

**EAST REGION  
EMERGENCY MEDICAL SERVICES  
& TRAUMA SYSTEM**

**S T R A T E G I C   P L A N**

**July 2009 - June 2012**

Submitted by the EAST Region EMS and Trauma Care Council  
September 29, 2009 final

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# EXECUTIVE SUMMARY

## Introduction

**Mission Statement:** It is the mission of the East Region EMS & Trauma Care Council to establish and promote a system of emergency medical and trauma services, which provides for timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury.

We recognize the changing methods and environment for providing optimal emergency care under the varied conditions throughout the State of Washington.

**Vision:** It is the vision of the East Region EMS and Trauma Care Council to have all EMS agencies verified and all hospitals trauma designated at the appropriate levels in order to provide every person in the region with access to emergency medical service and trauma care in all communities.

## System Leadership

**Statutory Authority:** The East Region EMS & Trauma Care Council (Regional Council) has legislative authority under RCW 70.168.100 to RCW 70.168.130 and WAC 246-976-960. It has a non-profit 501 (c-3) status. The region has a history of long standing membership on both regional and local councils. It is the volunteers in the region that provide system sustainability. The challenge today is recruiting new members and filling vacant positions. It is necessary for the council to develop a process to actively recruit and retain new members. To this end, our regional plan outlines System Leadership objectives to address system needs related to:

- Membership at both the Regional and Local Council levels is in compliance with RCW.
- Membership Committee will develop and education the Regional Council on member responsibilities.
- An information sharing process will be implemented regionwide.

## System Development

The East Region plays a significant role in the coordination of all stakeholders as it develops and sustains a system to reduce the incidence of inappropriate and inadequate trauma care and emergency medical services. To that end, our regional plan outlines System Development objectives to address system needs related to:

- Implement the objectives and strategies within 2009 -2012 East Region EMS and Trauma System Plan and maintain an updated plan.
- Utilize Washington State DOH standardized methodologies to determine min/max numbers for verified service types in each county.
- Determine trauma designation min/max numbers for each county in the region.
- Update the EMS & Trauma Care System Plan to address inconsistencies with the state strategic plan.
- Develop a 2012-17 strategic plan.
- Identify existing distribution channels for use in timely distribution of Steering Committee & TAC information to regional stakeholders on emerging issues and will develop and implement an information distribution process.
- Maintain processes that ensure key stakeholders remain involved in regional emergency preparedness & disaster planning activities.
- Regional hospitals will participate in a Region 9 preparedness event.

- For the Hospital Planning Committee to develop an After Action Report on the one preparedness drill, tabletop or exercise that Region 9 hospitals participated in.
- The Communication Committee, in collaboration with the East Region EMS/TC Council's Hospital Planning Committee and Region 9 Hospitals will implement a functional regional *Hospital to Hospital* narrow-band radio communication system.
- The Communications Committee will develop and distribute a guideline to support the use of HEAR as the primary tool for *prehospital to hospital* communications regionwide.
- Survey dispatch centers to determine the number of dispatchers / call certified in Emergency Medical Dispatch (EMD) for use in determine training needs

### **System Public Information & Education**

There is currently not a best practice public information and education system available for use in the East Region, although one is desperately needed. To this end the regional plan outlines System Public Information & Education objectives to address system needs related to:

- Develop and implement a 2-year (March 2010-July 2011) regional public information campaign to educate the public about the EMS and Trauma System.

### **System Finance**

So many EMS providers are volunteers that it is difficult for many Local EMS/TC Councils and EMS prehospital agencies to seek outside funding because of the lack of paid staff that have the time and skills to write grants. Many smaller rural agencies depend on bake sales and donations to fund their agency needs. To this end the regional plan outlines Finance objectives to address system needs related to:

- Develop a process by which the prehospital agencies, hospitals and other community partners receive information on funding resources.
- Regional Council's Finance Committee will prepare an annual operations budget for the next fiscal year for presentation to the Regional Council for its approval.

### **Injury Prevention and Control**

In the East Region, the Injury Prevention Program is contracted out to Spokane Regional Health District's Injury Prevention Program. The Regional Council's IPPE Committee's primary focus is to serve as a network for injury prevention falls prevention efforts throughout the region. To that end, our regional plan outlines Injury Prevention and Control objectives to address system needs related to:

- Provide information to all interested parties on evidence based injury prevention programs and resources available through the East Region EMS/TC Council.
- Conduct an assessment to identify what IPPE related programs are actively happening throughout the region and will provide this information to the Regional Council and appropriate agencies.
- East Region funded presentations will be formally evaluated.
- Injury prevention programs funded by the East Region EMS/TC Council will be data driven.

### **Pre-Hospital Care**

The East Region is the largest EMS region in the state of Washington. It is 15,556 square miles in size and is nine counties large. It consists of Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens and Whitman Counties. The East Region is diverse geographically in its mountainous terrain to the north and its farm land mid and south. Of the regions approximately 2100 EMS providers approximately 71% of them are currently volunteers. To that end, our regional plan outlines Pre-hospital Care objectives to address system needs related to:

- Review and adopt the revised Regional Patient Care Procedures for inclusion in the 2012-2017 East Region EMS and Trauma Care System Plan.
- Develop and implement an annual Training & Education delivery plan.

- Conduct an educational forum during Regional Council meeting on statutory requirements, council operational processes, and data from regional and other assessments and/or other system issues

### **Acute Hospital Care**

Several changes have occurred within the designated acute care trauma system within the last year. Deer Park Hospital was forced to close its doors due to economic factors. Two other facilities redesignated to a lower designation level. Deaconess Medical Center was sold to Community Health Systems (CHS), going from a non-profit to a for-profit status. Deaconess and Sacred Heart Medical Centers applied for separate Level II trauma designations. To that end, our regional plan outlines Acute Care Objectives to address system needs related to:

- Sacred Heart Medical Center (SHMC) in conjunction with regional QI will coordinate the establishment of an efficient means of transferring radiology images through the use of virtual private network (VPN).
- The Spokane Regional Trauma Education Committee will plan and hold a Trauma Conference annually in Spokane
- Sacred Heart Trauma Services will plan and hold a Rural Trauma Team Development Course annually in Spokane.

### **Pediatric Care**

The East Region has Sacred Heart Medical Center and Children’s Hospital which provides Level II pediatric trauma care for the entire region and adjacent regions. Pediatric patients make up the minority of EMS and Trauma patient volume in our region, therefore education is imperative for the pre-hospital providers. The region does not have pediatric specific protocols. To that end, our regional plan outlines Pediatric Objectives to address system needs related to:

- Establish a Pediatric Committee to research and identify training opportunities for prehospital EMS providers regionwide.
- Host an Emergency Medical Services for Children (EMSC) Conference in the East Region for Prehospital EMS and hospital education.

### **Trauma Rehabilitation**

St Luke’s Rehabilitation Institute is a Level I Trauma designated facility in the East Region. St Luke’s Rehabilitation Institute is the only Level I Trauma designated facility in Eastern Washington. To that end, our regional plan outlines Trauma Rehabilitation Objectives to address system needs related to:

- Publicize ongoing education opportunities on SCI, TBI and multi-trauma using a continuum of care from injury to discharge to community.
- Implement a process to identify and recruit membership from each of the nine counties of the region, to include: 1) the review and update of the Rehab Resource Directory; 2) the development of a Recruitment and Retention Plan for Rehab Committee Members; and 3) recruiting members for the committee.
- Identify and disseminate a list of resources, including funding resources, to community organizations involved in providing rehabilitation services.
- Annually provide a trauma case presentation to identified stakeholders to showcase the continuum of coordinated system care.

### **System Evaluation**

Data is not easily accessible; therefore it is not currently a valuable regional asset. To that end, our regional plan outlines Evaluation Objectives to address system needs related to:

- WEMSIS resource barriers and solutions will be identified by the Regional Council.
- East Region Hospital Trauma Program Coordinators will provide reports on the top four injury mechanisms from their particular trauma service to the IPPE Committee for completion of Goal 12, Objective 4, Strategies 1 and 2.

# REGIONAL SYSTEM GOALS – OBJECTIVES – STRATEGIES

**JUNE 2009 – JULY 2012**

## ADMINISTRATIVE COMPONENTS

### SYSTEM LEADERSHIP

#### **Introduction**

##### **Where We Are Currently**

The East Region EMS and Trauma Care Council has a multidisciplinary composition consisting of local councils, designated health care facilities, elected official, consumer, law enforcement, government agency, medical resource, physician, private ambulance, homeland security, rehab, helicopter service, fire and EMS, public health, information technology and positions for committee chairs if there is not a position identified else where. The Regional Council has a non-profit 501 (c-3) status and currently employs one Contracts & Grants Manager who also serves as the Regional Administrator.

Eight of the counties in the region have functioning Local EMS/TC County Councils and have membership rosters that vary by county. The business model used by Local Councils varies across the system. The East Region is the largest region in the state covering over 15,500 square miles. This represents a challenge for local councils to have multidisciplinary composition in its membership because of the large geographical area and the various terrains it represents as well as the economical factor involved in finding jobs in many of the rural areas of region.

Both Regional and Local Councils have dedicated long standing membership but are experiencing challenges finding new members to fill available positions.

Within the East Region a number of formal coalitions and other formal groups of health care providers are actively involved with the Regional Council and engaged together in system enhancement. Groups like the Falls Prevention Coalition, Injury Prevention and Public Education (IPPE) Committee, Hospital Planning Committee and the Communications Committee are highly functional, have some shared membership and actually function as coalitions however have chosen to exist under the umbrella of the Regional Council to benefit integration within the system.

Prehospital agency leaders may or may not have any formal leadership preparation to manage EMS operations. Larger agencies in Spokane, Pullman, and even in Clarkston have funding to support advanced leadership programs where the smaller rural volunteer agencies do not have the formalized leadership programs available to them that the urban agencies have. Although the Regional Council has acknowledged that there is a need for to help provide leadership programs to smaller rural EMS operations within the region it does not have the resources to do so at this time.

The Regional Council  
**Needs Addressed In The Plan**

- Membership at both the Regional and Local Council levels is in compliance with RCW.
- Membership Committee will develop and educate the Regional Council on member responsibilities.
- An information sharing process will be implemented regionwide.

<b>- Goal #1 -</b>	
There are viable, active local and regional EMS and trauma care councils comprised of multi-disciplinary, EMS and trauma system representation.	
<b>Objective 1.</b> By May of 2011, Regional and Local Councils will review and revise their respective memberships to ensure compliance with RCW 70.168.120 and current system representation needs.	<b>Strategy 1.</b> By September 2009, the Regional Council will establish a Membership Committee to oversee membership.
	<p><b>Strategy 2.</b> By January 2010 The Membership Committee will review Regional Council membership and will determine gaps in current and future membership positions and report the results to the Regional Council at the next meeting.</p> <p><b>Strategy 3.</b> By March 2010 the Regional Council Membership Committee will send to local councils, a current copy of the Regional Council Structure which identifies vacant positions available for application.</p> <p><b>Strategy 4.</b> By September 2009 the Regional Council's Membership Committee will develop a form that will identify Local Council Structure Membership categories as identified in RCW 70.168.120.</p>
	<b>Strategy 5.</b> By September 2009 the Regional Council's Membership Committee will distribute the Local Council Structure to each local council to identify current filled positions and gaps and the Local Councils will return it to the regional office.
	<b>Strategy 6.</b> By February 2010 the Regional Council's membership Committee will review the Local Council Structures and report to the Regional Council.
	<b>Strategy 7.</b> By May 2011, each of the Local Councils will add new members to reflect a balance of membership as described in RCW 70.168.120. and current system representation needs.
	<b>Strategy 8.</b> By May 2011, each of the Local Councils will determine if current system representation needs are necessary to their council structure and will report any additional positions they develop to the Regional Council.
<b>Objective 2:</b> By April 2012 the Regional Council's Membership Committee will develop and educate Regional Council members on member responsibilities.	<b>Strategy 1.</b> By January 2010 the Regional Council's Membership Committee will develop a List of Council Member Responsibilities.
	<b>Strategy 2.</b> By February 2010 the Regional Council's Membership Committee will distribute the List of Council Member Responsibilities to the Regional Council for review, comment and approval.

<p><b>Strategy 3:</b> By April 2010 the Regional Council's Membership Committee will distribute the approved List of Council Member Responsibilities to the Regional Council and provide education on responsibilities.</p>
<p><b>Strategy 4.</b> At the first meeting for new council members, the Regional Council's Membership Committee will provide education to all new council members on the Regional Council and its committees.</p>
<p><b>Strategy 5.</b> By April 2012 the Regional Council's Membership Committee will develop a Regional Council Membership Handbook, using the DOH tool as a guideline, which will be distributed to all Regional Council and committee members.</p>

## SYSTEM LEADERSHIP

### - Goal #2 -

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

<p><b>Objective 1.</b> By October 2009, the Regional Council will implement information sharing processes.</p>	<p><b>Strategy 1:</b> By July 2009 a process will be implemented by the Regional Council staff to ensure that EMS stakeholders have access to Regional Council and sub-committee meeting dates through email alert and calendars on the Website.</p>
	<p><b>Strategy 2:</b> By July 2009 a process will be implemented by the Regional Council staff to email meeting notices in advance of each meeting date to membership and meeting attendees.</p>
	<p><b>Strategy 3:</b> By August 2009 a process will be implemented by Regional Council staff to post meeting agendas and approved minutes on the Regional website in advance of each meeting date.</p>
	<p><b>Strategy 4:</b> By October 2009, Regional Council and subcommittee members who participate in related coalitions and meeting will provide relevant reports and presentations to Regional Council and sub-Committees meetings.</p>
	<p><b>Strategy 5:</b> By October 2009, the Regional Council staff will implement links to other agency websites on the Regional Council website.</p>

## **SYSTEM LEADERSHIP**

### **- Goal #3 -**

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

**The Regional Council chose to not address this goal in the plan at this time due to lack of resources**

# SYSTEM DEVELOPMENT

## Introduction

### Where We Are Currently

The East Regional Council plays a significant role in the coordination of bringing stakeholder groups together within the regional system. Local Councils, Region 9 hospitals, Healthcare Coalition partners, public health and Communication partners, the regional QI Committee and other stakeholder groups look to the Regional Council to convene groups for system planning.

The East Regional Council staff, Executive Committee, and other Regional Council standing committee chairs are tasked with preparing agendas and convening system focused meetings to address plan deliverables and to conduct general business.

The Regional Plan model and goals are closely aligned with the State Plan. Objectives and strategies represent the work that is needed at the regional system level over the next three years. By using the state goals and plan format in the development of this regional plan the result is an aligning of both the regional and state planning documents.

While it is desirable to get multidisciplinary input from across the system to regional plan development (prehospital agencies, hospitals, MPDs, and other groups) the size of the region provides a barrier to making this happen easily and necessitates the need for a unique regional process. Although it may seem that the organizations listed above may not have had input in this plan, as you read through the document, they have indeed provided input. Many of the East Region Committees are actually coalitions in their own right, and have multidisciplinary membership. The committees fall under the umbrella of the East Region EMS/TC Council at the request of our community partners simply because work identified in this EMS & Trauma Care System Plan is identified in specific RCW and WAC. The Regional Council and its committees have found that work identified in this plan does actually support outside funding.

Information is shared across the regional system in a number of different ways. The Regional Council shares information by email, postings on the web and at Regional Council meetings. Local Councils report to their membership at meetings by Regional Council members either in person or by written reports. Links to local council websites are also listed on the East Region website at [www.eastregion-ems.org](http://www.eastregion-ems.org). This communication is focused on informing participants in the system rather than the public.

The Communication Committee is working with the Region 9 Hospitals, Local County EMS Councils and Medical Program Directors, 911 Dispatch Centers, Washington State Patrol and the Department of Health to ensure reliable and narrow band compliant communications. The HEAR is the venue of choice for pre-hospital to hospital communication. The WHEERS will be the venue of choice for the Hospital to Hospital communication once all hospitals in the region have the system installed. Each system requires upgrades in user equipment and infrastructure. Working together we will pursue grants, partnerships and training to realize the goals in the Trauma Plan.

## Needs Addressed In The Plan

- Implement the objectives and strategies within 2009 -2012 East Region EMS and Trauma System Plan and maintain an updated plan.
- Utilize Washington State DOH standardized methodologies to determine min/max numbers for verified service types in each county.
- Determine trauma designation min/max numbers for each county in the region.
- Update the EMS & Trauma Care System Plan to address inconsistencies with the state strategic plan.
- Develop a 2012-2017 strategic plan.
- Identify existing distribution channels for use in timely distribution of Steering Committee & TAC information to regional stakeholders on emerging issues and will develop and implement an information distribution process.
- Maintain processes that ensure key stakeholders remain involved in regional emergency preparedness & disaster planning activities.
- Regional hospitals will participate in a Region 9 preparedness event.
- The Hospital Planning Committee will develop an After Action Report on the one preparedness drill, tabletop or exercise that Region 9 hospitals participated in.
- The Communication Committee, in collaboration with the East Region EMS/TC Council's Hospital Planning Committee and Region 9 Hospitals will implement a functional regional *Hospital to Hospital* narrow-band radio communication system.
- The Communications Committee will develop and distribute a guideline to support the use of HEAR as the primary tool for *prehospital to hospital* communications regionwide.
- Survey dispatch centers to determine the number of dispatchers / call takers certified in Emergency Medical Dispatch (EMD) for use in determine training needs

**- Goal #4 -**

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

<p><b>Objective 1.</b> Throughout July 2009 to May 2012 the Regional Council will implement the objectives and strategies within 2009 -2012 East Region EMS and Trauma System Plan and maintain an updated plan.</p>	<p><b>Strategy 1.</b> By August 2009 the Regional Council staff will provide copies of the plan and GANNT Chart to the Regional and Local Council members and stakeholders with assigned work identified in the plan.</p>
	<p><b>Strategy 2.</b> By October 2009 all committees with assigned work identified in the plan will receive their objectives and strategies for the fiscal year and instructions for reporting on work progress.</p>
	<p><b>Strategy 3.</b> At each bimonthly Regional Council meeting, stakeholders identified in plan objectives will submit a written report on the status of work due during that month.</p>
	<p><b>Strategy 4.</b> Beginning October 2009 and utilizing the GANNT Chart, the Regional Council will begin tracking the progress of the objectives and strategies.</p>

## SYSTEM DEVELOPMENT

### - Goal #5 -

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

<p><b>Objective 1.</b> By May, 2011 the Regional Council's Prehospital &amp; Transportation Committee will utilize Washington State DOH standardized methodologies to determine min/max numbers for verified service types in each county.</p>	<p><b>Strategy 1.</b> By January 2010, the Regional Council's Prehospital &amp; Transportation Committee will provide standardized methodologies to local councils for determining min/max numbers, levels and types of Prehospital verified services.</p>
	<p><b>Strategy 2.</b> By May 2011, the Regional Council's Prehospital &amp; Transportation Committee will survey Local Councils for recommended changes to min/max verified service numbers, levels and types for inclusion in the 2012-2017 Regional Plan.</p>
<p><b>Objective 2.</b> By April 2011 the Regional Council will update the EMS &amp; Trauma Care System Plan to address inconsistencies with the state strategic plan.</p>	<p><b>Strategy 1:</b> By November of 2010 the Regional Council will conduct a gap analysis to determine inconsistencies with the WA State Strategic Plan.</p>
	<p><b>Strategy 2.</b> By February 2011 the Regional Council will revise the East Region EMS &amp; TC Strategic Plan based on the gap analysis.</p>
	<p><b>Strategy 3:</b> By April 2011 the Regional Council will submit any revisions of the regional plan to the DOH.</p>
<p><b>Objective 3:</b> By April 2011 the Regional Council will determine min/max numbers for trauma designated services in each county.</p>	<p><b>Strategy 1.</b> By February 2011 the Regional Council will contact all hospitals in the region to determine if they intend to reapply for trauma designation in the next designation cycle and will ask at what level they plan to redesignate.</p>
	<p><b>Strategy 2.</b> By April 2011 the Regional Council will submit any revisions to the DOH.</p>
<p><b>Objective 4:</b> By September 2011 the Regional Council will develop a 2012-2017 regional plan.</p>	<p><b>Strategy 1.</b> By July 2010 the Regional Council will identify a planning work group.</p>
	<p><b>Strategy 2.</b> By September 2010 the Regional Council will conduct a work plan for completing the 2012-17 strategic plan.</p>
	<p><b>Strategy 3.</b> By March 2011 the Regional Council will develop a draft plan.</p>
	<p><b>Strategy 4.</b> By September 2011 the Regional Council will have a finalized 2012-17 strategic plan for submission.</p>

## SYSTEM DEVELOPMENT

### - Goal #6 -

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

<p><b>Objective 1.</b> By February 2010 Regional and Local Councils will identify existing distribution channels for use in timely distribution of Steering Committee &amp; TAC information to regional stakeholders on emerging issues and will develop and implement an information distribution process</p>	<p><b>Strategy 1.</b> By November 2009 Regional and Local Council representatives will identify <i>or</i> form a group representing all counties within the region to determine existing information distribution channels</p>
	<p><b>Strategy 2.</b> By January 2010 the identified group will develop a process for timely distribution of information on emerging issues.</p>
	<p><b>Strategy 3.</b> By February 2010 the emerging issues information dissemination process will be implemented within the regional system</p>

## SYSTEM DEVELOPMENT

### - Goal #7 -

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

<p><b>Objective 1:</b> By October 2009, the Regional Council will maintain processes that ensure key stakeholders remain involved in regional emergency preparedness &amp; disaster planning activities.</p>	<p><b>Strategy 1:</b> By August 2009, the Regional Council will identify a process that ensures hospital presence at Region 9 Healthcare Coalition Executive Committee meetings.</p>
	<p><b>Strategy 2:</b> By October 2009, a Region 9 Healthcare Coalition report will be added to the Regional Council Agenda.</p>
<p><b>Objective 2:</b> By August 2010 and August 2011 regional hospitals will participate in a Region 9 preparedness event.</p>	<p><b>Strategy 1:</b> By August 2010 Region 9 hospitals will participate in a minimum of one disaster drill, tabletop or exercise.</p>
	<p><b>Strategy 2:</b> By August 2011 Region 9 hospitals will participate in a minimum of one disaster drill, tabletop or exercise.</p>
<p><b>Objective 3:</b> By August 2010 and August 2011, the Hospital Planning Committee will develop an After Action Report on preparedness drill, tabletop or exercise.</p>	<p><b>Strategy 1:</b> By August 2010 Regional Council staff will work with representatives from the Hospital Planning Committee to develop the After Action Report for the 2010 preparedness event.</p>
	<p><b>Strategy 2:</b> By August 2011 Regional Council staff will work with representatives from the Hospital Planning Committee to develop the After Action Report for the 2011 preparedness event.</p>

## SYSTEM DEVELOPMENT

### - Goal #8 -

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

<p><b>Objective 1</b>(Hospital to Hospital) By April 2012, the East Region EMS/TC Council's Communication Committee, in collaboration with the East Region EMS/TC Council's Hospital Planning Committee and Region 9 Hospitals will implement a functional regional Hospital to Hospital narrow-band radio communication system.</p>	<p><b>Strategy 1.</b> By December 2009, the Communication Committee will compile, consolidate and distribute to hospitals, existing survey information related to the hospital to hospital communications system.</p>
	<p><b>Strategy 2.</b> By December 2010, Region 9 Hospitals will apply technical recommendations from existing survey information related to HEAR and WHEERS.</p>
	<p><b>Strategy 3.</b> April 2011, Region 9 Hospitals, in collaboration with the East Region EMS/TC Council's Hospital Planning Committee, will test WHEERS connectivity through a regional communication exercise.</p>
	<p><b>Strategy 4.</b> By March 2011, the Communication Committee will identify possible funding sources that community/system partners needing connectivity can apply for.</p>
	<p><b>Strategy 5:</b> By September 2009, the Communication Committee will identify repeater sites that will extend WHEERS connectivity to all Region 9 hospitals and make information available to community/system partners that would seek funding.</p>
	<p><b>Strategy 6:</b> Annually in April, the Communication Committee will review, update and distribute WHEERS training resources to Region 9 Hospitals.</p>
<p><b>Objective 2.</b> (Prehospital to Hospital) By April 2011 the Communications Committee will develop and distribute a guideline to support the use of HEAR as the primary tool for prehospital to hospital communications regionwide</p>	<p><b>Strategy 1.</b> By April 2010, the Communication Committee will identify reasons for non-use of HEAR system through a regional survey which will include preferred prehospital communication tools of Prehospital EMS agencies and Region 9 Hospitals.</p>
	<p><b>Strategy 2</b> By September 2010, the Communication Committee members will meet with local councils and/or Medical Program Directors (MPDs), from any counties not currently using HEAR, to discuss advantages for use of HEAR as the primary Prehospital to hospital communication method</p>
	<p><b>Strategy 3.</b> By April 2011, the Communication Committee will develop and distribute a guideline based on survey results and information from county councils and MPDs.</p>
<p><b>Objective 3:</b> Annually by March the Regional Council will survey dispatch centers to determine the number of dispatchers / call certified in Emergency Medical</p>	<p><b>Strategy 1:</b> Annually in February, the Regional Council's Communication Committee will survey dispatchers and call takers.</p>

Dispatch (EMD) for use in determine training needs	
	<b>Strategy 2:</b> Annually by March, Regional Council Staff will prepared a report for the Communications Committee on the results of the EMS dispatch center survey taken in February of the previous year for determining EMD training needs.

# SYSTEM PUBLIC INFORMATION & EDUCATION

## **Introduction**

### **Where We Are Currently**

There is currently not a best practice public information and education system available for use in the East Region, although one is desperately needed. Most communities learn about the EMS and trauma care system through the eyes of the local or regional media and/or word of mouth when 911 is called and an EMS provider and/or ambulance is needed. The best examples of information and education distribution are when local EMS agencies desire to ask for more funding or to continue an EMS type levy. It is then that articles come out in the newspaper and you see more news blips on TV. We don't do a good job of educating the public on the local or regional EMS & trauma care system. It's time to ask ourselves, "What can we do to assist our community in its education on the East Region EMS and Trauma Care System?"

### **Needs addressed in the Plan**

- Develop and implement a 2-year (March 2010-July 2011) regional public information campaign to educate the public about the EMS and Trauma System.

**- Goal #9 -**

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

<p><b>Objective 1:</b> By March 2011, the Regional Council and stakeholder Public Information Officers (PIOs) will develop and implement a 2-year (March 2010-July 2011) regional public information plan to educate the public about the EMS and Trauma System.</p>	<p><b>Strategy 1:</b> By January 2010, the Regional Council and stakeholder PIOs will review the State Public Information Plan and develop a regionalized public information plan which is consistent with State Public Information Plan.</p>
	<p><b>Strategy 2:</b> By June 2010, the Regional Council and PIOs will identify topics, and talking points which the public should know about the EMS system.</p>
	<p><b>Strategy 3:</b> By November 2010 and March 2011 the Regional Council &amp; PIOs will develop 1 pre-packaged public information message to send to media.</p>

**There is no Regional Plan goal #10**

# SYSTEM FINANCE

## Introduction

### Where We Are Currently:

The East Region is the largest geographical region in the state with 72 EMS agencies, 20 hospitals and one full-time staff person. The Regional Council, as a 501 © 3 non-profit corporation is looking into ways to further support the non-profit side of the organization. Until recently the council has been reliant upon contracting with the Department to provide support its many activities. Regional staff has begun to work with community partners and outside organizations to find out more about grants that might help rural EMS agencies. It is important to not only find funding for EMS agencies and hospitals, but also for the Regional Council to find ways to fund its own non-profit corporation.

The East Region currently has 3 of the poorest counties in the state: Ferry, Stevens, and Pend Oreille. Many rural volunteer agencies are small in size and depend strongly on the participation grants. Those EMS agencies that can, submit grants to the Assistant to Fire Fighters Grants which also has an EMS clause in it. Those agencies that participate in those grants seem to be very successful. There is still a need in the rural areas for equipment and training and training aids. The Regional Council surveys all of its surveys on an annual basis to determine what training needs they have and what kinds of training equipment they may need. Unfortunately the council isn't currently able to provide a grant program to fund any of those needs, but we do share any grant information that becomes available with our EMS agencies and hospitals via email and also post it on the website.

### Regional Project in the Works (Informational only)

In 2008 the DOH tasked each of the EMS regions to develop GIS Trauma Response Area (TRA) Maps. The East Region was lucky enough to have a volunteer who does GIS mapping as a profession. TRA maps were developed for all nine of the counties in the East Region in 2008. The Regional Council is pursuing GIS mapping as a means to support the non-profit side of the organization. The council has just received a grant for ArcView 9.3 software, training, books and single user license valued at approximately \$3,500. The professional volunteer who developed the TRA Maps has agreed to help get us going on what we need to know. The council has a Workstudy student working in the office from Gonzaga University who is majoring in Civil Engineering who will provide backup for this project. Through this mapping project we will be able to map each prehospital aid and ambulance vehicle by their GIS location, each designated facility, all H1N1 cases (illnesses and viruses), and alternate care facilities...the list is extensive depending on ones imagination. When the region was tasked with developing TRAs there were counties in the region that didn't have them. If the software and computer would have been available at the time, we could have charged for the maps and made a profit. The Regional Council anticipates that this will be the first EMS council and possibly even the first PHEPR Region in Washington State to use and or promote this type of project for profit.

The Chairs & Executive Committee begins the development of its annual budget in the spring.

It has become a tradition to fund OTEP (the only training funded by the region) training for rural EMS providers in the region. There are currently approximately 38 agencies that receive 4

classes through Regional Council funds on an annual basis. In the 2009-10 training year, an assessment of between \$10-15 per provider per agency will be assessed to help cover the cost of the per/student fee. This will be the first year that the as assessment has been charged for OTEP in this region.

The Regional Council also contracts with the Spokane Regional Health District to provide an Injury Prevention Coordinator. The IPPE program of choice in the region is Falls Prevention and has been for some time. The coordinator is part-time and focuses mainly on the rural counties of the region.

### **Needs Addressed In The Plan**

- Develop a process by which the prehospital agencies, hospitals and other community partners receive information on funding resources.
- Regional Council's Finance Committee will prepare an annual operations budget for the next fiscal year for presentation to the Regional Council for its approval.

**- Goal #11 -**

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

<p><b>Objective 1.</b> By February 2010 the Regional Council's Finance Committee will develop a process by which the prehospital agencies, hospitals and other community partners receive information on funding resources.</p>	<p><b>Strategy 1.</b> By November 2009 the Regional Council's Finance Committee will develop a process for notifying prehospital agencies, hospitals and other community partners of available funding resources.</p>
	<p><b>Strategy 2.</b> By February 2010 the Regional Council's Finance Committee will present the proposed process to the Regional Council for approval.</p>
	<p><b>Strategy 3.</b> By February 2010 the Regional Council's will implement the Notification of Resource Funding Process.</p>
<p><b>Objective 2:</b> Annually by July the Regional Council will develop and implement an operational budget.</p>	<p><b>Strategy 1.</b> Annually in May the Regional Council's Finance Committee will prepare a draft operational budget for the following fiscal year.</p>
	<p><b>Strategy 2.</b> Annually in July the Regional Council will implement an operational budget for the next fiscal year.</p>

# *CLINICAL COMPONENTS*

## **INJURY PREVENTION & CONTROL**

### **Introduction**

#### **Where We Are Currently**

Injury Prevention is an integral part of the EMS & Trauma System. Prevention resources in the East Region include, but are not limited to, those provided by hospitals, pre-hospital agencies, Public Health, traffic safety commission and task forces, law enforcement and fire agencies, and private industry.

Detailed information about specific programs offered by these groups has not been fully computed. The East Region EMS & Trauma Care Council's approach to Injury Prevention is to contract with an outside agency to carry out injury prevention initiatives that are supported by regional injury data. The Spokane Regional Health District's Injury Prevention Program is the current contractor. Regional Council funding supports a part-time Regional Injury Prevention and Public Education (IPPE) Coordinator who provides IPPE support for the Regional Council's IPPE programs and the Regional Council's IPPE Committee.

The Regional Council's IPPE Committee's primary focus is to serve as a network for injury prevention efforts throughout the region. The committee also serves as a clearing house for injury prevention programs.

The IPPE link on the Regional Council's website at [www.eastregion-ems.org](http://www.eastregion-ems.org) offers information on known injury prevention programs. Committee membership is comprised of representatives from agencies that work toward injury prevention throughout the region.

Additionally, an IPPE Network has been established and the list of members along with their known IPPE programs/activities is updated and submitted annually.

The table below provides information compiled from the Washington State Department of Health, Center of Health Statistics. This table identifies the leading causes of non-fatal hospitalizations and fatal injuries for Eastern Washington region 2002- 2006. The data identify the top four cause rates per 100,000 resident populations.

<b>Non-fatal injuries 2002- 2006</b>	<b>East Region EMS</b>	<b>WA State</b>	<b>Fatal Injuries 2002- 2006</b>	<b>East Region EMS</b>	<b>WA State</b>
Falls among adults 65+	1953.94	1738.11	Falls among adults 65+	102.35	66.58
MVC (to occupants, pedal-cyclists, motorcyclists and pedestrians)	79.86	78.78	MVC (to occupants, pedal-cyclists, motorcyclists and pedestrians)	15.64	11.65
Suicide	58.2	53	Suicide	15.64	13.07
Poisoning	31.15	32.7	Poisoning	13.77	10

### **Needs Addressed In The Plan**

- Provide information to all interested parties on evidence based injury prevention programs and resources available through the East Region EMS/TC Council.
- Conduct an assessment to identify what IPPE related programs are active throughout the region and provide this information to the Regional Council and appropriate agencies.
- East Region funded presentations will be formally evaluated.
- Injury prevention programs funded by the East Region EMS/TC Council will be data driven

**- Goal #12 -**

**INJURY PREVENTION AND CONTROL:**

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

<p><b>Objective 1.</b> By October of 2010, the IPPE Committee will provide information to all interested parties on evidence based injury prevention programs and resources available through the East Region EMS/TC Council.</p>	<p><b>Strategy 1.</b> By March of 2010, the IPPE Committee will compile a list of known evidence based injury prevention programs/resources available to the region.</p>
	<p><b>Strategy 2.</b> By April 2010 the IPPE Committee will develop a distribution list for prehospital, hospital, rehab and community partners and other interested parties.</p>
	<p><b>Strategy 3</b> Semi-annually in April and October of 2010, or as training opportunities arise, the IPPE Committee will make prehospital providers aware of evidence based injury prevention training opportunities and resources by providing information to local councils and prehospital agencies through email based flyers. .</p>
<p><b>Objective 2.</b> By May 2011 the Regional Council’s IPPE Committee will conduct an assessment to identify what IPPE related programs are active throughout the region and will provide this information to the Regional Council and appropriate agencies.</p>	<p><b>Strategy 1:</b> By December 2010 the IPPE Committee will work with Spokane Regional Health District Assessment staff to create a Survey Monkey survey to send to all East Region agencies (prehospital, hospital, rehab and community organizations) to find out what programs they are aware of in their communities and gather details regarding contacts and program information.</p>
	<p><b>Strategy 2:</b> By May 2011 the information gathered from the survey will be presented to the Regional council and posted to the IPPE portion of the EREMS website to reach appropriate agencies.</p>
<p><b>Objective 3:</b> By May 2011, the East Region funded presentations will be formally evaluated.</p>	<p><b>Strategy 1:</b> By September 2010, presenters for all East Region EMS/TC Council funded presentations will utilize standard evaluation tools, developed by the SRHD Community Health Assessment Team and acceptable to the DOH.</p>
	<p><b>Strategy 2:</b> By May 2011, the IPPE Committee will review evaluation summaries of East Region EMS/TC Council funded presentations, to evaluate effectiveness of presentations and presenters, develop a summary report and recommendations for improvement and submit to the Regional Council.</p>
<p><b>Objective 4:</b> By April 2012, injury prevention programs funded by the East Region EMS/TC Council will be data driven.</p>	<p><b>Strategy 1:</b> Annually in December the IPPE Committee will identify the top 4 injury mechanisms using available data sources and provide information on those mechanisms for injury prevention professionals through the East Region EMS/TC Council website and contacts with known existing IPPE programs in the region.</p>
	<p><b>Strategy 2:</b> Annually by March, the Injury Prevention Chair will formally present, or arrange a formal presentation, to the</p>

East Region EMS/TC Council's IPPE Committee, to provide information on data-driven best practice methodology related to the top four injury mechanisms.

**Strategy 3:** Annually by April, the IPPE Committee will review state, regional and local level injury data from the DOH Injury Tables, WEMISIS when available, and current and applicable Spokane Regional Health District (SRHD) assessments, to make funding recommendations to the Regional Council to target the top three injury mechanisms for injury prevention programs, with priority recommendations given to data driven prevention programs.

# PREHOSPITAL

## Introduction

### Where We Are Currently:

The East Region is the largest EMS region in the state of Washington. It is 15,556 square miles in size and is nine counties large. It consists of Adams, Asotin, Ferry, Garfield, Lincoln, Pend Oreille, Spokane, Stevens and Whitman Counties. The East Region is diverse geographically in its mountainous terrain to the north and its farming land mid and south. Spokane County used to be the only urban county in the region. What used to be 8 rural counties in now only 7 with Asotin County recently becoming a metropolis with the incorporation of its bus system into that of Lewiston, Idaho.

There are 72 EMS agencies in the East Region which are licensed and verified. Three of these agencies are in Idaho. Lewiston Fire Department provides ALS transport for Asotin County in Washington. Northwest MedStar provides air ambulance service for East Region as well as for most of eastern Washington and bordering states. Of the regions approximately 2100 EMS providers approximately 71% of them are currently volunteers who live in the rural counties of the region.

The Regional Council provides OTEP training for 38 rural EMS agencies through the Health Training Network. Classes are provided in-house and are also available through TeleHealth (video conferencing) for those who like to attend in their own communities at a local hospital. Inland Northwest Health Services also provides CME and OTEP training through *EMS Live @ Nite* throughout the year which is available through TeleHealth to all EMS providers region-wide along with agencies in Idaho, Montana, Oregon and Alaska. TeleHealth (video conferencing) was used 95 times last year for OTEP training by prehospital agencies throughout the region,. The highest usage was in Adams, Lincoln, Stevens and Ferry Counties. Agencies are responsible for skills maintenance after attending these OTEP sessions. A few agencies in this region are also beginning to use *EMS Online* and other online programs as another source of OTEP.

Trauma Response Area Maps have been developed for each county using GIS ARC VIEW Software. The specific GIS trauma response area descriptions are on file with the DOH. In 2008 each EMS agency was surveyed and the location of each aid and ambulance was identified. The GIS location if each agency has been mapped and some of the GIS locations of the agency aid and/or ambulances have been mapped. This is an ongoing project which continues to be updated on a regular bases.

Min/max numbers are reviewed on an as needed bases by local councils and then submitted to the Regional Council's Prehospital & Transportation Committee upon request from any of the County EMS/TC Councils for review. Once reviewed by the committee the document is forwarded to the Regional Council with a recommendation for review. If approved a recommendation is then forwarded to the Department of Health. The Regional Council and the Local Council will then be asked to make recommendation to the Steering Committee who then forwards a recommendation to the DOH, who approves or disapproves the recommendation. This process ensures there is no duplication of service.

Patient Care Procedures are reviewed annually for appropriateness and if necessary are revised with recommended changes going to the Regional Council for approval, changes posted on the website, and if no other recommendations are brought forward the Regional Council provides recommendation to the DOH for approval. Most often the Department requests that the Regional Council present the PCP to the Steering Committee for recommendation back to the DOH who then provides final approval of the document.

Changes occurred in the summer of 2009 when Deaconess Medical Center announced that it would not be participating in the Trauma System after August 30, 2009. The Regional Council held a meeting to determine whether or not there was a need to revise its Patient Care Procedures that govern triage and transport of the trauma patient, specifically of the Step 3 trauma patient. No changes were necessary, however Spokane County would be developing additional County Operating Procedures, appointing online medical control and training EMS providers. These were big changes for Spokane County.

### **Needs Addressed In The Plan**

- Review and adopt the revised Regional Patient Care Procedures for inclusion in the 2012-2017 East Region EMS and Trauma Care System Plan.
- Develop and implement an annual Training & Education delivery plan.
- Conduct an educational forum during Regional Council meeting on statutory requirements, council operational processes, and data from regional and other assessments and/or other system issues.

**- Goal #13 -**

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

<p><b>Objective 1:</b> By May 2012, the Regional Council will review and adopt the revised Regional Patient Care Procedures for inclusion in the 2012-2017 East Region EMS and Trauma Care System Plan.</p>	<p><b>Strategy 1:</b> By January 2010 the Prehospital and Transportation committee will review Regional Patient Care Procedures (PCP for appropriateness.)</p>
	<p><b>Strategy 2:</b> By September 2010, and as needed during the planning period, the Regional Council’s Prehospital &amp; Transportation Committee will review the Regional Patient Care Procedures, develop and submit recommended revisions to the Region Council for approval.</p>
	<p><b>Strategy 3.</b> By May of 2012 the Regional Council will submit any PCP approved recommendations to the DOH and the Steering Committee for approval.</p>
<p><b>Objective 2:</b> Annually by June the Regional Council’s Training &amp; Education Committee will develop and implement a Training &amp; Education delivery plan.</p>	<p><b>Strategy 1.</b> By March annually the Regional Council’s Training and Education Committee will develop an EMS training survey to include DOH required information.</p>
	<p><b>Strategy 2.</b> By March annually the Regional Council’s Training &amp; Education Committee will distribute the survey to prehospital agencies.</p>
	<p><b>Strategy 3.</b> Annually by May utilizing the training survey results the Regional Council’s Training &amp; Education Committee will assess the EMS training needs and develop a draft EMS Training Delivery Plan.</p>
	<p><b>Strategy 4.</b> Annually by June the Regional Council’s Training &amp; Education Committee will present the training delivery plan to the Regional Council for approval.</p>
<p><b>Objective 3.</b> By April in 2010 and 2011 the Regional Council will conduct an educational forum during its regular meeting on statutory requirements, council operational processes, data from regional and other assessments and/or other system issues through the East Region EMS/TC Council and other partners.</p>	<p><b>Strategy 1.</b> By January of 2010 and 2011 the Regional Council’s Prehospital &amp; Transportation Committee will identify the content of the educational forum and the speakers.</p>
	<p><b>Strategy 2.</b> In January of 2010 and 2011 the Regional Council’s Chairs &amp; Executive Committee will review the</p>

	information in Strategy 1 for appropriateness.
	<b>Strategy 3:</b> By February 2010 and 2011 the Regional Council's Prehospital & Transportation Committee will confirm the content and speakers for the educational forum to be held in April.
	<b>Strategy 4.</b> By February of 2010 and 2011 the Regional Council staff will distribute the agenda and other documents to the appropriate audience being invited to the educational forum.
	<b>Strategy 5.</b> In April of 2010 and 2011 the education will be conducted at the Regional Council meeting.

# ACUTE HOSPITAL

## Introduction

### Where we are currently:

Within the last year there have been several changes within East Region's designated acute care trauma system. Deer Park Hospital, a former level IV facility was forced to close due to economic factors. St. Joseph Regional Medical Center, Lewiston, ID dropped down to a Level III designated facility due to a lack of neurosurgical coverage. Pullman Regional Hospital also dropped designation status to level IV from level III. Deaconess Medical Center, part of Spokane Joint Trauma Service with Sacred Heart Medical Center, has been sold to Community Health Systems (CHS), going from a non-profit to a for-profit status. This organization's affiliates own operate or lease at least 118 hospitals in 29 states across the United States. As a result of this change in ownership, Deaconess and Sacred Heart Medical Centers are applying for separate Level II trauma designations. Sacred Heart Medical Center (SHMC) continues to expand to meet community needs, recently filing a certificate of need application for an additional 173 beds. If approved, SHMC will become the largest hospital in the state with 796 licensed beds.

In early summer Deaconess Medical Center also announced that it would not be participating in the East Region Trauma System effective August 30, 2009. This leaves Providence Sacred Heart Medical Center the only level II trauma designated facility in Eastern Washington. Much discussion has occurred at the regional and county level with regard to the level III trauma patients. Planning between all 4 of the urban hospitals began almost at once.

The East Region continues to utilize available technologies to improve the care of our trauma patients within our catchment area. One such technology incorporates the use of virtual private networks on the Internet to send radiographic images such as CTs and plain films between acute care facilities. The alternative is for referring facilities to send images on computer discs (CDs). There are several disadvantages to CDs. One, receiving facilities cannot always open these discs to view images. The choice then is to repeat studies or base a diagnosis and treatment on radiology reports alone. Repeating studies increase a patient's radiation and IV contrast exposure. Second, it takes time to download these CDs onto a PACS system, which creates a problem for subspecialty consults who could not access these images remotely. There are currently 25 facilities within the catchment area that have established VPN with one of our major PACS systems. There is still more work which continues as we implement new connections, educate providers and trouble shoot problems.

Telehealth is another technology that continues to be utilized extensively within the East Region. Within the non-profit organization of Inland Northwest Health Services (INHS), which represents the joint venture of all four of Spokane's major hospitals, TeleHealth allows long distance meetings, community or professional education and medical consults or exams. Currently, all of the region's designated acute care facilities have access to TeleHealth.

The region also has a robust health information technology network. In 2008, eighteen regional hospitals earned the distinction of being the most technology-advanced hospitals in the country according to *Hospital and Healthworks* magazine. Most wired hospitals are connected by Inland Northwest Health Services (INHS). INHS connects 38 hospitals and health care facilities through

a health information technology network, which allows physicians and healthcare staff to securely access patient information utilizing wired and wireless technology. The INHS health information technology network includes more than 4,000 physicians, 450 clinics and physician offices and 2.8 million electronic medical records.

Education for trauma acute care providers continues to be a regional priority. Each year, a one-day trauma conference is held in Spokane. Last year over 200 participants attended. The Spokane Regional Trauma Education Committee, whose members represent the four major Spokane hospitals and Northwest MedStar, the regional air ambulance service, organizes this educational offering. Conference speakers are recruited both locally and nationally. Continuing medical education category I credits are offered to physicians and continuing education units are offered to nursing professionals. Prehospital providers are also encouraged to attend with topics relevant to their focus.

In the past Spokane Joint Trauma Services has taken a lead role in providing trauma education to the region. Last spring, the Rural Trauma Team Development Course (RTTDC) was held in cooperation with Harborview Medical Center the day after the region's annual trauma conference. Thirty-seven participants from nine of Eastern Washington's rural trauma designated facilities participated. In the future, the Spokane Regional Trauma Education Committee will continue to provide the annual trauma conference in Spokane for regional providers and the RTTDC course will be sponsored by Sacred Heart Trauma Services.

The regional and global economy will continue to dictate acute healthcare resources with the east region. Within the trauma provider community, appropriate utilization of limited resources will continue to be the ultimate goal.

All of East Region's acute care facilities participate in our statewide trauma system. If these facilities remain viable it will depend on economic factors not under the control of either a regional or statewide trauma system. High-quality trauma patient care is and will continue to be the focus of our regional efforts.

NEED statement? There are several needs in acute care trauma service currently. One is bed availability. Available beds are reliant on two factors: available staff and physical beds. Obviously, this problem is not isolated to trauma and will continue to be addressed on many different levels within the healthcare system. Very often there is a shortage of acute care beds which is different from just regular staffed beds.

Another area of concern is the availability and willingness of subspecialists such as orthopedists and neurosurgeons to participate in the care of our trauma patients.

Each year, area hospitals pay hundreds of thousands of dollars to these physicians to take emergency/trauma call. Each year, these fees continue to increase and physicians who once were not compensated to take call, now request compensation to offset lost income in their clinical practice.

Even within the group of physicians that do agree to take call, there is a wide variance to their willingness to participate. Some subspecialists self-limit their practice by refusing to treat certain patient populations such as pediatrics or certain types of injuries. Again, these problems need to be addressed at many different levels.

**Current Trauma Designated Services (provided by DOH 9-2009)**

Sacred Heart Medical Center	Spokane	Level II adult Level II pediatric
St Joseph's Regional Medical Center	Lewiston, Idaho	Level III adult Level III pediatric
Holy Family Hospital	Spokane	Level III adult
Valley Hospital & Medical Center	Spokane	Level III adult
Pullman Regional Hospital	Pullman	Level III adult
Mount Carmel Hospital	Colville	Level IV adult
Newport Community Hospital	Newport	Level IV adult
St Joseph's Hospital of Chewelah	Chewelah	Level IV adult
Tri-State Memorial Hospital	Clarkston	Level IV adult
East Adams Rural Hospital	Ritzville	Level V adult
Ferry County Memorial Hospital	Republic	Level V adult
Garfield County Hospital District	Pomeroy	Level V adult
Lincoln Hospital	Davenport	Level V adult
Odessa Memorial Hospital	Odessa	Level V adult
Othello Community Hospital	Othello	Level V adult
Whitman Hospital and Medical Ctr.	Colfax	Level V adult
St Luke's Rehabilitation Institute	Spokane	Level I adult <i>Rehab</i>

**Needs Addressed In The Plan**

- Sacred Heart Medical Center (SHMC) in conjunction with regional QI will coordinate the establishment of an efficient means of transferring radiology images through virtual private network (VPN).
- The Spokane Regional Trauma Education Committee will plan and hold a Trauma Conference annually in Spokane
- Sacred Heart Trauma Services will plan and hold a Rural Trauma Team Development Course annually in Spokane.

**- Goal #14 -**

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

<p><b>Objective 1.</b> By January 2012, Sacred Heart Medical Center (SHMC) in conjunction with regional QI will coordinate the establishment of an efficient means of transferring radiology images through virtual private network (VPN).</p>	<p><b>Strategy 1.</b> By July 2010 SHMC in conjunction with regional QI will identify referring hospitals that do not have the infrastructure for VPN.</p>
	<p><b>Strategy 2.</b> By July 2011 SHMC in conjunction with regional QI will identify the infrastructure needs for referring hospitals for VPN.</p>
	<p><b>Strategy 3.</b> By January of 2012 SHMC will work with the QI Committee and Inland Imaging to develop the infrastructure required for referring hospitals to have virtual private networks (VPN) established for interfacility transfers to provide an efficient means of transferring radiology images when indicated.</p>
<p><b>Objective 2:</b> Annually, by April the Spokane Regional Trauma Education Committee (SRTEC) will plan and hold a Trauma Conference for all trauma providers for the region.</p>	<p><b>Strategy 1.</b> Annually by September the SRTEC will identify date of the trauma conference.</p>
	<p><b>Strategy 2:</b> Annually by November, the SRETC will compile a list of proposed speakers and subject matter for the conference</p>
	<p><b>Strategy 3:</b> Annually by December the SRETC will secure a venue for the conference</p>
	<p><b>Strategy 4:</b> Annually by December the SRETC will finalize the list of speakers and subject matter for the conference.</p>
	<p><b>Strategy 5:</b> Annually by February the SRETC will develop the Save the Date conference postcard and distribute it to providers regionwide.</p>
	<p><b>Strategy 6:</b> Annually by March the SRETC will develop the brochure for the conference and send it out to providers regionwide.</p>
	<p><b>Strategy 7:</b> Annually by April the Trauma Conference will be held.</p>
<p><b>Objective 3:</b> Annually by April Sacred Heart Trauma Services (SHTS) will plan and hold a Rural Trauma Team Development Course (RTTDC)</p>	<p><b>Strategy 1.</b> Annually by September SHTS will identify the date of the RTTDC.</p>

for all trauma providers to be held in Spokane.	
	<b>Strategy 2:</b> Annually by November, the SHTS will determine the RTTDC venue.
	<b>Strategy 3:</b> Annually by January the SHTS will coordinate a list of proposed RTTDC speakers.
	<b>Strategy 4:</b> Annually by February the SHTS will distribute a RTTDC announcement to Eastern Washington providers.
	<b>Strategy 5:</b> Annually by April the RTTDC will be held.

# PEDIATRIC

## Introduction

### Where We Are Currently

The East Region has a Children's Hospital located in Spokane, WA which is Sacred Heart Medical Center and Children's Hospital. It is a Level II pediatric trauma center, the only one located on the east side of the Cascade Mountain range. There are 90 pediatric specialists that work within the Children's Hospital. The pediatric ED is also located at Sacred Heart and it recently expanded to 24 hours per day. It is staffed with pediatric RN's and pediatric emergency physicians. St. Joseph's Regional Medical Center in Lewiston is a Level III pediatric trauma designated trauma center serving the southern portion of the region.

Pediatric patients make up the minority of the EMS and Trauma patient volume within the East Region. Due to the infrequency of pre-hospital pediatric emergency calls, added emphasis is needed in the ongoing training of prehospital providers in pediatric emergency care, and to provide the EMS provider with up to date, evidence based, pediatric protocols.

The East Region (Council) currently does not have a formal pediatric training and education committee. There has been an inactive pediatric committee for many years. In 2007, a small group of pediatric nurses, trauma coordinators, trainers and East Region staff brainstormed and formed an ad hoc conference committee to put on a Pediatric Conference in Spokane for EMS providers with funding from an EMSC grant. Conference attendees gave the ad hoc committee valuable feedback that the pediatric education was desired and very much needed in our region. With the development of a pediatric committee that consists of pediatric trauma coordinators, pediatric nurses, pediatric educators, and pre-hospital training personnel, the committee will have a well rounded team to move forward with an education plan.

The East Region doesn't have specific MPD pediatric protocols. Several of the East Region Council members are participating on the Washington Pediatric TAC, and are active in the process of developing the statewide pediatric protocols. Once these protocols are developed, the East Regional pediatric committee will need to be reconvened and will be responsible for the development of the methodology with MPDs for educating pre-hospital agencies

### Needs Addressed In The Plan

- Establish a Pediatric Committee to research and identify training opportunities for prehospital EMS providers regionwide.
- Host an Emergency Medical Services for Children (EMSC) Conference in the East Region for Prehospital EMS and hospital education.

**- Goal #15 -**

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

<p><b>Objective 1</b> Annually by October 2011 the East Region EMS/TC Council will research and identify training opportunities for Prehospital EMS providers</p>	<p><b>Strategy 1.</b> By December 2009, The East Region EMS/TC Council will establish a Pediatric Committee that will consist of hospital and prehospital providers.</p>
	<p><b>Strategy 2.</b> Semi-annually in April and October in 2010 and 2011 the East Region EMS/TC Council’s Pediatric Committee will research existing pediatric EMS training opportunities and will distribute at the Regional Council meeting and will post on the training page of the regional website.</p>
<p><b>Objective 2:</b> In October 2011, the East Region EMS/TC Council, in collaboration with the Sacred Heart Medical Center Children’s Hospital, will host a Emergency Medical Services for Children (EMSC) Conference in the East Region for Prehospital EMS and hospital education.</p>	<p><b>Strategy 1:</b> By January 2010, the East Region EMS/TC Council and Sacred Heart Medical Center Children’s Hospital will establish an EMSC Conference planning workgroup.</p>
	<p><b>Strategy 2:</b> By July 2010, the East Region EMSC Conference planning workgroup will compile a list of proposed speakers and subject matter for the conference.</p>
	<p><b>Strategy 3.</b> By November 2010, the East Region EMSC Conference planning workgroup will secure a venue for the conference.</p>
	<p><b>Strategy 4:</b> By December 2010, the East Region EMSC Conference planning workgroup will secure funding for the conference.</p>
	<p><b>Strategy 5:</b> By February 2011 the EREMSC Conference Committee will finalize the list of speakers and subject matter.</p>
	<p><b>Strategy 6:</b> By July 2011 the Save the Date postcard will be distributed to EMS providers regionwide by the Conference Committee.</p>
	<p><b>Strategy 7:</b> By August 2011, the brochure for the October conference will be developed by the East Region EMSC Conference Planning group and sent out to the identified EMS agencies.</p>
	<p><b>Strategy 8:</b> By October 2011 the EMSC Conference will be held.</p>

# TRAUMA REHABILITATION

## Introduction

### Where we are currently

St Luke's Rehabilitation Institute is a Level I Trauma designated facility in the East Region. St Luke's Rehabilitation Institute is the only Level I Trauma designated facility in Eastern Washington. St Luke's has a state license for 102 acute inpatient rehabilitation beds.

St. Luke's receives Spinal Cord Injury, Brain Injury and Multi-trauma patients from intra state trauma system and out of state trauma patients with identified diagnosis.

St. Luke' Rehab is the primary rehab representative on East Region committees including: East Region EMS and Trauma Council, Hospital Planning Committee, Quality Improvement Committee and Falls Prevention sub-committee.

The East Region Rehabilitation Committee is lead by a St Luke's representative. The Rehab Committee provides coordination of the East Region Rehab Resource Directory for stakeholders, updates of webpage with information related to education, trauma information and resources related to rehabilitation and provide ongoing case reviews to reflect the East Region Trauma System. Case presentations are provided through the rehab committee to the Regional QI committee, at East Region EMS Retreats, for the Regional EMS Council, and for the Governor's Steering Committee.

### Needs Addressed In The Plan

- Publicize ongoing education opportunities on SCI, TBI and multi-trauma using a continuum of care from injury to discharge to community.
- Implement a process to identify and recruit membership from each of the nine counties of the region, to include: 1) the review and update of the Rehab Resource Directory; 2) the development of a Recruitment and Retention Plan for Rehab Committee Members; and 3) recruiting members for the committee.
- Identify and disseminate a list of resources, including funding resources, to community organizations involved in providing rehabilitation services.
- Annually provide a trauma case presentation to identified stakeholders to showcase the continuum of coordinated system care.

**- Goal #16 -**

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

<p><b>Objective 1:</b> Beginning in September 2009 and ending May 2012 the East Region EMS/TC Council’s Rehab Committee, in conjunction with St. Luke’s Rehab Institute, will publicize ongoing education opportunities on SCI, TBI and multi-trauma using a continuum of care from injury to discharge to community.</p>	<p><b>Strategy 1:</b> Beginning in September 2009, quarterly education programs, coordinated through St. Luke’s Rehab Institute will be publicized by the East Region EMS/TC Council’s Rehab Committee through the East Region website and email distribution.</p>
	<p><b>Strategy 2:</b> Annually beginning May 2010, the East Region EMS/TC Council’s Rehab Committee, in conjunction with St. Luke’s Rehab Institute, will provide continuing education for caregivers, providers and patients.</p>
	<p><b>Strategy 3:</b> Semi-annually in August and February, the East Region EMS/TC Council’s Rehab Committee will coordinate and conduct case reviews for the East Region EMS/TC Council.</p>
	<p><b>Strategy 4:</b> Annually in November, the East Region will provide a Case Review Presentation to the Governor’s Steering Committee on EMS &amp; Trauma.</p>
<p><b>Objective 2:</b> By December 2011, the East Region EMS/TC Council’s Rehab Committee will implement a process to identify and recruit membership from each of the nine counties of the region</p>	<p><b>Strategy 1:</b> Annually in November, the East Region EMS/TC Council’s Rehab Committee will review and update the Regional Rehab Resource Directory which identifies hospitals, clinics and other organizations in the region that provide rehabilitation services.</p>
	<p><b>Strategy 2:</b> By October 2010, the East Region EMS/TC Council’s Rehab Committee will develop a Recruitment/Retention Plan for Rehab Committee membership.</p>
	<p><b>Strategy 3:</b> By December 2011, using the Regional Rehab Resource Directory, the East Region EMS/TC Council’s Rehab Committee members will identify and recruit rehabilitation stakeholders within the nine counties in the region to serve on the Rehab Committee.</p>
<p><b>Objective 3:</b> By June 2011, the East Region EMS/TC Council’s Rehab Committee will identify and disseminate a list of resources, including funding resources, to community organizations involved in providing rehabilitation services after hospital discharge for their use in seeking rehab resource support.</p>	<p><b>Strategy 1:</b> By June 2010, the East Region EMS/TC Council’s Rehab Committee will identify gaps and barriers within rehabilitation care for which resources are needed in local communities.</p>

	<p><b>Strategy 2:</b> By September 2010, the East Region EMS/TC Council’s Rehab Committee will prioritize the list of gaps and barriers based upon stakeholder’s market analysis, including DOH, Census Bureau, CDC and Medicare.</p>
	<p><b>Strategy 3:</b> By June 2011, the East Region EMS/TC Council’s Rehab Committee will develop a list of resources for the top three gaps/barriers and make available to community organizations and through the East Region website and distribute one time to identified rehab services.</p>
<p><b>Objective 4.</b> Annually, beginning in 2009, the Regional Rehab Committee will provide a trauma case presentation to identified stakeholders to showcase the continuum of coordinated system care.</p>	<p><b>Strategy 1.</b> Annually in October, the Regional Rehab Committee will identify audience stake holders.</p>
	<p><b>Strategy 2.</b> Beginning November 2009 and annually thereafter, the Regional Rehab Committee will present a trauma case review(s) to the Governors Steering Committee, Regional Council or other community partners.</p>

# SYSTEM EVALUATION

## Introduction

### Where we are currently:

Although the East Region has data available for use in evaluation and improvement across most sections of the EMS & Trauma Care System, *it is not easily accessible or usable; therefore it is not currently a valuable regional asset.*

Approximately 50% of EMS agencies in the East Region have signed up to submit data on WEMSIS. Some agencies like Spokane City and Valley Fire Departments are waiting for software interfaces to occur, while other agencies such as Ferry County EMS District #1 are waiting for funding to secure additional equipment such as a field bridge before they begin using WEMSIS. Others are trying to use WEMSIS but just require a bit more training.

St. Luke's Rehabilitation Institute has been collecting data via *Collector* since the inception of *Collector* back in the mid 1990s, however the DOH does not have an interface capability for rehab data rehab data, therefore this data is not accessible.

All Trauma designated facilities regionwide submit trauma data to the DOH using *Collector*. This data is available through the DOH.

Currently a bed tracking system is housed on the RAMSES website and is being used throughout Region 9 in all hospitals. The information not available except to Region 9 hospitals and is uploaded automatically through Meditech for all hospitals except Garfield County Memorial Hospital which uses a different system and must enter information manually (*Region 9 Hospital Preparedness Plan*). RAMSES also provides diversion information to EMS providers and lets other hospitals know the current status of regional hospitals. Region 9 hospitals are currently looking at a bed tracking system called WATrac which has been adopted by most of the other regions in the state.

Spokane County EMS/TC Council has a project which is being piloted in Sacred Heart and Deaconess Medical Centers, Holy Family Hospital and Valley Hospital & Medical Center called ***Pyramid***. This system will provide syndromic surveillance relevant to the possible use of biological, chemical and radiation weapons use currently within Spokane County. The system will provide a broad picture of emergent and emergency requests for medical care that will have daily relevance for prehospital & hospital based systems of care.

There is a need for an interface between *Collector* and ***WEMSIS*** or standardization/ equivalency of the required data fields of the prehospital and hospital databases, or possibly the purchase of a new hospital database that would interface with ***WEMSIS***. This need is not addressed in the objectives and strategies in this plan.

### **Needs Addressed In The Plan**

- WEMSYS resource barriers and solutions will be identified by the Regional Council.
- East Region Hospital Trauma Program Coordinators will provide reports on the top four injury mechanisms from their particular trauma service to the IPPE Committee for completion of Goal 12, Objective 4, Strategies 1 and 2.

**- Goal #17 -**

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

<p><b>Objective 1.</b>By August 2010 WEMSIS resource barriers and solutions will be identified by the Regional Council.</p>	<p><b>Strategy 1.</b> By January 2010 the East Region WEMSIS Mentors will analyze the needs assessment from 2008 and develop a report for the Regional Council that will include 1) equipment needs of the small rural agencies; 2) education needs; 3) current software interface needs; 4) funding needs.</p> <p><b>Strategy 2.</b> By February 2010 the Regional Council’s WEMSIS Committee will provide a report to the Regional Council on their recommendation regarding prehospital needs required to bring agencies on board for the submission of data.</p> <p><b>Strategy 3</b> By March 2010 the Regional Council’s Finance Committee in conjunction with the WEMSIS Committee will identify appropriate stakeholders to work towards funding the equipment needs of the prehospital agencies so that they can submit data.</p> <p><b>Strategy 4.</b> By August of 2010 the Regional Council will make available to prehospital agencies possible funding resources for WEMSIS equipment, education and software interfaces.</p>
<p><b>Objective 2:</b> By March 2012 the East Region Hospital Trauma Program Coordinators will provide reports on the top four injury mechanisms from their particular trauma service to the IPPE Committee for use in data-driven best practice methodology development.</p>	<p><b>Strategy 1.</b> Annually in January individual East Region trauma services will identify the number of admissions treated for the top 4 injury mechanisms available at their particular facility for the previous 12 months using Washington Trauma Registry data.</p> <p><b>Strategy 2.</b> Annually in March the Injury Prevention Chair will formally present, or arrange a formal presentation, to the East Region EMS/TC Council’s IPPE Committee, to provide information on data-driven best practice methodology related to the top four injury mechanisms.</p>

# SYSTEM EVALUATION

## Introduction

### Where we are currently:

The regional QI Committee meets quarterly at Sacred Heart Medical Center and has good attendance by hospitals in the East Region and some neighboring hospitals as well. An educational presentation is provided at most meetings. Last year the committee reviewed and updated its bylaws and its plan and is currently seeking additional membership in Medical Program Directors and BLS and ALS EMS providers.

The committee regularly reviews data at its meetings. Regional data is provided by St. Luke's Rehabilitation Institute and Northwest MedStar upon request. The DOH also provides requested data reports.

All hospitals in the East Region have QI processes in place. Most Local EMS/TC Councils have a QI process in place where run reports, protocols or other processes are reviewed by specific council members and the MPD. Some Local Councils have sanctioned QI Committees in place.

### Needs Addressed In The Plan

- Evaluate transfer data, provided by the state, to assess the appropriateness and timeliness of transfer.
- Make recommendations for changes to the East Region Transfer Guidelines to more accurately reflect regional needs and requirements.
- Revise the East Region QI Plan to more accurately reflect regional needs and requirements.

**- Goal #18 -**

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

<p><b>Objection 1.</b> By March 2012, the East Region QI Committee will evaluate transfer data, provided by the state, to assess the appropriateness and timeliness of transfer.</p>	<p><b>Strategy 1.</b> By March 2010, the East Region QI Committee will evaluate the workup of selected transfers meeting EMS trauma activation criteria for the timeliness and appropriateness of the diagnostic studies initiated at the referring facility.</p>
	<p><b>Strategy 2.</b> By September 2010, the East Region QI Committee will evaluate those air medical transfers requests declined by Northwest MedStar and its impact on the timeliness of transfers from a referring facility.</p>
	<p><b>Strategy 3.</b> By March 2011, the East Region QI Committee will evaluate those out of region transfers for patient whose needs may have been able to be met within East Region resources.</p>
	<p><b>Strategy 4.</b> By March 2012, the East Region QI Committee will report their findings and make recommendations to East Region EMS Council.</p>
<p><b>Objective 2.</b> By September 2010, the East Region QI Committee will make recommendations for changes to the East Region Transfer Guidelines to more accurately reflect regional needs and requirements.</p>	<p><b>Strategy 1.</b> By September 2009, the East Region QI Committee will evaluate the East Region Transfer Guidelines to determine needed changes.</p>
	<p><b>Strategy 2.</b> By June 2010, the East Region QI Committee will complete proposed changes to the East Region Transfer Guidelines.</p>
	<p><b>Strategy 3.</b> By September 2010, the East Region QI Committee will report their recommendations to East Region EMS Council.</p>
<p><b>Objective 3.</b> By September 2010, the East Region QI Committee will revise the East Region QI Plan to more accurately reflect regional needs and requirements.</p>	<p><b>Strategy 1.</b> By September 2009, the East Region QI Committee will evaluate the East Region QI plan to determine needed changes.</p>
	<p><b>Strategy 2.</b> By September 2010, the East Region QI Committee will report on the revised East Region QI Plan to East Region EMS Council.</p>

## APPENDICES

### **Appendix 1.**

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

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - <i>Minimum</i> number</b>	<b>State Approved - <i>Maximum</i> number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Adams</b>	Aid – BLS	0	0	0
	Aid – ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	2	2	2
	Amb – ILS	0	0	0
	Amb - ALS	0	0	0

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - <i>Minimum</i> number</b>	<b>State Approved - <i>Maximum</i> number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Asotin</b>	Aid – BLS	1	1	1
	Aid – ILS	1	1	1
	Aid – ALS	0	0	0
	Amb –BLS	1	0	1
	Amb – ILS	0	0	0
	Amb - ALS	1	1	1 (Idaho)

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - Minimum number</b>	<b>State Approved - Maximum number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Ferry</b>	Aid – BLS	0	0	0
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	2	2	2
	Amb – ILS	0	0	0
	Amb - ALS	0	0	0

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - Minimum number</b>	<b>State Approved - Maximum number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Garfield</b>	Aid – BLS	0	0	0
	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

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - Minimum number</b>	<b>State Approved - Maximum number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Lincoln</b>	Aid – BLS	2	2	3
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	6	6	6
	Amb – ILS	0	0	0
	Amb - ALS	0	0	0

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - Minimum number</b>	<b>State Approved - Maximum number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Pend Oreille</b>	Aid – BLS	6	7	7
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	2	3	3
	Amb – ILS	0	0	0
	Amb - ALS	0	0	0

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - Minimum number</b>	<b>State Approved - Maximum number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Spokane</b>	Aid – BLS	12	12	12
	Aid –ILS	0	0	0
	Aid – ALS	4	4	4
	Amb –BLS	1	1	1
	Amb – ILS	0	0	0
	Amb - ALS	2	2	2

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - Minimum number</b>	<b>State Approved - Maximum number</b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Stevens</b>	Aid – BLS	5	8	3
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	3	4	3
	Amb – ILS	0	0	0
	Amb - ALS	1	1	0

<b>County (Name)</b>	<b>Verified Service Type</b>	<b>State Approved - <i>Minimum number</i></b>	<b>State Approved - <i>Maximum number</i></b>	<b>Current Status (Total # Verified for each Service Type within the whole county)</b>
<b>Whitman</b>	Aid – BLS	10	13	11
	Aid –ILS	0	0	0
	Aid – ALS	0	0	0
	Amb –BLS	8	13	6
	Amb – ILS	1	5	0
	Amb - ALS	1	1	1

## Appendix 2.

### Trauma Response Areas by County

**\*\*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.

**\*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

<b>Adams County</b>	<b>Trauma Response Area Number</b>	<b>Description of Trauma Response Area's Geographic Boundaries</b> (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	<b>Type and # of Verified Services available in each Response Areas</b> (*use key below – **see explanation)
Adams	101	GIS description is on file with the DOH	D-1
Adams	102	GIS description is on file with the DOH	D-1
Adams	103	GIS description is on file with the DOH	D-1
Adams	104	GIS description is on file with the DOH	D-1
Adams	105	GIS description is on file with the DOH	D-1
Adams	106	GIS description is on file with the DOH	D-1

<b>Asotin County</b>	<b>Trauma Response Area Number</b>	<b>Description of Trauma Response Area's Geographic Boundaries</b> (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	<b>Type of Verified Services in each area</b>
Asotin	201	GIS description is on file with the DOH	B-1 F-1
Asotin	202	GIS description is on file with the DOH	B-1 F-1
Asotin	203	GIS description is on file with the DOH	B-1 F-1

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

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

<b>Ferry County</b>	<b>Trauma Response Area Number</b>	<b>Description of Trauma Response Area's Geographic Boundaries</b> (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	<b>Type of Verified Services in each area</b>
Ferry	1001	GIS description is on file with the DOH	D-2
Ferry	1002	GIS description is on file with the DOH	D-4,
Ferry	1003	GIS description is on file with the DOH	
Ferry	0CCT	GIS description is on file with the DOH	

**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

<b>Garfield County</b>	<b>Trauma Response Area Number</b>	<b>Description of Trauma Response Area's Geographic Boundaries</b> (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	<b>Type and # of Verified Services in each Response Area</b>
Garfield	1	GIS description is on file with the DOH	A1 D1
Garfield	0	GIS description is on file with the DOH (Covered by Oregon)	NA

**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

<b>Lincoln County</b>	<b>Trauma Response Area Number</b>	<b>Description of Trauma Response Area's Geographic Boundaries</b> (description must provide boundaries that <u>can be mapped</u> and encompass the entire trauma response area – may use GIS to describe as available)	<b>Type and # of Verified Services in each Area</b>
Lincoln	2201	GIS description is on file with the DOH	A-1 D-1
Lincoln	2202	GIS description is on file with the DOH	A-3 D-2
Lincoln	2203	GIS description is on file with the DOH	A-1 D-1
Lincoln	2204	GIS description is on file with the DOH	A-1 D-1
Lincoln	2205	GIS description is on file with the DOH	D-1
Lincoln	2206	GIS description is on file with the DOH	D-1
Lincoln	2207	GIS description is on file with the DOH	A-2 D-2

Lincoln	2208	GIS description is on file with the DOH	A-1 D-1
Lincoln	2209	GIS description is on file with the DOH	A-1 D-1
Lincoln	2210	GIS description is on file with the DOH	D-1
Lincoln	2211	GIS description is on file with the DOH	D-1
Lincoln	2212	GIS description is on file with the DOH	A-2 D-1
Lincoln	2213	GIS description is on file with the DOH	A-1 D-1
Lincoln	2214	GIS description is on file with the DOH	D-1
Lincoln	2215	GIS description is on file with the DOH	A-1 D-1
Lincoln	2216	GIS description is on file with the DOH	A-1 D-1
Lincoln	2217	GIS description is on file with the DOH	D-1
Lincoln	2218	GIS description is on file with the DOH	A-1 D-1
Lincoln	2219	GIS description is on file with the DOH	A-1 D-1
Lincoln	2220	GIS description is on file with the DOH	A-1 D-1
Lincoln	2221	GIS description is on file with the DOH	A-1 D-1
Lincoln	2222	GIS description is on file with the DOH	D-1
Lincoln	2223	GIS description is on file with the DOH	A-1 D-1
Lincoln	2224	GIS description is on file with the DOH	A-1 D-1
Lincoln	2225	GIS description is on file with the DOH	A-1 D-1
Lincoln	2226	GIS description is on file with the DOH	

**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

<b>Pend Oreille County</b>	<b>Trauma Response Area Number</b>	<b>Description of Trauma Response Area's Geographic Boundaries</b>	<b>Type and # of Verified Services in each Response Areas * use key</b>
Pend Oreille	2601	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2602	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2603	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2604	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2605	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2606	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2607	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2608	GIS description is on file with the DOH	A-1 D-1
Pend Oreille	2609	GIS description is on file with the DOH	D-1
Pend Oreille	3201	GIS description is on file with the DOH	D-1

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

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

<b>Spokane County</b>	<b>Trauma Response Area</b>	<b>Description</b>	<b>Type and # of Verified Services in each area</b>
Spokane	3201	GIS description is on file with the DOH	C-1 F-1
Spokane	3202	GIS description is on file with the DOH	A-1 D-1 F-1
Spokane	3203	GIS description is on file with the DOH	C-1 F-1
Spokane	3204	GIS description is on file with the DOH	A-1 F-2
Spokane	3205	GIS description is on file with the DOH	C-1 F-1
Spokane	3206	GIS description is on file with the DOH	C-1 F-1
Spokane	3207	GIS description is on file with the DOH	A-1 F-1
Spokane	3208	GIS description is on file with the DOH	C-1 F-1
Spokane	3209	GIS description is on file with the DOH	A-1 F-1
Spokane	3210	GIS description is on file with the DOH	A-1 F-1
Spokane	3211	GIS description is on file with the DOH	A-1 F-1
Spokane	3212	GIS description is on file with the DOH	A-1 F-1
Spokane	3213	GIS description is on file with the DOH	A-1 F-1
Spokane	3214	GIS description is on file with the DOH	A-1 F-1
Spokane	3215	GIS description is on file with the DOH	A-1 F-1
Spokane	3216	GIS description is on file with the DOH	A-2 F-1
Spokane	3217	GIS description is on file with the DOH	
Spokane	ONB	GIS description is on file with the DOH	

**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

<b>Stevens County</b>	<b>Trauma Response Area</b>	<b>Description</b>	<b>Type and # of Verified Services in each area</b>
Stevens	#3301	GIS description is on file with the DOH	A-1 D-1
Stevens	#3302	GIS description is on file with the DOH	A-1 D-1
Stevens	#3303	GIS description is on file with the DOH	D-1
Stevens	#3304	GIS description is on file with the DOH	D-1
Stevens	#3305	GIS description is on file with the DOH	A-1 D-1
Stevens	#3306	GIS description is on file with the DOH	D-1
Stevens	#3307	GIS description is on file with the DOH	D-1
Stevens	#3308	GIS description is on file with the DOH	A-1 D-1 F-1
Stevens	#3309	GIS description is on file with the DOH	A-1 D-1
Stevens	3310	GIS description is on file with the DOH	D-1
Stevens	#3311	GIS description is on file with the DOH	A-1 D-1

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

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

<b>Whitman County</b>	<b>Trauma Response Area Number</b>	<b>DESCRIPTION OF TRAUMA RESPONSE AREA</b>	<b>Type And Number Of Verified Services</b>
Whitman	3801	GIS description is on file with the DOH	A-1 D-1
Whitman	3802	GIS description is on file with the DOH	A-1 D-1
Whitman	3803	GIS description is on file with the DOH	A-1 D-1
Whitman	3804	GIS description is on file with the DOH	A-1 D-1
Whitman	3805	GIS description is on file with the DOH	A-1 D-1
Whitman	3806	GIS description is on file with the DOH	A-1 D-1
Whitman	3807	GIS description is on file with the DOH	A-1 F-1
Whitman	3808	GIS description is on file with the DOH	A-1 D-1
Whitman	3809	GIS description is on file with the DOH	A-1 D-1
Whitman	3810	GIS description is on file with the DOH	D-1
Whitman	3811	GIS description is on file with the DOH	A-1 D-1
Whitman	3812	GIS description is on file with the DOH	A-1 D-1
Whitman	3813	GIS description is on file with the DOH	A-1 D-1
Whitman	3814	GIS description is on file with the DOH	A-1 D-1
Whitman	3815	GIS description is on file with the DOH	D-1

Whitman	3816	GIS description is on file with the DOH	A-1 D-1
Whitman	3817	GIS description is on file with the DOH	D-1
Whitman	3818	GIS description is on file with the DOH	A-1 D-1
Whitman	3819	GIS description is on file with the DOH	A-1 D-1
Whitman	3820	GIS description is on file with the DOH	D-1 F-1
Whitman	3821	GIS description is on file with the DOH	A-2 D-1
Whitman	3822	GIS description is on file with the DOH	D-1
Whitman	3823	GIS description is on file with the DOH	A-1 D-1
Whitman	3824	GIS description is on file with the DOH	A-1 D-1
Whitman	3825	GIS description is on file with the DOH	A-1 F-1
Whitman	3826	GIS description is on file with the DOH	F-1
Whitman	3827	GIS description is on file with the DOH	A-1 F-1
Whitman	3828	GIS description is on file with the DOH	D-1 F-1
Whitman	3829	GIS description is on file with the DOH	D-1 F-1
Whitman	3830	GIS description is on file with the DOH	A-1 D-1

### **Appendix 3.**

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

<b>Level</b>	<b>State Approved</b>		<b>Current Status</b>
	Min	Max	
II	1	3	1 (1 joint)
III	3	4	3
IV	8	10	5
V	3	6	7
II P	1	2	1
III P	1	2	1 (Lewiston, Idaho)

#### **B. Approved Minimum/Maximum (min/max) numbers of Designated Rehabilitation Trauma Care Services in the Region by level**

<b>Level</b>	<b>State Approved</b>		<b>Current Status</b>
	Min	Max	
II	0	0	0
III*	0	0	0

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

**Appendix 4.**

**Patient Care Procedures (PCPs)**

## **EAST REGION PATIENT CARE PROCEDURE #1 DISPATCH OF MEDICAL PERSONNEL**

### **I. STANDARD:**

1. *Licensed aid and/or licensed ambulance services shall be dispatched to all emergency medical incidents by the appropriate 911 center.*
2. *Verified aid and/or verified ambulance services shall be dispatched to all known injury incidents, as well as unknown injury incidents.*
3. *All licensed and verified aid and licensed and verified ambulance services shall operate 24 hours a day seven days a week. (Current WAC)*
4. *All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.*

### **II. PURPOSE:** *(See County Specific Operating Procedures and Response Area Maps)*

1. To provide timely care to all emergency medical and trauma patients as identified in the *Current WAC*.
2. To minimize “System Response Time” in order to get certified personnel to the scene as quickly as possible.
3. To minimize “System Response Time” in order to get licensed and or verified aid and ambulance services to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of response agencies.

### **III. PROCEDURE:**

1. **Following the Region’s plan to promote the concept of tiered response, an appropriate licensed or verified service shall be dispatched per the above standards.**
2. **Dispatcher shall determine appropriate category of call using established Washington State EMD Guidelines.**
3. **Response shall be pre-planned by EMD response protocol. (See County Specific Operating Procedures and East Region Response Area Maps.)**

### **IV. DEFINITIONS**

“**System Response Time**” for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

- “Discovery Time”: The interval from injury to discovery of the injury;
- “System Access Time”: The interval from discovery to call received;
- “911 Time”: The interval from call received to dispatch notified, including the time it takes the call answerer to:
  - Process the call, including citizen interview; and
  - Give the information to the dispatcher;
- **“Dispatch Time”: The interval from the call received by the dispatcher to agency notification;**
- “Activation Time”: The interval from agency notification to start of response;
- “Enroute Time”: The interval from the end of activation time to the beginning of on-scene time;
- “Patient access time”: The interval from the end of enroute time to the beginning of patient care;
- “On Scene Time”: The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
- “Transport Time”: The interval from leaving the scene to arrival at the health care facility.

## V. QUALITY IMPROVEMENT:

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

Adopted by Regional Council	6/12/96
Approved DOH	7/16/96
Implemented	7/31/96
Reviewed ER Prehospital & Transportation Committee	11/11/98 1/13/99
Adopted by Regional Council	2/10/99
Final Review PH Committee	5/17/00
Adopted DOH	5/17/00
Implemented	6/00
Reviewed ER Prehospital & Transportation Committee	2/02 3/02 4/02
Adopted Regional Council	4/02
Submitted to DOH for Approval	8/21/02
DOH Approved	10/28/02
Reviewed by PH	3/10/04
Reviewed by PH	4/14/04

Adopted Regional Council	4/14/04
Approved DOH	2/2005
Implemented by Regional Council	3/2005
Reviewed by PH	11/9/05

**EAST REGION PATIENT CARE PROCEDURE #3  
TRAUMA TRIAGE AND TRANSPORT**

**I. STANDARD:**

*All verified ambulance and verified aid services shall respond to trauma incidents in a timely manner in accordance with current WAC.*

**II. PURPOSE:**

1. To provide trauma patients with appropriate and timely care.
2. To establish a baseline for data requirements needed for System Quality Improvement.

**III. PROCEDURES:**

1. The Regional Council shall work with all prehospital providers and Local Councils to identify response areas as urban, suburban, and rural or wilderness.
2. Verified ambulance and verified aid services shall collect and submit documentation to ensure the following response times are met 80% of the time; as defined in the current WAC.

<u>Aid Vehicle</u>		<u>Ambulance</u>	
Urban	8 minutes	Urban	10 minutes
Suburban	15 minutes	Suburban	20 minutes
Rural	45 minutes	Rural	45 minutes
Wilderness	ASAP	Wilderness	ASAP

3. Verified ambulance and verified aid services shall collect and submit documentation to show wilderness response times are “as soon as possible.”

**IV. DEFINITIONS:**

1. **URBAN:** An unincorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 and a population density over 2,000 per square mile.
  2. **SUBURBAN:** An incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.
  3. **RURAL:** Incorporated or unincorporated areas with total populations less than 10,000, or with a population density of less than 1,000 per square mile.
  4. **WILDERNESS:** Any rural area not readily accessible by public or private road.
- “System Response Time” for trauma means the interval from discovery of an injury until the patient arrives at the designated trauma facility. It includes:

## EAST REGION PATIENT CARE PROCEDURE #3 TRAUMA TRIAGE AND TRANSPORT

- “Discovery Time”: The interval from injury to discovery of the injury;
- “System Access Time”: The interval from discovery to call received;
- “911 Time”: The interval from call received to dispatch notified, including the time it takes the call answerer to:
  - Process the call, including citizen interview; and
  - Give the information to the dispatcher;
  - “Dispatch Time”: The interval from the call received by the dispatcher to agency notification;
  - “Activation Time”: The interval from agency notification to start of response;
  - “Enroute Time”: The interval from the end of activation time to the beginning of on-scene time;
  - “Patient access time”: The interval from the end of enroute time to the beginning of patient care;
  - “On Scene Time”: The interval from arrival at the scene to departure from the scene. This includes extrication, resuscitation, treatment, and loading;
  - “Transport Time”: The interval from leaving the scene to arrival at the health care facility.

### V. QUALITY IMPROVEMENT:

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

Adopted by Regional Council	6/12/96
Approved DOH	7/16/96
Implemented	7/31/96
Revised ER Prehospital & Transportation Committee	10/14/98
Adopted by Regional Council	12/16/98
Approved by DOH	3/17/00
Implemented	6/00
Reviewed by ER Prehospital & Transportation Committee	1/02 3/11/02 4/10/02
Adopted by Regional Council	4/02
Submitted to DOH for Approval	8/21/02
DOH Approved	10/28/02
Reviewed by PH	11.9.05

## **EAST REGION PATIENT CARE PROCEDURE #3 TRAUMA TRIAGE AND TRANSPORT**

### **I. STANDARD:**

1. *All verified ambulance verified aid services and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in the current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility*
2. *All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 if beyond the 30 minutes transport time to a designated facility OR if transport time to the appropriate facility may be reduced by more than 15 minutes.*
3. *Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.*

### **II. PURPOSE:**

1. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedure.
2. To ensure that all emergency medical and/or trauma patients are transported to the most appropriate designated facility in accordance with the current WAC.
3. To allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.

### **III. PROCEDURES:**

1. The first certified EMS/TC provider determines that a patient:
  - a. Needs definitive trauma care
  - b. Meets the trauma triage criteria
  - c. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure).
  - d. Determine if patients meet all hazards (procedure #8) criteria
2. The provider then proceeds with primary resuscitation for the patient.
3. The provider then determines what step in the Prehospital Triage Procedure that the patient's condition/injuries meet; determination of destination is made based upon the step identified and the following:
  - a. For patient meets Step 1 or Step 2 Criteria:
    1. Take the patient to the highest-level trauma center within 30 minutes transport time via ground or air transport according to

### **EAST REGION PATIENT CARE PROCEDURE #3 TRAUMA TRIAGE AND TRANSPORT**

2. DOH approved Regional Patient Care Procedures.  
Apply “Trauma ID Band” to the patient.
- b. Patient meets Step 3 Criteria:
  1. Take the patient to the nearest designated facility. (No change)
  2. Consult county procedure, IF:
    - (a) The patient requests to bypass the nearest facility\*
    - (b) EMS personnel judgment suggests that the patient be taken to a higher-level facility\*
  3. Apply “Trauma ID Band” to the patient.
4. On-line medical control for all counties shall be accessed per County Operating Procedures (COPs)
5. Communication will be initiated with the receiving facility as soon as possible to allow the receiving facility adequate time to activate their emergency medical and/or trauma response team.
6. *The receiving facility will notify the verified ambulance service about diversion according to COPs.*
7. Medical control and/or the receiving facility will be provided with the following information, as outlined in the Prehospital Destination Tool:
  - a. Identification of EMS agency
  - b. Vital signs. (Include First and/or Worst)
  - c. Level of consciousness
  - d. Anatomy of injury
  - e. Biomechanics of injury
  - f. Any co-morbid factors
  - g. Timely updates on patient status
8. The first EMS provider to determine that a patient meets the trauma triage criteria will attach a Washington State Trauma Registry Band to the patient’s wrist or ankle.
9. All information shall be documented on an appropriate medical incident report (MIR) form accepted by the County MPD, which meets trauma registry data collection requirements as outlined in WAC.

#### **IV. QUALITY IMPROVEMENT:**

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

**EAST REGION PATIENT CARE PROCEDURE #3  
TRAUMA TRIAGE AND TRANSPORT**

Adopted Regional Council	6/12/96
Approved DOH	7/16/96
Implemented	7/31/96
Revised ER Prehospital & Transportation Committee	10/14/98
Adopted by Regional Council	12/16/98
Final Review PH	5/17/00
Approved DOH	3/17/00
Implemented	6/00
Reviewed ER Prehospital & Transportation Committee	1/02 3/11/02 4/10/02
Submitted to DOH for Approval	8/21/02
DOH Approved	10/28/02
Reviewed by PH Committee	11.05
Recommended by Regional Council	11.05
Posted on the EREMSTCC Website	9.29.06
Submitted to the DOH for approval	10.4.06
Approved by Steering Committee	3/21/07

Approved

**PATIENT CARE PROCEDURE #3A  
 TRIAGE & TRANSPORT FOR  
 MEDICAL & NON-MAJOR TRAUMA PATIENTS**

**I. STANDARD**

*All licensed ambulance services shall transport patients to the most appropriate facility in accordance with County Operating Procedures (COPs).*

**II. PURPOSE**

1. To implement regional policies and procedures for all **medical and non-major trauma patients who do not meet the criteria for trauma system activation** as described in the Washington Prehospital Trauma Triage Tool.
2. To ensure that all medical and/or non-major trauma patients are transported to the most appropriate facility.

**III. PROCEDURES**

1. **Patients not meeting prehospital trauma triage criteria for activation of the trauma system, and all other patients will be transported to facilities based on County Operating Procedures (COPs).**

**IV. QUALITY IMPROVEMENT:**

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

Adopted Regional Council	6/12/96
Approved DOH	7/16/98
Implemented	7/31/96
Revised by ER Prehospital & Transportation Committee	10/14/98
Adopted by Regional Council	12/16/98
Final Review PH	5/17/00
Approved DOH	3/17/00
Implemented	4/01/00
Reviewed & revised ER Prehospital & Transportation Committee	3/11/02
Adopted by Regional Council	4/10/02
Submitted to DOH for Approval	8/21/02
DOH Approved	10/28/02
Reviewed by PH Committee	11.05

## **EAST REGION PATIENT CARE PROCEDURE #3B**

### ***PEDIATRIC TRAUMA TRIAGE & TRANSPORT***

#### **I. STANDARD**

1. *All verified ambulance, verified aid services, and affiliated agencies shall comply with the Washington Prehospital Trauma Triage Procedures as defined in current WAC. All verified ambulance services shall transport patients to the most appropriate designated facility.*
2. *All verified ambulance and verified aid services shall consider activating ALS rendezvous or helicopter response - Patient Care Procedure #7 - if beyond the 30-minute transport time to a designated facility OR if transport time to the appropriate facility may be reduced by more than 15 minutes.*
3. *Each trauma-designated facility will determine when it is appropriate to alert verified ambulance services to divert to another trauma designated facility.*

#### **II. PURPOSE**

1. To ensure that consideration is given to early transport of a child to the regional pediatric trauma center(s) when required surgical or medical subspecialty care of resources are unavailable.

#### **III. PROCEDURES**

1. The first certified EMS/TC provider determines that a pediatric patient:
  - A. Needs definitive trauma care
  - B. Meets the trauma triage criteria
  - C. Presents the factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure
  - D. Determine if patient meets Patient Care Procedure #8 for All Hazards Mass Casualty
2. The provider then proceeds with airway management and primary resuscitation for the pediatric patient.
3. Apply "Trauma ID Band" to the patient.
4. Take the pediatric patient to the highest-level pediatric trauma center within 30 minutes transport time via ground or air transport according to DOH approved regional patient care procedures and approved County Operating Procedures (COPs).
5. If a pediatric designated facility is not available within 30 minutes, take the patient to the highest adult designated facility within 30 minutes.

**IV. QUALITY IMPROVEMENT:**

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

Adopted Regional Council	6/12/96
Approved DOH	7/16/96
Implemented	7/31/96
Revised by ER Prehospital & Transportation Committee	10/14/98
Adopted by Regional Council	12/16/98
Final Review PH	5/17/00
Approved DOH	3/17/00
Reviewed, revised and accepted by ER Prehospital & Transportation Committee	4/10/02 5/8/02
Adopted by Regional Council	6/12/02
Submitted to DOH for Approval	8/21/02
DOH Approved	10/28/02
Reviewed by PH Committee	11.05
Recommended by Regional Council	11.05
Posted on East Region website	9.26.06
Submitted to DOH for approval	10.4.06
Approved by Steering Committee	3.21.07

**EAST REGION EMS/TC COUNCIL  
REGIONAL PATIENT CARE PROCEDURE #4  
INTERFACILITY TRANSFER OF PATIENTS**

**I. STANDARD**

1. All interfacility transfers via ground or air shall be provided by the appropriate licensed and/or verified services with personnel and equipment to meet patient needs.
2. Immediately upon determination that the patient's needs exceed the scope of practice and/or their Medical Program Director (MPD) approved protocols, or physician standing orders for non-EMS personnel, the licensed and/or verified service personnel shall advise the facility personnel that they do not have the resources to do the transfer.

**II. PURPOSE**

Provide a procedure that will facilitate the goal of transferring high-risk trauma and medical patients.

**III. PROCEDURES**

1. Medical responsibility during transport should be arranged at the time of initial contact between receiving and referring physicians. The transferring physician should write the transfer orders after consultation with the receiving physician. Facilities having transfer agreements for trauma patients are attached as a reference.
2. Prehospital MPD protocols shall be followed prior to and during transport.
3. While en-route, the transporting agency should communicate patient status and their estimated time of arrival (ETA) to the receiving facility per Medical Program Director (MPD) approved protocols or physician standing orders for non-EMS personnel.

**IV. DEFINITIONS**

- **Scope of Practice:** Patient care within the scope of approved level of certification and/or specialized training.
- **Facilities** are DOH designated trauma care services and licensed acute care hospitals.
- **Non-EMS Personnel:** Licensed Health Care Professionals including Physicians, Physicians Assistants, Registered Nurses, and Advanced Registered Nurse Practitioners.

**V. QUALITY ASSURANCE**

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

Approved Department of Health (DOH)	7/16/96
Implemented by Regional Council	7/31/96
Reviewed East Region Prehospital & Transportation Committee (PH)	11/11/98 1/13/99
Final Review PH	3/10/99
Final Revision	5/12/99 9/8/99
Adopted by Regional Council	10/99
Final Review PH	5/17/00
Approved DOH	3/17/00
Implementation by Regional Council	6/00
Reviewed, revised and accepted PH	4/10/02 5/8/02
Adopted by Regional Council	6/12/02
Submitted to DOH	6/02
Revised by PH	6/03
Adopted by Regional Council	6/03
Approved DOH	2/2005
Reviewed by PH	11/05
Reviewed and revised PH	10/07
Revised by PH	4/08
Reviewed and accepted PH	5/08
Reviewed and accepted Chairs & Executive Committee	5/08
Reviewed & approved by Regional Council	6/11/08
Approved by EMS Steering Committee & DOH	7/08

**PATIENT CARE PROCEDURE #5  
MEDICAL GROUP SUPERVISOR AT THE SCENE**

**I. STANDARD:**

1. *The Incident Command System and National Incident Management System shall be used.*

**II. PURPOSE:**

1. To define who has overall patient care responsibility at the EMS scene, and to define the line of authority when multiple agencies respond.

**III. PROCEDURE:**

1. An incident commander will designate those ICS positions as necessary. When no other incident commander has been appointed the highest medical person shall be in command until a person of equal or greater training relieves him/her. EMS personnel shall direct patient care per County Operating Procedures (COPs) and Medical Program Director protocols.
2. The Medical Group Supervisor should be the individual with the highest level of medical certification who is empowered by County Operating Procedures (COPs).
3. Diversion from this PCP shall be reviewed by responding agencies, and then reported to the county MPD in the jurisdiction of the incident.

**IV. QUALITY IMPROVEMENT:**

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

Adopted by Regional Council	6/12/96
Approved by DOH	7/96
Implemented	7/31/96
Reviewed by ER Prehospital & Transportation Committee	11/98
Adopted by Regional Council	2/99
Final Review PH	5/17/00
Approved DOH	5/17/00
Implemented	6/00
Reviewed by ER Prehospital & Transportation Committee	5/8/02
Adopted by RC	6/12/02
Submitted to DOH for Approval	8/21/02
DOH Approved	10/28/02
Reviewed by ER Prehospital &	4/14/04

Transportation Committee	
Adopted by RC	4/14/04
Submitted to DOH	9/04
DOH Approved	2/2005
Implemented	3/2005
Reviewed by PH	11/9/05
Recommended by Chairs & Exec.	11/09/05
Posted on East Region website	9/06
Submitted to DOH for approval	10/04/06
Approved by Steering Committee	3.212007

**PATIENT CARE PROCEDURE #6**  
**EMS/MEDICAL CONTROL – COMMUNICATIONS**

**I. STANDARD:**

1. *Communications between prehospital personnel and receiving facilities will utilize the most effective communications to expedite patient information exchange.*

**II. PURPOSE:**

1. To define methods of expedient communications between prehospital personnel and receiving facilities.

**III. PROCEDURE:**

1. The preferred communications method should be direct between an EMS prehospital provider and the facility. An alternative method of communications should be addressed in County Operating Procedures.
2. Local Medical Program Director, county councils and communications centers will be responsible for establishing communications procedures between the prehospital provider(s) and the facility (ies).
3. The provider agencies will maintain communications equipment and training needed to communicate in accordance with WAC.
4. Problems with communications affecting patient care will be reviewed by the provider agency, county council, MPD, communications center, and if necessary report to the Regional Communications Committee for review.
5. **All patient information communicated between agencies shall be in compliance with current HIPAA standards.**

**DEFINITION**

**V. QUALITY IMPROVEMENT:**

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

Adopted Regional Council	6/12/96
Approved DOH	7/16/96
Implemented	7/31/96
Reviewed ER Prehospital & Transportation Committee	1/13/99 2/10/99 3/10/99
Final Review PH	9/8/99
Adopted Regional Council	10/13/99
Approved DOH	5/17/00
Implemented	6/00
Reviewed ER Prehospital & Transportation Committee	5/8/02
Adopted by Regional Council	8/21/02
Approved by DOH	10/28/02
Reviewed by PH	3/10/04
Adopted Regional Council	4/14/04
Approved DOH	2/2005
Implemented	3/2005
Reviewed by PH	11.9.05
Reviewed by Chairs & Exec.	11.9.05
Posted on East Region website	9/06
Submitted to DOH for approval	10.04.06
Approved by Steering Committee	3.21.2007

**EAST REGION EMS/TC COUNCIL  
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE  
Mass Casualty Incident (MCI)**

**REGIONAL PATIENT CARE PROCEDURE #7  
HELICOPTER RESPONSE**

***Standard:***

1. *Initiate a helicopter response as soon as medically necessary.*
2. *Helicopter transport should be considered when transport time to the appropriate facility may be reduced by more than 15 minutes.*
3. *The highest level of pre-hospital EMS provider on scene may cancel the helicopter response if they determine the patient condition does not warrant air transport.*

Note: County Operating Procedures (COPS) may be added as an addendum to DOH approved PCPS to clarify implementation and operation within each county.

***Purpose:***

1. To define who may initiate the request for an on-scene medical helicopter and under what circumstances non-medical personnel may request on-scene helicopter service.

***Procedure:***

1. The highest level of pre-hospital personnel on scene may request a helicopter be placed on standby or that a helicopter(s) be launched to the scene per COPS.

**Note: If the request is to place a helicopter on standby, this helicopter and crew will remain dedicated to the standby until released by the requesting agency.**

2. This call shall be initiated through the appropriate medical emergency-dispatching agency per COPS. If possible, landing zone (LZ) or rendezvous sites, and/or LZ hazard assessments, should be identified at this time.
3. The helicopter service communications staff will give an approximate launch time and flight time to the dispatchers requesting service.
4. Helicopter personnel will contact ground EMS personnel as soon as possible while en-route to the scene.
5. Any citizen on scene may request a helicopter be launched to the scene. If a citizen requests a launch, the dispatching service receiving the helicopter request will assure that local EMS is dispatched to the scene at the same time.

**EAST REGION EMS/TC COUNCIL**  
**ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE**  
**Mass Casualty Incident (MCI)**

6. After assessing the patient, if the highest level EMS personnel on scene determines that the patient's condition does not warrant air transport, they may cancel the responding helicopter and assume responsibility for patient care and transport.
7. Helicopter personnel shall follow the Incident Command System (ICS) and National Incident Management System (NIMS).
8. Helicopter personnel will make radio contact with the receiving hospital as soon as possible after liftoff from the scene.

***Definitions:***

1. **Standby:** Upon receiving the request, helicopter dispatch personnel will notify the pilot and crew of the possible flight. The crew will respond to the helicopter and load appropriate equipment. The crew will then remain at or near the helicopter until such time they are launched or released from the standby.
2. **Launch Time:** The time at which the helicopter lifts from the pad en-route to the scene. Assuming the helicopter has been on standby this will require approximately one to two minutes run-up time. Temperatures below freezing may require a little longer run-up.
3. **Flight time:** The estimated time from launch to the helicopter landing at the scene.
4. **Landing Zone (LZ) Hazard Assessment:** On-scene EMS will identify a helicopter-landing zone as close to the scene as safely possible. Ideally this will be a flat area, a minimum of 75 feet by 75 feet during daylight and 100 feet by 100 feet at night. Personnel designating the LZ must complete a hazard assessment including, but not limited to, overhead wires, rocks, uneven surfaces, loose debris, trees, vehicles, foot traffic, and high winds. Such hazards will be relayed to the pilot as the helicopter approaches the LZ.
5. **Rendezvous:** An alternate site for patient transfer from ground ambulance to air ambulance when terrain, weather, or other restraints hinder the helicopter from landing at the requested scene or hospital. The landing zone hazard assessment shall be completed for the rendezvous LZ as for any other LZ.

***Quality Improvement:***

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

**EAST REGION EMS/TC COUNCIL  
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE  
Mass Casualty Incident (MCI)**

Adopted by Regional Council	6/96
Approved by DOH	7/96
Reviewed by PH & Transportation Committee	5/9/01
Adopted by Regional Council	6/13/01
<b>Approved by DOH</b>	4/1/02
Implemented	5/1/02
Reviewed by PH	3/10/04
Adopted by Regional Council	4/14/04
Approved by DOH	2/2005
Implemented	3/2005
Reviewed by PH	11.9.05
Recommended by Chairs & Exec.	11.9.05
Posted on East Region website	9/06
Submitted to DOH for approval	10.04.06
Approved by Steering Committee	3.21.2007

Approved

**EAST REGION EMS/TC COUNCIL  
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE  
Mass Casualty Incident (MCI)**

**I. STANDARD:** EMS personnel, licensed ambulance and licensed aid services shall respond to a Mass Casualty Incident as identified in this document.

1. All verified ambulance and verified aid services shall respond to an MCI per the county MCI plans.
2. Licensed ambulance and licensed aid services shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and/or in support of verified EMS services.
3. EMS certified first response personnel shall assist during an MCI per county MCI plans when requested by command through dispatch in support of county MCI Plan and /or in support of verified EMS services.
4. Pre-identified patient mass transportation, EMS staff and equipment to support patient care may be used.
5. All EMS agencies working during an MCI event shall operate within the National Incident Management System or the Incident Command System (ICS) as identified in the jurisdiction that has authority, protocol and MCI plan.

**II. PURPOSE:**

1. To develop and communicate the information of regional trauma plan section VII prior to an MCI.
2. To implement county MCI plans during an MCI.
3. **Severe Burns:** *To provide trauma and burn care to at least 50 severely injured adult and pediatric patients per region.*
4. To provide safe mass transportation with pre-identified EMS personnel, equipment, and supplies per the approved County Disaster Plan and/or the Hazardous Mitigation Plan.

**III. PROCEDURES:**

1. Incident Commander (IC) shall follow the county MCI Plan to inform medical control and the disaster medical control hospital when an MCI condition exists. (Refer to county specific Department of Emergency Management Disaster Plan.)
2. Medical Program Directors agree that protocols being used by the responding agency should continue to be used throughout the transport of the patient, whether it is in another county, region or state. This ensures consistent patient care will be

**EAST REGION EMS/TC COUNCIL  
ALL HAZARDS REGIONAL PATIENT CARE PROCEDURE  
Mass Casualty Incident (MCI)**

provided by personnel trained to use specific meds, equipment, procedures, and/or protocols until delivery at the receiving facility has been completed.

3. EMS personnel may use the *Prehospital Mass Casualty Incident (MCI) general Algorithm* during the MCI incident (attached).

**IV. QUALITY IMPROVEMENT:**

The East Region Prehospital & Transportation Committee will review this PCP upon receipt of suggested modifications from a county provider, the East Region QI Committee, the Department of Health, or any other entity suggesting modifications to the document, at least biennially.

Post incident after action review is completed within 30 days. It shall be the responsibility of the agency managing the incident to coordinate the review.

**V. Definitions**

- **CBRNE** - Chemical, Biological, Radiological, Nuclear Explosive
- **County Disaster Plan** –Comprehensive Emergency Management Plan (CEMP)
- **Medical Control:** MPD authority to direct the medical care provided by certified EMS personnel in the prehospital EMS system.

**Routing Box**

Sample Rec'd from Mike Smith, DOH	5/2/05
Emailed to Josie Breshears	5/2/05
Reviewed PH Committee	5/11/05
Reviewed to RAC	5/17/05
Reviewed by PH	6/8/05
Reviewed by PH	7/13/05
Reviewed by PH	8/2/05
Distributed to Regional Council for Review	8/10/05
Distributed to MPDs for Review	9/23/05
Reviewed by PH	11.9.05
Reviewed by Chairs & Exec	11.9.05
Submitted to DOH for approval	11.9.05
Approved EMS & Trauma Steering Committee	11.16.05

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Mass Casualty Incident (MCI)**

**Prehospital Mass Casualty Incident (IC) General Algorithm**

Receive dispatch

Respond as directed

Arrive at scene & Establish Incident Command (IC)

Scene Assessment and size-up

Determine if mass casualty conditions exist

Implement county MCI plan

Request additional resources as needed

The dispatch center shall coordinate notification and dispatch of required agencies and resources including notification of the Regional Disaster Control Hospital (RCH). The Spokane Regional Health District (SRHD) shall be notified in events where a public health threat exists.

Identify hazards and determine needs to control or eliminate them. Take immediate action to isolate and deny access (Site Access Control) or mitigate the hazards as necessary to prevent additional injuries.  
Consider possibility of terrorist attack (WMD, secondary device)

Initiate START

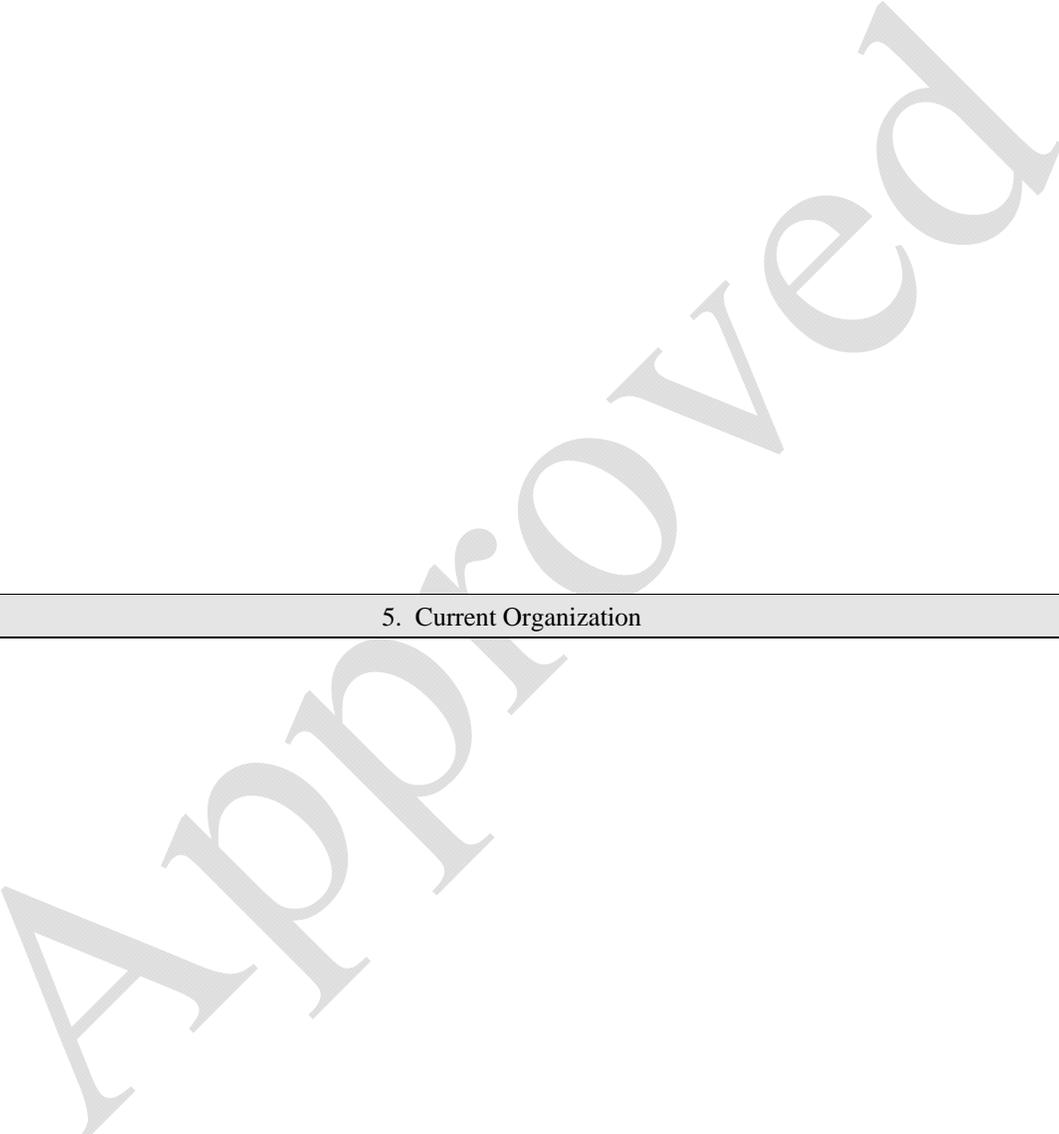
Reaffirm additional resources

Initiate ICS 201 or similar tactical worksheet (See attached)

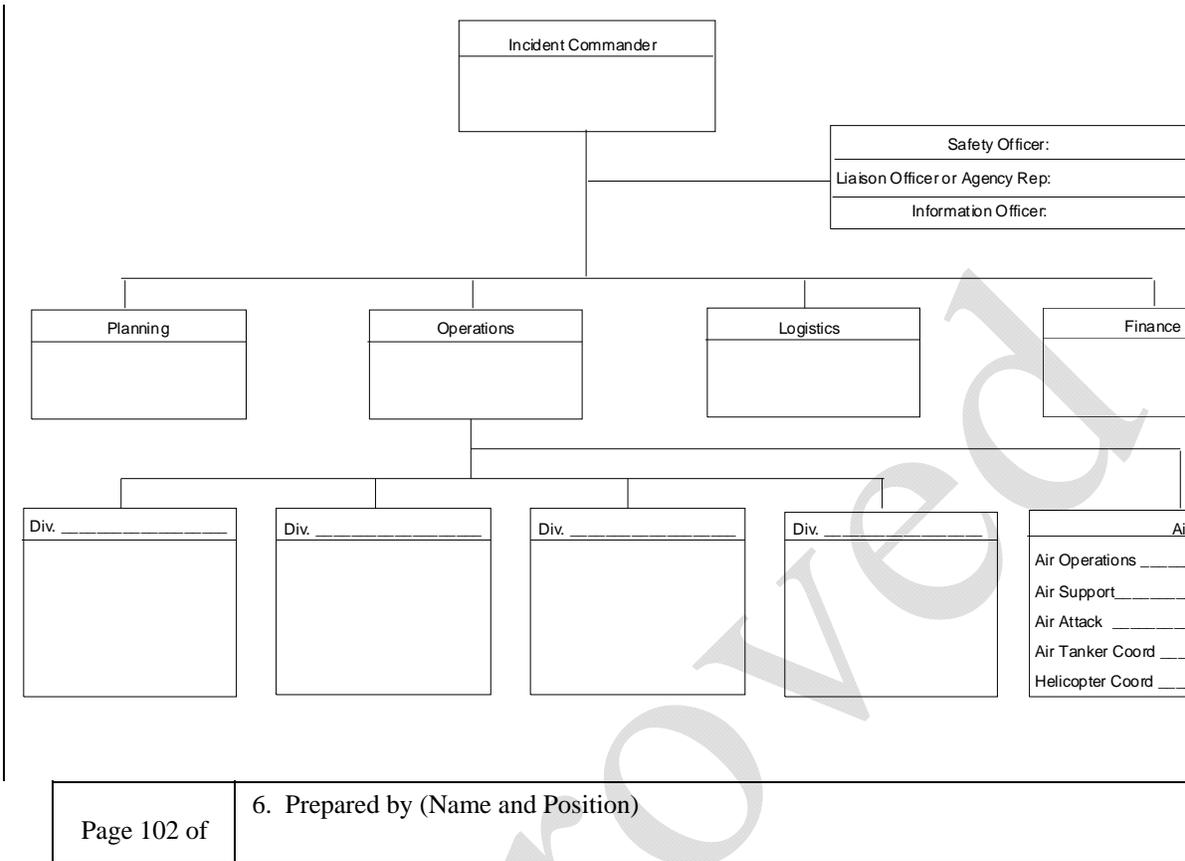
Upon arrival at Medical Center, transfer care of patients to medical centers staff (medical center should activate their respective MCI Plan as necessary.

Prepare transport vehicle to return to service

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Mass Casualty Incident (MCI)**

<b>INCIDENT BRIEFING</b>	1. Incident Name	2. Date	3. Time
4. Map Sketch			
			
5. Current Organization			

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 Mass Casualty Incident (MCI)**



Page 102 of	6. Prepared by (Name and Position)
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**Appendix 5.**  
**July 2009- June 2012 Regional Plan Gantt Chart**

Approved

## APPENDICES - ADDITIONAL

**Appendix A.**

**Appendix B.**

Approved