Southwest Region EMS & Trauma Care Council

SYSTEM PLAN

July 1, 2017 – June 30, 2019

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Approved by EMS and Trauma Steering Committee on May 17, 2017

Table of Contents

Introduction	3
Goal 1	8
Goal 2	11
Goal 3	15
Goal 4	18
Appendix 1 Min/Max of Verified Trauma Services	21
Appendix 2 Trauma Response Area Maps	25
Appendix 3 Min/Max of Designated Trauma Services	30
Appendix 4 Min/Max Designated Rehabilitation Services	31
Appendix 5 Categorized Cardiac and Stroke Facilities	32
Appendix 6 Regional Patient Care Procedures	33

The Southwest Region Emergency Medical Services (EMS) and Trauma Care Council's (Regional Council) mission is to promote and support a comprehensive emergency medical care system within Clark, Cowlitz, Klickitat, Skamania, South Pacific, and Wahkiakum counties in collaboration with the Washington State EMS Care system. The Regional Council is responsible for the coordination and planning of the EMS and Trauma Care System within the region as well as providing resources including technical assistance and grant funding to County EMS & 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, 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 has proven to be extremely beneficial to the EMS system in the region and statewide.

The Region 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 Region and County Councils with system planning, evaluation, and making quality improvement recommendations to the State EMS & 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 is 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 individuals shouldered the majority of the work. Standing sub-committees have been replaced by ad hoc work-groups that 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 within 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 Southwest Regional Council and South Central Regional Council have successfully consolidated administrative services via contract since July 2012. This consolidation has reduced 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:

- Clark County is located in the middle of the Southwest Region. It is mostly urban and industrial and has a population 459,495 making it the fifth most populous county in Washington State. The County Council meets the first Thursday of every odd month.
- Cowlitz County has a population of 103,468 and is a mostly rural and semi-industrial and is also home to the active Mt St Helens National Volcanic Monument as well as DNR and National Forest lands which draw many tourists to the area. The County Council meets the first Wednesday of every month.
- Klickitat County is located along the Columbia River, is geographically large and very rural county has a population of 21,026. Due to the rural nature of this county they have long response and transport times. The county has two critical access hospitals. The County Council meets the Monday after the last Wednesday of every odd month.
- Skamania County has a population of 11,339. This extremely rural county is 90% national forest land. This means that response times can be long and accessing patients can be difficult at times due to the many tourists who come to the area to participate in outdoor activities. The County Council meets the Monday after the first Wednesday of every odd month.
- Only the southern half of Pacific County is located in the Southwest Region. The population of Pacific County is 20,848; the southern portion is approximately half of that. This county is bordered by the Columbia River to the south and the

Pacific Ocean to the west. Due to its location, this county has tourism throughout the year and specialized EMS responses (such as ocean rescues) happen quite often. The County Council meets the Tuesday after the first Wednesday of every odd month.

- Wahkiakum County is a small rural county is located along the lower Columbia River and has a population of 4,032. The EMS agencies in this county are 100% volunteer. This rural county has no hospital and no ALS service so it relies on neighboring counties for transport of ALS patients. The County Council meets on the fifth Wednesday of months that have five Wednesdays.

Services and Facilities

Pre Hospital Verified Services

Depicted in the Prehospital Verified Services chart is the total number of agencies and verification level within 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
Clark	5		2			4
Cowlitz	2			2		5
Klickitat	8			4		1
Skamania	2					1
South Pacific	1			2		1
Wahkiakum				2		

Designated Trauma and Rehabilitation Care Facilities

Depicted in the Designated Trauma Care Facilities chart is the total number of hospital receiving facilities within 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
1	1	3	0	0	0	1	0

Categorized Cardiac and Stroke Facilities

Depicted in the Categorized Cardiac and Stroke Facilities chart is the total number of participating categorized hospitals within 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
Southwest

Cardiac Level I	Cardiac Level II	Cardiac Uncategorized	Stroke Level I	Stroke Level II	Stroke Level III	Stroke Uncategorized
1	5	0	1	1	4	0

Successes and Challenges

The Regional Council has 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, and supporting injury and violence prevention initiatives.
- The Regional Council extended training grant options by starting a scholarship program for new EMS certification trainees, while also continuing direct course reimbursement to County Councils. This has been especially useful in smaller counties which don't 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 & 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 Region/County Council meetings to increase participation and engagement. This allows effective use of time and saves travel expenses. To further increase participation, beginning in January 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 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 within the Southwest Region.

GOAL 1

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

The 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 QA 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 QA 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 QA 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, QA 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 QA Committee of the designated trauma and rehabilitation service min/max numbers and take action.
Objective 4 By March 2018, the Regional Council will review and document	Strategy 1 By November 2017, Regional Council will analyze the state list of categorized cardiac and stroke facilities and contact information to ensure the region's list

categorized cardiac and stroke facilities.	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. Regional 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 2018, the Regional Council	Strategy 1 By September 2017, the Regional Council will coordinate and host regular meetings in September,

will coordinate and facilitate open communication with system partners to enhance EMS & trauma care within the region.	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 By September 2017, 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 & 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 2017, 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 council training conference/workshops (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 June annually, the County Councils will submit grant applications for the following fiscal year.
	Strategy 3 By July 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 is received by the Region. (for exhibit B reporting award chart will be inserted here)
	Strategy 6 By June annually, the Regional Council grants contract administration will be completed for the fiscal year.
Objective 2 By March 2018, 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 December 2017, 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 2018, regional staff will collate all suggested PCPs edits and provide a copy of the revised draft PCPs for Council Member review.
	Strategy 5 By March 2018, the draft revised PCPs will be considered for approval at a Regional Council meeting.
	Strategy 6 By March 2018 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's website. Area hospitals and EMS agencies also host a multitude of prevention activities that specifically address local issues as well as universal initiatives. In addition, the Regional Council provides for grants to local County Councils in the region to support injury prevention projects. Solid evidenced-based injury prevention projects on the small scale that the Region is equipped to support are rare. The Regional 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 QA 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 QA 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 QA 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 QA 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 QA Committee and MPDs will develop a method to receive KPI measurements and review the KPIs results.
	Strategy 4 By May 2018, the Regional QA 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.
Objective 5 By June annually, The Regional Council will support programs that reduce the incidence and impact of injury and violence prevention (IVP).	Strategy 1 By June annually, the County Councils will submit injury prevention grant applications for the following fiscal year.
	Strategy 2 By each July, the Regional Council will allocate available funding to support injury prevention projects which use best or promising practices based on locally identified IVP priorities.
	Strategy 3 By each September, the Regional Council will establish injury prevention grant contracts with each County Council.

	Strategy 4 By June annually, funds are distributed throughout the year as injury prevention projects occur and complete documentation is received by the Region. (for exhibit B reporting award chart will be inserted here)
	Strategy 5 By June annually, the Regional Council injury prevention grants contract administration will be completed.

Appendix 1

Approved Min/Max numbers of Verified Trauma Services

County (Name)	Verified Service Type	State Approved - *Minimum number*	State Approved - *Maximum number*	Current Status (# Verified for each Service Type)
Clark	Aid – BLS	1	12	5
	Aid –ILS	0	0	0
	Aid – ALS	1	12	2
	Amb –BLS	1	4	0
	Amb – ILS	0	0	0
	Amb – ALS	1	4	4
Cowlitz	Aid – BLS	1	5	2
	Aid –ILS	0	0	0
	Aid – ALS	1	5	0
	Amb –BLS	1	5	2
	Amb – ILS	0	0	0
	Amb – ALS	1	5	5
Klickitat	Aid – BLS	1	11	9
	Aid –ILS	0	0	0
	Aid – ALS	1	4	0
	Amb –BLS	1	4	4
	Amb – ILS	0	0	0
	Amb – ALS	1	2	1
Skamania	Aid – BLS	1	6	2
	Aid –ILS	0	0	0
	Aid – ALS	1	1	0
	Amb –BLS	1	1	0
	Amb – ILS	0	0	0
	Amb – ALS	1	1	1
South Pacific	Aid – BLS	1	2	1
	Aid –ILS	0	0	0
	Aid – ALS	1	1	0
	Amb –BLS	1	2	2
	Amb – ILS	0	0	0
	Amb – ALS	1	3	1
Wahkiakum	Aid – BLS	1	1	0
	Aid –ILS	0	0	0
	Aid – ALS	1	1	0
	Amb –BLS	1	3	2
	Amb – ILS	0	0	0
	Amb – ALS	1	2	0

Southwest Region Prehospital Trauma Verified Service List

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

20D11	Klickitat County FPD # 11 Wishram							X
20D12	Klickitat County FPD # 12 Klickitat	X						
20D13	Klickitat County FPD #13 Appleton	X						
20D14	Klickitat County FPD #14	X						
20D15	Klickitat County FPD #15	X						
20X01	Klickitat EMS District # 1						X	
20M01	White Salmon Volunteer Fire Dept.	X						
20M07	Goldendale Fire Department	X						
	Klickitat County Current Status	9	0	0	4	0	1	2
	APPROVED MAX #	11	0	4	4	0	2	-
Skamania		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed (Not Verified)
30X01	Public Hospital District Stevenson						X	
30D01	Skamania FPD #1 Carson							X
30D04	Skamania FPD #4 Washougal	X						
30D05	Skamania FPD #5 North Bonneville							X
30D06	Skamania County FPD #6 Cougar	X						
	Skamania County Current Status	2	0	0	0	0	1	2
	APPROVED MAX #	6	0	1	1	0	1	-
South Pacific		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed (Not Verified)
25D01	Pacific Fire District #1Ocean Park						X	
25D02	Pacific Fire District # 2 Chinook							X
25M01	Ilwaco Fire Department				X			
25X03	Medix Ambulance Ilwaco-Chinook							X
25X01	Naselle Volunteer Fire Department				X			
25X0	Long Beach Fire Department	X						
	Pacific County Current Status	1	0	0	2	0	1	2
	APPROVED MAX #	2	0	1	2	0	3	-
Wahkiakum		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed (Not Verified)
35D03	Wahkiakum FD #3 Greys River Rosburg				X			
35D02	Wahkiakum FD # 2 Skamokawa							X
35M01	Cathlamet Fire Department				X			
	Wahkiakum County Current Status	0	0	0	2	0	0	1
	APPROVED MAX #	1	0	1	3	0	2	-
		AID BLS	AID ILS	AID ALS	AMB BLS	AMB ILS	AMB ALS	Licensed (Not Verified)
	SW Region 49 Agencies Current Status	19	0	2	10	0	12	8

Appendix 2

Trauma Response Areas by County
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.

Clark County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	# 2	Within the boundaries of Vancouver Fire Department	C-1, F-1
	# 3	Within the boundaries of Clark FPD # 3	A-1, F-1
	# 5	Within the boundaries of Clark FPD # 5	C-1, F-1
	# 6	Within the boundaries of Clark FPD # 6	C-1, F-1
	# 7	Within the city limits of Camas	F-1
	# 8	Within the city limits of Washougal	A-1, F-1
	# 9	Within the boundaries of Clark FPD #9 and # 1	A-1, F-1
	# 10	Within the boundaries of Clark FPD # 10	A-1, F-1
	# 11	Within the boundaries of Clark FPD # 11 and the city limits of Battleground	C-1, F-1

	# 12	Within the boundaries of Clark FPD # 12	C-1, F-1
	# 13	Within the boundaries of Clark FPD # 13	F-1
	# 20	Within the boundaries of Clark FPD # 2	A-1, F-1
	# 100	Northeast of Trauma Response Area # 13, east of Trauma Response Area # 10 to the northern and eastern county line	None
	# 101	Land Area between Trauma Response Areas # 3, # 5, and # 9	None
	# 102	Parcel between Trauma Response Area # 5 and # 9	None
	# 103	Area bordering the eastern county line between Trauma Response Area # 3, #9, and # 13	None
	# 104	Area between Trauma Response Area # 10 to the northern county line	None
	# 105	Area between Trauma Response Area # 10 to the northern county line	None
	# 106	Area between Trauma Response Area #2, #6, and # 12 to the western county line	None
Cowlitz County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	# 1	Within the boundaries of Cowlitz FPD # 1 and the city limits of Woodland	D-2, F-1
	# 2	Within the boundaries of Cowlitz FPD # 2 and the city limits of Kelso	F-1
	# 3	Within the boundaries of Cowlitz FPD # 3	A-1, F-1
	# 4	Within the boundaries of Cowlitz FPD # 4	A-1
	# 5	Within the boundaries of Cowlitz FPD # 5	F-1
	# 6	Within the boundaries of Cowlitz FPD # 6 and the city limits of Castle Rock	F-1
	# 7	Within the boundaries of Cowlitz-Skamania FPD # 7	A-1, F-1
	# 8	Within the city limits of Long View and land area to the southern county line	A-1, F-1
	# 100	All land area between Trauma Response	None

		Area # 2, # 4, # 6, and the northern and western county line	
Klickitat County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	# 1	Within the boundaries of Klickitat FPD # 1	A-1, F-1
	# 2	Within the boundaries of Klickitat FPD # 2	D-1, F-1
	# 3	Within the boundaries of Klickitat FPD # 3	A-1, F-1
	# 4	Within the boundaries of Klickitat FPD # 4	A-1, F-1
	# 5	Within the boundaries of Klickitat FPD # 5	F-1
	# 6	Within the boundaries of Klickitat FPD # 6	F-1
	# 7	Within the boundaries of Klickitat FPD # 7	A-1, F-1
	# 8	Within the boundaries of Klickitat FPD # 8	D-1, F-1
	# 9	Within the boundaries of Klickitat FPD # 9	A-1, F-1
	# 10	Within the boundaries of Klickitat FPD # 10	A-1, F-1
	# 11	Within the boundaries of Klickitat FPD # 11	F-1
	# 12	Within the boundaries of Klickitat FPD # 12	A-1, F-1
	# 13	Within the boundaries of Klickitat FPD # 13	A-1, F-1
	# 14	Within the boundaries of Klickitat FPD # 14	A-1, F-1
	# 15	Within the boundaries of Klickitat FPD # 15	A-1, F-1
	# 100	Land Area west of Glenwood Rd. to the western and northern county lines outside Trauma Response Areas # 1, #3, #4, and #13	None

	# 101	Land area east of Glenwood Rd. to Status Loop Rd. to the northern county line outside Trauma Response Areas # 5, #6, #7, #12, #14 and #15	None
	# 102	Land area east of Status Loop Rd. to the northern county line outside Trauma Response Areas # 2, #7, and # 9	None
Skamania County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	# 1	Within the boundaries of Skamania FPD # 1	F-1
	# 2	Within the boundaries of Skamania FPD # 2	F-1
	# 3	Within the boundaries of Skamania FPD # 3	F-1
	# 4	Within the boundaries of Skamania FPD # 4	A-1, F-1
	# 5	Within the boundaries of Skamania FPD # 5	F-1
	# 6	Within the boundaries of Skamania FPD # 6	A-1, F-1
	# 7	Within the boundaries of Cowlitz-Skamania FPD # 7	F-1
	# 100	All land area outside Trauma Response Areas # 1, 2, 3, 4, 5, 6, 7, to the northern, southern, western, and eastern county lines	None
South Pacific County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	# 1	Within the boundaries of Pacific FPD # 1 and the city limits of Long Beach	F-1
	# 2	Within the boundaries of Pacific FPD # 2	A-1, F-1
	# 3	Within the city limits of Ilwaco	F-1
	# 4	Within the boundaries of Pacific FPD # 4	F-1

		and the city limits of Naselle, north to the north/south Pacific County division boundary line	
	# 100	All land area outside Trauma Response Areas # 1, 2, and 4, to the north/south Pacific County division line and eastern, southern and western county lines	None
	# 101	Northern tip of peninsula beyond Trauma Response Area # 1 boundary	None
	# 102	Southern tip of peninsula beyond Trauma Response Area # 3 boundary	None
Wahkiakum County	**Trauma Response Area Number**	**Description of Trauma Response Area's Geographic Boundaries**	**Type and # of Verified Services available in each Response Areas**
	# 1	Within the boundaries of Wahkiakum FPD # 1 and # 4, and the city limits of Cathlamet	D-1
	# 2	Within the boundaries of Wahkiakum FPD # 2	D-1
	# 3	Within the boundaries of Wahkiakum FPD # 3	D-1
	# 100	All land area outside Trauma Response Area # 3 west of mile post 22 on State Route 4, to the western, northern, and southern county lines	None
	# 101	All land area outside Trauma Response Areas # 1 and # 2 east of mile post 22 on State Route 4, to the eastern, northern, and southern county lines	None

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

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

(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 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	1	1	1
III*	0	0	0

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

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

(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 5

WA State Emergency Care Categorized Cardiac and Stroke System Hospitals
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
1	5	0	1	1	4	0

Cardiac Level	Stroke Level	Name	City	County
II	III	Klickitat Valley Health	Goldendale	Klickitat
II	II	Legacy Salmon Creek Medical Center	Vancouver	Clark
II	III	Ocean Beach Hospital	Ilwaco	Pacific
II	III	Skyline Hospital	White Salmon	Klickitat
I	I	Peace Health Southwest Medical Center	Vancouver	Clark
II	III	Peace Health St John Medical Center	Longview	Cowlitz

(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 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.

Southwest Region Emergency Medical Services and Trauma Care Council

Patient Care Procedures

Revised: February 11, 2011
Adopted: November 6, 2002

Table of Contents

1. Definitions -WAC 246-976-010
2. Dispatch / Response Times
3. Cancellation / Slow Down / Staging
4. Time on the Scene
5. Pre-hospital Communications
6. Trauma - Activating the Trauma System / Pediatric Major Trauma Patients
7. Designated Trauma Centers
8. Diversion
9. Prolonged Transport of Trauma Patients
10. Medical Patients
11. Cardiac Patients
12. Stroke Patients
13. Air Ambulance
14. Non Transport of Patients
15. Patients Refusing Care
16. Private Physician and/or Medical Professional at the Scene
17. Do Not Resuscitate Orders
18. Inter-Facility Transfer
19. Multi-Casualty Incidents and Medical Incident Command Center
20. Quality Assessment (QA)

DEFINITIONS

WAC 246-976-010

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

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

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

DISPATCH/RESPONSE TIMES

Dispatch

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

It is the responsibility of the responding agency to have trained prehospital medical and trauma life support technicians respond to the scene. If a prehospital agency does not

have personnel available who are trained in prehospital trauma life support or cardiac and stroke care, the agency should immediately notify the 911 Dispatch Center to dispatch another service to the scene of the call to assist with the patient(s).

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

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

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

Verified Aid Services (response times, 80 percent target)

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

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

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

CANCELLATION/SLOWDOWN/STAGING

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

Cancelling of Response

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

Slow Down

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

Diversion

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

Staging

A. Stage/standby may be done when responding to scenes involving acts of violence or other scene safety issues until the scene is secured by law enforcement or other means. Items to consider:
    1. Information from Dispatch indicating violence or potential for violence

e.g., assault with weapon, violent individual(s), or hostage situation.

2. Information that raises questions regarding the safety of responders, e.g., hazardous material or other special rescue situation.

B. Units will advise Dispatch of intent to stage and request Law Enforcement response (if not already done). Dispatch will notify all responding units of intent to stage.
   1. When a response unit declares intent to stage all responding agencies will stage until the scene is deemed safe to enter.
   2. The responsibility to stage rests with the responding agency. Communication of intent to stage will be shared between multiple responding agencies.

C. Dispatch should provide ALL pertinent information to the responding units so they can make a determination as to whether to stage. This should be the same complete information provided to law enforcement responding units.

TIME ON THE SCENE

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

**Note: Document extenuating circumstance.

PRE-HOSPITAL COMMUNICATIONS

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

A. Emergency Report Format:
   1. Unit identification
   2. Age and sex of patient
   3. Transport code (emergent/non-emergent)
   4. Chief complaint or reason for transport
   5. Very brief pertinent medical history (one sentence if possible)
   6. Vital signs
   7. Pertinent treatment rendered

8. Request for additional information or treatment
9. Estimated time of arrival (ETA)

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

C. Advise Medical Control or receiving emergency department of changes in patient's condition in route and/or request further treatment.

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

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

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

Written Reports/Documentation

A. An EMS Medical Incident Report (MIR) form (or other electronic report format) must be documented and filed for any call for EMS assistance resulting in patient contact regardless of patient transport. This will apply to all responding agencies, both basic and advanced life support units and includes public assist calls.
   1. Patient contact occurs when a provider contacts/sees/hears a patient, even if other providers are on scene. The treatments and evaluations provided, while provider is in contact with the patient, shall be documented.

B. Documentation Format:
   1. If a written format is used, S.O.A.P. charting is the most acceptable method of report writing.
   2. If an electronic report format is used then it is necessary to follow the MPD approved documentation guidelines for that particular charting application.

C. Documentation of Response Determinant
   1. Complete documentation of patient care will include the determinant assigned at initial dispatch and any upgrades received while en-route.

D. The patient care report should reflect the patient care incident as accurately as possible. As such, the report will be completed as soon as feasible after the patient encounter to ensure an accurate accounting of the incident. ALL REPORTS MUST BE COMPLETED WITHIN 24 HOURS.
   1. Transporting units are required to leave at minimum an abbreviated written report prior to leaving the hospital.
   2. Transport units are required to provide the receiving facility a complete written or electronic patient care report within 24 hours of patient arrival.

TRAUMA

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

Activating the Trauma System

A. When a prehospital trauma verified service has identified a patient as a "major" trauma patient, the prehospital service should ensure the following:
   1. Contact with a Level I or Level II Designated Trauma Center, where available or;
   2. The highest level designated facility within the agency's immediate response jurisdiction if a Level I or Level II Designated Trauma Center is not within a 30 minute transport time.

B. To activate the Trauma System in the Southwest Region, contact with the Designated Trauma Center shall be preceded with the phrase: "THIS IS A TRAUMA SYSTEM ENTRY."

C. It is important for the EMS agency to provide the Designated Trauma Center with the following information:
   1. Identification of the EMS agency or Trauma Verified Service
   2. Patient's chief complaint(s) or problem: identification of biomechanics and anatomy of injury
   3. Approximate age of the patient
   4. Basic vital signs (palpable pulse rate, where pulse was palpated, and rate of respiration)
   5. Level of consciousness (Glasgow Coma Score)
   6. Provider impression

7. Other factors that require consultation with the base station
8. Number of patients (if known)
9. Estimated Time of Arrival
10. Whether an air ambulance has been activated for scene, field, or hospital rendezvous

Pediatric Major Trauma Patients

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

DESIGNATED TRAUMA CENTERS

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

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

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

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

policy to divert patients to other designated facilities based on its ability to manage each patient at a particular time.
EMS agencies in the Southwest Region will be notified if and when a Designated Trauma Center is on diversion status. Trauma verified services will follow County Operating Procedures (COPs) on where trauma patients should be taken, in the event a Designated Trauma Center is not accepting patients.

PROLONGED TRANSPORT

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

MEDICAL PATIENTS

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

CARDIAC PATIENTS

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

STROKE PATIENTS

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

AIR AMBULANCE

General considerations

Consider the following when deciding on air transport:

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

Standby

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

A. Air Ambulance may be placed on standby by:
    1. Emergency Medical Responder
    2. EMT
    3. Paramedic
    4. Any physician
    5. Any law enforcement
    6. 911 Dispatch Center
B. Air Ambulance may be placed on standby prior to personnel arrival if first response unit arrival at the scene will be greater than 20 minutes or the information dispatched purports to be the type of patient who will benefit from Air Ambulance. Examples of situations:
    1. Gunshot or penetrating trauma
    2. MVA; person trapped or multiple patients
    3. Auto-pedestrian
    4. Severe burns
    5. Major amputation
    6. Entrapment (e.g., cave-in, machine on person, etc.)
    7. Critical pediatric patients
    8. Acute cardiac or neurological emergencies

Activation

A. The decision to activate Air Ambulance rests with the highest level EMS

provider (or a physician on scene):

1. As EMS provider arrives on scene and evaluates patient.
2. Based upon information relayed by people on scene.

B. In some cases, Air Ambulance can be immediately activated to the scene prior to the arrival of a first-in unit or highest level EMS responder when:
   1. Travel time for that first-in unit will be over 30 minutes and the situation as known purports to be the type of patient who will benefit Air Ambulance.
   2. Where it is known ground access will be difficult but where the helicopter can get near the patient.
   3. Where the reporting party relates some other special circumstance indicating the need for its immediate activation.

   **Note: In those situations (A or B above), activation shall be done through Dispatch with concurrence of responding highest level EMS responder.

C. Criteria for Activation
   1. Patient(s) meet "major trauma" criteria and extrication and/or ground transport will be greater than 30 minutes, or;
   2. Patient meets cardiac/stroke triage criteria and ground transport will be greater than 30 minutes.
   3. Type of injury or illness may dictate immediate transport to a Designated Trauma Center, Burn Center, or Hyperbaric Center etc.
   4. Multiple victims meeting 'major trauma" criteria.

D. Destination Hospital
   1. Unless diversion criteria apply, the destination hospital shall be indicated to Air Ambulance by the highest level EMS responder in charge. The highest level EMS responder will consult with Medical Control to determine destination.

Cancellation

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

Quality Assessment, Case Reviews

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

NON-TRANSPORT OF PATIENTS

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

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

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

Patients refusing care and/or transport (classified as follows):

A. No medical need exists.
B. A person with normal decision making capacity who, after having been informed of risks and benefits of treatment/transport, voluntarily declines further services.

Impaired decision making capacity defined:

A. Inability to understand the nature of his/her illness/injury.
B. Inability to understand risks or consequences of refusing care/transport.
C. Individuals impaired for any reason including but not limited to:
    1. Alcohol and/or drugs
    2. Psychiatric conditions
    3. Injuries (head injury, shock, etc.)
    4. Organic Brain Syndrome (Alzheimer's, etc.)
    5. Minors (<18 years old)
    6. Language/communication barrier (including deafness)

Criteria for informed refusal/consent

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

Pre-Hospital Guidelines for Patients Refusing Care

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

A. Capable of making informed decision, NO medical need exists (e.g. passersby report traffic accident; all persons deny injury when EMS arrives):
    1. A refusal form is not necessary.
    2. MIR documentation will include the events necessitating the call to EMS as well as all criteria for no patient/medical need.
B. Capable of making informed decision, minor medical need exists:

1. A refusal form is necessary. Form and MIR must be completed by highest level EMS provider attending the patient.
2. MIR documentation shall include:
    a. The patient’s chief complaint
    b. Events prior/reason for call to EMS
    c. Pertinent medical history
    d. Description of scene (if relevant to patient's c/c)
    e. Physical exam including vital signs and clinical impression
    f. Prehospital interventions
    g. Consultation with medical control
    h. Patient's response to medical care and/or transport attempts
    i. Instructions to patient and/or family including risks/benefits of treatment/transport

C. Capable of making informed decision, immediate medical care and/or ambulance transport necessary:
1. A refusal form is necessary. Form and MIR must be completed by the highest level EMS provider attending patient.
2. Every effort will be made to convince these patients to accept necessary pre-hospital intervention and transport to definitive care. Options available:
    a. Solicit assistance from family, friends, and/or other close associates to persuade the patient to accept necessary treatment and transport.
    b. Solicit assistance from law enforcement (police hold), mental health professional (psychiatric hold), and/or clergy as the situation directs.
3. CONSULTATION WITH MEDICAL CONTROL IS MANDATORY.
4. MIR documentation shall include:
    a. The patient's chief complaint
    b. Events prior/reason for call to EMS
    c. Pertinent medical history
    d. Description of scene (if relevant to patient's c/c)
    e. Physical exam including vital signs
    f. Clinical impression
    g. Prehospital interventions
    h. Consultation with medical control
    i. Patient's response to medical care and/or transport attempts
    j. Instructions to patient and/or family including risks/benefits of treatment/transport
5. If the patient still refuses treatment/transport, the highest level EMS provider will be responsible for explaining the REFUSAL FORM. Completion of the form includes:

a. Explanation of instructions and release of liability to the patient
b. Receipt of signature (dated) from patient or legal guardian
c. Completion of patient assessment, medical control consult, and patient disposition

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

c. Completion of patient assessment, medical control consult, and patient disposition sections

6. Every reasonable effort should be made to ensure patients receive necessary medical treatment and transport. If the patient seems hesitant regarding their medical care/transportation or any doubt exists, you should provide care/transportation.
7. Should the above efforts prove fruitless, it may be necessary to leave these patients at the scene. Aforementioned documentation guidelines will be adhered to.

E. Patient in Custody and/or Incident Involving Law Enforcement:
   1. If patient competent, follow protocol outlined above regarding medical need. The patient will require a full medical exam, pertinent to the nature of the chief complaint and mechanism of injury. If the patient refuses care and/or transport a refusal form must be signed by the patient.
   2. If patient refusing transport is under arrest and/or restrained by officers, document refusal in MIR with signature of arresting police officer on refusal form.
   3. All other patients will be transported to the hospital by ambulance

PRIVATE PHYSICIAN AND/OR MEDICAL PROFESSIONALS AT THE SCENE

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

The physician at the scene may:

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

Transport

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

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

DO NOT RESUSCITATE ORDERS

Definitions

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

Procedures

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

INTER-FACILITY TRANSFER (HOSPITAL TO HOSPITAL)

General responsibilities and instructions

A. It is the responsibility of the transferring facility to insure:
    1. Medical requirements for safe patient transfer are met including stabilization
    2. State of WA Trauma, Cardiac, &/or Stroke patient destination guidelines are adhered to
B. Medical instructions of the attending physician will be followed unless contrary to standing orders; Medical Control will be contacted for clarification of contrary orders.
C. Attendance of the patient during transport, by;
    1. Physician - he or she will direct all care regardless of standing orders
    2. Registered Nurse – he or she will direct the care of the patient via orders from the physician at transfer or the receiving hospital physician. The registered nurse may desire to defer emergency care in some situations to the highest level EMS provider.

Stabilization prior to transfer

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

Other considerations

A. If a BLS transport is requested and it is the judgment of the BLS crew that the patient needs to be transported by an ALS ambulance, it is mandated that dispatch be contacted and an ALS crew dispatched. Under no circumstances should a BLS crew transport a patient, if in their judgment, this is an ALS call.
B. Emergencies en route:
    1. Prehospital protocols and guidelines will immediately apply
    2. Medical Control should be contacted for concurrence of any orders as needed; the receiving facility should be contacted as soon as possible to inform them of changes in the patient's condition

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

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

HAZARDOUS MATERIALS INCIDENT

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

MULTI-CASUALTY INCIDENTS AND MEDICAL INCIDENT COMMAND CENTER

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

QUALITY ASSESSMENT (QA)

Quality Assessment & Improvement (QA) is an integral component of the Southwest Region's Trauma System, EMS and Cardiac/ Stroke System. For all patients, EMS and health care providers will follow their agency's specific QA plan. If an agency does not have a QA Plan, one should be developed and adopted. Issues that are identified by a local QA committee for review and recommendations should be submitted directly to the Region QA committee for consideration. QA prehospital problems, issues, case reviews, areas of improvement, can be "flagged" by checking the "QI" Box on the medical incident reporting form. Any system issues that affect patient care are encouraged to be submitted.

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