8 By November annually, the BARS report will be submitted to the State Auditor's Office, as required.
Objective 3 By May 2018, the Regional Council will periodically review and revise governing and operational documents.	Strategy 1 By January 2018, the current bylaws will be discussed at a regular council meeting and emailed to all Council Members for review and suggested updates.
	Strategy 2 By March 2018, Regional Council will discuss whether the current positions as outlined in the bylaws ensure broad representation of system partners in the Region.
	Strategy 3 By March 2018, the bylaw revisions will be drafted based on suggestions, then will be emailed to all Council Members for review 30 days prior to approval.
	Strategy 4 By May 2018, the Regional Council will vote on the revised draft bylaws. The approved bylaws will be distributed to all Council members and put on the region's website.
	Strategy 5 By January 2018 the office policies document will be discussed at a regular council meeting and emailed to all Council Members for review seeking suggested updates.
	Strategy 6 By March 2018, the office policies document revisions will be drafted based on suggestions, then will be sent to all Council Members prior to the Regional Council meeting for review.
	Strategy 7 At the May 2018, Regional Council meeting, the revised office policies document will be on the agenda for approval.
Objective 4 By June 2018, the Regional Council will promote sustainability, leadership, and succession	Strategy 1 By July 2017 Regional and County Council information will be available on the region's website (meeting schedules, council documents, new member packet, etc.).

planning to ensure the continued growth and development of the Council.	Strategy 2 By June annually the Regional Council will host a council training conference (topics will address system information, Regional and County Council sustainability, leadership, and succession planning to ensure the continued growth and development of the Councils).
	Strategy 3 By March 2018, invitations to the council training conference will be extended to all Regional and County Council members from around the state, and system partners.
	Strategy 4 By June 2018, a copy of the agenda and summary report of the outcome of the council training conference will be presented at the next Regional Council meeting and submitted to DOH.
Objective 5 By June 2019, the Regional Council will develop the next Regional System Plan.	Strategy 1 By November 2018, the Regional Council will begin the process of developing the next Regional System Plan (2019-2021) by providing all council members a copy of the Plan Development Guidance from DOH.
	Strategy 2 By November 2018, Council Members and County Councils will be emailed the current plan and be asked to submit any suggestions for the next System Plan.
	Strategy 3 By January 2019, the Regional Council will revise the System Plan with any suggested changes from County Councils, members as well as information provided by the DOH.
	Strategy 4 By February 2019, the draft System Plan will be provided to the Regional Council Members for further input, review, and approval.
	Strategy 5 By March 2019, the Regional Council approved System Plan will be submitted to the DOH for approval.
	Strategy 6 By June 2019, the DOH approved System Plan will be sent to all Regional Council members and system partners as well as placed on the Region's website.

GOAL 3

Promote and enhance the sustainability of the emergency care system by educating providers, utilizing standardized evidence-based procedures and performance measures, and continuous quality improvement.

Some of the most important components of the regional EMS system are contained in this goal namely: EMS provider training, ongoing development of PCPs/COPs, and data collection and utilization. The Regional Council will review these parts of our trauma system in order to ensure the system continues to evolve to meet the needs of the EMS system providers as well as the residents, visitors, and citizens in our region. Regional Patient Care Procedures (PCPs) as well as County Operating Procedures (COPs) are in place to get the right patient, to the right care destination, in the right amount of time thus improving the patient outcome by reducing morbidity and mortality. Regional PCPs provide operational guidelines throughout the Region. Some of the County Councils have also developed COPs with their MPDs to provide county specific operational guidelines. The Regional Council reviews the COPS to assure they are congruent with the PCPs and in line with prehospital system operations.

EMS agencies continually strive to meet increasing operational requirements. Providing EMS services comes at a cost of time, effort, and money for essentials such as initial and ongoing training for EMS providers, ambulance supplies, gear for employee and volunteer use, and keeping up with the continual evolution of technology used in the field to provide ever-advancing emergency medical care to the residents, visitors, and citizens of our region. All facets are dependent on diminishing resources. To bridge the gap of training resources, the Regional Council provides training grant funding to each County Council to supplement the unique needs of each County. The Region emphasizes support to encourage volunteers directly by offsetting training costs. Volunteers remain the backbone of the rural EMS and Trauma System.

Objective 1 By June annually, the Regional Council will support training for prehospital EMS providers.	Strategy 1 By March annually, the Regional Council will initiate a grant process to support prehospital training for the next fiscal year by requesting each County Council conduct a training needs assessment.
	Strategy 2 By August annually, the County Councils will submit grant applications for the following fiscal year.
	Strategy 3 By September annually, the Regional Council will allocate available funding to support prehospital training based on locally identified training need priorities.
	Strategy 4 By September annually, the Regional Council will establish grant contracts with each County Council for prehospital training.
	Strategy 5 By June annually, grant funds will be distributed

	throughout the year as training occurs and complete documentation received by the Region.
	Strategy 6 By June annually, the Regional Council grants contract administration will be completed for the fiscal year.
Objective 2 By March 2019, the Regional Council will review and revise the Regional Patient Care Procedures (PCPs) as needed and work toward statewide standardization of PCPs.	Strategy 1 By September 2017, as available the Regional Council will work with the RAC, and DOH, to standardize PCPs.
	Strategy 2 By September 2017, the Regional Council in collaboration with DOH will provide a training session on the process of development and uses of PCPs and COPs.
	Strategy 3 By September 2018, all Regional Council members will be provided a copy of the current PCPs and asked for suggestions for review and revision.
	Strategy 4 By January 2019, region staff will collate all suggested PCPs edits and provide a copy of the revised draft PCPs for Council Member review.
	Strategy 5 By March 2019, the draft revised PCPs will be considered for approval at a Regional Council meeting.
	Strategy 6 By March 2019 the Council approved PCPs will be submitted to the DOH for approval.
Objective 3 By March 2019, the County Councils will review and revise County Operating Procedures (COPs), and ensure consistency with the PCPs and definitions in RCW and WAC (insert link to RCW and WAC).	Strategy 1 By May 2018, the Regional Council in collaboration with the DOH, will provide a training session for County Councils on the process of development and uses of PCPs and COPs.
	Strategy 2 By May 2018, the Regional will request each MPD and County Council review and revise the COPs and ensure COPs address operations that are specific to the county and not addressed in the PCPs.
	Strategy 3 By September 2018, each MPD and County Council will vote on revised COPs, and submit approved revised COPs to the Regional Council and DOH for approval.
	Strategy 4 By December 2018, the draft revised COPs will be considered for approval at a Regional Council meeting.

	Strategy 5 By March 2019, upon DOH approval the Regional Council will post revised COPs or link on the Region's website.
Objective 4 By September 2018, the Regional Council will promote prehospital EMS services participation in the WA EMS Information System (WEMSIS) data collection program.	Strategy 1 By May 2018, the Regional Council will survey EMS agencies to determine data collection and submission to WEMSIS, describe the experience of the transition to the WEMSIS.3 version, as well as identify any barriers to data submission.
	Strategy 2 By September 2018, the Regional Council will provide summary results of the survey to agencies, DOH, WEMSIS TAC, and Regional and County Council Members.
Objective 5 By June 2019, the Regional Council will collaborate with the DOH to develop, review, and revise DOH identified needs assessment tools.	Strategy 1 By March 2019, the Regional Council will work with DOH and RAC on developing and reviewing DOH identified needs assessment tools.
	Strategy 2 By June 2019, the Regional Council will request agency and system partner participation in DOH identified needs assessments.
Objective 6 By June 2019 the Regional Council will identify and explore emerging concepts for Mobile Integrated Healthcare (MIHC)/Community Paramedicine.	Strategy 1 By May 2019, the Regional Council will invite an existing WA Community Paramedic Program representative to present at a Regional Council meeting to increase awareness and identify areas of adaptability to other agencies.
	Strategy 2 By June 2019 or as available, the Regional Council will share information on emerging best practices such as MIHC/community paramedicine.

GOAL 4 **Promote programs and policies to reduce the incidence and impact of injuries, violence, and illness.**	
The first point on the continuum of care is prevention. The Regional Council provides prevention resource information and links to injury prevention activities and organizations on the region website. Area hospitals and EMS agencies also host a multitude of prevention activities that specifically address local issues as well as universal initiatives. Solid evidenced-based injury prevention projects on the small scale that the Regional is equipped to support are rare. The Region Council will continue supporting injury prevention efforts by maintaining prevention resource links on the region website.	
Objective 1 By January 2018, the Regional Council will build sustainable prevention partnerships and share information on prevention, interventions, and outcomes.	Strategy 1 By December 2017, the Regional Council IVP representative will participate in IVP TAC meetings and webinars as available to build sustainable prevention partnerships.
	Strategy 2 By December 2017 or as available, the Regional Council will provide WA State fatal and non-fatal injury data to County Councils and EMS agencies and the Regional CQI committee.
	Strategy 3 By January 2018, the Regional Council will include updated injury prevention news and information on its website for all to access.
	Strategy 4 Each month, the Regional Council will include news and information in its e-newsletter on injury prevention, cardiac/stroke, and trauma.
Objective 2 By June 2018, the Regional Council will encourage collaboration and participation by the County Councils and EMS agencies in Emergency Management (EM) activities.	Strategy 1 By March 2018 or as available the Regional Council will provide notice of, and encourage participation in, EM activities such as drills, exercises, and other events which enhance collaboration and education between EMS and disaster preparedness organizations.
	Strategy 2 By September 2017, the Regional Council will assess the practicality of holding Health Care Coalition meetings in conjunction with Regional Council meeting in order to maximize participation as well as enhance the dissemination of information.
	Strategy 3 By June 2018, the Regional Council will conduct an online survey of all agencies in the region to determine

	what types of EM activities they participate in; this information will be shared with County Councils and the DOH.
Objective 3 By May 2018, the Regional Council will collaborate with the Regional CQI Committee in order to maximize participation as well as dissemination of information.	Strategy 1 By September 2017, the Regional Council will collaborate with the Regional CQI Committee to hold meetings in conjunction with Regional Council meetings in order to maximize participation as well as the dissemination of information.
	Strategy 2 By September 2017, the Regional CQI Committee and MPDs will determine how key performance indicators (KPIs) are being measured by EMS agencies and hospitals.
	Strategy 3 By January 2018, the Regional CQI Committee and MPDs will develop a method to receive KPI measurements and review the KPIs results.
	Strategy 4 By May 2018, the Regional CQI Committee and MPDs will develop system recommendations based on KPIs.
Objective 4 By June 2019, the Regional Council will determine what IVP activities are occurring throughout the region.	Strategy 1 By January 2019, the Regional Council will survey hospitals, EMS Agencies, and County Councils to determine what IVP activities are occurring in the region.
	Strategy 2 By May 2019, the Regional Council will collate the survey results.
	Strategy 3 By June 2019, the Regional Council will provide the report to members, DOH, Hospitals, and EMS agencies.

Appendix 1

Approved Min/Max numbers of Verified Trauma Services

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

South Central Region Prehospital Trauma Verified Service List							
Benton County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Benton County Fire District #1 (Kennewick) AIDV BLS AIDV.ES.00000007	X						
West Benton Fire Rescue (Prosser) AIDV BLS AIDV.ES.60583166	X						
Benton County Fire Protection District #2 (Benton City) AMBV ILS AMBV.ES.00000008					X		
Benton County Fire District #4 (West Richland) AMBV BLS AMBV.ES.60202198				X			
Benton County Fire District #5 (Prosser)AIDV BLS AIDV.ES.60551559	X						
Benton County Fire District #6 (Paterson) AMBV ILS AMBV.ES.00000011					X		
Kennewick Fire Department (Kennewick) AMBV ALS AMBV.ES.00000017						X	
Richland Fire and Emergency Services (Richland) AMBV ALS AMBV.ES.00000018						X	
Hanford Fire Department (Richland) AMBV ALS AMBV.ES.60473490						X	
American Medical Response (Yakima) AMBV ALS AMBV.ES.60789012						X	
Prosser Memorial Hospital EMS (Prosser) AMBV ALS AMBV.ES.00000026						X	
Life Flight Network (Richland, Aurora OR) AMBV ALS AMBV.ES.60661332						X	
Horn Rapids Motorsports Complex (Richland) Licensed AID BLS Licensed AID.ES.60013634							X
Mid Columbia Pre Hospital Care Assn (Kennewick) Licensed AID BLS Licensed AID.ES.60355652							X
Benton County Total	3	0	0	1	2	6	2
Columbia County	AID	AID	AID	AMB	AMB	AMB	Licensed EMS

	BLS	ILS	ALS	BLS	ILS	ALS	Agency (Not Verified)
Columbia County Fire District #1 (Starbuck) AIDV BLS AIDV.ES.00000092	X						
Columbia County Rural #3 (Dayton) AMBV BLS AMBV.ES.00000093				X			
Columbia County Total	1	0	0	1	0	0	0
Franklin County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Franklin County Fire Protection District #3 (Pasco) AMBV BLS AMBV.ES.60334626				X			
Pasco Fire Department (Pasco) AMBV ALS AMBV.ES.00000132						X	
Franklin County PHD #1 (Eltopia, Mesa) AMBV BLS AMBV.ES.00000133				X			
American Medical Response (Yakima) AMBV ALS AMBV.ES.00000024						X	
Franklin County Total	0	0	0	2	0	2	0
Kittitas County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Kittitas County Fire District #1 (Thorp) AIDV BLS AIDV.ES.00000344	X						
Kittitas County Fire District # 3 (Easton)N AIDV BLS AIDV.ES.00000346	X						
Kittitas County Fire District #4 (Vantage) AIDV BLS AIDV.ES.00000347	X						
Kittitas County Fire District #8 (Easton) AIDV BLS AIDV.ES.00000349	X						
South Cle Elum Fire (South Cle Elum) AIDV BLS AIDV.ES.00000358	X						
Kittitas County Fire District #6 (Ronald) AIDV BLS AIDV.ES.60119626	X						
Kittitas Valley Fire and Rescue (Ellensburg) AMBV ALS AMBV.ES.00000345						X	

Kittitas County Fire & Rescue 7 (Kittitas) AMBV BLS AMBV.ES.00000348				X			
Cle Elum Fire Department (Cle Elum) AMBV BLS AMBV.ES.00000354				X			
Upper Kittitas County Medic One (Cle Elum) AMBV ALS AMBV.ES.00000359						X	
Roslyn Fire Department (Roslyn) AID BLS Licensed AID.ES.00000356							X
Kittitas County Total	6	0	0	2	0	2	1
Walla Walla County	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
Walla Walla Fire District #1 (Walla Walla) AIDV BLS AIDV.ES.00000764	X						
Eureka Fire Protection District # 3 (Prescott) AIDV BLS AIDV.ES.00000766	X						
Walla Walla Fire Protection District #6 (Touchet) AIDV BLS AIDV.ES.00000769	X						
Walla Walla Fire Protection District #7 (Prescott) AIDV BLS AIDV.ES.60446434	X						
Walla Walla County Fire District #8 (Dixie) AIDV BLS AIDV.ES.00000771	X						
College Place Fire Depart (College Place) AMBV BLS AMBV.ES.60779352				X			
Walla Walla County Fire District #4 (Walla Walla) AMBV BLS AMBV.ES.00000767				X			
Walla Walla County Fire District #5 (Burbank) AMBV ALS AMBV.ES.60444006						X	
City of Walla Walla Fire Department (Walla Walla) AMBV ALS AMBV.ES.00000777						X	
Columbia-Walla Walla Fire District #2 (Waitsburg) AMB BLS AMBV.ES.60619143				X			
Walla Walla County Total	5	0	0	3	0	2	0
Yakima County Total	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)

Highland Fire Department (Cowiche) AIDV BLS AIDV.ES.00000855	X						
Selah Fire Department (Selah) AIDV BLS AIDV.ES.00000856	X						
Naches Fire Department (Naches) AIDV BLS AIDV.ES.00000857	X						
Yakima County Fire District # 4 (East Valley Yakima) AIDV BLS AIDV.ES.00000858	X						
Yakima County Fire District #5 (Lower Valley) AIDV BLS AIDV.ES.00000859	X						
Yakima County Fire District # 6 Gleed Fire (Yakima) AIDV BLS AIDV.ES.00000860	X						
Naches Heights Fire Department (Naches Heights) AIDV BLS AIDV.ES.00000861	X						
West Valley Fire Department West Valley Yakima) AIDV BLS AIDV.ES.00000863	X						
Nile-Cliffdell Fire Department (Naches) AIDV BLS AIDV.ES.00000864	X						
Grandview Fire Department (Grandview) AIDV BLS AIDV.ES.00000873	X						
City of Granger Fire Department (Granger) AIDV BLS AIDV.ES.00000874	X						
Mabton Fire Department (Mabton) AIDV BLS AIDV.ES.60440190	X						
Toppenish Fire Department (Toppenish) AIDV BLS AIDV.ES.00000879	X						
Wapato Fire Department (Wapato) AIDV BLS AIDV.ES.00000881	X						
Yakima Fire Department (Yakima) AIDV BLS AIDV.ES.00000882	X						
Zillah City Fire (Zillah) AIDV BLS AIDV.ES.00000883	X						
City of Sunnyside Fire Department (Sunnyside) AMBV ALS AMBV.ES.00000877						X	
White Swan Ambulance (White Swan) AMBV ILS					X		

AMBV.ES.00000892							
American Medical Response (Yakima) AMBV ALS AMBV.ES.00000893						X	
Advanced Life Systems (Yakima) AMBV ALS AMBV.ES.00000894						X	
White Pass Co Inc. AID ALS AID.ES.60526766							X
Yakima County Total	16	0	0	0	1	3	1
	AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed EMS Agency (Not Verified)
South Central Region Total Agencies 63	32	0	0	9	3	15	4

Appendix 2

Trauma Response Areas
DOH Map Link to Trauma Response Areas
https://fortress.wa.gov/doh/eh/maps/EMS/index.html

- Trauma Response Areas are used by the Regional Council for planning purposes. The identified areas within the maps are a description of general geographic areas. The maps are used as a means of describing what level of EMS service is available in any given geographic area (i.e. area 1 has 2 BLS AID services and 1 ALS AMB service). Although the trauma response areas identified may sometimes align with an EMS agency borders, the trauma response areas do not determine any EMS agency's actual service boundary. The level of EMS service provided in a given area is in the chart.

***Key: For each level the type and number should be indicated**
Aid-BLS = A Ambulance-BLS = D
Aid-ILS = B Ambulance-ILS = E
Aid-ALS = C Ambulance-ALS = F
Explanation: The *type and number* column of this table accounts for the level of care available in a specific trauma response area that is provided by verified services. Some verified services (agencies) may provide a level of care in multiple trauma response areas therefore the **total type and number of verified services depicted in the table may not represent the actual number of State verified services available in a county; it may be a larger number in Trauma Response Area table. The verified service minimum/maximum table will provide accurate verified service numbers for counties.

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

		boundaries of Benton County Fire District #2	
	#5	Within the current boundaries of Prosser Hospital District, Benton County FD #3, south on Highway 22 to south of Horrigan Road, west boundary the county line, north boundary with trauma service area #3, east boundary with trauma service areas #4 and #6.	A-1 F-1
	#6	Within the current city limits of Paterson, the boundaries of Benton County FD #6, north to Sellards Road, east to Plymouth Road, west to county line, south to the Columbia River, east to boundary with trauma service area #1.	E-1
Columbia County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	#1	Within the boundaries of Columbia County	A-1 D-1
Franklin County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	#1	Within the current City limits of Pasco, Franklin County FD #3 boundaries, and north to Sagemore Road.	A-1 F-1
	#2	Within the boundaries of Franklin County Hospital District #1 that includes the communities of Connell, Mesa, Basin City and Merrill's Corner, west to the Columbia River and south to Sagemore Road.	D-1
	#3	Within the current city limits of Kahlotus and the boundaries of Franklin County Fire District #2	None
Kittitas County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	#1	From the southern county boundary to the east and west county boundaries encompassing the boundaries of Kittitas County Public Hospital	A-3 F-1

		District #1 to Exit 93 (Elk Heights and including Sunlight Waters to the development, *south* on 182 to milepost 18.5 (N. Umptanum turnaround), *south* on SR 821 to mile post 14 (Weimer Cut), *west* on State Route 10 to mile post 93 (east end of Bristol Flats), *west* of Lauderdale on State Route 97, *north* to 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-4 D-2 F-1
Walla Walla County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	#1	Within the current boundaries of Walla Walla County	A-6 D-3 F-1
Yakima County	**EMS & Trauma Response Area #**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available 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	A-16 E-1 F-2

		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.	
	#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

(The appendices within this plan contain detailed charts with specific information for use in system planning. These are living documents and as such change during the plan period.)

Appendix 3

Approved Minimum/Maximum (Min/Max) numbers of Designated Trauma Care Services in the Region (General Acute Trauma Services) by level
http://www.doh.wa.gov/Portals/1/Documents/Pubs/530101.pdf

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

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

Appendix 4

Approved Minimum/Maximum (min/max) numbers of Designated Rehabilitation Trauma Care Services in the Region by level
http://www.doh.wa.gov/Portals/1/Documents/Pubs/689168.pdf

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

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

Designated Trauma Rehabilitation Care Services in the South Central Region		Designated Rehab
County	Facility Name	
Yakima	Yakima Regional Medical & Cardiac Center	II
Benton	Kadlec Regional Medical Center	II
Franklin	Lourdes Medical Center	II
Walla Walla	Providence St Mary Medical Center	II

Appendix 5

Categorized Cardiac and Stroke Facilities
http://www.doh.wa.gov/Portals/1/Documents/Pubs/345299.pdf

Cardiac Level I	Cardiac Level II	Cardiac Uncategorized	Stroke Level I	Stroke Level II	Stroke Level III	Stroke Uncategorized
6	5	0	0	8	3	0

Cardiac Level	Stroke Level	Name	City	County
II	III	Dayton General Hospital	Dayton	Columbia
I	II	Kadlec Regional Medical Center	Richland	Benton
I	II	Kennewick Public Hospital District Trios	Kennewick	Benton
II	II	Kittitas Valley Community Hospital	Ellensburg	Kittitas
II	II	Lourdes Health Network	Pasco	Franklin
II	III	Prosser Memorial Hospital	Prosser	Benton
I	II	Providence St Mary's Medical Center	Walla Walla	Walla Walla
I	III	Sunnyside Community Hospital Assn.	Sunnyside	Yakima
II	II	Toppenish Community Hospital	Toppenish	Yakima
I	II	Yakima Regional Medical Cardiac Center	Yakima	Yakima
I	II	Yakima Valley Memorial Hospital	Yakima	Yakima

Appendix 6

Regional Patient Care Procedures (PCPs)

- Regional PCPs are Department of Health approved written operating guidelines. The PCPs identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an interfacility transfer be necessary. PCPs do not relate to direct patient care as only MPD written, and DOH approved, county protocols direct patient care.

County Operating Procedures (COPs)

- COPs are county-specific operational procedures that are either not addressed in the regional PCPs or diverge in some way from the PCPs. COPs do not relate to direct patient care as only MPD written and DOH approved county protocols direct patient care.

Patient Care Procedures
South Central Region EMS & Trauma Care Council

Table of Contents

DEFINITIONS WAC (246-976-010)

"Region Patient Care Procedures" or "PCPs" means Department of Health (DOH) approved written operating guidelines adopted by the Region emergency medical services and trauma care council, in consultation with the local emergency medical services and trauma care councils, emergency communications centers, and the emergency medical services medical program directors, in accordance with state-wide minimum standards. The patient care procedures shall identify the level of medical care personnel to be dispatched to an emergency scene, procedures for triage of patients, the level of trauma care facility to first receive the patient, and the name and location of other trauma care facilities to receive the patient should an inter-facility transfer be necessary. Patient care procedures do not relate to direct patient care.

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

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

PATIENT CARE PROCEDURE #1
DISPATCH
Effective date: 7/24/1996

Standard

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

service area changes as soon as possible.

D. Dispatchers should be trained in an Emergency Medical Dispatch (EMD) Program.

Purpose

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

Procedure

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

B. Local EMS and Trauma Care Council's should identify primary and secondary PSAPs per county and provide information to the Region Council.

C. The nearest "appropriate" aid and/or ambulance service shall be dispatched per the above standards.

D. Trauma verified and licensed EMS services should proceed in an emergency response mode until they have been advised of non-emergent status.

Definitions

A. **Appropriate** – Defined as the trauma verified or licensed EMS service that responds within an identified service area that can meet the patient care needs. Appropriate agency may be part of a tiered response.

B. **Emergency Response** – Defined as a response using warning devices such as lights, sirens, and use of Opticom devices where available.

C. **PSAP** – Public Safety Answering Point – is a call center regulated by the FCC that is responsible for answering calls to an emergency telephone number for police, firefighting, and ambulance services. Trained telephone operators are also usually responsible for dispatching these emergency services.

D. **Dispatch Interval** – Defined as the time the call is received by the dispatcher to the time the first unit is dispatched.

Quality Assurance

A. The South Central Region Continuous Quality Improvement Committee (CQI), consisting of at least one member of each designated/categorized health care services staff, an EMS provider, and a member of the South Central Region EMS

and Trauma Care Council, have developed a written plan to address issues of compliance with the above standards and procedures. The Region CQI Committee will analyze data for patterns and trends and compliance with Region standards of care.

PATIENT CARE PROCEDURE #2
RESPONSE TIMES
Effective date: 7/24/1996

Standard

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

Purpose

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

Procedure

A. Each local EMS and Trauma Care Council may recommend County Operating Procedures (COPs) that meet or exceed the **STANDARD** and **PURPOSE** of the South Central Region identified above. The local Council will provide the Region Council with a copy of their COPs for review, adoption and inclusion with the Region Patient Care Procedures. The Region Council will make a recommendation to Department of Health that the COPs be approved.
B. Detailed maps of service areas are available through the Department of Health EMS and Trauma web site (http://ww4.doh.wa.gov/gis/ems.htm).
C. Trauma verified aid and/or ambulance services are responsible for documenting the WEMSIS data elements.
D. Included in the WEMSIS information will be unit response times. Verified aid and/or ambulance services shall meet the minimum agency response times to response areas as defined in WAC 246-976-390.

Trauma Verified AID Service

Urban 8 minutes or less, 80% of the time

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

Trauma Verified AMBULANCE Service

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

Definitions

A. **Urban** – Incorporated area over thirty thousand; or an incorporated or unincorporated area of at least ten thousand people and a population density over two thousand people per square miles WAC 246-976-010.
B. **Suburban** – Incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of less than 1,000 to 2,000 people per square mile WAC 246-976-010.
C. **Rural** – Incorporated or unincorporated areas with total population less than 10,000 or with a population density of less than 1,000 per square mile WAC 246-976-010.
D. **Wilderness** – Any rural area that is not accessible by public or private maintained roadways WAC 246-976-010.
E. **Response Time** – Interval of time from agency notification to arrival on the scene. It is the combination of activation and in route times defined under response times WAC 246-976-390.
F. **EMS Personnel** –means an individual certified by the secretary or the University Of Washington School Of Medicine under chapters 18.71 and 18.73 RCW to provide prehospital emergency response, patient care and transportation.
G. **WEMSIS** – Washington EMS Information System

Quality Assurance

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

PATIENT CARE PROCEDURE #3
TRIAGE AND TRANSPORT
Effective date: 7/24/1996

Standard

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

Purpose

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

Procedure

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

a designated/categorized service in accordance with the State of Washington Prehospital Triage Destination Procedures, Region PCPs, and COPs.

3. If Prehospital personnel are unable to effectively manage a patient's airway, an Advanced Life Support (ALS) rendezvous or an immediate stop at the nearest health care service capable of immediate definitive airway management should be considered.
4. South Central Region Designated Trauma services and maps of their locations are available from the DOH web site (http://ww4.doh.wa.gov/gis/ems.htm).

C. Designated trauma services shall have written procedure and protocol for diversion of trauma patients when the facility is temporarily unable to care for trauma patients. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be life saving. **Exceptions to diversion:**
   1. **Airway compromise**
   2. **Traumatic arrest**
   3. **Active seizing**
   4. **Persistent shock**
   5. **Uncontrollable hemorrhaging**
   6. **Urgent need for IV access, chest tube, etc.**
   7. **Disaster**

D. Non Critical Trauma (do not meet trauma, cardiac, or stroke triage tools),
   1. Prehospital personnel may request response or rendezvous with ALS/Intermediate Life Support providers and all EMS providers may request emergency aero-medical evacuation if they are unable to effectively manage a patient.
   2. Medical and injured patients who do not meet Prehospital triage criteria for trauma, cardiac, or stroke system activation will be transported to local facilities according to local MPD protocols, COPs, and Region PCPs.
   3. While in route and prior to arrival at the receiving facility, the transporting agency should provide a complete report to the receiving hospital regarding the patient's status via radio or other approved communication system according to local MPD protocols, COPs, and Region PCPs.

E. Before leaving the receiving facility, the transporting agency will leave a completed approved medical incident report form for all patients. The additional information for the medical incident report (MIR) either written or electronic shall be made available to the receiving facility within twenty-four hours of arrival, in accordance with WAC 246-976-330.

Definitions

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

Quality Assurance

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

PATIENT CARE PROCEDURE #4
INTERFACILITY TRANSFER
Effective date: 7/24/1996

Standard

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

Purpose

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

Procedure

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

Definitions

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

Quality Assurance

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

PATIENT CARE PROCEDURE #5
MEDICAL COMMAND AT SCENE
Effective date: 7/24/1996

Standard

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

Purpose

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

Procedure

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

Quality Assurance

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

PATIENT CARE PROCEDURE #6
EMS/MEDICAL CONTROL COMMUNICATIONS
Effective date: 7/24/1996

Standard

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

Purpose

A. To define methods of expedient communications between Prehospital personnel

and all health care services, including trauma, cardiac, and stroke health care services and medical control.

Procedure

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

Quality Assurance

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

PATIENT CARE PROCEDURE #7
HELICOPTER ALERT, RESPONSE, AND TRANSPORT
Effective date: 7/24/1996

Standard

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

Purpose

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

Procedure

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

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

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

Definitions

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

Quality Assurance

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

PATIENT CARE PROCEDURE #8
DIVERSION
Effective date: 7/24/1996

Standard

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

Purpose

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

Procedure

A. Each local EMS and Trauma Care Council may approve County Operating Procedures (COPs) that meet or exceed the STANDARD and PURPOSE described above. The local Council will provide the Region Council with a copy of their COPs for review and inclusion with the Region PCPs. The Region Council will make a recommendation to DOH that the COPs be approved.
B. Each trauma designated service will have written policies and procedures that outline reasons to divert patients from their service.
C. Designated Trauma Services must consider diversion when essential services including but not limited to the following are **not** available:
    1. Surgeon
    2. Operating room

3. For a Level II—CT
4. For a Level II—Neurosurgeon
5. ER is unable to manage additional patients

D. When the designated/categorized service is unable to manage major trauma, cardiac and stroke patients, they will have an established procedure to notify the EMS transport agencies and other designated services in their area that they are on divert. However, where diversion results in a substantial increase in transport time for an unstable patient, patient safety must be paramount and must over-ride the decision to divert when stabilization in the closest emergency department might be lifesaving. **Note: Exceptions to Diversion:**
   1. Airway compromise
   2. Traumatic arrest
   3. Active seizing
   4. Persistent shock
   5. Uncontrolled hemorrhage
   6. Urgent need for IV access, chest tube, etc.
   7. Disaster

E. Each designated service will maintain a diversion log providing time, date and reason for diversion. This log will be made available to the Region Continuous Quality Improvement Committee (CQI) for review, if required.

F. For Cardiac STEMI patients, there is a "no divert" policy that also identifies a backup plan for situations when the hospital's cardiac care resources are temporarily unavailable.

Quality Assurance

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

PATIENT CARE PROCEDURE #9
BLS/ILS AMBULANCE RENDEZVOUS WITH ALS AMBULANCE
Effective date: 5/22/1997

Standard

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

Purpose

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

Procedure

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

Definitions

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

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

Quality Improvement

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

PATIENT CARE PROCEDURE #10
EMS AND HEALTH CARE SERVICES DATA COLLECTION
Effective date: 5/22/1997

Standard

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

Purpose

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

Procedure

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

approved.

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

Quality Improvement

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

PATIENT CARE PROCEDURE #11
ROUTINE EMS RESPONSE OUTSIDE OF RECOGNIZED SERVICE AREA
Effective date: 9/15/1999

Standard

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

Purpose

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

Procedure

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

the COPs be approved.

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

Definitions

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

Quality Assurance

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

PATIENT CARE PROCEDURE #12
EMERGENCY PREPAREDNESS/SPECIAL RESPONDERS

Effective date: 9/15/1999

Standard

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

Purpose

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

Procedure

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

Quality Assurance

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

PATIENT CARE PROCEDURE #13
ALL HAZARDS/MCI/SEVERE BURNS
Effective date: 12/2005

Standard

A. During an all hazards mass casualty incident (MCI) that can include severely

burned adult and pediatric patients;

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

Purpose

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

Procedure

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

Definition

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

Quality Assurance

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

PATIENT CARE PROCEDURE #14
EMS PROVIDERS IN THE SOUTH CENTRAL REGION IDENTIFY TRENDS OF ILLNESS OR POTENTIAL TERRORISM EVENTS
Effective date: 12/2006

Standard

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

Purpose

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

Procedure

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

Health Department	**Main Telephone**

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

Quality Assurance

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

PATIENT CARE PROCEDURE #15
CARDIAC TRIAGE AND TRANSPORT DESTINATION PROCEDURE
Approved: January 25, 2018

Standard

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

Purpose

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

Procedure

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

Definitions

Cardiac Patient is identified as meeting the symptoms of the "Applicability for Triage" and "Assess for Immediate Criteria" found in the State of Washington

Prehospital Cardiac Triage Destination Procedure.
http://www.doh.wa.gov/hsqa/hdsp/mdems.htm

PATIENT CARE PROCEDURE #16
STROKE TRIAGE AND TRANSPORT DESTINATION PROCEDURE
Approved: January 25, 2018

Standard

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

Purpose

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

Procedure

Prehospital providers will utilize the most current Washington State Prehospital Stroke Triage (Destination) Procedure, local EMS and Trauma Council County Operating Procedures (COPs), and MPD protocols to direct prehospital providers to transport patients to a specific State categorized stroke hospital. The triage (destination) procedures will be implemented in accordance with resource readiness and Department of Health approved COPs.

Definitions

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

PATIENT CARE PROCEDURE #17
MENTAL HEALTH / CHEMICAL DEPENDENCY ALTERNATE DESTINATION TRANSPORT PROCEDURE (SHB1721)
Approved: January 25, 2018

Standard

In 2015, the WA State legislature passed legislation (SHB 1721) allowing Emergency Medical Services (EMS) licensed ambulance and aid services to transport patients from the field to mental health or chemical dependency

services.

Purpose

Operationalize licensed EMS aid and/or ambulance services may transport patients from the field to mental health or chemical dependency services in accordance with WA State legislation SHB 1721.

Procedure

A. Prior to any regional or local implementation; the department of health will identify and approve mental health and/or chemical dependency treatment receiving facilities. Region Councils will be provided a list of approved receiving facilities.
B. Prehospital EMS Services agencies and receiving mental health and/or chemical dependency facility participation is voluntary.
C. Participating agencies and facilities will adhere to the WA State Department of Health Guideline for Implementation of SHB 1721.
D. Facilities that participate will work with the medical program director (MPD) and EMS agencies to establish criteria that all participating facilities and EMS agencies will follow for accepting patients.
E. MPD and Local EMS and Trauma Care Council will develop county operating procedures.
F. Upon implementation and during ongoing operation of transport to alternate receiving facilities the following will be in place;
    a. County operating procedure
    b. MPD patient care protocol
    c. EMS and DOH approved EMS provider education
    d. List of participating receiving facilities approved by DOH

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